Variation in Marketplace Enrollment Rates in 2015 by State and Income

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October 2015
With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010 (ACA). The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at www.rwjf.org and www.healthpolicycenter.org. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally.

IN BRIEF

We estimate that just over 24 million people were eligible for tax credits for health coverage purchased through Affordable Care Act’s (ACA’s) health insurance marketplaces in 2015. As of the beginning of March 2015, 10 million people eligible for tax credits had selected marketplace plans, representing a plan selection rate of 41 percent of the population estimated to be eligible for tax credits. By the end of June, 2015, 8.6 million had actually enrolled in marketplace coverage with tax credits, representing an enrollment rate of 35 percent.

We find considerable variation across the 13 states that operated their own marketplace websites, with plan choice rates in the other states ranging from about 50 percent in some states to single-digit rates in others. There was less variation among the 37 states using HealthCare.gov —except for Florida where the rate was 71 percent—with plan choice rates ranging from 18 percent to 46 percent.

In this report, we also examine how plan selection rates vary across states and income groups with information available from the 37 states that used HealthCare.gov. We find that across all states using HealthCare.gov, plan selection rates among the tax credit eligible population declined with higher incomes, ranging from a median rate of 62 percent for incomes below 200 percent of the federal poverty line (FPL), 29 percent for those with incomes between 200 and 300 percent FPL, to only 13 percent for those with incomes between 300 and 400 percent FPL. The consistency across states in the estimated plan selection rates within these income groups indicates much lower willingness of eligible people to pay for health coverage with the ACA’s tax credits among those with incomes above 200 percent and particularly above 300 percent of the FPL. The limits of this willingness to pay could make increases in future enrollment difficult to achieve without policy changes to improve affordability.

INTRODUCTION

The ACA established health insurance marketplaces in every state, along with premium tax credits and cost sharing reductions to make coverage and care more affordable for qualified low- and middle-income families. In states that have expanded Medicaid eligibility for qualified adults up to 138 percent FPL, tax credits are available to those with incomes between 138 and 400 percent FPL who are lawfully present in the United States and who do not have an affordable offer of coverage in the family. Lawfully present immigrants with incomes below 138 percent FPL who are ineligible for Medicaid are also eligible. In states that have not expanded Medicaid eligibility, the income range for tax credits is between 100 and 400 percent FPL, and lawfully present immigrants with lower incomes can also qualify.

In this report, we examine two measures of marketplace enrollment. First, the most detailed data released by the U.S Department of Health and Human Services (HHS) show the number of people eligible for marketplace premium tax credits who chose marketplace plans by March 2015. The number of people who selected plans divided by the total number of people who we estimate were eligible is called the plan
selection rate. In this report, we present plan selection rates for each state and at different income levels within each state. Second, after a family selects a plan, they have to submit required paperwork and pay the first month’s premium in order to effectuate the plan and start their coverage. HHS released data on effectuated enrollment by state as of June 2015, but these data were not available in greater detail. In this report, we computed enrollment rates—the number of effectuated enrollments divided by the number eligible for tax credits—by state.

**METHODS**

The number of people eligible for tax credits was estimated using the latest version of the Health Insurance Policy Simulation Model (HIPSM). The data are based on the 2012 and 2013 American Community Survey (ACS) data aged to 2016 using the population projections of the Urban Institute’s Mapping America’s Futures project. These population projections match Census projections on the national level. Census does not release any projections by state. We used 2016 for compatibility with other publications using HIPSM. The number estimated to be eligible for tax credits in 2015 would be approximately one percent lower than the number eligible in 2016.

We then compute modified adjusted gross income (MAGI) for each observation in our data, imputing unemployment compensation, which is not available on the survey. In order to compute eligibility for tax credits, we also need to compute eligibility for Medicaid. To determine eligibility for both programs, we compute MAGI as a percent of poverty in two ways. The first implements the final regulations for determining MAGI-based Medicaid eligibility under the ACA, and the second implements the final regulations for determining marketplace tax credit eligibility. We impute immigration status and offers of affordable employer-based coverage, particularly for those people who are not actually enrolled in employer-based plans. Details of these imputations are available in the HIPSM-ACS methodology description.  

The imputation of affordable offers of coverage is very important for estimating the size of the eligible population. Wave 6 of the Survey of Income and Program Participation and other data sources show that, while take-up of employer offers of health coverage is generally high, worker take-up rates decline as family income decreases. Thus, ignoring such offers of coverage will overstate the number of people eligible for marketplace tax credits.

There are several important sources of uncertainty in our estimates of tax credit eligibility. The most important is that it is based on income reported on an annual survey. By design, the marketplace allows families to enroll based on expected income for the year, provided it does not contradict information from data matches. If the attested income differs enough from the latest available tax data or if no tax data are available because the person did not previously file taxes, the applicant is asked to provide documentation to support the attested income. As a result, some people whose incomes were not in the relevant range at the time of application can still legitimately apply for and receive marketplace tax credits. The final amount of the credits will be reconciled at tax time, based on the applicant’s income for the year. Our estimates of tax credit eligibility thus understate the number of people who could potentially have enrolled and claimed tax credits. Other limitations include potential misreporting of income on the survey data and uncertainty in imputing immigration status and employer offers of health coverage.

We separate states which expanded Medicaid from those which did not because Medicaid expansion affects the population eligible for marketplace tax credits. Among expansion states, we separated those using HealthCare.gov from those using their own websites. State marketplace websites varied considerably in their operational readiness in 2014, and some still had unresolved problems during the 2015 open enrollment period.

For HealthCare.gov states, data on plan selections by county and income group were taken from the HHS/ASPE July 2015 update, which provided additional detail for plan selections at the end of the 2015 open enrollment period. These data were provided only at the county level. Counties with very small sample sizes (less than 10 observations) were suppressed and state totals were not provided, so these data by income group do not exactly match state-level totals. However, the difference only amounts to 0.3 percent of enrollees with tax credits.
credits nationwide. Even in small rural states, the difference is a fraction of a percent. For states not using HealthCare.gov, we used plan selection data for the same period compiled for an earlier Urban Institute analysis of marketplace enrollment. The number of plan selections with tax credits was available for all states except Minnesota. Minnesota released the overall number of plan selections, but not the number eligible for tax credits. Just under half of effectuated enrollees in that state received tax credits, so we applied the same percentage to the overall number of plan selections in order to estimate the number of plan selections with tax credits.

For all states, data on effectuated enrollment were derived from a July 2015 report release by HHS/ASPE. Effectuated enrollment was given by state, but not by income level. In general, effectuated enrollment was lower than the earlier number of plan selections. However, in a few states, effectuated enrollment was actually a little higher than the number of plan selections. People who did not select plans by the end of the open enrollment period can still enroll if they have certain life events, such as getting married or losing health coverage because of job loss. Some people who had pending applications that could not be completed by the end of open enrollment due to system problems could also select plans after the deadline. Lastly, in 2015, those who owed a tax penalty for not having health coverage in 2014 could also enroll in a plan after the open enrollment period.

RESULTS

Nationwide, we estimate that 24.1 million people were eligible for marketplace premium tax credits in 2015 (Figure 1). As of the beginning of March 2015, 10 million people eligible for tax credits had selected marketplace plans, representing a plan selection rate of 41 percent of the population estimated to be eligible for tax credits. By the end of June 2015, 8.6 million had effectuated their chosen plans and claimed tax credits by paying their first month’s premium and supplying needed paperwork. This represents an enrollment rate of 35 percent nationwide.

Figure 1. Marketplace and Tax Credits Eligibility and Enrollment

![Figure 1: Marketplace and Tax Credits Eligibility and Enrollment](image)

Source: The Urban Institute. HIPSACS 2015.
Differences in Enrollment Rates Across States

Expansion states using their own websites vary enormously in their effectuated enrollment rates, ranging from California and Vermont, who enroll about half of those eligible, to Hawaii and D.C., who have estimated enrollment rates in the single digits (Figure 2). The executive director of Hawaii’s marketplace has stated publicly that its enrollment is much higher than has been reported by HHS so we may be understating take-up in Hawaii. In D.C., the Medicaid eligibility threshold for adults is over 200 percent of the FPL, so only those with higher incomes are eligible for marketplace tax credits. Similarly, Minnesota, which also has a notably low enrollment rate, is different from other state marketplaces because people below 200 percent of the FPL who would be eligible for marketplace coverage with tax credits in other states are instead eligible for the MinnesotaCare program. As demonstrated below, marketplace take-up rates decline as income increases, which explains in large part why D.C. and Minnesota stand out.

By contrast, there is far less variation in effectuated enrollment rates among the 17 expansion states using HealthCare.gov. Rates range from 34 percent in Michigan and New Hampshire to 19 percent in Iowa and Alaska. Most states in this group are at the low end of this range; the median effectuated enrollment rate was 23 percent.

The non-expansion states using HealthCare.gov tended to have higher enrollment rates than expansion states, which is driven by the inclusion of more people with incomes below 150 percent of the FPL in marketplace coverage. Florida stands out from all other states with an estimated effectuated enrollment rate of 57 percent. South Dakota has the lowest rate of any of these non-expansion states, at 18 percent. However, more than half of the expansion states using HealthCare.gov have enrollment rates of 24 percent or lower, only slightly higher than South Dakota. The median effectuation rate among the non-expansion states using HealthCare.gov is 31 percent, not far from the highest participation rate among expansion states using HealthCare.gov (which was 34 percent for New Jersey).

Our results suggest that enrollment in many states could potentially benefit from additional outreach efforts. Most of the expansion states using HealthCare.gov have enrollment rates below 25 percent: West Virginia, Arkansas, North Dakota, Arizona, Nevada, Ohio, Alaska, and Iowa. Other expansion states using HealthCare.gov have achieved take-up rates up to 10 percentage points higher, so additional outreach efforts may be effective in increasing enrollment in those states. While enrollment rates are generally higher among non-expansion states, there are non-expansion states with low rates. South Dakota has an enrollment rate of 18 percent, Oklahoma has a rate of 23 percent, and four non-expansion states have rates of 25 to 26 percent: Kansas, Mississippi, Tennessee, and Wyoming.

Figure 2. Effectuated Enrollment Rates by State

Source: The Urban Institute. HIPSM-ACS 2015. Medicaid expansion status is being defined as of September 2015, Effectuated Enrollment Data from CMS. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-08.html
Differences in Plan Selections by Income Across States

Based on the information available from the 37 states that use Healthcare.gov under the ACA, we find that plan selection rates fall sharply as family income increases, from 75 percent among those below 200 percent of the FPL to 31 percent among those with incomes between 200 and 300 percent of the FPL to only 14 percent for those with incomes between 300 and 400 percent of the FPL (Table 1).

When we compare expansion and non-expansion states, we find an almost identical pattern of plan selection for comparable income levels among those above 150 percent of the FPL (Figure 3 and Table 1). Plan selection rates for those with incomes between 150 and 200 percent FPL are 54 percent for expansion states and 56 percent for non-expansion states. At the other end of the income range, plan selection rates among those with incomes between 300 and 400 percent FPL are 14 percent in expansion and 13 percent in non-expansion states using HealthCare.gov.

It is only among those with incomes below 150 percent FPL that we see noticeable differences in plan selection rates between expansion and non-expansion states: 98 percent among non-expansion and 79 percent among expansion states. As indicated above, this is one reason why rates tend to be higher among non-expansion than among expansion states. Another reason is that a much larger share of eligible people in non-expansion states is in this income range than in the expansion states. By design, there is a basic difference between expansion and non-expansion states in the income distribution of those eligible for tax credits below 150 percent of the FPL. If a state has not expanded Medicaid, people between 100 and 138 percent FPL can be eligible for tax credits provided there is not an affordable offer of coverage in their family.10 People below 138 percent of the FPL in states that have expanded Medicaid can only be eligible for tax credits if they are legally present immigrant residents not eligible for Medicaid. We did not estimate state-level plan selection rates for those with incomes between 100 and 150 percent of the FPL in expansion states because of small sample sizes at the state level in that income band.

The average plan selection rates for non-expansion states at low incomes are raised by a single, large outlier state: Florida (Figure 4). Florida has a plan choice rate of 124 percent for those with incomes below 200 percent FPL (Table 1). As a result, the average plan choice rate for those with incomes below 200 percent of the FPL is notably higher than the median rate (Figure 4), 75 percent compared with 62 percent. In contrast, at higher incomes, the means and medians are close. The median state enrollment rates are 62 percent for those with incomes below 200 percent of the FPL, 29 percent for those with incomes between 200 and 300 percent FPL, and only 13 percent of those with incomes between 300 and 400 percent of the FPL (Figure 4).

No individual state provides an exception to the steep decline in plan choice rates as income rises. The range of plan choice rates across states narrows considerably at higher incomes, and, at every income level, the highest state plan choice rate

Figure 3. Plan Selection Rates by Income Level and State Group

Table 1. Plan Choice Rates for Marketplace Coverage With Advanced Premium Tax Credits by Income Level and State Group, States Using Healthcare.gov, 2015

<table>
<thead>
<tr>
<th>Non-expansion states</th>
<th>Plan Selection Rate</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>100-150% FPL</td>
</tr>
<tr>
<td>Alabama</td>
<td>76.8%</td>
</tr>
<tr>
<td>Florida</td>
<td>168.9%</td>
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<tr>
<td>Georgia</td>
<td>111.5%</td>
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<td>Kansas</td>
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<td>Louisiana</td>
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<td>Maine</td>
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<td>Mississippi</td>
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<td>Missouri</td>
<td>75.3%</td>
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<td>Montana</td>
<td>64.0%</td>
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<td>Nebraska</td>
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<td>North Carolina</td>
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<td>Oklahoma</td>
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<td>South Carolina</td>
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<td>South Dakota</td>
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<td>Tennessee</td>
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<td>Texas</td>
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<td>Virginia</td>
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<tr>
<td>Wisconsin</td>
<td>73.5%</td>
</tr>
<tr>
<td>Wyoming</td>
<td>43.6%</td>
</tr>
</tbody>
</table>

1. Income category not computed for expansion states due to small sample size.
2. Alaska Expanded Medicaid in September 2015
3. Indiana Expanded Medicaid in year 2015
4. Pennsylvania Expanded Medicaid in year 2015
Very High Enrollment Rates and Uncertainty in Our Estimates

Among non-expansion states, Florida has an estimated 170 percent plan choice rate for those with incomes between 100 and 150 percent of the FPL (Table 1). This means that the number enrolled in the marketplace with tax credits who reported income between 100 and 150 percent of the FPL is 70 percent higher than the number of people in that income range we estimate to be eligible for tax credits. Two other states have rates over 100 percent at this income range, Georgia and North Carolina, though their rates are still notably lower than Florida’s.

There are three important sources of uncertainty in our estimates of the number of people eligible for tax credits that affect our estimated enrollment rates. First, by design, HealthCare.gov allows people to enroll in coverage based on attested income, provided it is not too far off from the latest available tax data and does not contradict more recent information available for certain types of income, such as social security.11 Also, a person may report the current month’s income, rather than projected annual income. At tax filing time, the amount of tax credits received in advance will be reconciled with the tax credit amount based on the family’s actual income.

Source: The Urban Institute. HIPSM-ACS 2015, Plan Selection and Enrollment Data from CMS. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-08.html

Figure 4. Plan Selection Rates in States Using HealthCare.gov by Income, Median and Distribution Box Plot

is below the 25th percentile of rates at the next lower income level (lower edge of the boxes in Figure 2). Also, the highest plan choice rate among states for the 300 to 400 percent of the FPL range is lower than the lowest rate among states for those below 200 percent of the FPL.
for the year. Thus, people whose income was somewhat below 100 percent FPL or somewhat above 150 percent FPL could legitimately enroll and be counted in this group. If we count all of those with incomes between 80 and 170 percent of the FPL and otherwise eligible for tax credits as being in the 100 to 150 percent group, the enrollment rates for Georgia and North Carolina drop to 82 percent and 80 percent respectively (data not shown). Thus, the high rates in these states are not necessarily wrong or impossible. However, the rate for Florida is still 125 percent even after expanding the income definition by 20 percentage points in each direction.

Second, our survey data do not include information on offers of employer coverage, so we had to impute the presence of offers that disqualify families from tax credit eligibility (See Methods). However, even if we assume that no one who is not actually enrolled in employer-sponsored coverage has a disqualifying offer of coverage; Florida’s rate is still well above 100 percent for those between 100 and 150 percent FPL.

Third, we have no information on how effectuated enrollment varied by income. We do not know if plan selections among those between 100 and 150 percent of the FPL were more or less likely to drop out than plan selections among those with higher incomes. However, even if we assume that all of the lost plan selections in Florida were for people in this income group, that is still not enough to lower the rate below 100 percent. Thus, even if we make extreme assumptions about each source of uncertainty, none alone is sufficient to lower the statewide rate to a plausible level.

Among states that have not expanded Medicaid, Florida also saw the largest drop in the uninsured among non-elderly adults from 2013 to 2014 according to the latest results from the ACS. The share of uninsured nonelderly adults dropped by five percentage points, well above the 3.2 percentage point average for non-expansion states and slightly above the average 4.8 percentage point drop among states that did expand Medicaid.

Accurate eligibility determinations are important for ensuring that federal spending on tax credits and cost sharing reductions is disbursed properly. We do not have access to data that would enable us to research the cause of these high rates.

CONCLUSION

The uniformity of 2015 marketplace plan selection rates at different income levels across the 37 states using HealthCare.gov is striking. In part, it may reflect people's judgments about the affordability of marketplace coverage at different income levels. Premium tax credits, cost sharing reductions, and actuarial value levels are the same across states, so marketplace enrollment data may provide valuable information on people’s willingness to pay for marketplace health coverage. This conclusion is reinforced by several studies that have shown that many people who shopped for marketplace coverage but did not choose a plan, considered the available options to be unaffordable.

This may pose challenges for efforts to increase marketplace enrollment in the future, though the rising penalties may make more uninsured willing to pay the going prices for marketplace coverage. There are three options for reducing the cost of coverage for those eligible for marketplace tax credits. First, the law could be changed to make tax credits and cost sharing reductions more generous, but the possibility of such action by the current Congress seems remote.

Second, the Basic Health Program (BHP) could allow states to provide more affordable coverage to those with incomes below 200 percent FPL using federal money that would have been spent on tax credits and cost sharing reductions. However, the large majority of current marketplace enrollees are below 200 percent FPL, so moving them to BHP could challenge the sustainability of marketplaces, particularly in states that run their own marketplaces. Minnesota currently runs MinnesotaCare, a BHP which provides more comprehensive coverage at a lower cost to beneficiaries than standard ACA tax credits and cost sharing reductions. MinnesotaCare covered about 118,000 people in July 2015, compared with approximately 26,000 people between 200 and 400 percent FPL enrolled in that state’s marketplace. New York will fully implement a BHP beginning in 2016.

Third, states could use ACA state innovation waivers (Section 1332) to submit their own plans for improving the affordability of coverage for low-income people beginning in 2017. However, HHS has not released regulatory guidance for such waivers, so the extent to which they can be used to address affordability is unknown.

Another potential issue related to affordability is the high enrollment rate among those with incomes between 100 and 150 percent FPL in non-expansion states based on plan selection rates. Even excluding Florida, the plan choice rate was 81 percent. This would be considered a high rate even for Medicaid coverage, which has no or nominal premiums or cost sharing and is generally more comprehensive. Many
people in this income range could apply their premium tax credit to a Bronze plan, resulting in zero or near-zero premiums. However, they would lose cost sharing reductions. Deductibles in many Bronze plans are $4,000 to $5,000, which is more than most people with incomes this low could afford. HHS has not released data on how many people in this income range chose Bronze plans, but the high enrollment raises concerns that some people may be making health coverage decisions based on low premiums alone, without considering cost sharing.

States that launched their own marketplace websites in 2014 had very diverse outcomes. Some, such as Oregon and Nevada, abandoned the sites they had developed and used HealthCare.gov in 2015. Others were still trying to address problems with their sites through the 2015 open enrollment period. But other states were much more successful. As a result, there was great diversity in 2015 marketplace take-up rates among states that ran their own websites. California and Vermont achieved enrollment rates of about 50 percent—higher than all HealthCare.gov states except Florida—while other states saw single-digit take-up. Minnesota and D.C. are special cases in that they both have programs that cover people up to 200 percent FPL who would otherwise qualify for marketplace tax credits. Take-up rates are lower in these states largely because eligibility is limited to higher incomes, which, as we have seen, enroll at notably lower rates.

As of March 2015, the ACA’s health insurance marketplaces had enrolled nearly 9 million people with incomes low enough to qualify for premium tax credits. We do not yet know exactly to what extent the new marketplaces have contributed to the historic drop in the number of uninsured people that has been measured in several surveys, but the number appears to be substantial. In particular, gains in coverage have occurred under the ACA even in states that have not expanded Medicaid. In this analysis of marketplace enrollment rates among those eligible for tax credits, we have found patterns across states and income groups that should be useful for policymakers and stakeholders concerned with increasing marketplace enrollment in the upcoming 2016 open enrollment period.

ENDNOTES

1. Specifically, if any family member is offered single coverage that costs up to 9.66 percent of family income in 2015, the family is not eligible for tax credits if the employer offers any dependent coverage.

2. For example, legally present adult immigrants resident less than five years are not eligible for Medicaid.


10. See note 1.

11. If no tax or wage data are available for the person, they will be asked to provide documentation of income.

12. If the advanced tax credit is higher than the tax credit based on the year’s income, people may have to repay all or part of the difference. On the other hand, people can get a tax refund if the advanced tax credit is lower or if their income is below 100 percent of the FPL.


18. Vermont subsidized premiums beyond the level of federal tax credits, which may have contributed to high take-up. But California did not.

About the Authors and Acknowledgements
Matthew Buettgens is a senior research associate in the Health Policy Center at the Urban Institute, where he is the mathematician leading the development of Urban’s Health Insurance Policy Simulation Model (HIPSM). The model was used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington as well as to the federal government. His recent work includes a number of research papers analyzing various aspects of national health insurance reform, both nationally and state-by-state. Research topics have included: the costs and coverage implications of Medicaid expansion for both federal and state governments; small firm self-insurance under the Affordable Care Act and its effect on the fully insured market; state-by-state analysis of changes in health insurance coverage and the remaining uninsured; the effect of reform on employers; the affordability of coverage under health insurance exchanges; and the implications of age rating for the affordability of coverage.

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The authors are grateful for the comments and suggestions provided by Stephen Zuckerman, John Holahan, Linda Blumberg, Judy Solomon and Katherine Hempstead.

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