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# **OBAMACARE AND HEALTH INSURANCE COMPANIES**

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**Why are they leaving the Marketplaces?**

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## INTRODUCTION

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Health reform has been a constant dispute on US political battlefield during the past decades. The two main problems that have been echoing again and again are cost and coverage. On the one hand, by 2007 the US expense on health care was a 16.2% of GDP<sup>1</sup>, which considered on a per capita basis, was more than two times the median spending of a country of the Organisation for Economic Cooperation and Development (OECD), while the quality of care was average or even below<sup>2</sup>. On the other hand, by 2008 the number of people without health coverage was estimated that reached the 45.7 million<sup>3</sup>, which raised great concerns.

In this context, the need of a Health Reform was finally put at the center of the 2008 presidential campaign. With the victory of President Obama, his proposal for a broad reform of the US healthcare system was eventually approved, though after some hard bargaining. Despite some initial success among the insurers, last year (2016) an important number of them declared that they would withdraw from the Marketplaces that the reform had provided, where they offered regulated and subsidised health coverage.

Therefore, the aim of this work is to understand the mechanisms that rule the health reform, commonly known as Obamacare; as well as to try to figure out why the insurance companies are leaving the Marketplaces. In order to do so, this dissertation starts with a general economic introduction to the Health Care Industry and how it would work in a free market, in Chapter 1. Then it proceeds in Chapter 2 with a legal introduction to the Health Reform, and the legal challenges that it had to overtake at the US Supreme Court. Chapter 3 focuses on the economic elements of Obamacare, and Chapter 4 tries to understand these elements by means of some practical research through the Marketplaces. Finally, Chapter 5 concludes this thesis and tries to answer some important questions based on the results of the research.

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<sup>1</sup> Fernandez, Bernadette (Coordinator), “*Health Care Reform: An Introduction*”, US Congressional Research Service, August 31<sup>st</sup> 2009. Page 4.

<sup>2</sup> Idem, page 1.

<sup>3</sup> Idem, page 2.

# 1 THE HEALTH CARE INDUSTRY IN A FREE MARKET

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## *Introduction*

First of all, it is important to analyse how the insurance industry works from an economic point of view. In this sense, an insurance company is a business that works as a collective pool of money to which all its customers contribute periodically, and in exchange they get financial protection (known as *coverage*) whenever they need to get medical services. In order to keep the business running, insurers instinctively charge a higher contribution (the so-called *premium*) to the customers who are expected to need a major coverage –that is to say, the unhealthy. This policy is economically sensible –though not usually socially sensitive-, as the ones who are due to extract more from the pool are the ones who have to provide more money to it in the first place. Therefore, prior to providing any insurance, the insurer computes the chances that a potential customer will need to receive health care, in order to estimate the proper amount of the premium to charge.

But this theoretical mechanism has some important problems when put into practice. Social concerns apart, the two main obstacles are the phenomena of *moral hazard* and *adverse selection* –the latter eventually leading, in the worst scenario, to a *death spiral*.

## *The concept of risk*

Before proceeding to their explanation, the concept of *risk* should be clarified. The general definition of *risk* is “*the possibility of something bad happening*”<sup>4</sup>, so in the insurance industry, the *risk* is essentially the possibility that a customer may use the health care coverage –as it means a subtraction of money from the common pool. Following this logic, a *low risk* individual is somebody who looks healthier and presumably will not make much use of their coverage, while a *high risk* individual is

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<sup>4</sup> Cambridge Dictionary, Cambridge University Press, 2017.

somebody who is apparently unhealthy –or even obviously so, due to known pre-conditions in their medical records, or because of their advanced age-, and consequently is more likely to ask for coverage. It should be noted that the notion of *risk* is always used in reference to a future-to-be, and therefore there is no certainty about whether a *low/high risk* individual may use little or major coverage.

## 1.1 MORAL HAZARD

Regarding the aforementioned problems that insurers encounter when implementing their health plans, the first one is a natural behaviour of any individual, whichever their level of risk. As a matter of fact, there are two types of *moral hazard*<sup>5</sup>, depending on whether the risk profile of an individual changes *before* using the medical coverage (*ex-ante moral hazard*) or whether the individual is more inclined to use more coverage *after* needing it (*ex-post moral hazard*), but without changing its risk profile.

### *Ex-ante moral hazard*

According to the *ex-ante moral hazard*, a person who is insured is more inclined to take greater risks than an uninsured person because they know that they have medical coverage. The rationale behind this instinctive behaviour is that, as people do not suffer from the results of their decisions –at least economically-, they increase the risks they take. As a result, the risk profile of a person is likely to increase once they buy insurance, taking a more risky way of life, and consequently raise the odds of needing coverage. This concept can be illustrated with the example of a beginner skier, who without coverage would not take risks and would go down the easy slopes, being thus labelled as a *low risk* person. However, if this very same

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<sup>5</sup> STANCIOLE, Anderson E., “*Health Insurance and Lifestyle Choices: Identifying Ex Ante Moral Hazard in the US Market*”, The Geneva Papers, N° 33, pages 627-644. Palgrave Macmillan UK, 2008. Pages 627 and 628.

person has full coverage in case of accident, they are more likely to take the risk to ski down harder slopes, hence changing its profile to a *higher risk* person than before<sup>6</sup>.

### ***Ex-post moral hazard***

On the other hand, *ex-post moral hazard* does not imply a change in the risk propensity of the individual, but a change in their inclination to use a medical service in case they need it. The logic behind this type of moral hazard is the very simple economic law of supply and demand: if the use of medical services is cheaper (because of the insurance coverage), then the demand for it will be higher. Consequently, an insured individual of any risk profile, and without changing its risk propensity, may be more likely to benefit from their medical coverage for any little trifle such as a simple headache, whereas they would not resort to it if they were not insured. This behaviour leads to a more intensive use of medical services by the insured customers, compared with the services they would use if uninsured. Continuing with the previous example, an insured *low risk* person may ski down an easy slope and fall, luckily without any apparent injuries. If they were insured, they may make use of the coverage in order to check whether there are any imperceptible but serious damages underneath. Contrarily, if they are uninsured and they do not perceive any pain, they are likely to abstain from doing any further checking.

### ***How to avoid moral hazard: cost-sharing schemes***

The existence of moral hazard is undoubtedly counterproductive for insurers, as customers tend to claim more coverage than the one they bargained for. That is why the insurance companies have devised some mechanisms to lower the impact of moral hazard. The most common approach is the establishment of *cost-sharing* schemes, such as *co-payment*, *deductibles*, and *co-insurance*. The essential idea behind these tools is that a part of the costs of the coverage is assumed by the

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<sup>6</sup> As STANCIOLE points out, this theoretical behaviour is softened when applied in practice, because besides the economic factor, individuals also take into account the potential pain and suffering they may experience following a riskier and unhealthier lifestyle.

customer. In the *co-payment*, the insured pays a prearranged fixed price each time they receive a medical service, so that the more the insured uses their insurance's services, the more they have to co-pay. Hence, any individual will think twice before using their insurance. In the same way, the *deductibles* is an amount of money the insured has to pay out of their own pocket before getting coverage from the insurance, and the *coinsurance* is a percentage of the costs of a health care service that the insured has to pay, the remnant being covered by the insurance.

These *cost-sharing* schemes help to palliate the effects of both *ex-ante* and *ex-post moral hazard*. As regards *ex-ante moral hazard*, the fact that the insured has to contribute to the costs of its coverage means that now they have to partake at least in a part of the consequences of their actions. Therefore, they will act more carefully and their risk is less likely to change. In other words, the beginner skier will prefer to keep going down the easy slopes, in order to avoid having to pay for an important part of the cost of a rescue service and its subsequent medical assistance. Actually, the greater is the part of the costs that the customer has to share, the most likely they will remain in their level of risk.

Concerning the *ex-post moral hazard*, the reasoning is quite similar. The customer, regardless of their risk profile, will try to use the medical services only when necessary, as they will ponder in each case whether it is avoidable or not to retort to the coverage, considering the share they have in it. In this case, the skier who fell going down the easy slope will consider the circumstances of the accident and the gravity of the crash before deciding whether it is necessary to spend the part they have to assume from the coverage. Consequently, the intensity on the use of the coverage will be inversely proportional to the extent of the share that the customer has to undertake.

For example, if we consider an insurance plan where there is a deductible of \$1,000, as well as a subsequent coinsurance of 20% of the expenses until \$2,000, up from which the insured customer need not assume any further cost (capped payment).



As can be seen in Figure 1, this cost-sharing scheme is designed in order to avoid moral hazard for routine medical services, as any small expense is paid out of the insured's pocket. However, if the medical coverage is of significance costs, such as an accident or an important illness, then the customer is relieved from any further expenditure above the \$1,200.

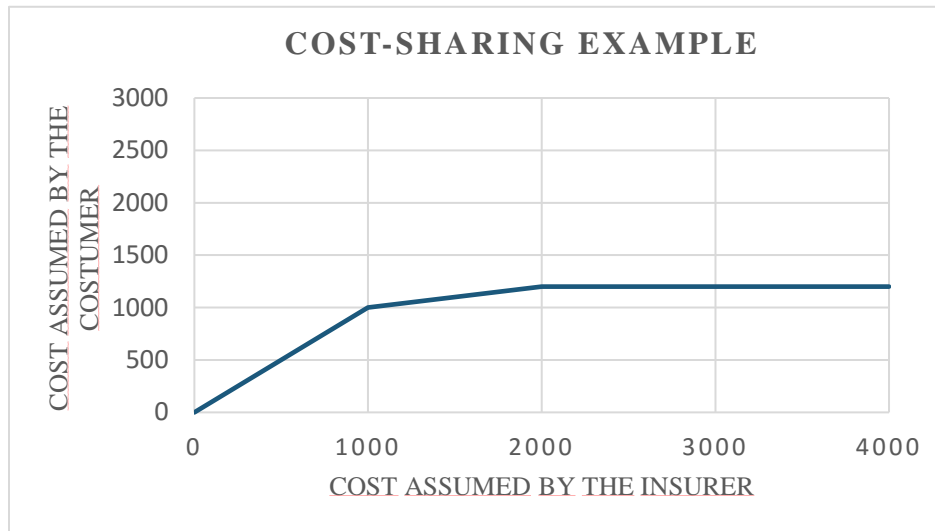


Figure 1. Cost-Sharing Example

## 1.2 ADVERSE SELECTION AND DEATH SPIRAL

### *Adverse selection*

In the theoretical scheme introduced above, the essential principle was that low risk individuals should pay less than high risk individuals. In order to implement it successfully, it is fundamental that the insurer knows exactly the state of health of each of its customers. But in real life, this premise is impracticable; on the contrary, there is asymmetry of information, as customers usually are better informed about their health than insurers are. The result is what is known as *adverse selection*: the person who is better informed (the insured) can choose a product which they value more than its real price (a relatively cheap insurance, in relation to their risk), because the other trading partner (the insurer) does not know that they would (and should) pay

more for it. Thus, the customer can make a selection that is *adverse* to the insurer – that is, it has a negative effect on the insurer's business.

### ***Diversity of menus on offer***

In order to control adverse selection, insurers diversify their offer of insurance, creating various *menus* with different premiums and different ranges of coverage and co-payment schemes. The diversity of plan options implies that costumers have to choose whether to have more or less advantages, depending on the price. Thus, low risk individuals will apply for the cheaper, less assorted plans, and consequently they will not be so prone to taking more risk –especially if such risk is out of coverage. Besides, the cheap plans have more expenses derived from cost-sharing payments, which in turn affects the intensity of healthcare use by their customers. As a result, the low-cost plans attract low risk individuals who want coverage against the worst-case scenarios, and in contrast do not mind paying for most of the routine care from their own pocket.

The diversity of menus is a thoroughly useful tool, as it distributes each individual to the coverage that is more appropriate to their risk profile. What is more interesting is that this classification of customers is made by the individuals themselves, as it is the purchaser the one who chooses the plan. In other words, the menus are an indirect solution to the adverse selection, as the insurer does not force the choice of the customer.

### ***Market differentiation***

Another way of curbing adverse selection is to set premiums according to *market differentiation*. That is to say, to classify the market population in different groups, taking into account various variables, such as age, tobacco use, or family and personal background. Then, insurers estimate the average risk of each group, with the help of some statistics –or simply by randomly selecting one person from the group. And finally, they set a premium for each group based on their average risk. In this

sense, the more variables the insurers use –and therefore, the more they differentiate the market-, the better, as there will be less variations from the average risk. As a matter of fact, Obamacare limits considerably the scope for market differentiation, as it establishes that premiums can vary only according to age and tobacco use –and it even sets maximum ratios for the premium increases.

However, the threat of adverse selection is still present: those individuals who know that they have a higher risk than the average of their group will be attracted to buy the insurance, as they will value the insurance above the premium price –that is, they will find the premium cheap. Conversely, those who have a below-average risk will not be interested in buying the insurance, as they will value the insurance below the premium price –i.e. they will think the premium is too expensive. Following this reasoning, each policy is very likely to have more people with an above-average risk than people with a below-average risk. Consequently, the pool of money is in danger of running out of money, as the input money provided by the premiums can be less than the output money dispensed for the customers' coverage.

### *The death spiral*

The instinctive reaction of the insurers is to raise premiums, but then the same situation develops again –though worsened, as a major number of individuals find the new pricier premium too expensive and get out of the insurance. Only those with a higher risk value the insurance above its price and are interested in remaining insured, which implies that once more, the pool of money is prone to be emptied much quicker than it is filled. And that is how the adverse selection eventually leads to a *death spiral*: a vicious cycle where insurers increase premiums to cope with the higher amount of sicker customers, which feeds back into the healthier ones leaving the insurance, forcing the insurers to raise prices again.

Another common response to adverse selection is to not let people with higher risk into the pool –that is to say, to not let sicker people buy insurance, based on their

pre-existing medical conditions. Thus the death spiral is averted, though in an ethically questionable way.

### **1.3 CONCLUSION**

All this approach to the health insurance industry is based on the rules of a free market, where there is no interference of State regulations. In this scenario, insurers can retort to different mechanisms, which can be reduced to three alternatives: to raise premiums, to lower coverage or to choose clients.

As already seen, raising premiums is the more immediate response in order to keep the pool with enough money to cope with the coverage costs, but it has the drawback of entering into the vicious cycle of a death spiral. That is why this tool is accompanied by a differentiation of various menus, where the cheapest have less coverage and more cost-sharing policies. Thus, the insurance company can attract healthier people, concerned about being insured especially in case of important accidents or sicknesses. Conversely, the other tool is focused to the other group of customers: those who are sicker may have to pay much more, or may even be expelled from the insurance.

However, the government wants to alleviate some of these drastic measures, and in order to do so it uses some countermeasures. Thus, it avoids high raises on premiums regulating the market prices; it averts the lessening of coverage by requiring generous minimums by law; and it can even forbid insurers to expel clients based on their health preconditions. These are precisely some of the steps followed by the Obamacare, whose aim is to correct the inefficiencies of the healthcare market but, at the same time, introduce some policies designed to correct some social differences.

## **2 LEGAL APPROACH TO OBAMACARE: APPROVAL AND LEGAL CHALLENGES**

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### **2.1 APPROVAL OF THE AFFORDABLE CARE ACT (ACA)**

The reform of the US healthcare system was brought again at the front page of the political debate up from 2008, especially thanks to Obama's campaign for the presidency. As a matter of fact, health reform was one of the central aims of his platform. His proposal, though watered down through the subsequent Congressional debate, would finally enforce a few important principles that have been henceforth fundamental, namely: the individual mandate, the Medicaid expansion and its subsidies, and the requirement to companies to accept all customers. The essential idea behind these bases is that if healthy individuals are compelled to get insured (individual mandate), then the insurance companies can pool the risk of healthier and sicker people together, and offer a more affordable price for all of them. This way, together with the expansion of subsidies and Medicaid coverage for the poorer, and the obligation for insurers to accept applications -regardless of their preconditions-, the result should be an increase of coverage and a decrease in costs.

But such a reform plan encountered a fierce opposition from the Republican Party, as the costs of its implementation were at odds with its principle of small government. The main concern was about the supposed unconstitutionality of the individual mandate, which afterwards would be brought in front of the Supreme Court. Furthermore, there was political debate about two other itchy points, such as the establishment of a "public option" or the expansion of Medicare. The "public option" aim is to create a government-run health care plan that would work as an alternative to private ones -or even as a fallback, in case all other private insurers pull out. Due to its ambition, this idea was vehemently opposed by the Republicans, who would only cede to some limited degree of Medicaid expansion. That is because the Medicaid program is more reduced than the "public option", as it focuses exclusively on children and adults with limited income and resources.

*Approval procedure*

The legislative procedure that ended with the approval of the Affordable Care Act (from now on, ACA) has been a conjunction of luck, timing and arithmetic. Thanks to the favourable results of the 2008 elections, the Democrats gained the majority in both Chambers of Congress: 257 Democrats against 199 Republicans in the House of Representatives, and 57-41 in the Senate. Additionally, two independents caucused with the Democrats, so the support for the healthcare reform in the Senate was, by the opening of the new Congress, of 59-41. That meant that they were only missing one senator to reach the supermajority of 60 needed to avoid a filibuster, which is a parliamentary ruse that allows lawmakers to delay the vote on a proposed legislation by making time-consuming trivial speeches. Consequently, political arrangements were made and eventually, on April 28 2009, Pennsylvania Republican Senator Arlen Specter changed parties and gave Democrats the coveted 60-40 supermajority.

However, a few months later the Massachusetts Democrat Senator Ted Kennedy died, leaving at stake the 60<sup>th</sup> vote. As a Democrat interim senator was appointed until the special elections would take place, on January 19 2010, the Democrats rushed the health reform proposition through the Senate on December 24 2009, where it won 60-40. The bill had already been approved by the House of Representatives on November 7, on a tight 220-215 vote (39 Democrats voted against it), though there it included the “public option”, whereas the one in the Senate didn’t. Following the victory of Republican Senator Scott Brown in Massachusetts, the Democrats decided to pass the Senate-approved bill through the House, in order to avoid any further delay. That’s how the final bill, without the “public option”, was approved by the House of Representatives on March 21 2010 –by a 219-212 vote, with 34 Democrats against–, and finally signed into law by President Obama on March 23.

The final outcome of all this political horse-trading has been the Patient Protection and Affordable Care Act (PPACA) –commonly known as the Affordable Care Act (ACA) or Obamacare. As previously explained, the final bill had to relinquish the “public option” and part of the Medicaid expansion, as well as guarantee some antiabortion measures, in order to gain a broader backing among the legislative. In this aspect, it was necessary for President Obama to sign the Executive Order 13535<sup>7</sup>, barring Federal funding for abortion, in order to gain the adhesion of Democrat B. Stupak and 7 congressmen more. These votes would be essential for passing the bill by 219-212, on March 21 2010. All the same, it was only supported by Democrats –and even some Democrat Representatives voted against it-. That’s why it has been widely criticised for its lack of more broad and bipartisan consensus, as is usually the case in such important reforms.

## **2.2 FIRST RULING: *NATIONAL FEDERATION OF INDEPENDENT BUSINESS V. SEBELIUS* (JUNE 28 2012)**

The first legal action against Obamacare was over the supposed unconstitutionality of the individual mandate. As a matter of fact, as soon as the law was approved, 13 States filed suit, joined afterwards by 13 more States, as well as the National Federation of Independent Business and four private individuals. Thus, 26 of the 50 States that make up the USA were against the bill. Together with the issue regarding the individual mandate, the plaintiffs also objected the Medicaid expansion, as it was regarded as coercive for the States and exceeding the Federal Government’s authority. There were also 2 procedural complaints, thought incidental and not important for the current study (so they will be simply stated, but not explained): whether the case couldn’t be decided until the mandate would take effect, in 2015, and whether the rest of the law was supposed to be invalid if the individual mandate was unconstitutional.

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<sup>7</sup> The Executive Order can be consulted in the following link: <https://www.whitehouse.gov/the-press-office/executive-order-patient-protection-and-affordable-care-acts-consistency-with-longst>.

***Individual mandate***

The individual mandate is a “*requirement to maintain minimum essential coverage*” that is established in Section 5000 of title 26 of the United States Code (hereinafter, USC). As its brief legal designation reveals, it consists of a mandate for any individual to be insured under a “*minimum essential*” health insurance coverage. Non-compliance with such obligation implies a penalty, called “*shared responsibility payment*” (26 USC §5000(b)). Actually, the amount of the fine depends on the coverage, the income of the individual and the size of their family, so it is based on the principle of proportionality. In this regard, there are some exemptions that take into account the individual’s household income (§5000(e)(1)) –though there are also some genuine American peculiarities among the exceptions, such as the members of Indian tribes, or the members of certain religious sects or divisions (§5000(d)(2)), presumably the result of political concessions to gain some conservative votes-.

The Obama administration justified the individual mandate on the basis of the constitutional mandate for Congress “*to regulate Commerce among the several States*” (art. 1, sec. 8, cl. 3 of the Constitution of the United States), also known as the interstate commerce clause. Thus, their point was that, as the health care industry accounted for nearly 18% of USA’s GDP, Congress had the power to intervene in order to lower the cost of care. Subsidiary, the administration also claimed that the penalty accompanying the mandate had to be classified as a tax, and was accordingly included in the Congress’ constitutional right to tax (art. 1, sec. 8, cl. 1 of the Constitution). On the other hand, the plaintiffs argued that the individual mandate was an excess of the Congress’ powers, as it was interfering in economic inactivity. Hence they contended that individuals couldn’t be forced to take action –that is, enrol into a health insurance plan-, in the scope of the commerce clause. The States also challenged the tax nature of the penalty, though without giving much importance to it. Actually, at first the very same Democrats had passed the bill insisting that the mandate was not a tax.



Finally, the Supreme Court sided in favour of the bill –with an important limitation, though. On June 28 2012, the court ruled<sup>8</sup>, by 5 votes to 4, that the individual mandate was not based on the commerce clause, but on the right to tax. The defence’s main argument of regulating under the commerce clause was rejected because the court confirmed the plaintiff’s point that “*the power to regulate commerce presupposes [indeed] the existence of commercial activity to be regulated*” (opinion of Chief Justice Roberts, Supreme Court’s ruling of 28 June 2012, page 18).

Conversely, the ruling unexpectedly upheld the backup argument of the Obama administration. Thus, the court confirmed that, taking into account the characteristics of the penalty, it could be legally identified as a tax. Among different considerations, it observed that its payment is included with the taxpayer’s annual return to the Federal Government, and that the Act states that the penalty must be assessed and collected in the same manner as a tax penalty (§5000(g)(1)). Furthermore, the concern about interference on non-activity was solved, because the US Constitution “*protects us from federal regulation under the Commerce Clause so long as we abstain from the regulated activity. But [...] the Constitution has made no such promise with respect to taxes*” (opinion of the court, Supreme Court’s ruling of 28 June 2012, page 42). Therefore, the court points out that the Constitution does not allow individuals to avoid taxes through inactivity, as many taxes are based on the mere existence of the individual (opinion of the court, *idem*, page 41).

Although apparently a little nuance regarding the legal source that allows the individual mandate to be enforced, this difference is actually important. The consequence is a distinctive degree of control over individual behaviour. Thus, while the commerce clause would allow Congress to command individuals to do as it directs, punishing incomppliance with criminal sanctions; the right to tax is more limited and simply permits Congress to require the payment to the Federal Treasury, but nothing more.

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<sup>8</sup> The Supreme Court’s June 28<sup>th</sup> 2012 ruling can be consulted in the following link:  
<https://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf>.

*Medicaid expansion*

The other grand issue was the expansion of Medicaid. The bill increased considerably the obligations of the States under Medicaid. Originally, the program was limited and covered only certain discrete categories of needy individuals – pregnant, women, children, needy families, the blind, the elderly, and the disabled-, and the States enjoyed significant flexibility in the way they applied such coverage. But ACA reformed and expanded State Medicaid programs. The main changes were the requirement for States to cover all individuals under the age of 65 with incomes below 133% of the federal poverty line, as well as the establishment of an “*essential health benefits*” package, available to all Medicaid recipients, which would guarantee the fulfilment of the individual mandate.

However, the disagreement was not on the substance of the expansion, but on the way it was pursued, as it was deemed aggressive towards the States. Certainly, the health reform allowed the Secretary of Health and Human Services to withhold all further payments to the States that didn’t comply with any Medicaid requirements – the expansion ones included (United States Code title 42, section 1396 (c)). This provision implied that, in practice, Congress was threatening the States that did not comply with the Medicaid expansion with the withdrawal of all Medicaid federal funds. Despite affirming Congress’s authority to condition the payment of funds to the States with restrictions on the use of those funds, the court rules that in this case the conditions have exceeded this power and are unjustified. That is because these conditions are seen as “*threats to terminate other significant independent grants*” (opinion of Chief Justice Roberts, *National Federation of Independent Business v. Sebelius*, page50)–such as the funds that the States already received until the reform-, and are therefore perceived as means of pressure towards the States, for them to unwillingly accept the policy changes.

As the same court points out, a middle ground could have been to let the States choose whether to join the expansion and therefore get additional payments, or

to forgo the expansion keeping the existing payments. But as the bill did not provide this option, and as the Supreme Court cannot rewrite the bill, the ruling simply states that the reform of USC 42, §1396c is unconstitutional, and does not propose the moderate solution just explained above, but merely states that no condition can be made based on Federal payments.

## **2.3 SECOND RULING: *KING V. BURWELL* (25 JUNE 2015)**

The upholding of the individual mandate did not deter the opponents of the ACA, and soon afterwards came a second legal complaint in the Supreme Court. This time, the plaintiffs were 4 individuals from the State of Virginia, and their objection to the ACA was statutory –not constitutional-, though also of fundamental importance, as the own court asserted in its deliberation. The essential question brought up to the court was whether the tax credits granted by the ACA included individuals who bought insurance from a Federal Exchange, as the ACA explicitly established that individuals entitled to such tax credits had to be “*enrolled in through an Exchange established by the State*” (26 USC §36B(b)(2)).

It must be clarified that the ACA provides the creation of *Exchanges*, which are health insurance marketplaces where individuals can compare and purchase insurance plans. These exchanges can be created by the States, or otherwise by the Federal Government if the State does not. On the other hand, the ACA establishes a series of refundable tax credits in order to subsidise the coverage to a wide number of individuals, depending on their income. Finally, it must be taken into account that the act provides a general exemption to the individual mandate, which applies when the cost of buying insurance exceeds 8% of an individual’s income.

Considering the three elements above described (the types of exchanges, the tax credits and the exemptions), the 4 plaintiffs objected paradoxically that, as Virginia had a Federal Exchange, they should not be able to receive a tax credit. The explanation to their rejection was quite simple, though: if it were not for the tax credit,

they would be exempted of buying insurance, as its cost would be more than 8% of their income.

The Supreme Court's ruling was again favourable to the ACA, and this time the court was more concerned about the structure of the act and the interconnection between its elements, as well as the importance of health reform, and the important precedent of the Massachusetts own health reform of 2006. Thus, the court summarizes the three essential elements of Obamacare (which will be explained in more detail later): the individual mandate, the subsidies and the insurance market regulations –which include the prohibition of discriminatory premium rates and the prohibition of non-coverage based on preconditions-. As the own court explains, these three elements are intertwined and are crucial in order to avoid the main obstacle to the health reform: a death spiral.

In this case, the Supreme Court rules that the ACA's tax credits apply both in State and Federal Exchanges, because otherwise the intent of the act would be compromised. If citizens in Federal Exchanges were not eligible for subsidies, then insurance would be unaffordable for a growing number of people, which would prefer to pay the individual mandate's penalty –or would even be exempted of it, as the plaintiffs' case-. This would consequently lead to a rise in premiums, as only the sick would stay insured. This situation results in what is commonly known as a *death spiral*, and is what already had happened in Massachusetts before 2006, as Chief Justice Roberts explains: “*as premiums rose higher and higher, and the number of people buying insurance sank lower and lower, insurers began to leave the market entirely*” (opinion of Chief Justice Roberts, Supreme Court's ruling of 25<sup>th</sup> June 2015, case *King v. Burwell*, page 6). Therefore, the court rejects the petitioners' objection, as *it would destabilize the individual insurance market in any State with a Federal Exchange, and likely create the very “death spirals” that Congress designed the Act to avoid*” (opinion of Chief Justice Roberts, *King v. Burwell*, page 20).

### 3 ECONOMIC APPROACH TO OBAMACARE: THE THREE KEYS OF OBAMACARE

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The Affordable Care Act's main concern is to grant an extensive coverage of health insurance in the United States, and at the same time avoid the development of a *death spiral* that may lead to the exit of the insurers from the marketplace. As already seen, a *death spiral* consists of a vicious circle in which increasing premiums in an insurance lead to decreasing buyers of this insurance, and eventually the insurer may disappear. In order to avert it, Obamacare is based on three pillars: a couple of market regulations (the community rating requirement and the open enrolment), the individual mandate and the subsidies.

#### 3.1 INSURANCE MARKET REGULATIONS

In order to avoid a *death spiral*, the common solution among insurers is to not let sick people in, by surcharging them with much higher premiums. This way, insurers can keep premiums lower for healthier people, who may stay insured and thus help pool the risk and its costs. But Obamacare's aim is to expand access to coverage for all citizens, regardless of their risk or sickness. In order to achieve such goal, the ACA sets two essential insurance market regulations: the prohibition of discriminatory premium rates –known as the community rating requirement–, and the prohibition of non-coverage based on preconditions –known as the guaranteed issue requirement, or more commonly, the *open enrolment*–.

The *community rating requirement* is introduced by the modification of title 42 USC, §300gg(a)(1)<sup>9</sup>, which regulates the factors that can affect premium rates.

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<sup>9</sup> “With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market-

(A) such rate shall vary with respect to the particular plan or coverage involved only by-

(i) whether such plan or coverage covers an individual or family;

(ii) rating area, as established in accordance with paragraph (2);

These factors can only be four: the number of individuals covered by the plan –in case of a family plan-, the rating area -established by the State-, the age of the individuals and their tobacco use. Consequently, insurers have discretion to alter premiums taking into account essentially three variables –location, age and tobacco use-; and the law even restricts the rate at which the premiums can diverge: less than 3 to 1 for the age, and less than 1.5 to 1 for the tobacco use.

Regarding the *guaranteed issue requirement*, the ACA also modifies title 42 USC, §300-1(a), concerning availability of coverage. It provides that “*each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage*”, subject to certain admissible restrictions relating to restricted enrolment periods, network plans and financial capacity limits, in which cases these restrictions must apply to all employers or individuals in the group or individual market in the State. This way, any denial of coverage based on preconditions concerning the medical history of any individual is forbidden. Together with the prohibition of discrimination of prices, these provisions try to force the insurers to let in individuals with a higher risk of sickness with no restrictions.

Furthermore, Obamacare also regularises the price of the premiums, especially in relation to the *cost-sharing scheme* that they follow, which include mainly deductibles, co-payment, and coinsurance (as already seen above). As a result, when entering the exchanges individuals can choose between 4 main *metal categories* of plans (bronze, silver, gold and platinum), according to how is distributed the sharing of the health care costs. Thus, in the *bronze* category, customers must pay on average about 40% of the costs, while in the *platinum* category they usually pay on average 10% of the costs (see figure 2).

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(iii) *age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 300gg–6(c) of this title); and*  
 (iv) *tobacco use, except that such rate shall not vary by more than 1.5 to 1; and*  
 (B) *such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A)”.*

Plan Category	The insurance company pays	You pay
Bronze	60%	40%
Silver	70%	30%
Gold	80%	20%
Platinum	90%	10%

**Figure 2.** Estimated averages for a typical population.

**Source:** US Federal Government healthcare website

(<https://www.healthcare.gov/choose-a-plan/plans-categories/>)

## 3.2 INDIVIDUAL MANDATE

### *Introduction*

Unfortunately, these insurance market regulations alone cannot accomplish the universal coverage purpose, as they lead to a *death spiral* anyway. The problem is that healthy people have no incentive to buy insurance until they get sick, and therefore the number of people with a below-average risk decreases. That leads to an inevitable *dead spiral*, as premiums rise and insured people decline.

As noticed before in *King v. Burwell*, the first State to find a solution to this problem was Massachusetts, in 2006. Curiously enough, the popularly known as *Romneycare* was precisely a Republican proposal, which successfully added two new crucial elements to the mix: the individual mandate and the subsidies. That is how Obamacare, inspired by Romneycare, took the individual mandate into the federal level –which was then fiercely attacked by the Republican opposition-. Leaving political controversies aside, the essence of the mandate is to force healthy people into the insurance plans in order to compensate its costs. Together with both the

community rating and guaranteed issue requirements, as well as the subsidies, this new mechanism makes the plans affordable for any individual, especially the sick ones.

The individual mandate is introduced by the modification of title 26 USC, §5000A(a), which establishes a “*requirement to maintain a minimum essential coverage*” (already explained above). Its payment is made when filing the federal tax return for the taxable year that the taxpayer does not have coverage.

### ***The shared responsibility payment***

In case of non-compliance with the mandate, the law provides a penalty or “*shared responsibility payment*” (hereinafter, the SRP), which consists of 1/12<sup>th</sup> of the annual SRP for each month that the individual does not have coverage and does not qualify for a coverage exemption –though there is a short gap for the first three consecutive months, in which the fine is not applicable, as will be seen below in the exemptions-. The annual amount of the SRP can be calculated<sup>10</sup> in two different ways, either as a percentage of household income or as a flat dollar amount per person, being whichever is higher the one to pay as fine (26 USC §5000A(b) and (c)).

On the one hand, the percentage of the household income is 2.5 % for 2016 and subsequent years, and only applied on the income that is above the tax return filing threshold<sup>11</sup>. It must be taken into account that this percentage has progressively increased from 2014, when it was 1% -though the 2.5 percentage is the last legally provided raise, being from now on that fixed rate. On the other hand, the flat dollar amount is calculated on a family basis, adding \$695 per adult and \$347.50 per child

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<sup>10</sup> The *Internal Revenue Service* (IRS), which is US’ tax collection agency, provides an online interactive estimator where any individual can introduce its personal information anonymously, and get an estimation of the SRP they would have to pay: <https://taxpayeradvocate.irs.gov/estimator/isrp/>.

<sup>11</sup> The *tax return filing threshold* is the minimum amount of gross income an individual must make to be required to file a tax return, depending on their age and filing status (e.g. single, married, head of household, widow with dependent children, etc.). For example, the 2016 federal tax filing threshold of an under 65 is \$10,350 if he/she is single or \$20,700 if he/she is married and filing jointly. For more information: <https://www.irs.gov/affordable-care-act/individuals-and-families/aca-individual-shared-responsibility-provision-calculating-the-payment>.



under 18, up to a maximum of \$2,085 per household. Here there has also been an escalation of costs, as the law provided an amount of \$95 and \$325 per adult and \$47.50 and \$162.50 per child in 2014 and 2015, respectively; as well as a maximum of \$285 and \$975. Indeed, the rise of the quantity to pay is highly noticeable, as a result of a mechanism to encourage progressive enrolment to the marketplaces.

In any case, there is a cap on the SRP annual amount, determined by the national average yearly premium for a Bronze level health plan available through the Marketplace. This limit is quite coherent with the goal of the penalty, as the individual can choose between either pay the fine and get nothing, or buy a bronze plan for the same price and at least have a basic insurance. Therefore, the SRP can be seen as an incentive for individuals to insure themselves, and not as a punitive fine. Actually, if the fine had not that cap, and could be even higher than the Bronze plan, then the most reasonable manoeuvre by the affected would be to buy such Bronze plan in order to avoid paying the SRP in the first place.

### ***Health Coverage Exemptions***

Separately, the ACA also provides some exemptions, gathered in title 26 USC, §5000A(e). These include individuals who cannot afford coverage, taxpayers with income below filing threshold, members of Indian tribes, individuals who went without coverage for less than three consecutive months a year (the so called *short coverage gap*) or individuals who can prove hardships to obtain coverage. Furthermore, there are some special groups which are explicitly exempted from the individual mandate, such as certain noncitizens, incarcerated individuals or members of certain religious sects, among others.

Concerning the aim of this essay, it is interesting to take a look at the aforementioned exemption granted to those individuals who cannot afford coverage. This exemption provides that when the individual's annual SRP required for the months not covered exceeds 8% of their yearly household income, that individual is excused from paying the penalty. As seen in *King v. Burwell*, this exemption is only

applicable when considering the cost after the deduction of the subsidies, which reduces considerably the real number of people released from complying with the individual mandate, as will be seen in the next point.

### 3.3 TAX CREDITS

The third arrow of the Obamacare system is a series of so called “*premium tax credits*”, which subsidise the costs of insurance for those with low or moderate incomes (26 USC §36B(b)-(c)). It consists of a refundable tax credit that the eligible recipient can choose to benefit either as a monthly payment for the premiums via the known as Advance Payments of the Premium Tax Credit (hereinafter, the APTC) – which are directly paid to the insurer, and have to be complemented, when necessary, with the individual’s payment of the remainder of the premium-, or as a direct refund to the taxpayer’s pocket at the end of the year –needless to say, when the amount of the tax credit is higher than the amount of any other tax liabilities of the taxpayer-. The beneficiary can also choose to have some of the APTC directly paid to the insurance company to lower the monthly premiums, and get the rest refunded when doing the tax return.

In order to be eligible for the premium tax credit, the taxpayer must comply with different requirements, among which a fundamental one is to be insured through an Exchange –that is, one of the State or Federal marketplaces created by the ACA. Another essential condition is the household income range, which is between 100% and 400% of the federal poverty line. In this regard, the reference figures are the poverty guidelines<sup>12</sup> -loosely referred to as the federal poverty line-, which vary depending on the number of members of the household. In 2016 the federal poverty line was \$11,880 for a household with one member, \$16,020 with two, \$20,160 with

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<sup>12</sup> The *poverty guidelines* are issued on an annual basis by the US Department of Health and Human Services (HHS). They are a simplification of the poverty thresholds, and used for administrative purposes, such as determining financial eligibility for a premium tax credit. The poverty guidelines can be consulted in the following link: <https://aspe.hhs.gov/poverty-guidelines>.

three, and so on (see Figure 3). By way of example, a family of four members would be eligible to get a tax credit if it had an income of between \$24,300 and \$97,200.

2016 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
For families/households with more than 8 persons, add \$4,160 for each additional person.	
1	\$11,880
2	16,020
3	20,160
4	24,300
5	28,440
6	32,580
7	36,730
8	40,890

*Figure 3. 2016 US Poverty Guidelines.*

*Source: US Department of Health and Human Services (HHS)*

The APTC that an eligible individual and their family can receive depends on three variables: the location, the household income and the household size. According to these inputs, the amount of the credit<sup>13</sup> is based on a sliding scale. That means that, for a certain location and a fixed number of family members, the credit increases in a linear manner –and needless to say, in an inverse proportion to their income. Therefore, keeping the other variables constant (location and household size), the more income a household earns, the less tax credit it receives to help cover the insurance costs.

To be more precise, the premium contribution that an individual is due to pay for the insurance is limited to a percentage of their income for each income level, according to the proportions set by law (see Figure 4); and the remaining cost of the insurance is subsidised. However, there is a limit to the extent of the subsidy: the tax credit is tied to the cost of the second cheapest silver plan available. Consequently, if

<sup>13</sup> The Internal Revenue Service also provides an online estimator where individuals can anonymously know the amount of premium tax credit they are entitled to receive:  
<https://taxpayeradvocate.irs.gov/estimator/premiumtaxcreditchange/>.

the household enrolls a more expensive coverage (up from another more expensive silver plan), then they will assume any additional amount of the costs. Conversely, if the household opts for a cheaper plan, such as the bronze, then their share of the premium will also be less.

In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is-	The final premium percentage is-
Up to 133%	2.0%	2.0%
133% up to 150%	3.0%	4.0%
150% up to 200%	4.0%	6.3%
200% up to 250%	6.3%	8.05%
250% up to 300%	8.05%	9.5%
300% up to 400%	9.5%	9.5%

**Figure 4.** Premium contribution by household depending on their income.

*Source:* USC 26 §36B(b)(3)(A)(i).

It is important to observe that only incomes up from 250% of the federal poverty line have to contribute more than 8% of their income in health care plans expense. It has significant implications when taking into account the exemption of the individual mandate based on individuals who cannot afford coverage, as the requirement to apply such dispensation is that the health coverage be above 8% of their income. It can be proved hence that the Obamacare regulation wants to make sure that low income families have access to health care –or at least, that they cannot allege that it is unaffordable.

Furthermore, the ACA also provides some extra subsidies for the cost-sharing expenses, such as deductibles and co-payments; but only for people enrolled in a Silver plan. It is clear that the regulation aims at incentivising the purchase of Silver health insurance, as they offer a higher premium than the Bronze plans, but with much more moderate extra costs when in need of coverage. Thus, the goal of the ACA is to extend health coverage but with a higher standard than the simple Bronze category, where the lowest premiums are compensated by the highest costs when people use the care coverage. As a matter of fact, Bronze plans are only profitable for those who usually use few medical services and simply want to be spared the large costs of really serious sicknesses or injuries.

### 3.4 OTHER ELEMENTS OF OBAMACARE

Finally, another decisive provision of the ACA is the creation of the *Health Insurance Marketplaces*, commonly known as the *Exchanges*. They are platforms where individuals can get information about the health insurance options available and compare between them, in order to choose a plan and enrol it also through the Exchange platform. The Exchanges also inform about subsidies, as well as the cost-sharing schemes the plans include.

The aim of these Exchanges is to encourage competition among insurers, and facilitate informed access to coverage for individuals. That is why they are easily accessible, not only through websites, but also call centres and personalised assistance. There is a federal marketplace run by the federal government, but States can also create and run their own exchanges.

## **4 RESEARCH THROUGH THE EXCHANGES AND AETNA**

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Once explained the main characteristics of Obamacare, the dissertation proceeds to put into practice these elements by means of some research through the Exchanges and the private market. The final aim of this work is to decipher why big health insurers are leaving the Exchanges, and in order to do so it will focus on one specific insurance company –Aetna. In the summer of 2016, Aetna pulled back from most of the Exchanges, and currently it is only available through the Marketplaces of four States: Delaware, Iowa, Nebraska and Virginia<sup>14</sup>.

### **4.1 INTRODUCTION TO THE RESEARCH**

As already seen, Obamacare restricts the variables capable of affecting premiums (for a same level of coverage) to four: household size, location, age and tobacco use. Therefore, this research undertakes a comparison between the costs of health care for four different groups of individuals, divided according to their age and tobacco use. Concerning the other variables, the household size is always fixed to only one member, in order to simplify the study and its calculations; and the location is set in two different States: one where Aetna is still part of the Exchange (Delaware), and another where Aetna is not into the Exchange (Massachusetts).

On the other hand, another variable which is important to be taken into account is the household income. Despite not affecting directly the price of the premium, the income is important when considering both the individual's spending choices and the subsidies they can get in order to lower the cost of buying insurance. The research has set the income of each of the four individuals to \$30,000, which is 252.52% of the poverty level for a household of one member.

Concerning the sources, it must be taken into account that unfortunately the Marketplaces are inaccessible without identification (and after passing a thorough ID

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<sup>14</sup> Aetna webpage: <https://www.aetna.com/individuals-families/health-insurance-exchange.html>.

check). Therefore, the only sources available have been the Aetna website concerning purchase of private health plans, and the Health Insurance Marketplace Calculator provided by the Kaiser Family Foundation<sup>15</sup>. This Calculator has two important limitations, as it only provides prices of the Bronze and Silver plans, and it does not take into account the tobacco use factor. However, the two plans are precisely the two most relevant categories for the purpose of this dissertation, as the Bronze is crucial when considering the amount of the fine for non-compliance with the individual mandate, and the second cheapest Silver plan sets the amount of the maximum proportion of subsidies an individual can get.

The four fictional individuals who apply for insurance in the Exchanges in this research are: Billy (25 non-smoker), William (60 non-smoker), Danny (25 smoker), and Daniel (60 smoker). The research will focus firstly on their incentive to buy insurance in order to avoid paying the individual mandate, and it will proceed to analyse other important aspects, such as the range of menus available and the effect of the subsidies.

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<sup>15</sup> The Kaiser Family Foundation Health Insurance Marketplace Calculator can be accessed online through the following link: <http://kff.org/interactive/subsidy-calculator/>

## 4.2 DATA OBTAINED ON THE RESEARCH

### *Delaware (19904, Kent County, Dover, DE)*

Delaware		Exchange (estimation through the Calculator) <sup>16</sup>				Aetna (into the Exchange)			
		Bronze		Silver		Bronze	Silver	Gold	Top Gold
		Premium	Premium after subsidies	Premium	Premium after subsidies				
Non smokers	Billy, 25 years	285.67	160	333	207	285.73	325.35	421.76	435.33
	William, 60 years	772.33	80	899	207	772.38	879.49	1,140.09	1,176.77
Smokers	Danny, 25 years	No data	No data	No data	No data	314.30	357.89	463.94	478.86
	Daniel, 60 years	No data	No data	No data	No data	849.62	967.44	1,254.10	1,294.45

*Figure 5. Premiums offered in the Exchange and the Aetna private shop in Delaware (amounts in \$).*

*Sources: Kaiser Family Foundation and Aetna.*

### *Massachusetts (02130, Suffolk County, Jamaica Plain, MA)*

Massachusetts		Exchange (estimation through the Calculator)				Aetna (out of the Exchange)			
		Bronze		Silver		Bronze	Silver	Gold	Top Platinum
		Premium	Premium after subsidies	Premium	Premium after subsidies				
Billy and Danny, 25 years <sup>17</sup>		174.17	172	210	207	214.81 or 221.22	229.19	295.82	593.53
William and Daniel, 60 years		348.17	136	419	207	429.44 or 442.25	458.19	591.40	1,186.56

*Figure 6. Premiums offered in the Exchange and the Aetna private shop in Delaware (amounts in \$).*

*Sources: Kaiser Family Foundation and Aetna.*

<sup>16</sup> **Observation:** in this case, Aetna is part of the Exchange, so actually the prices of both the Exchange and the Aetna private market should be the same. However, the premiums of the Exchange are estimated through the KFF Calculator, and therefore have a certain margin of error. Actually, the margin of error is relatively small, as can be assessed by comparing the prices of the bronze and silver plans of both markets.

<sup>17</sup> In Massachusetts, the ratio applicable to tobacco use is set by law to 1:1, which means that there can be no discrimination on prices based on that variable.



*US average*

US average	Exchange (estimation through the Calculator)			
	Bronze		Silver	
	Premium	Premium after subsidies	Premium	Premium after subsidies
Billy and Danny, 25 years	229,25	153	283	207
William and Daniel, 60 years	618,08	60	766	207

*Figure 7. Premiums offered in the Exchange, US average (amounts in \$).**Sources: Kaiser Family Foundation and Aetna.***4.3 STUDY OF THE EXCHANGES THROUGH THE DATA OBTAINED***The individual mandate: coverage or fine?*

The first step in this study is to consider the incentives of each individual to join the Exchange and get coverage, from an economical point of view. In order to do so, it is essential to reckon the amount of the Individual Shared Responsibility (ISR), that is to say, the fine that an individual is due to pay if they do not comply with the individual mandate—providing that they are not exempted.

As already explained, the ISR is the higher amount of either the 2.5% of household income above the tax return filing threshold, or the flat dollar amount per person. In any case, the cap for the ISR is the premium of the Bronze plan of the Marketplace. Taking into account all these considerations, Figure 8 proceeds to determine the ISR for all the four individuals, taking into account that the tobacco use is not relevant here.

Income excess amount	Annual income	\$30,000.00
	Tax return filing threshold for singles under 65	\$10,350.00
	Annual income above the tax return filing threshold	\$19,650.00
	2.5% of total income excess amount	\$491.25
Flat dollar amount		\$695.00
Annual penalty amount (the higher of excess income amount or flat dollar amount)		\$695
Monthly penalty amount		\$57.92

*Figure 8. Individual Shared Responsibility of Billy and Danny.*

It is noticeable that the penalty is far smaller than the premium of the Bronze plan. Indeed, if the ISR was higher than the bronze premium, then it would be capped by it and its amount would be the amount of that premium. However, in the case of our study, it is clear that the cap does not apply, and therefore the monthly penalty amount, for any of the four individuals, is the same: \$57.92. At first glance, the decision of any of the individuals will be not to join any insurance plan and simply pay the monthly penalty. Nevertheless, there are other factors that may influence to their choice, as whether they feel or actually are more or less healthy, and consequently, less or more inclined to buy insurance anyway.

It is necessary to consider an annual income far higher, of \$100,000, for a single person to have an ISR capped by the bronze premium, and only in certain Marketplaces. In this case, the ISR would be \$186.77 (see Figure 9), which would be higher than the bronze plan in the Massachusetts Exchange (where it costs \$174.17),

and therefore a rational individual would prefer buying insurance. However, it would not be higher than the bronze premium in the Delaware Exchange (where it costs \$285,67, as the income range is not eligible for subsidies), or even the US average bronze premium, which is \$229 (see Figure 7). As a result, it can be concluded that for a single person the influence of the individual mandate is very small, only applicable for relatively high annual incomes.

Single person (25 years old)	Income excess amount	Annual income	\$100,000.00
		Tax return filing threshold for singles under 65	\$10,350.00
		Annual income above the tax return filing threshold	\$89,650.00
		2.5% of total income excess amount	\$2,241.25
	Flat dollar amount		\$695.00
	Annual penalty amount (the higher of excess income amount or flat dollar amount)		\$2,241.25
	Monthly penalty amount		\$186.77

*Figure 9. Individual Shared Responsibility of a single person with an annual income of \$100,000.*

Despite the conclusion reached, the research will proceed to consider the four individuals as single, as it is a simplification useful when studying the following aspects of Obamacare.

#### *The range of menus available*

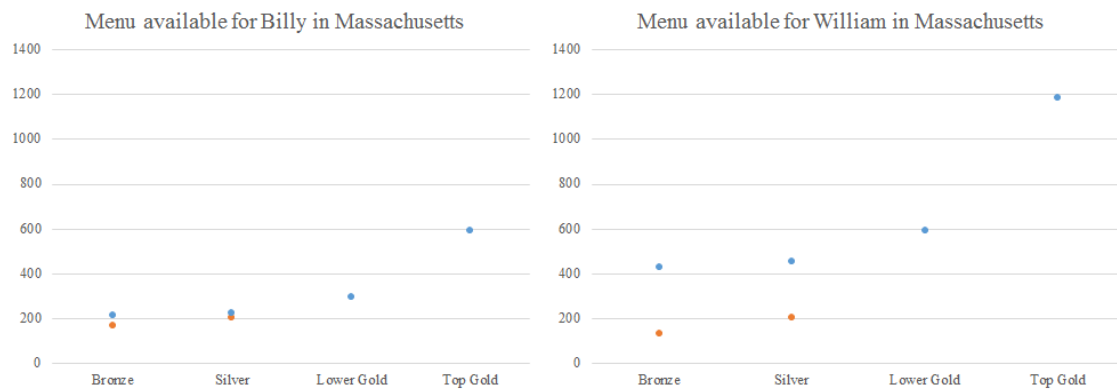
The second important aspect to consider in this research is the variety of different options or menus available in the market for each individual. As already

seen, the diversity of menus on offer is a way of indirectly assign the appropriate health plan to each individual, according to their risk profile. This way, low risk individuals will be attracted to a low cost bronze plan, and higher risk individuals will be inclined to buy silver or gold plans, depending on their risk level and their income. It is an interest way to avoid direct discrimination from the insurer, according to the risk level of each customer, as it is illegal. Instead, it is the own customer who self-allocate themselves in the plan that is more appropriate to their risk profile.

In this sense, the broader the range of premiums, the better. This can be assessed by the difference between the cheapest and the most expensive plan, as it shows the variety of expense options available for any individual. As can be observed in Figures 10 and 11, the difference between the bronze and the top gold plans is quite important. As a matter of fact, there are two tendencies that should be highlighted: on the one hand, the range is wider when the customer is older; and on the other hand, the range is wider when Aetna is out of the Marketplace. The first observation is the result of the stronger subsidies that receive elders, which help to lower considerably the premium of the bronze and silver plans; and the higher risk that they have to need coverage, which increases the average cost, especially if considering the real cost charged by the insurer, once it receives both the money from the customer's pocket and from the subsidies.



**Figure 10.** Menus available for Billy and William in Delaware (in blue, premiums without subsidies, in red premiums after subsidies).



**Figure 11.** Menus available for Billy and William in Massachusetts (in blue, premiums without subsidies, in red premiums after subsidies).

Concerning the larger difference of premium costs when Aetna is out of the Exchange, it can be the effect of the less strict regulations concerning premiums rates on the private market. In this regard, it is noticeable that the premiums of the different categories (bronze, silver and even gold) are actually cheaper in Massachusetts for the elder (William), where Aetna is outside the Exchange; but the top gold plan is more expensive. That leads to a much broader range in Massachusetts, especially if the subsidies are not taken into account (see Figure 12). It could be one of the reasons why Aetna has pulled out of most of the Exchanges, as they can charge more freely, though there is an important drawback: in the private market, individuals cannot benefit from the tax credits, which have an important weight when considering lower income households.

State	Risk profile (according to age)	Premium range <sup>18</sup>
Delaware	Billy, 25	\$149.60
	William, 60	\$404.39
Massachusetts	Billy, 25	\$378.72
	William, 60	\$757.12

**Figure 12.** Premium ranges available in the private market for each individual according to age.

<sup>18</sup> The *premium range* is the difference between the most expensive and the cheapest plans in each private market, without considering subsidies. For example, in Delaware, the premium range for Billy is the difference between the premiums of the top gold plan (\$435.33) and the bronze (\$285.73).

### *The subsidies*

Last but not least, it is important to analyse the effect of the subsidies on the actual cost of the plan for the individual. The essential goal of the subsidies is to foster cross-subsidisation of the cost of coverage between rich and poor citizens, but in a greater extent for the elder than the younger, as will be seen.

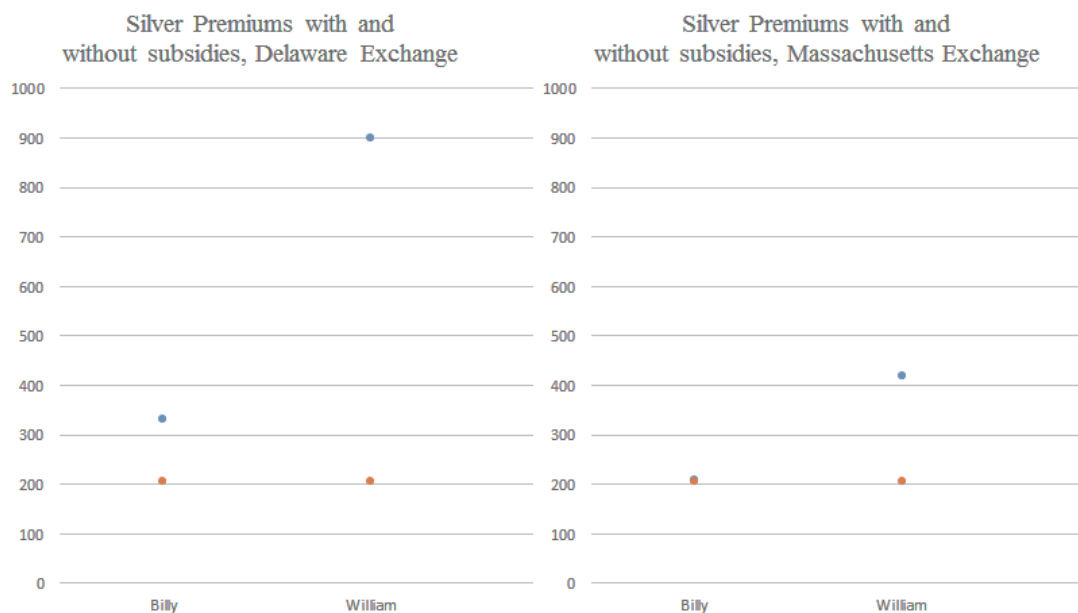
Firstly, it is necessary to compute the amount of the premium applicable to the individuals of the research. To do so, the only relevant variables are their income and their household size, so they all are entitled to the same premium price. Their annual income of \$30,000 is 252.52% the poverty line (\$11,880 for a single-member family), so they should spend only up to the 8.28% of their income on health coverage. It means that, no matter the cost of the plan they buy, it will cost a maximum of \$207 (the 8.28% of \$30,000, on a monthly basis). There is a limit though: this subsidised final cost is tied to the second cheapest silver plan available.

The result of the tax credit system is that for any market price of the premium that the insurer charges according to the age of the customer ( $p_a$ ), there is a subsidy the amount of which will eventually also depend on the age of the customer ( $s_a$ ). The real cost for the customer ( $c_a$ ) is the subtraction of the subsidy to the market price of the premium:  $p_a - s_a = c_a$ . Taking into account that the market premiums for the elder are far higher than the ones for the younger ( $p_{60} > p_{25}$ ), and that the cost for the customer is the same when their incomes are the same ( $c_{60} = c_{25}$ ), then the subsidies of the elder are also higher than the ones of the younger ( $s_{60} > s_{25}$ ). The amount of the subsidies is precisely the subtraction of the cost for the customer to the market price of the premium:

$$s_{25} = p_{25} - c_{25} = \begin{cases} \text{in Delaware:} & 333 - 207 = 126 \\ \text{in Massachusetts:} & 210 - 207 = 3 \end{cases}$$

$$s_{60} = p_{60} - c_{60} = \begin{cases} \text{in Delaware:} & 899 - 207 = 692 \\ \text{in Massachusetts:} & 419 - 207 = 212 \end{cases}$$

The result of this system of tax credits is a clear preference to subsidise the elder than the younger (see Figure 13). This favourable treatment of the elder is even more obvious when considering the bronze premiums after subsidies (see Figure 14). If an individual chooses a bronze plan, as it is cheaper than the benchmark plan (the second cheapest silver plan), the same amount of the subsidy applies to the bronze premium. For example, the \$692 subsidy for William in Delaware applied to the bronze premium of \$772.33 results in a final cost of \$80.33; while the \$126 subsidy for Billy in the same State, applied to his bronze premium of \$285.67, results in a cost of \$159.67 (see Figure 5). This is a highly curious outcome, because despite originally having a far higher bronze premium (\$772.33 compared with \$285.67), the elder ends up paying a plan for half the price of that of the younger (\$80 compared with \$160).



**Figure 13.** Silver Premiums in each Exchange (in blue, premiums without subsidies, in red, premiums after subsidies).



**Figure 14.** Bronze Premiums in each Exchange (in blue, premiums without subsidies, in red, premiums after subsidies).

Another important observation is that, as the real cost for the consumer is the same when the income is the same, there is a kind of compensation between States. That is to say, the States where the premiums are higher receive more subsidies by individual of the same age and income, as is the case of Delaware compared to Massachusetts (see Figures 13 and 14).



## 5 CONCLUSION. WHY ARE SOME INSURANCE COMPANIES LEAVING THE EXCHANGES?

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### *Advantages of the Exchanges*

The research has clarified some aspects of the ACA, but at the same time it has posed some questions. On the one hand, it has proven the significant role of the subsidies as a means to redistribute costs and help low income households, focusing especially on the elder. It has also highlighted the fact that any person on any State will have to pay the same silver coverage, if eligible for tax credits and provided that they have the same income and household size.

Indeed, the essential element that benefits both insurers and customers is the subsidy. The subsidy comes from the federal pocket (and therefore, it comes from the taxpayers' contribution), and lets the insurer keep high premiums, while the insured benefits from a at times considerable deduction. Thanks to this mechanism, the Obamacare ensures access to coverage for the more vulnerable, especially the elder. But in order to keep it, it is essential that the government guarantee an important part of the budget to subsidies –which is currently under threat, under the new presidency of Trump.

A decisive drawback for the insurers that leave the Exchanges is that their customers are not entitled to get tax credits. Taking into account the generous subsidies that the marketplaces offer, especially to the poorer and the elder, it can be a crucial inconvenience for many clients. But maybe the aim of the insurers is precisely to avoid this kind of customers, as they tend to be the less healthy.

### *Disadvantages of the Exchanges*

On the other hand, the study has proven that the individual mandate has practically no influence when considering a household of only one individual. The research has been limited by the simplification pursued in this regard, and it could be

interesting for any other future research to proceed with the comparison of the effect of the individual mandate on households of other sizes.

Concerning the reason why private insurers such as Aetna are leaving the Marketplaces, the main reason probably is the strict regulation imposed by Obamacare. However, it is not clear the extent to which this argument is decisive. In the first place, the regulation of prices into the Exchanges may constraint the capacity of the insurance companies to raise premiums, but the research has proven that the prices are not much higher outside the Exchange.

An important uncontested advantage of being out of the Exchange is the wider range of premiums between the cheapest and the most expensive menus. It may be one of the factors that influence on the companies who leave, as it allows them a broader offer of choices for the potential customers to self-allocate themselves according to their risk profile. This helps the company to reach a larger amount of people, and to distribute them more appropriately. Nevertheless, the research has shown that the range of menus available inside the Marketplaces is actually quite broad, so this factor cannot be the only one.

The main reason given by the insurance companies for leaving is basically that they incur in important losses. These losses can be the result of not attracting enough young and healthy individuals, which may in turn be due to the weak effect of the individual mandate. This feeble influence of the mandate is the consequence of either a too low fine, or a too high bronze premium. Therefore, a reasonable solution could be either to raise the amount of the fine from the current 2.5% of income, or to subsidise more strongly the younger.

### ***Final conclusion***

In conclusion, this thesis proposes to increase the penalty for non-compliance with the individual mandate, and at the same time, to readjust the distribution of the subsidies more proportionally between the younger and the elder. The current system

prioritises the elder, which is socially sensible. However, from an economic point of view, it is also important to incentivise the younger to enter the Exchanges, as it is the only way to compensate the expenses of the elder for the insurer. Furthermore, as the new regulation does not allow insurers to discriminate on no other basis than age or tobacco use, it is relevant that the insurers can get some more leverage when fixing prices, which could imply widening the current 3:1 rate for premium variation according to the age.

## 6 ABBREVIATIONS

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ACA	Affordable Care Act (also referred to as Obamacare)
APTC	Advanced Payments of the Premium Tax Credit
KFF	Kaiser Family Foundation
SRP	Shared Responsibility Payment
Obamacare	Affordable Care Act (ACA)
US(A)	United States (of America)

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### 7.3 LAWS AND CASE-LAW

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US CONSTITUTION

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## 8 ANNEX I. INSURANCE PLANS AVAILABLE ON AETNA PRIVATE MARKET


### 8.1 DELAWARE

*Billy*

Aetna Bronze Deductible Only HSA Eligible HNOnly	Aetna Bronze Deductible Only HSA Eligible HNOnly PD	Aetna Bronze Deductible Only HSA Eligible PPO	Aetna Bronze \$45 Copay HNOnly
\$285.73 per month	\$289.77 per month	\$291.04 per month	\$294.78 per month
ADD TO CART	ADD TO CART	ADD TO CART	ADD TO CART
ADD MY DOCTOR	ADD MY DOCTOR	ADD MY DOCTOR	ADD MY DOCTOR
Bronze	Bronze	Bronze	Bronze
\$6,550 / \$13,100 in-network Unlimited out-of-network	\$6,550 / \$13,100 in-network Unlimited out-of-network	\$6,550 / \$13,100 in-network \$13,100 / \$26,200 out-of-network	\$7,150 / \$14,300 in-network Unlimited out-of-network
\$6,550 / \$13,100 in-network Unlimited out-of-network	\$6,550 / \$13,100 in-network Unlimited out-of-network	\$6,550 / \$13,100 in-network Unlimited out-of-network	\$7,150 / \$14,300 in-network Unlimited out-of-network
Not Covered	Not Covered	Not Covered	Not Covered
Not Covered	Not Covered	50% after deductible is met	Not Covered
\$0 after deductible is met	\$0 after deductible is met	\$0 after deductible is met	\$45 copay
\$0 after deductible is met	\$0 after deductible is met	\$0 after deductible is met	\$0 after deductible is met
\$0 after deductible is met	\$0 after deductible is met	\$0 after deductible is met	\$45 copay

24 plans available	Aetna Silver \$15 Copay \$5500 HNOnly	Aetna Silver \$15 Copay \$5500 HNOnly PD	Aetna Silver \$15 Copay \$5500 PPO	Aetna Silver \$15 Copay \$5500 PPO PD
	\$325.35 per month	\$329.60 per month	\$332.68 per month	\$336.89 per month
	ADD TO CART	ADD TO CART	ADD TO CART	ADD TO CART
Your Providers FIND A DOCTOR	ADD MY DOCTOR	ADD MY DOCTOR	ADD MY DOCTOR	ADD MY DOCTOR
Metallic level	Silver	Silver	Silver	Silver
Individual/family deductible	\$6,500 / \$11,000 in-network Unlimited out-of-network	\$6,500 / \$11,000 in-network Unlimited out-of-network	\$6,500 / \$11,000 in-network \$10,000 / \$20,000 out-of-network	\$6,500 / \$11,000 in-network \$10,000 / \$20,000 out-of-network
Individual/family out-of-pocket maximum	\$7,000 / \$14,000 in-network Unlimited out-of-network	\$7,000 / \$14,000 in-network Unlimited out-of-network	\$7,000 / \$14,000 in-network Unlimited out-of-network	\$7,000 / \$14,000 in-network Unlimited out-of-network
Pharmacy Deductible per Member	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-network services	Not Covered	Not Covered	50% after deductible is met	50% after deductible is met
Primary care physician	\$15 copay	\$15 copay	\$15 copay	\$15 copay
Specialist	\$60 copay	\$60 copay	\$60 copay	\$60 copay
Walk in retail clinic	\$15 copay	\$15 copay	\$15 copay	\$15 copay



24 plans available	Aetna Gold \$10 Copay HNOOnly	Aetna Gold \$10 Copay HNOOnly PD	Aetna Gold \$10 Copay PPO	Aetna Gold \$10 Copay PPO PD
	\$421.76 per month	\$427.05 per month	\$430.03 per month	\$435.33 per month
	<a href="#">ADD TO CART</a>	<a href="#">ADD TO CART</a>	<a href="#">ADD TO CART</a>	<a href="#">ADD TO CART</a>
Your Providers	<a href="#">ADD MY DOCTOR</a>	<a href="#">ADD MY DOCTOR</a>	<a href="#">ADD MY DOCTOR</a>	<a href="#">ADD MY DOCTOR</a>
<a href="#">FIND A DOCTOR</a>				
Metallic level	Gold	Gold	Gold	Gold
Individual/family deductible	\$1,400 / \$2,800 in-network Unlimited out-of-network	\$1,400 / \$2,800 in-network Unlimited out-of-network	\$1,400 / \$2,800 in-network \$6,750 / \$13,500 out-of-network	\$1,400 / \$2,800 in-network \$6,750 / \$13,500 out-of-network
Individual/family out-of-pocket maximum	\$5,200 / \$10,400 in-network Unlimited out-of-network	\$5,200 / \$10,400 in-network Unlimited out-of-network	\$5,200 / \$10,400 in-network Unlimited out-of-network	\$5,200 / \$10,400 in-network Unlimited out-of-network
Pharmacy Deductible per Member	\$250 in-network Not Covered out-of-network	\$250 in-network Not Covered out-of-network	\$250 in-network \$500 out-of-network	\$250 in-network \$500 out-of-network
Out-of-network services	Not Covered	Not Covered	50% after deductible is met	50% after deductible is met
Primary care physician	\$10 copay	\$10 copay	\$10 copay	\$10 copay
Specialist	\$45 copay	\$45 copay	\$45 copay	\$45 copay
Walk in retail clinic	\$10 copay	\$10 copay	\$10 copay	\$10 copay

**William**

24 plans available	Aetna Bronze Deductible Only HSA Eligible HNOOnly	Aetna Bronze Deductible Only HSA Eligible HNOOnly PD	Aetna Bronze Deductible Only HSA Eligible PPO	Aetna Bronze \$45 Copay HNOOnly
	\$772.38 per month	\$783.29 per month	\$786.73 per month	\$796.84 per month
	<a href="#">ADD TO CART</a>	<a href="#">ADD TO CART</a>	<a href="#">ADD TO CART</a>	<a href="#">ADD TO CART</a>
Your Providers	<a href="#">ADD MY DOCTOR</a>	<a href="#">ADD MY DOCTOR</a>	<a href="#">ADD MY DOCTOR</a>	<a href="#">ADD MY DOCTOR</a>
<a href="#">FIND A DOCTOR</a>				
Metallic level	Bronze	Bronze	Bronze	Bronze
Individual/family deductible	\$6,550 / \$13,100 in-network Unlimited out-of-network	\$6,550 / \$13,100 in-network Unlimited out-of-network	\$6,550 / \$13,100 in-network \$13,100 / \$26,200 out-of-network	\$7,150 / \$14,300 in-network Unlimited out-of-network
Individual/family out-of-pocket maximum	\$6,550 / \$13,100 in-network Unlimited out-of-network	\$6,550 / \$13,100 in-network Unlimited out-of-network	\$6,550 / \$13,100 in-network Unlimited out-of-network	\$7,150 / \$14,300 in-network Unlimited out-of-network
Pharmacy Deductible per Member	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-network services	Not Covered	Not Covered	50% after deductible is met	Not Covered
Primary care physician	\$0 after deductible is met	\$0 after deductible is met	\$0 after deductible is met	\$45 copay
Specialist	\$0 after deductible is met	\$0 after deductible is met	\$0 after deductible is met	\$0 after deductible is met
Walk in retail clinic	\$0 after deductible is met	\$0 after deductible is met	\$0 after deductible is met	\$45 copay

24 plans available

< MORE PLANS

	Aetna Silver \$15 Copay \$5500 HNOnly	Aetna Silver \$15 Copay \$5500 HNOnly PD	Aetna Silver \$15 Copay \$5500 PPO	Aetna Silver \$15 Copay \$5500 PPO PD
	\$879.49 per month	\$890.98 per month	\$899.29 per month	\$910.67 per month
	ADD TO CART	ADD TO CART	ADD TO CART	ADD TO CART
Your Providers	ADD MY DOCTOR	ADD MY DOCTOR	ADD MY DOCTOR	ADD MY DOCTOR
<b>FIND A DOCTOR</b>				
Metallic level	Silver	Silver	Silver	Silver
Individual/family deductible	\$5,500 / \$11,000 in-network Unlimited out-of-network	\$5,500 / \$11,000 in-network Unlimited out-of-network	\$5,500 / \$11,000 in-network \$10,000 / \$20,000 out-of-network	\$5,500 / \$11,000 in-network \$10,000 / \$20,000 out-of-network
Individual/family out-of-pocket maximum	\$7,000 / \$14,000 in-network Unlimited out-of-network	\$7,000 / \$14,000 in-network Unlimited out-of-network	\$7,000 / \$14,000 in-network Unlimited out-of-network	\$7,000 / \$14,000 in-network Unlimited out-of-network
Pharmacy Deductible per Member	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-network services	Not Covered	Not Covered	50% after deductible is met	50% after deductible is met
Primary care physician	\$15 copay	\$15 copay	\$15 copay	\$15 copay
Specialist	\$60 copay	\$60 copay	\$60 copay	\$60 copay
Walk in retail clinic	\$15 copay	\$15 copay	\$15 copay	\$15 copay

> MORE PLANS

24 plans available

< MORE PLANS


	Aetna Gold \$10 Copay HNOnly	Aetna Gold \$10 Copay HNOnly PD	Aetna Gold \$10 Copay PPO	Aetna Gold \$10 Copay PPO PD
	\$1,140.09 per month	\$1,154.40 per month	\$1,162.46 per month	\$1,176.77 per month
	ADD TO CART	ADD TO CART	ADD TO CART	ADD TO CART
Your Providers	ADD MY DOCTOR	ADD MY DOCTOR	ADD MY DOCTOR	ADD MY DOCTOR
<b>FIND A DOCTOR</b>				
Metallic level	Gold	Gold	Gold	Gold
Individual/family deductible	\$1,400 / \$2,800 in-network Unlimited out-of-network	\$1,400 / \$2,800 in-network Unlimited out-of-network	\$1,400 / \$2,800 in-network \$6,750 / \$13,500 out-of-network	\$1,400 / \$2,800 in-network \$6,750 / \$13,500 out-of-network
Individual/family out-of-pocket maximum	\$5,200 / \$10,400 in-network Unlimited out-of-network	\$5,200 / \$10,400 in-network Unlimited out-of-network	\$5,200 / \$10,400 in-network Unlimited out-of-network	\$5,200 / \$10,400 in-network Unlimited out-of-network
Pharmacy Deductible per Member	\$250 in-network Not Covered out-of-network	\$250 in-network Not Covered out-of-network	\$250 in-network \$500 out-of-network	\$250 in-network \$500 out-of-network
Out-of-network services	Not Covered	Not Covered	50% after deductible is met	50% after deductible is met
Primary care physician	\$10 copay	\$10 copay	\$10 copay	\$10 copay
Specialist	\$45 copay	\$45 copay	\$45 copay	\$45 copay
Walk in retail clinic	\$10 copay	\$10 copay	\$10 copay	\$10 copay

> MORE PLANS

**Danny**

24 plans available	<div> <div> <div>Aetna Bronze Deductible Only HSA Eligible HNOnly</div> <div>\$314.30 per month</div> <div>ADD TO CART</div> </div> <div> <div>Aetna Bronze Deductible Only HSA Eligible HNOnly PD</div> <div>\$318.74 per month</div> <div>ADD TO CART</div> </div> <div> <div>Aetna Bronze Deductible Only HSA Eligible PPO</div> <div>\$320.14 per month</div> <div>ADD TO CART</div> </div> <div> <div>Aetna Bronze \$45 Copay HNOnly</div> <div>\$324.25 per month</div> <div>ADD TO CART</div> </div> <div> <div>&gt;</div> <div>MORE PLANS</div> </div> </div>			
	<div> <div> <div>Your Providers</div> <div>FIND A DOCTOR</div> </div> <div>ADD MY DOCTOR</div> <div>ADD MY DOCTOR</div> <div>ADD MY DOCTOR</div> <div>ADD MY DOCTOR</div> </div>			
Metallic level	Bronze			
Individual/family deductible	<div>\$6,550 / \$13,100 in-network</div> <div>Unlimited out-of-network</div>			
Individual/family out-of-pocket maximum	<div>\$6,550 / \$13,100 in-network</div> <div>Unlimited out-of-network</div>			
Pharmacy Deductible per Member	Not Covered			
Out-of-network services	Not Covered			
Primary care physician	\$0 after deductible is met			
Specialist	\$0 after deductible is met			
Walk in retail clinic	\$0 after deductible is met			

24 plans available	<div> <div> <div>Aetna Silver \$15 Copay \$5500 HNOnly</div> <div>\$357.89 per month</div> <div>ADD TO CART</div> </div> <div> <div>Aetna Silver \$15 Copay \$5500 HNOnly PD</div> <div>\$362.56 per month</div> <div>ADD TO CART</div> </div> <div> <div>Aetna Silver \$15 Copay \$5500 PPO</div> <div>\$365.95 per month</div> <div>ADD TO CART</div> </div> <div> <div>Aetna Silver \$15 Copay \$5500 PPO PD</div> <div>\$370.58 per month</div> <div>ADD TO CART</div> </div> <div> <div>&gt;</div> <div>MORE PLANS</div> </div> </div>			
	<div> <div> <div>Your Providers</div> <div>FIND A DOCTOR</div> </div> <div>ADD MY DOCTOR</div> <div>ADD MY DOCTOR</div> <div>ADD MY DOCTOR</div> <div>ADD MY DOCTOR</div> </div>			
Metallic level	Silver			
Individual/family deductible	<div>\$5,500 / \$11,000 in-network</div> <div>Unlimited out-of-network</div>			
Individual/family out-of-pocket maximum	<div>\$7,000 / \$14,000 in-network</div> <div>Unlimited out-of-network</div>			
Pharmacy Deductible per Member	Not Covered			
Out-of-network services	Not Covered			
Primary care physician	\$15 copay			
Specialist	\$60 copay			
Walk in retail clinic	\$15 copay			

24 plans available	Aetna Gold \$10 Copay HNOOnly	Aetna Gold \$10 Copay HNOOnly PD	Aetna Gold \$10 Copay PPO	Aetna Gold \$10 Copay PPO PD
	\$463.94 per month <b>ADD TO CART</b>	\$469.76 per month <b>ADD TO CART</b>	\$473.04 per month <b>ADD TO CART</b>	\$478.86 per month <b>ADD TO CART</b>
Your Providers <b>FIND A DOCTOR</b>	<a href="#">ADD MY DOCTOR</a>	<a href="#">ADD MY DOCTOR</a>	<a href="#">ADD MY DOCTOR</a>	<a href="#">ADD MY DOCTOR</a>
Metallic level	Gold	Gold	Gold	Gold
Individual/family deductible	\$1,400 / \$2,800 in-network Unlimited out-of-network	\$1,400 / \$2,800 in-network Unlimited out-of-network	\$1,400 / \$2,800 in-network \$6,750 / \$13,500 out-of-network	\$1,400 / \$2,800 in-network \$6,750 / \$13,500 out-of-network
Individual/family out-of-pocket maximum	\$5,200 / \$10,400 in-network Unlimited out-of-network	\$5,200 / \$10,400 in-network Unlimited out-of-network	\$5,200 / \$10,400 in-network Unlimited out-of-network	\$5,200 / \$10,400 in-network Unlimited out-of-network
Pharmacy Deductible per Member	\$250 in-network Not Covered out-of-network	\$250 in-network Not Covered out-of-network	\$250 in-network \$500 out-of-network	\$250 in-network \$500 out-of-network
Out-of-network services	Not Covered	Not Covered	50% after deductible is met	50% after deductible is met
Primary care physician	\$10 copay	\$10 copay	\$10 copay	\$10 copay
Specialist	\$45 copay	\$45 copay	\$45 copay	\$45 copay
Walk in retail clinic	\$10 copay	\$10 copay	\$10 copay	\$10 copay

*Daniel*

24 plans available	Aetna Bronze Deductible Only HSA Eligible HNOOnly	Aetna Bronze Deductible Only HSA Eligible HNOOnly PD	Aetna Bronze Deductible Only HSA Eligible PPO	Aetna Bronze \$45 Copay HNOOnly
	\$849.62 per month <b>ADD TO CART</b>	\$861.62 per month <b>ADD TO CART</b>	\$865.40 per month <b>ADD TO CART</b>	\$876.52 per month <b>ADD TO CART</b>
Your Providers <b>FIND A DOCTOR</b>	<a href="#">ADD MY DOCTOR</a>	<a href="#">ADD MY DOCTOR</a>	<a href="#">ADD MY DOCTOR</a>	<a href="#">ADD MY DOCTOR</a>
Metallic level	Bronze	Bronze	Bronze	Bronze
Individual/family deductible	\$6,550 / \$13,100 in-network Unlimited out-of-network	\$6,550 / \$13,100 in-network Unlimited out-of-network	\$6,550 / \$13,100 in-network \$13,100 / \$26,200 out-of-network	\$7,150 / \$14,300 in-network Unlimited out-of-network
Individual/family out-of-pocket maximum	\$6,550 / \$13,100 in-network Unlimited out-of-network	\$6,550 / \$13,100 in-network Unlimited out-of-network	\$6,550 / \$13,100 in-network Unlimited out-of-network	\$7,150 / \$14,300 in-network Unlimited out-of-network
Pharmacy Deductible per Member	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-network services	Not Covered	Not Covered	50% after deductible is met	Not Covered
Primary care physician	\$0 after deductible is met	\$0 after deductible is met	\$0 after deductible is met	\$45 copay
Specialist	\$0 after deductible is met	\$0 after deductible is met	\$0 after deductible is met	\$0 after deductible is met
Walk in retail clinic	\$0 after deductible is met	\$0 after deductible is met	\$0 after deductible is met	\$45 copay

24 plans available	<b>Aetna Silver \$15 Copay \$5500 HNOnly</b>	<b>Aetna Silver \$15 Copay \$5500 HNOnly PD</b>	<b>Aetna Silver \$15 Copay \$5500 PPO</b>	<b>Aetna Silver \$15 Copay \$5500 PPO PD</b>	<a href="#">MORE PLANS</a>
<a href="#">MORE PLANS</a>	\$967.44 per month	\$980.07 per month	\$989.22 per month	\$1,001.74 per month	<a href="#">MORE PLANS</a>
<a href="#">FIND A DOCTOR</a>	<a href="#">ADD TO CART</a>	<a href="#">ADD TO CART</a>	<a href="#">ADD TO CART</a>	<a href="#">ADD TO CART</a>	
Your Providers	<a href="#">ADD MY DOCTOR</a>	<a href="#">ADD MY DOCTOR</a>	<a href="#">ADD MY DOCTOR</a>	<a href="#">ADD MY DOCTOR</a>	
<b>Metallic level</b>	Silver	Silver	Silver	Silver	
<b>Individual/family deductible</b>	\$8,500 / \$11,000 in-network Unlimited out-of-network	\$8,500 / \$11,000 in-network Unlimited out-of-network	\$8,500 / \$11,000 in-network \$10,000 / \$20,000 out-of-network	\$8,500 / \$11,000 in-network \$10,000 / \$20,000 out-of-network	
<b>Individual/family out-of-pocket maximum</b>	\$7,000 / \$14,000 in-network Unlimited out-of-network	\$7,000 / \$14,000 in-network Unlimited out-of-network	\$7,000 / \$14,000 in-network Unlimited out-of-network	\$7,000 / \$14,000 in-network Unlimited out-of-network	
<b>Pharmacy Deductible per Member</b>	Not Covered	Not Covered	Not Covered	Not Covered	
<b>Out-of-network services</b>	Not Covered	Not Covered	50% after deductible is met	50% after deductible is met	
<b>Primary care physician</b>	\$15 copay	\$15 copay	\$15 copay	\$15 copay	
<b>Specialist</b>	\$60 copay	\$60 copay	\$60 copay	\$60 copay	
<b>Walk in retail clinic</b>	\$15 copay	\$15 copay	\$15 copay	\$15 copay	


24 plans available	<b>Aetna Gold \$10 Copay HNOnly</b>	<b>Aetna Gold \$10 Copay HNOnly PD</b>	<b>Aetna Gold \$10 Copay PPO</b>	<b>Aetna Gold \$10 Copay PPO PD</b>	<a href="#">MORE PLANS</a>
<a href="#">MORE PLANS</a>	\$1,254.10 per month	\$1,269.84 per month	\$1,278.71 per month	\$1,294.45 per month	<a href="#">MORE PLANS</a>
<a href="#">FIND A DOCTOR</a>	<a href="#">ADD TO CART</a>	<a href="#">ADD TO CART</a>	<a href="#">ADD TO CART</a>	<a href="#">ADD TO CART</a>	
Your Providers	<a href="#">ADD MY DOCTOR</a>	<a href="#">ADD MY DOCTOR</a>	<a href="#">ADD MY DOCTOR</a>	<a href="#">ADD MY DOCTOR</a>	
<b>Metallic level</b>	Gold	Gold	Gold	Gold	
<b>Individual/family deductible</b>	\$1,400 / \$2,800 in-network Unlimited out-of-network	\$1,400 / \$2,800 in-network Unlimited out-of-network	\$1,400 / \$2,800 in-network \$6,750 / \$13,500 out-of-network	\$1,400 / \$2,800 in-network \$6,750 / \$13,500 out-of-network	
<b>Individual/family out-of-pocket maximum</b>	\$5,200 / \$10,400 in-network Unlimited out-of-network	\$5,200 / \$10,400 in-network Unlimited out-of-network	\$5,200 / \$10,400 in-network Unlimited out-of-network	\$5,200 / \$10,400 in-network Unlimited out-of-network	
<b>Pharmacy Deductible per Member</b>	\$250 in-network Not Covered out-of-network	\$250 in-network Not Covered out-of-network	\$250 in-network \$500 out-of-network	\$250 in-network \$500 out-of-network	
<b>Out-of-network services</b>	Not Covered	Not Covered	50% after deductible is met	50% after deductible is met	
<b>Primary care physician</b>	\$10 copay	\$10 copay	\$10 copay	\$10 copay	
<b>Specialist</b>	\$45 copay	\$45 copay	\$45 copay	\$45 copay	
<b>Walk in retail clinic</b>	\$10 copay	\$10 copay	\$10 copay	\$10 copay	

## *Billy and Danny*

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
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Individual and Family health plans Sort by: Price ▼

Plan	Office Visit	Deductible	Drug Savings	Monthly Cost	
 <b>Minuteman Health.</b> MyDoc HMO Gold 1500 Gold <a href="#">Compare</a>	\$25 <a href="#">Find Doctors</a>	\$1,500	<a href="#">Add Rx drugs to see savings</a>	<b>\$294.93</b>	<a href="#">Apply</a> <a href="#">Details</a>
 <b>Minuteman Health.</b> MyDoc HMO Gold Basic Gold <a href="#">Compare</a>	\$20 <a href="#">Find Doctors</a>	\$500	<a href="#">Add Rx drugs to see savings</a>	<b>\$295.82</b>	<a href="#">Apply</a> <a href="#">Details</a>
 <b>Minuteman Health.</b> MyDoc HMO Gold Plus Gold <a href="#">Compare</a>	\$30 <a href="#">Find Doctors</a>	\$1,000	<a href="#">Add Rx drugs to see savings</a>	<b>\$300.33</b>	<a href="#">Apply</a> <a href="#">Details</a>

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Individual and Family health plans Sort by: Price ▼

Plan	Office Visit	Deductible	Drug Savings	Monthly Cost	
 <b>Direct Care Copay 1000 ...</b> Platinum <a href="#">Compare</a>	\$5 <a href="#">Find Doctors</a>	\$0	<a href="#">Add Rx drugs to see savings</a>	<b>\$510.97</b>	<a href="#">Details</a>
 10 days to apply for February 01, 2017 start date (Subject to carrier's guidelines)					
 <b>fallonhealth</b> Select Care Copay 1000 ... Platinum <a href="#">Compare</a>	\$5 <a href="#">Find Doctors</a>	\$0	<a href="#">Add Rx drugs to see savings</a>	<b>\$580.62</b>	<a href="#">Apply</a> <a href="#">Details</a>
 10 days to apply for February 01, 2017 start date (Subject to carrier's guidelines)					
 <b>Harvard Pilgrim HealthCare</b> Affordable HMO 25 Platinum <a href="#">Compare</a>	\$25 <a href="#">Find Doctors</a>	\$0	<a href="#">Add Rx drugs to see savings</a>	<b>\$593.53</b>	<a href="#">Apply</a> <a href="#">Details</a>
 2 days to apply for February 01, 2017 start date (Subject to carrier's guidelines)					

*William and Daniel*

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**Company**

- ☐ Fallon Health (6)
- ☐ Harvard Pilgrim H... (5)
- ☐ Minuteman Health (13)

**Monthly Cost**

- ☐ Under \$500 (8)
- ☐ \$500 to \$600 (2)
- ☐ \$600 to \$700 (2)
- ☐ \$700 to \$800 (2)
- ☐ \$800 to \$900 (3)
- ☐ \$900 to \$1,000 (3)
- ☐ \$1,000 to \$1,100 (2)
- ☐ \$1,100 & Above (2)

**Deductible**

- ☐ Under \$500 (5)

Individual and Family health plans Sort by: Price

Plan	Office Visit	Deductible	Drug Savings	Monthly Cost	
<b>Minuteman Health.</b> MyDoc HMO Bronze HS... Bronze <a href="#">Compare</a>	\$50 Copay after deductible <a href="#">Find Doctors</a>	\$3,400	<a href="#">Add Rx drugs</a> to see savings	<b>\$429.44</b>	<a href="#">Apply</a> <a href="#">Details</a>
<b>Minuteman Health.</b> MyDoc HMO Bronze 1750 Bronze <a href="#">Compare</a>	\$50 Copay after deductible <a href="#">Find Doctors</a>	\$1,750	<a href="#">Add Rx drugs</a> to see savings	<b>\$442.25</b>	<a href="#">Apply</a> <a href="#">Details</a>
<b>Minuteman Health.</b> MyDoc HMO Bronze Sta... Bronze <a href="#">Compare</a>	\$25 Copay after deductible <a href="#">Find Doctors</a>	\$2,750	<a href="#">Add Rx drugs</a> to see savings	<b>\$449.70</b>	<a href="#">Apply</a> <a href="#">Details</a>
<b>Minuteman Health.</b>					<a href="#">Apply</a>

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Individual and Family health plans Sort by: Price

Plan	Office Visit	Deductible	Drug Savings	Monthly Cost	
<b>Minuteman Health.</b> MyDoc HMO Silver Plus Silver <a href="#">Compare</a>	\$15 Copay after deductible <a href="#">Find Doctors</a>	\$2,000	<a href="#">Add Rx drugs</a> to see savings	<b>\$458.19</b>	<a href="#">Apply</a> <a href="#">Details</a>

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<b>Minuteman Health.</b> MyDoc HMO Silver Basic... Silver <a href="#">Compare</a>	\$35 <a href="#">Find Doctors</a>	\$2,050	<a href="#">Add Rx drugs</a> to see savings	<b>\$465.47</b>	<a href="#">Apply</a> <a href="#">Details</a>
<b>Minuteman Health.</b> MyDoc HMO Silver Basic Silver <a href="#">Compare</a>	\$30 <a href="#">Find Doctors</a>	\$2,000	<a href="#">Add Rx drugs</a> to see savings	<b>\$468.04</b>	<a href="#">Apply</a> <a href="#">Details</a>





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Individual and Family health plans Sort by: Price ▾

Plan	Office Visit	Deductible	Drug Savings	Monthly Cost	
 <b>Minuteman Health.</b> MyDoc HMO Gold 1500 Gold <a href="#">Compare</a>	\$25 <a href="#">Find Doctors</a>	\$1,500	<a href="#">Add Rx drugs to see savings</a>	<b>\$589.61</b>	<a href="#">Apply</a> <a href="#">Details</a>
 <b>Minuteman Health.</b> MyDoc HMO Gold Basic Gold <a href="#">Compare</a>	\$20 <a href="#">Find Doctors</a>	\$500	<a href="#">Add Rx drugs to see savings</a>	<b>\$591.40</b>	<a href="#">Apply</a> <a href="#">Details</a>
 <b>Minuteman Health.</b> MyDoc HMO Gold Plus Gold <a href="#">Compare</a>	\$30 <a href="#">Find Doctors</a>	\$1,000	<a href="#">Add Rx drugs to see savings</a>	<b>\$600.41</b>	<a href="#">Apply</a> <a href="#">Details</a>
 <b>Minuteman Health.</b>					<a href="#">Apply</a>

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Individual and Family health plans Sort by: Price ▾

Plan	Office Visit	Deductible	Drug Savings	Monthly Cost	
<b>Direct Care Copay 1000 ...</b> Platinum <a href="#">Compare</a>	\$5 <a href="#">Find Doctors</a>	\$0	<a href="#">Add Rx drugs to see savings</a>	<b>\$1,021.50</b>	<a href="#">Details</a>
 10 days to apply for February 01, 2017 start date (Subject to carrier's guidelines)					
 <b>fallonhealth</b> Select Care Copay 1000 ... Platinum <a href="#">Compare</a>	\$5 <a href="#">Find Doctors</a>	\$0	<a href="#">Add Rx drugs to see savings</a>	<b>\$1,160.74</b>	<a href="#">Apply</a> <a href="#">Details</a>
 10 days to apply for February 01, 2017 start date (Subject to carrier's guidelines)					
 <b>Harvard Pilgrim HealthCare</b> Affordable HMO 25 Platinum <a href="#">Compare</a>	\$25 <a href="#">Find Doctors</a>	\$0	<a href="#">Add Rx drugs to see savings</a>	<b>\$1,186.56</b>	<a href="#">Apply</a> <a href="#">Details</a>
 2 days to apply for February 01, 2017 start date (Subject to carrier's guidelines)					