Uninsured + Unbanked = Unenrolled:

How Health Insurance Companies May Exclude 1 in 4 Eligible Americans from ACA Coverage—and What the Federal Government Can Do to Stop It

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Executive Summary

- **More than one in four uninsured Americans eligible for the new premium assistance tax credits under the ACA does not have a checking account.** Among the uninsured, non-elderly population with household incomes in the tax credit eligible range, 27 percent are effectively "unbanked."

- **Many insurance companies plan to require customers to pay premiums automatically through a checking account.** While such restrictions may help insurers reduce administrative costs, unbanked customers will not be able to pay their required share of insurance premiums. Though contrary to the spirit and intent of the ACA, such restrictions are permissible under current federal guidance absent a policy clarification.

- **These restrictions will undermine efforts to expand health coverage under the ACA.** Requiring enrollees to pay their premiums using a checking account would effectively deny coverage to the more than eight million unbanked Americans who are otherwise eligible for the new tax credits under the ACA. Unless addressed, such restrictions may hollow out the ACA's expansion of coverage.

- **The impact will be especially large among African Americans and Hispanic Americans,** who are over 40 percent more likely to be unbanked relative to white residents in the same income category. This is particularly concerning given the existing disparities in access to health coverage and health status for minority groups. Further, as many as five million veterans and other Americans who receive federal benefits on prepaid debit cards may not be able use those same cards to pay their premiums for federally-subsidized insurance.

- **The impact on the unbanked will be disproportionately large in states where the federal government operates a health insurance marketplace.** Federal marketplaces will operate in 11 of the 12 states with the highest proportion of unbanked among those eligible for tax credits. For example, more than one in three uninsured residents of Illinois in the tax credit eligible income range is likely to be unbanked. Because the federal exchange will operate in Illinois and 34+ other states in 2014, the federal government has the unique ability to address this issue.

- **Fortunately, federal policy makers have an easy solution to fix this problem before 2014, but they must act now.** The federal government could require insurance companies to accept commonly used forms of payment available to unbanked Americans, such as prepaid debit cards. However, federal officials must clarify this policy soon to ensure that the ACA coverage programs do not exclude one in four eligible Americans.

Background and Context

A surprisingly high number of Americans do not have a checking account and are considered "unbanked." Current estimates place the total number of unbanked Americans at just below 50 million individuals.[1] This population is likely to grow in the near term as the cost of traditional banking continues to rise.[2]

Prepaid debit cards are one of the few avenues for the unbanked to access the mainstream financial system and make electronic payments.[3] The use of general purpose reloadable prepaid debit cards is increasing dramatically among the unbanked,[4] and many see the cards as a lower-cost alternative to traditional checking accounts.[5] The federal government itself now issues prepaid debit cards to more than five million federal beneficiaries[6] like veterans and social security recipients, many of whom are unbanked.[7] These debit cards could allow unbanked, uninsured Americans to pay their health insurance premiums—but only if insurance companies accept them.

Uninsured consumers clearly prefer to pay insurance premiums with debit cards. According to recent consumer research data, uninsured consumers between 100 - 400% FPL view (by a large margin) debit cards as the single most preferred method for paying premiums for qualified health plans in which they may enroll. More than half of such

This issue brief is part of an occasional series by Jackson Hewitt Tax Service about federal health reform. At its core, the Affordable Care Act (ACA) is a tax bill, and the ACA's signature expansions of health insurance coverage are done through the federal tax code. With the implementation of the ACA next year, April 15th will become the most important day in health care!

individuals already pay their utility bills with debit cards, and well over two-thirds indicated that they would consider paying their health insurance premiums using this form of payment.[8]

Despite the high number of unbanked Americans, insurance companies may limit enrollment to people who can pay premiums via a traditional checking account.[9] Insurance companies face strong incentives to minimize administrative expenses like the transaction costs associated with debit cards.[10] Under the new medical loss ratio (MLR) rules,[11] card transaction fees are treated as part of the MLR denominator—increasing the incentives to minimize these expenses. In the absence of a rule requiring insurers to accept debit cards, those that do may put themselves at a competitive disadvantage. For example, based on publicly-available data about Tennessee, at least 76% of customers in that state's individual insurance market may not be able to pay recurring premiums with debit cards because at least three of the larger insurers refuse to accept these as a form of recurring premium payment.[12]

Surprisingly, federal rules appear to allow insurance companies to reject debit card payments from unbanked customers, thereby excluding them from tax credits and affordable coverage.[13] The federal government currently does not require insurance companies to accept commonly-used forms of payment like debit cards.[14] In its 58-page letter to insurers dated April 5, 2013, the Department of Health and Human Services did include a single sentence noting that insurer must accept payments in ways that are "non-discriminatory." However, the federal government has not provided any technical or operational clarification on this issue.

This failure to clarify policy may limit access to affordable health insurance for uninsured Americans who are also unbanked. To date, however, policy makers have lacked information about the proportion of uninsured individuals who are both (1) eligible for the ACA's insurance affordability programs and (2) unbanked and, therefore, potentially excluded by insurer restrictions on acceptable forms of premium payments. This report helps to quantify the impact of federal inaction on this issue.

The IRS may assess substantial tax penalties on unbanked, lower-income families—and may withhold their tax refunds.

A family of three making $59,000 per year might have a monthly premium liability of approximately $467 and a tax credit worth approximately $533 per month.[15] If that family were blocked from joining the health insurance marketplace altogether, they might face an IRS penalty of $590 for being uninsured for 12 months in 2014[16] as well as forgoing $6,396 worth of tax credits. These penalties will more than double over the next two years.[17] Furthermore, IRS officials recently testified to Congress that it would be within the authority of the IRS to withhold a refund from a taxpayer in order to enforce these penalties—further increasing the magnitude of economic hardship.[18]

Methods

We used data from the 2008 Survey of Income and Program Participation (SIPP), a longitudinal household survey conducted by the U.S. Census Bureau, to generate national and state-level estimates of the number of non-elderly uninsured households that are also unbanked.

The SIPP data allowed us to categorize the insurance and relative poverty status of households in a straightforward way. First, the survey includes detailed monthly information on health insurance coverage. This allowed us to stratify the nonelderly population by insurance status. Second, the survey releases information on relationships within each household. This permitted us to group household members into Health Insurance Eligibility Units (HIEUs), which are defined as related household members who could enroll under the same health insurance plan. For example, a grown 30-year-old living at home with her parents would constitute a separate HIEU from her parents, even though she lives in the same household and is related. Third, the survey includes detailed monthly earned and unearned income information, which allowed us to construct measures of HIEU income relative to the poverty line.

We derived data on banked/unbanked status from detailed SIPP questions asked of each individual on their assets and other investments. We categorized individuals as "banked" if they, or anyone else in their HIEU, individually or

jointly owned a checking or savings account. Notably, the availability of individual-specific data on banked status in the SIPP stands in contrast to other surveys such as the FDIC and FINRA,[20] which ask questions on bank accounts only among the economically dominant individual in each household. The SIPPs structure, by contrast, allowed us to consider unbanked status among all individuals within each HIEU in the household.

We used additional data to generate estimates for specific demographic subpopulations. For example, we made use of the SIPP periodic topical survey modules that include questions on health care utilization and self-reported health status. We matched these supplemental survey data to the core SIPP respondents to consider banked status by self-reported health status. Likewise we used other SIPP measures including demographics (gender, age, race/ethnicity) and household composition (e.g., dependent child in HIEU) to explore other correlations with unbanked status.

In terms of statistical methods, we survey-weighted all national figures (means and population totals) to be representative of the nonelderly, non-institutionalized U.S. population at a point in time. We obtained standard errors and confidence intervals by adjusting for the SIPP's complex survey design using the Stata statistical programming language. We also used these and other data to generate state-level estimates of uninsured, unbanked households by income/eligibility group.[21]

Results

Roughly 8.5 million Americans are likely eligible for the new ACA but will be unable to enroll because they do not have a bank account to pay their premiums. The impact will be especially large among African Americans and Hispanic Americans, who are over 40 percent more likely to be unbanked relative to white residents in the same income category. Further, as many as five million veterans and other Americans who receive federal benefits on prepaid debit cards may not be able use those same cards to pay their premiums for federally-subsidized insurance.

African American and Hispanic American Unbanked Will Be Harder-Hit

One out of every three tax credit eligible African Americans and Hispanic Americans is unbanked—they are 43 percent more likely to be unbanked than white residents. That represents nearly five million persons out of 8.5 million.[22] By comparison, one in four tax credit eligible white residents is unbanked. These findings are concerning, particularly given the existing disparities for minority populations in access to health coverage and health status.[23]

Interestingly, the tax credit eligible uninsured, unbanked between 100–400% FPL are not more likely to be in poor health. While being unbanked does appear to correlate to poorer health status in the general uninsured population, Table 1 on p. 6 shows that for those with incomes between 100–400% FPL, those reporting 'very good' health are equally likely to be unbanked as those reporting 'fair or poor' health.[24] This indicates that accepting these unbanked customers may not significantly degrade insurance companies' risk pools or increase their claims costs through adverse selection—as they appear to fear today.

The impact on the unbanked is most significant in states that will have federal health insurance marketplaces in 2014. As Table 2 on p. 7 reports, federally-facilitated or federal Partnership marketplaces will be in place in 11 of the 12 states with the highest proportion of unbanked among those eligible for tax credits.[25] In contrast, the two most populous State-based marketplaces—New York and California—have the second and third lowest unbanked rates in the country among uninsured individuals with incomes between 100%-400% FPL.[26]

Discussion

Efforts to help Americans gain access to affordable coverage may be undermined by federal inattention to their banking status. Nearly half of the twenty million people projected to use premium assistance tax credits to purchase coverage through the new health insurance marketplaces by 2016 may be excluded if they are denied the ability to pay their premiums with prepaid debit cards and other non-bank account financial products.[27]

Millions of Americans who receive federal benefits on prepaid debit cards may not even be able to use those same cards for premiums on the federal insurance exchanges. The federal government increasingly relies on prepaid debit cards to distribute benefits to unbanked members of various programs. According the Department of the Treasury, as of May 2013 more than five million people received federal benefits on the "Direct Express" debit card[28] and in 2012 two-thirds of these individuals did not have traditional bank accounts.[29] Treasury distributes benefits on behalf of several major federal agencies including Social Security, Veterans Affairs, and FEMA.[30] Treasury also launched two pilot programs in 2011 to encourage the use of prepaid cards for tax refunds.[31]

Uninsured, Unbanked Veterans

More than one million non-elderly veterans and nearly a million of their family members lack health insurance nationwide.[32] Of those uninsured veterans and their families, approximately half, or 1.1 million, have incomes in the eligibility range for tax credits under the ACA.[33] Many of these veterans and their families receive benefits through the U.S. Treasury's 'Direct Express' prepaid debit cards, suggesting that they do not have bank accounts. As of May 2013, the VA distributes benefits to 62,000 veterans and their families through the Direct Express debit card.[34] According to the VA's website, "the Direct Express debit card offers beneficiaries the opportunity to receive their payments electronically even if they do not have a bank account." It is important to note that this 62,000 figure likely significantly underestimates the total number of unbanked veterans receiving benefits on a prepaid card because the VA also distributes benefits to bank-issued prepaid debit cards outside of the 'Direct Express' program.

The results of this study likely understate the size of the problem. This study does not focus on the banking status of uninsured individuals under the poverty level. However, there is strong evidence to suggest that given the significant income volatility in that income range—one-third or more of those individuals and families may 'churn' into exchange and tax credit eligibility at some point in a given year.[35] While 'churn' works both ways, and some people will move out of exchange eligibility, the entire 'churn' population may be tax credit eligible at some point in a given year—during which time they would potentially be affected by a bank-only premium payment policy. Further, those churning into tax credit eligibility are even more likely to be unbanked, given that nearly half of the uninsured population with income below the poverty line is unbanked.[36]

The Federal government controls the health plan standards for the majority of the unbanked population in question. Given the concentration of the unbanked uninsured in states served by the federal exchange, the federal government could simply issue an administrative decision that all qualified health plans offered on the federal exchange must accept debit cards for both the initial and subsequent month premiums. Such action would be entirely consistent with the letter that HHS issued on April 5, 2012—advising insurers to be able to accept premium payment in ways that are not discriminatory.[37] Federal adoption of such enhanced requirements would be particularly meaningful, as our results demonstrate that an even higher proportion of individuals in states served by the federal exchange are unbanked. Federal officials could also promote this as a best practice for state-based exchanges to adopt.

Conclusion

The disenfranchising impact of a bank-only premium payment requirement may undermine efforts to expand access to affordable health insurance. Forgone credits could exceed $15 billion for as many as 8.5 million Americans.[38] And with a maximum projected tax-credit subsidized enrollment of 22 million Americans in the new health insurance marketplaces, excluding 8.5 million people would be hugely disruptive of the efforts to expand access to affordable health insurance coverage in America. The fact that more than half of those excluded individuals will be African American or Hispanic American is particularly alarming in light of HHS Secretary Sebelius' recent affirmation that the new insurance affordability programs under the ACA should play a significant role in improving minority access to insurance coverage and health care.[39]

Federal policy makers should act now to stop insurers from discriminating against the unbanked through their payment acceptance policies. The only way to adequately resolve this issue and promote enrollment in affordable health insurance is to implement a system-wide rule governing acceptable forms of payment. Given the dilemma presented to insurance companies by the strong financial incentives to discourage non-bank payment mechanisms, insurers are unlikely to resolve this issue without federal action. The federal government should require insurers to accept 'swipe' or 'signature' transactions from debit cards, as well as other forms of payment that are more commonly used among unbanked persons who are likely to be eligible for the insurance affordability programs.

Federal officials have all necessary legal authority to act but time is running out. Enrollment begins on October 1, 2013—so the federal government must act quickly to avoid disenfranchising the unbanked Americans who comprise 1 in 4 of the uninsured, tax credit eligible.

Disclosure

The authors affiliated with Jackson Hewitt Tax Service (George Brandes and Brian Haile) acknowledge that Jackson Hewitt does have a limited commercial interest with prepaid debit cards. Specifically, Jackson Hewitt offers its customers the option of receiving their tax refunds on prepaid debit cards as a less costly alternative to many storefront checking-cashing entities. The company's offering reflects its understanding of the challenges faced by unbanked consumers—and the recommendations in this report are borne out of that same concern. For reference, both authors made similar recommendations to federal officials in their previous roles in state government prior to joining Jackson Hewitt.

The expertise and guidance expressed by the author affiliated with Vanderbilt University Medical Center (John Graves) is that of his own and does not represent the position of Vanderbilt University or Vanderbilt University Medical Center pertaining to the ability of citizens to obtain or pay for health insurance through the Affordable Care Act. Neither Vanderbilt University nor Vanderbilt University Medical Center has a financial interest in the sale or citizen's use of prepaid debit cards.

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Table 1: Proportion Unbanked Among Non-Elderly Uninsured by Income Group, Race, and Health Status

	All Incomes	Uninsured, Non-elderly		
		Health Insurance Eligbility Unit Income		
		<100% FPL	100-400% FPL	>400% FPL
Unbanked (percent of total)	**29%**	**40%**	**27%**	**14%**
Race: White, Non-Hispanic	23%	34%	23%	11%
Race: Black, Non-Hispanic	37%	48%	33%	15%
Race: Hispanic	36%	46%	32%	26%
Race: Other	20%	29%	19%	9%
Health Status: Excellent	25%	38%	22%	11%
Health Status: Very Good	29%	38%	29%	14%
Health Status: Good	31%	41%	29%	16%
Health Status: Fair or Poor	35%	46%	30%	12%
Total Population (millions)	52.8	14.7	31.5	6.6
Number Unbanked (millions)	15.3	5.9	8.5	0.9

Table 2: Unbanked Health Insurance Eligiblity Units, Overall and by Characteristic

	Federal or State-Run Marketplace	All Incomes	Uninsured, Non-elderly Health Insurance Eligibility Unit Income		
			<100% FPL	100-400% FPL	>400% FPL
National		**29%**	**40%**	**27%**	**14%**
AL	Federal	37%	46%	33%	17%
AK	Federal	22%	37%	21%	8%
AZ	Federal	29%	38%	27%	22%
AR	Federal Partnership	34%	43%	32%	17%
CA	State	21%	34%	19%	7%
CO	State	27%	34%	26%	14%
CT	State	25%	33%	24%	17%
DE	Federal Partnership	24%	35%	23%	14%
DC	State	27%	37%	26%	15%
FL	Federal	34%	42%	34%	18%
GA	Federal	36%	46%	33%	16%
HI	State	40%	49%	35%	36%
ID	State	30%	40%	28%	13%
IL	Federal Partnership	36%	52%	35%	8%
IN	Federal	32%	42%	30%	13%
IA	Federal Partnership	25%	35%	23%	11%
KS	Federal	31%	40%	29%	16%
KY	State	32%	42%	29%	13%
LA	Federal	35%	46%	32%	16%
ME	Federal	21%	23%	21%	19%
MD	State	25%	35%	23%	13%
MA	State	19%	30%	19%	7%
MI	Federal Partnership	29%	39%	26%	12%
MN	State	16%	23%	17%	6%
MS	Federal	37%	47%	33%	16%
MO	Federal	32%	43%	30%	13%
MT	Federal	25%	36%	24%	10%
NE	Federal	28%	38%	27%	14%
NV	State	27%	37%	24%	9%
NH	Federal Partnership	25%	37%	23%	13%
NJ	Federal	28%	41%	25%	21%
NM	State	29%	40%	27%	11%
NY	State	19%	31%	18%	4%
NC	Federal	34%	44%	32%	16%
ND	Federal	25%	35%	24%	11%
OH	Federal	25%	36%	23%	8%
OK	Federal	30%	39%	27%	15%
OR	State	27%	37%	24%	10%
PA	Federal	29%	39%	27%	15%
RI	State	26%	36%	25%	13%
SC	Federal	31%	42%	27%	11%
SD	Federal	26%	36%	25%	13%
TN	Federal	34%	44%	31%	15%
TX	Federal	29%	39%	27%	14%
UT	Federal	30%	39%	27%	13%
VT	State	18%	34%	17%	10%
VA	Federal	25%	43%	20%	17%
WA	State	26%	37%	24%	10%
WV	Federal Partnership	30%	40%	27%	13%
WI	Federal	25%	29%	24%	19%
WY	Federal	27%	38%	26%	15%

About the Authors

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Endnotes

Appendix – Standard Error Estimates for Table 1

	All Income Groups	Uninsured, Non-elderly		
		Health Insurance Eligbility Unit Income		
		<100% FPL	100-400% FPL	>400% FPL
Unbanked (percent of total)	0.0069	0.0146	0.0090	0.0137
Race: White, Non-Hispanic	0.0078	0.0202	0.0098	0.0146
Race: Black, Non-Hispanic	0.0173	0.0300	0.0214	0.0330
Race: Hispanic	0.0140	0.0252	0.0180	0.0469
Race: Other	0.0172	0.0379	0.0204	0.0342
Health Status: Excellent	0.0107	0.0281	0.0124	0.0214
Health Status: Very Good	0.0096	0.0193	0.0129	0.0199
Health Status: Good	0.0100	0.0201	0.0154	0.0209
Health Status: Fair or Poor	0.0143	0.0274	0.0165	0.0327

1 See the 2011 study by the RAND Corporation estimating that 15.5 percent of the US population is unbanked and the 2012 US Census Bureau report estimating that 15.7 percent of the US population is uninsured. Hung, Angela and Joanne K. Yoong, "New Findings on the Unbanked in America. Results from the 2011 American Life Panel Survey," RAND Occasional Paper, 2012, available at http://www.rand.org/pubs/occasional_papers/OP369-1.html, accessed March 27, 2013. See also Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2011 Current Population Reports, U.S. Census Bureau, p. 21. Available at http://www.census.gov/prod/2012pubs/p60-243.pdf (accessed May 7, 2013). By comparison, the most recent U.S. Census Bureau estimates show a roughly equal number of uninsured Americans.

2 For example, the limits on interchange fees from the Durbin Amendment are predicted to swell the ranks of the unbanked, as banking houses seek to recoup lost revenues through higher retail banking fees, driving more Americans out of traditional banking. See David S. Evans, Robert E. Litan & Richard Schmalensee, Economic Analysis of the Effects of the Federal Reserve Board's Proposed Debit Card Interchange Fee Regulations on Consumers and Small Businesses 40 (Feb. 22, 2011), (http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1769887&rec=1&srcabs=1843628). Further evidence of this trend can be seen in the fact that fewer than half of retail banks offered free checking accounts in 2011 and bank account fees of all types increased from 2011 to 2012. See Bankrate's 2011 Checking Account Survey results, cited by Claes Bell, 'Free credit union checking still thrives,' Bankrate.com, August 13, 2012. (http://www.bankrate.com/finance/checking/free-credit-union-checking-still-thrives.aspx) and See Richard Barrington, 'Bank Fees Survey mid-2012: Checking and ATM costs jump again,' MoneyRates.com, August 13, 2012. http://www.money-rates.com/research-center/bank-fees/mid-2012.htm

3 Many unbanked consumers rely on prepaid debit cards because they cannot get traditional bank accounts. Often, they are barred because of being listed on ChexSystems or TeleCheck for mishandling accounts in the past. Bretton Woods Inc., Branded Pre-Paid Card Report, February 16, 2012, page 8. See also Wall Street Journal, 'At Banks, New Fees Replacing Old Levies,' January 5, 2011. (http://online.wsj.com/article/SB10001424052748703808704576062251813426390.html). And Bretton Woods Inc., Analysis of Reloadable Prepaid Cards in an Environment of Rising Consumer Banking Fees: comparative analysis of reloadable prepaid cards to basic checking accounts and check-cashing, March 2011.

4 Between 2010 and 2011, the proportion of unbanked households that have used a prepaid debit card increased from 12.2 percent to 17.8 percent—a nearly 50% annual increase. See Federal Deposit Insurance Corporation, 2011 FDIC National Survey of Unbanked and Underbanked Households, September 2012, p. 35.

5 According to the 2011 FDIC National Survey of Unbanked and Underbanked Households, nearly one in four unbanked households that were previously banked had used prepaid debit cards, while only 10% of 'never-banked' households had used them – strongly suggesting that these cards are a substitute to checking accounts. See Table A-56, Federal Deposit Insurance Corporation, 2011 FDIC National Survey of Unbanked and Underbanked Households, September 2012, p. 100. See also Bretton Woods Inc., Branded Pre-Paid Card Report, February 16, 2012, page 9.

6 Personal communication to the authors from Barbara Iverson, Weber Shandwick, based on information communicated to her from the U.S. Department of the Treasury and with full permission to use in this way. May 10, 2013.

7 The federal government is now expanding the use of their electronic payment system to the point of making electronic payments mandatory, including prepaid cards for veterans, and others without a bank account. The deadline to choose between direct deposit to a bank account or Direct Express prepaid cards was in March 2013. The final rule from the Department of the Treasury required that anyone applying for benefits on or after May 2011 to receive all payments electronically, either through direct deposit at a depository institution or on a Direct Express prepaid card account. Those already receiving checks were required to switch to an electronic payment method by March 2013. See 75 Fed. Reg. 80315 (December 22, 2010) http://www.fms.treas.gov/eft/regulations/31cfr208_text.html

8 Personal communication from Stuart Tomey, Jackson Hewitt Tax Service, dated May 16, 2013.

9 There is compelling evidence that insurance companies have already begun discouraging non-bank payments. In response to a Request for Information issued by the Tennessee Insurance Exchange Planning Initiative, at least five health insurers responded that they opposed requirements that compelled them to accept credit and debit cards. See Responses to State of Tennessee's Request for Information (RFI) for Potential Qualified Health Plan Procurement, September 28, 2012 and related actuarial analyses. Other examples include the fact that, as early as 2011, Anthem Blue Cross stopped accepting ongoing premium payments via debit and credit cards (See http://abcnews.go.com/Business/insurer-stop-accepting-credit-card-payments/story?id=14574940). In 2012, Blue Cross Blue Shield of Tennessee stopped accepting payments by credit and debit cards, except for the first month's payment.

10 Automatic Clearing House (ACH) transactions through bank accounts represent an attractive payment option for insurers because ACH incurs lower transaction costs compared to transactions that utilize the card networks like Visa and MasterCard. And while some prepaid cards do enable the user to make payments through the ACH network (like a virtual checking account), others do not support ACH debits or bill pay. Even among those cards that do enable ACH transactions, the fraud

and insufficient funding rates are elevated among ACH transactions originating from debit cards—which reduces the benefits of ACH and will further discourage insurance companies from accepting debit cards in any form. Therefore, insurers that accept forms of payment with higher transaction costs like debit cards will have higher administrative costs compared to their competitors that do not. See See Hub, "Prepaid Cards Report – 2012," available at (http://www.cardhub.com/edu/prepaid-cards-report-2012/#chase-liquid) Accessed May 7, 2013.

11 These rules limit to 20% of total premium revenue the amount of money that insurers can devote to administrative costs and profit for individual market policies. 75 Fed. Reg. 74864 (December 1, 2010) codified at 45 CFR part 158) as amended by 75 Fed. Reg. 82277 (Dec. 30, 2010) (adopting medical loss ratio rules); 76 Fed. Reg. 76574 (Dec. 7, 2011) as amended by 77 Fed. Reg. 28790 (May 16, 2012) (adopting premium rebate requirements).

12 Responses to State of Tennessee's Request for Information (RFI) for Potential Qualified Health Plan Procurement, September 28, 2012 and related actuarial analyses.

13 Federal law requires that individuals and families receiving tax credits to buy health insurance through the exchanges must pay their share of premiums to their insurance company every month in order to start and maintain their insurance coverage, continue receiving their tax credits, and avoid tax penalties when they file their taxes the next year. See generally § 1412(c) of the ACA, as amended; 77 Fed. Reg. 18310, 18471 (March 27, 2012) (to be codified at 45 CFR § 156.270); id. at 18463 (March 27, 2012) (to be codified at 45 CFR § 155.430). For tax penalties associated with the 'individual mandate' to purchase health insurance see, IRC § 5000A as added by § 1501(b) of the ACA.

14 We base this assertion on numerous conversations with both insurers and federal officials over the past three years, though the CCIIO State Program Officer for Tennessee did formalize this answer in email correspondence to state officials in 2012. See letter from author to CCIIO State Exchange Group, dated September 24, 2012 and email from Brian Haile to CCIIO Program Officer, dated June 19, 2012. Notwithstanding the recent letter from CCIIO to insurers dated April 5, 2013 stating that "QHP insurers must be able to accept payment in ways that are non-discriminatory…", federal officials have never spoken definitively to the question about required forms of payment that insurers must accept (if any), and insurers appear to be proceeding under the impression that they will be able to refuse to accept debit and other forms of payment.

15 "QHP insurers must be able to accept payment in ways that are non-discriminatory." See Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, Affordable Exchanges Guidance, Letter to Insurers on Federally-facilitated and State Partnership Exchanges, April 5, 2013. p. 35 (http://cciio.cms.gov/resources/regulations/Files/2014_Letter_to_Issuers_04052013.pdf)

16 This assumes that the family enrolls in a second-lowest cost silver tier plan with an annual premium cost of $12,000. For the tax credit calculation, see 77 Fed. Reg. 30377 (May 23, 2012) (to be codified at 26 CFR § 1.36B–3(g).

17 Individual mandate penalty for this family is calculated at 1% of the household's annual income ($590). See 26 USC 5000A.

18 See, IRC § 5000A as added by § 1501(b) of the ACA.

19 Testimony of J. Russell George, Treasury Inspector General for Tax Administration at the IRS before the Senate Financial Services and General Government Subcommittee, May 8, 2013. Reported by Bloomberg BNA.

20 The FDIC, FINRA and RAND all issued recent studies of the unbanked and underbanked in the U.S. While the FDIC and FINRA estimate, respectively, that 8 and 12 percent of the US population is unbanked, the 2011 study by the RAND Corporation estimated the unbanked population may be as high as 15.5 percent. See Federal Deposit Insurance Corporation, 2011 FDIC National Survey of Unbanked and Underbanked Households, September 2012; FINRA Investor Foundation, Financial Capability in the United States: National Survey – Executive Summary, December 2009, pp. 11-12; and Hung, Angela and Joanne K. Yoong, "New Findings on the Unbanked in America. Results from the 2011 American Life Panel Survey," RAND Occasional Paper, 2012, available at http://www.rand.org/pubs/occasional_papers/OP369-1.html, accessed March 27, 2013.

21 Because the SIPP was not designed to produce direct state estimates, we relied on an indirect estimation approach for our state results. This approach is conceptually identical to that used by HHS to crosswalk (also using the 2008 SIPP) current state Medicaid eligibility rules to a value of Modified Adjusted Gross Income (MAGI) for use in new Medicaid determinations starting in 2014. More detailed information on this methodology, including the reweighted survey data itself, can be found at http://dvn.iq.harvard.edu/dvn/dv/jagravesvandy.

22 Non-elderly, uninsured, unbanked counts by race/ethnicity equal 3.36 million white (non-Hispanic); 1.39 million African American (non-Hispanic); 3.37 million Hispanic; and 0.38 million other. These data are derived from the 2008 SIPP analysis but not published as a separate table in this report.

23 According to research by the Agency for Healthcare Research and Quality, health care quality and access are suboptimal, especially for minority and low-income groups. See the National Healthcare Disparities Report 2010, AHRQ, pp. 2-5. (http://www.ahrq.gov/research/findings/nhqrdr/nhqrdr10/qrdr10.html) accessed on May 17, 2013.

24 See Table 1.

25 See Table 2.

26 See Table 2.

27 Currently, the CBO projects that 20 million people will enroll in the tax credit subsidized component of the new health insurance marketplaces by 2016. Congressional Budget Office, "CBO's February 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage," (http://cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf) accessed May 10, 2013.

28 Personal communication to the authors from Barbara Iverson, Weber Shandwick., based on information communicated to her from the U.S. Department of the Treasury and with full permission to use in this way. May 10, 2013.

29 See PRNewswire, "U.S. Treasury's Direct Express Prepaid Debit Card Earns High Marks from Social Security Population," July 17, 2012. Available at (http://www.prnewswire.com/news-releases-test/us-treasurys-direct-express-prepaid-debit-card-earns-high-marks-from-social-security-population-162679366.html) accessed May 7, 2013.

30 Federal agencies that routinely pay benefits to unbanked beneficiaries include: Veterans Administration, IRS, Social Security Administration, HHS, and FEMA. See also Board of Governors of the Federal Reserve System, "Report to the Congress on Government-Administered, General-Use Prepaid Cards," July 2011, available at http://www.federalreserve.gov/publications/other-reports/government-prepaid-report-201107.htm, accessed March 27, 2013 (noting, "Examples of federal, state, and local government-funded programs that use general-use prepaid cards include Social Security; Temporary Assistance for Needy Families (TANF); Women, Infants, and Children (WIC); state unemployment; and court-ordered payments… [Another] notable general-use prepaid card program that is federally funded and state administered is electronic benefit transfer (EBT). The EBT card is used in all 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam to disburse electronically the Supplemental Nutrition Assistance Program (SNAP) benefits, formerly known as the Food Stamp Program."). Other recipients include OPM's retirement benefits to federal employees, the Railroad Retirement Board for retired railroad workers, and the DOL for victims of black lung disease.

31 The first pilot is for "MyAccountCard" prepaid cards. The second pilot is for payroll card uses to have their refund deposited on their payroll cards. See U.S. Department of Treasury, "Treasury Launches Pilot Program of Prepaid Debit and Payroll Cards for Fast, Safe and Convenient Tax Refunds" [Press release], January 13, 2011, available at http://www.treasury.gov/press-center/press-releases/Pages/tg1021.aspx, accessed March 27, 2013 (noting that, "Nationwide, more than 1.7 million workers use payroll cards to receive and access their wages, often because they do not have bank accounts…").

32 Jennifer Haley and Genevieve M. Kenney, 'Uninsured Veterans and Family Members: who are they and where do they live?,' Urban Institute, May 2012. (http://www.urban.org/UploadedPDF/412577-Uninsured-Veterans-and-Family-Members.pdf) See also, Jennifer Haley and Genevieve M. Kenney, 'Uninsured Veterans and Family Members: state and national estimates of expanded Medicaid eligibility under the ACA, Urban Institute, March 2013. (http://www.urban.org/uploadedpdf/412775-Uninsured-Veterans-and-Family-Members.pdf)

33 Totals of number of uninsured veterans, spouses of veterans, and children of veterans between 138% FPL and 400% FPL, 2008-2001 American Community Survey, US Census Bureau. Additional tabulations by Jennifer Haley, The Urban Institute.

34 Personal communication to the authors from Barbara Iverson, Weber Shandwick, based on information communicated to her from the U.S. Department of the Treasury and with full permission to use in this way. May 10, 2013.

35 See Benjamin D. Sommers and Sara Rosenbaum, "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," Health Affairs, 30, no. 2 (2011): 228-236. See also John A. Graves, "Better Methods Will Be Needed to Project Incomes to Estimate Eligibility for Subsidies in Health Insurance Exchanges," Health Affairs, 31, no. 7 (2012): 1613-1622. See also Matthew Buettgens, Austin Nichols, and Stan Dorn, "Churning Under the ACA and State Policy Options for Mitigation," The Urban Institute, June 2012.

36 According to our analysis, 40% of uninsured, non-elderly persons with incomes below 100% FPL are unbanked. See Table 1.

37 However, the guidance in the April 5, 2013 letter does not elaborate on what CMS would consider discriminatory or in any way encumber the ability of insurers to reject unbanked consumers. See Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, Affordable Exchanges Guidance, Letter to Issuers on Federally-facilitated and State Partnership Exchanges, April 5, 2013. p. 35 (http://cciio.cms.gov/resources/regulations/Files/2014_Letter_to_Issuers_04052013.pdf)

38 The CBO estimates $15 billion in premium tax credit spending for six million enrolled lives in 2014. With an uninsured, unbanked population of 8.5 million, it is reasonable to expect similar levels of forgone spending if this population does not enroll. This does not count forgone cost-sharing reductions and other related spending. Congressional Budget Office, "CBO's February 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage," (http://cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf) accessed May 10, 2013.

39 See HHS Secretary Kathleen Sebelius' Statement on National Minority Health, April 2, 2013 emphasizing the importance the ACA in improving access to insurance coverage and health care for minority populations. (http://www.hhs.gov/news/press/2013pres/04/20130402b.html) accessed May 17, 2013.