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How Much Do Marketplace and Other Nongroup Enrollees Spend on Health Care Relative to Their Incomes?

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Timely Analysis of Immediate Health Policy Issues

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In-Brief

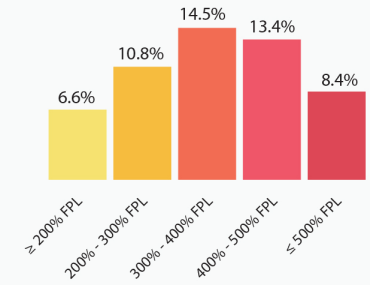
The Affordable Care Act (ACA) improved health insurance affordability for many by expanding Medicaid and providing financial assistance for marketplace-based coverage for those with incomes below 400 percent of the federal poverty level (FPL). Together with new insurance regulations and a requirement for many to enroll in coverage or pay a penalty, these affordability provisions were intended to substantially reduce the number of uninsured. In recent months, however, an increasing number of voices have drawn attention to high deductibles and out-of-pocket costs and the affordability of marketplace insurance in general. While the "right" or "just" level of health care financial burdens is inherently subjective, financial burdens that are high relative to income can lower enrollment levels and compromise the ability of the ACA to reach its goals.

In this paper, we examine premiums and out-of-pocket costs, as well as total financial burdens for individuals with different characteristics enrolled in ACA-compliant nongroup coverage. We show that despite the additional assistance available, individuals across the income distribution who are ineligible for Medicaid can still face very high expenditures. At the median, financial burdens can be reasonably high, particularly for those with incomes between 300 and 400 percent of FPL (Figure 1). As medical care needs increase, however, financial burdens grow appreciably across the income distribution. Even with federal financial assistance, 10 percent of 2016 nongroup marketplace enrollees with incomes below 200 percent of FPL will pay at least 18.5 percent of their income toward premiums and out-of-pocket medical costs. Ten percent of marketplace enrollees with incomes between 200 and 500 percent of FPL will spend more than 21 percent of their income on health care costs. Those in fair or poor health and those over age 45 are most likely to face high median financial burdens. We conclude that the affordability of marketplace premiums and out-of-pocket limits need to be further addressed to reduce the risk that enrollment and reductions in the number of uninsured will be well below the law's objectives.

Household Spending on Premiums & Out-of-Pocket Expenses by Marketplace Enrollees, Relative to Income

People at the median pay more for health care as a percentage of their income than 50 percent of the population

Median



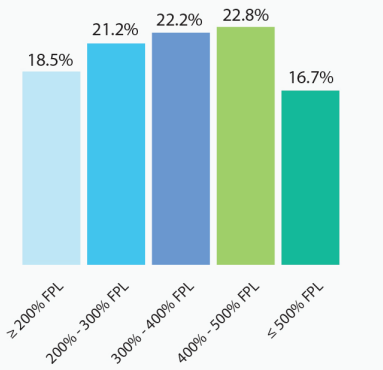
The **percentage** of **non elderly adults** who report **problems paying** their **medical bills** in the previous year **fell** from **22.0 percent** in **2013** to **17.3 percent** in **2015** -- representing a **significant improvement** in **affordability**.[2] Despite this, **affordability remains an issue**.

Federal Poverty Level amounts used for this analysis:

Single person - $11,770
2 person family - $15,930

People in the 90th percentile pay more for health care as a percentage of their income than 90 percent of the population

90th Percentile



Source: *The Urban Institute's Health Insurance Policy Simulation Model (HIPSM), 2015*

Note: *Sample includes those individuals and families with incomes below 400 percent of the FPL enrolling in nongroup marketplace coverage with a premium tax credit and all those with incomes above 400 percent of the FPL buying nongroup coverage either inside or outside the marketplaces in 2016. ACA is simulated as fully phased-in in 2016. Financial burdens are calculated at the family (health insurance unit) level, i.e., family health expenses relative to family income.*

Introduction

Since the implementation of the ACA's coverage reforms, insurance coverage among nonelderly adults has increased by 15 million people, or 42.5 percent (comparing September 2013 with March 2015).[1] During that same period, the share of nonelderly adults who reported having problems paying their medical bills in the previous year fell from 22.0 percent to 17.3 percent.[2] This decrease in financial hardship, a 21 percent decline, represents a significant improvement in affordability. But with over 17 percent of nonelderly adults continuing to report challenges paying their families' medical bills, affordability remains an issue; it is central to concerns that further marketplace enrollment gains will be increasingly difficult.

The ACA has expanded insurance coverage through several mechanisms, chief among them an expansion of Medicaid coverage (taken up in 30 states and Washington, D.C.) and income-related premium tax credits and cost-sharing reductions for the purchase of private nongroup health insurance through health insurance marketplaces. Those eligible for Medicaid have the most affordable insurance available to them, facing no premiums[3] and little or no cost-sharing requirements to impinge their access to services. And although the tax credits and cost-sharing reductions have significantly improved affordable access to care for many, some still face substantial medical financial burdens. While it is impossible to know the "right" amount for people to pay at each income level, we do know that affordability is the most common reason given for those remaining uninsured. It is the most frequent response given by navigators, concerning remaining barriers to enrollment in the ACA's qualified health plans.[4]

Recent reports suggest that many individuals eligible for financial assistance remain uninsured because the cost of available plans is still too high, particularly at income levels where tax credits and cost-sharing reductions are phased out. Buettgens, Kenney, and Pan find that take-up rates among the tax credit–eligible population decline sharply with income.[5] Nationally, plan selection rates in 2015 among states whose marketplaces used HealthCare.gov averaged 62 percent of eligible individuals with incomes below 200 percent of FPL, 29 percent of those eligible with incomes between 200 and 300 percent of FPL, and 13 percent of those eligible with incomes between 300 and 400 percent of FPL. Thus, as financial assistance falls and income increases, the share of eligible individuals enrolling in coverage drops precipitously.

This analysis assesses (1) the health care financial burdens facing the modest-income population enrolling in marketplace coverage using federal financial assistance (those with incomes below 400 percent of FPL) as well as (2) the health care financial burdens facing higher-income individuals and families who are purchasing qualified health plans in the nongroup market entirely with their own funds. We define health care financial burdens in this analysis as direct household payments for premiums and out-of-pocket requirements for the family (e.g., deductibles, co-payments, coinsurance) relative to family income.[6] We provide financial burdens at the median and at the 90th percentile for those enrolled in nongroup insurance plans with tax credits and for those with higher family incomes (above 400 percent of FPL) in the nongroup market both inside and outside the marketplaces. We simulate the ACA as if it were fully phased-in in 2016.

What Financial Assistance Is Currently Available for the Purchase of Marketplace-Based Coverage?

To assess the health care financial burdens of those enrolling in marketplace-based coverage, we must take the available financial assistance into account. Those eligible for financial assistance through the ACA's nongroup marketplaces have the following characteristics:

- They have incomes below 400 percent of FPL but are not eligible for Medicaid or Medicare. In states that have expanded Medicaid, those with incomes between 138 and 400 percent of FPL are potentially eligible for tax credits; in states that have not expanded Medicaid, those with incomes between 100 and 400 percent of FPL are potentially eligible.[7]
- They do not have access to an employer-sponsored insurance offer (either through their own employer or a family member's) that the law deems adequate and affordable.
- They are legal residents.

Those who meet such criteria are eligible for advanced premium tax credits, and those below 250 percent of FPL are also eligible for cost-sharing reductions. The premium and cost-sharing financial assistance at each income level are summarized in Table 1. Those with family income below 138 percent of FPL are required to pay no more than 2.03 percent of income in 2016 toward the premium for the second-lowest-cost silver plan available to them in their marketplace.[8] The maximum required contribution increases rapidly as the percentage of income relative to FPL rises, increasing to 6.41 percent of family income at 200 percent of FPL. Maximum premium contributions increase to 8.18 percent of income at 250 percent of FPL and 9.66 percent of income at 300 percent of FPL. Those between 300 and 400 percent of FPL pay a maximum of 9.66 percent of family income for the second-lowest-cost silver plan available to them. Those who pick a less expensive plan pay less; those who pick a more expensive plan pay more. The caps on percentage of income consumers pay increase each year if medical costs grow faster than the consumer price index. Those with incomes above 400 percent of FPL receive no premium assistance for marketplace coverage.

Cost-sharing reductions (CSRs) are also available for those receiving premium tax credits who have incomes below 250 percent of FPL. To receive a CSR, eligible individuals must purchase a

Table 1. Premium Tax Credit Caps as a Percentage of Income and Cost-Sharing Reductions Under the ACA, 2016

Income Relative to Federal Poverty Level (% of FPL)	Premium Tax Credit Schedule: Household Premium as Percentage of Income for the Applicable Income Category[a]	Cost-Sharing Reduction Schedule: Actuarial Value Level of Plan Provided to Eligibles Enrolling in Silver Level of Coverage (70 % AV)
≤ 100 - 138	2.03	94
138 - 150	3.05 - 4.07	94
150 - 200	4.07 - 6.41	87
200 - 250	6.41 - 8.18	73
250 - 300	8.18 - 9.66	70
300 - 400	9.66	70
400 and higher	NA	70

Source: https://www.irs.gov/pub/irs-drop/rp-14-62.pdf.

Notes: ACA = Affordable Care Act; AV = actuarial value; FPL = federal poverty level; n.a. = not applicable

[a] Premium tax credit amounts are set to limit household premium contirbutions for the second lowest cost silver premium available to the given percentage of income. If enrollees choose a more expensive plan, they pay more; if they choose a less expensive plan, they pay less.

silver-tier marketplace plan (those with actuarial value [AV] of 70 percent; that is, plans that reimburse an average of 70 percent of the costs of covered benefits across an average population). The CSRs increase the AV of a silver plan to 94 percent for those with incomes up to 150 percent of FPL, to 87 percent for those with incomes between 150 and 200 percent of FPL, and to 73 percent for those with incomes between 200 and 250 percent of FPL. The cost-sharing requirements across silver plans vary, but without CSRs the median deductible is $3,600 for single coverage in 2016 and $7,600 for family coverage.[9] The median silver plan's out-of-pocket maximum is $6,500 for single policies and $13,000 for family policies. The limits under the ACA for out-of-pocket maximums for those not eligible for cost sharing reductions are $6,850 for single policies and $13,700 for family policies. Thus, both premiums and out-of-pocket costs can be high relative to income, particularly for those above 200 percent of FPL, who are not eligible for any significant CSRs.

What We Did

We estimate the health care financial burdens of those enrolled in nongroup marketplace coverage with marketplace financial assistance and of those with higher incomes who are enrolled in ACA-compliant nongroup coverage either inside or outside of the marketplace. The analysis does not include those in Medicaid or Medicare, those who have employer-sponsored insurance or those who remain uninsured. We use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM).[10] Health care financial burdens for those eligible for tax credits are simulated here as if they were enrolled in silver marketplace plans. This approach allows us to assess financial burdens without the added complexity of adjusting for how the population is distributed across different AV plans. Silver plans are the most frequently chosen among those eligible for financial assistance. In addition, individuals choosing a bronze, gold, or platinum plan are not eligible for CSRs even if their incomes are below 250 percent of FPL. Those with incomes above 400 percent of FPL are assumed to predominantly choose silver plans, but some also choose bronze, gold, or platinum. We then estimate total health expenditures for each individual enrolled in an ACA-compliant plan. These expenditures are based upon their previous spending levels and previous health insurance status (comprising health status, out-of-pocket spending requirements, income, education, and other factors) adjusted to take into account changes in utilization resulting from enrollment in qualified health plans. The individuals' direct expenditures depend on their eligibility for premium tax credits and CSRs, the premiums available to them, and their simulated health care needs (premiums for qualified health plans are benchmarked to national average reference premiums). We then calculate the median and 90th percentile of the distribution of direct household spending relative to income separately for premiums, out-of-pocket expenses, and total financial burdens, accounting for available financial assistance.

Results

In this section we provide data on how much individuals receiving financial assistance pay for marketplace nongroup coverage and how much higher-income individuals ineligible for assistance pay for nongroup coverage inside or outside the marketplaces relative to income at both the median and 90th percentile. We include both household contributions toward premiums and payments for out-of-pocket costs. Table 2 shows premiums and out-of-pocket payment burdens by income level. Premium contributions relative to income increase as income increases and tax credits phase down. The median financial burden for individuals below 200 percent of FPL is 4.4 percent of income devoted to health insurance premiums. The median financial burden for persons with incomes between 300 and 400 percent of FPL is 9.6 percent of their income for premiums. Premiums as a share of income then decline as income increases beyond the CSR eligibility levels. Out-of-pocket payments change similarly: they increase as a share of income as CSRs phase down, and they fall as a percentage of income as incomes increase. For those with incomes below 200 percent of FPL who do not have high medical care needs (most of that demographic), financial burdens are well-contained because of

Table 2. Health Care Financial Burdens for Nongroup Enrollees Under the ACA, by Income, 2016 (Direct Household Payments for Premiums and Out-of-Pocket Expenses Relative to Income)

	Median			90th Percentile		
Income relative to FPL	Premium contribution	Out-of-pocket payments	Total	Premium contribution	Out-of-pocket payments	Total
Less than 200% of FPL	4.4%	2.3%	6.6%	6.1%	13.9%	18.5%
200% to 300% of FPL	7.7%	2.8%	10.8%	9.2%	13.6%	21.2%
300% to 400% of FPL	9.6%	4.9%	14.5%	9.6%	12.6%	22.2%
400% to 500% of FPL	9.2%	3.4%	13.4%	15.6%	10.4%	22.8%
Over 500% of FPL	5.8%	2.1%	8.4%	11.3%	6.8%	16.7%

Source: The Urban Institute's Health Insurance Policy Simulation Model (HIPSM), 2015.

Notes: FPL = the federal poverty level. Sample includes those individuals and families with incomes below 400 percent of FPL enrolling in nongroup marketplace coverage with a premium tax credit and those with incomes above 400 percent of FPL buying nongroup coverage either inside or outside the marketplaces in 2016. The Affordable Care Act is simulated as fully phased in in 2016. Calculations are family health expenses relative to family income. Component percentages do not sum to the total because median and 90th percentile values are computed separately for premium contributions, out-of-pocket payments, and total household spending.

the combination of generous premium tax credits and substantial CSRs. But for those with incomes between 300 and 500 percent of FPL, median financial burdens range from 13.4 percent to 14.5 percent.

At the 90th percentile, financial burdens are dramatically higher, even for the lowest-income population. Although those with incomes below 400 percent of FPL have their premium contributions capped as a percentage of income, the premium caps vary for individuals of different incomes within each income category, and these differences are reflected in the different financial burdens between the median and 90th percentile. As discussed, premium contributions relative to income increase as income increases and as premium tax credits phase down. For those with incomes above 400 percent of FPL there are no income-related caps on premiums. Those at the 90th percentile of financial burdens with incomes from 400 percent to 500 percent of FPL pay 15.6 percent of their income toward their premiums. The difference in premium contributions relative to income at the 90th percentile compared with the median reflects the fact that age rating allows higher premiums to be charged to older adults for the same coverage. In addition, even if they are the same age and face the same premium, individuals at the lower end of that income range have to devote a higher percentage of their income to purchase that coverage than do individuals at the higher end of that income range. At the 90th percentile, out-of-pocket expenses consume over 13 percent of income for those with incomes below 300 percent of FPL; the out-of-pocket financial burdens decline as income increases (though they remain high). Out-of–pocket financial burdens at the high end of the distribution are surprisingly high for those with incomes below 200 percent of FPL given the significant CSRs, but these burdens largely reflect their very low incomes. CSRs are extremely modest, however, for those with incomes between 200 percent and 250 percent of FPL, and there are none for those with higher incomes.

The total financial burdens at the 90th percentile are very high for all income groups. The combination of high premium contributions relative to income and high out-of-pocket costs for those with significant health care needs leads to individuals at those income levels paying 16.7 percent to 22.8 percent of income for their medical care. Thus, even with all of the ACA's financial protections, individuals across the income distribution who are ineligible for Medicaid can still face very high expenditures.

Table 3 provides data on health care financial burdens by health status. At the median, premiums account for about 6 percent of income and do not vary noticeably with health status. However, out-of-pocket financial burdens do increase as health status worsens, even at the median. Median financial burdens for premiums and out-of-pocket costs combined rise from 8.7 percent of income for those in excellent health to 11.4 percent for those in fair or poor health. At the 90th percentile, financial burdens increase with health status because of rising out-of-pocket costs. For those in excellent health, out-of-pocket costs at the 90th percentile consume 9.2 percent of income; for those in fair or poor health, out-of-pocket costs at the 90th percentile consume about 14.9 percent of income. Total burdens at the 90th percentile are 18.1 percent of income and 19.5 percent of income for those in excellent and very good health, respectively. For those in fair or poor health, total burdens amount to 23.2 percent of income. Again, burdens for the sickest are high despite the ACA's financial protections.

In Table 4 we examine the distribution of financial burdens by age group. We limit this analysis to singles and couples without children in order to avoid the complexities of premiums that vary because of different numbers of children in the family Expenditures for singles

Table 3. Health Care Financial Burdens for Nongroup Enrollees Under the ACA, by Health Status, 2016 (Direct Household Payments for Premiums and Out-of-Pocket Expenses Relative to Income)

	Median			90th Percentile		
	Premium contribution	Out-of-pocket payments	Total	Premium contribution	Out-of-pocket payments	Total
Excellent	6.3%	1.8%	8.7%	9.6%	9.2%	18.1%
Very good	6.2%	2.5%	9.3%	9.6%	10.6%	19.5%
Good	6.5%	3.1%	10.2%	9.6%	12.7%	21.5%
Fair to poor	6.1%	4.4%	11.4%	9.6%	14.9%	23.2%

Source: The Urban Institute's Health Insurance Policy Simulation Model (HIPSM), 2015.

Notes: FPL = the federal poverty level. Sample includes those individuals and families with incomes below 400 percent of FPL enrolling in nongroup marketplace coverage with a premium tax credit and those with incomes above 400 percent of FPL buying nongroup coverage either inside or outside the marketplaces in 2016. The Affordable Care Act is simulated as fully phased in in 2016. Calculations are family health expenses relative to family income. Component percentages do not sum to the total because median and 90th percentile values are computed separately for premium contributions, out-of-pocket payments, and total household spending.

Table 4. Health Care Financial Burdens for Nongroup Enrollees Under the ACA, by Age Group, Singles and Couples Without Children, 2016 (Direct Household Payments for Premiums and Out-of-Pocket Expenses Relative to Income)

	Median			90th Percentile		
Age	Premium contribution	Out-of-pocket payments	Total	Premium contribution	Out-of-pocket payments	Total
18 - 24	4.9%	1.2%	6.7%	7.8%	7.3%	12.7%
25 - 34	5.6%	1.0%	7.2%	8.2%	8.1%	14.8%
35 - 44	5.9%	1.3%	7.8%	9.2%	8.6%	15.7%
45 - 54	6.4%	2.6%	9.6%	9.6%	11.5%	20.1%
55 - 64	7.4%	4.0%	12.0%	12.8%	15.2%	24.5%

Source: The Urban Institute's Health Insurance Policy Simulation Model (HIPSM), 2015.

Notes: FPL = the federal poverty level. Ages are of oldest adult in family without dependents. Sample includes those individuals and families with incomes below 400 percent of FPL enrolling in nongroup marketplace coverage with a premium tax credit and those with incomes above 400 percent of FPL buying nongroup coverage either inside or outside the marketplaces in 2016. The Affordable Care Act is simulated as fully phased in in 2016. Calculations are family health expenses relative to family income. Component percentages do not sum to the total because median and 90th percentile values are computed separately for premium contributions, out-of-pocket payments, and total household spending.

and couples without children provide a clearer idea of spending across ages. For those with median financial burdens, premiums as a percentage of income increase modestly with age, from 4.9 percent for those ages 18 to 24 to 7.4 percent for those ages 55 to 64. The increase reflects the effect of age rating on the population ineligible for tax credits. Premium contributions relative to income also increase by age at the 90th percentile for the same reason. Differences between the 90th percentile and the median reflect both (a) that some individuals are eligible for premium tax credits and others are not, and (b) that even within an age category of those ineligible for credits, older individuals are charged higher premiums than younger individuals (i.e., the premium charged a 24-year-old is higher than that charged an 18 year old). Out-of-pocket financial burdens increase with age because health care utilization increases with age. Younger adults tend to have lower incomes than older adults, and therefore they more frequently benefit from financial assistance. The increase in out-of-pocket costs is particularly striking at the 90th percentile, at which point spending as a share of income increases from 7.3 percent of income for those ages 18 to 24, to 11.5 percent of income for those ages 45 to 54, and to 15.2 percent of income for those ages 55 to 64.

Because of the increase in both premiums and out-of-pocket costs across ages, total financial burdens for those with median expenditures increase from 6.7 percent of income for those ages 18 to 24 to 12.0 percent of income for those ages 55 to 64. At the 90th percentile, total financial burdens increase from 12.7 percent of income for those ages 18 to 24, to 20.1 percent of income for those ages 45 to 54, and to 24.5 percent of income for those ages 55 to 64. Thus, the combination of premium age rating and higher out-of-pocket costs as health utilization increases with age leads to particularly high financial burdens for those over age 45.

Conclusion

In this paper we have shown that, for those enrolling in marketplace coverage using federal financial assistance, at both the median and the 90th percentile, premium payments relative to income increase as household incomes increase and the ACA's premium tax credits phase down. Premium payments then decline as incomes increase further and individuals are ineligible for financial assistance. Premium contributions relative to incomes also increase with age but do not vary with health status. However, financial burdens related to out-of-pocket expenses increase with worsening health status and for older individuals. Out-of-pocket expenses increase with incomes up to a point because cost-sharing assistance decreases, eventually disappearing for those with incomes above 250 percent of FPL. Ultimately, financial burdens are high for many individuals, particularly those with substantial health care needs. For those at the median, expenditures are over 10 percent of income for those with incomes between 200 percent and 500 percent of FPL. Expenditures are also over 10 percent of income at the median for those in good, fair, or poor health. Median financial burdens for those aged 45 to 64 are 9.6 percent; they are 12.0 percent for those ages 55 to 64. But financial burdens are extremely high for a significant segment of the population. For those at the 90th percentile, total health care financial burdens are close to or exceed 20 percent of income for those with incomes up to 500 percent of FPL, for those across the health status distribution, and for those ages 45 to 64. Thus, the combination of high premiums for silver plans coupled with high deductibles and high out-of-pocket limits mean that coverage and access to care are difficult for many to afford despite the ACA's substantially increased assistance relative to the previous system. Many who have modest income have high financial burdens even with average medical expenses. But as is well-known, health care utilization is highly skewed: a small share of the population accounts for the bulk of expenditures.[11] For those at the top of the spending distribution, financial burdens are very high.

Under current law, options for improving the affordability of marketplace coverage are limited. Massachusetts and Vermont have supplemented federal financial assistance with their own funds. The ACA also offers a state option for a basic health program (BHP). Minnesota and New York now use a BHP (called MinnesotaCare and the Essential Plan, respectively) to provide coverage to people with incomes up to 200 percent of FPL, offering lower premiums and cost sharing than would be available in the marketplaces. But BHPs have serious problems, for example, they reduce the size of marketplaces and the amount of federal dollars available to them each year is uncertain, rendering state obligations uncertain in turn.

ACA reforms could improve the affordability of marketplace coverage.[12] Linking tax credits to gold plans (those with 80 percent AV), rather than silver plans (those with 70 percent AV), would reduce deductibles and out-of-pocket payments from current levels for tax credit–eligible individuals. Additional targeted assistance could be provided through improved CSRs for low-income marketplace enrollees. Introducing an additional tax credit category that limits the percentage of income that those above 400 percent of FPL would be required to contribute toward marketplace coverage would reduce financial burdens for middle-income older adults, who are most affected by age rating.

The risk of not making coverage more affordable is that more individuals may choose not to purchase coverage, pay the tax penalty instead, and hinder the ACA's ability to achieve and maintain its coverage objectives.

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Linda J. Blumberg is a senior fellow, John Holahan is an Institute fellow, and Matt Buettgens is a senior research associate, all in the Urban Institute's Health Policy Center. The authors appreciate the comments and suggestions of Stephen Zuckerman.

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Notes

1 Long SK, Karpman M, Kenney GM, Zuckerman S, Wissoker D, Shartzer A, Anderson N, and Hempstead K. *Taking Stock: Gains in Health Insurance Coverage under the ACA as of March 2015*. Washington: Urban Institute, 2015. http://hrms.urban.org/briefs/Gains-in-Health-Insurance-Coverage-under-the-ACA-as-of-March-2015.html.

2 Karpman M and Long SK. 9.4 *Million Fewer Families Are Having Problems Paying Medical Bills*. Washington: Urban Institute, 2015. http://hrms.urban.org/briefs/9-4-Million-Fewer-Families-Are-Having-Problems-Paying-Medical-Bills.html.

3 The exception is that some Section 1115 waiver states require some Medicaid enrollees to contribute up to 2 percent of their income toward the cost of coverage.

4 Shartzer A, Kenney GM, Long SK, and Odu Y. *A Look at Remaining Uninsured Adults as of March 2015*. Washington: Urban Institute, 2015. http://hrms.urban.org/briefs/A-Look-at-Remaining-Uninsured-Adults-as-of-March-2015.html; Holahan H, Blumberg LJ, Wengle E, Hill I, Peters R, and Solleveld P. *Factors that Contributed to Low Marketplace Enrollment Rates in Five States in 2015*. Washington: Urban Institute, 2015. http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000488-Factors-That-Contributed-To-Low-Marketplace-Enrollment-In-Five-States-In-2015.pdf.

5 Buettgens M, Kenney GM, and Pan CW. *Variation in Marketplace Enrollment Rates in 2015 by State and Income*. Washington: Urban Institute, 2015. http://www.urban.org/research/publication/variation-marketplace-enrollment-rates-2015-state-and-income.

6 We use family here to refer to the tax unit. The tax unit includes…

7 Some documented immigrants with incomes below those lower income thresholds, who would otherwise be eligible for Medicaid but who have been in the US for less than 5 years, are also eligible for marketplace tax credits.

8 Internal Revenue Service. *26 CFR 601.105: Examination of Returns and Claims for Refund, Credit, or Abatement; Determination of Correct Tax Liability*. Washington: Internal Revenue Service. https://www.irs.gov/pub/irs-drop/rp-14-62.pdf.

9 Authors' calculations based on the 34 federally facilitated marketplaces and partnership marketplaces in the HealthCare.gov data set. The data include information on all insurance plans offered through the marketplaces in these states.

10 Buettgens M. *Health Insurance Policy Simulation Model (HIPSM) Methodology Documentation*. Washington: Urban Institute, 2011. http://www.urban.org/research/publication/health-insurance-policy-simulation-model-hipsm-methodology-documentation.

11 Health Care's 1%: The Extreme Concentration of U.S. Health Spending. National Institute for Health Care Management Foundation. http://www.nihcm.org/concentration-of-health-care-spending-chart-story. Accessed December 4, 2015.

12 For a full discussion of affordability concerns in the ACA and an array of potential reforms to address them, see Blumberg LJ and Holahan J. *After King v. Burwell: Next Steps for the Affordable Care Act*. Washington: Urban Institute, 2015. http://www.urban.org/research/publication/after-king-v-burwell-next-steps-affordable-care-act. Household financial burdens presented here differ somewhat from those presented in the paper cited above, due to incorporating updated data and including those over 400 percent of FPL purchasing nongroup coverage outside marketplaces.