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November 2017

HEALTH INSURANCE EXCHANGES

Changes in Benchmark Plans and Premiums and Effects of Automatic Re-enrollment on Consumers' Costs

GAO-18-68

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GAO Highlights

Highlights of GAO-18-68, a report to congressional requesters

Why GAO Did This Study

During open enrollment, eligible returning consumers may re-enroll in their existing health insurance exchange plan or choose a different plan. Those who do not actively enroll in a plan may be automatically re-enrolled into a plan. According to the Department of Health and Human Services, automatic re-enrollment is intended to help ensure consumers' continuity in coverage. However, some have questioned whether automatic re-enrollment could have unintended financial consequences for consumers.

GAO was asked to review automatic re-enrollment and benchmark plans. GAO examined 1) the extent to which plans identified as benchmark plans remained the same plans from year to year, and how premiums for benchmark plans changed; 2) the proportion of exchange consumers who were automatically re-enrolled into the same or similar plans, and how these proportions compared to those for consumers who actively re-enrolled, and 3) the extent to which consumers' financial responsibility for premiums changed for those who were automatically re-enrolled compared to those who actively re-enrolled.

GAO reviewed relevant guidance and analyzed county-based data from the Centers for Medicare & Medicaid Services (CMS) for the 37 states that used the federal information platform, healthcare.gov, from 2015 through 2017. GAO also interviewed CMS and ASPE officials and analyzed information from ASPE on re-enrollment from 2015 to 2016.

View GAO-18-68. For more information, contact John E. Dicken at (202) 512-7114 or dickenj@gao.gov.

What GAO Found

Through the exchanges established under the Patient Protection and Affordable Care Act, consumers can directly compare and select among health plans based on a variety of factors, including premiums. Most consumers who purchase health plans through the exchanges receive tax credits to help them pay for their premiums. The value of a consumer's premium tax credit is based, in part, on the premium for the benchmark plan, which is the second lowest cost option available in the consumer's local area within the exchange's silver metal tier (one of four metal tiers that indicate the value of plans). Because plan premiums and plan availability can change over time, the benchmark plan in each local market can also change over time. GAO analyzed changes in benchmark plans and premiums from 2015 through 2017 and found:

- In most of the nearly 2,600 counties included in the analysis, the plans identified as benchmark plans, and the premiums for these plans, changed from year to year. For example, in 85 percent of counties, the 2015 benchmark plans were not benchmark plans in either 2016 or 2017.
- Gross benchmark premiums (exclusive of tax credits) increased from year to year, and increases were higher from 2016 to 2017 than they were from 2015 to 2016.
- Premium tax credits would limit the costs of increasing premiums for most consumers, though some consumers, including those not eligible for premium tax credits, would have incurred more or all of the higher premium costs.

During the annual open enrollment period, consumers who do not make an active plan selection are automatically re-enrolled into their existing plan or, if that plan is no longer available, they are generally re-enrolled into a similar plan if one has been identified. GAO analyzed information from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) for consumers enrolled in both 2015 and 2016 and found:

- About 30 percent of consumers were automatically re-enrolled in 2016, while the remaining 70 percent chose to actively re-enroll.
- Median net monthly premiums—what consumers paid after premium tax credits—increased less from 2015 to 2016 for those who actively enrolled ($5) than for those who were automatically re-enrolled ($22), although there was variation. Our findings are consistent with other work by ASPE that suggests that consumers consider possible cost savings when deciding to switch plans.

The Department of Health and Human Services provided technical comments on a draft of this report, which GAO incorporated as appropriate.

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Abbreviations

ASPE	Office of the Assistant Secretary for Planning and Evaluation
CMS	Centers for Medicare & Medicaid Services
FPL	federal poverty level
HHS	Department of Health and Human Services
MIDAS	Multidimensional Insurance Data Analytics System
PPACA	Patient Protection and Affordable Care Act

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

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The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Greg Walden
Chairman
Committee on Energy and Commerce
House of Representatives

The Honorable Fred Upton
House of Representatives

Since 2014, millions of consumers have purchased individual market health insurance plans through the health insurance exchanges—or marketplaces—established under the Patient Protection and Affordable Care Act (PPACA).[1] These consumers purchase health insurance for a variety of reasons, including being self-employed or a small business owner, or because their own employer does not offer insurance. Through the exchanges, consumers can directly compare and select among health plans based on a variety of factors, such as premiums and provider networks. PPACA also established requirements for the benefits that must be covered by health plans—referred to as essential health

[1]Private health insurance includes individual and group market plans. Participants in the individual market purchase health insurance directly from an issuer. Group market participants generally obtain health insurance through a group health plan, usually offered by an employer. The Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE) estimated that 11.1 million consumers purchased health insurance for 2016 through the exchanges as of March 2016.

PPACA required the establishment of health insurance exchanges in each state beginning in 2014. Some states established their own state-based exchanges. In states that did not elect to operate their own state-based exchange, PPACA required the federal government to establish and operate an exchange in the state, referred to as a federally facilitated exchange. All federally facilitated exchanges and some state-based exchanges use a federal information technology system called the federal platform (healthcare.gov) that maintains a common set of data elements from participating exchanges. See PPACA, Pub. L. No. 111-148, §§ 1311(b), 1321(c), 124 Stat. 119, 173, 186 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010). In this report, references to PPACA include any amendments made by the Health Care and Education Reconciliation Act of 2010.

benefits—and required issuers to market their plans according to defined categories (or metal tiers) that indicate the extent to which the plans would be expected to cover the costs of consumers' medical care.[2]

Each year, there is an open enrollment period during which new consumers may enroll for coverage and consumers who are already enrolled in an exchange plan may re-enroll into that plan or choose a different plan. Eligible consumers who do not make an active re-enrollment selection are to be automatically re-enrolled in their existing plan if it remains available. If that plan is no longer available, they are generally automatically re-enrolled in a similar plan if one was identified, or the consumers would have to actively re-enroll if a similar plan was not identified. We refer to the similar plans into which automatic re-enrollees were enrolled if their original plan was no longer available to them as a "similar crosswalked plan" throughout this report.[3] According to guidance from the Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS), the automatic re-enrollment process was established to help ensure continuity in coverage. This process can help ensure that continuity, but because the exchanges are dynamic and plan availability and premiums can change from year to year, some have questioned whether it could have unintended financial consequences for consumers.

PPACA includes a variety of provisions related to the exchanges that could impact what consumers pay for their health insurance. For example, most consumers purchasing health insurance through the exchanges are eligible for premium tax credits that can reduce their out-of-pocket payments for premiums. The amount of this credit is based on the consumer's household income relative to the cost of premiums for the second lowest cost silver plan available to the consumer—referred to as a benchmark plan—even if the consumer chooses to enroll in a

[2]PPACA standardized health insurance plans into four "metal" tiers of coverage—bronze, silver, gold, and platinum—that reflect out-of-pocket costs that may be incurred by a consumer. Bronze plans tend to have the lowest premiums, but subject consumers to the highest out-of-pocket costs (such as deductibles) when they receive health care services, while platinum plans tend to have the highest premiums and the lowest out-of-pocket costs.

[3]The criteria HHS established to identify appropriate similar crosswalked plans for federally facilitated exchanges have changed over time, but the similar crosswalked plan is typically the same metal tier level as the original plan.

different plan.[4] A consumer who is eligible for the tax credit and enrolled in a benchmark plan is responsible for paying a premium amount that is limited to a certain percentage of his or her income, and the tax credit generally covers the rest of the premium. If, however, the consumer enrolls in a plan with a higher premium than the benchmark plan premium, then the tax credit does not increase and the consumer must make up the difference. In contrast, if the consumer enrolls in an eligible plan with a lower premium than the benchmark plan premium, the tax credit generally does not decrease and the consumer's payments would be lower than if enrolled in the benchmark plan. Because plan premiums and plan availability can change over time, the benchmark plan in each local market can also change from year to year. Therefore, a consumer enrolled in a benchmark plan in one year who is re-enrolled, either actively or automatically, into the same plan the following year may find that it is no longer the benchmark plan, and so may have to pay a lower or higher share of income on premiums. Consumers who actively re-enrolled in an exchange plan may have considered the financial implications of remaining in the same plan or switching to a new plan. Consumers who were automatically re-enrolled in an exchange plan, however, may not have taken those considerations into account.

You asked us to examine various aspects of automatic re-enrollment and the potential implications for consumers. We examined:

1. the extent to which plans identified as benchmark plans remained the same plans or changed to different plans from year to year and how premiums for those plans changed;
2. the proportion of 2015 exchange consumers who were automatically re-enrolled in the same or similar crosswalked plans, and how those proportions compared to those for consumers who re-enrolled actively; and
3. the extent to which consumers' financial responsibility for premiums changed for those who were automatically re-enrolled compared to those who actively re-enrolled.

To examine the extent to which plans identified as benchmark plans remained the same plans or changed to different plans from year to year, and how premiums for those plans changed, we reviewed relevant

[4]Premium tax credits are generally available to certain eligible tax filers with household incomes from 100 to 400 percent of the federal poverty level.

guidance and analyzed data maintained by CMS. These data included information about the qualified health plans and premiums available for individual market consumers in 2,598 counties in the 37 states that used the federal platform from 2015 through 2017.[5] Specifically, we analyzed data from CMS's Qualified Health Plan Landscape files and Plan Attributes Public Use files to determine the plans and gross premiums (exclusive of any premium tax credits) offered to consumers through the exchanges during each year and to identify the likely benchmark plans by county and year.[6] We also analyzed data from CMS's Plan ID Crosswalk Public Use files for the 2015 to 2016 and 2016 to 2017 transitions to map

[5]States using the federal platform (healthcare.gov) for enrollment and eligibility in 2015 through 2017—all states with federally facilitated exchanges and the states with state-based exchanges that chose to use the federal platform in these years—included Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming. Throughout this report, we refer to these 37 states collectively as states that used the federal platform. We excluded two states that began to use the federal platform at some point after the start of the 2015 plan year—Hawaii and Kentucky—and we excluded all 11 states and the District of Columbia, which were not using the federal platform as of 2017.

[6]We downloaded the various files used in our analyses on or after November 15, 2016. The information contained in these files was subject to updates throughout the course of each year. Premium tax credits are based on the benchmark plan (i.e., the second lowest cost silver plan available to a consumer in the consumer's local area at the time of enrollment), and may vary over the year, for example, if a plan is discontinued, added, or reaches its maximum enrollment limit. Plans that became unavailable to consumers prior to November 15, 2016, because they were withdrawn from all markets or stopped taking new enrollees mid-year, would not have been included in our data. CMS officials told us that the percentage of plans that became unavailable to new consumers during any given year declined from 2015 through 2017. Moreover, most plans that are available in a part of a county are available throughout a county, but there are some exceptions, which are not captured in these files. In the cases of these exceptions, it is possible that some benchmark plans we identified differed from the benchmark plans that would have been available to consumers when they enrolled. If there was only one silver plan in a county, or if two plans were tied for the lowest cost plan, we followed Internal Revenue Service guidance by defining such plans as the benchmark plans. Similarly, if two plans were tied for the second lowest cost plan, we classified both as benchmark plans.

health plan and premium changes across years.[7] For our analyses, we selected six consumer categories that represented a broad range of nonsmoking consumers who have shopped for individual market health insurance each year. They included individuals, aged 21; individuals, aged 27; couples, aged 30, with no children; individuals, aged 40, with one child; couples, aged 50, with 2 children; and individuals, aged 60.[8] The premium amounts and supporting plan information in each data source used were self-reported by each issuer, and CMS required each issuer to comply with a data validation and attestation process.

To determine the proportion of 2015 exchange consumers who were automatically re-enrolled in the same or similar crosswalked plans, how those proportions compared to those for consumers who actively re-enrolled, and the extent to which consumers' financial responsibility for premiums changed for those who were automatically re-enrolled compared to those who actively re-enrolled, we examined analyses conducted by HHS's Office of the Assistant Secretary for Planning and Evaluation (ASPE). Specifically, we examined analyses conducted as part of ASPE's previously issued work on 2015 and 2016 enrollment data from CMS's Multidimensional Insurance Data Analytics System (MIDAS),

[7]The Plan ID Crosswalk Public Use files we used were last updated by CMS in January 2016 for the 2015 to 2016 transition and in November 2016 for the 2016 to 2017 transition. These files include data on the reasons individual health plans were linked to one another from year to year. For the purposes of our report, we identify plans as "same plans" if the issuer stated that the plans were the same and CMS accepted that characterization. We identify plans as "similar crosswalked plans" if the issuer or exchange stated, and CMS accepted, that a plan available in one year was crosswalked to a similar plan in the next year. (For the 2015 to 2016 transition, all similar crosswalked plans were identified by issuers and were plans by the same issuer as the original plan. For the 2016 to 2017 transition, CMS allowed exchanges to identify similar crosswalked plans offered by alternative issuers.) We did not independently assess plan similarity. Plans that were no longer available were not always crosswalked to plans in the next year; in these cases, we assumed that automatic re-enrollment did not occur. Our analyses assume that relevant consumer attributes (such as locality and income relative to the federal poverty level) remained constant from 2015 through 2017.

[8]Each state in our analyses uses a uniform age rating curve to specify premiums across all adult age bands, so our findings would generally apply to premiums for all age categories, with some exceptions. For example, plans' rules about certain aspects of family configurations, such as the number of dependents that may be covered, can differ, which could result in more variation across issuers in premiums for family plans.

as well as new analyses that built upon that work.[9] At our request and in accordance with specifications we provided, ASPE conducted additional analyses and provided information on the percentages of consumers who were automatically and actively re-enrolled in the same plans, similar crosswalked plans, or other plans during the 2015 to 2016 transition and the net change in monthly premiums, after the premium tax credit for these consumers.[10] This information was based on plan selections for consumers enrolled in both 2015 and 2016 through exchanges using the federal platform for enrollment and eligibility as of February 1, 2016—the day after open enrollment for health insurance in 2016 ended.[11]

To assess the reliability of the data on benchmark plans and premiums, we conducted a series of manual and electronic tests to identify missing data and other anomalies. These analyses were informed by our review of relevant documentation and interviews with knowledgeable officials from CMS. To assess the reliability of the data obtained from ASPE on re-enrollment during the 2015 to 2016 transition, we conducted a series of logic tests, including comparisons to ASPE's previously published data. We also reviewed relevant documentation and interviewed knowledgeable officials from ASPE and CMS. Using these methods, we determined that the data were sufficiently reliable for the purposes of our reporting objectives.

[9]See HHS, *Health Insurance Marketplaces 2016 Open Enrollment Period, Final Enrollment Report: For the period: November 1, 2015 – February 1, 2016* (Washington, D.C.: Mar. 11, 2016). MIDAS is a data repository and analytics platform used by CMS to capture, aggregate, and analyze enrollment and other data from multiple sources, including state-based and federally facilitated exchanges.

[10]Neither active selection nor automatic re-enrollment in a plan guarantees health insurance—payment is also required to effectuate coverage, and more people enroll than effectuate their health insurance. For example, ASPE projected that 13.8 million people would select a plan for 2017, and estimated that 11.4 million of them would effectuate their health insurance.

[11]Consumers who were in line to enter their plan selections in time were able to do so. Plan selections, whether active or automatic, may require reconciliation of data anomalies through processes that were likely not complete by the day after open enrollment ended. For example, consumers who forgot their passwords may have opened a new account to make an active re-enrollment selection, even though already automatically re-enrolled. In such cases, the consumer's active selection would override the automatic re-enrollment but identifying and eliminating the automatic re-enrollment might not have been completed. Because of these exceptions, information about plan selections may not fully align with final plan enrollments and the final proportion of consumers who were automatically re-enrolled could be somewhat lower than we report.

We conducted this performance audit from August 2016 to November 2017, in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

There are several aspects of individual market plans sold through the exchanges for consumers to consider when selecting a plan, including: (1) metal tiers; (2) premium variation and plan availability; (3) covered benefits; and (4) premium tax credits. Current exchange consumers who are eligible for continued health insurance and do not actively select and enroll in a health plan for the subsequent year may be automatically re-enrolled in the same or a similar crosswalked plan.

Considerations for Selecting and Enrolling in Individual Market Health Plans through the Exchanges

Metal Tiers

Plans sold through exchanges are offered at one of four levels of coverage, or metal tiers—bronze, silver, gold, and platinum—that reflect the out-of-pocket costs that may be incurred by a consumer. The four metal tiers correspond to the plan's actuarial value—a measure of the relative generosity of a plan's benefits that is expressed as a percentage of the covered medical expenses expected to be paid, on average, by the issuer for a standard population and set of allowed charges for in-network providers.[12] The actuarial values of these metal tiers are as follows: bronze (60 percent), silver (70 percent), gold (80 percent), and platinum

[12]Health plans typically establish a network of providers with which they negotiate reimbursement rates. The actuarial value for each plan is calculated assuming all services are obtained within the network. Consumers who choose to access services from providers outside their plans' networks may incur higher costs.

(90 percent). If an issuer sells a plan on an exchange, it must offer at least one plan at the silver level and one plan at the gold level. Issuers are not required to offer bronze or platinum plans.[13]

Premium Variation and Plan Availability

As we have previously reported, the range of premiums for health plans offered through the exchanges can vary widely across counties and states, and the number and type of plans available in the health insurance exchanges vary from year to year.[14] Issuers can add new plans and adjust or discontinue existing plans from year to year, or they can extend or restrict the locations in which plans are offered. As a result, the options available to consumers can change from year to year.

Covered Benefits

PPACA requires that health insurance plans offered through the exchanges be certified as qualified health plans, meaning that they must provide essential health benefits, comply with cost sharing limits, and meet certain other requirements.[15] Essential health benefits include items and services within ten categories.[16] Some health insurance plans offered through the exchanges include benefits above and beyond the minimum requirements. For these plans, only the percentage of the plan premium that covers the essential health benefits is considered when determining the consumer's benchmark plan.

[13]In addition to the metal tiers, catastrophic plans are available to consumers who meet certain criteria, and generally provide health insurance for services only after a high deductible is met.

[14]See, for example, GAO, *Private Health Insurance: The Range of Premiums and Plan Availability for Individuals in 2014 and 2015*, GAO-15-687 (Washington, D.C.: August 10, 2015).

[15]Health insurance exchanges must certify qualified health plans prior to the beginning of the open enrollment period. Plans are generally re-certified each calendar year.

[16]The ten categories of essential health benefits are (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services (including behavioral health treatment); (6) prescribed drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

Premium Tax Credits

Certain consumers purchasing health insurance through the exchanges are eligible for and receive premium tax credits that may reduce their out-of-pocket costs for premiums.[17] To be eligible for premium tax credits, individuals and families must generally have a household income of at least 100, but no more than 400, percent of the federal poverty level (FPL).[18]

Consumers who are eligible for premium tax credits and enrolled in the benchmark plan are responsible for paying premiums that are generally limited to a percentage of household income, such that individuals and families with lower household incomes contribute a smaller portion of their income toward the health plan premium than individuals and families with higher incomes, and premium tax credits may be applied to only the portion of the premium that covers essential health benefits. For example, in 2016, the percentage of household income that consumers who were eligible for premium tax credits and who lived in the United States were expected to pay toward the portion of their premiums for their benchmark plan that covered essential health benefits was 2.03 percent for those at 100 percent of the FPL, 8.18 percent for those at 250 percent of FPL, and 9.66 percent for those at 400 percent of FPL. A consumer's required contribution to the premium is the amount of that benchmark plan premium that is not covered by the premium tax credit. (See table 1.)

[17]Premium tax credits are refundable, which means that eligible consumers may receive the full amount of the premium tax credit at the time they file their federal income taxes for the preceding year, or they may be paid in advance, on a monthly basis—concurrent with monthly premium payments—to an issuer on behalf of an eligible individual to offset premiums owed. GAO found that CMS has been at increased risk of making improper advance premium tax credit payments to issuers on behalf of consumers. See *Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit*, GAO-17-467 (Washington, D.C.: July 13, 2017). Certain consumers who are eligible for advanced premium tax credits, earn less than 250 percent of the federal poverty level, and purchase silver plans through an exchange, and certain American Indian and Alaskan Natives who purchase plans of any metal tier through an exchange, may also be eligible for cost-sharing subsidies, an additional form of federal financial assistance that further reduce consumers' out-of-pocket costs for medical expenses.

[18]In states that chose to expand Medicaid under PPACA, premium tax credits are generally available to those with household incomes of from 138 through 400 percent of the FPL, because individuals eligible for Medicaid are not eligible for premium tax credits.

Table 1: Hypothetical Example of Differences in Premium Contributions and Tax Credits, by Income Level, for an Eligible Consumer Enrolled in a Benchmark Plan in 2016

Income (dollars)	Percent of federal poverty level	Maximum percent of consumer's household income paid towards premiums for a benchmark plan	Consumer's maximum annual premium contribution for essential health benefits, if enrolled in a benchmark plan (dollars)	Premium tax credit, if enrolled in a benchmark plan with an annual premium of $6,000 (dollars)
11,770	100	2.03	239	5,761
29,425	250	8.18	2,407	3,593
47,080	400	9.66	4,548	1,452

Source: GAO analysis of Internal Revenue Service information. | GAO-18-68

Note: Premium tax credit eligibility for 2016 was determined using 2015 federal poverty guidelines; because poverty levels were higher for Alaska and Hawaii, residents of those two states are not covered by these hypothetical examples. Premium tax credits are based on a consumer's family size and annual income and may be received when filing federal income taxes for the applicable year, or may be paid to the issuer in advance, in which case they are subject to adjustment—or reconciliation—when the consumer files an income tax return for that year. The premium contributions and tax credit amounts in this table are rounded to the nearest dollar amount. Actual premium contributions and tax credit amounts may vary based on actual plan enrollment, household income, and other factors. A consumer's' maximum annual contribution for premiums is based on the percentage of the benchmark premium that is allocated for essential health benefits; the benchmark premium—and the consumer's responsibility—will be higher if the plan covers benefits in addition to the essential health benefits.

Although consumers' premium tax credit amounts are determined in part based on the cost of premiums for their local benchmark plan, the credit can also be applied towards the premiums for other eligible exchange plans. However, the premium tax credit available to consumers does not increase if they enroll in exchange plans with higher premiums than the local benchmark plan. In such cases, consumers are responsible not only for their required contribution but also for the difference in premiums. Similarly, if a consumer chooses to enroll in an exchange plan with lower premiums than the local benchmark plan premium, then the consumer's premium tax credit would also generally remain the same, so the consumer would pay less for that plan. The tax credit cannot, however, exceed the total value of the premium. Because most consumers enrolling in exchange plans are eligible for premium tax credits, most consumers' out-of-pocket premium costs are lower than the advertised cost of premiums. (See table 2.)

Table 2: Hypothetical Example of Differences in Net Annual Premiums for an Individual with a Household Income at 250 Percent of the Federal Poverty Level Who Was Eligible for a Premium Tax Credit in 2016

Plan type	Annual premium (dollars)	Consumer's maximum annual premium contribution, if enrolled in the benchmark plan (dollars)	Premium tax credit amount (dollars)	Net annual premium (dollars)
Hypothetical benchmark plan	6,000	2,407	3,593	2,407
Plan with premiums 10 percent lower than the benchmark plan	5,400	2,407	3,593	1,807
Plan with premiums 10 percent higher than the benchmark plan	6,600	2,407	3,593	3,007

Source: GAO analysis of Internal Revenue Service information. | GAO-18-68

Note: Premium tax credit eligibility for 2016 was determined using 2015 federal poverty guidelines; because poverty levels were higher for Alaska and Hawaii, residents of those two states are not covered by these hypothetical examples. Premium tax credits are based on a consumer's family size and annual income and may be received when filing federal income taxes for the applicable year, or may be paid to the issuer in advance, in which case they are subject to adjustment—or reconciliation—when the consumer files an income tax return for that year. The premium contributions and tax credit amounts in this table are rounded to the nearest dollar. Actual premium contributions and tax credit amounts may vary based on actual plan enrollment, household income, and other factors. The hypothetical plans in this analysis do not cover benefits that go beyond the essential health benefits. A consumer's' maximum annual contribution for premiums is based on the percentage of the benchmark premium that is allocated for essential health benefits; the benchmark premium—and the consumer's responsibility—will be higher if the plan covers benefits in addition to the essential health benefits.

Process for Automatically Re-enrolling Consumers into Exchange Plans

Re-enrollment in an exchange plan may occur through either an active choice by a consumer or through automatic re-enrollment by the exchange.[19] Eligible returning consumers may enroll in a health insurance plan through the exchange each year during an open enrollment period.[20] Federally facilitated exchanges automatically re-enroll eligible exchange

[19]The exchanges determine consumers' initial eligibility and, prior to re-enrollment each year, generally must re-determine eligibility. GAO has conducted work examining the enrollment process and has identified limitations to the verification controls used for the federal platform. For more information, see *Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk*, GAO-16-29 (Washington, D.C.: February 23, 2016).

[20]The open enrollment periods have changed over time, and health insurance obtained through an open enrollment period is for a calendar year. For example, the 2017 open enrollment period was from November 1, 2016, to January 31, 2017, and the 2018 open enrollment period will be from November 1 to December 15, 2017. Outside the open enrollment period, consumers can generally enroll in a health insurance plan for the remainder of the calendar year only if they qualify for a special enrollment period due to a qualifying life event, such as getting married, having a baby, or losing other health insurance.

consumers for the next year, unless their health insurance is terminated or the consumer makes an active plan selection.[21] Through automatic re-enrollment a consumer is re-enrolled in the same plan for the next year if that plan remains available to him or her; if the same plan is no longer available (e.g., because the issuer decided to discontinue a particular plan or to stop offering the plan in certain locations), then the consumer is generally re-enrolled in a similar crosswalked plan. The criteria HHS established for identifying appropriate similar crosswalked plans have changed over time, but the similar crosswalked plan is typically the same metal tier level as the original plan.[22] During the 2015 to 2016 transition, all similar crosswalked plans were plans offered by the same issuer as the original plan. If that issuer no longer offered an exchange plan, there was generally no crosswalked plan and automatic re-enrollment was not an option.[23] Starting with the 2016 to 2017 transition, if the original issuer did not offer a similar plan, then automatic re-enrollment could be into a health plan offered by a different issuer, with plan similarity determined using established criteria.[24]

Both issuers and exchanges have had roles in informing consumers about the enrollment process. For example, prior to the start of the 2015 and 2016 open enrollment periods, both the exchange and health plan issuer were to provide current exchange consumers with general information about the upcoming enrollment period, including key dates

[21]Certain circumstances—such as expired lawful permanent residence status or an unexpected problem with an exchange application identified late in the year—may prevent or delay automatic re-enrollment. All exchanges are authorized to facilitate automatic re-enrollment, though the procedures used by states with a state-based exchange may differ from the federally facilitated exchanges.

[22]For example, among the 2,598 counties included in our analysis, when a plan that had been available in 2015 was no longer available in 2016, the similar crosswalked plan was a plan of a different metal level in about 11 percent of counties. Among silver plans that were not available in a subsequent year, the metal level of the similar crosswalked plan was something other than silver in less than 1 percent of counties in the transition from 2015 to 2016, and in no counties in the transition from 2016 to 2017.

[23]According to HHS officials, some 2015 exchange consumers in Florida were automatically re-enrolled into a plan for 2016 that was offered by a different issuer.

[24]Starting in 2017, if a consumer's current plan is not available and no qualified health plans from the original issuer are available, federally facilitated exchanges are to automatically re-enroll the consumer into a qualified health plan that services the consumer's local area, taking into account the issuer's ability to absorb new enrollment and the lowest premium plans, unless otherwise directed by the state's regulatory authority. According to these criteria, consumers should be automatically re-enrolled in a qualified health plan of the same metal level and network type when possible.

and information regarding eligibility for re-enrollment. In addition, some consumers were also to receive special notices from the exchange that provided more detailed information regarding their application status, eligibility for enrollment and affordability programs, and potential effects on enrollment if they had not updated information about their income or eligibility or reviewed their re-enrollment options with the exchange prior to the end of the open enrollment period. Consumers who were automatically re-enrolled by an exchange were to receive an additional notice with updated information about their re-enrollment status. According to CMS officials, automatically re-enrolled consumers were provided with information about their new premium amount and any new advance premium tax credit amounts in a message confirming their enrollment.

From 2015 to 2017, Most Plans Identified as Benchmark Plans Changed and Benchmark Plan Premiums Generally Increased

In most of the nearly 2,600 counties included in our analysis, the plan that we identified as the benchmark plan changed from 2015 to 2017.[25] For example, in 85 percent of the counties included in our analysis, the 2015 benchmark plans were not benchmark plans in either 2016 or 2017, the other 2 years we studied. The benchmark plan was the same plan in all 3 years in only 3 percent of counties.[26] (See table 3.)

[25]Our identification of benchmark plans was based on rank-ordering of the dollar amount of the portion of the premium that covered essential health benefits for plans offered by issuers that participated in the exchanges on Nov. 15, 2016.

[26]In the 86 counties where the benchmark plan remained the same during all 3 years, lack of competition does not seem to have been a primary cause. For each year, there were generally from two through four issuers (85 percent or more of the 86 counties) and five or more available silver plans (97 percent or more of these counties).

Table 3: Number and Percent of Counties in Which the Benchmark Plan in One Year for an Individual Aged 21 Was a Benchmark Plan in Other Years, 2015 to 2017

Years in which the plan was a benchmark plan	2015		2016		2017	
	Number	Percent	Number	Percent	Number	Percent
2015 only	2,217	85.3	—	—	—	—
2016 only	—	—	1,939	74.6	—	—
2017 only	—	—	—	—	2,108	81.1
2015 and 2016 only	232	8.9	232	8.9	—	—
2015 and 2017 only	63	2.4	—	—	63	2.4
2016 and 2017 only	—	—	341	13.1	341	13.1
2015, 2016, and 2017	86	3.3	86	3.3	86	3.3
Total	**2,598**	**100**	**2,598**	**100**	**2,598**	**100**

Source: GAO analysis of data from the Centers for Medicare & Medicaid (CMS). | GAO-18-68

Note: Data are based on distribution across 2,598 counties in the 37 states using the federal platform, healthcare.gov, for enrollment and eligibility from 2015 through 2017. Although we present the results for individuals aged 21, the pattern of results was generally the same for all consumer groups we analyzed, which also included individuals aged 27; couples aged 30 with no children; individuals aged 40 with one child; couples aged 50 with two children; and individuals aged 60. Percentages may not sum to 100 because of rounding. In some cases, the benchmark plans we identified could have differed from those available to a consumer at the time of enrollment.

In addition, benchmark plan premiums were more likely to increase than decrease from year to year, and increases were higher from 2016 to 2017 than they were from 2015 to 2016. Among all the counties in our analysis, the median change in monthly premiums for the benchmark plans was an increase of 11 percent from 2015 to 2016, and 28 percent 2016 to 2017.[27] As shown in figure 1, the gross premiums for benchmark plans increased by more than 55 percent from 2016 to 2017 in 12.4 percent of the counties in our analysis but did not increase by more than 55 percent in

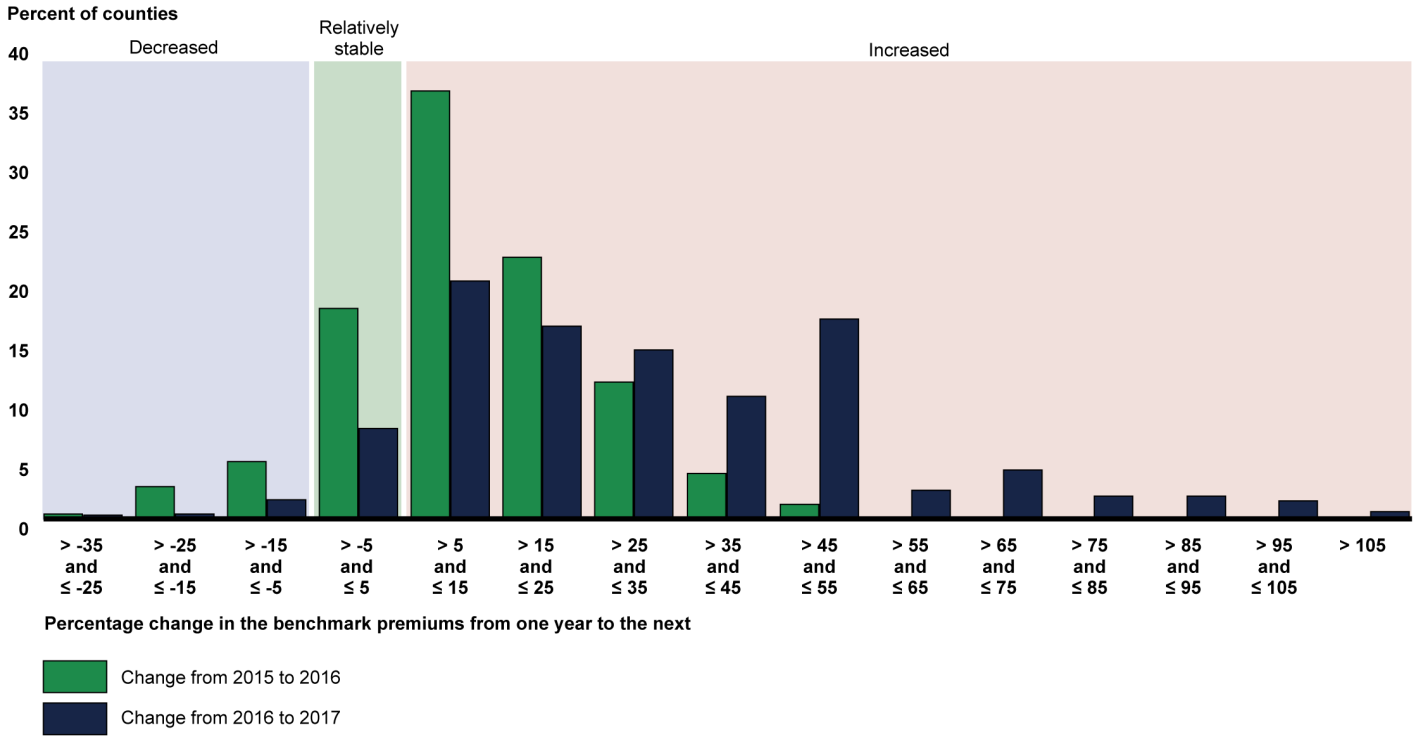
[27]For this analysis, we examined actual premiums for benchmark plans, including any amount for coverage of benefits beyond the essential health benefits. We computed the difference from year to year in the benchmark plan's premium in each county, and then rank-ordered those differences to identify the median. This method yielded a different estimate than if we had calculated the median benchmark plan premium in each year and then calculated the difference between those medians, because one method is based on a comparison of premiums within counties, while the other is not. Plans that became unavailable to consumers prior to November 15, 2016, because they were withdrawn from all markets or stopped taking new enrollees mid-year, would not have been included in our data. If the premiums for such plans had been among the two lowest cost silver plans in any of the counties in our analyses, the benchmark plan premiums could have been lower than those we identified. Our analyses of gross premiums do not take into account plan enrollment; that is, they do not weight premiums or their changes based on plan enrollment, nor do they consider the impact of premium tax credits.

any counties from 2015 to 2016. In contrast, although not particularly common, relatively stable or even decreasing premiums from year to year were more likely from 2015 to 2016 than from 2016 to 2017.[28] Appendix I provides examples of median benchmark plan premiums for 2015, 2016, and 2017 for select groups of consumers. Because premium tax credits limit eligible consumers' payments for benchmark plan premiums to a percentage of their income, an increase in premiums may not increase their financial responsibility. Instead, for eligible consumers, the amount of the tax credit would increase.[29] According to HHS, most exchange consumers have been eligible for these tax credits; those who were not eligible for tax credits would not have this protection from premium increases. The premium increases for consumers who were not eligible for premium tax credits, or for those who were eligible but who chose plans that had higher premiums than their benchmark plan premiums, could have had a more substantial financial impact, because premium tax credits would not have offset, or fully offset, the higher premiums.

[28]These findings regarding past changes in benchmark plan premiums cannot be used to predict future changes in benchmark plan premiums. As of August 2017, premiums for 2018 plans had not been finalized, although preliminary rate filings with state insurance regulators suggest that they may often be higher than 2017 premiums and are likely to vary across locations. See, for example, Kaiser Family Foundation, *An Early Look at 2018 Premium Changes and Insurer Participation on ACA Exchanges* (Menlo Park, CA: August, 2017).

[29]Because most consumers who used an exchange were eligible for premium tax credits, the impact of higher premiums for benchmark plans might have been greater for the government (and so for taxpayers) than for consumers. An assessment of the impact on the government was beyond the scope of our work.

Figure 1: Percent of Counties in Which the Benchmark Plan Premium for Individuals Aged 21 Changed, and the Extent of Those Changes, 2015 to 2017



Source: GAO analysis of data from the Centers for Medicare & Medicaid Services (CMS). | GAO-18-68

Note: Data are from 2,598 counties in the 37 states using the federal platform, healthcare.gov, for enrollment and eligibility from 2015 through 2017. Although we present the results for individuals aged 21, the pattern of results was generally the same for all consumer groups we analyzed, which also included individuals aged 27; couples aged 30 with no children; individuals aged 40 with one child; couples aged 50 with two children; and individuals aged 60. This analysis does not weight premiums or their changes based on plan enrollment, nor does it consider the impact of premium tax credits. In some cases, the benchmark plans we identified could have differed from those available to a consumer at the time of enrollment. Plans that became unavailable to consumers prior to November 15, 2016, because they were withdrawn from all markets or stopped taking new enrollees mid-year, would not have been included in our data. If the premiums for such plans had been among the two lowest cost silver plans in any of the counties in our analyses, the benchmark plan premiums could have been lower than those we identified.

Although gross premiums for benchmark plans were likely to increase from 2015 to 2016 and from 2016 to 2017, we found that in many counties, the implications for automatically re-enrolled consumers were modest because net premiums—after accounting for tax credits for those eligible for those credits—were limited. We compared the 2016 premiums for plans that had been benchmark plans in 2015 to the 2016 benchmark plan premiums, and we compared the 2017 premiums for plans that had

been benchmark plans in 2016 to the 2017 benchmark plan premiums.[30] To focus this analysis on the potential effects for those who were automatically re-enrolled, we limited our comparisons to plans that were available in both years, or plans for which a similar crosswalked plan had been identified for the second year. For this analysis, we excluded plans that were benchmark plans in one year and were also benchmark plans, or were crosswalked to a benchmark plan, in the following year.[31] We found that in many counties, the new premiums for plans that had been (but were no longer) benchmark plans differed only modestly from the new benchmark plan premiums. For example, in 60 percent or more of the counties in our analysis, the premium for the previous benchmark plan was within plus or minus about 7.5 percent of the new benchmark plan premium. This finding indicates that automatic re-enrollment from a benchmark plan into a plan that was not a benchmark plan did not necessarily result in substantially higher premiums compared to the premiums for the new benchmark plans, and the same would be true for consumers who actively chose their same or similar crosswalked plan.[32]

While modest premium differences were not uncommon in either year, figure 2 also shows that some differences were substantial. (See fig. 2.) Although consumers who were eligible for premium tax credits were somewhat insulated from large differences in premiums, if they were automatically re-enrolled in a plan with a premium that was higher than their benchmark plan premium, no matter how great the difference, they would have been be required to pay a larger share of their incomes on those premiums.[33] And, as already noted, the premium differences for consumers who were not eligible for premium tax credits, or for those who were eligible but who chose plans that had higher premiums than their benchmark plan, could have had a more substantial financial impact

[30]This analysis was based on full benchmark plan premiums, regardless of the percentage of the premium that covered essential health benefits.

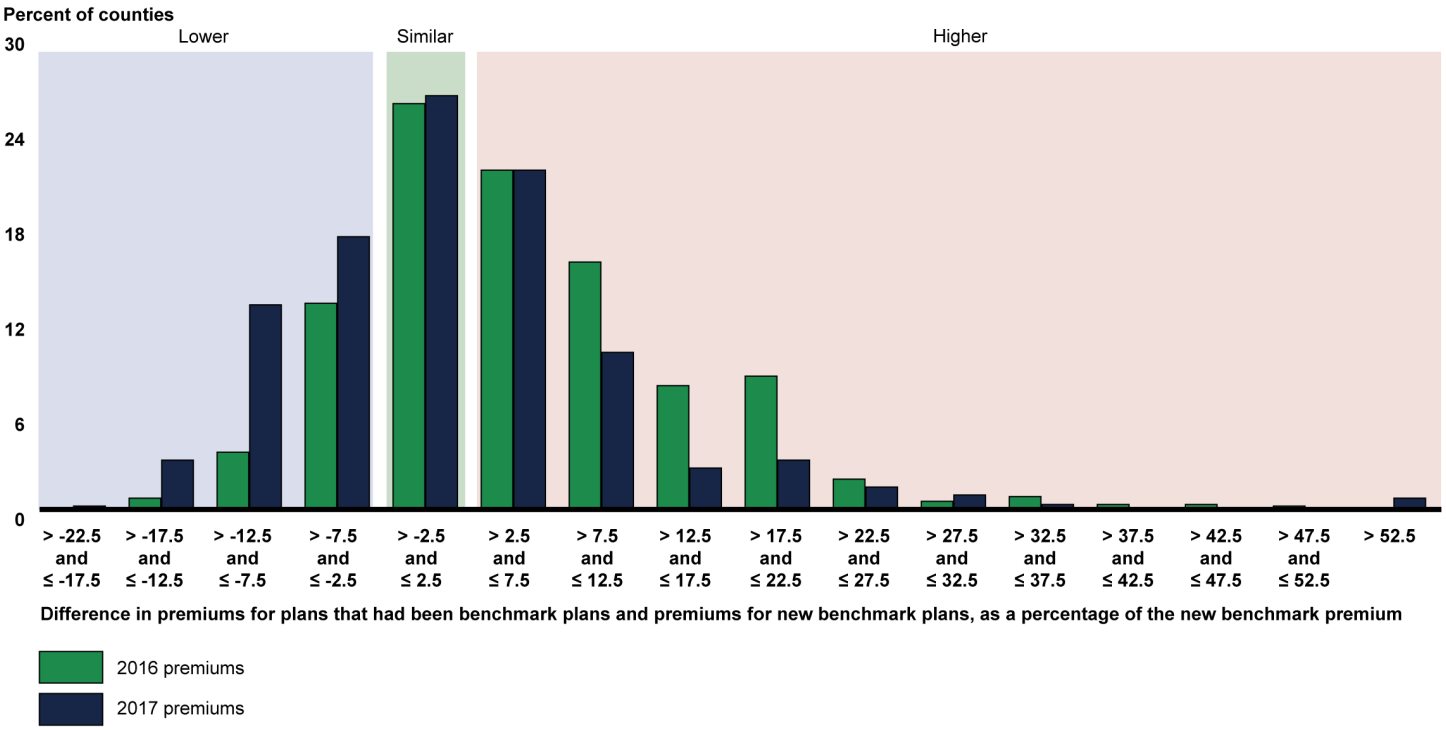
[31]Specifically, we excluded plans that were benchmark plans in both years and, if the prior year's benchmark plan was no longer available in a county, we determined whether its similar crosswalk plan was the benchmark plan. If so, we excluded it from the analysis. If it was not the benchmark plan, we compared its premium to the new benchmark plan's premium.

[32]This analysis assumes that the old and new plans both covered only the essential health benefits.

[33]Although a difference of 7.5 percent is modest in comparison to the range of full range of differences we observed, that difference could represent a meaningful difference to consumers, particularly those with low incomes.

because premium tax credits would not have offset, or fully offset, the higher premiums.

Figure 2: Percent of Counties in Which Premiums for Plans That Had Been Benchmarks Differed from the Benchmark Plan Premium in the Next Year, by Percentage Difference in Premiums, for Individuals Aged 21, 2016 and 2017



Source: GAO analysis of data from the Centers for Medicare & Medicaid Services (CMS). | GAO-18-68

Note: Data are from 2,598 counties in the 37 states using the federal platform, healthcare.gov, for enrollment and eligibility from 2015 through 2017. For this analysis, we excluded plans that were benchmark plans in one year and were also benchmark plans in the following year. If the prior year's benchmark plan was no longer available in a county, we determined whether its similar crosswalk plan was the benchmark plan, and if so, we excluded it from the analysis. If it was not the benchmark plan, we compared its premium to the new benchmark plan's premium. Although we present the results for individuals aged 21, the pattern of results was generally the same for all consumer groups we analyzed, which also included individuals aged 27; couples aged 30 with no children; individuals aged 40 with one child; couples aged 50 with two children and individuals aged 60. This analysis does not weight premiums or their changes based on plan enrollment, nor does it consider the impact of premium tax credits. In some cases, the benchmark plans we identified could have differed from those available to a consumer at the time of enrollment.

Thirty Percent of Consumers Who Re-enrolled in 2016 Were Automatically Re-enrolled, and the Remaining Consumers Actively Re-enrolled, Generally into Different Plans

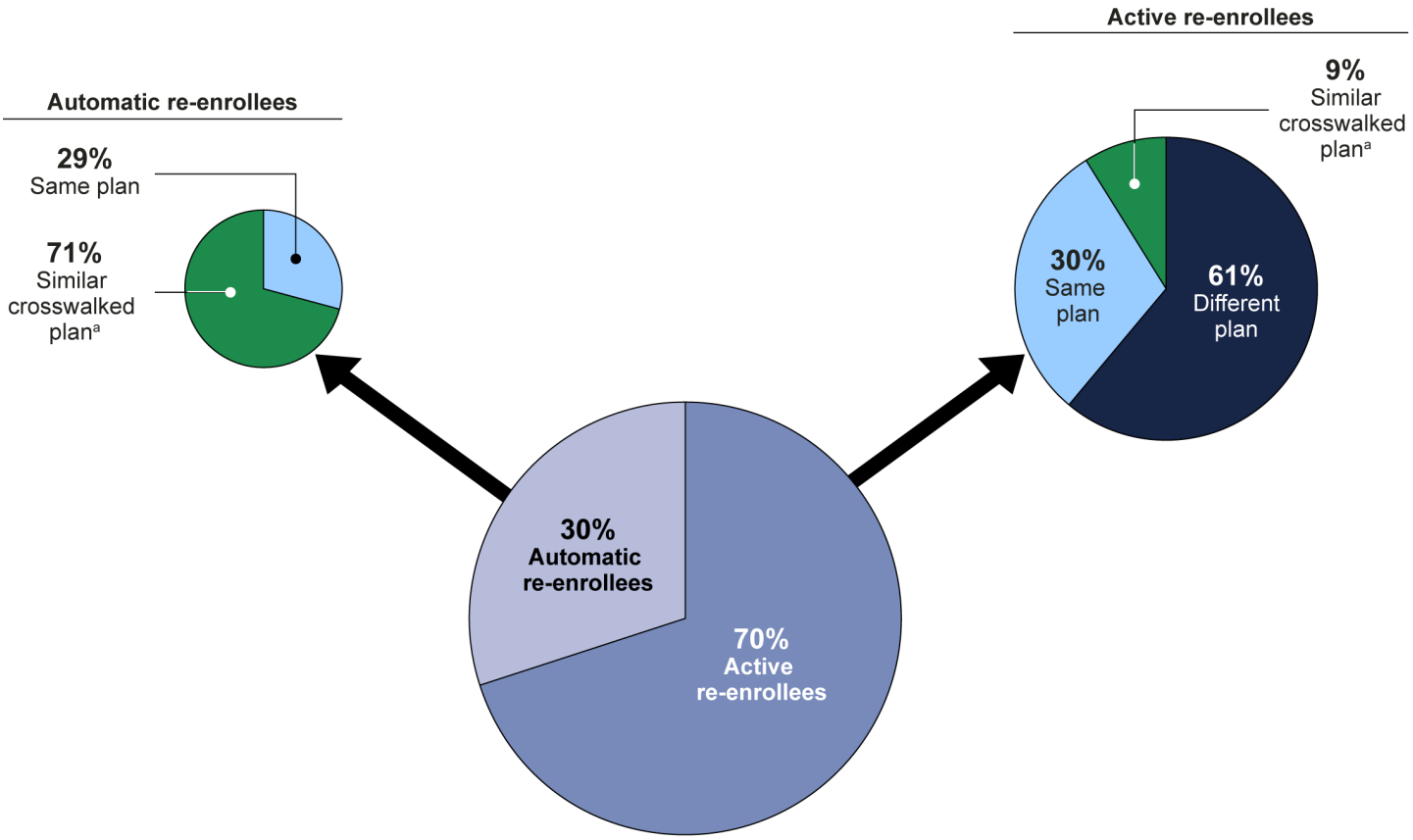
Among consumers who were enrolled in plans through the federal platform in both 2015 and 2016, 30 percent (about 1.7 million consumers) were automatically re-enrolled.[34] Of those consumers who were automatically re-enrolled, 71 percent were re-enrolled in their same plan and 29 percent were re-enrolled in a similar crosswalked plan, because their 2015 plan had been discontinued or was no longer offered in the consumer's local area.[35] These data do not indicate whether these consumers explored their options for switching plans and made an active decision not to change plans.

The remaining 70 percent of consumers who enrolled in exchange plans through the federal platform in both 2015 and 2016 (more than 3.9 million consumers) actively re-enrolled in 2016. Of these consumers, 39 percent chose the same plan in which they had been enrolled in 2015 or the similar crosswalked plan to which they would have been automatically re-enrolled. The majority of consumers who re-enrolled actively, 61 percent, switched to a plan that was neither their 2015 plan nor the similar crosswalked plan. (See fig. 3.) Of those consumers who actively switched plans, more than half (54 percent) would have been automatically re-enrolled in their same plan if they had not actively switched plans, indicating that plan discontinuation was not the only factor involved in consumers' decisions to change plans.

[34]According to ASPE, more than 9.6 million consumers—4 million new consumers and more than 5.6 million re-enrolling consumers—were in one of the 37 states using the federal platform throughout 2015 and 2016. Re-enrolling consumers who made an active selection using a new account might also have been automatically re-enrolled under their prior account, and full reconciliation of such anomalies would not likely have occurred as of Feb. 1, 2016. As a result, the estimate of the number of consumers who re-enrolled automatically is likely to be somewhat inflated.

[35]In 2016, consumers were not eligible for automatic re-enrollment if the issuer of their 2015 plan did not offer a qualified health plan in their local market in 2016, although starting with the 2016 to 2017 transition, exchanges could also automatically re-enroll consumers into health plans offered by different issuers. These data reflect enrollment immediately after the end of the open enrollment period, on February 1, 2016, and so reflect all active decisions subsequent to automatic re-enrollment.

Figure 3: Plan Selections for 2016 by Consumers Who Re-enrolled Actively and Automatically



Source: GAO and Office of the Assistant Secretary for Planning and Evaluation (ASPE) analyses of data from the Centers for Medicare & Medicaid Services (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the federal platform, healthcare.gov, for enrollment and eligibility during 2015 and 2016. | GAO-18-68

Note: This analysis is limited to consumers who enrolled for health insurance through the federal platform—healthcare.gov—in both 2015 and 2016.

[a]Similar crosswalked plans were identified by issuers for plans that were no longer available to consumers in 2016.

Consumers' Financial Responsibility for Premiums Generally Increased Less with Active Re-enrollment than with Automatic Re-enrollment

Consumers' median net monthly premiums (after premium tax credits) generally increased less from 2015 to 2016 for those who actively re-enrolled ($5) than for those who were automatically re-enrolled ($22).[36] As shown in table 4, consumers who actively re-enrolled had a lower median increase in their net monthly premiums than consumers who were automatically re-enrolled for both the same and similar crosswalked plans. Moreover, table 4 also shows that consumers who re-enrolled actively, and who switched plans from 2015 to 2016, enrolled in plans with median monthly net premiums that increased the least overall—a median net increase of $1 compared to $13 per month for those who enrolled in the same plan. In addition, the table shows that enrollment in a similar crosswalked plan did not generally result in a higher median net premium than enrollment in the same plan: whether enrollment was active or automatic, consumers' median net monthly premiums increased less for those who enrolled in a similar crosswalked plan than for those who enrolled in the same plan.[37] Changes in net monthly premiums varied around these medians, however, with some consumers facing large increases or, in some cases, large decreases in their net monthly premiums. Large increases or decreases in net monthly premiums could result from changes to eligibility for tax credits, selections of plans of different metal levels, or other circumstances.

[36]According to ASPE, most consumers (85 percent) who enrolled in a health insurance plan in 2016 through the federal platform qualified for premium tax credits, and HHS officials told us that a majority—about 60 percent—were eligible for cost-sharing reductions. ASPE also reported that a greater percentage of active re-enrollees (90 percent) were eligible for one or both of these financial supports than automatic re-enrollees (77 percent). See HHS, *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report* (Washington, D.C.: Mar. 11, 2016).

[37]Because the premium tax credit amounts are determined in part based on the benchmark plan premium, the overall impact on the premium tax credits paid (which reflect the government's share of the premium costs) would generally not be affected by active or automatic re-enrollment.

Table 4: Median Increase in Net Monthly Premiums from 2015 to 2016 for Consumers Who Re-enrolled Actively and Automatically

	Plan selection			
Type of re-enrollment	**Same plan (dollars)**	**Similar crosswalked plan[a] (dollars)**	**Different plan (dollars)**	**All plans (dollars)**
Active	12.93	6.70	1.05	5.09
Automatic[b]	23.25	18.81	n/a	22.15

Source: GAO and Office of the Assistant Secretary for Planning and Evaluation (ASPE) analyses of data from the Centers for Medicare & Medicaid (CMS) Multidimensional Insurance Data Analytics System (MIDAS) for states using the federal platform, healthcare.gov, for enrollment and eligibility during both 2015 and 2016. | GAO-18-68

Note: Net monthly premiums are premiums less the premium tax credits for which consumers are eligible.

[a]Similar crosswalked plans were identified by issuers for plans that were no longer available to consumers in 2016.

[b]Automatic re-enrollment was into the same plan if available or into a similar crosswalked plan if the same plan was not available.

Our findings are consistent with other work by ASPE that suggested that consumers consider possible cost savings when deciding to switch plans. For example, ASPE found that average net monthly premium for the 61 percent of consumers who actively switched plans in 2016 was $132, which represented an average savings of $42 per month compared to what they would have paid if they stayed in their same or similar crosswalked plans. This work also found that the net monthly premiums of consumers who actively chose to remain in their same or similar crosswalked plans in 2016 were, on average, only $10 more than those for consumers who actively switched plans.[38] In addition, ASPE found that consumers' plan selections indicated sensitivity to net premiums. For example, ASPE found that consumers were much more likely to switch plans when the net premium of their 2015 plan increased than when the gross premium of their 2015 plan increased, but the net premium did not.[39]

[38]According to ASPE, average savings in net premiums include savings from all consumers who switched plans, metal levels, or issuers, including savings associated with a reduction in level of coverage. See HHS ASPE, *Health Insurance Marketplaces 2016 Open Enrollment Period: November 1, 2015 to February 1, 2016* (Washington, D.C.: Mar. 11, 2016).

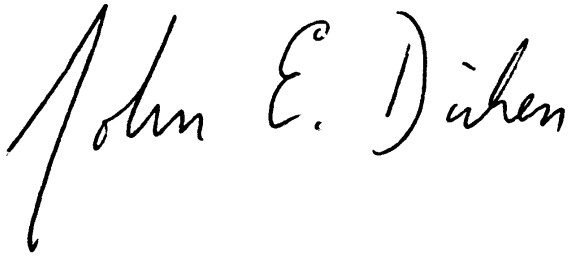
[39]HHS ASPE, *Did Consumers Respond to Changes in Gross Premiums or to Changes in Premiums Net of Tax Credits When Making Health Plan Choices in the 2016 ACA Marketplaces?* (Washington, D.C.: Jan. 18, 2017).

Agency Comments

We provided a draft of this report to HHS for review and comment. HHS provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Acting Secretary of Health and Human Services and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.



John E. Dicken
Director, Health Care

Appendix I: Median Benchmark Plan Premiums for Select Groups of Consumers, 2015 through 2017

Benchmark plan premiums generally increased from 2015 through 2017. Table 5 shows the median monthly gross benchmark plan premiums (exclusive of any applicable premium tax credits) for select consumer groups.

Table 5: Median Monthly Gross Premiums for Select Groups of Consumers, 2015 through 2017

Consumer group	Median monthly benchmark plan premium (dollars)		
	2015	2016	2017
Individual, aged 21	216.61	239.02	321.82
Individual, aged 27	227.89	251.74	341.85
Couple, aged 30 with no children	491.72	545.18	730.54
Individual, aged 40 with 1 child	414.38	457.77	615.65
Couple, aged 50 with 2 children	1,048.84	1,158.68	1,558.26
Individual, aged 60	587.89	649.46	873.42

Source: GAO analysis of data from the Centers for Medicare & Medicaid (CMS). | GAO-18-68

Note: Data are from 2,598 counties in the 37 states using the federal platform, healthcare.gov, for enrollment and eligibility from 2015 through 2017. This analysis does not weight premiums or their changes based on plan enrollment. Plans that became unavailable to consumers prior to November 15, 2016, because they were withdrawn from all markets or stopped taking new enrollees mid-year, would not have been included in our data. If the premiums for such plans had been among the two lowest cost silver plans in any of the counties in our analyses, the benchmark plan premiums could have been lower than those we identified.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

John E. Dicken, (202) 512-7114 or dickenj@gao.gov

Staff Acknowledgments

In addition to the contact named above, Gerardine Brennan, Assistant Director; Kristen Joan Anderson, Analyst-in-Charge; Todd Anderson; and LaKendra Beard made key contributions to this report. Also contributing were Muriel Brown; Daniel Lee; Laurie Pachter; and Emily Wilson.