

Comments for the Record
U.S. House Committee on Ways and Means,
Subcommittee on Oversight
Hearing on Health Insurance Individual Responsibility

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Chairman Buchanan, Ranking Member Lewis, and members of the Subcommittee on Oversight, my name is John E McDonough and I am a professor of practice in the Department of Health Policy and Management at the Harvard T.H. Chan School of Public Health in Boston, Massachusetts. I hold a doctoral degree in public health and a master's degree in public administration. Formerly I worked between 2008 and 2010 as a senior advisor on national health reform for the U.S. Senate Committee on Health, Education, Labor and Pensions where I participated in the writing and passage of the Affordable Care Act (ACA). Between 2003 and 2008, I served as executive director of Health Care for All, Massachusetts' leading consumer health advocacy organization where I was deeply involved in the passage and implementation of the 2006 Massachusetts Health Reform Law. Between 1985 and 1997, I served as a member of the Massachusetts House of Representatives where I held many health policy positions of responsibility, including co-chair of the committees on health care and insurance.

I am here to offer testimony on the ACA's "requirement to maintain minimum essential coverage" (Section 1501, 42 USC 18091), as well as a similar provision enacted as part of the 2006 Massachusetts health reform law that served as a model for Title 1 of the ACA. Though popularly – or unpopularly – known as the "individual mandate," that term is not used in either federal or state statutes to describe the "individual responsibility" provisions of the law. I advance six points, outlined below:

- The individual mandate is a core mechanism to ensure a healthy risk pool and more stable premiums in a guaranteed issue market that bans the practices of medical underwriting and pre-existing condition exclusions in insurance contracting in the individual market.
- To eliminate the mandate and leave in place guaranteed issue is a sure and proven formula for major disruption in the individual health insurance market nationally, a concern that is neither speculative nor hypothetical.
- Between the late 1980s and 2009, the individual mandate was largely an idea championed by both conservative and moderate Republicans until former President

Barack Obama endorsed it in June 2009.

- Other mechanisms could be used to replace the individual mandate, such as late enrollment penalties or the proposed “continuous coverage” requirement advanced in Speaker Paul Ryan’s “Better Way” health proposal, though the latter requirement would be far more punitive towards individual consumers than the ACA’s individual mandate.
- No empirical evidence I can find suggests that the individual mandate is the cause of the stresses recently experienced during the 2017 enrollment cycle in many of the federal and state health insurance exchanges. Other causes more effectively explain these recent problems.
- Finally, the suggestion that the size of the individual mandate’s tax penalty should be increased to enhance the uptake of individual health insurance is misguided. More effective would be increasing premium and cost sharing subsidies for income eligible consumers to more closely mirror affordability levels in the Massachusetts health insurance system.

I will elaborate on these in turn.

First, the individual mandate is a core mechanism to ensure a healthy risk pool and more stable premiums in a guaranteed issue market that bans the practices of medical underwriting and pre-existing condition exclusions in insurance contracting in the individual market.

In the 2006 Massachusetts and 2010 U.S. health reform laws, the individual mandate was recognized as an essential component of a “three-legged stool” to expand health insurance coverage, especially in the private individual (non-group) health insurance market. The other two legs are: first, guaranteed issue of individual health insurance to all qualified persons regardless of medical history or current health status; and second, premium and cost sharing support/subsidies to make the purchase of health insurance affordable for those who would otherwise be unable to afford the cost of coverage. Like a stool, all three of the legs are necessary for the structure to stand reliably.

The “three-legged stool” structure, including the individual mandate, has proven effective in the achievement of a principal goal of both the Massachusetts and U.S. health reform laws, that is the lowering of the numbers of persons without insurance. In Massachusetts, the rate of uninsured dropped from 7.7% in 2006 to 2.5% in 2015.¹ In the U.S. the number of uninsured Americans has dropped from 48.6 million in 2010 to 28.6 million in 2015.² The U.S. uninsurance rate, now between 8-9%, is the lowest it has even been recorded in the nation.

Research studies have reached differing conclusions on the precise impact of the individual mandate itself in achieving these reductions in rates and numbers of uninsured. For example, in a 2015 RAND Research Brief, Eibner and Saltzman found that the absence of the ACA mandate would lead to a 20% drop in individual market enrollment, and a 27% drop in

enrollment among young adults.³ On the other hand, Frean et al in a 2016 Working Paper for the National Bureau of Economic Research, found only “small and inconsistent effects of the individual mandate in 2014 and 2015 with minimal policy impact.”⁴

Regardless of the empirical evidence, the health insurance industry as well as health insurance experts have been clear for nearly three decades that some form of a coverage obligation is essential to provide a balanced risk pool and to provide necessary confidence that guaranteed issue can be maintained in a financially sustainable manner. A December 7 2016 letter to Speaker Paul Ryan and Leader Nancy Pelosi from the American Academy of Actuaries describes this dynamic well:

“A sustainable health insurance market depends on enrolling enough healthy people over which the costs of the less healthy people can be spread. To ensure viability when there is a guarantee that consumers with pre-existing conditions can obtain health insurance coverage at standard rates requires mechanisms to spread the cost of that guarantee over a broad population. The ACA’s individual mandate encourages even the young and healthy to obtain coverage.”⁵

Among health insurance and health policy experts, widespread consensus exists that to maintain guaranteed issue without any pre-existing condition exclusions requires some enforceable mechanism to provide a robust and diverse risk profile among eligible consumers.

Second, to eliminate the mandate and leave in place guaranteed issue is a sure and proven formula for major disruption in the individual health insurance market nationally, a concern that is neither speculative nor hypothetical.

The experiences of states between the early 1990s and today demonstrates that the concern about the workability of guaranteed issue without some enforceable mechanism such as an individual mandate is a legitimate and essential issue. Eight states adopted guaranteed issue, most during the 1990s. When the damage from guaranteed issue without some form of mandate became evident, some states abandoned the protections, while other states accepted the damage to their individual market risk pool and continued the practice.

As of 2012, only five states (Maine, Massachusetts, New Jersey, New York, and Vermont) required individual market health insurers to guarantee issue all products to all residents. These five states maintained their guaranteed issue requirements despite a collapse in participation by individual consumers in the face of growing unaffordable health insurance premiums. The impact was most dramatically evident in New York State where participation in the individual market dropped from 752,000 covered lives in the early 1990s when guaranteed issue was first adopted to about 34,000 covered lives in 2009.⁶ Massachusetts saw a similar form of insurance “death spiral” when it adopted guaranteed issue in its individual health insurance market in 1996 without an accompanying mandate, only seeing the non-group market return to viability after implementation of the state’s individual mandate in 2007.⁷ Other states, notably New Hampshire, Kentucky, and Washington repealed or restricted their

guaranteed issue rules once the market impact became clear. Four states (Michigan, Pennsylvania, Rhode Island, and Virginia, plus the District of Columbia) in 2012 still required their Blue Cross Blue Shield carrier to act as insurer of last resort, an increasingly unworkable formula as the cost of care for clients in the individual markets became increasingly unsustainable.⁸

Though guaranteed issue and the related banning of medical underwriting and pre-existing condition exclusions remain among the most popular features of the ACA, with public promises to retain it from President Trump, House Speaker Ryan, and Senate Majority Leader McConnell, the certain danger of maintaining guaranteed issue without an enforceable mandate of some form is neither speculative nor hypothetical. The Congressional Budget Office released a report as recently as January 17 concluding that “eliminating the mandate penalties and the subsidies while retaining the market reforms would destabilize the nongroup market and the effect would worsen over time.”⁹

Third, between the late 1980s and 2009, the individual mandate was largely an idea championed by both conservative and moderate Republicans until former President Barack Obama endorsed it in June 2009.

The policy idea of a mandate on individuals to purchase health insurance as a mechanism to achieve near-universal coverage was introduced in the American health policy sphere in the late 1980s by Professor Mark Pauly of the University of Pennsylvania’s Wharton School as an alternative to single-payer or employer mandate proposals to reach the same goal.¹⁰ The idea was advanced and promoted by the Heritage Foundation, and especially by Dr. Stuart Butler, in the same period.¹¹ In the years 1993-1994 when the President Bill Clinton promoted national health reform legislation, Senators Robert Dole, John Chafee and Charles Grassley, along with 19 other Republican members of Congress as co-sponsors, advanced a proposal to establish a national mandate on most Americans to purchase health insurance as an alternative to the Clinton Administration’s approach.¹² In the late 1990s, Louisiana Senator John Breaux became the first prominent Democrat to embrace the concept of the individual mandate.

In 2004, Massachusetts Governor Mitt Romney proposed legislation to establish a statewide individual mandate that drew support from overwhelming Democratic majorities in the State Senate and House of Representatives, from U.S. Senator Edward Kennedy, and from President George W. Bush whose Administration provided key financing for the program. The legislation was signed into law on April 12, 2006 in a ceremony in Boston’s historic Faneuil Hall. Seated on the stage was a representative of the Heritage Foundation which consulted with Governor Romney on structuring the individual mandate and creating the Massachusetts Health Insurance Connector Authority, the first governmental example of a health insurance exchange, another concept championed by the Heritage Foundation.¹³

The Massachusetts law incorporated the “three-legged stool” concept that is the organizing idea behind Title 1 of the ACA: systemic insurance market reform including guaranteed issue, an individual mandate to purchase health insurance, and premium/cost sharing subsidies to

make the buying of insurance affordable. When Governor Romney left his position in January 2007 to begin his first campaign for the Republican nomination for U.S. President, full implementation of the law was left to his successor, Gov. Deval Patrick. During Romney's 2008 campaign, he received the endorsement of Sen. James DeMint who noted in his letter of support that as Governor, Romney had "passed innovative health care reforms."¹⁴

During the 2008 campaign for the Democratic nomination for U.S. President, leading candidates Hillary Clinton and John Edwards both advanced health care reform proposals that included an individual mandate, while candidate Barack Obama did not. Indeed, President Obama did not officially endorse inclusion of an individual mandate in health reform legislation until June 2009, well after the Congressional process had started in earnest. It was in this period that many Congressional Republicans began to distance themselves from the individual mandate. Exemplifying this change was Senator Charles Grassley who stated on Fox News in June 2009: "When it comes to states requiring it for automobile insurance, the principle then ought to lie the same way for health insurance because everybody has some health insurance costs, and if you aren't insured, there's no free lunch. Somebody else is paying for it."¹⁵ Three months later, in September 2009, his views had shifted: "Individuals should maintain the freedom to choose whether to purchase health insurance coverage or not."¹⁶

Democrats embraced the individual mandate concept in the 2000s in good faith to find common ground on universal coverage with Republicans and conservatives on a key structural feature championed by the latter groups. But as the ground shifted for Democrats leading them to support the mandate was a practical way forward, the ground shifted for Republicans compelling them to abandon a policy they had themselves promoted for nearly two decades.

Fourth, other mechanisms could be used to replace the individual mandate, such as late enrollment penalties or the proposed "continuous coverage" requirement advanced in Speaker Paul Ryan's "Better Way" health proposal, though the latter requirement would be more punitive towards individual consumers than the ACA's individual mandate.

Several mechanisms have been proposed to replace the ACA's individual mandate in replacement legislation. One of these is a "late penalty" fee such as the ones included in Medicare Parts B and D.¹⁷ The alternative most often advanced in recent months is the proposal that guaranteed issue only be applied to individuals who maintain "continuous coverage" of their health insurance policies within defined limits. This proposal received prominent backing in the House Republican Leadership's "A Better Way" health proposals released this past June 2016:

"Our plan also proposes a new patient protection for those Americans who maintain continuous coverage. ... If an individual experiences a qualifying life event, he or she would not be charged more than standard rates – even if he or she is dealing with a serious medical issue. ... However, making the decision to forego coverage during this one-time open enrollment period will result in the forfeiture of continuous coverage

protections and lead to higher health insurance coverage costs for that individual for a period in the future.”¹⁸

Individuals and families unable to avoid undefined coverage gaps permitted under the Better Way plan would be subject to medical underwriting and pre-existing condition exclusions for, as mentioned above, “a period in the future.” Those individuals with any pre-existing conditions found to be relevant by health insurance companies for underwriting purposes would be denied coverage. Under the Better Way plan, their recourse for denied insurance applicants would be to seek coverage from newly re-established state high risk pools. The experience with state high risk pools has been mixed at best. Pools first established in the 1970s were chronically underfunded, often with long waiting lists and high premiums, with coverage limits that were banned by the ACA, such as lifetime and annual benefit caps, waiting periods, and limited benefits.¹⁹

Beyond these concerns is the issue of just how many individuals would be newly subjected to what I refer to as the “medical underwriting circle of hell.” The current estimate of uninsured Americans by the CDC is 29 million, while the CBO estimates that as many as 32 million Americans potentially losing their insurance under Republican repeal legislation vetoed by President Obama one year ago. While we can hope that any ACA repeal will be accompanied by a robust replacement law that will fully cover all who may otherwise lose coverage, no such guarantee exists today. This new era of insurance industry medical underwriting will subject at least tens of millions of Americans to renewed medical underwriting. By comparison, in 2015 an estimated 7.5 million Americans paid the ACA individual mandate assessment on their tax return.²⁰

Even though the health insurance industry has been vocal in advocating for changes to the ACA in line with its priorities, including for example repeal of the health insurance industry tax and adjustment to special enrollments periods, no leading industry voices have been urging the Congress or Administration to re-impose medical underwriting and pre-existing condition exclusions. My conversations with insurance industry executives reveal no desire to return to that sordid work. Americans take pride that the days of classifying our fellow citizens according to their medical histories are in the past, and they show no desire to return to them.

Fifth, no empirical evidence I can find suggests that the individual mandate is the cause of the stresses recently experienced during the 2017 enrollment cycle in some federal and state health insurance exchanges. Other causes more effectively explain these recent problems.

It is well known that many of the federal and state health insurance exchanges have experienced turbulent times leading up to 2017 enrollment year characterized by rising premiums and market disruption. Some suggest that problems with health exchanges in this period demonstrate a fatal marketplace meltdown, justifying calls to scrap the ACA’s private insurance coverage structure and replace it with something new. It is a legitimate question – whether exchanges face fundamental dysfunction or temporary and fixable disruption. Regardless of one’s conclusions on this question, no convincing evidence ties the disruption to

the individual mandate. A related and legitimate question is whether the mandate's financial penalties are high enough – a question I will address in the next and final section.

Regarding the state of the ACA exchanges, a December 22 2016 "RatingsDirect" report from S&P Global concludes:

"S&P Global Ratings expects U.S. health insurers to report improved underwriting performance in the individual market in 2016 versus 2015. Although most insurers will still report an underwriting loss for 2016, the losses will be smaller than in 2015. This means the changes made to network design and premium pricing are gaining traction, though more still needs to be done. For 2017, we expect continued improvement, with more insurers reporting close to break-even or better results for this segment."

S&P also believes that premium hikes for 2018 "will be well below the 2017 hike."²¹ Despite the controversies over the future of the ACA and premium increases, signups in the 2016-17 open enrollment period were the most robust since the launch of the marketplaces in 2013-14.²²

A noteworthy development involves the state of Alaska where, last spring, alarms sounded when premiums were projected to rise by more than 40% in the state's individual health insurance market. Rather than accept the increases, the Republican-controlled state legislature passed a law to establish a reinsurance mechanism for the individual market, a move that rapidly lowered premium increases to about 7%. The ACA included three recognized mechanisms to moderate premium growth: risk adjustment, reinsurance, and risk corridors. Under the ACA, the latter two expired after the first 3 years at the end of 2016, and the risk adjustment has been subject to controversial limitations imposed by the Congress. These developments significantly exacerbated the 2016-17 turmoil in the ACA markets.

Beyond this, variation exists among the 51 state and federal exchanges, and a pattern emerges. Most states that have actively worked to make their exchanges succeed by meeting the needs of their citizens outperform exchanges where state political leaders have been antagonistic or apathetic to their success.

Sixth and finally, finally, the suggestion that the size of the individual mandate's tax penalty should be increased to enhance the uptake of individual health insurance is misguided. More effective would be increasing premium and cost sharing subsidies for income eligible consumers to more closely mirror affordability levels in the Massachusetts health insurance system.

Numerous commentators, inside and outside of the insurance industry, have suggested that the individual mandate is too weak to be effective and that the monetary penalty should be increased to provide a greater incentive to motivate individuals to purchase coverage.²³ The penalty for non-purchase of health insurance under the ACA applies to individuals and families deemed able to afford the cost. For 2017 and beyond, the penalty is \$695 (adjusted for inflation in future years) or 2.5% of income, whichever is higher, for a full year without

coverage. Under Massachusetts health reform, once fully implemented, the tax penalty for non-coverage reached a maximum of approximately \$900 per year. Though different, the two sets of individual mandate penalties were fairly close in financial impact for non-coverage.

Once implemented, Massachusetts health reform triggered a major drop in the state’s uninsurance rate from 7.7% in 2006 to 2.5% in 2015, and the rate had dropped to below 3% by 2008. Far more significant for Massachusetts than the size and scope of the individual mandate penalty was – and is – the extent of premium and cost sharing subsidies available to eligible consumers. The Massachusetts affordability formula for eligible consumers using the state’s exchange is far more generous, as Table 1 below demonstrates:

Table 1: Individual Contributions to Subsidized Coverage under the 2006 MA Health Reform Law compared with the ACA, for Select Income Levels relative to the Federal Poverty Level

Income Relative to Poverty (%)	MA – Required contribution to subsidized single coverage as share of income (%)	ACA – Required contribution to subsidized coverage as share of income, 2015 (%)
100	0	2.01
150	0	4.02
200	2.1	6.30
250	3-4	8.10
300	4.2	9.56
350	No Cap	9.56
400	No Cap	9.56
Over 400	No Cap	No cap

Source: Urban Institute²⁴

While not strictly comparable to Massachusetts, the current uninsurance rate for the U.S. is 8.6%.²⁵ Rather than increasing the size of the individual mandate tax penalty, more effective would be to address the reality that the affordability formulas for premium and cost sharing subsidies in the ACA is not generous enough for many families in the target income categories, most importantly for households with incomes over 250% of the Federal Poverty Line.

Conclusion

Though the individual mandate is the most controversial and unpopular aspect of the ACA, it is a foundational element that enables the ACA to provide coverage to tens of millions of Americans who would otherwise be uninsured. It is also a key feature that permits the highly popular guaranteed issue rule to function effectively. Removing the individual mandate by itself would have negative consequences for the health security of many tens of millions of Americans and would move our nation backwards in terms of addressing the key challenges we face in continuously improving our nation’s health and health care.

Footnotes:

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³ Eibner C, Saltzman (2015). How does the ACA individual mandate affect enrollment and premiums in the individual insurance market? RAND Research Brief. Available at:

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¹¹ Butler SM (1989). Assuring affordable health care for all Americans. Heritage Foundation. Accessed electronically 1/16/17 at <http://www.heritage.org/research/lecture/assuring-affordable-health-care-for-all-americans>

¹² M. Cooper. "Conservatives Sowed Idea of Health Care Mandate, Only to Spurn It Later." *New York Times*. February 14, 2012. Available at:

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