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UnitedHealth Center for
Health Reform & Modernization

ADVANCING PRIMARY CARE DELIVERY

Practical, Proven, and Scalable Approaches

September 2014

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EXECUTIVE SUMMARY

A snapshot of the U.S. primary care system

Primary care represents an estimated 6 percent to 8 percent of national health care spending — approximately $200 to $250 billion annually.[1]

Primary care visits account for 55 percent of the 1 billion physician office visits each year in the United States.[2] The Affordable Care Act could generate an additional 25 million primary care visits annually through:[3]

- Increases in insurance coverage;
- Requirements for coverage of certain essential health benefits; and
- Elimination of copayments for preventive services.

Assessing value and capacity

Primary care is central to effectively treating patients. A higher supply of primary care physicians is related to lower rates of mortality and more effective delivery of preventive care.[4] High rates of avoidable visits to emergency departments and avoidable hospitalizations are a sign that many patients could be treated more appropriately and cost effectively in a primary care setting. An estimated 70 percent of emergency department visits by commercially insured patients in the United States are for non-emergencies.[5]

An analysis by the UnitedHealth Center for Health Reform & Modernization and Optum Labs underscores that primary care physicians contribute to high-quality, cost-effective care. In local health care markets with a greater supply of primary care physicians, there are lower rates of avoidable hospital admissions and emergency department visits, as well as less use of costly high-technology diagnostic imaging when traditional imaging is often just as effective.

Approximately 50 million Americans live in areas with an under-supply of primary care physicians.[6] Most of these areas are rural. Notably, the percentages of nurse practitioners (15 percent) and physician assistants (17 percent) who practice in rural areas are greater than the percentage of physicians (10 percent) who practice in rural areas.[7]

An analysis by the UnitedHealth Center for Health Reform & Modernization and Optum Labs shows that socioeconomic factors help explain geographic variation in primary care physician supply.

- **Primary care physicians are concentrated in areas with higher median household incomes.** In the 10 percent of local health care markets with the lowest concentration of primary care physicians, the median household income was $46,000. In the 10 percent with the highest concentration, it was $66,000.
- **Primary care physicians are concentrated where residents — and potential patients — are more likely to have insurance coverage.** In the 10 percent of local markets with the lowest concentration of primary care physicians per capita, the uninsured rate for the non-elderly was 17 percent; in those with the highest, it was 11 percent.
- **There is a higher concentration of non-physician primary care providers — nurse practitioners (NPs) and physician assistants (PAs) — in areas with lower median household incomes and higher rates of uninsured residents.** In the 10 percent of local markets with the lowest concentration of primary care physicians, the concentration of NPs and PAs was highest, and there were approximately equal numbers of physician and non-physician providers.

The supply of primary care physicians is concentrated away from rural areas, away from lower-income communities, and away from the uninsured. Therefore, increasing physician supply may not be enough to effectively address unmet demand for primary care services in all areas of the country, in part because lower reimbursement rates and salaries in primary care practice may help steer some medical graduates with substantial student debt toward higher-paying specialties. Increased roles for NPs and PAs would add to the system's overall primary care capacity, and could help target capacity to areas where there are fewer primary care physicians.

Building blocks for bolstering capacity

Building blocks for enhancing capacity and improving primary care service delivery include:

- **Leveraging a diverse workforce.** Advancing effective roles for NPs and PAs depends on greater use of evidence-based guidelines, rigorous quality measurement frameworks, and quality improvement initiatives for non-physician providers. A significant barrier to achieving more dramatic and rapid progress is payment policy. Medicare and Medicaid generally reimburse less for services delivered by NPs and PAs than for the same services when performed by physicians.
- **Assembling multi-disciplinary care teams.** A primary care physician with a panel of 2,000 patients would need to spend an estimated 17.4 hours per day to provide recommended preventive, chronic, and acute care — and many primary care physicians have larger panels.[8] Assembling multi-disciplinary care teams can leverage additional capacity to help practices see more patients.
- **Utilizing health information technology (HIT).** HIT, including electronic health records (EHRs) and interoperable data exchange, allows primary care practices to organize and disseminate information across the delivery system in real time — improving care coordination, increasing quality, and lowering costs.[9] Broader implementation of HIT can increase systemwide capacity to meet increased demand, improving access to primary care.[10]

Advanced service delivery and payment models

Private and public payers continue to work with providers to implement patient-centered medical homes (PCMHs) and accountable care organizations (ACOs). These approaches show great promise; however, their success has not been uniform. Medical home and accountable care models can advance the Triple Aim goals of improving quality and the patient experience of care, improving population health, and reducing the cost of care — provided they are well designed and implemented. One key to success is a financial model that moves past fee-for-service reimbursement by rewarding value over volume.

- Evidence from UnitedHealthcare's medical home programs in four states shows average third-year net savings of 6.2 percent of medical costs, resulting in a return on investment of 6 to 1.
- WESTMED's commercial ACO improved care on nine of 10 health quality metrics, while achieving an 8 percent reduction in emergency department utilization, a 5 percent decrease in hospital inpatient costs, and a 1.3 percent reduction in costs per member in one year.
- Monarch HealthCare was the top performing of 32 Medicare Pioneer ACOs on three measures of quality and the second ranked Pioneer ACO in achieved cost savings. It reduced Medicare spending by 5.4 percent in 2012 from the 2011 baseline for attributed beneficiaries, compared to a 1.1 percent increase for a reference cohort.

These successful models all embraced payment reforms that move beyond fee-for-service reimbursement. Under fee-for-service, physicians are paid for the volume and complexity of care delivered. This approach incents the delivery of a greater quantity and higher intensity of services; it does not encourage better quality care.[11] As much as half of wasteful health care spending results from failures of care delivery and care coordination, as well as overtreatment — all of which could be improved by moving away from the fee-for-service reimbursement model.[12]

Models that delink payment from units of primary care, and instead prioritize value, include:

- Performance-based bonuses as modifications to traditional fee-for-service payments;
- Risk-adjusted monthly payments for primary care services;
- Gain-sharing through shared savings, without risk; and
- Risk-adjusted capitation payments to group practices and integrated delivery systems.

Approaches to expand access and target capacity

In addition to changing service delivery and payment models within primary care practices, there are a range of proven and scalable approaches to expand and better target primary care capacity:

- **Leveraging the retail health infrastructure.** Clinics in large retail outlets hold the potential for large-scale innovation in primary care. Between 2007 and 2012, the volume of retail clinic visits grew more than six-fold, from 1.5 million to 10 million annually.[13] Close to half of retail clinic visits take place when physician offices are closed.[14] Evidence indicates that the quality and cost of services provided by retail clinics offer significant value, expanding access to primary and preventive care and reducing unnecessary utilization of costly services, such as hospital admissions.
- **Reaching patients where they live.** Delivering primary care and preventive services to individuals in their homes is an effective approach to improving access and care delivery. A key advantage of conducting clinical visits in the home is the review of environmental and social conditions, which provides valuable information and context to inform an individual's treatment plan. Optum's HouseCalls, a care management program that provides annual in-home clinical visits, employs more than 1,200 licensed physicians and nurse practitioners. In 2013, HouseCalls conducted approximately 670,000 visits in 37 states.
- **Utilizing group visits.** Group visits represent an evolving approach for improving access to primary care. Under this model, patients have both private examinations and group education sessions. One advantage of group models is that they are an efficient use of provider time compared to individual care.[15] Shared medical visits can decrease emergency department and specialty visits, reduce hospital admissions, increase patient satisfaction, and improve patient outcomes.[16]
- **Engaging complex patients.** Making the most effective use of primary care services and better leveraging capacity to reduce overall spending requires a greater focus on complex and costly patients. In a single year, 5 percent of the population accounts for 50 percent of health care costs; and more than one in three (38 percent) of these "super-utilizers" remains in the most costly 5 percent of people the following year.[17] Targeting complex patients requires analytic models that map patient clinical characteristics to utilization levels and payment models that support resource-intensive targeting and care management efforts.

Conclusion

There is no single set of clinical, organizational, and financial models that successfully expands primary care capacity and improves service delivery. **The approaches examined in this report offer multiple complementary pathways that can be tailored to local market conditions and policy environments. When implemented successfully, their common threads include focusing on the patient; the quality of service delivery, rather than who is delivering care and in what setting; and paying for value.** These approaches challenge longstanding assumptions about the scale, pace, and intensity of change that are both possible and necessary.

Championing, deploying, and implementing these approaches — effectively and at scale — ultimately will require sustained efforts from policymakers, regulators, health plans, providers, and consumers.

A SNAPSHOT OF THE U.S. PRIMARY CARE SYSTEM

Defining primary care

Primary care is the foundation of the U.S. health care system. It encompasses individuals' first contact with providers for any and all health symptoms or concerns, as well as a broad range of ongoing care. Primary care includes the treatment of common conditions, illnesses, and accidents, including colds and the flu, sore throats, burns and rashes, ear and intestinal infections, and sprains and strains. Preventive services, including health screenings, comprehensive physical exams, and vaccinations, are part of the broad universe of primary care — as is the ongoing treatment and management of individuals with chronic disease and behavioral health conditions. Individuals need primary care services across their life spans, through various states of wellness and disease.

Primary care providers, the frontline of care, serve patients with a wide range of health needs. In some cases they provide routine preventive or follow-up care; at other times they serve as a gateway for patients needing specialist services or hospital care. The efficacy of primary care impacts health expenditures systemwide, as effective preventive care and care coordination can minimize downstream utilization of more expensive services delivered by specialists or in hospitals.

In recent years, the functions and responsibilities of many primary care providers and practices have expanded to address the growing burden of disease prevalence, chronic conditions, mental illness, and substance use disorders. When primary care works well, it initiates and prioritizes care coordination and management; ensures that interventions continue across delivery settings; improves quality, outcomes, and patient experiences; and contains costs by helping patients use services efficiently.

Traditional physician office visits remain the most common way patients receive primary care; however, over time, these visits are increasingly taking place at larger physician group practices, rather than at a small group practice or solo practitioner's office. Individuals also receive primary care services in a range of settings outside of the physician office, including:

- Approximately 1,250 Federally Qualified Health Centers (FQHCs) that provide services at 8,000 individual clinic sites.[18]
- Approximately 3,800 rural health clinics (RHCs); among these, approximately half are freestanding practices and half operate within larger hospitals or health care systems.[19]

- More than 2,000 school-based health clinics (SBHCs), and an estimated 1,000 free clinics that primarily serve the uninsured.[20]
- Retail clinics, which are expected to number more than 3,200 by 2015, compared to approximately 1,300 in 2012.[21]
- Approximately 9,000 urgent care centers, providing services that do not rise to the level of emergency trauma.[22]
- Hospital emergency departments, which remain the default primary care provider for many uninsured individuals and Medicaid beneficiaries.

Primary care represents an estimated 6 percent to 8 percent of national health care spending — approximately $200 to $250 billion annually.[23] Primary care visits account for 55 percent of the 1 billion physician office visits each year in the United States.[24] Primary care office visits decreased slightly, by 0.7 percent, between 2012 and 2013; by contrast, specialist office visits increased by 4.9 percent (see Exhibit 1).[25]

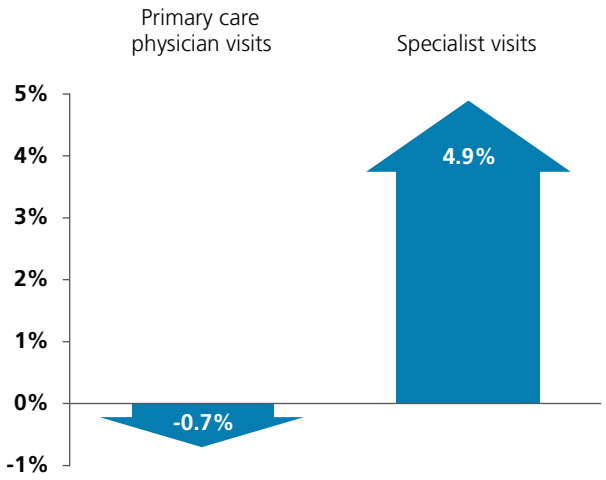
The use of primary care providers to manage patients varies among conditions, depending on a range of factors, including co-occurrence of other health conditions; patient characteristics, including type of insurance coverage; and local market conditions, including the supply of primary care physicians and specialists. For example, diabetes, a chronic condition requiring close patient management and provider coordination, involves use of both primary care providers and specialists. Overall, primary care physicians manage approximately half of diabetes-related outpatient visits; the share is higher for some conditions (85 percent of outpatient visits for chronic obstructive pulmonary disease) and lower for others (37 percent of visits for atrial fibrillation).[26]

Shifting demand

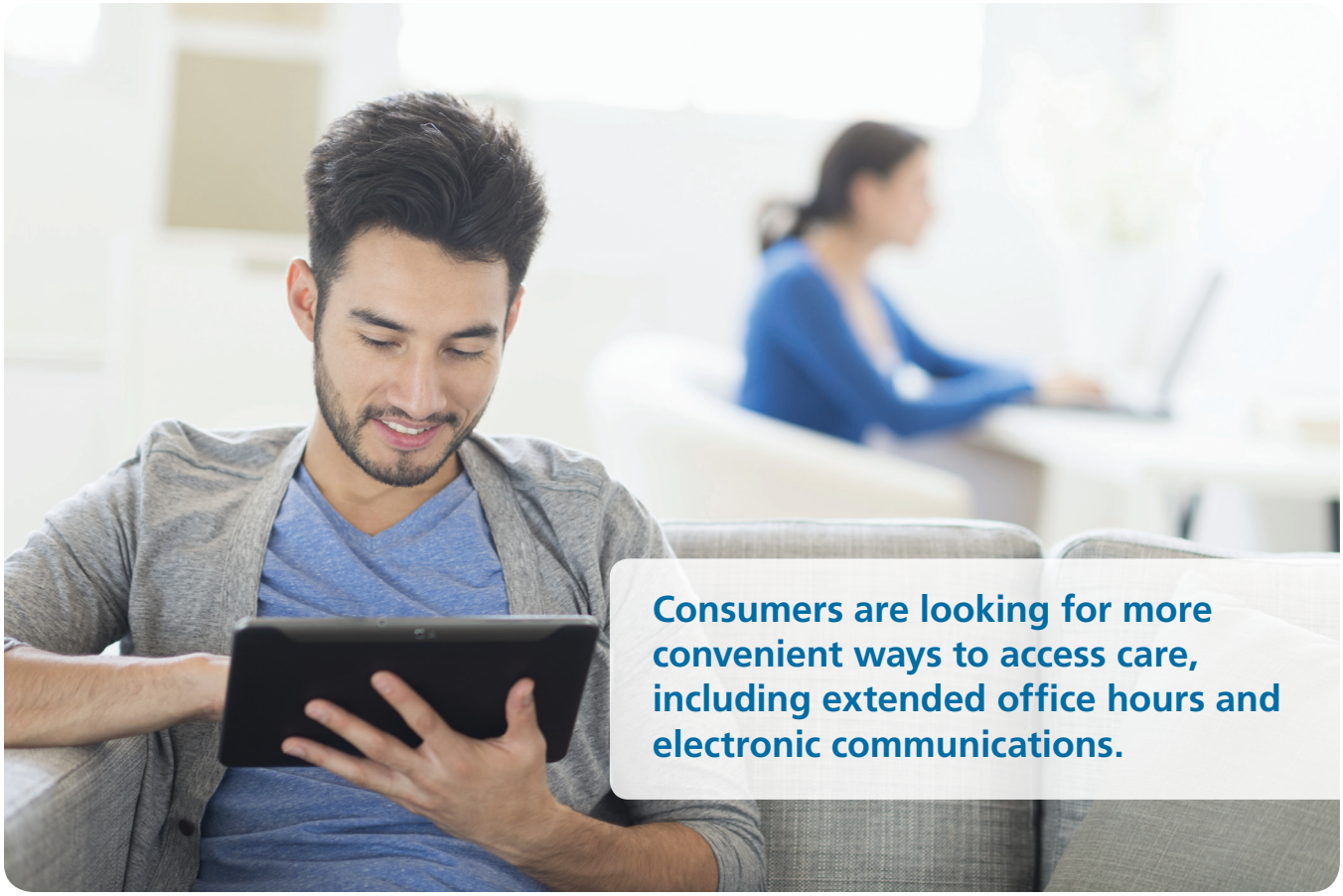
Several forces are leading to higher demand for primary care, including growth of the elderly population. The number of Medicare beneficiaries is projected to increase by one-third in the next decade, from 54 million in 2014 to 72 million by 2024.[27] Medicare beneficiaries have access to certain preventive services without cost-sharing, including an annual wellness visit and personalized prevention plans.

The Affordable Care Act (ACA) ultimately is expected to provide insurance coverage to approximately 30 million additional individuals through state health insurance marketplaces and Medicaid.[28] Requirements for coverage of certain essential health benefits — including maternity

Exhibit 1; Change in office visits by provider type, 2012 to 2013



Source: IMS Institute for Health Informatics, "Medicine Use and Shifting Costs of Healthcare: A Review of the Use of Medicines in the U.S. in 2013," April 2014.



and newborn care, preventive services, and chronic disease management — and the elimination of copayments for preventive services will contribute to increased use of primary care services. These factors could translate to an additional 25 million primary care visits annually.[29]

Changes from the ACA could result in an additional 25 million primary care visits annually.

The nature of demand for primary care is also changing, reflecting a more complex and higher-need population. Today, nearly 80 percent of Medicare beneficiaries have at least one chronic condition and two-thirds of beneficiaries have two or more chronic conditions.[30] Rates of chronic disease are increasing, not only for seniors, but also among adults under age 65 and children.[31] Individuals with chronic conditions have a greater need for ongoing treatment, monitoring, and care coordination. Rising demand for mental health services also drives greater reliance on primary care providers, who provide approximately half of all mental health treatments, mostly screening and treatment for depression.[32]

Consumers are increasingly looking for more convenient ways to access care, including in the evenings or on weekends when physician offices are often closed. At the same time, there is increased consumer interest in communicating with providers and accessing their health information electronically. Consumers are open to new avenues for basic clinical encounters that differ from the traditional office visit model.

ASSESSING VALUE AND CAPACITY

The value of primary care

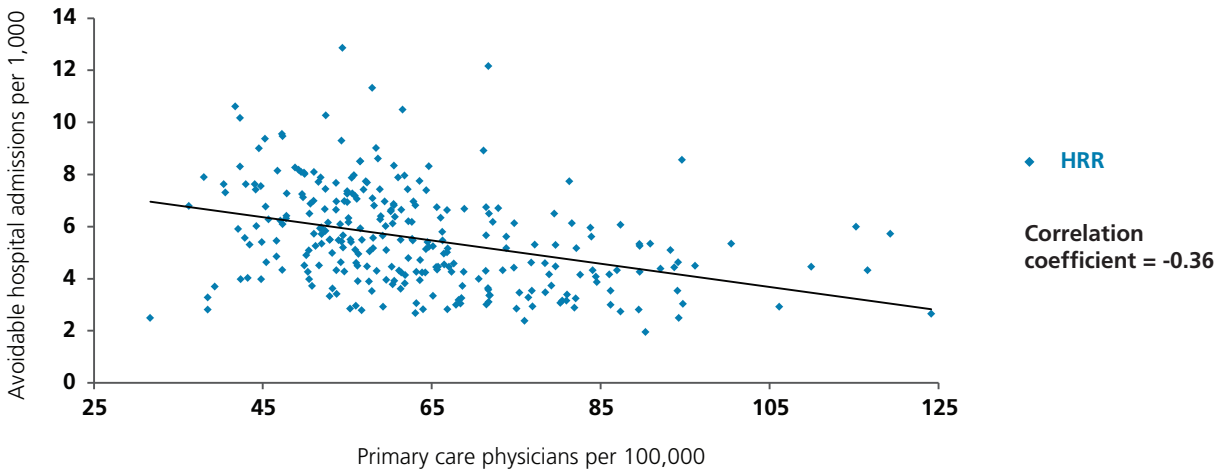
Primary care is central to effectively treating patients. A higher supply of primary care physicians is related to better population health, including lower rates of mortality and more effective delivery of preventive care.[33] An increase of one primary care physician per 10,000 people is associated with fewer hospital inpatient admissions (5.5 percent), outpatient visits (5 percent), emergency department visits (11 percent), and total surgeries (7 percent).[34] There is an association between higher numbers of primary care physicians and more favorable Medicare patient outcomes — specifically lower death rates and fewer hospital visits.[35]

Geographic variation in health care utilization, costs, and outcomes is a strong indicator of differences in access and quality. High rates of avoidable visits to emergency departments and avoidable hospitalizations are a sign that many patients could be treated more appropriately and cost effectively in a primary care setting. An estimated 70 percent of emergency department visits by commercially insured patients in the United States are for non-emergencies.[36]

Among the commercially insured, 70 percent of emergency department visits are for non-emergencies.

An analysis by the UnitedHealth Center for Health Reform & Modernization and Optum Labs underscores that primary care physicians contribute to high-quality, cost-effective care. In areas with a greater supply of primary care physicians, there was lower utilization of costly and avoidable hospital services. Among Health Referral Regions (HRR), geographic units with similar hospital referral patterns, those with a greater number of primary care physicians per 100,000 people had lower rates of avoidable hospital admissions and emergency department visits (correlation coefficients are -0.36 and -0.40, respectively; see Exhibits 2 and 3, and see Appendix for methodology).

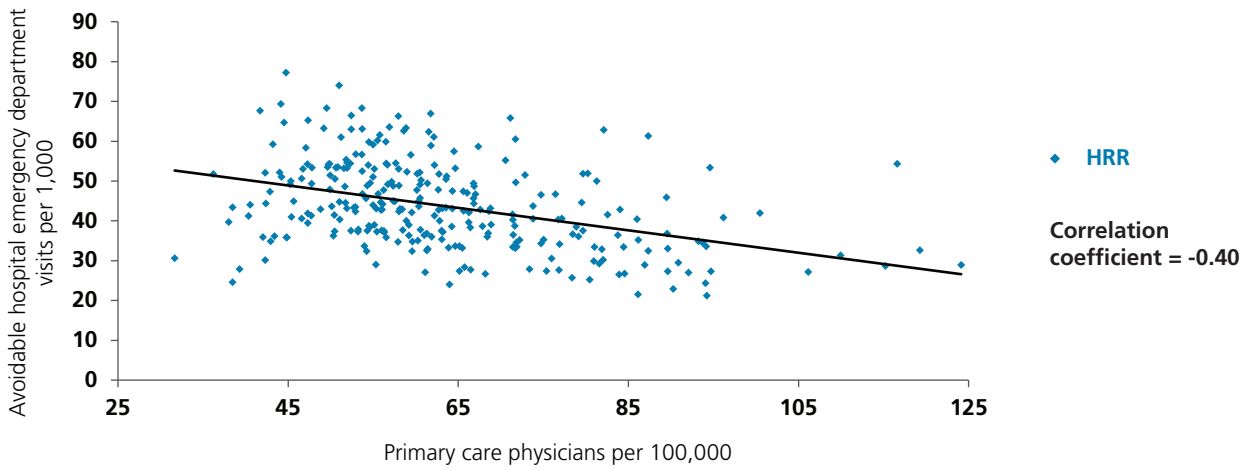
Exhibit 2; Avoidable hospital admissions and primary care physician supply



Source: UnitedHealth Center for Health Reform & Modernization and Optum Labs analysis, 2014.

Note: See Appendix for methodology.

Exhibit 3; Avoidable hospital emergency department visits and primary care physician supply



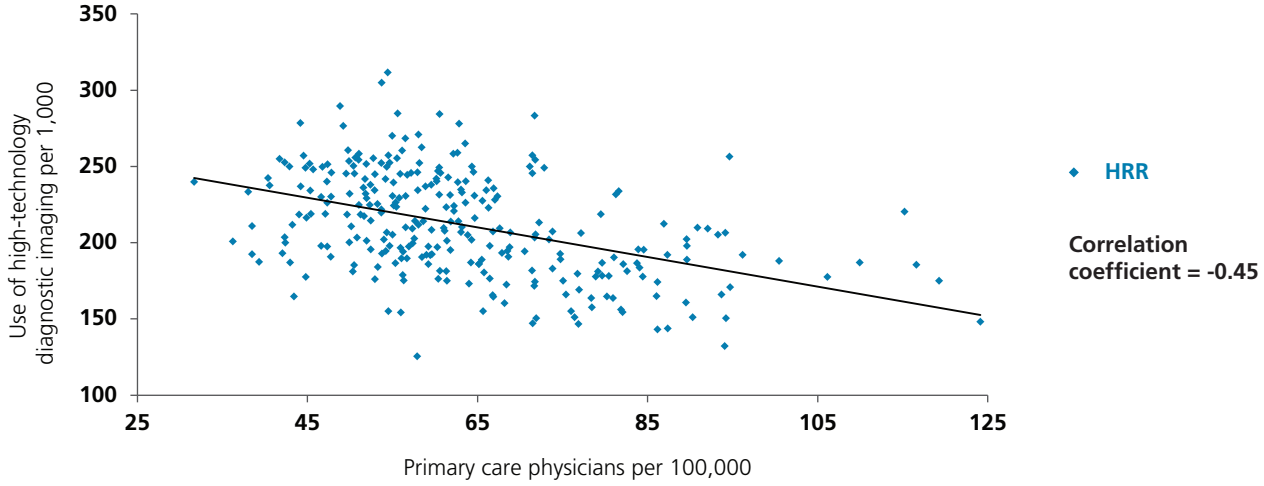
Source: UnitedHealth Center for Health Reform & Modernization and Optum Labs analysis, 2014.

Note: See Appendix for methodology.

In HRRs where there was a greater primary care physician supply, there was less use of high-technology diagnostic imaging (correlation coefficient = -0.45; see Exhibit 4). It appears that communities with a strong primary care infrastructure rely more on traditional and less costly imaging techniques, which often provide enough precision for a physician to achieve an accurate diagnosis.

Where there are more primary care physicians per capita, there are lower rates of avoidable hospital admissions and emergency department visits, and there is less use of high-technology diagnostic imaging. Deficits in primary care contribute to conditions going undiagnosed, health care needs going unmet, and costly utilization of preventable or unnecessary services.

Exhibit 4; Use of high-technology diagnostic imaging and primary care physician supply



Source: UnitedHealth Center for Health Reform & Modernization and Optum Labs analysis, 2014.

Note: See Appendix for methodology.

Provider supply

Understanding primary care capacity and how it is deployed is essential. Many definitions of capacity start with estimates of the supply of primary care physicians. These estimates vary widely, depending on the defined scope of primary care, whether the count is limited to actively practicing physicians or includes all licensed physicians, and whether those in part-time practice are adjusted downward to shares of full-time equivalents (FTEs).

The Association of American Medical Colleges (AAMC) estimates there were 275,000 active primary care physicians in the United States in 2011 — specializing in internal medicine, family medicine, general practice, and pediatrics — including those working 20 hours per week or more.[37] A definition of primary care that includes geriatricians, obstetricians, and gynecologists would result in a higher estimate; an adjustment converting all active physicians to FTEs would result in a lower estimate. The Health Resources and Services Administration (HRSA), using a definition of primary care that includes geriatricians, excludes primary care hospitalists, and converts physicians working part-time to FTE equivalents, estimates there were 205,000 primary care physicians in the United States in 2010.[38]

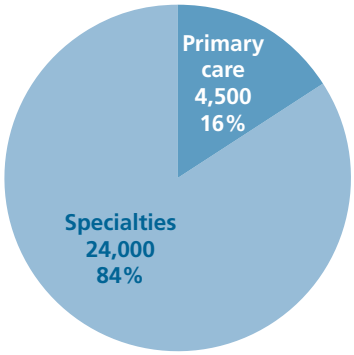
Approximately a third of practicing physicians in the United States are primary care physicians — although the share varies depending on the parameters of the estimate. The ratio of primary care physicians to specialists will likely decline in the near term as the nation's graduate medical programs produced 4,500 primary care physicians and 24,000 specialists in 2014 (see Exhibit 5).[39]

Primary care physicians annually earn approximately half the compensation of orthopedists, cardiologists, and radiologists.[40] In the Medicare program, physician fee-for-service reimbursement is based on the complexity and intensity of the service provided, reducing incentives for physicians to offer primary care services under the program.[41] Lower reimbursement rates and salaries in primary care practice may help steer some medical graduates with substantial student debt toward higher-paying specialties.

Several organizations have expressed concerns about the primary care system's ability to meet the growing demand, with capacity typically estimated through projections of the future supply of primary care physicians. HRSA has estimated a primary care physician shortage of 20,000 FTEs in 2020; AAMC has estimated a shortage of 45,000 primary care physicians in 2020.[42]

Estimates of future supply shortages rely on projections of how new graduates might add to the current workforce in future years, and how retirements based on the age of current providers might decrease it. Estimates also account for greater demand in the future, attributable to the ACA's coverage expansion, the growing number of seniors, and the increase in disease prevalence, including obesity. But complex and interrelated factors make such projections challenging.

Exhibit 5; New medical graduates by field of residency, 2014



Source: National Resident Matching Program, "Results and Data, 2014 Main Residency Match," April 2014.

In some ways, these projections may *understate* the challenge. Planned initiatives to promote primary care in medical schools are not necessarily implemented in a timely fashion.[43] Estimates of retirement rates generally rely on models based on past behavior. They do not account for potential early retirements among physicians in solo or small practices or for new cohorts of graduating physicians who may decide to work fewer hours for significant components of their careers, including when they have young children.

Projecting the adequacy of the future primary care physician workforce depends on a range of assumptions about supply, including rates of retirements and new medical graduates, as well as demand, including rates of insurance coverage and disease prevalence.

However, projections of primary care physician shortages also *understate* overall primary care capacity, by discounting the future supply of all primary care providers including non-physicians. Nurse practitioners and physician assistants are substantial components of the existing and future primary care workforce. The work they perform varies across states and is largely determined by state scope-of-practice laws.

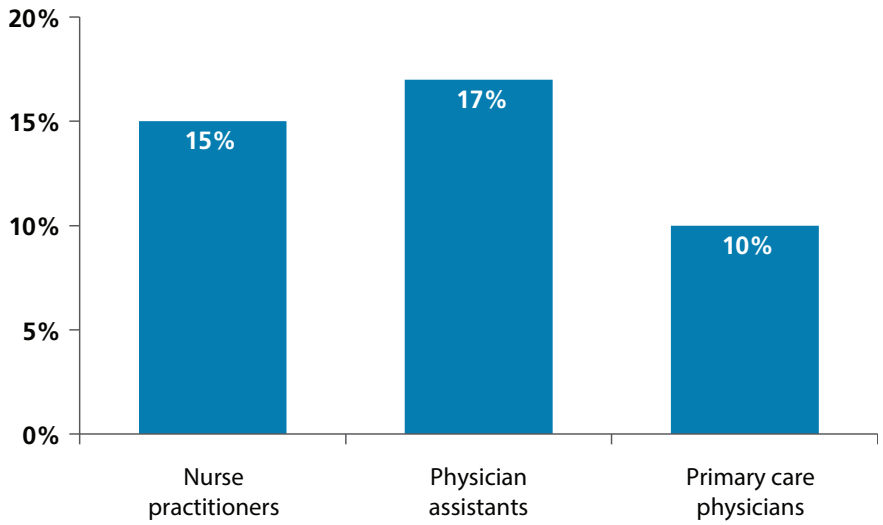
- **Nurse practitioners** (NPs) are advanced practice registered nurses (APRNs) credentialed with at least a master's degree and certified by professional or specialty nursing organizations. In 2013, there were 192,000 NPs in the United States, and almost 85 percent practiced primary care.[44] The number of NP graduates each year has doubled from 6,000 in 2003 to more than 12,000 in 2011; going forward, that figure is projected to increase by 9 percent annually, with the Doctor of Nursing Practice (DNP) becoming the prevailing degree for NPs.[45] Most graduating NPs go on to practice primary care. Approximately half of all states allow NPs to diagnose and treat patients without physician oversight. Eighteen states allow them to independently prescribe medications.[46] Some states allow for less direct physician supervision in nursing homes and community or public health clinics.[47]
- **Physician assistants** (PAs) occupy roles designed as an extension of physicians' capacity, rather than intended for independent practice. Approximately 90,000 individuals have been certified nationally as PAs.[48] In 2010, there were 6,000 graduating PA students and 6,600 first-year PA students.[49] The share of PAs practicing in primary care was 31 percent in 2010, down from 51 percent in 1996.[50] The reasons for this decline include higher pay in specialty fields and increased use of PAs by hospitals in recent years.[51] PAs are allowed to practice and prescribe medication under the supervision of a physician. In some settings, PAs maintain their own panel of patients.

The health care system of the future may have approximately the same number of primary care physicians as are practicing now. An alternative to framing primary care capacity in terms of physician ratios or access to specific *providers* is to focus on consumers' ability to access high-quality primary care services, in a timely fashion, at low costs.

Distribution of resources

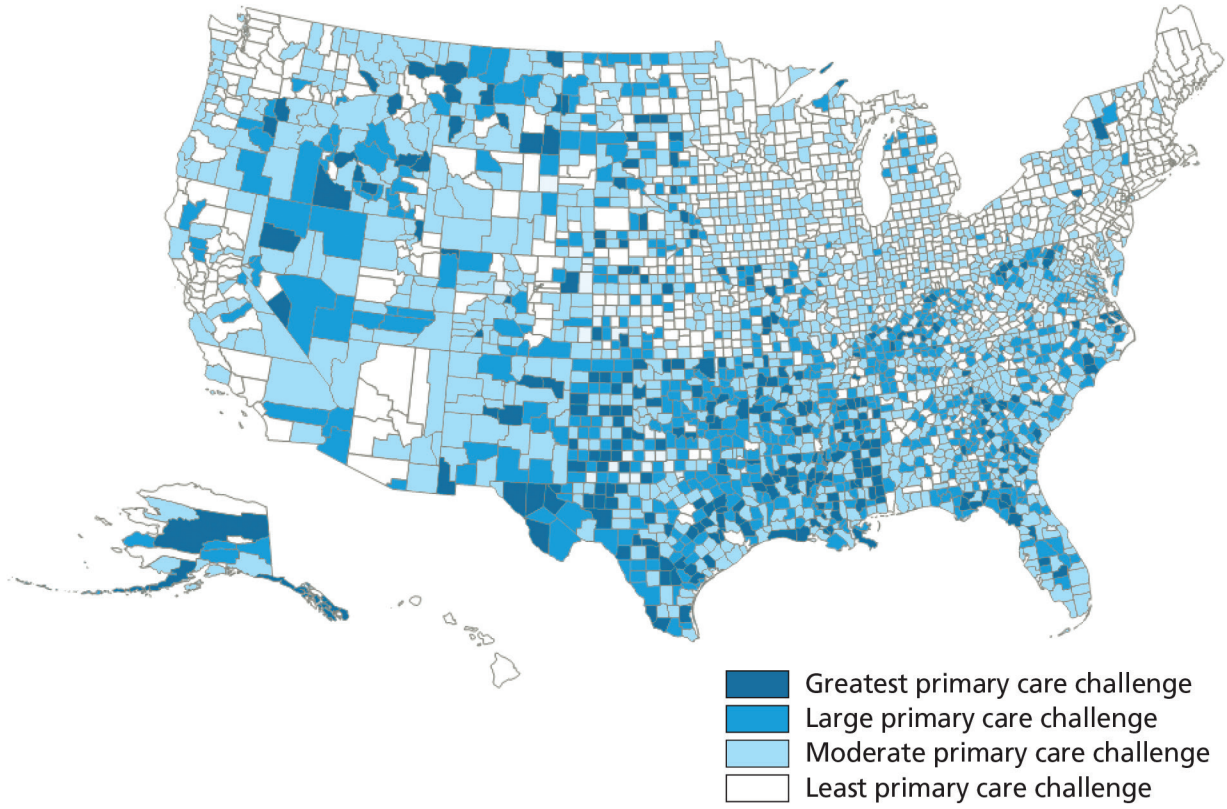
While the nation's overall primary care capacity can be debated, there is clearly a mismatch between the supply of primary care physicians and those in need of primary care services. Approximately 50 million Americans live in areas with an under-supply of primary care physicians, defined as an area with a ratio of one primary care physician per 3,500 people or more.[52] Most of these areas are rural, where the ratio of practicing primary care physicians to residents is less than half that in the rest of the nation.[53] Overall, 59 million individuals live in rural areas, representing about 19 percent of the population.[54] Notably, the percentage of NPs (15 percent) and PAs (17 percent) who practice in rural areas is greater than the percentage of primary care physicians (10 percent) practicing in rural areas (see Exhibit 6).[55]

Exhibit 6; Shares of providers practicing in rural areas, where 59 million individuals live



Source: See Appendix.

Exhibit 7; Primary care challenge by county, 2014



Source: UnitedHealth Center for Health Reform & Modernization analysis, 2013.

Note: Analysis assumes all states ultimately adopt the Affordable Care Act's Medicaid expansion. See Appendix for methodology.

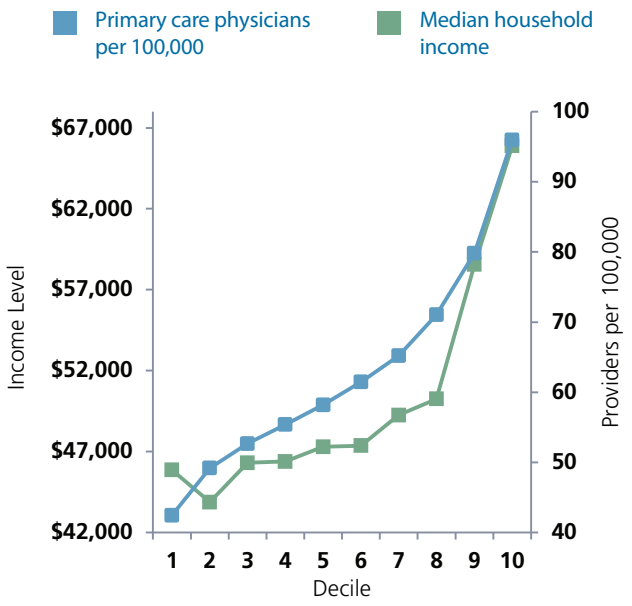
An analysis of the counties expected to face the greatest challenges in ensuring primary care capacity in the coming years indicates that some areas of the country face greater challenges than others, including parts of the West and the South (see Exhibit 7).

An analysis by the UnitedHealth Center for Health Reform & Modernization and Optum Labs shows that socioeconomic factors help explain geographic variation in primary care physician supply. Primary care physicians are more concentrated in higher-income areas. In the 10 percent of HRRs with the lowest concentration of primary care physicians (42 per 100,000 people), the median household income was $46,000. In the 10 percent with the highest concentration (96 per 100,000 people), it was $66,000 (see Exhibit 8).

Primary care physicians also are concentrated where residents — and potential patients — are more likely to have insurance coverage. In the 10 percent of HRRs with the fewest primary care physicians, the uninsured rate for the non-elderly was 17 percent; in those with the highest concentration, it was 11 percent (see Exhibit 9).

There is a higher concentration of non-physician primary care providers where the supply of primary care physicians is lower. Thus, NPs and PAs are concentrated in areas with lower median household incomes and higher rates of uninsured residents.

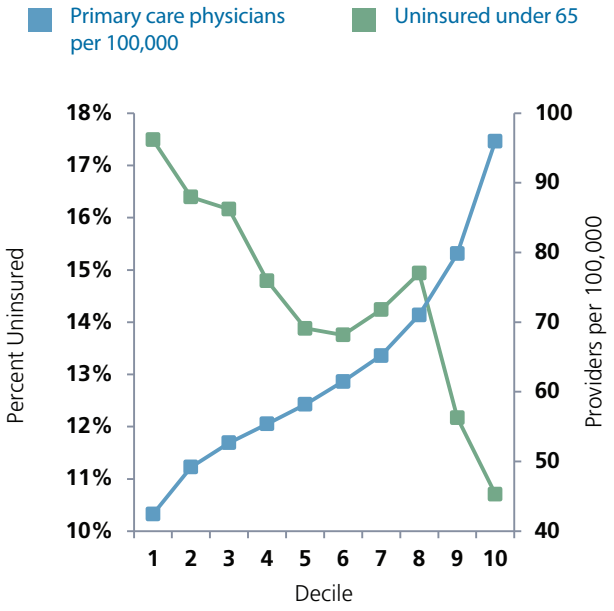
Exhibit 8; Median household income and primary care physician supply



Source: UnitedHealth Center for Health Reform & Modernization and Optum Labs analysis, 2014.

Note: See Appendix for methodology.

Exhibit 9; Uninsured rate for nonelderly and primary care physician supply

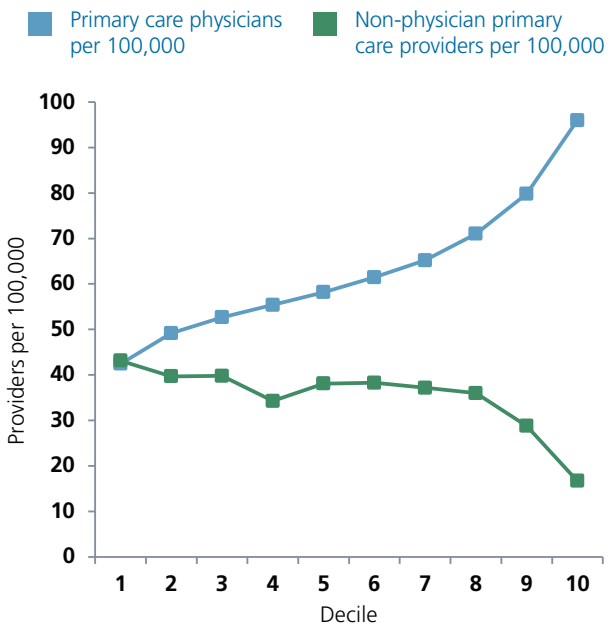


Source: UnitedHealth Center for Health Reform & Modernization and Optum Labs analysis, 2014.

Note: See Appendix for methodology.

In the 10 percent of HRRs with the lowest concentration of primary care physicians, the concentration of NPs and PAs was highest (43 per 100,000 people), and there were approximately equal numbers of physician and non-physician providers (see Exhibit 10). By contrast, in the 10 percent of HRRs with the most primary care physicians per capita, the concentration of NPs and PAs was lowest (17 per 100,000 people) and there were nearly six physicians for every NP or PA.

Exhibit 10; Supply of primary care physicians and non-physician primary care providers



Source: UnitedHealth Center for Health Reform & Modernization and Optum Labs analysis, 2014.

Note: See Appendix for methodology.

Because the supply of primary care physicians is concentrated away from rural areas, in higher-income communities, and away from the uninsured, simply increasing physician supply may not be enough to effectively address unmet demand for primary care services in all areas of the country. The same patterns hold for specialist physicians, indicating that capacity and access are challenges not only for primary care delivery.

These findings corroborate conclusions by Dartmouth University researchers that training more physicians may, in fact, increase regional inequities, since four out of five new physicians will likely practice in high-supply regions rather than underserved areas.[56] Increased roles for NPs and PAs would add to the system's overall primary care capacity, and could help target capacity to areas where there are fewer primary care physicians.

BUILDING BLOCKS FOR BOLSTERING CAPACITY

Leveraging a diverse workforce

Current initiatives aimed at training more primary care physicians alone might not meet growing primary care demands, especially in low-income and rural areas. One solution to increasing primary care capacity and improving access to services may include leveraging other clinicians, including NPs and PAs, as integrated parts of the health care delivery system.

Some primary care physician practices have undertaken an approach that enables NPs and PAs to "practice at the top of their licenses." This approach allows physician practices to grow their panel size and see more patients, with patients benefitting from shorter wait times. These integrated multi-level practices have distributed care delivery responsibilities to match the varied complexities of patient needs with the skill sets of physicians, NPs, and PAs.

Studies have shown that specific primary care services provided by nurse practitioners were comparable to those provided by physicians.

There is evidence supporting greater roles for NPs in delivering primary care services. A broad range of research studies, including three randomized controlled trials, have found that specific primary care services provided by NPs were comparable to those provided by physicians.[57] In some instances, NPs have had better results on measures of patient follow-up, consultation time, and the provision of screening, assessment, and counseling.[58] Finally, there is evidence that NPs in states with tighter restrictions on scopes of practice provide a comparable standard of care as in states where they have more clinical responsibilities and autonomy.[59]

States have been active recently in reforming scope-of-practice laws, with almost all states having considered doing so since 2011.[60] Non-physician clinicians are voluntarily increasing their credentialing, including through the use of clinical doctoral programs and extended years of education.[61] In addition, HRSA has launched an initiative to increase the number of PAs practicing in primary care settings by recruiting and training recently discharged military medical personnel who lack civilian PA certification.[62]

Use of non-physicians can increase the capacity of primary care practices, allowing physicians to care for nearly twice as many patients and focus on more complex tasks.

Allowing non-physicians to take on increased responsibility could result in a capacity windfall for primary care practices, including a near-doubling of patient panel size per physician and a pathway for physicians to focus on more complex tasks.[63] Changes in the use of non-physician providers are already underway at the practice level in all states. This is a reflection of NPs' and PAs' existing credentials and their capacity to help address demand for primary care services.

Advancing effective roles for NPs and PAs depends on greater use of evidence-based guidelines, rigorous quality measurement frameworks, and quality improvement initiatives for non-physician providers. A significant barrier to achieving more dramatic and rapid progress is payment policy. Medicare and Medicaid generally reimburse less for services delivered by NPs and PAs than for the same services when performed by physicians.[64]

Assembling multi-disciplinary care teams

As both panel size and rates of chronic conditions increase, it may become difficult for primary care physicians to spend large quantities of time with all of their patients, or even see each patient at every visit.[65] A primary care physician with a panel of 2,000 patients would need to spend an estimated 17.4 hours per day providing recommended preventive, chronic, and acute care — and many primary care physicians have larger panels.[66]

Assembling multi-disciplinary care teams can leverage additional capacity to help practices deliver services to their patients. Practices can rethink how non-physicians work most effectively with physicians and with each other in well-integrated and high-functioning teams. In a transformed primary care practice, the physician's scarce time can be deployed in a more deliberate and targeted fashion. Moving toward team-based care and sharing clinical responsibilities with non-physicians is one of several practice changes linked to improving primary care physicians' satisfaction with their work.[67]

Multi-disciplinary care teams allow physicians to use their time and skills more deliberately, while practices provide high-quality primary care to more patients. Physicians practicing in multi-disciplinary teams have greater satisfaction with their work.

Integrating behavioral health and pharmacy services into primary care practices is a further step in developing the team-based approach.[68] When a redesigned care setting includes co-location or integration of behavioral health providers, practices can more uniformly screen for and treat mental health conditions and substance use disorders. Pharmacists, who have expertise in medication management and in counseling patients on adherence, side effects, and other issues, can play an increased role when embedded within a primary care practice.[69]

A critical function of team-based care is care coordination. The typical primary care physician in a single year coordinates with an average of 229 other physicians in 117 different practices for their Medicare patients.[70] Various members of the care team need to be able to share information about patients and coordinate their component of the treatment plan with colleagues. High-performing practices have achieved both practice efficiencies and improved patient care through greater staff capacity, including deploying medical assistants to issue pre-visit questionnaires, manage patients' health records, prepare post-exam summaries, and reinforce care plans with patients.[71] In addition, health coaches can work with patients to focus on behavioral change.

The typical primary care physician must coordinate with 229 other physicians in 117 different practices for their Medicare patients each year. Sharing information among team members helps primary care practices coordinate care.

Standardizing care processes and protocols can drive significant improvements in care delivery and can help practices shift toward non-visit-based population health management.[72] With work delegated to medical assistants and health coaches, NPs can perform more direct patient care, including more chronic disease management.[73] Such approaches can be self-sustaining, allowing for a greater number of patient visits and, thus, increased practice revenue to cover the costs of additional team members.[74]

Almost half of primary care physicians worked in practices of one or two physicians in 2010.[75] Many primary care physicians are leaving solo and small-group practices in favor of larger primary care or multi-group practices, including hospital-owned practices. Group practices — whether single-specialty or multi-specialty — offer some advantages for improving practice efficiency and building team-based care. These include pooled capital; shared overhead costs, particularly related to information systems; and increased care coordination capacity.

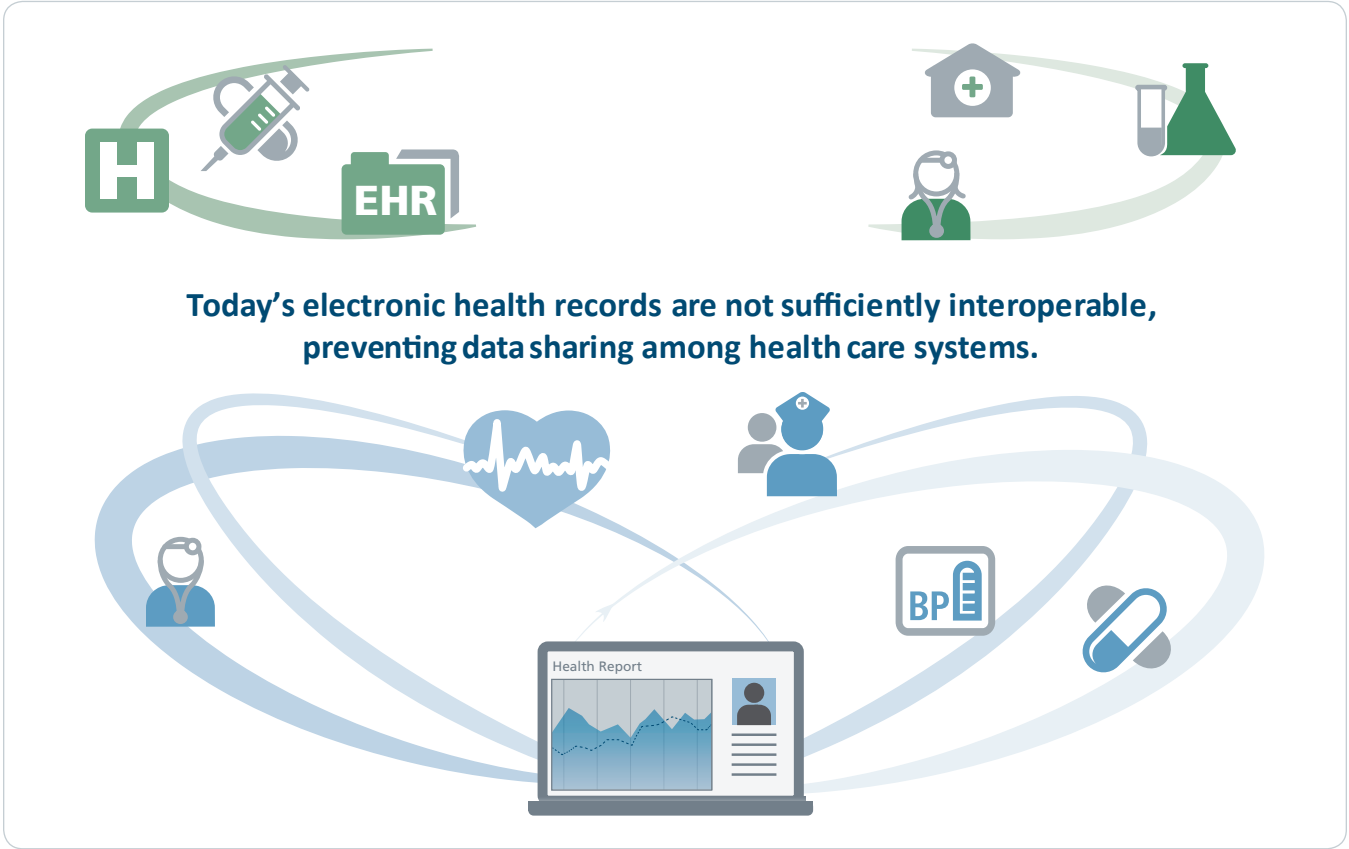
Utilizing health information technology

Health information technology (HIT), including electronic health records (EHRs) and interoperable data exchange, allows primary care practices to organize and disseminate information across the delivery system in real time — improving care coordination, increasing quality, and lowering costs.[76] Broader implementation of HIT, along with greater use of teams that include non-physicians, can expand systemwide capacity to meet increased demand while improving access to primary care.[77]

Adoption of EHRs alone is insufficient to achieve dramatic improvements in primary care delivery, but it is an essential building block for broad and ambitious efforts to leverage HIT. Adoption rates for EHRs among primary care physicians are approximately 70 percent, double the rate of five years ago, with younger physicians and those who practice in a group setting even more likely to have adopted an EHR.[78] But rates of adoption are higher than rates of satisfaction and impactful use. Approximately two-thirds of primary care physicians practicing internal medicine (65 percent) and family medicine (63 percent) reported that investing in EHRs had led to revenue losses for their practices.[79]

The federal government has invested substantially in providing financial incentives to physician practices to adopt EHRs and to leverage their capabilities through a staged functionality approach known as meaningful use. But barriers to impactful use remain significant. Data is fragmented and cannot be shared easily across incompatible health information systems; therefore, today's EHRs are not sufficiently interoperable. Additional barriers to adoption and impactful use include ongoing system administration and maintenance costs; technical issues related to training, support, customization, and reliability; a decrease in productivity stemming from initial adoption; and concerns regarding privacy and security.[80]

Physicians ultimately approve of EHRs in concept. However, investments in the deployment and impactful use of HIT require significant time commitments and upfront costs that will pose difficulty for some primary care practices. This gap — between the level of change needed and the capacity for change management — is a fundamental challenge for primary care, and for the health care delivery system more broadly.



ADVANCED SERVICE DELIVERY AND PAYMENT MODELS

Medical homes

Private and public payers continue to work with providers to implement patient-centered medical homes (PCMHs), sometimes simply called medical homes.[81] Operated primarily by physician group practices, typically staffed by multi-disciplinary care teams, and enabled by HIT, medical homes bring to bear several core building blocks for bolstering primary care capacity. Financial support, from public or private payers, is designed to address primary care needs by enabling more coordination of care and better patient management. Some states are using health homes, a Medicaid option under the ACA, to build on the medical home model, for example by integrating behavioral health providers to treat severe mental illness and substance use disorders, and by coordinating support services accessible through other means-tested programs.

Medical home models have shown promise for years, and some have achieved successful results. Group Health Cooperative in Washington state has operated medical homes in 25 clinics through an approach employing multi-disciplinary primary care teams, care management for patients with chronic conditions, electronic health records, and patient outreach and education.[82] Group Health also used capitated payments to encourage care coordination activities and to make providers accountable for the health care utilization and health outcomes of their patients.[83] Over a two-year period, Group Health generated a $1.50 return on each dollar invested in the PCMH and achieved a $10 per member per month (PMPM) reduction in total costs, in part due to a 16 percent reduction in hospital admissions and a 29 percent reduction in emergency department visits (see Exhibit 11).[84]

Success, however, has not been uniform. A recent evaluation of one of the nation's largest multi-payer medical home pilots, the Pennsylvania Chronic Care Initiative, found no statistically significant differences in

total or ambulatory care-sensitive hospital admissions or emergency department visits, or in overall health care costs, between pilot and comparison practices.[85] Of the study's 11 quality measures related to diabetes, asthma, and preventive care, patients in the medical home pilot fared statistically better on one measure.[86] A second independent study, focused on a largely overlapping sample of medical home practices, also found no significant reductions in costs for the overall population, but identified reductions in downstream utilization and total spending for the highest-risk patients.[87]

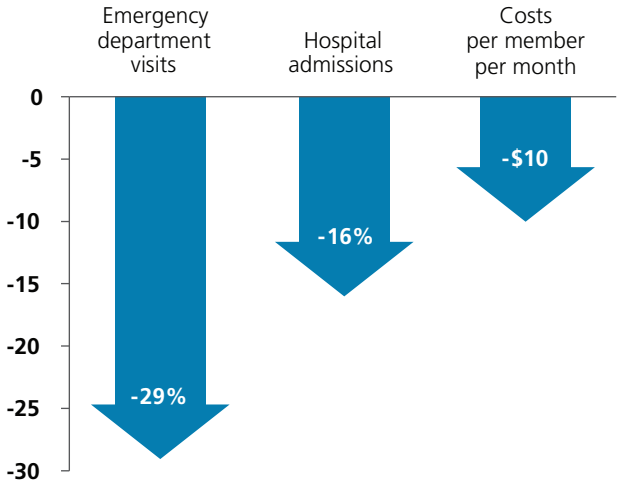
Evidence indicates the size as well as the HIT and analytic capabilities of physician practices are factors in achieving results through medical homes. In general, smaller practices appear to have greater difficulty than larger ones in improving patients' health outcomes and

lowering costs.[88] Larger practices, and those with more management capacity and greater use of EHRs, have shown more success.[89] Often medical homes lack the timely feedback and data necessary to effectively manage patients' downstream utilization of care.

Another key factor appears to be how medical homes are reimbursed. Some programs that link bonus payments to achieving recognition as an accredited PCMH, as well as other measures of structure or processes, do not provide incentives to contain overall patient costs, such as through gain-sharing or partial capitation payment models.[90] Without such clear incentives, it is more challenging to define success around health outcomes, appropriate utilization, and overall costs.

UnitedHealthcare's medical home model integrates a range of capabilities. These include support for practice transformation, an engaged physician leadership, the integration of care management in practice workflow through a dedicated care manager, the exchange of data and analytics between the medical home and the payer that is real-time and bi-directional, upfront investments in HIT, and patient engagement in the care process over the long term. Even when all of these criteria are met, success also depends on a financial model that rewards value (see Box 1).

Exhibit 11; Group Health Cooperative PCMH change in cost and utilization, 2007 to 2009



Source: Robert Reid, Katie Coleman, Eric A. Johnson, Paul A. Fishman, Clarissa Hsu, Michael P. Soman, Claire E. Trescott, Michael Erikson, and Eric B. Larson, "The group health medical home at year two: cost savings, higher patient satisfaction, and less burnout for providers," *Health Affairs*, 2010, 29(5): 835-843.

Box 1; Results from UnitedHealthcare's patient-centered medical home programs

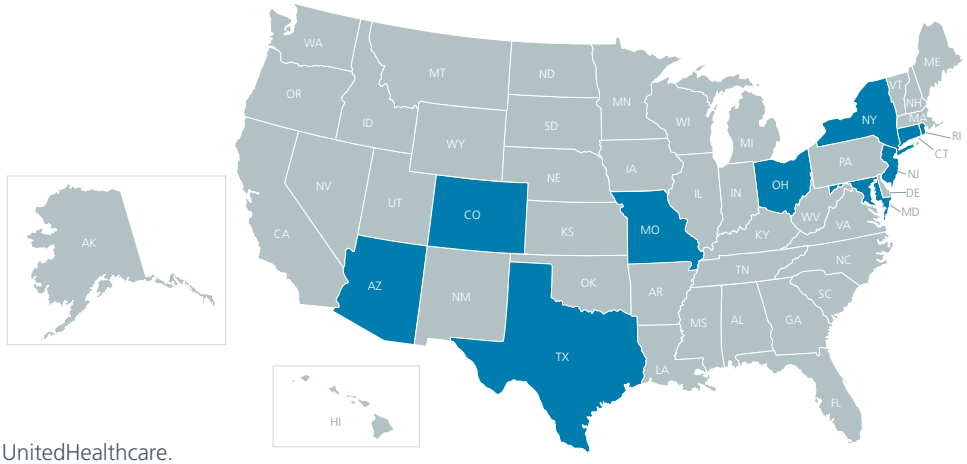
UnitedHealthcare currently operates 13 medical home programs in 10 states for the commercially insured population (see Exhibit 12). These programs include more than 2,000 participating physicians and 300,000 members. An actuarial evaluation of four programs in Arizona, Colorado, Ohio, and Rhode Island, based on three full years of operation between 2009 and 2012 for 40,000 members, found **average gross savings of 7.4 percent of medical costs in the third year** compared to a control group. Every dollar invested in care coordination activities produced $6 in savings in the third year (a return on investment of approximately 6 to 1). The costs of the interventions were 1.2 percent of medical costs and they offset 16 percent of the gross savings. **Including the cost of the intervention, the programs saved approximately 6.2 percent of medical costs on average.**

Achieving returns takes time as there are substantial upfront costs when setting up the medical home program, including making infrastructure investments. Demonstrated infrastructure and capacity are prerequisites for practices to participate, rather than program goals. These models also focus on process measures of quality, measures of health outcomes, and reductions in downstream utilization and costs, depending on the maturity of the model. Internal actuarial analyses showed reductions in inappropriate emergency department utilization and lower readmission rates.

Additional analysis examined the results for a cohort of individuals who were in the medical home practice on day one of the study period and remained in the medical home for the full period of analysis. The purpose of this analysis was to test whether longer member engagement leads to greater reductions in cost and utilization. In the four states noted above, there were larger annual reductions in cost growth for this cohort than for the full population. The return on investment was 7 to 1, suggesting higher returns from approaches that focus resources on a population over time to drive improvements in their health.

Independent third-party evaluations completed for four medical home programs in three states (Rhode Island, Colorado, and Ohio) showed improvement on quality measures for preventive and chronic care, access, care coordination, use of health information technology, and patient satisfaction. In particular, chronic care quality measures improved, reflecting practice investments in that area. Success was notable for diabetes management. However, not all measures met program targets, particularly those related to some cancer screenings, suggesting opportunities for improvement.

Exhibit 12; States with UnitedHealthcare medical home programs



Source: UnitedHealthcare.

Accountable care organizations

Another emerging service delivery model is the accountable care organization (ACO), in which the primary care group practice is often a critical component of an integrated system of care delivery. Federal government initiatives to advance ACOs include the Medicare Shared Savings Program, which allows participating providers to share financial gains from reduced utilization and costs, and the Medicare Pioneer ACO Program, in which a small number of leading integrated delivery systems have opportunities for a larger financial upside through shared savings but also face downside risk. In addition, health plans are partnering with providers, including primary care practices, to implement ACO models in commercial markets and in state Medicaid programs.

Evidence about the efficacy of the ACO model has been mixed to date. In the first year of Medicare's Pioneer ACO program, only eight of 32 organizations had significantly lower growth in total Medicare spending per beneficiary than their local market comparison groups.[91] By the second year, several ACOs had left the program.

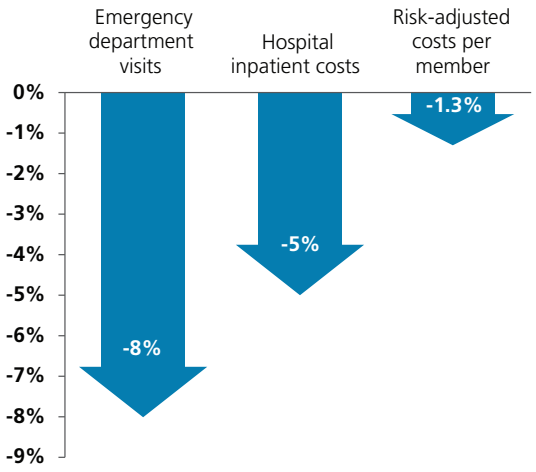
UnitedHealth Group participates in ACOs as a payer and as an analytic partner to help providers assess patients' needs and redesign care delivery. See Box 2 and Box 3 for two of those experiences. As in the medical home model, success depends on an integrated approach to creating measureable value that includes a central role for payment reform.

Box 2; Results from WESTMED's accountable care organization

WESTMED Practice Partners (WESTMED) is a multi-specialty group practice in New York, with 250 physicians and 1,000 employees. WESTMED operates a physician-led ACO for fully insured commercial members of UnitedHealthcare plans. Launched in 2012, WESTMED's ACO emphasizes primary care through a medical home program, uses state-of-the-art systems and EHRs, and has weekend and evening hours. Its physicians rely on Optum's analytic tools to access health information about their patients, to view evidence-based guidelines to support decisions at the point of care, to identify best practices for disease management, and to measure their own performance areas over time. **These analytic tools also provide WESTMED physicians, for the first time, a view of what services their members receive outside of the practice to enhance their management capacity across the care continuum.** Payment is linked to cost and quality through bonus arrangements; performance metrics included those that measure quality, health outcomes, patient satisfaction, and reduction of medical costs through appropriate service use.

In its first year of operation, for 13,000 covered lives, **the ACO improved on nine of 10 health quality metrics, increased patient satisfaction, and reduced health care costs**. There were significant improvements in patients taking their prescription medications properly; people with diabetes had more routine screenings and kept better control of blood sugar levels. **Between 2011 and 2012, there was an 8 percent reduction in emergency department utilization, a 5 percent decrease in hospital inpatient cost, and a 1.3 percent reduction in risk-adjusted costs per member** (see Exhibit 13).

Exhibit 13; WESTMED ACO change in utilization and costs, 2011 to 2012



Source: UnitedHealthcare and Optum.

Box 3; Results from Monarch HealthCare's accountable care organization

Monarch HealthCare is a multi-specialty independent physician group practice of about 2,500 physicians, including more than 700 primary care physicians, in Southern California. CMS recognized Monarch for its strong track record of offering coordinated, patient-centered care, and for having the experience and capacity to bear financial risk based on its performance, awarding it Pioneer ACO status.

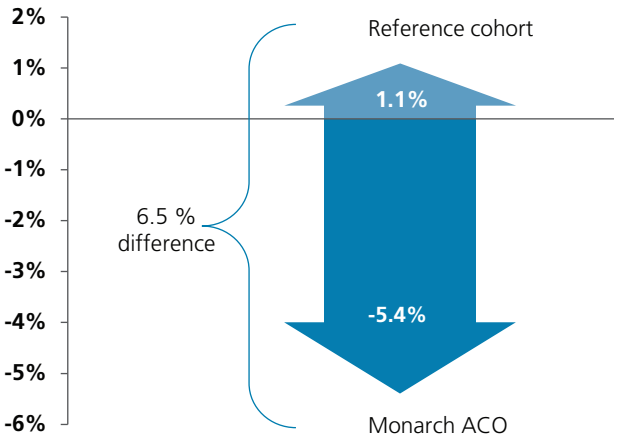
Monarch HealthCare®
A Medical Group, Inc.

Monarch's ACO identifies the individuals that benefit from the practice's disease management programs; these include patients with diabetes, congestive heart failure, chronic obstructive pulmonary disease, or kidney failure. Using Optum's analytic tools to conduct a risk analysis, Monarch identifies high-risk patients within those chronic condition cohorts. Monarch then determines the appropriate care management models. All models rely on multi-disciplinary care teams with a care navigator, responsible for triaging care needs and scheduling appointments, serving as the primary contact for patients.

Patient engagement occurs during physician office visits, through extensive physician training and scripting; during or immediately after a hospital admission or other acute event, using notifications of admissions through hospital partnerships; and immediately following a new diagnosis, through education and counseling. Web-based point-of-care tools allow physicians to review key events and encounters in a patient's medical history, perform health risk assessments, review lab results and prescriptions, and identify required screenings and gaps in care. Monarch also is working to provide physicians and patients with more information on comparative pricing.

In the first year of the Medicare Pioneer ACO demonstration, **Monarch was the top performing of 32 ACOs on three measures of quality: physician communication with the patient, overall patient satisfaction with their physician, and prevention of admissions for ambulatory care sensitive conditions.** Monarch's Pioneer ACO ranked second out of 32 on containing costs. It reduced Medicare spending by 5.4 percent in 2012 from the 2011 baseline for attributed ACO beneficiaries, compared to a 1.1 percent increase for a reference cohort (see Exhibit 14). The cost savings were achieved principally through reductions in hospital admissions, skilled nursing facility utilization, and unit costs.

Exhibit 14; Monarch ACO change in total Medicare spending, 2011 to 2012



Source: Optum.

Paying for value

Under fee-for-service, the dominant payment model for primary care in the United States, physicians are reimbursed for the volume of care delivered, with a payment value attached to each unit of service.[92] This approach incents the delivery of a greater quantity and higher intensity of services; it does not promote high-quality care based on best practices and coordination among providers.[93] Studies have shown that physicians who are reimbursed under fee-for-service react to those incentives by recommending more services than physicians who are reimbursed through alternative methods.[94] As much as half of wasteful health care spending results from failures of care delivery and care coordination, as well as overtreatment — all of which could be improved by moving away from the fee-for-service reimbursement model.[95]

Reforms that delink payments from units of care, and instead prioritize value, are fundamental to increasing primary care capacity and improving the effectiveness and efficiency of service delivery. Examples include:

- Performance-based bonuses as modifications to traditional fee-for-service payments. These payments can be linked to quality measures and utilization benchmarks.
- Risk-adjusted monthly payments for primary care services. This model could be developed with payments geographically adjusted to address variation in underlying practice patterns.[96]
- Gain-sharing through shared savings. This model orients providers to the total cost of care, without exposing them to downside risk.
- Risk-adjusted aggregate capitation payments to group practices and integrated delivery systems. This model promotes accountability for clinical outcomes and cost management at the practice level, without assigning too much financial risk to individual providers — an approach that generally has less appeal to primary care physicians.

These value-based approaches rely to a large extent on group practices and integrated delivery systems, because scale is an important criterion for spreading the fixed costs of building a care management and HIT infrastructure, as well as for spreading risk. While there is increasing participation in value-based payment models among primary care physicians, many practices continue to rely on a volume-based model for a substantial share of their revenue.[97] Some smaller practices may need financial support and technical assistance to acquire and implement the HIT infrastructure and practice protocols necessary to transition successfully away from a fee-for-service model.

APPROACHES TO EXPAND ACCESS AND TARGET CAPACITY

Leveraging the retail health infrastructure

Clinics in large retail outlets — such as CVS, Walgreens, Target, and Walmart — hold potential for large-scale innovation in primary care by providing consumers with convenient access to high-quality care that is affordable. The retail clinic model typically includes central roles for non-physician providers, allowing for an expansion in primary care capacity.

The range of services offered at retail health clinics varies. Some focus on preventive and primary care; others provide a broader continuum of care. Optum Clinic offers a diverse range of services, allowing consumers to address more of their needs in a convenient setting. This model uses multi-disciplinary care teams to deliver wellness exams; treatment of illnesses, sprains, and factures; wound closures; and same-day, on-site labs and x-rays.

Between 2007 and 2012, the volume of retail clinic visits grew more than six-fold, from 1.5 million to 10 million annually.[98] Close to half of retail clinic visits take place when physician offices are closed.[99] Retail clinics are particularly popular among 18- to 44-year-olds, who account for 43 percent of clinic patients.[100]

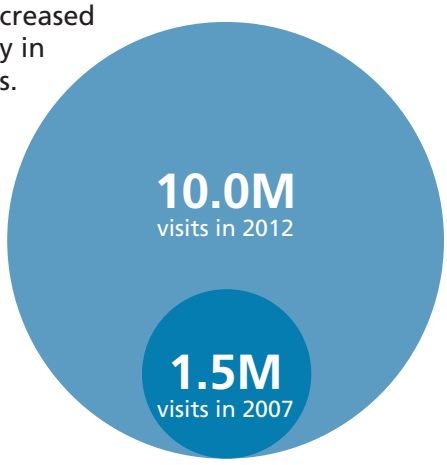
Nearly all retail clinics accept reimbursement from private insurance; a slightly lower share accepts Medicare; and approximately 60 percent accept Medicaid.[101] Overall, private or public insurance covers two-thirds of retail clinic visits.[102] Retail clinics also offer value to uninsured patients, as costs per visit tend to be more affordable than in physician offices.[103]

Evidence indicates that the quality and cost of services provided by retail clinics offer significant value. One study found retail clinics' performance on 12 quality measures was comparable to that of physician offices and urgent care centers and higher than that of hospital emergency departments.[104] Retail clinic treatment costs for several common illnesses are substantially lower than those for similar episodes at physician offices, urgent care centers, and emergency departments.[105]

Since many retail clinics are based on a one-time or episodic model of care, there are questions about whether they will complement and support other models of primary care delivery and promote continuity of patient-provider relationships. In addition, research suggests that retail clinics may not be increasing access for many under-served communities, because they are more likely located in metropolitan versus rural areas.[106]

However, retail clinics often accept more forms of insurance than office-based physicians — typically at lower cost. A RAND study found that retail clinics typically serve younger adult patients who do not have a regular health care provider.[107] In such cases, there is no continuity of care to be disrupted. Moreover, a component of many retail clinics' business models is to serve the uninsured.

The number of retail clinic visits has increased dramatically in recent years.



Retail clinics can be and are increasingly integrated into primary care delivery. They commonly use EHRs and share them with the patient's primary care or other provider, though they face the same challenges to impactful use of HIT as other providers.[108] Many retail clinics are investing in new infrastructure to ensure interoperability for EHRs.

Retail clinics are investing in new infrastructure to ensure interoperability for EHRs and greater clinical integration into primary care delivery.

Several plans and large employers have formed partnerships with retail clinics, focused on lowering consumers' out-of-pocket costs. By including these clinics in their networks and encouraging members to use them — and by ensuring the clinic transmits information to a patient's regular primary care provider — payers can advance retail clinics' integration into the health care delivery system, both clinically and financially.

Reaching patients where they live

Delivering primary care and preventive services to individuals in their homes is an effective approach to improving access and care delivery. A key advantage of conducting clinical visits in the home is that the review of environmental and social conditions provides valuable information and context to inform an individual's treatment plan. For example, assessment and remediation of trip hazards for the purpose of preventing falls among the elderly is an important benefit of an in-home visit, as is a first-person observation of medication supplies for patients with multiple chronic conditions. These services are difficult to replicate in an office setting. In addition, observing changes in the home environment over time adds an important line of sight into the life and overall well-being of the patient, particularly those with functional limitations (see Box 4).

Box 4; Optum's HouseCalls program

HouseCalls is a care management program that provides annual in-home clinical visits to health plan members, including those with chronic conditions. These visits help to identify and close gaps in clinical care, and are an important part of the care continuum. HouseCalls employs more than 1,200 licensed physicians and nurse practitioners who conduct home visits. In 2013, HouseCalls conducted approximately 670,000 visits in 37 states — an increase from six states in 2011.

The 45 to 60 minutes of scheduled one-on-one time with a clinician is longer than a typical office visit and provides clinically robust encounters that are in many ways indistinguishable from other professional medical services. During the HouseCalls visit, the clinician performs: a review of the patient's health history; a thorough medication review; a physical exam including screenings for key health metrics and symptoms, including nutrition, depression, pain, cognitive impairment, and functional status; where possible, collection of lab specimens and administration of a flu vaccine; identification of gaps in care; and an opportunity for the patient and any caregivers to discuss their health and ask questions about their current conditions and treatment.

HouseCalls visits support ongoing care and promote care coordination for beneficiaries. **After a visit, a Plan of Care is provided to both the member and his or her primary care provider.** A key component of the treatment plan includes educating and counseling members on managing chronic conditions, identifying signs and symptoms of disease exacerbation, and mitigating risk factors. The member is provided with an "Ask Your Doctor" letter, which includes diagnoses made during the visit and the HouseCalls clinician's recommendations for follow-up care. Information provided to the member's primary care provider includes a diagnosis list; an assessment of each diagnosis; recommendations for each diagnosis; a current medication list, including any noted adherence issues; vital signs; screening results; recommendations for screenings and vaccines; and narrative notes.

Results from the HouseCalls program

The HouseCalls program leads directly to needed follow-up encounters and closes gaps in care. Among UnitedHealthcare Medicare Advantage members receiving a HouseCalls visit in 2013:

- Nearly two-thirds (64 percent) received a follow-up service under Medicare within 30 days.
- There was a 5.1 percent increase in colorectal screening and a 6.9 percent increase in breast cancer screening.

Source: UnitedHealthcare and Optum.

Utilizing group visits

An evolving approach for improving access to primary care and increasing the efficient use of primary care resources is shared medical appointments, sometimes termed group visits. Under this model, patients attend medical appointments with groups of patients with similar needs, sometimes on a frequent basis. During those visits, patients have both private examinations and group education sessions.

One advantage of group visit models is that they are an efficient use of provider time compared to individual care.[109] NPs can support direct clinical needs, and additional members of a multi-disciplinary care team can support the educational components of the program. Patient groups commonly number five to 20 for a period of one to two hours, depending on their condition.

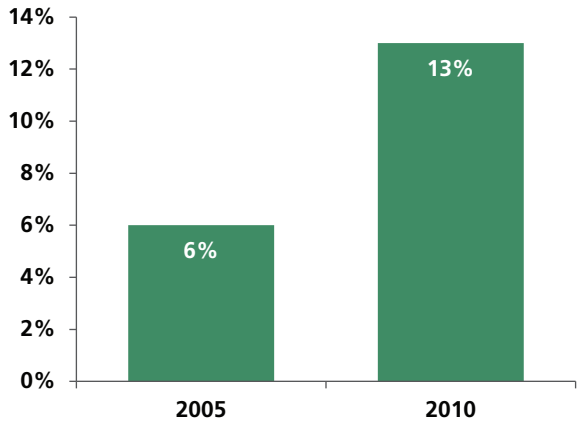
One example is UnitedHealth Group's Expect With Me program for prenatal care, in which a physician or midwife and a trained assistant deliver comprehensive prenatal care to groups of eight to 12 women of the same gestational age. During each two-hour visit, women participate in self-care, checking their weight and blood pressure, and receive an individual examination by the midwife or physician, before joining the group for education and skills building. The program offers greater practice efficiency by combining each woman's traditional 15-minute appointment with a two-hour group session. Studies have also demonstrated that women who participate in group prenatal care have better birth outcomes than women in individual prenatal care.[110]

Shared medical visits can decrease emergency department and specialty visits, reduce hospital admissions, increase patient satisfaction, and improve patient outcomes.[111] Multiple randomized controlled trials have demonstrated that shared visits have achieved success on a range of measures, including reducing hospital admissions and emergency department visits among chronically ill older patients; improving problem-solving ability, quality of life, and clinical outcomes among patients with diabetes; and reducing the risk of preterm birth and improving sexual risk behavior among pregnant women.[112]

The group visit model succeeds in part due to higher levels of patient engagement and activation. The group dynamic helps individuals learn successful lifestyle management strategies, obtain greater self-management skills and confidence, and develop self-motivational and peer support.[113] Research shows that an individual's health-related behaviors are influenced by the behaviors of those around them and that social support within group care is tied to greater patient satisfaction.[114]

Use of group visits is not widespread, in part because approaches to provider reimbursement vary and are still evolving.[115] In 2010, 13 percent of family physicians provided at least some care through group visits, up from 6 percent in 2005 (see Exhibit 15).[116] This trend may accelerate as care delivery and payment models evolve and achieve greater acceptance among physicians and patients.

Exhibit 15; Share of family physicians utilizing group visits, 2005 and 2010



Source: Victoria Stagg Elliott, "Group Appointments Can Serve Both Patients and Practices," *American Medical News*, September 19, 2011.

Engaging complex patients

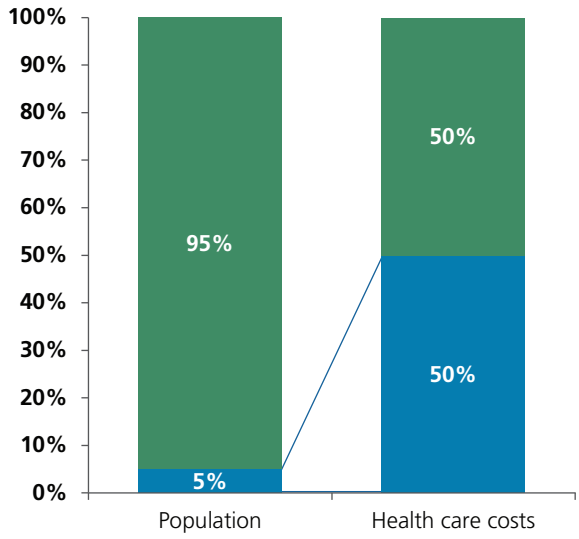
Making the most effective use of primary care services and better leveraging capacity to reduce overall spending requires a greater focus on complex and costly patients. In a study of more than 3 million commercial patients over more than three years, 40 percent of those with a single claim had more than one chronic condition (see Exhibit 16).[117] In general, 5 percent of the population accounts for 50 percent of health care costs each year, with more than one in three (38 percent) of these "super-utilizers" remaining in the most costly 5 percent of people the following year (see Exhibit 17).[118]

"Super-utilizers" typically have chronic conditions and rely frequently on hospital emergency departments and inpatient services to address needs that often can be managed through earlier and less costly interventions. These individuals, more often men than women, are more likely to have serious and persistent mental illness, substance use disorders, or both; and they often face poverty, unemployment, and fragmented home and community environments.[119]

When providers and health plans use data effectively, they can identify high-risk patients that will benefit from primary care interventions, and they can target specific approaches to address those patients' needs. Targeting "super-utilizers" requires analytic models that map patients' clinical characteristics to utilization levels, in order to better capture the difference between expected and actual utilization.[120]

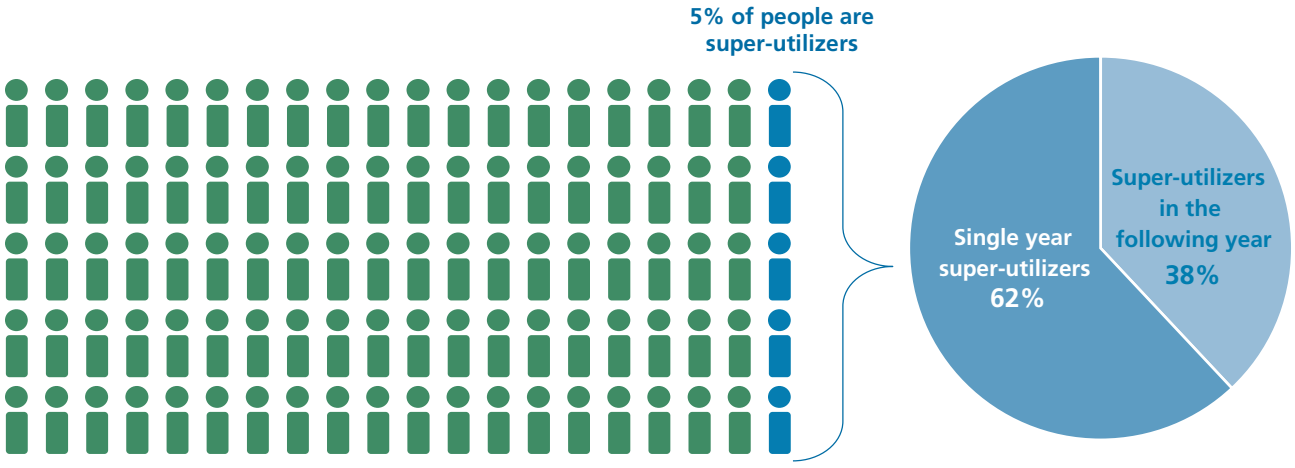
Payment models that appropriately reimburse for such an intensive level of primary care services are still evolving.[121] These models should reflect the importance of underlying data and analytics and should incorporate payments for bundles of services tailored to defined patient subgroups.[122] Advancing payment reform is fundamental for scaling interventions that are tailored to "super-utilizers."

Exhibit 16; Super-utilizers as share of population and share of health care costs



Source: Robert Greene, Edwin Dasso, Sam Ho, Jerry Frank, Graeme Scandrett, Ash Genaidy, "Patterns and Expenditures of Multi-Morbidity in an Insured Working Population in the United States: Insights for a Sustainable Health Care System and Building Healthier Lives," *Population Health Management*, 2013, 16(6):381-9.

Exhibit 17; Super-utilizers as share of population in a single year and the following year



Source: Steven Cohen, Namrata Uberoi, "Differentials in the Concentration in the Level of Health Expenditures across Population Subgroups in the U.S., 2010," *Statistical Brief #42*, Agency for Healthcare Research and Quality, Rockville, MD, August 2013. Steven Cohen, William Yu. "The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2008 – 2009," *Statistical Brief #354*, Agency for Healthcare Research and Quality, Rockville, MD, January 2012.

APPENDIX: DATA SOURCES AND METHODS

Primary care challenge by county

The UnitedHealth Center for Health Reform & Modernization developed state-level estimates of the number of individuals who will be newly eligible for and who will newly enroll in Medicaid under the ACA's coverage expansion, assuming that all states ultimately would implement this expansion; estimates of those who will enroll in the new state health insurance marketplaces; and estimates of the number of people who otherwise would have been uninsured. Estimates of the county-level distribution of newly insured people in each state use county-level distributions of the non-elderly population and the uninsured from the U.S. Census.

The U.S. Census Small Area Health Insurance Estimates are the source of the county-level uninsured figures. County-level estimates of the newly insured were combined with data on the supply of health professionals and facilities from the Health Resource and Services Administration's Area Health Resource File. The micro-simulation used to estimate coverage under the ACA produced state-level estimates. Distributions of those results across counties contain additional uncertainty because they are based on current county-level estimates of the uninsured. Because these estimates include many undocumented persons, county-level distributions of the newly insured in some areas may be weighted too heavily.

Primary care quality and supply of providers by Hospital Referral Region

Commercial claims data for the period 2011-2012 were aggregated to the Hospital Referral Region (HRR) level. This data includes 19.5 million members, including both self-insured and fully insured. Utilization rates are based on member enrollment in a given month to adjust for variations in enrollment over the data period. Condition prevalence measures are based on enrollment during the analytic period.

The 306 HRRs included in the analysis were split into 10 equivalently sized groups based on the number of primary care providers per 100,000 people. The 31 HRRs with the lowest primary care physician concentration were included in the bottom decile, while the HRRs with the highest primary care physician rates were in the top decile. The relationships between physician supply and measures of interest were studied by taking the means of those measures in each decile of physician supply.

The analysis examined the variation between primary care physician supply and other characteristics at the HRR level, relying on correlation coefficients to determine the strength of the relationship between two variables. It compared variation in primary care physician supply per 100,000 to avoidable hospital admissions per 1,000, avoidable emergency department visits per 1,000, and high-technology diagnostic imaging procedures per 1,000.

Measures of quality were obtained using the Evidence Based Medicine (EBM-Connect) software application, a leading tool for assessing gaps in care. Measurements of avoidable admissions and avoidable emergency department visits were developed internally, based on the algorithms of avoidable utilization used by AHRQ and the Massachusetts Department of Health.[123] Avoidable admissions and avoidable emergency department visits were based on the primary discharge diagnosis.

Examples of diagnoses included in the avoidable admissions measure are admissions for asthma, congestive heart failure (CHF), dehydration, and ear, nose and throat (ENT) infection. Examples of avoidable emergency department visits include ear infection, pharyngitis, back pain, and asthma. High-technology diagnostic imaging is an area of possible over-utilization among the commercially insured population. The high-technology diagnostic imaging rate per 1,000 members is gathered through procedure codes, including imaging use in both outpatient and inpatient settings.

Estimates of the number of non-physician primary care providers — NPs and PAs — per 100,000 residents are from the U.S. Office of the National Coordinator for Health Information Technology, for the year 2011. Estimates of primary care physicians per 100,000 residents are from the American Medical Association Physician Master File, for 2010. Estimates of median household income are from the American Community Survey, for the years 2005 through 2009. Estimates of the rates of uninsured are from the U.S. Census Bureau's Small Area Health Insurance Estimates program, for 2009.

Providers practicing in rural areas

The source for Exhibit 6 on page 12, "Shares of providers practicing in rural areas, where 59 million individuals live," is as follows: Thomas Bodenheimer, Hoangmai H. Pham, "Primary Care; Current Problems and Proposed Solutions," *Health Affairs*, 2010, 29(5):799-805. Susan M. Skillman, Louise Kaplan, Meredith A. Fordyce, Peter D. McMenamin, Mark P. Doescher, "Understanding Advanced Practice Registered Nurse Distribution in Urban and Rural Areas of the United States Using National Provider Identifier Data," Final Report, Rural Health Research Center, University of Washington, 137, 2012. American Academy of Physician Assistants, "Quick Facts." Accessed February 25, 2014.

UnitedHealthcare's medical home evaluation

UnitedHealthcare's actuarial evaluation methodology relied on a statistical approach that compares the annual change in performance for the medical home population versus a comparison population, called a *difference-in-differences* approach. To establish the comparison population, matching data were used — through a process called *propensity score matching* — from 12 months leading up to the medical home launch in the same market.

Patients were matched using claims data for a broad range of measures including age, sex, utilization, spending, and presence of certain chronic conditions. The evaluation looked at all commercial members attributed to a given practice, not just those participating in a medical home program, and it included those who left or joined the medical home during the life of the program. Over the study period, there was a 10 percent to 20 percent increase in the attributed population per year in the study programs.

REFERENCES

1 Allan H. Goroll, Robert A. Berenson, Stephen C. Schoenbaum, Laurence B. Gardner, "Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care," *Journal of General Internal Medicine*, 2007, 22(3):410-415. Robert L. Phillips, Andrew Bazemore, "Primary Care and Why it Matters for US Health System Reform," *Health Affairs*, 2010, 29(5):806-810. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "National Health Expenditure Data Projections 2012-2022," November 2013.

2 Table 1; Source: Physician office visits, by selected physician characteristics: United States, Centers for Disease Control and Prevention, 2010 National Ambulatory Medical Care Survey, CDC/NCHS, 2010.

3 Adam N. Hoffer, Jean M. Abraham, Ira Moscovice, "Expansion of Coverage Under the Patient Protection and Affordable Care Act and Primary Care Utilization," *The Milbank Quarterly*, March 2011, 89(1):69-89.

4 Barbara Starfield, Leiyu Shi, James Macinko, "Contribution of Primary Care to Health Systems and Health," *The Milbank Quarterly*, 2005, 83(3):457-502. Michael Chernew, Lindsay Sabik, Amitabh Chandra, Joseph P. Newhouse, "Would Having More Primary Care Doctors Cut Health Spending Growth?" *Health Affairs*, 2009, 28(5):1327-1335. James Macinko, Barbara Starfield, Leiyu Shi, "Quantifying the Health Benefits of Primary Care Physicians Supply in the US," *International Journal of Health Services Research*, 2007, 37(1):111-126.

5 Robert Wood Johnson Foundation, "What We're Learning: Reducing Inappropriate Emergency Department Use Requires Coordination with Primary Care," Quality Field Notes, Issue Brief 1, September 2013.

6 U.S. Department of Health and Human Services, Health Resources and Services Administration, "Shortage Designation: Health Professional Shortage Areas and Medically Underserved Areas/Populations," 2014.

7 Thomas Bodenheimer, Hoangmai H. Pham, "Primary Care; Current Problems and Proposed Solutions," *Health Affairs*, 2010, 29(5):799-805. Susan M. Skillman, Louise Kaplan, Meredith A. Fordyce, Peter D. McMenamin, Mark P. Doescher, "Understanding Advanced Practice Registered Nurse Distribution in Urban and Rural Areas of the United States Using National Provider Identifier Data," Final Report #137, Rural Health Research Center, University of Washington, 2012. American Academy of Physician Assistants, "Quick Facts." Accessed February 25, 2014.

8 Thomas Bodenheimer, Hoangmai H. Pham, "Primary Care; Current Problems and Proposed Solutions," *Health Affairs*, 2010, 29(5):799-805.

9 Mark W. Friedberg, Kathryn L. Coltin, Dana Gelb-Safran, Marguerite Dresser, Alan M. Zaslavsky, Eric C. Schneider, "Associations Between Structural Capabilities of Primary Care Practices and Performance on Selected Quality Measures," *Annals of Internal Medicine*, 2009, 151(7):456-463. Marci Nielsen, Nwando Olayiwola, Paul Grundy, Kevin Grumbach, "The Patient-Centered Medical Home's Impact on Cost & Quality, An Annual Update of the Evidence, 2012-2013," Patient Centered Primary Care Collaborative, January 2014. Ronald A. Paulus, Karen Davis, Glenn D. Steele, "Continuous Innovation in Health Care: Implications of the Geisinger Experience," *Health Affairs*, 2008, 27(5):1235-1245. Onur Asan, Enid Montague, "Physician Interactions with Electronic Health Records in Primary Care," *Health Systems*, 2012, 1(2):1-8.

10 Linda V. Green, Sergei Savin, Yina Lu, "Primary Care Physician Shortages Could Be Eliminated through Use of Teams, Nonphysicians and Electronic Communication," *Health Affairs*, 2013, 32 (1):11-19.

11 Harold Miller, "From Volume to Value: Better Ways to Pay for Health Care," *Health Affairs*, 2009, 28(5):1418-1428. Institute of Medicine, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America,* National Academies Press, 2013, 229.

12 Donald Berwick, Andrew Hackbarth, "Eliminating Waste in US Health Care," *Journal of the American Medical Association*, 2012, (14):1513-1516.

13 Stephanie Watson, "More Americans Using Retail Health Clinics," *Harvard Health Blog*, May 10, 2013.

14 RAND, "Use of Retail Medical Clinics Continues to Grow; Older Patients and Preventive Services on Rise," August 15, 2012.

15 Tricia M. Leahey, Rajiv Kumar, Brad M. Weinberg, Rena R. Wing, "Teammates and Social Influence Affect Weight Loss Outcomes in a Team-based Weight Loss Competition," *Obesity*, 2012, 20(7):1413-1418.

16 Kelly B. Bartley, Rebecca Haney, "Shared Medical Appointments: Improving Access, Outcomes and Satisfaction for Patients with Chronic Cardiac Diseases," *Journal of Cardiovascular Nursing*, 2010, 25(1):13-19. Jeffrey Bendix, Amanda Brower, "The Benefits of Sharing: Shared Medical Appointments Can Improve Your Patients' Outcomes and Your Practice's Efficiency," *Medical Economics*, 2011, 88(3):68-71. Karen S. Yehle, Laura P. Sands, Patricia A. Rhynders, Gail D. Newton, "The Effect of Shared Medical Visits on Knowledge and Self-Care in Patients With Heart Failure: A Pilot Study," *Heart Lung*, 2009, 38(1):25-33.

17 Steven Cohen, Namrata Uberoi, "Differentials in the Concentration in the Level of Health Expenditures across Population Subgroups in the U.S., 2010," *Statistical Brief #42*, Agency for Healthcare Research and Quality, Rockville, MD, August 2013. Steven Cohen, William Yu, "The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2008-2009," *Statistical Brief #354*, Agency for Healthcare Research and Quality, Rockville, MD, January 2012.

18 Kaiser Commission on Medicaid and the Uninsured, "Community Health Centers: Opportunities and Challenges of Health Reform," September 13, 2010.

19 Working Paper 6, Modernizing Rural Health Care: Coverage, Quality and Innovation, UnitedHealth Center for Health Reform and Modernization, July 2011.

20 Jessamy Taylor, "The Primary Care Safety Net: Strained, Transitioning, Critical," George Washington University Policy Forum, Background Paper #79, September 28, 2010. Working Paper 6, Modernizing Rural Health Care: Coverage, Quality and Innovation, UnitedHealth Center for Health Reform and Modernization, July 2011.

21 RAND, "Use of Retail Medical Clinics Continues to Grow; Older Patients and Preventive Services on Rise," August 15, 2012. Stephanie Watson, "More Americans Using Retail Health Clinics," *Harvard Health Blog*, May 10, 2013. Nicole Ostrow, "Retail Health Clinics More Popular on Ease for Patients," *Bloomberg*, July 22, 2013. The market is dominated by three major corporations: CVS Caremark, Target and Walgreens.

22 Tracey Yee, Amanda Lechner, Ellyn Boukus, "The Surge in Urgent Care Centers: Emergency Department Alternative or Costly Convenience?" Center for Studying Health System Change Research Brief 26, July 2013.

23 Allan H. Goroll, Robert A. Berenson, Stephen C. Schoenbaum, Laurence B. Gardner, "Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care," *Journal of General Internal Medicine*, 2007, 22(3):410-415. Robert L. Phillips, Andrew Bazemore, "Primary Care and Why it Matters for US Health System Reform," *Health Affairs*, 2010, 29(5):806-810. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "National Health Expenditure Data Projections 2012-2022," November 2013.

24 Table 1; Source: Physician office visits, by selected physician characteristics: United States, Centers for Disease Control and Prevention, 2010 National Ambulatory Medical Care Survey, CDC/NCHS, 2010.

25 IMS Institute for Health Informatics, "Medicine Use and Shifting Costs of Healthcare: A Review of the Use of Medicines in the U.S. in 2013," April 2014.

26 Exhibit 1; Source: "Number and percentage of outpatient chronic condition visits by physician type in the past year, based on the 2008 National Ambulatory Medical Care Survey," from "Patients With High-Cost Chronic Conditions Rely Heavily on Primary Care Physicians," *Journal of the American Board of Family Medicine*, 2014, 27:11-12.

27 U.S. Congressional Budget Office, "April 2014 Medicare Baseline." Figures are average monthly enrollment during the federal fiscal year for Medicare Part A.

28 U.S. Congressional Budget Office, "Updated Budget Projections: 2014-2024," April 14, 2014.

29 Adam N. Hoffer, Jean M. Abraham, Ira Moscovice, "Expansion of Coverage Under the Patient Protection and Affordable Care Act and Primary Care Utilization," *The Milbank Quarterly*, 2011, 89(1):69-89.

30 U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Chronic Conditions Among Medicare Beneficiaries Chartbook: 2012 Edition," 2012.

31 U.S. Department of Health and Human Services, National Center for Health Statistics, "Health, United States, 2013: With Special Feature on Prescription Drugs," Hyattsville, MD, 2014.

32 Bazelon Center for Mental Health Law, "Primary Care Providers' Role in Mental Health," Healthcare Reform Issue Brief, 2009.

33 Barbara Starfield, Leiyu Shi, James Macinko, "Contribution of Primary Care to Health Systems and Health," *The Milbank Quarterly*, 2005, 83(3):457-502. Michael Chernew, Lindsay Sabik, Amitabh Chandra, Joseph P. Newhouse, "Would Having More Primary Care Doctors Cut Health Spending Growth?" *Health Affairs*, 2009, 28(5):1327-1335. James Macinko, Barbara Starfield, Leiyu Shi, "Quantifying the Health Benefits of Primary Care Physicians Supply in the US," *International Journal of Health Services Research*, 2007, 37(1):111-126.

34 Stephen J. Kravet, Andrew D. Shore, Redonda Miller, Gary B. Green, Ken Kolodner, Scott M. Wright, "Health Care Utilization and the Proportion of Primary Care Physicians," *American Journal of Medicine*, 2008, 121(2):142-148.

35 Chiang-Hua Chang, Therese A. Stukel, Ann Barry Flood, David C. Goodman, "Primary Care Physician Workforce and Medicare Beneficiaries' Health Outcomes," *Journal of the American Medical Association*, 2011, 305(20):2096-2104.

36 Robert Wood Johnson Foundation, "What We're Learning: Reducing Inappropriate Emergency Department Use Requires Coordination with Primary Care," Quality Field Notes, Issue Brief 1, September 2013.

37 Association of American Medical Colleges, Center for Workforce Studies, 2012 Physician Specialty Databook, November 2012.

38 Health Resources and Services Administration, U.S. Department of Health and Human Services, "Projecting the Supply and Demand for Primary Care Practitioners Through 2020," November 2013.

39 National Resident Matching Program, "Results and Data, 2014 Main Residency Match," April 2014.

40 Medscape, "Physician Compensation Report, 2013," 2013.

41 Medicare physician reimbursement is based on a complex formula called the resource-based relative value scale (RBRVS). This assessment of the relative value of services provided by a given physician measures inputs like the time, technical skill, mental effort, and judgment required to perform a service, as well as practice expenses.

42 Health Resources and Services Administration, U.S. Department of Health and Human Services, "Projecting the Supply and Demand for Primary Care Practitioners Through 2020," November 2013. Association of American Medical Colleges, "The Impact of Health Care Reform on the Future Supply and Demand for Physicians - Updated Projections Through 2025," June 2010.

43 Casey Tilton, Sana Danish, Clese Erickson, "U.S. Medical Schools' Ongoing Efforts to Meet Physician Workforce Needs," Association of American Medical Colleges, Analysis in Brief, June 2013.

44 American Association of Nurse Practitioners, "NP Fact Sheet," 2014.

45 Mary D. Naylor, Ellen T. Kurtzman, "The Role of Nurse Practitioners in Reinventing Primary Care," *Health Affairs*, 2010, 29(5):893-899. In 2004, the American Association of Colleges of Nurses recommended increasing qualification for an Advanced Practice Registered Nurse (APRN) from a master's degree to a Doctor of Nursing Practice (DNP) by 2015. Entry level NPs can extend their training to three or four years of advanced nursing education or additional education beyond their current two-year masters training.

46 Stephen Isaacs, Paul Jellinek, "A Decision-Makers Guide to Scope of Practice," The Physicians Foundation, October 2012: 12-15. *Health Affairs* and the Robert Wood Johnson Foundation, "Nurse Practitioners and Primary Care," *Health Policy Brief*, October 25, 2012. Tracy Yee, Ellyn Boukus, Dori Cross, Divya Samuel, "Primary Care Workforce Shortages: Nurse Practitioners Scope-of-Practice Laws and Payment Policies," National Institute for Health Care Reform, Research Brief No. 13, February 2013. "Primary Care Professionals: Recent Supply Trends, Projections, and Valuation of Services," Statement of A. Bruce Steinwald, Director, Health Care, Government Accountability Office, before the Health Education, Labor and Pensions Committee, February 12, 2008. Tine Hansen-Turton, Jamie Ware, Frank McClellan, "Nurse Practitioners in Primary Care," *Temple Law Review*, 2009, 82:1235-1262.

47 Tracy Yee, Ellyn Boukus, Dori Cross, Divya Samuel, "Primary Care Workforce Shortages: Nurse Practitioner Scope-of-Practice Laws and Payment Policies," National Institute for Health Care Reform, Research Brief 13, 2013. Kaiser Family Foundation, "Improving Access to Adult Primary Care in Medicaid," March 1, 2011. Rebecca Bryan, Marianne Buzby, Ann O'Sullivan, "The Healthcare Reform Law and APRN Practice," Medscape, April 24, 2012. The ACA listed APRNs among Medicare's ACO professionals and eligible for bonus payments under the Medicare program. The ACA also funded educational programming to train NPs and funded demonstration projects to increase NP and APRN utilization.

48 U.S. Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, 2014-2015 Edition, Physician Assistants, 2014.

49 American Academy of Physician Assistants, "Quick Facts." Accessed February 25, 2014.

50 Bettie Coplan, James Cawley, James Stoehr, "Physician Assistants in Primary Care: Trends and Characteristics," *Annals of Family Medicine*, 2013, 11(1):75-79.

51 Tracy Keizer, "Five Things Physicians Should Know about Physician Assistants," *Minnesota Medicine*, 2012, 97(11):45-46. The American Academy of Physician Assistants, American College of Physicians, "Internists and Physician Assistants: Team-Based Primary Care: A Policy Monograph," 2010.

52 U.S. Department of Health and Human Services, Health Resources and Services Administration, "Shortage Designation: Health Professional Shortage Areas and Medically Underserved Areas/Populations," 2014.

53 Thomas Bodenheimer, Hoangmai H. Pham, "Primary Care; Current Problems and Proposed Solutions," *Health Affairs*, 2010, 29(5):799-805.

54 U.S. Census Bureau, "Frequently Asked Questions: How many people reside in urban or rural areas for the 2010 Census? What percentage of the U.S. population is urban or rural?" 2011.

55 Thomas Bodenheimer, Hoangmai H. Pham, "Primary Care; Current Problems and Proposed Solutions," *Health Affairs*, 2010, 29(5):799-805. Susan M. Skillman, Louise Kaplan, Meredith A. Fordyce, Peter D. McMenamin, Mark P. Doescher, "Understanding Advanced Practice Registered Nurse Distribution in Urban and Rural Areas of the United States Using National Provider Identifier Data," Final Report #137, Rural Health Research Center, University of Washington, 2012. American Academy of Physician Assistants, "Quick Facts." Accessed February 25, 2014.

56 David C. Goodman, Elliott S. Fisher, Kristen K. Bronner, "Hospital and Physician Capacity Update: A Brief Report from the Dartmouth Atlas of Health Care," March 30, 2009.

57 Stephen Isaacs, Paul Jellinek, "Accept No Substitute: A Report on Scope of Practice," The Physicians Foundation, November 2012. Institute of Medicine, "The Future of Nursing," October 5, 2010. Mary D. Naylor, Ellen T. Kurtzman, "The Role Of Nurse Practitioners In Reinventing Primary Care," *Health Affairs*, 2010, 29(5):893-899. Joanne M. Pohl, Charlene Hanson, Jamesetta A. Newland, Linda Cronenwett, "Unleashing Nurse Practitioners' Potential to Deliver Primary Care and Lead Teams," *Health Affairs*, 2010, 9(5):900-905. Kaiser Family Foundation, "Improving Access to Adult Primary Care in Medicaid: Exploring the Potential Role of Nurse Practitioners and Physician Assistants," Kaiser Commission on Medicaid and the Uninsured Issue Paper, March 2011. Catherine Dower, Sharon Christian, and Edward O'Neil, "Promising Scope of Practice Models for the Health Professions," Center for the Health Professions, University of California, San Francisco, 2007.

58 Mary D. Naylor, Ellen T. Kurtzman, "The Role Of Nurse Practitioners In Reinventing Primary Care," *Health Affairs*, 2010, 29(5):893-899.

59 Mary D. Naylor, Ellen T. Kurtzman, "The Role Of Nurse Practitioners In Reinventing Primary Care," *Health Affairs*, 2010, 29(5):893-899. Mary Mundinger, Robert L. Kane, Elizabeth R. Lenz, Annette M. Totten, Wei-Yann Tsai, Paul D. Cleary, William T. Friedewald, Albert L. Siu, Michael L. Shelanski, "Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians," *Journal of the American Medical Association*, 2000, 283(1):59-68. Harold Sox, "Independent Primary Care Practice by Nurse Practitioners," *Journal of the American Medical Association*, 2000, 283(1):106-107.

60 National Conference of State Legislatures, "Scope of Practice Legislative Data Base, 2011-2012." National Conference of State Legislatures, "Scope of Practice Overview," June 13, 2013. Stephen Isaacs, Paul Jellinek, "Accept No Substitute: A Report on Scope of Practice," The Physicians Foundation, November 2012.

61 Stephen Isaacs, Paul Jellinek, "A Decision-Maker's Guide to Scope of Practice," The Physicians Foundation, October 22, 2012.

62 Douglas Brock, Shannon Bolon, Keren Wick, Kenneth Harbert, Paul Jacques, Timothy Evans, Athena Abdullah, F. J. Gianola, "The Military Veteran to Physician Assistant Pathway: Building the Primary Care Workforce," *Academic Medicine*, 2013, 88(12):1890-4.

63 Mary D. Naylor, Ellen T. Kurtzman, "The Role Of Nurse Practitioners In Reinventing Primary Care," *Health Affairs*, 2010, 29(5):893-899. Justin Altschuler, David Margolius, Thomas Bodenheimer, Kevin Grumbach, "Estimating a Reasonable Patient Panel Size for Primary Care Physicians With Team Based Delegation," *Annals of Family Medicine*, 2012, 10(5):396-400.

64 A nurse practitioner can bill 100 percent of the physician rate if he or she bills under a physician's provider number, and some states allow aligned payment for those practitioners.

65 David Margolius, Thomas Bodenheimer, "Transforming Primary Care: From Past Practice To The Practice Of The Future," *Health Affairs*, 2010, 29(5):5779-5784.

66 Thomas Bodenheimer, Hoangmai H. Pham, "Primary Care; Current Problems and Proposed Solutions," *Health Affairs*, 2010, 29(5):799-805.

67 Christine A. Sinsky, Rachel Willard-Grace, Andrew M. Schutzbank, Thomas A. Sinsky, David Margolius, Thomas Bodenheimer, "In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices," *Annals of Family Medicine*, 2013, 11(3):272-278.

68 Robert Wood Johnson Foundation, "Thirty Primary Care Practices Selected As Exemplary Models of Workplace Efficiency and Innovation," April 22, 2013. The Robert Wood Johnson Foundation-MacColl Center for Health Innovation at the Group Health Research Institute initiative began in 2012 to examine the practice patterns of 30 providers considered leaders in primary care innovation. LEAP (Learning from Effective Ambulatory Practices) providers represent a variety of locations, sizes, settings and configurations in 20 states. Institute for Health Care Improvement, "WIHI: New Staffing Models for Primary Care," October 10, 2013.

69 Carole W. Cranor, Barry A. Bunting, Dale B. Christensen, "The Asheville Project: Short Term Outcomes of a Community Pharmacy Diabetes Care Program," *Journal of the American Pharmacy Association*, 2003, 43(2):173-184. Jeanette L. Altavela, Matt K. Jones, Merrilee Ritter, "A Prospective Trial of a Clinical Pharmacy Intervention in a Primary Care Practice in a Capitated Payment System," *Journal of Managed Care Pharmacy*, 2008, 14(9):831-843.

70 Hoangmai H. Pham, Ann S. O'Malley, Peter B. Bach, Cynthia Saiontz-Martinez, Deborah Schrag, "Primary Care Physicians' Links to Other Physicians Through Medicare Patients: The Scope of Care Coordination," *Annals of Internal Medicine*, 2009,150(4):236-242.

71 Christine A. Sinsky, Rachel Willard-Grace, Andrew M. Schutzbank, Thomas A. Sinsky, David Margolius, Thomas Bodenheimer, "In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices," *Annals of Family Medicine*, 2013, 11(3):272-278. Institute for Health Care Improvement, "New Staffing Models for Primary Care," audio conference featuring Ed Wagner, Trissa Torres, Kirsten Meisinger, Thad Schilling, October 10, 2013.

72 Benjamin J. Chesluk, Eric S. Holmboe, "How Teams Work-Or Don't-In Primary Care: A Field Study on Internal Medicine Practices," *Health Affairs*, 2010, 29(5):874-879.

73 Institute for Health Care Improvement, "New Staffing Models for Primary Care," audio conference featuring Ed Wagner, Trissa Torres, Kirsten Meisinger, Thad Schilling, October 10, 2013.

74 Christine A. Sinsky, Rachel Willard-Grace, Andrew M. Schutzbank, Thomas A. Sinsky, David Margolius, Thomas Bodenheimer, "In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices," *Annals of Family Medicine*, 2013, 11(3):272-278.

75 Thomas Bodenheimer, Hoangmai H. Pham, "Primary Care: Current Problems and Proposed Solutions," *Health Affairs*, 2010, 29(5):5799-5805.

76 Mark W. Friedberg, Kathryn L. Coltin, Dana Gelb-Safran, Marguerite Dresser, Alan M. Zaslavsky, Eric C. Schneider, "Associations Between Structural Capabilities of Primary Care Practices and Performance on Selected Quality Measures," *Annals of Internal Medicine*, 2009, 151(7):456-463. Marci Nielsen, Nwando Olayiwola, Paul Grundy, Kevin Grumbach, "The Patient-Centered Medical Home's Impact on Cost & Quality, An Annual Update of the Evidence, 2012-2013," Patient Centered Primary Care Collaborative, January 2014. Ronald A. Paulus, Karen Davis, Glenn D. Steele, "Continuous Innovation in Health Care: Implications of the Geisinger Experience," *Health Affairs*, 2008, 27(5):1235-1245. Onur Asan, Enid Montague, "Physician Interactions with Electronic Health Records in Primary Care," *Health Systems*, 2012, 1(2):1-8.

77 Linda V. Green, Sergei Savin, Yina Lu, "Primary Care Physician Shortages Could Be Eliminated through Use of Teams, Nonphysicians and Electronic Communication," *Health Affairs*, 2013, 32(1):11-19.

78 Molly Porter, "Adoption of Electronic Health Records in the United States," Kaiser Permanente International, February 2013. Timothy K. Lake, Tricia C. Higgins, Paul B. Ginsburg, "Fostering Health Information Technology in Small Physician Practices: Lessons from Independent Practice Associations," National Institute of Healthcare Reform (NIHCR) Research Brief No. 5, June 2011.

79 Daniel R. Verdon, "Physician Outcry on EHR Functionality, Cost Will Shake the Health Information Technology Sector," *Medical Economics*, February 10, 2014.

80 Molly Porter, "Adoption of Electronic Health Records in the United States," Kaiser Permanente International, February 2013. Timothy K. Lake, Tricia Collins Higgins, Paul B. Ginsburg, "Fostering Health Information Technology in Small Physician Practices: Lessons from Independent Practice Associations," NIHCR Research Brief No. 5, June 2011.

81 U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), "Comprehensive Primary Care Initiative." States include Arkansas, Colorado, New Jersey, New York, Ohio and Kentucky, Oklahoma and Oregon. In 2012, CMS launched the Comprehensive Primary Care Initiative — a four-year demonstration project involving 45 Medicare, Medicaid, and commercial insurers with 500 practices serving 300,000 patients in seven markets. Participating practices receive a risk-adjusted payment per member per month that ranges from $8 to $40 for the first two years, with lower payments in subsequent years. In the third and fourth year, practices have the opportunity to share in a portion of any savings derived in their market. Program participation requires providers to deliver intensive care management that includes individualized care plans, 24/7 accessibility, proactive preventive care and patient engagement, and HIT use to ensure care is provided across the medical neighborhood. U.S. Department of Health and Human Services, CMS," Multi-Payer Advanced Primary Care Practice Demonstration." States include Maine, Michigan, Minnesota, New York, North Carolina, Pennsylvania, Rhode Island and Vermont. An additional eight states, and 900,000 patients, are participating in the CMS Multi-Payer Advanced Primary Care Practice demonstration, which gives states flexibility to combine pay for performance incentives and/or shared savings alongside fee-for-service payments.

82 Group Health Cooperative, "Group Health Medical Centers Clinics Earn Highest Recognition Status for NCQA Medical Home," March 24, 2014.

83 Commonwealth Fund, "Group Health Cooperative: Reinventing Primary Care by Connecting Patients with a Medical Home," Case Study, July 2009.

84 Robert Reid, Katie Coleman, Eric A. Johnson, Paul A. Fishman, Clarissa Hsu, Michael P. Soman, Claire E. Trescott, Michael Erikson, Eric B. Larson, "The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers," *Health Affairs*, 2010, 29(5):835-843.

85 Mark W. Friedberg, Eric C. Schneider, Meredith B. Rosenthal, Kevin G. Volpp, Rachel M. Werner, "Association Between Participation in a Multipayer Medical Home Intervention and Changes in Quality, Utilization, and Costs of Care," *Journal of the American Medical Association*, 2014, 311(8):815-825.

86 Mark W. Friedberg, Eric C. Schneider, Meredith B. Rosenthal, Kevin G. Volpp, Rachel M. Werner, "Association Between Participation in a Multipayer Medical Home Intervention and Changes in Quality, Utilization, and Costs of Care," *Journal of the American Medical Association*, 2014, 311(8):815-825.

87 Susannah Higgins, Ravi Chawla, Christine Colombo, Richard Snyder, Somesh Nigam, "Medical Homes and Cost and Utilization," *American Journal of Managed Care*, 2014, 20(3):e61-e71.

88 Urvashi Patel, Carl Rathjen, Elizabeth Rubin, "Horizon's Patient-Centered Medical Home Program Shows Practices Need Much More than Payment Changes to Transform," *Health Affairs*, 2012, 31(9):2018-2027. Jaan E. Sidorov, "The Patient-Centered Medical Home for Chronic Illness: Is It Ready for Prime Time?" *Health Affairs*, 2008, 27(5):1231-1234. Deborah Peikes, Aparajita Zutshi, Janice L. Genevro, Michael L. Parchman, David S. Meyers, "Early Evaluations of the Medical Home: Building on a Promising Start," *American Journal of Managed Care*, 2012, 18(2):105-116. Thomas C. Rosenthal, "The Medical Home: Growing Evidence to Support a New Approach to Primary Care," *Journal of the American Board of Family Medicine*, 2008, 21(5):427-440.

89 Cynthia N. Rosenberg, "Results from a Patient-Centered Medical Home Pilot at UPMC Health Hold Lessons for Broader Adoption of the Model," *Health Affairs*, 2012, 31(11):2423-2431. Jill Bernstein, Deborah Chollet, Deborah Peikes, G. Gregory Peterson, "Medical Homes: Will They Improve Primary Care?" Mathematica Policy Research Issue Brief, June 2010.

90 Mark W. Friedberg, Eric C. Schneider, Meredith B. Rosenthal, Kevin G. Volpp, Rachel M. Werner, "Association Between Participation in a Multipayer Medical Home Intervention and Changes in Quality, Utilization, and Costs of Care," *Journal of the American Medical Association*, 2014, 311(8):815-825.

91 L&M Policy Research, Evaluation of CMMI Accountable Care Organization Initiatives, Contract HHSM-500-2011-0009i/HHSM-500-T0002, "Effect of Pioneer ACOs on Medicare Spending in the First Year," November 3, 2013.

92 Harold Miller, "From Volume to Value: Better Ways to Pay for Health Care," *Health Affairs*, 2009, 28(5):1418-1428.

93 Harold Miller, "From volume to value: better ways to pay for health care," *Health Affairs*, 2009, 28(5):1418-1428. Institute of Medicine, *Best care at lower cost: the path to continuously learning health care in America,* National Academies Press, 2013, 229.

94 Institute of Medicine, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America,* National Academies Press, 2013, 229.

95 Donald Berwick, Andrew Hackbarth, "Eliminating Waste in US Health Care," *Journal of the American Medical Association*, 2012, (14):1513-1516.

96 Katie Merrell, Robert A. Berenson, "Structuring Payment for Medical Homes," *Health Affairs*, 2010, 29(5):852-858.

97 Availity, "Provider Attitudes Toward Value-Based Payment Models," An Availity Research Study, April 2014.

98 Stephanie Watson, "More Americans Using Retail Health Clinics," *Harvard Health Blog*, May 10, 2013.

99 RAND, "Use of Retail Medical Clinics Continues to Grow; Older Patients and Preventive Services on Rise," August 15, 2012.

100 Harris Interactive, "Popularity of 'Walk-In' Retail Health Clinics Keeps Growing: Poll," January 7, 2013.

101 Robin Weinick, Craig Pollack, Michael Fisher, Emily Gillen, Ateev Mehrotra, "Policy Implications of the Use of Retail Clinics," RAND Technical Report, 2010.

102 Ateev Mehrotra, Margaret Wang, Judith Lave, John Adams, Elizabeth McGlynn, "Retail Clinics, Primary Care Physicians, And Emergency Departments: A Comparison Of Patients' Visits," *Health Affairs*, 2008, 27(5):1272-1282.

103 Ateev Mehrotra, Judith Lave, "Visits to Retail Clinics Grew Fourfold from 2007 to 2009, Although Their Share of Overall Outpatient Visits Remains Low," *Health Affairs*, 2012, 31(9):2123-2129. RAND, "Use of Retail Medical Clinics Continues to Grow; Older Patients and Preventive Services on Rise," August 15, 2012. National Conference of State Legislatures, "Retail Health Clinics; State Legislation and Laws," September 2012.

104 RAND, "Health Care on Aisle 7, The Growing Phenomenon of Retail Clinics," Research Highlights, 2010.

105 RAND, "Health Care on Aisle 7, The Growing Phenomenon of Retail Clinics," Research Highlights, 2010. Ateev Mehrotra, Hangsheng Liu, John L. Adams, Margaret C. Wang, Judith R. Lave, N. Marcus Thygeson, Leif I. Solberg, Elizabeth A. McGlynn, "Comparing Costs and Quality of Care at Retail Clinics With That of Other Medical Settings for 3 Common Illnesses," *Annals of Internal Medicine*, 2009, 151(5):321-328. Michelle Lieker, "Retail Clinics: Coming to a Location Near You?" *Wisconsin Medical Journal*, 2006, 205(7):51-52.

106 Ateev Mehrotra, "Retail Clinics, Primary Care Physicians, and Emergency Departments: A Comparison of Patients' Visits," *Health Affairs*, 2008, 27(5):1272-1282. RAND, "Use of Retail Medical Clinics Continues to Grow; Older Patients and Preventive Services on Rise," 2012. National Conference of State Legislatures, "Retail Health Clinics: State Legislation and Laws," September 2012.

107 RAND, "Health Care on Aisle 7, The Growing Phenomenon of Retail Clinics," Research Highlights, 2010.

108 Craig E. Pollack, Courtney Gidengil, Ateev Mehrotra, "The Growth of Retail Clinics and the Medical Home: Two Trends in Concert or in Conflict," *Health Affairs*, 2010, 29(5):998-1003.

109 Tricia M. Leahey, Rajiv Kumar, Brad M. Weinberg, Rena R. Wing, "Teammates and Social Influence Affect Weight Loss Outcomes in a Team-based Weight Loss Competition," *Obesity*, 2012, 20(7):1413-1418. Jeffrey Bendix, Amanda Brower, "The Benefits of Sharing: Shared Medical Appointments Can Improve Your Patients' Outcomes and Your Practice's Efficiency," *Medical Economics*, 2011, 88(3):68-71.

110 Jeannette R. Ickovics, Trace S. Kershaw, Claire Westdahl, Urania Magriples, Zohar Massey, Heather Reynolds, Sharon Schindler Rising, "Group Prenatal Care and Perinatal Outcomes: A Randomized Controlled Trial," *Obstetrics and Gynecology*, 2007, 110(2):330-339.

111 Kelly B. Bartley, Rebecca Haney, "Shared Medical Appointments: Improving Access, Outcomes and Satisfaction for Patients with Chronic Cardiac Diseases," *Journal of Cardiovascular Nursing*, 2010, 25(1):13-19. Jeffrey Bendix, Amanda Brower, "The Benefits of Sharing: Shared Medical Appointments Can Improve Your Patients' Outcomes and Your Practice's Efficiency," *Medical Economics*, 2011, 88(3):68-71. Karen S. Yehle, Laura P. Sands, Patricia A. Rhynders, Gail D. Newton, "The Effect of Shared Medical Visits on Knowledge and Self-Care in Patients With Heart Failure: A Pilot Study," *Heart Lung*, 2009, 38(1):25-33.

112 Arne Beck, John Scott, Patrick Williams, Barbara Robertson, Deborah Jackson, Glenn Gade, Pamela Cowan, "A Randomized Trial of Group Outpatient Visits for Chronically Ill Older HMO Members: The Cooperative Health Care Clinic," *Journal of the American Geriatrics Society*, 1997, 45(5):543-549. Eric A. Coleman, Theresa B. Eilertsen, Andrew M. Kramer, David J. Magid, Arne Beck, Doug Conner, "Reducing Emergency Visits in Older Adults with Chronic Illness. A Randomized, Controlled Trial of Group Visits," *Effective Clinical Practice*, 2001, 4(2):49-57. Marina Trento, Pietro Passera, Marina Bajardi, Marco Tomalino, Giorgio Grassi, Enrica Borgo, C. Connola, Franco Cavallo, P. Bondonio, Massimo Porta, "Lifestyle Intervention by Group Care Prevents Deterioration of Type II Diabetes: A 4-year Randomized Controlled Clinical Trial," *Diabetologia*, 2002, 45(9):1231-1239. Marina Trento, Pietro Passera, Enrica Borgo, Marco Tomalino, Marina Bajardi, Franco Cavallo, Massimo Porta, "A 5-Year Randomized Controlled Study of Learning, Problem Solving Ability, and Quality of Life Modifications in People With Type 2 Diabetes Managed by Group Care," *Diabetes Care*, 2004, 27(3):670-675. John C. Scott, Douglas A. Conner, Ingrid Venohr, Glenn Gade, Marlene McKenzie, Andrew M. Kramer, Lucinda Bryant, Arne Beck, "Effectiveness of a Group Outpatient Visit Model for Chronically Ill Older Health Maintenance Organization Members: A 2-year Randomized Trial of the Cooperative Health Care Clinic," *Journal of the American Geriatrics Society*, 2004, 52(9):1463-1470. Jeannette R. Ickovics, Trace S. Kershaw, Claire Westdahl, Urania Magriples, Zohar Massey, Heather Reynolds, Sharon Schindler Rising, "Group Prenatal Care and Perinatal Outcomes," *Obstetrics and Gynecology*, 2007, 110(2 Pt 1):330-339. David Edelman, Sonja K. Fredrickson, Stephanie D. Melnyk, Cynthia J. Coffman, Amy S. Jeffreys, Santanu Datta, George L. Jackson, Amy C. Harris, Natia S. Hamilton, Helen Stewart, Morris Weinberger, "Medical Clinics Versus Usual Care for Patients With Both Diabetes and Hypertension: A Randomized Trial," *Annals of Internal Medicine*, 2010, 152(11):689-696. Susan Kirsh, Sharon Watts, Kristina Pascuzzi, Mary Ellen O'Day, David Davidson, Gerald Strauss, Elizabeth O. Kern, David C. Aron, "Shared Medical Appointments Based on the Chronic Care Model: A Quality Improvement Project To Address the Challenges of Patients With Diabetes With High Cardiovascular Risk," *Quality and Safety in Health Care*, 2007, 16(5):349-353. Shannon Cohen, Sarah Hartley, Jasbir Mavi, Bridgette Vest, Monica Wilson, "Veteran Experiences Related to Participation in Shared Medical Appointments," *Military Medicine*, 2012, 177(11):1287-1291. David Edelman, Jennifer R. McDuffie, Eugene Oddone, Jennifer M. Gierisch, John W. Williams Jr, Avishek Nagi, Liz Wing, "Shared Medical Appointments for Chronic Medical Conditions: A Systematic Review," Department of Veterans Affairs, Evidence-Based Synthesis Program, July 2012. Kathie Culhane-Pera, Kevin A. Peterson, A. Lauren Crain, Mayseng Lee, Bee Her, Tely Xion, "Group Visits for Hmong Adults With Type 2 Diabetes Mellitus: Pre-Post Analysis," *Journal of Health Care for the Poor and Underserved*, 2005, 16(2):315-327.

113 Susan L. Norris, Phyllis J. Nichols, Carl J. Caspersen, Russell E. Glasgow, Michael M. Engelgau, Leonard Jack Jr., Susan R. Snyder, Vilma G. Carande-Kulis, George Isham, Sanford Garfield, "Increasing Diabetes Self-Management Education in Community Settings: A Systematic Review," *American Journal of Preventive Medicine*, 2002, 22(4):39-66. Nicholas A. Christakis, James H. Fowler, "The Spread of Obesity in a Large Social Network Over 32 Years," *New England Journal of Medicine*, 2007, 357(4):370-379. Nicholas A. Christakis, James H. Fowler, "The Collective Dynamics of Smoking in a Large Social Network," *New England Journal of Medicine*, 2008, 358(21):2249-2258.

114 Jeannette R. Ickovics, Trace S. Kershaw, Claire Westdahl, Urania Magriples, Zohar Massey, Heather Reynolds, Sharon Schindler Rising, "Group Prenatal Care and Perinatal Outcomes: A Randomized Controlled Trial," *Obstetrics and Gynecology*, 2007, 110(2):330-339.

115 Raja Jaber, Amy Braksmajer, Jeffrey S. Trilling, "Group Visits: A Qualitative Review of Current Research," *Journal of the American Board of Family Medicine*, 2006, 19(3):276-290. Anna Gorman, "Group Meetings Turn Doctor Visits Inside Out," *Los Angeles Times*, September 13, 2013. Susan Kirsh, Sharon Watts, Kristina Pascuzzi, Mary Ellen O'Day, David Davidson, Gerald Strauss, Elizabeth O. Kern, David C. Aron, "Shared Medical Appointments Based on the Chronic Care Model: A Quality Improvement Project To Address the Challenges of Patients With Diabetes With High Cardiovascular Risk," *Quality and Safety in Health Care*, 2007, 16(5):349-353. Mary Ann Hodorowicz, "Reimbursement for Shared Medical Appointments Incorporating Diabetes Self-Management Education/Training or Diabetes Medical Nutrition Therapy," *Diabetes Spectrum*, 2012, 25(2):84-90.

116 Victoria Stagg Elliott, "Group Appointments Can Serve Both Patients and Practices," *American Medical News*, September 19, 2011.

117 Robert Greene, Edwin Dasso, Sam Ho, Jerry Frank, Graeme Scandrett, Ash Genaidy, "Patterns and Expenditures of Multi-Morbidity in an Insured Working Population in the United States: Insights for a Sustainable Health Care System and Building Healthier Lives," *Population Health Management*, 2013, 16(6):381-9.

118 Steven Cohen, Namrata Uberoi, "Differentials in the Concentration in the Level of Health Expenditures across Population Subgroups in the U.S., 2010," *Statistical Brief #42*, Agency for Healthcare Research and Quality, Rockville, MD, August 2013. Steven Cohen, William Yu, "The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2008-2009," *Statistical Brief #354*, Agency for Healthcare Research and Quality, Rockville, MD, January 2012.

119 Steven Cohen, Namrata Uberoi, "Differentials in the Concentration in the Level of Health Expenditures across Population Subgroups in the U.S., 2010," *Statistical Brief #42*, Agency for Healthcare Research and Quality, Rockville, MD, August 2013.

120 Jianying Hu, Fei Wang, Jimeng Sun, Robert Sorrentino, Shahram Ebadollahi, "A Healthcare Utilization Analysis Framework for Hot Spotting and Contextual Anomaly Detection," American Medical Informatics Association Annual Symposium Proceedings, 2012.

121 Tracy Yee, Amanda E. Lechner, Emily Carrier, "High-Intensity Primary Care: Lessons for Physician and Patient Engagement," National Institute for Health Care Reform, Issue Brief No. 9, October 2012.

122 Michael E. Porter, Erika A. Pabo, Thomas H. Lee, "Redesigning Primary Care: A Strategic Vision to Improve Value by Organizing Around Patients' Needs," *Health Affairs*, 2013, 32(3):517-523.

123 Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, Prevention Quality Indicators Technical Specifications - Version 4.5, March 2013.

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Drawing on our internal expertise and data and extensive external experiences and partnerships, the UnitedHealth Center for Health Reform & Modernization analyzes key health care issues and develops innovative policies and practical solutions for the health care challenges facing our nation. We share this information in the United States and internationally with policymakers, academicians, researchers, providers, health plans, employers, the public, and other key health care stakeholders. In January 2009, UnitedHealth Group launched the UnitedHealth Center for Health Reform & Modernization to present proven strategies to contain costs and improve quality and care, and today, we continue to demonstrate our commitment to health care modernization by offering solutions based on proven policies and best practices.

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Availability and Use of Enrollment Data from the ACA Health Insurance Marketplace

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Contents

INTRODUCTION

The Affordable Care Act (ACA) has presented new challenges for states to implement health insurance marketplaces, expand and modify Medicaid and eligibility, develop new models for health system and payment reform, and fund effective outreach and enrollment strategies. At the same time there is increased and critical attention to the effective implementation of the ACA and in the evaluation of different state-based approaches to implementation.

Despite a rocky start for both the federally-facilitated marketplace (FFM) and several state-based marketplaces (SBMs), enrollment statistics point to positive results for the first ACA open enrollment period (October 1, 2013-April 19, 2014, which includes special enrollment period activity). Nationwide, over 8 million people selected health insurance plans through the new exchanges — surpassing the Congressional Budget Office's April 2014 estimation that 6 million people would enroll.[1] Consumer interest was also high, as measured by 98 million website visits and 33 million calls to call centers during the first open enrollment period.[2]

Still, many questions remain about the performance of exchanges during the first open enrollment period and their viability in the future, answers to which have almost immediate relevance as states and the federal government approach the second open enrollment period for coverage beginning in 2015. For example:

- What are the demographic characteristics of enrollees and what do they suggest about access to coverage and financial stability of the exchange? How can this information inform outreach efforts for future enrollment periods?
- How many people who enroll in insurance via exchanges or expanded Medicaid programs were previously uninsured? How many switched plans from current coverage to the new offerings in the exchange?
- Have enrollment and outreach efforts been targeted and successful?
- How well have the exchanges done in monitoring and achieving high levels of consumer assistance and satisfaction?
- How did state variation in implementation impact exchange performance and carrier decisions?

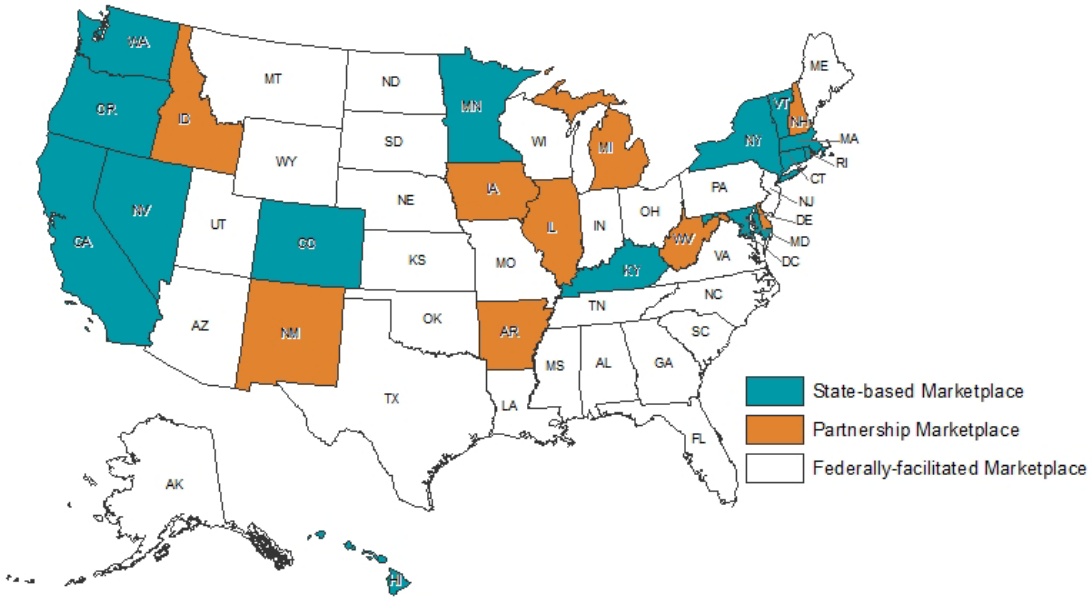
A better understanding of the diverse sources of administrative data available from the state and federal health insurance marketplaces will be required to help respond to these and other questions. To that end, this paper will examine enrollment-related data issues faced by states during the first ACA open enrollment period, including variation on data elements collected through marketplace applications as well as state approaches to public reporting on enrollment data. Finally, this paper will look ahead to potential research questions and uses for data already collected and new data collection needs.

BACKGROUND

Marketplace Oversight and Structure

The ACA allowed states to create their own state-based marketplaces (SBM), defer to a federally-facilitated marketplace (FFM), or choose a state-federal partnership marketplace whereby the state could leverage the federally-run marketplace but retain certain functions related to plan management and/or consumer assistance and outreach. During the first open enrollment period, 14 states and the District of Columbia (DC) operated SBMs, 29 states had FFMs, and 7 states elected state-federal partnerships.[3] Two states that were conditionally approved to operate SBMs, Idaho and New Mexico, were considered by the Centers for Medicare and Medicaid Services (CMS) as "supported SBMs" for the first open enrollment, utilizing the FFM system to process applications and enrollments.[4] For the remainder of this paper, partnership states and the two "supported SBMs" are included in the FFM category. Therefore, 36 states are included in the FFM, and 15 states (including DC) are counted as SBMs.

Figure 1. Marketplace Decisions, First Open Enrollment Period



Among other things, state decisions about marketplace oversight have important implications for data collection, enrollment operations, and reporting activities. For example, states that established their own marketplaces operate their own web portals and call centers, and have some flexibility in designing their enrollment applications, application processes, and information technology platforms, all of which have a significant impact on the availability of enrollment data. While SBMs were required to report certain data to CMS (part of the Department of Health and Human Services (HHS)) on a weekly basis during the first open enrollment period, SBMs also make important independent decisions about how their marketplace enrollment data are used and communicated to state officials, stakeholders, the

media, and the public. As will be summarized in this paper, SBMs differed in how much enrollment data they made public, how their data were summarized and visualized, and how their data were released.

In contrast, in states using the FFM, HHS assumes primary responsibility for most (or all) marketplace operations related to the enrollment process itself. Consumers in these states enroll in Qualified Health Plans (QHPs) using a federal application, application process, and website (healthcare.gov). Data on these states for the first open enrollment period were collected through the FFM and synthesized, summarized, and disseminated (along with the information reported to CMS by SBMs) by HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE) through monthly issue briefs during the open enrollment period. These ASPE issue briefs are described further on page 8 of this paper.

APPLICATION FORMS AND POTENTIAL DATA ELEMENTS

The application process is a primary means for generating enrollment data. As such, this paper examines the application forms in terms of federal requirements and guidance, FFM forms, and SBM forms.

Legal and Policy Requirements for Application Forms

The ACA required the HHS Secretary to create a "single, streamlined" application form incorporating all questions required both for the health insurance application and for financial assistance. The purpose of this integrated application was to develop a "no wrong door" approach to accessing coverage by providing a single form that individuals and families could use to apply for any of the insurance programs and financial supports offered through the marketplace (premium tax credits, cost-sharing reduction payments and Medicaid). In addition, the design of the form was intended to minimize the burden on applicants and to help ensure applications would be correctly processed. The Act also allowed states to create their own forms as long as they followed a specific set of standards also required of the federal form.[5]

In March 2012, the Federal Register published an HHS Final Rule regarding implementation of the single streamlined application. The rule confirmed that the federal form would be used only to determine eligibility for coverage and subsidies (not for other human services programs such as the Supplemental Nutrition Assistance Program). The rule also confirmed that states could develop alternative forms subject to HHS approval; states were prohibited from requiring applicants to answer questions beyond those necessary for insurance and subsidy determinations, stating specifically that "this provision limits the application to information that is pertinent to the eligibility and enrollment process."[6]

CMS developed three model application forms and released them in April 2013:[7]
1) *Application for Health Coverage and Help Paying Costs*
2) *Application for Health Coverage and Help Paying Costs (Short Form)* for certain applicants

3) *Application for Health Coverage* for those not applying for financial assistance

In June 2013, CMS released guidance for states developing their own modified applications. In this guidance, CMS advised that SBM-specific forms must follow several guiding principles, including reaffirmation of the rule that questions not essential for eligibility determinations (for coverage or assistance) could not be required, though they could be included on applications and listed as optional. The guidance suggested several examples of simple changes states could make to the form without CMS approval (e.g. using state names for Medicaid or removing unnecessary questions from the federal model), as well as examples of more substantive changes that would require CMS approval.[8]

The analysis below outlines variations in the elements collected through the paper applications used by federal and state marketplaces (specifically, paper versions of the *Application for Health Coverage and Help Paying Costs* forms).[*] Though there are a total of 16 different *Application for Health Coverage and Help Paying Costs* forms (FFM and SBMs), all the forms are based on the federal model and most are very similar. That said, the differences among the forms provide some SBMs with additional data elements compared to the federal form; specific differences are highlighted below.

Federal Application and Data Elements

Thirty-six states (those in white and orange in Figure 1 on page 2), as part of the FFM, utilized the federal health insurance application form during the first open enrollment period.

The federal application, as required by law, is structured both as an application for health insurance coverage and a tool to determine whether the applicant is eligible for financial assistance. The application includes a series of questions in several categories about each person in the household who needs health insurance:

- Contact information
- Demographic data
- Disability status
- Immigration status
- Employment and income information
- Current health insurance coverage from any source[†]
- Detailed information on any employer-sponsored insurance coverage the family is eligible for, and

[*] This analysis examined the FFM application form and those from all SBMs except Connecticut and New York. SHADAC's attempts to obtain the Connecticut and New York forms were unsuccessful. It is important to note that the other paper application types and the online versions may differ slightly from the information contained here.

[†] Note: the "current health insurance coverage" question does not appear on the version of the *Application for Health Coverage* for those not requesting financial assistance to pay for coverage.

- An appendix with additional questions for any American Indian or Alaska Native household member

Please see visit SHADAC's State Health Reform Data Analytics Website for a copy of the complete federal application form from the first open enrollment period.

SBM Applications and Data Elements

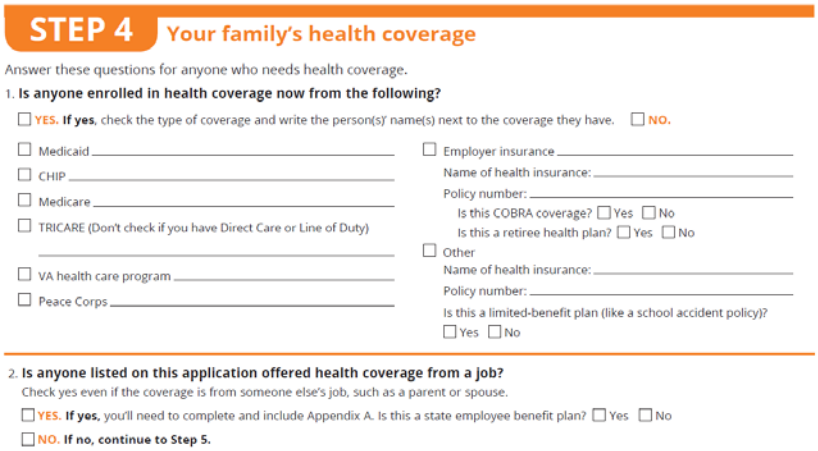
Fifteen states (including the District of Columbia) operated SBMs during the first open enrollment period (states in green in Figure 1 on page 2). Some states adopted the federal application in its entirety, changing only state names, contact information, logos, etc., while others adjusted it in various ways. Tables 1 and 2 summarize how states adapted the federal form, either by modifying questions (Table 1) or by adding completely new questions (Table 2). These added SBM data elements are grouped into thematic areas in these tables, but the wording is generalized; not all states use the exact same wording. State abbreviations are given in the tables so that those interested in the exact question wording can consult the relevant SBM applications.

It should also be noted that there is variation among states about who answers the questions below. The person completing the form for a household is not always applying for coverage for himself or herself, but rather may be applying only on behalf of other members of the household. Some questions are asked only of those applying for coverage, while other questions are also asked of the primary contact (regardless of whether that person is applying for coverage), and some questions are asked for anyone in the household. Some SBM applications, particularly when someone answers "yes" on disability-related questions, require applicants to complete additional worksheets containing follow-up questions not listed here.

Table 1 presents a summary of added data elements collected on SBM applications, through altered or expanded versions of questions contained in the federal application. The most common modification was to collect specific information on disabilities and applicants' needs for assistance with related services, with 10 states modifying this section of the federal application form.

The other common modification was on prior (current at the time of application) enrollment in health insurance coverage; seven states varied or added detail to the federal question on this topic. Some asked whether applicants were eligible for (not just enrolled in) coverage from an employer, while other states looked for anticipated changes to coverage. A few states asked about recent loss of coverage.

Table 1. Enhanced SBM Enrollment Forms: Altered or Expanded Versions of Federal Questions

Disability
Federal question: *Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?* • Some states make specific mention of disability, blindness, and injury, illness, or disability lasting at least 12 months (CA, CO, HI, KY, MA, MN, NV, OR, RI). • Several states ask whether someone needs help with activities of daily living, with reasonable accommodation, or with long-term care, home health, or other related services (CA, CO, MA, MN, NV, OR, RI, WA).
Prior Eligibility and Enrollment
Federal questions:  **STEP 4** Your family's health coverage Answer these questions for anyone who needs health coverage. 1. **Is anyone enrolled in health coverage now from the following?** ☐ YES. **If yes**, check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ NO. ☐ Medicaid ☐ CHIP ☐ Medicare ☐ TRICARE (Don't check if you have Direct Care or Line of Duty) ☐ VA health care program ☐ Peace Corps ☐ Employer insurance Name of health insurance: Policy number: Is this COBRA coverage? ☐ Yes ☐ No Is this a retiree health plan? ☐ Yes ☐ No ☐ Other Name of health insurance: Policy number: Is this a limited-benefit plan (like a school accident policy)? ☐ Yes ☐ No 2. **Is anyone listed on this application offered health coverage from a job?** Check yes even if the coverage is from someone else's job, such as a parent or spouse. ☐ YES. **If yes**, you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No ☐ NO. **If no, continue to Step 5.** • Some states adjust question 1 above to ask if members of the household are **eligible for or offered any** coverage, whether or not they are enrolled now (CO, OR) . • Some SBMs request detail about anticipated upcoming changes to employer-sponsored insurance, including plans to drop, plans to enroll, eligibility changes, plan changes (CA, CO, RI). • CA looks for unenrolled eligibles for public programs by asking about special populations such as those > age 65, the disabled, those with special health care needs, or children <1 whose mothers were on Medi-Cal at time of delivery. • Three states ask about recently being uninsured, or recently turning down, dropping or losing coverage for themselves or their children (CO, NV, WA). • CO also asks whether anyone in the household has an individual shared responsibility exemption. • MA requests additional information on applicant's current employer: Does this employer have 50 or fewer full-time employees? Is this job a sheltered workshop? • States have also added additional coverage type options on their applications (some are the same as federal options, but with state-specific names or different wording). Additional choices states have included beyond those on the federal application are: o KCHIP (Kentucky's CHIP Program) o TRICARE/CHAMPUS o Veteran's Health Care Program

- Veteran's Coverage
- Employer/Union/College/University Sponsored Coverage
  - COBRA
  - Retiree Health Program/Plan
- Child Health Plan Plus (CHP+)
- Dr. Dynasaur (Vermont's CHIP program)
- Federal Employee Program
- MCHP
- AmeriCorps
- Medical Assistance
- MinnesotaCare
- Nevada Check Up
- Private Health Insurance

Table 2 summarizes the additional topic areas not included in the federal application but added by states. The most frequently added questions were about tobacco use (six states) and applicant interest in voter registration (four states). Some states include questions related to specific eligibility categories for state Medicaid programs (e.g. Massachusetts covers some individuals with breast cancer, cervical cancer, or HIV, and includes these as optional questions). Other states use optional questions to check for interest in other state-specific social/human services programs or to inquire about how consumers learned about the SBM.

Table 2. Enhanced SBM Enrollment Forms: Questions not Included in Federal Application

Tobacco Use	
• Regular tobacco use, generally defined as four or more times per week on average over the past 4-6 months (CO, KY, MN, NV, OR, WA). • MN also asks for the date of the last time tobacco was used regularly.	
Specific Populations	
Disease-specific	• Applicant has breast cancer, cervical cancer, or HIV (MA).
Homelessness	• Applicant is homeless or without a fixed address (MA, WA).
Victims of torture	• Applicant is receiving services from the Center for Victims of Torture (MN).
Non-citizens with critical health needs	• Non-citizen applicant has been treated recently for an emergency medical condition; needs dialysis; cancer treatment; anti-rejection medication due to organ transplant; needs nursing home, assisted living, or in-home care (WA).
Children	• Any child in the household was adopted by a single parent; has a parent who has died; has a parent who is unknown (MA).
Affordability and Access	
Employer coverage	• Applicant considers employer coverage affordable based on a particular definition of affordability (CO).
Doctor	• Applicant has a general doctor who treats a variety of illnesses (CO).
Injury care	• Applicant is getting medical care for an accident or injury (MN).
Barriers to care	• Anyone who is enrolled in health insurance is unable to get health services

	due to safety concerns, distance from providers, other (OR).
Program Linkages	
Other social service programs	• Applicant would like to be referred to programs for food assistance, help paying for a medical emergency, or other support (CA, KY, MN).
Voter registration	• Include contact information, a request for a voter registration application to be mailed, or an actual voter registration form included in the exchange application packet (KY, MN, NV, WA).
Other Questions	
Interest in health insurance/the exchange	• How applicants heard about their programs (CA, NV). • KY requests permission for the exchange to send text message alerts to applicant's phone. • CA asks if the applicant has "had any recent changes in your life that made you want to apply for health insurance?"
Plan choice for public programs	• Some applications allow the applicant to choose a specific [Medicaid MCO/Medicaid CCO/pediatric dental/Covered California] plan (CA, NV, OR).

PUBLIC REPORTING

There are multiple types of official reporting on ACA-related enrollment activity. The federal government and each SBM state presumably have **internal reporting** processes used for management and internal decision-making. All SBM states also conduct **federally-required reporting** - sending data to CMS on a regular basis - for use in the ASPE briefs and for other federal purposes. Finally, states and the FFM undertake **public reporting** on operations and enrollment outcomes. The focus of this section is the content and approach used for this **public reporting** during the first ACA open enrollment period.

Federal Reporting

From November 2013 to May 2014, ASPE released monthly Issue Briefs on health insurance marketplace enrollment figures. These reports included both FFM data and data submitted to CMS from all SBMs. The final ASPE report for the first enrollment period can be downloaded from SHADAC's Insurance Marketplace Enrollment Reports Website. The briefs regularly included outcome and process summary measures for all states, including:

- Number of completed applications through marketplaces
- Total number of individuals included in completed applications
- Number of individuals determined eligible to enroll in marketplace plan
- Total number of individuals who have selected a marketplace plan (includes paid premium and not yet paid)
- Unique visitors on SBM and FFM websites
- Calls to SBM and FFM call centers

These statistics were provided for each state, as sub-totals for SBMs and the FFM, and the grand total for the country. As the enrollment period progressed, additional indicators were added, including detail on demographic characteristics and metal level choices of enrollees, as well as trends over time during the period. ASPE also incorporated information from other sources into these briefs, such as reports from insurance carriers on non-marketplace enrollment in ACA-compliant plans, the estimates on health insurance coverage from Gallup and RAND surveys, and other relevant data for the period. The May 2014 report was ASPE's final brief for the first open enrollment period, and the reports are currently no longer being released.

As these ASPE reports were released each month, SHADAC created infographic summaries of data extracted from the reports. The complete collection of these infographics from the first open enrollment period is available on SHADAC's State Health Reform Data Analytics Website.

SBM Reporting Efforts to Date

There is a wide variety of state-initiated public reporting on SBM processes and outcomes. States vary in the content of their reports, the frequency and breadth of reporting, and the formats they use to publicize data. Even a "common" measure publicly reported by all 15 SBMs, the number of individuals enrolled in Qualified Health Plans (QHPs), was defined differently by different states, with some counting "plans selected," others counting "first month's premium paid" (i.e. effectuated enrollment) and others counting "applications completed, pending payment."

Another source of variation is the optional questions that some states include on their applications. As described in the "Legal and Policy Requirements for Application Forms" section of this paper (page 3), states can include enrollment form questions that are not essential for determination of eligibility (for coverage or financial assistance), but they cannot be required-response items on the application forms. One question that is optional for a particular population segment is that of prior insurance coverage (a topic of considerable interest to policymakers and the public). Because this question is not asked of all applicants, it has not (to date) been widely analyzed for public consumption. In fact, only two states have reported on the proportion of marketplace enrollees who were previously uninsured (Kentucky[9] and New York, see state spotlight on page 11). This caveat applies throughout: much of the reporting cited below comes from optional questions on the application forms, so the responses are not necessarily representative of the entire applicant population or the general population of the state. Despite this limitation, many states chose to report on the data they did have available from respondents who answered the optional questions. This reporting is of interest because it supplements the basic statistics on enrollment, but should be interpreted with an understanding of the limitations inherent in the data.

What Are SBMs Reporting?

Total QHP Enrollment

The number of individuals enrolled in QHPs is the critical indicator of interest to SBM outcome reporting; all 15 SBMs reported on this measure. However, as described above, there is variation in how states define "enrollment" and in how much detail is reported. Table 3 summarizes the numbers of SBMs using various indicators related to total QHP enrollment.

Table 3. Public Reporting of SBM Enrollment

Metric/Data Specification	Number of SBMs Reporting (Out of 15 SBMs)
Number of individuals enrolled in QHPs	15
Stage of enrollment process specified:	
• Plan selected	3
• Premium paid	6
• Unclear from reporting	7
Number of individuals enrolled in Medicaid, CHIP, or other public programs	12

Characteristics of Individuals Enrolled and Plans Selected

Most SBMs provided enrollment data disaggregated by at least basic individual or plan characteristics. The most common characteristics publicly reported were age of individual enrollees (11 states) and metal level of QHP (10 states). Figure 2 shows the seven most frequently reported individual or plan characteristics from public SBM reports. Table 4 summarizes less commonly used data breakouts that may be of interest to more states as they consider their public reporting plans for future enrollment cycles.

Figure 2. Common Enrollment Breakdowns

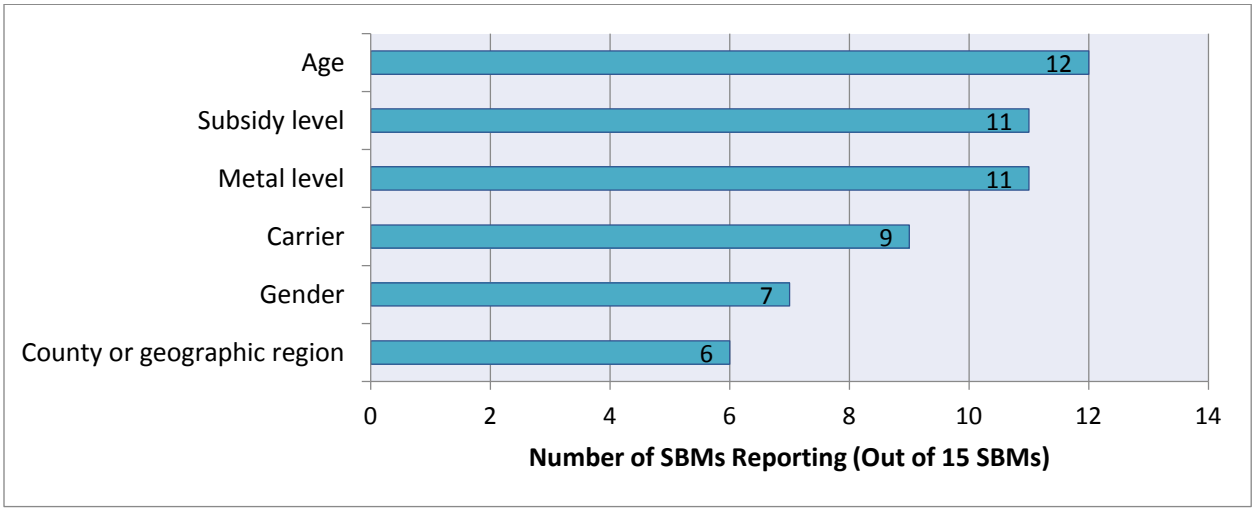


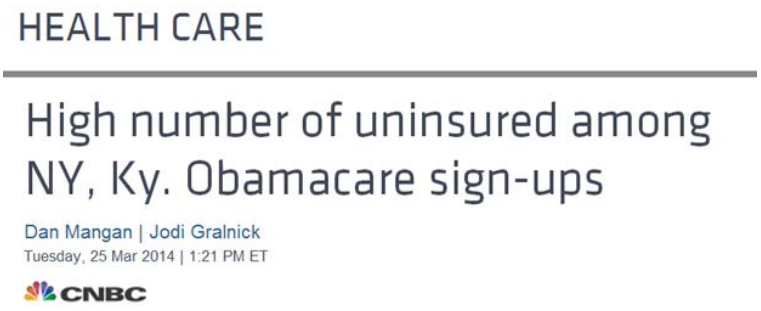
Table 4. Less Common Enrollment Metrics of Interest

Metric/Data Specification	SBMs Reporting
Number of individuals enrolled in QHPs by…	
• Race/ethnicity	CA, NV, NY, WA
• Enrollment pathway	CA, CO, NY, WA
• Poverty level	NV, NY, WA
• Language or language preference	CA, NY
• Previously uninsured	NY

Questions on race and ethnicity are optional on all state (and federal) exchange applications. For this reason, reporting on enrollment by enrollees' race or ethnicity will inevitably be incomplete, but can still be a useful gauge to see who the exchanges are serving and to help assess potential impact on disparities in coverage by race or ethnicity. Potentially, this information could also help to better target outreach efforts for enrollment. California, Nevada, New York, and Washington were the only states reporting publicly on enrollment by race or ethnicity during or at the end of the first open enrollment period. All four of these states reported on the number or percent of enrollees in QHPs by race and ethnicity, and some reports contained further analysis such as cross-tabulations of race by subsidy status. These states reported different categories for race, all based on the federal standards but some with expanded options (Nevada in one report including 14 categories) and in some reports collapsing the groups into fewer categories. Three of these states specifically noted in their reports that there was a high rate of non-response to this question on their applications (of those states that reported non-response, the highest non-response rate was 25%, both in New York and California).

Spotlight: Previously Uninsured in New York

All SBMs and the FFM ask about current insurance coverage on their marketplace applications, but the question is not asked of all applicants. In most (possibly all) cases only those applying for financial assistance are presented with this question; this means that calculations of new enrollees who were previously uninsured do not necessarily represent the entire applicant pool. Due to this limitation of the data, ASPE has expressed concern about its interpretation and use, and there has been only limited information formally reported from the FFM and SBMs on the total proportion of enrollees who were previously uninsured.[2] However, if interpreted with caution and with an understanding of the limitations of the data, the calculation can still be informative.


HEALTH CARE

High number of uninsured among NY, Ky. Obamacare sign-ups

Dan Mangan | Jodi Gralnick
Tuesday, 25 Mar 2014 | 1:21 PM ET

CNBC

Of the public reports we found, only New York has provided this statistic in its enrollment reports. In its final open enrollment period report in June 2014, New York reported that 93% of Medicaid enrollees were uninsured at time of application, along with 63% of QHP enrollees (79% of the subsidized QHP enrollees). The report also noted that enrollees who were uninsured at the time of application tended to enroll later in the open enrollment period. While this may not be representative for all new enrollees, this type of information can still add to the public's (and decision-makers') understanding about an exchange's achievements and about how to plan and anticipate for future enrollment periods.

Stages of the Enrollment Process

As for all other aspects of SBM-initiated public reporting, states varied in whether and how much data they released on application process measures during the enrollment period. The most frequently reported measure in this category was number of applications created (seven states), while only two states gave the additional information on number of individuals included in these completed applications. Table 5 summarizes SBM reporting in this area.

Table 5. Common Metrics Describing Stages of Enrollment Process

Commonly Reported Metrics	Number of SBMs Reporting (Out of 15 SBMs)
Number of accounts created	6
Number of applications completed	7
Number of individuals applying for coverage in completed applications	2
Number of individuals determined eligible for enrollment	4
Number of individuals with confirmed plan selections	5
Number of individuals with payment received	2

Consumer Support and Operating Metrics

All SBMs provided at least basic statistics on their website or call center operations. Some states went in depth (see spotlights on Colorado and Minnesota, page 17), while others focused only on the most critical status indicators (website visits, calls received). The most commonly reported process metrics in this category were call volume (12 states) and unique visitors to the SBM website (9 states). Less common but occasionally reported were calls handled in languages other than English or Spanish, and website availability (percent of time). Table 6 summarizes these measures.

Table 6. Most Commonly Reported Customer Support and Operating Metrics

Commonly Reported Metrics	Number of SBMs Reporting (Out of 15 SBMs)	Less Common, But Related Metrics
Call center:		
Call volume	12	Handled/deferred calls
Average wait time	8	Other language calls
Average call time	5	Abandonment rate
Website:		
Unique visitors	9	Website availability
Web visits	7	Average response time
Page views	4	

How Are SBMs Reporting?

States not only varied the content of their public reporting, but also their communication methods and channels. States routinely released enrollment figures via standard text reports, website entries, graphical dashboards, press releases, board meeting minutes, and social media. Some states kept the emphasis on the most critical statistics by releasing only a limited number of indicators (such as enrollment in qualified health plans and Medicaid), while other states selected formats to allow full detail on process measures and detailed breakdowns of enrollee data as well. Some states targeted the public directly by reporting via social media, while some used the press or their websites to disseminate reports and data. SHADAC collects and posts publicly-available enrollment reports from all SBMs; the full collection can be found here: http://www.shadac.org/publications/insurance-marketplace-enrollment-reports.

Although all states have unique styles and formats for public reporting, a few states are highlighted below due to particular aspects of their public reports that may be of interest to other states as they consider future plans.

Spotlight: Social Media in California

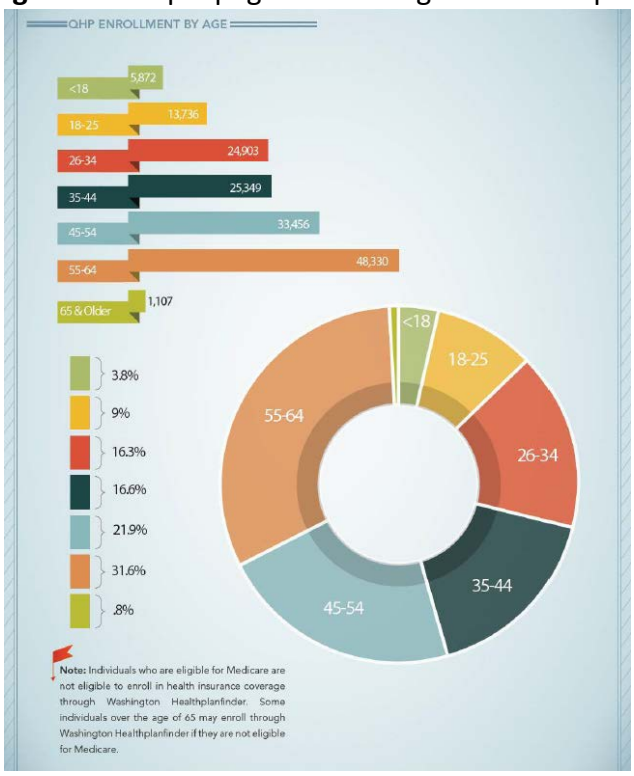
In addition to periodic reports and press releases to keep the public updated on enrollment figures, several states use Twitter, Facebook, Instagram, and YouTube to promote enrollment and answer ACA-related questions. A few states also periodically release enrollment figures through social media. But California is unique in its extensive reach, with Covered California (the state marketplace) tweeting enrollment updates to nearly 38,000 followers (over 33,000 more than any other state exchange, as of August 2014). Covered California's 4000+ tweets are not primarily focused on reporting, but rather on enrollment promotion and information, insurance facts and terminology, promotion of healthcare utilization among newly-covered enrollees, and healthy lifestyle tips. The Twitter feed is visually appealing, and includes not only information but also photographs, videos, celebrity endorsements of health insurance coverage, quotes from satisfied enrollees, and other items of interest. By including enrollment reporting in this format, Covered California takes advantage of an opportunity to reach the public with its data directly, in an accessible and interesting way. Click here to follow Covered California on Twitter: https://twitter.com/CoveredCA .

Figure 3. Screenshot of Covered California's Twitter feed

Spotlight: Comprehensive Reporting in Washington

Washington's reporting on its health exchange included a unique final enrollment report at the end of the open enrollment period. The report includes breakdowns of enrollment by an extensive set of characteristics including demographics, metal level, county, carrier, federal poverty level, tax credit percentage, and other variables. The data are presented visually, through distinctive and interesting graphics that allow a reader to take in large amounts of information in an "at-a-glance" format, so although the report is 24 pages long and contains a large amount of data, it is easy to scan the whole report quickly for items of interest, and then to look deeper at the data on any specific topic.

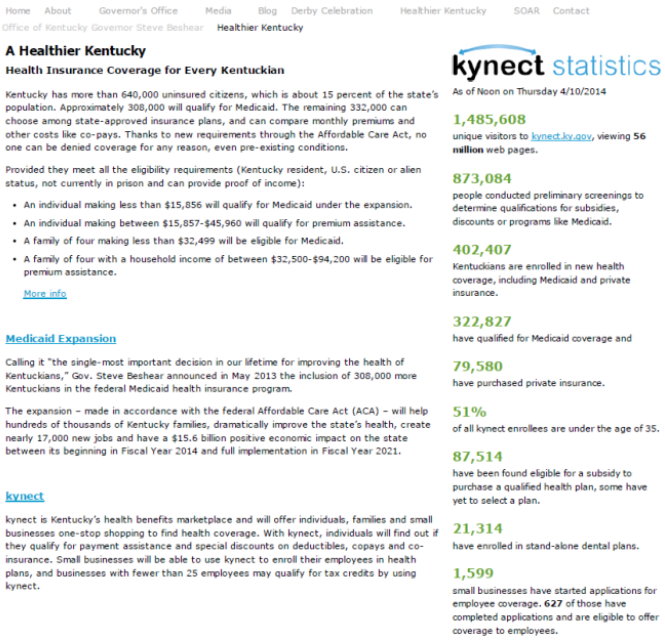
Figure 4. Sample page of Washington's final report



See Washington's final report here: http://wahbexchange.org/files/4513/9821/1124/WAHBE_End_of_Open_Enrollment_Data_Report_FINAL.pdf

Spotlight: Dashboards in Massachusetts and Kentucky

Figure 5. Sample 1-page snapshot from Kentucky


Home About Governor's Office Media Blog Derby Celebration Healthier Kentucky SOAR Contact
Office of Kentucky Governor Steve Beshear Healthier Kentucky

A Healthier Kentucky

Health Insurance Coverage for Every Kentuckian

Kentucky has more than 640,000 uninsured citizens, which is about 15 percent of the state's population. Approximately 308,000 will qualify for Medicaid. The remaining 332,000 can choose among state-approved insurance plans, and can compare monthly premiums and other costs like co-pays. Thanks to new requirements through the Affordable Care Act, no one can be denied coverage for any reason, even pre-existing conditions.

Provided they meet all the eligibility requirements (Kentucky resident, U.S. citizen or alien status, not currently in prison and can provide proof of income):

- An individual making less than $15,856 will qualify for Medicaid under the expansion.
- An individual making between $15,857-$45,960 will qualify for premium assistance.
- A family of four making less than $32,499 will be eligible for Medicaid.
- A family of four with a household income of between $32,500-$94,200 will be eligible for premium assistance.

More info

Medicaid Expansion

Calling it "the single-most important decision in our lifetime for improving the health of Kentuckians," Gov. Steve Beshear announced in May 2013 the inclusion of 308,000 more Kentuckians in the federal Medicaid health insurance program.

The expansion – made in accordance with the federal Affordable Care Act (ACA) – will help hundreds of thousands of Kentucky families, dramatically improve the state's health, create nearly 17,000 new jobs and have a $15.6 billion positive economic impact on the state between its beginning in Fiscal Year 2014 and full implementation in Fiscal Year 2021.

kynect

kynect is Kentucky's health benefits marketplace and will offer individuals, families and small businesses one-stop shopping to find health coverage. With kynect, individuals will find out if they qualify for payment assistance and special discounts on deductibles, copays and co-insurance. Small businesses will be able to use kynect to enroll their employees in health plans, and businesses with fewer than 25 employees may qualify for tax credits by using kynect.

kynect statistics

As of Noon on Thursday 4/10/2014

1,485,608
unique visitors to kynect.ky.gov, viewing **56 million** web pages.

873,084
people conducted preliminary screenings to determine qualifications for subsidies, discounts or programs like Medicaid.

402,407
Kentuckians are enrolled in new health coverage, including Medicaid and private insurance.

322,827
have qualified for Medicaid coverage and

79,580
have purchased private insurance.

51%
of all kynect enrollees are under the age of 35.

87,514
have been found eligible for a subsidy to purchase a qualified health plan, some have yet to select a plan.

21,314
have enrolled in stand-alone dental plans.

1,599
small businesses have started applications for employee coverage. **627** of those have completed applications and are eligible to offer coverage to employees.

Dashboards can be a very effective way to communicate data and trends, highlighting the most important indicators and making key figures easy to find. Several state exchanges used this kind of approach for enrollment reporting, placing the key summary statistics into a simple, 1-page format and updating it on a regular basis.

The Massachusetts Health Exchange released weekly 1-page dashboards during open enrollment. These dashboards summarized information of interest each week, initially focusing on the process of overcoming the application backlog (reporting on applications

reviewed and supplemental staffing), and in later weeks turning to enrollment figures while also including process measures such as call volume and website traffic. The Massachusetts dashboard used a combination of graphics and short pieces of text to convey the key messages in a simple format.

Throughout the first open enrollment period, Kentucky also used a regularly-updated 1-page format highlighting the most important measures on its state health exchange, called kynect. Regular updates to individual, SHOP, and Medicaid enrollment figures, along with a few key statistics on website and call center activity, were provided in a clear and simple format. Kentucky was unique among states in that kynect reports were released by the Office of the Governor rather than the state health exchange itself.

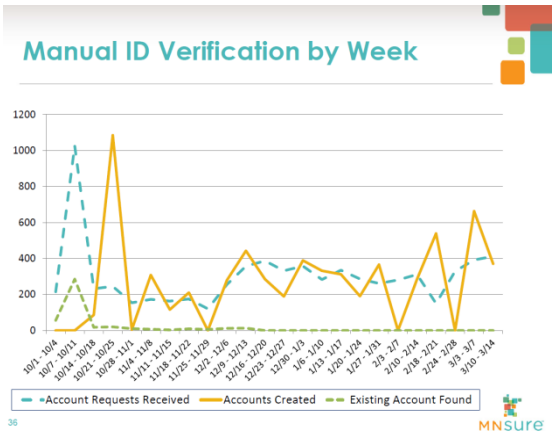
See sample 1-pagers from MA and KY here:

- Massachusetts
- Kentucky

Spotlight: In-Depth Reporting on Topics of Interest in Colorado and Minnesota

Throughout the first open enrollment period, Colorado used an extensive "Customer Support Network" to communicate with the public, promote the state's exchange (called Connect for Health Colorado), and assist in enrollment. This network included Customer Service Center Representatives, specially trained brokers/agents, Certified Health Coverage Guides, Certified Application Counselors, and community organizations. The public outreach strategy included Street Outreach Teams, Walk-in Sites, and a branded RV travelled around the state. A highlight of the Connect for Health Colorado final report for the open enrollment period was its thorough coverage of the work conducted by these groups. The report included numbers of consumers reached with promotional activities, number of miles travelled by staff, number of hours spent talking with the public, and numbers of enrollments assisted by various groups. This depth of reporting on outreach work was a helpful way to document the level of promotional effort required to meet enrollment goals, and including this in the final report also demonstrated the state's appreciation for the staff and volunteers involved in the work.

Figure 6. Sample of reporting on technical operations metrics from Minnesota



Minnesota used its exchange's Board of Directors Meetings (reports from which were publicly shared) as one of its methods of enrollment reporting. But this state went a step beyond the standard metrics by including in-depth on the technical operations of its call center and exchange website, called MNsure. Detailed technical process measures included: % system uptime/downtime, website new and returning visitors, website visits by geography within the

state, weekly manual ID verification processing (# of cases and average # days to complete), data requests received and fulfilled (number and megabytes), estimated hours of staff time processing data requests, weekly appeals, independent validation and verification reviews, call center types of calls received (top 10 specific questions from public and from brokers), and error rates in MNsure marketplace. This in-depth topical reporting provided a broader view not just of enrollments, but of the efforts and processes behind the operation.

Read reports from Colorado and Minnesota here:

- Colorado
- Minnesota

DISCUSSION AND LOOKING AHEAD

A review of the type of enrollment data generated by FFMs and SBMs shows great variation in what is being collected and how it is being used and reported. Despite differences in how states are leveraging enrollment data, all states are faced with the reality of a rapidly approaching second open enrollment period. While states continue to analyze data from the first open enrollment period, officials estimate an even larger surge of enrollment in year two.[1] The final section of this report discusses some of the challenges and opportunities states face regarding the collection and use of marketplace enrollment data for the second open enrollment period.

Challenges

Discontinuation of Federal Marketplace Data Reports. As noted, the ASPE issue briefs were arguably the most important source for comparative information about marketplace enrollment across states and the sole source of enrollment data for FFM states. ASPE discontinued these reports in May 2014 and, although open enrollment ended, marketplaces have continued to enroll individuals under special enrollment circumstances.[‡] In the absence of the ASPE issue briefs, cross-state comparisons of key enrollment metrics have been difficult. In addition, there has been no official source of information on the enrollment status of FFM states. For FFMs wishing to transition to a SBM, this has been particularly challenging, because they lack the data and analytics needed to make projections and initiate planning. It is important to note, however, that ASPE may resume disseminating these issue briefs again during the next open enrollment period.

Lack of Common Definitions. Another area of challenge for states has been the lack of common definitions used by SBMs in their public reporting. As discussed above, even a concept

[‡] Individuals qualify for special enrollment periods (a time during which they can sign up for health insurance coverage) following certain life events that involve a change in family status (for example, marriage or birth of a child) or loss of other health coverage.

seemingly as simple as "enrollment in QHPs" has been linked to several different definitions. This has led to frustration among SBM staff who are called upon to answer questions about how their state enrollment numbers compare to other states. SHADAC has been in discussion with SBM staff about the possibility of generating standard definitions, and most states concede that modified marketplace data systems towards this goal are not a priority. As an alternative, SHADAC is working with the National Academy of State Health Policy (NASHP) State Health Exchange Leadership Network to compile a glossary of all the different meanings various enrollment terms might have (anticipated publication in August 2014). The glossary is intended to be a reference for states in both their comparisons and reporting.

Enrollment Definitions. As discussed above, states varied in their definition of "enrollment," and most states and the federal government considered a completed enrollment to be at the stage of plan selection or pre-effectuated enrollments. A consequence of using this definition is that it is artificially high, because some people will fail to pay their first month's premium. This means that actual enrollment will be less than published reports. This poses both a political and public relations challenge for states that will need to rectify this discrepancy at some point.

Dynamic Nature of Enrollment. Despite great enrollment gains in the first open enrollment period, it is important to recognize that insurance coverage is dynamic and many people experience changes in their coverage over time. As time passes, some enrollees are likely to drop marketplace-obtained coverage due to affordability issues or other reasons (e.g., they obtain a job with health benefits). These types of changes are common for people with non-group insurance coverage. For instance, one recent study found that over one-third of people with non-group coverage in May 2008 no longer had non-group coverage four months later.[10] To date, marketplaces have reported the total number of individuals to enroll in coverage since the start of open enrollment ("ever enrolled"), rather than reporting net enrollment. As with the choice of enrollment definition described above, this time frame presents the most optimistic picture of marketplace enrollment. At some point, states will need to start reporting net enrollment and may face technical/administrative challenges obtaining this information and accounting for this drop in enrollment.

Incomplete Data from Application Process. States are balancing their data needs with the legal requirements and limitations related to data collection. Despite state flexibility to design a single streamlined application, the rule that questions not essential for eligibility determinations must be optional poses a challenge for some states in their ability to link enrollees to other social service programs and to collect and analyze additional data such as previous source of coverage. In addition, high non-response rates for optional questions can make it difficult for accurate analysis of a state's outreach and enrollment status. For example, two states noted a 25% non-response rate on questions about race and ethnicity. While it is impossible to know whether there is systematic non-response among certain population groups, this is possible, making it difficult for states to assess the effectiveness of their promotional and enrollment activities across all population groups.

Use of data collected. We have not yet truly harnessed the power of the data that have been collected through ACA enrollment processes. Data would ideally be used internally by state and federal managers and also made available for analysis to researchers, but there are challenges in both external and internal use. Due to the highly sensitive nature of ACA-related data, some states may be reticent to release their datasets for detailed analysis, especially while open enrollment periods are underway. Internally, states do use the operations data (call center volume, language assistance needs, geographic enrollment, etc) to adjust promotion and support efforts, but many states wish they had more capacity to focus on more extensive analysis, and are hard-pressed to prioritize this, particularly during busy open enrollment periods.

Opportunities

Lessons from the 2014 Open Enrollment Period. As described in this paper, there was a huge variety in state messaging around open enrollment. An opportunity exists for states to compare the type of measures, modes and venues used to distribute messages about marketplace enrollment and identify best practices. Potential best practices might include:

- Select the measures on which to report in advance to assure data systems can generate them easily for politically-charged topics, choose benchmarks/goals carefully.
- Consider aligning key definitions with other states or the federal government (e.g. enrollment).
- Consider the implications of definitions used (e.g. reporting "ever enrolled" vs point-in-time enrollment).
- Report on the same set of measures consistently, and on a set schedule.
- Utilize multiple venues to distribute the message (website, twitter, meetings, etc).
- Use graphic depictions to highlight key messages.

Linking Enrollment Data to External Data Sources. States have a great opportunity to link enrollment data with external data to conduct additional analyses and guide operations. Most notably, enrollment data can be linked with federal or state survey data to identify enrollment "penetration rates" and areas that need continued outreach. This can be done by geography or by enrollee characteristics. For example, a state could use the U.S. Census Bureau's American Community Survey to determine the number of potentially marketplace eligible in each zip code and compare that to marketplace enrollment in those zip codes. This would provide a picture of how well a state did at targeting enrollment in areas where there were high numbers of potentially-eligible and where states need to focus efforts in the next open enrollment period. This same exercise could be done by income group, age, etc. Enrollment data could also be linked to claims data to study changes in health care utilization and expenditures among various population and enrollment groups.

Leveraging Enrollment Data and Electronic Systems to Administer Surveys. Historically, some state Medicaid agencies have utilized enrollment files to survey enrollees about their

experience, utilization and satisfaction with the program. State marketplaces can utilize a similar approach to survey their enrollees and potential enrollees (e.g. conducting an optional web-based survey as people go through the online enrollment process). As states consider surveys that target marketplace enrollees, they should keep in mind that the HHS is in the process of developing and implementing two surveys: a marketplace survey and an enrollee satisfaction survey. The marketplace survey will be developed, implemented and analyzed by HHS. The enrollee satisfaction survey will be developed by HHS, based on the Consumer Assessment of Healthcare Providers and Systems surveys, but implemented by QHPs through an approved list of vendors. Draft versions of the survey instruments can be found here:

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html

Investment in Enrollment Data Systems: The ACA has brought new focus and attention to enrollment data systems. In spite of some early enrollment system problems, it is likely that this infusion of funding and technology will help states in the long term. By shifting from legacy systems and investing in new infrastructure, states have the opportunity to build both data and analytic capacity. Some new areas of opportunity might include: setting up a system that can track individuals across the coverage continuum to monitor churn; tracking denial and disenrollment reasons to understand why individuals drop or lose coverage; or linking health care data with data from other social service programs.

CONCLUSION

Experiences from the first ACA open enrollment period will surely inform state and federal efforts to prepare for future enrollment periods. A few states have already indicated plans to change from a full SBM operation to a supported SBM (Nevada, Oregon) or potentially to transition from the FFM or a supported SBM to a full SBM (Arkansas, Idaho, Illinois, Missouri, New Mexico). Other states will continue using the same marketplace model used in the first open enrollment, but perhaps with adjustments in data collection and reporting based on first round lessons learned, the need for specific types or breakdowns of data, or a desire to enhance public reporting to reach additional audiences. It is hoped that this paper will provide insight to states and others interested in learning from the first open enrollment and reporting process in order to ensure that future efforts continue to be successful.

REFERENCES CITED

1. Congressional Budget Office. *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act*.; 2014. Available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf

2. Office of the Assistant Secretary for Planning and Evaluation (HHS). *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period*.;

2014. Available at: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf

3. Centers for Medicare & Medicaid Services. *State Health Insurance Marketplaces*.; 2013. Available at: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/state-marketplaces.html Accessed August 12, 2014.

4. Medicaid.gov. State Medicaid & CHIP Policies for 2014 | Medicaid.gov. Available at: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html Accessed August 12, 2014.

5. 111th Congress. *Patient Protection and Affordable Care Act*.; 2010. Available at: http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdfAccessed August 12, 2014.

6. United States Government. *Final Rule on 45 CFR § 155.315(g). Health and Human Services Department*.; 2012:Vol. 77, No. 59. Available at: https://www.federalregister.gov/articles/2012/03/27/2012-6125/patient-protection-and-affordable-care-act-establishment-of-exchanges-and-qualified-health-plans#h-93. Accessed August 12, 2014.

7. CMS Center for Medicaid and CHIP Services. Model Eligibility Application and Guidance on State Alternative Applications. *C Informational Bull*. 2013. Available at: http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-04-30-2013.pdf Accessed August 12, 2014.

8. CMS Center for Consumer Information & Insurance Oversight. Guidance on State Alternative Applications for Health Coverage. 2013. Available at: http://medicaid.gov/AffordableCareAct/Provisions/Downloads/Alternative-App-Guidance-061813-508-comp.pdf Accessed August 12, 2014.

9. Mangan D, Gralnick J. High number of uninsured among NY, Ky. Obamacare sign-ups. *cnbc.com*. http://www.cnbc.com/id/101523615. Published 2014. Accessed August 12, 2014.

10. Sommers BD. Insurance cancellations in context: stability of coverage in the nongroup market prior to health reform. *Health Aff (Millwood)*. 2014;33:887-94. doi:10.1377/hlthaff.2014.0005.

California's Implementation of the Affordable Care Act

Implications for Immigrants in the State

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The Immigrant Access to Health and Human Services project maps and describes the legal and policy contexts that govern and affect immigrant access to health and human services. Through a synthesis of existing information, supplemented by in-depth visits to purposively selected sites, the study aims to identify and describe federal, state, and local program eligibility provisions related to immigrants; major barriers (such as language and family structure) to immigrants' access to health and human services for which they are legally eligible; and innovative or promising practices that can help states manage their programs.

Introduction

This brief examines how the implementation of the Patient Protection and Affordable Care Act of 2010 (ACA) in California might affect immigrants' access to health care in the state.[1] We first describe the implementation of the ACA in California generally, and then turn to implications for immigrants (particularly low-income immigrants) in the state. We highlight promising state-specific policies that may increase the share of immigrants with some form of health insurance coverage. We also describe ongoing challenges in connecting immigrants to insurance for which they are eligible. We conclude by highlighting areas where California's experience could provide useful approaches for other states to consider as they implement the ACA and work to improve health insurance coverage of all residents in their state.

Background

Across the United States, approximately 15 percent of the population had no form of health insurance as of 2012 (DeNavas-Walt, Proctor, and Smith 2012). Immigrants make up a disproportionate share of

the uninsured population: they were 20 percent of the uninsured population in 2012, but only 7 percent of the US population overall (DeNavas-Walt, Proctor, and Smith 2012).[2] As states across the country begin implementing the ACA, they face many policy choices within the provisions of the law. The choices states make may affect whether and how immigrants are able to find new sources for health insurance coverage. In this brief, we examine one state—California—as a case study to help better understand how state decisions may affect immigrants' access to health insurance under the ACA.

Nationwide, immigrants are less likely than citizens to have health insurance. For example, among nonelderly immigrants, about 51 percent of adults had no health insurance in 2009, compared with 17 percent of US-born citizen adults (Kenney and Huntress 2012). This gap in insurance coverage is driven by lower rates of both employer-sponsored insurance coverage and public coverage for immigrants. Lower rates of public health insurance coverage stem, in part, from Medicaid and Children's Health Insurance Program (CHIP) eligibility criteria that generally exclude recent legal permanent residents (LPRs) for their first five years in the country and exclude unauthorized immigrants for as long as they are unauthorized. However, there is some state flexibility regarding providing public health insurance to lawfully present immigrants, particularly pregnant women and children, within their first five years of legal residence. And states are free to use state funding to provide public insurance to immigrants regardless of legal status, though few do so and such insurance is generally provided only to children. The share of the uninsured population who are immigrants is expected to rise as ACA implementation progresses. While many US citizens and a substantial share of LPRs gain new access to Medicaid under the ACA, most new LPRs and unauthorized immigrants do not.

California has more immigrants than any other state, so its policies affect the lives of many immigrants. About one-quarter of the foreign-born population in the United States, or 10 million foreign-born people, live in California. While 13 percent of the US population is foreign born, in California this share is 27 percent (Migration Policy Institute 2013). It is also estimated that more unauthorized immigrants live in California than any other state: about 2.6 million, or just under a quarter of the estimated 11.2 million national total (Passel and Cohn 2011). Half of all children (49.6 percent) in California have at least one foreign-born parent (Migration Policy Institute 2013).

This brief is based on a site visit to California in February 2013 and publicly available information. The site visit included discussions with state and local government agencies, nonprofit service providers, advocacy organizations, professional organizations for health care workers, public-private service providers, and a private company contracting with the state. No immigrant families were contacted during the site visit. This brief provides information about California's policies and practices before the ACA, plans for ACA implementation, and knowledge about the likely impact of state and local policies on immigrants seeking health insurance.

Below, we briefly outline changes in federal policy under the ACA and the policies California is implementing within this context. We then highlight the impacts of these policies on immigrants in California. Finally, we highlight California's promising practices, as well as ongoing challenges in connecting the state's immigrant population with health insurance options.

California's Policies under the Affordable Care Act

A previous brief in this series, "The Affordable Care Act: Coverage Implications and Issues for Immigrant Families," outlines the implications of federal ACA provisions for immigrant families (Kenney and Huntress 2012). This section briefly reviews federal policy changes under the ACA and then identifies the decisions that California has made within the federal framework.

Medicaid. The ACA gives states the option of expanding federally funded Medicaid to individuals with household incomes at or below 133 percent of the federal poverty level (FPL), with the federal government picking up most of the cost of this expansion.[3] California's legislature voted in June 2013 to undertake this expansion. Prior to the ACA, many states, including California, did not offer Medicaid to nondisabled, childless adults, and income eligibility guidelines for adults generally fell far below 133 percent of FPL. Many counties in California began preparing for the anticipated expansion by creating Low Income Health Plans (LIHPs). The California LIHPs, which launched in July 2011, were federally funded demonstration projects that extended public insurance to adults who were not previously eligible. Those covered under the LIHPs included citizens and qualified[4] immigrants with incomes meeting county eligibility criteria, most often below 133 percent of FPL, whether parents or childless adults. The LIHPs provided coverage through the end of 2013, when those covered were enrolled in Medi-Cal (the state's Medicaid program) or the state health insurance marketplace,[5] called Covered California (California Department of Health Care Services 2011). Some counties, such as Los Angeles, opened their LIHPs to nonqualified immigrants using local funding only. Los Angeles County will continue its LIHP, Healthy Way L.A., in 2014 and beyond using local funds, to continue providing insurance to those with low incomes who are not eligible for Medi-Cal or Covered California, such as nonqualified immigrants (Insure the Uninsured Project 2013).

Health insurance marketplaces. The ACA creates state health insurance marketplaces where lawfully present immigrants who do not have sufficient employer-provided health insurance can purchase private insurance. Those with family incomes up to 400 percent of FPL are eligible for tax credits that limit the premium paid for health insurance to a percentage of income—ranging from 2 percent for those with incomes at or below 133 of FPL to 9.5 percent for those at 400 percent of FPL. Those with incomes below 250 percent of FPL are also eligible for cost-sharing subsidies to help pay deductibles and copayments. Lawfully present[6] immigrants may participate in state insurance marketplaces and receive tax credits and subsidies for which they are income-eligible even during their first five years of legal status. California was the first state in the country to set up a state health insurance marketplace. The marketplace, Covered California, opened for enrollment in October 2013, and insurance coverage started in January 2014.

Funding for primary care. The ACA also offers some changes in federal funding for health insurance and health care providers that could affect safety net care for individuals who remain uninsured under the ACA, such as unauthorized immigrants. The ACA mandates increased funding for community health centers and other federally qualified health centers (FQHCs) and FQHC look-alikes, which are a key source of care for the uninsured. The ACA also temporarily increases federal payment rates for primary

care provided through Medicaid for 2013 and 2014, increasing revenues to local providers. Additionally, the ACA provides funding streams intended to increase the supply of primary care providers (Hill 2012). The inflow of new funding streams and an increase in the share of patients with insurance could free up additional funding to provide primary care for remaining uninsured individuals, such as unauthorized immigrants. At the same time, as the proportion of patients with insurance rises, the ACA will gradually lower funding for disproportionate share hospital payments to hospitals that serve large numbers of low-income, uninsured patients.

Outreach. The ACA requires states to set up systems of Navigators—individuals trained to provide outreach and assist state residents with enrollment in state health insurance marketplaces "in a manner that is culturally and linguistically appropriate to the needs of the population being served."[7] These service providers could increase coverage among eligible immigrant populations who may otherwise face information or language barriers in applying. The Department of Health and Human Services will provide $150 million in funding for community health centers across the country to provide patients with assistance enrolling in new health insurance options, and $67 million in grants to fund Navigators (Hill, Courtot, and Wilkinson 2013).[8]

Changes in public insurance for children. Leading up to implementation of the ACA, California changed how it administers the provision of health insurance for children in low-income families covered under the Children's Health Insurance Program. CHIP covers insurance for children in working poor families with incomes above the eligibility limit for Medi-Cal. Until 2013, California ran a separately administered CHIP program called Healthy Families that covered children with family incomes up to 250 percent of FPL. In 2013, most children who had insurance under Healthy Families were transitioned onto insurance plans paid with CHIP funds but administered by Medi-Cal.

Bridge Plan for lower-income families. California's health benefits exchange board approved a proposal, in 2013, for a Bridge Plan to help low-income families maintain continuous health insurance coverage as their incomes fluctuate over time.[9] The ACA gave states the option of creating a special insurance plan—termed the "Basic Health Plan"—for families with incomes on the border of Medi-Cal eligibility. Low-income families often have incomes that vary over time, placing them within the income-eligibility range for Medicaid in some periods and above the range in other years. This churning in and out of Medicaid eligibility can lead to gaps in health insurance coverage and access to health care. By one estimate, half of adults with family incomes below 200 percent of FPL churn in or out of Medicaid eligibility in any given year nationwide (Sommers and Rosenbaum 2011).

Rather than create a separate health insurance program for those at the border of Medi-Cal eligibility, California proposed to maintain continuity of coverage and care for low-income families by allowing those at risk of churning to maintain coverage under the same managed care system that they access through Medi-Cal. Under the Bridge Plan, families would be able to maintain coverage if their incomes rose above 133 percent of FPL, as long as their incomes remained below 200 percent of FPL.

Parents of children with Medi-Cal would also be able to obtain coverage so that even parents ineligible for Medi-Cal could access care through the same providers as their children (the Medi-Cal

income eligibility cutoff for adults will be set at 133 percent of FPL, versus 250 percent of FPL for children). The state has also debated opening Bridge Plan eligibility to individuals with incomes below 200 percent of FPL who are not transitioning off Medi-Cal, but it has not pursued this option. Under the current proposal, Bridge Plan insurance would be purchased through the marketplace. Covered California would negotiate contracts with the managed care plans operating under Medi-Cal, in order to create plans with lower monthly premium costs than other plans purchased through the marketplace (Insure the Uninsured Project 2013).

Implications of California's ACA Policies for Immigrants and Their Families

California's policies under the ACA should substantially increase the availability of insurance for lower-income residents, including immigrants. In this section, we highlight the consequences of California's new health care policies for particular subgroups of the immigrant population.

Adult LPRs with at least five years in the country. California's new policies under the ACA expand coverage for many lawfully present immigrants in the state who have been LPRs for at least five years. Those with incomes below 133 percent of FPL are now eligible for Medi-Cal, even if they do not have dependent children. The Urban Institute estimates that 262,000 qualified immigrants in California could obtain Medi-Cal coverage under the ACA, making up 14 percent of the newly eligible population (Kenney et al. 2012). Low-income LPRs with incomes above 133 percent of FPL also benefit from the availability of subsidized insurance through the marketplace.

Adult LPRs with fewer than five years in the country. Recent LPRs in their first five years of residence benefit as well. Prior to the ACA's implementation, recently arrived LPR parents with family incomes below 100 percent of FPL could obtain Medi-Cal funded by the state. Under the ACA, new LPR adults who do not have children and have household income below 100 percent of FPL are able to obtain state-funded Medi-Cal, while new LPRs who are low income but not technically poor (family incomes between 100 and 400 percent of FPL) can purchase subsidized insurance through the state marketplace. For new LPRs with incomes between 100 and 133 percent of FPL, California uses a "premium assistance option" to help them purchase insurance through Covered California (Insure the Uninsured Project 2013).

Unauthorized immigrant adults. Unauthorized immigrant adults have no new insurance options under the ACA, but changes in funding streams might affect the availability of primary and emergency care for such immigrants, as explained above. As before the ACA's implementation, unauthorized immigrants in California, as in the rest of the country, are ineligible for Medicaid or Medi-Cal and are not allowed to purchase insurance through health insurance marketplaces, even if they use their own money to do so.[10] This category of federally excluded individuals includes young adults who have benefited from Deferred Action for Childhood Arrivals (DACA), which provides a temporary reprieve from deportation and work authorization to unauthorized youth who arrived as children and who meet

certain eligibility criteria.[11] However, DACA recipients are eligible for state-funded, full-scope Medi-Cal under California law with the same income requirements as other California children and adults (Brindis et al. 2014).

California has various programs that provide health insurance, prescription medicine, and health care to select groups of high-need individuals, regardless of immigration status.[12] Some counties in California fund access to a broad system of care, regardless of immigration status. Among the most comprehensive is San Francisco County's Healthy San Francisco program, which provides low-income uninsured individuals who are ineligible for other insurance with access to primary and specialized care, hospital care, and prescriptions using state and local funds. This program is continuing as the ACA goes into full effect. Also, California is requiring that anyone selling insurance through the marketplace offer the same products at similar (unsubsidized) costs outside the marketplace, potentially opening new insurance coverage options even to those who cannot participate in the marketplace.

Children of immigrants. Children of immigrants have often had constrained access to health insurance—even though they themselves may be eligible—because of their parents' ineligibility for insurance, fears about accessing government benefits, and misunderstandings about different eligibility rules (Perreira et al. 2012). Most children of immigrants nationwide and in California are themselves US citizens or LPRs, so they are eligible for Medi-Cal if they live in low-income families (Passel and Cohn 2011). The ACA requires that states maintain current levels of Medicaid coverage for LPR children through September 2019, meaning that for at least that period, California children in their first five years of LPR status will remain eligible for Medi-Cal if their parents have incomes below 250 percent of FPL. The expansion of Medi-Cal and subsidized private insurance to many LPR parents could also increase the likelihood that parents know about and enroll their children in available insurance plans.

Under the ACA, unauthorized immigrants have new options for obtaining health insurance for their US-citizen children. Unauthorized immigrant parents can purchase insurance for their US-citizen children through state health care marketplaces, even though they are not allowed to purchase insurance for themselves. Income-eligible families can also access subsidies for children's insurance.

For the roughly 20 percent of children of unauthorized immigrants who are themselves unauthorized, the ACA does not open new options beyond those that already exist in some communities in California, though these children, like their parents, might be affected by changing funding streams for primary care and hospital services. Many children in California have greater access to health insurance coverage than their parents or than children in many other parts of the country because of county-level initiatives. The Children's Health Initiatives in some counties and communities provide health insurance coverage to all income-eligible children between birth and age five who are not otherwise eligible for Medi-Cal, including unauthorized immigrant children. Funding for these programs, which provide coverage similar to what was offered under Healthy Families, is provided by county First Five programs, which are funded through a state tobacco tax. Some programs have been able to temporarily fund health insurance for older children through a mix of public and private foundation funding, but insurance is generally not available for older unauthorized immigrant children in most counties. Another program, the Child Health and Disability Prevention Program Gateway,

provides all children in low-income families limited access to preventive checkups on a frequency schedule according to age, and up to two months of care following each checkup if necessary. The program aims to provide a pathway to Medi-Cal enrollment for eligible children, but children who are not eligible for Medi-Cal can use the gateway program for limited periodic health care access.

California's Successes in Connecting Immigrants to Health Insurance

California has taken many steps to increase immigrants' ability to access health insurance before and during ACA implementation. California has devoted considerable state and local financing to providing insurance to low-income immigrants who are ineligible for public insurance, particularly new LPRs, pregnant women and young children of all immigration statuses, and immigrants with particularly severe health challenges. Even prior to 2014, the state had already connected some residents—including longer-term LPRs, who are newly eligible for public insurance under the ACA—to temporary public insurance options through county-run LIHPs. Below we describe some of the state's other efforts that could help connect immigrants to health insurance.

Addressing Medi-Cal churning and mixed eligibility within immigrant families. California's proposed Bridge Plan to address churning in and out of Medicaid could benefit many immigrant families in California, who are disproportionately likely to be low income. Providing lower-income lawfully present immigrant parents with the same low-cost health insurance as their children, with lower premiums than they would face through Covered California, would lower the cost burden of insurance for these families. Ensuring that parents and children have access to the same providers under the same plan could greatly improve families' ability to locate health care providers and access services by reducing transportation and other logistical challenges that are often particularly severe for immigrant families.

Outreach. In recent decades, California has conducted outreach and application assistance aimed at increasing the enrollment of immigrant and limited English proficient populations in its public health insurance system. California's enrollment program for the recently eliminated Healthy Families (CHIP) program enlisted various nonprofit agencies, including some focused on serving immigrant populations, to serve as enrollment entities (EEs). Within EEs, individuals could become certified application assistants (CAAs) by completing a five-hour web-based training course and passing an online exam. CAAs were enlisted primarily to help eligible children enroll in Healthy Families, but they also enrolled eligible children in Medi-Cal. EEs have been able to use community connections and staff language skills to enroll immigrant community members in health insurance. This experience likely prepared organizations to conduct similar outreach in immigrant communities for Covered California.[13] Covered California's enrollment assistance Navigators, required under the ACA, are funded by both per-application payments and grants. Navigators will help ensure that hard-to-reach geographic areas and subsets of the population are served (Covered California 2013).

Language access. California has translated outreach materials and information about available health insurance programs into a wide variety of languages for many years. California law requires that Medi-Cal agencies provide language assistance in any language needed by 3,000 enrollees or 5 percent of the enrollee population, whichever is lower. Such languages are considered "threshold languages." California is actively working with Covered California and the provider of the eligibility system for the state marketplace to facilitate eligibility screening in all threshold languages and to provide broad language access in online, telephone, and written communication. The private company managing California's Medi-Cal managed care enrollment process monitors language demand for call centers and hires for language skills as needed.

Finally, California has extensive experience developing application materials and processes that address immigrants' sensitivities and challenges. Streamlined Medi-Cal and Covered California application forms clearly state that applicants need only provide Social Security numbers for people who are applying for insurance; the forms also explain that parents can apply for their children even when parents are ineligible for coverage. The forms further state that applying for public insurance for their children does not hurt immigrants' chances of becoming permanent residents or citizens.

Challenges for Immigrant Inclusion

Despite these strengths, there are a number of reasons immigrants in California might remain without insurance after the ACA is fully implemented.

Costs for lower-income families. The cost of insurance could remain out of reach for lawfully present immigrants who are not eligible for Medi-Cal. Such immigrants are now eligible to purchase insurance through Covered California, with their share of the cost of the insurance premium capped on a sliding scale from 2 percent of family income for those with incomes at or below 133 percent of FPL to 9.5 percent for those with incomes at 400 percent of FPL. But some advocates and service providers are concerned that paying nearly 10 percent of family income for health insurance may be burdensome for lower-income families, who may choose to allocate income to other necessities instead.

Outreach and enrollment assistance challenges. Service providers we spoke with in California were concerned about an apparent lack of state coordination of enrollment outreach plans. They feared that without coordination, outreach efforts would not reach all geographic areas or all immigrant and language groups. They worried that lower-incidence immigrant groups, those speaking less common languages, and those in rural areas of the state might not have access to outreach and application assistance. Additionally, per-application payments for enrollment assistance are limited to applications for Covered California, while many of the uninsured lawfully present immigrants in California are eligible for Medi-Cal. The lack of reimbursement for Medi-Cal application assistance could limit outreach to immigrant populations.

Enrollment assistance for immigrant families may require more time and effort than enrollment for other families because some immigrants see public insurance as stigmatized, some are misinformed about eligibility requirements, and some falsely believe that accessing Medi-Cal could hurt their

chances of later obtaining LPR status or citizenship. The need for better information is often compounded by the fact that some immigrant families face complicated mixes of insurance eligibility within the same family due to different immigration statuses, ages, and durations of residence. In particular, unauthorized immigrant parents whose children are eligible for Medi-Cal or Covered California may assume their children are ineligible, or they may be reluctant to fill out the paperwork required to apply for child-only insurance for their children.

Conducting outreach and providing assistance to all of California's diverse language groups is an ongoing challenge. Outreach efforts involve many forms of media, including brochures, print ads, radio and television ads, and information sessions, and applications may be completed online, by mail, by phone, or in person. Translating all forms of messaging, application materials, and assistance into all threshold languages may not be feasible. In addition, some immigrant populations have limited literacy in their native languages, making even translated materials potentially inaccessible.

Accommodating immigrants in the integrated eligibility verification system, called the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), may present challenges. Under the ACA, applicants seeking health insurance, whether through Medi-Cal or the state marketplace, apply through one streamlined system that can automatically verify eligibility through queries to immigration databases and the Social Security Administration. The system is designed to be easily accessible online, though applicants may also apply by phone, by mail, or in person. Immigrants, however, may not have the documents required by the system for verifying immigration status, income, or residency. For example, some lawfully present immigrants who are eligible for Medi-Cal based on their immigration status do not have Social Security numbers,[14] but many systems are not set up to facilitate enrollment in these situations, and many agency workers may not be trained to handle more complicated applications. Likewise, plans for how CalHEERS will verify the income of unauthorized parents applying for benefits for their children are still being completed. Parents who are unauthorized immigrants may not have a Social Security number or a taxpayer ID number, or they may not have reported income or used their own name to pay federal taxes (although many unauthorized immigrant workers do pay such taxes). Immigrants may not wish to provide information about the incomes of all members of the family or household for fear of exposing unauthorized immigrants in their household to the government. Applicants can opt out of automated immigration and income verification processes and opt for manual verification instead, but it remains unclear whether this option will be widely understood.

Provider shortages. Interviews revealed worries that there are not enough doctors accepting Medi-Cal patients. California has one of the lowest payment rates for Medicaid providers, and it is implementing a further 10 percent reduction in Medi-Cal payment rates. Respondents reported that many doctors are reluctant to accept Medi-Cal because of these low rates and stigma associated with Medi-Cal. Shortages of Medi-Cal doctors could become more severe as increasing numbers of Californians obtain Medi-Cal coverage and seek health care; these shortages may be particularly severe for immigrant communities in poor neighborhoods or rural areas where doctors may be reluctant to work and live. The temporary increase in primary care reimbursements in Medicaid under the ACA in

2013–14 could provide some relief for providers, though California did not implement the higher payments until November 2013, retroactive to the beginning of the year.

Lessons from California

California's policy decisions related to the ACA have been made within a specific context: the state has a particularly large immigrant population, long-term experience with a sizable population of unauthorized immigrants, a large population spread across a broad geographic area, and a large budget. Although state-to-state conditions vary, California's efforts to include immigrants within its plans for the ACA highlight important considerations for other states weighing impacts on immigrants alongside other costs and benefits of new health policy decisions.

California has learned to address the special complexities involved in enrolling immigrants in public health insurance programs, including accommodating foreign language needs, limited literacy, and documentation challenges. Key to this work has been reliance on community groups who can conduct outreach and help immigrants with the application process and materials, as well as strong efforts within government agencies to hire staff with foreign-language skills and translate materials into relevant languages. California is also working to provide outreach to places and populations that are difficult to reach by offering grant-based funding for application and enrollment assistance.

Covered California designed enrollment and eligibility verification systems that seem like they will function well for immigrant families containing complicated mixes of eligibility, who may lack complete documentation for all family members. The state also allows multiple modes of application to accommodate populations without regular access to the Internet or a stable phone number, as well as those who have difficulty filling out paper forms because of language and literacy barriers. Applications that allow ineligible parents to apply for insurance for their children could particularly improve the ability of immigrants in the state to obtain new insurance under the ACA.

California's proposed Bridge Plan would help ensure continuity of coverage for families churning in and out of Medicaid because of income fluctuations. Rather than create a separate Basic Health Plan for those at the border of Medi-Cal eligibility, the Bridge Plan would allow families to maintain coverage under the same managed care plan as they fluctuate in and out of Medi-Cal eligibility. This plan would also allow more parents and children to access care through the same managed care system. If implemented, this approach could enable better insurance coverage for all low-income families in California, including immigrant families.

California has made creative use of available federal, state, and local funds to meet state policy goals in providing health insurance to some subgroups of the immigrant population. For example, drawing on federal CHIP funding, a state tobacco tax, other state and county funds, and private funding, California has found ways to finance health insurance coverage and access to health care for very young unauthorized immigrant children, pregnant women, individuals seeking family planning services, and men and women with certain types of cancer. Some counties, such as San Francisco, have even been able to provide access to basic health care for all low-income residents.

California, like other states, will continue to face challenges in ensuring that those with Medicaid and those who remain uninsured will have access to primary care and follow-up care for health conditions. Ensuring an adequate supply of primary care providers will likely be an ongoing challenge for California and other states. Since immigrants are likely to form a disproportionate share of the residually uninsured after the ACA is fully implemented, they may be particularly affected by a restricted supply of primary care providers under the public safety net systems. Further, the language skills and cultural competencies of these providers will affect the quality of care accessed by immigrants in California and across the country.

Appendix. Definitions

Foreign-born: Someone born outside the United States and its territories, except those born abroad to US-citizen parents. The foreign-born include those who have obtained US citizenship through naturalization and people in different immigration statuses. People born in the United States, Puerto Rico, and other territories, or born abroad to US-citizen parents, are native-born.

Immigrant: A foreign-born person who is not a citizen of the United States as defined by the Immigration and Nationality Act, Section 101 and the following (similar to the statutory term "alien"). This definition of immigrant is narrower than some common definitions that treat any foreign-born person as an immigrant, including those who have become naturalized citizens. Since a central focus of this study is on immigrant eligibility, and citizenship is a key factor in determining eligibility for benefit programs, this brief adheres to the legal definition of immigrant.

Lawful permanent residents (LPRs): People lawfully admitted to live permanently in the United States by either qualifying for immigrant visas abroad or adjusting to permanent resident status in the United States. Many but not all LPRs are sponsored (i.e., brought to the United States) by close family members or employers.

Naturalized citizens: LPRs who have become US citizens through naturalization. Typically, LPRs must be in the United States for five or more years to qualify for naturalization. Immigrants who marry citizens can qualify in three years, and some smaller categories can qualify sooner. LPRs generally must take a citizenship test—in English—and pass background checks before qualifying to naturalize.

Refugees and asylees: People granted legal status because of persecution or a well-founded fear of persecution in their home countries. Refugee status is granted before entry to the United States. Asylees usually arrive in the United States without authorization (or overstay a valid visa), claim asylum, and are granted asylee status once their asylum applications are approved. Refugees and asylees are eligible to apply for permanent residency after one year.

Undocumented or unauthorized immigrants: Immigrants who are not LPRs, refugees, or asylees and have not otherwise been granted permission under specific authorized temporary statuses for lawful residence and work.

Lawfully present immigrants: Lawfully present immigrants include LPRs, refugees, and asylees, as well as other foreign-born persons who are permitted to remain in the United States either temporarily or indefinitely but are not LPRs. Some lawfully present immigrants have entered for a temporary period for work, as students, or because of political disruption or natural disasters in their home countries. Some may seek to adjust their status and may have a status that allows them to remain in the country but does not grant the same rights as LPR status. The term "lawfully present" is used for applying for Title II Social Security benefits and is defined in the Department of Homeland Security regulations at 8 CFR 103.12(a). The same definition is also used by the US Department of Agriculture for determining eligibility for food stamp benefits. In 2010, the Centers for Medicare and Medicaid issued guidance to states that further defined "lawfully present" for determining eligibility for Medicaid and CHIP benefits under the Children's Health Insurance Program Reauthorization Act of 2009.

Qualified immigrants: The following foreign-born people are considered eligible for federal benefits:

- LPRs
- refugees
- asylees
- people paroled into the United States for at least one year
- people granted withholding of deportation or removal
- people granted conditional entry (before April 1, 1980)
- battered spouses and children (with a pending or approved spousal visa or a self-petition for relief under the Violence Against Women Act)
- Cuban and Haitian entrants (nationals of Cuba and Haiti who were paroled into the United States, applied for asylum, or are in exclusion or deportation proceedings without a final order)
- victims of severe human trafficking (since 2000, victims of trafficking and their derivative beneficiaries [e.g., children], are eligible for federal benefits to the same extent as refugees and asylees)

Nonqualified immigrants: Immigrants who do not fall into qualified immigrant groups, including immigrants formerly considered permanently residing under color of law, immigrants with temporary protected status, asylum applicants, other lawfully present immigrants (such as students and tourists), and unauthorized immigrants.

Five-year ban: Under TANF, SNAP, Medicaid, and CHIP, post-enactment qualified immigrants, with important exemptions, are generally banned from receiving federal means-tested benefits during their first five years in the United States.

Notes

1. This brief was written in late 2013 and early 2014 and may not reflect the most recent shifts in federal and California health policy.
2. Under this project, "immigrants" refers to foreign-born persons who have not naturalized, who are not US citizens. See the appendix for a definition of terms used in this brief.
3. The eligibility threshold is generally stated as 133 percent of FPL, but it is effectively 138 percent since 5 percent of income is disregarded when determining eligibility. The federal government will cover 100 percent of the cost of Medicaid for the newly eligible population for 2014–17, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and thereafter.
4. See the definition of "qualified immigrants" in the appendix.
5. State health insurance marketplaces are often called "exchanges." Marketplaces (exchanges) offer a set of government-regulated health insurance policies, generally offered by private companies.
6. See the definition of "lawfully present" in the appendix. This category is slightly broader than the category of "qualified immigrants"—the category of immigrants who may be eligible for Medicaid if they meet income criteria.
7. Patient Protection and Affordable Care Act §1311(i), 42 USC § 18001 et seq. (2010).
8. "Health Centers to Help Uninsured Americans Gain Affordable Health Coverage," US Department of Health and Human Services press release, July 10, 2013, http://www.hhs.gov/news/press/2013pres/07/20130710a.html.
9. Insurance is not yet available through the Bridge Plan in 2014, and details of the proposed plan are still in the works.
10. Unauthorized immigrants and other noncitizens who are ineligible for Medi-Cal, but have incomes that would otherwise make them eligible, remain eligible for emergency Medi-Cal. Emergency Medi-Cal covers the cost of emergency medical care during life-threatening situations.
11. Pre-Existing Condition Insurance Plan Program, 77 Fed. Reg. 52,614 (Aug. 30, 2012). DACA recipients are also barred from accessing federally funded Medicaid and CHIP under the state option to cover "lawfully residing" children and pregnant women: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/ SHO-12-002.pdf. Those granted deferred action through other channels retain the same eligibility for Medi-Cal that they had before the ACA (NILC 2012).
12. This includes prenatal care, delivery, and limited postpartum care for pregnant women; the Every Woman Counts program to provide free breast and cervical cancer screenings to women; the Breast and Cervical Cancer Treatment Program to provide cancer treatment to women; the IMPACT program to provide screening and treatment for prostate cancer; the AIDS Drug Assistance Program to provide access to medication for people living with HIV/AIDS; the Major Risk Medical Insurance Program for individuals unable to obtain insurance because of a preexisting condition; California Children's Services for children in low-income families with major illnesses; Family Planning, Access, Care, and Treatment to provide access to family planning services for low-income men and women; the Access for Infants and Mothers program for prenatal and infant care for middle-income women ineligible for no-cost Medi-Cal; and the Genetically Handicapped Person Program for adults with certain genetic diseases. These programs are expected to continue.
13. For more on how other states are using their experience conducting outreach about CHIP to design outreach on available insurance under the ACA, see Hill, Courtot, and Wilkinson (2013).
14. For example, those in the process of applying for visas based on being a victim of crime or experiencing domestic violence.

References

Brindis, Claire D., Max W. Hadler, Ken Jacobs, Laurel Lucia, Nadereh Pourat, Marissa Raymond-Flesch, Rachel Siemons, and Efrain Talamantes. 2014. *Realizing the Dream for Californians Eligible for Deferred Action for Childhood Arrivals (DACA): Demographics and Health Coverage*. Los Angeles: UCLA Center for Health Policy Research.

California Department of Health Care Services. 2011. *California's Bridge to Reform Demonstration - Low Income Health Program*. Sacramento: California Department of Health Care Services. http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/LIHP%20Fact%20Sheet.pdf.

Covered California. 2013. "Covered California Assisters Program: In-Person Assistance and Navigator Webinar." West Sacramento: Covered California. http://www.healthexchange.ca.gov/StakeHolders/Documents /Assisters%20Webinar%20FINAL02072013.pdf.

DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica C. Smith. 2012. *Income, Poverty, and Health Insurance Coverage in the United States: 2011*. Suitland, MD: Census Bureau.

Hill, Ian. 2012. *Cross Cutting Issues: Will There Be Enough Providers to Meet the Need? Provider Capacity and the ACA*. Washington, DC: Urban Institute. http://www.urban.org/publications/412700.html.

Hill, Ian, Brigette Courtot, and Margaret Wilkinson. 2013. *Reaching and Enrolling the Uninsured: Early Efforts to Implement the Affordable Care Act*. Washington, DC: Urban Institute. http://www.urban.org/publications/412917.html.

Insure the Uninsured Project. 2013. *ObamaCare 101 Tool Kit*. Santa Monica, CA: Insure the Uninsured Project.

Kenney, Genevieve M., and Michael Huntress. 2012. "The Affordable Care Act: Coverage Implications and Issues for Immigrant Families." ASPE Issue Brief. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation. http://www.urban.org/publications/413262.html.

Kenney, Genevieve M., Stephen Zuckerman, Lisa Dubay, Michael Huntress, Victoria Lynch, Jennifer Haley, and Nathaniel Anderson. 2012. *Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?*Washington, DC: Urban Institute. http://www.urban.org/publications/412630.html.

Migration Policy Institute. 2013. *2011 American Community Survey and Census Data on the Foreign Born by State*. Washington, DC: Migration Policy Institute. http://www.migrationinformation.org/datahub/acscensus.cfm.

NILC (National Immigration Law Center). 2012. *"Lawfully Present" Individuals Eligible under the Affordable Care Act*. Washington, DC: NILC.

Passel, Jeffrey S., and D'Vera Cohn. 2011. *Unauthorized Immigrant Population: National and State Trends, 2010*. Washington, DC: Pew Research Center.

Perreira, Krista M., Robert Crosnoe, Karina Fortuny, Juan Manuel Pedroza, Kjersti Ulvestad, Christina Weiland, Hirokazu Yoshikawa, and Ajay Chaudry. 2012. "Barriers to Immigrants' Access to Health and Human Services Programs." ASPE Research Brief. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation. http://www.urban.org/publications/413260.html.

Sommers, Benjamin D., and Sara Rosenbaum. 2011. "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth between Medicaid and Insurance Exchanges." *Health Affairs* 30 (2): 228–36. doi:10.1377/hlthaff.2010.1000.

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Essential Health Benefits: 50-State Variations on a Theme

In-Brief

All qualified health plans under the Affordable Care Act must cover a package of essential health benefits (EHBs) equal in scope to a typical employer plan. The law laid out 10 general categories of services that EHBs must cover, but did not itemize those services. As an interim policy for 2014 and 2015, the Department of Health and Human Services allowed each state to identify an existing plan as a benchmark for these EHBs. The result of this policy is that EHBs vary from state to state, often because of a legacy of different state-mandated benefits (such as treatments for autism, infertility, or temporomandibular joint disorders). This Data Brief analyzes state variation in coverage and limits for these non-uniform benefits.

Before the Affordable Care Act (ACA), no national standard defined a core set of benefits that should be provided by health insurance plans. States had widely varying mandates on specific services, providers, or populations that had to be covered, and on whether the mandates applied to plans sold on the individual, small-group, or large-group market. Self-insured plans were generally exempt from state mandates because they are governed by federal ERISA rules. State mandates were often the result of protracted political battles by advocacy groups and have been criticized for adding to premiums and reducing the affordability of coverage. However, the marginal costs of most state-mandated services are less than 1%, and their collective impact on premiums is generally less than 5% (see, for example, this Maryland analysis). Nevertheless, state mandates rarely reflect systematic decisions about the value and effectiveness of a particular service.

The ACA was supposed to change that. It required that new plans sold on the individual market or to small groups include a package of "essential health benefits (EHBs)" that covered 10 broad categories: (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) prescription 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. It directed the Secretary of the Department of Health & Human Services (DHHS) to specify the exact nature of the essential benefits package.

For both political and practical reasons, DHHS chose to allow states to define their own EHBs in 2014 and 2015 by picking an existing benefits package offered by one of a number of "benchmark plans" in the state. States could choose among the following benchmarks:

- one of the three largest plans, by enrollment, in the state's small-group market;
- one of the state's three largest state employee plans;
- one of the three largest Federal Employees Health Benefit Program options;
- the state's largest non-Medicaid HMO.

If the state did not choose, the default plan would be the largest small-group plan in the state. The benchmark plan's benefit package is taken as a whole, although plans could substitute an "actuarially equivalent" service within a given category. Most benchmark plans did not have coverage for three required categories: habilitative services, and pediatric oral and vision care. DHHS provided separate guidance on how states could augment their benchmark plans to cover these services.

States had an incentive to pick (or default to) a small-group plan, because that allowed states to incorporate the vast majority of their mandated services into their EHBs, at least for 2014 and 2015. This was important because the ACA requires states to defray the costs of state-mandated benefits that exceed EHBs in qualified health plans (QHPs).

Thus, EHBs in states in 2014 and 2015 are a product of 1) the state mandates in place in 2011 [prior to the ACA] and 2) the choice of a benchmark plan. While all EHBs include the 10 broad categories, they also include various state-mandated benefits, creating benefit packages that vary by state. This Data Brief reviews the choices each state made for a benchmark plan, and highlights some of the benefits that are not uniformly covered or are covered differently across states.

STATE CHOICES OF BENCHMARK PLANS

The following map displays each state's benchmark plan choices. Twenty-five states defaulted to the largest small-group plan in the state; 20 states and DC chose one of the small-group plans; two states chose a state employee plan; and three chose the largest HMO. None chose a federal employee plan.

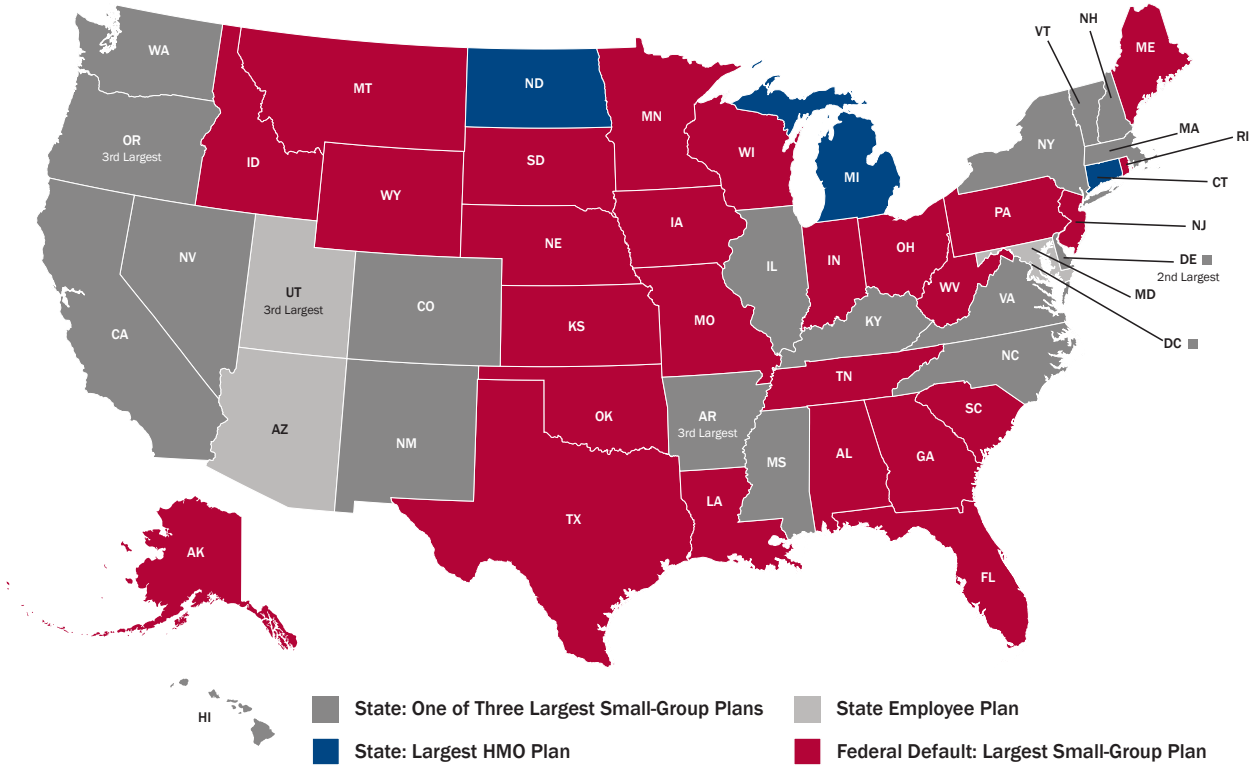
It is not surprising that 45 of 50 states have a small-group benchmark. Choosing a federal plan could have exposed the state to extra costs if a state-mandated benefit were not in the plan; alternately, the federal plan could have included benefits not generally available in the state's individual or small-group market. By choosing a benchmark plan that included state-mandated benefits, a state could avoid financial exposure, or the political ramifications of repealing existing state mandates.

Many of the states that chose a benchmark relied on actuarial analyses to assess the impact of each option on coverage of state-mandated benefits. The three states choosing their largest HMO as a benchmark did so after analyses showed that the option would cover all state-mandated benefits. Analyses in ND and MI concluded that the HMO was the least expensive alternative; in contrast, CT chose the HMO as a compromise between the "too generous" state employee plan and the "too restrictive" small-group plan in terms of several non-uniform benefits.

WHAT WE DID

The majority of data used in this brief was collected from the CMS Revised Benchmark Benefits Worksheet published May 22, 2014. This data set contained a collection of state-specific worksheets detailing essential health benefits, state required benefits, quantitative limits on benefits and other general coverage information for all 50 states and the District of Columbia. These worksheets were compiled to create summary data sets in order to compare the quantity of benefits covered between states and the rates of coverage by benefits. Summary statistics were calculated based on these compiled sets to allow for comparisons. We focused on 11 of the non-uniform services across EHBs, many of which were the subject of different state mandates. One frequent target of state mandates—Autism Spectrum Disorder (ASD)—was not systematically included in

State Essential Health Benefit Benchmark Plans



Source: Centers for Medicare and Medicaid Services

the CMS worksheets. To supplement, we gathered data on EHB coverage from Autism Speaks, an advocacy group monitoring the issue. We were unable to systematically identify the quantitative limits set on autism coverage, although many states had these limits prior to the ACA. We compiled data on five other services with highly variable quantitative limits, including three that were uniformly covered in all EHBs: hospice, home health, and outpatient rehabilitation.

WHAT WE FOUND

The interim policy that defined EHBs by benchmark plans resulted in benefit packages that varied considerably across states. On one hand, chiropractic care was most frequently included (45 states). On the other hand, acupuncture was rarely included (5 states). CA was an exception, because it included acupuncture in its EHBs but not chiropractic care. Just 20 states included routine foot care.

In terms of condition-specific services, 19 states included infertility treatments, 26 states covered autism spectrum disorder, and 31 states covered treatments for TMJ. Even within one condition, the range of services covered varied. For obesity, 23 states included bariatric surgery, but only 12 of them cover nutrition counseling and just three of them cover weight loss programs. Two states (DC and MI) cover the full range of nutrition counseling, weight loss programs, and bariatric surgery.

Autism Speaks identified 25 states and the District of Columbia that include applied behavior analysis in their benchmark plan. This is fewer than the 32 states that had state mandates prior to the EHB determination.

BENEFIT	STATES THAT CONSIDER BENEFIT AN EHB (%)
Chiropractic Care	45 (88%)
Treatment for TMJ Disorders	31 (61%)
Hearing Aids	26 (51%)
Autism Spectrum Disorder Services (including Applied Behavior Analysis)	26 (51%)
Nutrition Counseling	25 (49%)
Bariatric Surgery	23 (45%)
Routine Foot Care	20 (39%)
Infertility Treatments	19 (37%)
Private-Duty Nursing	19 (37%)
Acupuncture	5 (10%)
Weight Loss Programs	5 (10%)

Each state's EHB coverage is detailed below. States cluster into more "expansive" states that cover at least 8 of these services (IL, NM, NV) and less "expansive" ones, covering just one or two (AL, ID, NE, SC, PA, UT).

State	Infertility Treatments	Private-Duty Nursing	Bariatric Surgery	Chiropractic Care	Hearing Aids	Routine Foot Care	Acupuncture	Weight Loss Programs	Treatment for TMJ	Nutrition Counseling	ASD Services
AK				✓			✓				✓
AL	✓			✓							
AR	✓			✓	✓	✓			✓	✓	✓
AZ			✓	✓	✓	✓			✓	✓	✓
CA			✓				✓		✓		✓
CO		✓			✓					✓	✓
CT	✓			✓	✓					✓	✓
DC								✓		✓	✓
DE			✓	✓	✓						
FL				✓		✓			✓		
GA	✓			✓					✓		
HI	✓		✓		✓					✓	
IA	✓	✓	✓	✓					✓	✓	
ID				✓						✓	
IL	✓	✓	✓	✓	✓	✓			✓	✓	✓

State	Infertility Treatments	Private-Duty Nursing	Bariatric Surgery	Chiropractic Care	Hearing Aids	Routine Foot Care	Acupuncture	Weight Loss Programs	Treatment for TMJ	Nutrition Counseling	ASD Services
IN		✓		✓					✓		✓
KS	✓	✓		✓		✓			✓		
KY		✓		✓	✓				✓		✓
LA		✓		✓	✓	✓				✓	✓
MA	✓		✓	✓		✓		✓			✓
MD	✓		✓	✓	✓		✓		✓	✓	
ME			✓	✓	✓					✓	✓
MI			✓	✓				✓	✓	✓	✓
MN				✓	✓				✓		
MO		✓		✓	✓						
MS				✓		✓			✓		✓
MT	✓			✓		✓		✓	✓		✓
NC	✓	✓	✓	✓	✓	✓			✓		
ND		✓	✓	✓		✓			✓	✓	
NE				✓					✓		
NH			✓	✓	✓	✓			✓		✓
NJ	✓		✓	✓	✓				✓	✓	✓
NM	✓		✓	✓	✓		✓	✓	✓		✓
NV	✓	✓	✓	✓	✓	✓			✓		✓
NY	✓		✓	✓	✓				✓	✓	✓
OH		✓		✓					✓	✓	✓
OK		✓	✓	✓	✓	✓					
OR					✓	✓				✓	
PA				✓							
RI	✓	✓	✓	✓	✓	✓				✓	
SC				✓		✓					
SD	✓	✓	✓	✓					✓		
TN				✓	✓				✓	✓	
TX				✓	✓	✓			✓	✓	✓
UT										✓	
VA		✓		✓					✓	✓	
VT		✓	✓	✓		✓				✓	✓
WA				✓	✓	✓	✓		✓	✓	
WI				✓	✓				✓		✓
WV		✓	✓	✓					✓		✓
WY	✓	✓	✓	✓							

QUANTITATIVE LIMITS OF COVERAGE

The ACA prohibits annual or lifetime dollar limits on EHBs. However, states that had mandates with dollar limits could impose non-monetary limits on services that were actuarially equivalent to the dollar limit.

States varied considerably on whether they imposed quantitative limits of services, and on the range of episodic, yearly, or lifetime limits if they did so. For example, all states cover home health as an EHB, but 31 limit coverage to an average of 83.6 days/visits per year, ranging from 30 days/visits in OK and UT to 180 days/visits in MT. Similarly, all states cover outpatient rehabilitation, but 11 states impose limits ranging from 20 visits per year in MS and WY to 60 visits per year in AZ and NV. All states cover hospice services, but 10 states limit coverage in a variety of units, from 14 days per lifetime in WA, 30 days per year in MN, 210 visits per year in NY, 6 months per episode in SC, and 6 months per lifetime in MS. Of the 48 states that cover skilled nursing facilities as an EHB, 37 impose a limit that averages 74 days per year or benefit period, with a range from 25 days in TX to 200 days in NY.

Of the states including chiropractic care, about half impose limits that average 18.6 visits per year, with a range of 10 visits in WA and 40 visits in ME. Interestingly, two states report dollar limits on chiropractic care ($600 per year in AL, $1,000 per year in IL), although those limits cannot be applied to EHBs under the ACA.

POLICY IMPLICATIONS

By design, EHBs vary from state to state in the first two years of the ACA. DHHS chose this strategy to take advantage of existing benefit plans and pricing in the states and to avoid a potentially long and difficult negotiation to define one national benefits package. DHHS has said that it will re-evaluate this strategy for 2016.

This brief describes some of these differences, often a legacy of the many state insurance mandates fought for, and won, in state capitals. This is a far less viable strategy for expanding coverage now, since no mandates passed beyond 2011 are considered EHBs.

In 2011, the Institute of Medicine (IOM) recommended a process for establishing a single national benefit package. It focused on selecting services based on medical effectiveness and affordability, rather than simply including state mandates. These recommendations have yet to be implemented.

The range and scope of services included in EHBs directly affect the affordability of coverage in the individual and small-group market. On the one hand, some might argue that the market has determined this trade-off in each state, and that the benefit package in the benchmark plan fairly represents EHBs as reflected in a typical employer plan. On the other hand, others might argue for a more comprehensive approach that uses consistent criteria and methods to determine uniform EHBs in all states. For now, some benefits will remain essential in some states, and not essential in others.

BENEFIT (STATES THAT COVER BENEFIT)	STATES W/QUANTITATIVE LIMIT ON BENEFIT	AVERAGE LIMIT OF DAYS/VISITS PER YEAR OR BENEFIT PERIOD (RANGE)
Skilled Nursing Facility (48)	37	74.1 (25-200)
Home Health (51)	31	83.6 (30-180)
Chiropractic (45)	27	18.6 (10-40)
Outpatient Rehab (51)	11	35.9 (20-60)
Hospice (51)	10	N/A

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This Data Brief was written by Janet Weiner, MPH, and Christopher Colameco.

About The Leonard Davis Institute of Health Economics

The Leonard Davis Institute of Health Economics (LDI) is the University of Pennsylvania's center for research, policy analysis, and education on the medical, economic, and social issues that influence how health care is organized, financed, managed, and delivered. LDI, founded in 1967, is one of the first university programs to successfully cultivate collaborative multidisciplinary scholarship. It is a cooperative venture among Penn's health professions, business, and communications schools (Medicine, Wharton, Nursing, Dental Medicine, Law School, and Annenberg School for Communication) and the Children's Hospital of Philadelphia, with linkages to other Penn schools, including Arts & Sciences, Education, Social Policy and Practice, and Veterinary Medicine.

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ACA Implementation—Monitoring and Tracking

Narrow Networks, Access to Hospitals and Premiums:

An Analysis of Marketplace Products in Six Cities

October 2014

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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. This report is one of a series of papers focusing on particular implementation issues in case study states. 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. For more information about the Robert Wood Johnson Foundation's work on coverage, visit **www.rwjf.org/coverage**.

INTRODUCTION

One objective of the health insurance Marketplaces created through the Affordable Care Act (ACA) is to encourage competition among insurers with the goal of lower premiums for consumers and lower subsidy costs for the federal government. This has already been achieved in many geographic areas.[1] One strategy insurers have used to offer lower premiums and capture market share has been the creation of "narrow networks" of providers and facilities. The option to offer limited network plans can be used to negotiate lower provider payment rates. For example, insurers can choose to exclude high-cost hospitals to keep premiums low. Or insurers can direct higher volumes of patients to hospitals that are willing to negotiate lower provider payment rates and meet other standards for care management.

In this first year of ACA implementation, many insurers negotiated new hospital network arrangements for Marketplace products. In some cases, providers or facilities that have historically been "in-network" for a given insurer may not be included in that insurer's new Marketplace plans. In other cases, insurers with historical relationships with providers might have leverage to negotiate lower rates, which can lead to lower premiums for consumers without the need to use narrow networks. In strategic partnerships, hospital systems may be willing to negotiate lower than historic rates if their competitors are excluded from an insurer's new network.

Though narrow network products might be sufficient for some consumers, they could be too narrow for others. For example, a network that excludes an academic medical center (AMC) could be problematic for some consumers who require access to specific expertise or innovative types of care that are not considered medically necessary by the insurer. However, insurers will often pay for medically necessary care even if that care is not available in the plan's network; this means that individuals might have access to non-network hospitals in certain circumstances, although there is disagreement about what is "medically necessary."

The ACA includes network adequacy requirements, but there remains considerable variation in the breadth of acceptable hospital networks and the options available in each. In this brief, we investigate which hospitals are included in Marketplace plans in major cities in six states. We also examine how hospital networks vary across plans within a single insurer and across all insurers.

We conclude that almost all insurers offer plans that include in their networks access to many highly ranked hospitals. Moreover, all hospitals in the cities we examined were in at least one Marketplace plan's networks. Finally, the size of networks was not necessarily tied to premiums. Though narrowing networks generally led to more-competitive and lower premiums (and certainly lower than if the same insurer had a broader network), some plans with broad networks had low premiums and some with narrow networks had high premiums. Insurer market share and negotiating power can influence premiums independently of network size.

METHODS

In this brief, we examine six cities: Denver, Colorado; Portland, Oregon; New York City (Manhattan), New York; Providence, Rhode Island; Baltimore, Maryland; and Richmond, Virginia. In each area, we count the number of hospitals included in each plan offered by each insurer for each of their silver-tier Marketplace plans. We look at the silver-tier products because cost-sharing subsidies are tied to plans in this tier (though premium subsidies can also be applied to plans at other tiers). Hospitals are limited to general- or acute-care hospitals that were within city (or borough) limits (e.g., Portland, but not Vancouver; Manhattan, but not Brooklyn). We make an exception to include Aurora (just outside Denver) in Colorado, because two major hospitals, including the University of Colorado Hospital, are located there. Additionally, specialty hospitals, rehabilitation hospitals, psychiatric hospitals and Veterans Health Administration hospitals are excluded from the analysis. Women's and children's hospitals are included only if they were a stand-alone hospital (i.e., children's hospitals that are associated with a general hospital were not counted individually). We include one specialty hospital: Memorial Sloan Kettering Cancer Center in Manhattan. Although it is not a typical acute-care hospital, Memorial Sloan Kettering Cancer Center provides state-of-the-art cancer care, and we wanted to study its inclusion in hospital networks among products offered in Manhattan.

To establish which hospitals were included within the network of a given insurer, we use the provider and facility search functions available on each insurer's website. These provider search functions' ease of use varies widely. In some cases, it is not possible to view the specific provider networks associated with a certain plan; instead, the consumer can only view the insurer's entire network of providers for all plans. If insurers use different networks for their Marketplace products and do not indicate this on their website, these differences could be missed. At the time of writing, only one study state, Colorado, has hospital search functionality embedded on its state-based Marketplace. For Colorado, we first use the Marketplace's embedded hospital search function. We confirm the findings by using insurer's websites, and where there were discrepancies, we report the information found on the insurer's website instead of the Colorado Marketplace. Colorado's Marketplace provider and hospital search functionality is somewhat limited at the time of our study, as described in previous research.[2]

We use outside data to classify hospitals by "top hospital" status, defined as whether or not they were ranked by *U.S. News and World Report* as a top hospital in 2013. The *U.S. News and World Report* rankings are based on data from the Centers for Medicare and Medicaid Services's MedPAR database, the Agency for Healthcare Research and Quality, the American Hospital Association, other professional organizations and physician surveys. Hospitals are scored in four domains: reputation, patient survival, patient safety and care-related factors (e.g., nurse staffing and the variety of patient services). The methodology is described in further detail in a report published by RTI.[3]

We also classify hospitals by whether they are AMCs. AMCs are hospitals that are affiliated with an accredited medical school and frequently conduct clinical research and cutting-edge procedures, especially for rare conditions. Though there is not clear evidence showing that AMCs consistently provide better quality of care, this is generally the case, especially for conditions that require state-of-the-art care. For example, every AMC in our sample is also considered a top hospital by *U.S. News and World Report*. AMCs also tend to be more expensive than non-AMCs for many reasons, including that they serve as training centers for medical professionals and that they are sometimes primary sources of care for the indigent and uninsured. There is no universal definition for AMCs, and no exhaustive list, so for the purposes of this study we define AMCs as member teaching hospitals of the Association of American Medical Colleges.[4] The Association of American Medical Colleges comprises approximately 400 teaching hospitals and health systems throughout the country. There is at least one AMC in each of our study areas. Top hospital and AMC totals in each urban area can be found in tables 2a through 2f.

We also include a patient experience measure: we note which hospitals scored better than their state's average on a measure of the percentage of patients who said they would "definitely recommend the hospital." The data for this measure comes from the Hospital Consumer Assessment of Healthcare Providers and Systems survey, which is administered to a random sample of patients between 48 hours and six weeks after discharge.[5] The data was collected between October 1, 2012, and September 30, 2014.[5]

We also note plan type (health maintenance organization [HMO], preferred provider organization [PPO], exclusive provider organization [EPO], or point of service plan [POS]) as an indication of relative network size. Generally, HMOs and EPOs offer more-limited networks; PPOs and POSs tend to afford greater choice with both in-network and out-of-network options. HMOs and EPOs generally do not reimburse for care received from an out-of-network provider except for emergency care and other specific conditions. PPO and POS plans provide some reimbursement for care received from out-of-network providers, though this care comes at a higher out-of-pocket cost to the consumer. Some states' Marketplace websites prominently display plan type for each product; in other cases, this information is less clear.[2]

In our analysis, we focus on hospitals instead of physicians or another type of facility (e.g., clinics) because there is not a universally accepted way to rank physicians; therefore, we would not have had an effective way to designate which physicians were the best, and it would have been misleading to extrapolate about what it meant for any certain physicians to be included or excluded from a network. Similarly, it would be difficult to determine which clinics were the best. This is not intended to indicate that physicians are an unimportant element of networks; in fact, physicians may be more critical to network adequacy than hospitals, and certainly a necessary part of discussions on network adequacy. Past research highlighted the challenges consumers face in determining physician network breadth and quality.[2]

LIMITATIONS

Our research is based on the available provider search functions for each insurer; we did not confirm the accuracy of those directories. Most provider search functions included a recommendation that the consumer call their desired provider to ensure that she, he, or the facility was included in the network before purchasing the product. Confirming the accuracy of the hospital networks described here would require confirming with each insurer in each study area; this was outside the scope of this project. Instead, we report on the information that is available to consumers using the hospital search functions for the insurers in the study areas.

It is difficult to establish which hospitals are top hospitals based on any objective criteria. There is no universal standard for designating which hospitals provide the highest-quality care or what the most appropriate quality measures are. There are many databases and surveys available that attempt to rank hospitals based on several data sources. *U.S. News and World Report* is one of these sources; we use it because we believe it serves as an acceptable summary measure. The *U.S. News and World Report* hospital rankings are intended for "the most difficult patients."[6] We supplement these rankings with a patient experience measure obtained from the Centers for Medicare and Medicaid Services's Medicare Compare tool. We acknowledge that the ranking methodologies of hospitals are imperfect, but there is no perfect alternative.

Lastly, our analysis includes only urban areas. Networking arrangements might be different in suburban or rural areas. Generally, it is difficult to develop narrow networks in rural areas because they already offer few providers to choose from.

RESULTS

Health insurance plans offer many hospital network configurations. In most areas, consumers can choose between relatively narrow and relatively broad hospital networks. With one exception, every insurer in our analysis offers a hospital network that included at least one top hospital (discussed below). Further, every hospital in our study is included in at least one plan's network. Our review of provider directories indicated that the majority of insurers use one hospital network across all their products, rather than using differently sized networks for differently priced products. Table 1 shows the number of hospitals included in each plan's network and the subset of those hospitals that are top hospitals (as defined by *U.S. News and World Report*) or an AMC. If insurers offer the same network for all plans, these are listed together in a single row. If insurers offer several plans with different networks, these are listed in individual rows.

Table 1. Hospital Networks for Health Insurance Marketplace Plans

		Plan Type	Premium range for all insurers' silver plans (27 year-old)	Number of hospitals in network (out of total hospitals in area)	Number of top hospitals in network (out of total top hospitals in area)	Number of academic medical centers in network (out of total AMCs in area)	Number of hospitals in network with high patient experience score (out of total hospitals with high patient experience scores in area)[a]
Denver, Colorado	Kaiser	HMO	$201 to $214	3 (of 9)	2 (of 8)	1 (of 4)	2 (of 4)
	Humana	HMO	$205 to $208	2 (of 9)	2 (of 8)	1 (of 4)	0 (of 4)
	Colorado HealthOP	EPO	$224	1 (of 9)	1 (of 8)	0 (of 4)	0 (of 4)
	Colorado HealthOP	PPO	$258	6 (of 9)	6 (of 8)	4 (of 4)	3 (of 4)
	Denver Health	HMO	$225	1 (of 9)	1 (of 8)	1 (of 4)	0 (of 4)
	Denver Health	HMO	$262	3 (of 9)	3 (of 8)	3 (of 4)	1 (of 4)
	Rocky Mountain Health Plan	HMO	$254 to $320	6 (of 9)	5 (of 8)	2 (of 4)	3 (of 4)
	Cigna	PPO	$261 to $293	9 (of 9)	8 (of 8)	4 (of 4)	4 (of 4)
	Anthem BCBS	HMO	$262 to $291	4 (of 9)	4 (of 8)	1 (of 4)	2 (of 4)
	Access Health Colorado	PPO	$372 to $377	[provider search unavailable]			
Baltimore, Maryland	CareFirst	HMO/POS	$187 to $194	8 (of 13)	7 (of 12)	4 (of 6)	6 (of 9)
	Blue Cross Blue Shield multistate plan	PPO	$197	8 (of 13)	7 (of 12)	4 (of 6)	6 (of 9)
	Evergreen	HMO/POS	$207 to $259	11 (of 13)	11 (of 12)	5 (of 6)	9 (of 9)
	Kaiser	HMO	$221 to $233	2 (of 13)	2 (of 12)	0 (of 6)	1 (of 9)
	United	EPO	$270 to $282	12 (of 13)	11 (of 12)	5 (of 6)	8 (of 9)

Table 1. Hospital Networks for Health Insurance Marketplace Plans *continued*

		Plan Type	Premium range for all insurers' silver plans (27 year-old)	Number of hospitals in network (out of total hospitals in area)	Number of top hospitals in network (out of total top hospitals in area)	Number of academic medical centers in network (out of total AMCs in area)	Number of hospitals in network with high patient experience score (out of total hospitals with high patient experience scores in area)[a]
New York (Manhattan), New York	MetroPlus	HMO	$359 to $374	5 (of 11)	3 (of 8)	2 (of 7)	1 (of 4)
	Health Republic	EPO	$365 to $387	9 (of 11)	7 (of 8)	6 (of 7)	3 (of 4)
	Oscar	EPO	$385 to $419	11 (of 11)	8 (of 8)	7 (of 7)	4 (of 4)
	EmblemHealth	HMO	$385	4 (of 11)	4 (of 8)	4 (of 7)	2 (of 4)
	Fidelis Care	HMO	$390	10 (of 11)	7 (of 8)	6 (of 7)	4 (of 4)
	Empire Blue Cross	HMO	$416 to $439	5 (of 11)	5 (of 8)	5 (of 7)	3 (of 4)
	Healthfirst	HMO	$440	8 (of 11)	5 (of 8)	4 (of 7)	2 (of 4)
	Affinity	HMO	$440 to $442	6 (of 11)	5 (of 8)	5 (of 7)	4 (of 4)
	United	EPO	$642	9 (of 11)	6 (of 8)	5 (of 7)	3 (of 4)
Portland, Oregon	Moda	PPO	$159	2 (of 6)	2 (of 5)	0 (of 1)	2 (of 6)
	Moda	PPO	$165	4 (of 6)	3 (of 5)	1 (of 1)	4 (of 6)
	Moda	PPO	$175 to $204	6 (of 6)	5 (of 5)	1 (of 1)	6 (of 6)
	HealthNet	POS	$176 to $181	3 (of 6)	2 (of 5)	0 (of 1)	3 (of 6)
	Providence	EPO	$192 to $232	2 (of 6)	2 (of 5)	0 (of 1)	2 (of 6)
	PacificSource	PPO	$203 to $216	5 (of 6)	5 (of 5)	1 (of 1)	5 (of 6)
	LifeWise	PPO	$203 to $220	3 (of 6)	3 (of 5)	1 (of 1)	3 (of 6)
	Kaiser	HMO	$210	2 (of 6)	2 (of 5)	1 (of 1)	2 (of 6)
	Health Republic	EPO	$210 to $221	2 (of 6)	2 (of 5)	0 (of 1)	2 (of 6)
	Oregon's Health Co-op	PPO	$223 to $230	6 (of 6)	5 (of 5)	1 (of 1)	6 (of 6)
	Bridgespan	PPO	$228	2 (of 6)	1 (of 6)	1 (of 6)	2 (of 6)
Providence, Rhode Island	Blue Cross Blue Shield of Rhode Island	PPO	$225 to $250	5 (of 5)	3 (of 3)	3 (of 3)	3 (of 3)
Richmond, Virginia	Coventry	POS	$188	6 (of 6)	2 (of 2)	1 (of 1)	6 (of 6)
	Anthem	HMO	$208 to $221	3 (of 6)	0 (of 2)	0 (of 1)	3 (of 6)
	Aetna	PPO	$260 to $284	6 (of 6)	2 (of 2)	1 (of 1)	6 (of 6)
	Optima	HMO	$285	6 (of 6)	2 (of 2)	1 (of 1)	6 (of 6)

[a] *Hospitals receive a "high patient experience score" if they score higher than their state's average on the percentage of patients who say they would "definitely" recommend the hospital.*

Specific results are described here by city.

Denver, Colorado

There are nine hospitals in Denver; eight are designated as top hospitals and four are AMCs. Each hospital is included in at least one plan, and some are included in nearly all plans. For example, Porter Adventist Hospital is included in all plans except those offered by Denver Health and Anthem. Cigna offers the most generous hospital network in Denver: it includes all nine hospitals; it also has relatively high premiums. Colorado HealthOP and Denver Health each offer two separate hospital networks for their two plans: one wider network and one narrower network. For example, Colorado HealthOP's low-cost narrow EPO network includes only a single hospital in Denver. Its pricier PPO product includes the majority of hospitals in Denver: six in total, including six top hospitals and four AMCs. Rocky Mountain Health Plan is based in Grand Junction and is a dominant insurer in that part of the state. When they began offering products in the Denver area, Rocky Mountain Health Plan had to create new contracting arrangements because they did not have historical relationships with providers in that area. Their Marketplace offerings in Denver have a relatively wide hospital network, which likely contributes to high premiums.

On the other hand, Kaiser has a relatively small hospital network in this area and offers the lowest-cost plan in Denver. As an integrated health plan, Kaiser can use several strategies to keep premiums low, though they are not the lowest-cost plan in all our study areas (see Maryland). Humana also has a narrow hospital network and low premiums. Even with narrower networks, however, the plans offered by these carriers each include multiple hospitals, among which are an AMC, top hospitals, and hospitals with high patient experience ratings.

Baltimore, Maryland

Maryland is unique in that it utilizes an all-payer rate-setting system for hospital services. Under this system, all insurers pay the same rates for services provided by a given hospital. These rates can and do vary between hospitals, however. In Maryland, insurers don't have the ability to negotiate for lower payment rates based on increased volume. They can, however, contract with lower-cost hospitals; insurers that contract with lower-cost hospitals can offer lower premiums.

Baltimore boasts a large number of high-quality hospitals. There are 13 hospitals in total; 12 are top hospitals and 6 are AMCs. Of the five insurers that offer plans in Baltimore, all but Kaiser include a majority of these hospitals. CareFirst and the Blue Cross Blue Shield multistate plan are the lowest-cost products in Baltimore; each includes 8 of the 13 hospitals in their networks. CareFirst and the Blue Cross Blue Shield multistate plans have the lowest premiums in the city, despite their broad networks; this is perhaps because of their negotiation leverage with other providers. Other insurers offer even broader hospital networks in Baltimore. Of the 13 hospitals in Baltimore, Evergreen (a co-op) includes 11 and United includes 12. Evergreen and United have the highest premiums in the city. Conversely, Kaiser covers only two hospitals, neither of which is an AMC. Based on its limited network, one might expect that Kaiser would be one of the cheapest plans in the area, but its premiums are well above CareFirst's. This may reflect problems developing their physician network.

Johns Hopkins Hospital, the highest-ranked hospital in Baltimore according to *U.S. News and World Report*, is included in three of the five insurer's networks. Kaiser and United both exclude it and it is the only hospital in Baltimore that United excludes. The Johns Hopkins system has another teaching hospital in East Baltimore called the Johns Hopkins Bayview Medical Center. This is also a highly ranked teaching hospital and it is included in all networks except Kaiser's.

New York (Manhattan), New York

In Manhattan, there are 11 hospitals, 8 of which are top hospitals and 7 of which are AMCs. Of the 11 hospitals in Manhattan, only 4 received higher than average scores on the patient experience measure (data was unavailable for two of the hospitals).

The nine insurers offering products in Manhattan include anywhere from 4 of the 11 hospitals (EmblemHealth) to all 11 (Oscar). In general, networks are broad. Some hospitals are included in networks more frequently than others. For example, Beth Israel Medical Center—a highly ranked teaching hospital affiliated with the Mount Sinai School of Medicine—is included in every insurer's network. Similarly, St. Luke's-Roosevelt Hospital Center, another highly ranked teaching hospital affiliated with Mount Sinai School of Medicine, is in-network for all insurers except MetroPlus. Conversely, the Memorial Sloan Kettering Cancer Center is only included in Health Republic (a co-op) and Oscar's networks. Other hospitals are included in a majority of insurer's networks. Consequently, a consumer can purchase virtually any plan offered in Manhattan and be assured that she or he will have access to a top hospital.

There is not a clear link between hospital networks and premiums. Manhattan is unique in that there are several insurers (e.g., MetroPlus and Fidelis Care) that previously offered Medicaid-only insurance products. Because of this, these insurers already had well-established relationships

with providers in Manhattan and presumably were able to negotiate or maintain rates lower than typical private-sector levels. Not all former Medicaid plans, however, have low premiums (e.g., Health First and Affinity). United stands out as a carrier with a broad network and high premiums, but Oscar has an even broader hospital network and lower premiums.

Portland, Oregon

There are six hospitals in Portland; only one is an AMC, but five are top hospitals. The AMC is associated with the Oregon Health and Sciences University and includes a children's hospital. All six hospitals in Portland received higher than the state's average on the patient experience measure. Of the nine insurers that offer products in Portland, one (Moda) uses different networks for its various plans. Moda offers five silver plans in Portland with premiums ranging from $159 to $204 for a 27-year-old. The lowest-cost plan has a relatively narrow network that includes only two hospitals (both in the Providence system) and excludes the AMC. The network for Moda's midrange silver-tier plan includes four hospitals, one of which is the AMC. Moda's highest-cost silver-tier plan considers all six Portland hospitals to be in-network. The other insurers in Portland include between two and four hospitals, with the exceptions of PacificSource, which includes five hospitals, and Oregon's Health Co-op, which covers all six hospitals in the city.

HealthNet is a good example of an insurer that utilizes a relatively narrow network (it includes three hospitals in Portland and excludes the AMC) and is thus able to offer low premiums. Similarly, Providence is an integrated health system; thus, it is able to rely on its own hospitals in the hospital network and offer lower premiums. The two co-ops in Oregon—Health Republic and Oregon's Health Co-op—offer some of the most expensive products in the study area. This could be because they are unable to negotiate favorable rates with providers given their lack of historical relationships. However, the two co-ops take different approaches to building hospital networks: Health Republic offers a very limited network in Portland, but Oregon's Health Co-op includes all six hospitals in the city.

Overall, each hospital in Portland is included in the network of at least one insurer, and the AMC is included in at least one plan offered by six of the nine insurers in the city. Many insurance products offered in Portland also include health facilities across the border in Washington, though we do not include those facilities in our analysis.

Providence, Rhode Island

Blue Cross Blue Shield Rhode Island is the only insurer offering individual coverage in Providence. Neighborhood Health Plan offers coverage to those with incomes under 250 percent of the federal poverty level. We only included Blue Cross Blue Shield Rhode Island in this analysis. Blue Cross Blue Shield Rhode Island's network includes all five hospitals in Providence, three of which are top hospitals and AMCs associated with Brown University's Warren Alpert Medical School. An individual purchasing Blue Cross Blue Shield Rhode Island through the state's Marketplace should have access to all acute-care hospitals in Providence. Because Blue Cross Blue Shield Rhode Island is the dominant insurer in Providence (and throughout Rhode Island), it does not face the same pressures to keep premiums low as carriers in other states. Consequently, it offers a broad hospital network at a relatively high cost.

Richmond, Virginia

There are six general, acute-care hospitals in Richmond, two of which are top ranked and one of which is an AMC. Of the six hospitals in Richmond, three are Hospital Corporation of America (HCA, a major national chain) affiliates, two are in the Bon Secours system and one is the AMC associated with the Virginia Commonwealth University School of Medicine. All six hospitals in Richmond received relatively high scores on the patient experience measure. Of the four insurers that offer plans in Richmond, all but Anthem include all six hospitals in their networks. Anthem includes only the three HCA hospitals, none of which are top hospitals or AMCs. These three hospitals however, all scored well on the patient experience measure. The Anthem–HCA relationship, together with its leverage over nonhospital providers, keeps its premiums relatively low.

Cross-Study Area Observations

The majority of insurers in our study areas offer the same hospital network, whether it is relatively narrow or relatively broad, for all its products. The number of hospitals included in these networks varies widely among insurers. One reason for this is insurers can lower costs by contracting with only a select number of hospitals and directing volume toward those facilities. It is not necessarily beneficial for insurers to contract with different hospitals for different health insurance products.

Some insurers offer only a limited network (for example, Colorado HealthOP and Denver Health each offer a narrow network plan that includes only one hospital); other insurers offer an extensive network (for example, Cigna in Denver and Oscar in Manhattan each include all hospitals in their respective areas). Most offer a network of hospitals, though not all hospitals in the area. In some cases, even though a carrier includes a relatively small number of hospitals, the included hospitals are AMCs or top hospitals. For example, in Colorado, Kaiser's network includes only three of Denver's nine hospitals, but two of these are top hospitals and

one is an AMC. In other words, even though the network is relatively narrow, it is likely that a consumer could still access high-quality care.

Looking across carriers, almost every hospital is included in at least one plan's network. AMCs are included in nearly all products offered in Manhattan, Baltimore, Richmond and Providence, but they are included in only about half of the products offered in Denver and Portland. With only a single AMC in Portland, one might expect that all insurers would include it in their hospital networks, but that was not the case. Conversely, in an area rich with AMCs such as Manhattan, every insurer includes at least two.

There is some correlation between the price of a product and the size of its network, but this relationship is not perfect. For example, Oscar in New York and CareFirst in Baltimore have very broad hospital networks but relatively low premiums. United in New York and Baltimore have broad networks and high premiums. Moda Health in Portland has a narrow network plan and the lowest premium, but MetroPlus in Manhattan has a fairly broad network, but offers the cheapest product. This is likely because of MetroPlus's existing relationships with providers having strengthened its ability to negotiate favorable rates.

In addition to price, plan type is somewhat correlated with network size. HMO and EPO products generally have more-restrictive networks, but this correlation is not strong. However, as noted earlier, consumers who purchase PPO and POS products have the option to receive care out-of-network, albeit at a higher cost to them.

Interestingly, some of the co-ops in our sample areas have some of the widest hospital networks: Colorado HealthOP's PPO product, Evergreen, and Oregon's Health Co-op are among the widest hospital networks in Denver, Baltimore and Portland, respectively. However, this was not true in all cases. Health Republic, a co-op in Oregon, offers one of the highest-priced products in Portland but has the smallest hospital network in the city. Its hospital network includes only two hospitals, neither of which is the AMC in the city. One reason co-ops tend to have high prices and relatively broad networks is because they have a harder time negotiating favorable rates. This is because they are new participants in a market and thus lack pre-ACA market share.

We find that generally, it would be cumbersome for a consumer to discern the relative size of hospital networks among Marketplace products. If a consumer knows the name of a specific facility, it is possible to use an insurer's website to establish whether the facility is included in the network. But, as described earlier, each insurer's website is different, and there is no straightforward way to compare plans' networks directly. For all our study areas, with the exception of Denver, the consumer needs to leave the Marketplace and navigate a new website to learn about the plan's network. Leaving the Marketplace can be complicated for someone who is not computer-savvy, and doing so creates many distractions that could prevent an individual from ultimately selecting a plan. Unfortunately, these conditions mean that many consumers are likely unaware of exactly what they are purchasing on the Marketplace and whether his or her desired facility (or provider) is included in the network. Another paper in this series deals with this issue in greater depth, focusing on physician search functionality.[2] As we find in the current analysis, plans vary widely in the size of their hospital networks and some are very narrow. Thus, that consumers may not be aware of what they are buying is worrisome.

CONCLUSION

Our analysis shows that hospital networks vary widely among health insurance plans offered in Marketplaces in our study areas. Almost all insurers offer access to highly ranked hospitals in their networks. And all hospitals in an area are included in at least one insurer's network. Finally, though narrow networks usually lead to lower premiums, this is not always true. Some plans with broad networks have low premiums and some with narrow networks have high premiums. Thus, other factors affecting insurer negotiating power are important.

Of some concern is the finding that it is difficult for the average consumer to accurately compare the size and quality of hospital networks across insurance plans. Consumers who know what hospital they want included in their network may be able to select an appropriate plan, but it would be difficult to otherwise compare plans by the breadth of hospital networks. Although outside the scope of this research, physician network adequacy is another important aspect of this discussion. Future improvements to state-based and federally facilitated Marketplace websites should better enable consumers to view the size and quality of each plan's network. In the meantime, this research indicates that in six major cities, most consumers can find a plan on the Marketplace that includes his or her desired hospital, and that even relatively narrow networks are likely to include at least one high-quality hospital.

Table 2a. General Acute-Care Hospital Networks for Marketplace Plans in Denver and Aurora, Colorado

Insurer	Plan type	Premium range for 27-year-old	Children's Hospital Colorado*+a	Denver Health Medical Center*+	Exempla St. Joseph Hospital^	Medical Center of Aurora*	National Jewish Health*+^	Porter Adventist*	Presbyterian-St. Luke's Medical Center*	Rose Medical Center*^	University of Colorado Hospital*+^
Kaiser	HMO	$201 to $214			✓		✓	✓			
Humana	HMO	$205 to $208	✓					✓			
Colorado HealthOP	EPO	$224						✓			
Colorado HealthOP	PPO	$258	✓	✓			✓	✓		✓	✓
Denver Health	HMO	$225		✓							
Denver Health	HMO	$262	✓	✓							✓
Rocky Mountain Health Plan	HMO	$254 to $320	✓		✓		✓	✓	✓	✓	
Cigna	PPO	$261 to $293	✓	✓	✓	✓	✓	✓	✓	✓	✓
Anthem	HMO	$262 to $291				✓			✓	✓	✓
Access Health	PPO	$372 to $377	[provider search was unavailable at the time of our study]								

Key
* *Top hospital*
\+ *Academic Medical Center*
^ *Hospital ranked equal to or higher than the state average for a patient experience measure: "percent of patients who reported they would definitely recommend the hospital." In Colorado the state average is 76 percent.*
a *Patient experience data not available for most recent reporting period.*

Table 2b. General Acute-Care Hospital Networks for Marketplace Plans in Baltimore, Maryland

Insurer	Plan type	Premium range for 27-year-old	Bon Secours Baltimore	Greater Baltimore Medical Center*^	Harbor Hospital*^	Johns Hopkins Hospital*+^	Johns Hopkins Bayview Medical Center*+	Maryland General Hospital*+	MedStar Franklin Square Medical Center*+^	MedStar Good Samaritan*^	MedStar Union Memorial*^	Mercy Medical Center*+^	Sinai Hospital of Baltimore*^	St. Agnes Hospital*	University of Maryland Medical Center*+^
CareFirst	HMO/POS	$187 to $194	✓	✓	✓	✓	✓					✓	✓		✓
BCBS MSP	PPO	$197	✓	✓	✓	✓	✓					✓	✓		✓
Evergreen	HMO/POS	$207 to $259		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Kaiser	HMO	$221 to $233		✓										✓	
United	EPO	$270 to $282	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓

Key
* *Top hospital*
\+ *Academic Medical Center*
^ *Hospital ranked equal to or higher than the state average for a patient experience measure: "percent of patients who reported they would definitely recommend the hospital." In Maryland the state average is 67 percent.*

Table 2c. General Acute-Care Hospital Networks for Marketplace Plans in New York (Manhattan), New York

Insurer	Plan type	Premium range for 27-year-old	Bellevue Hospital Center	Beth Israel Medical Center*+	Harlem Hospital Center*	Lenox Hill Hospital*+^	Memorial Sloan-Kettering Cancer Center*+a	Metropolitan Hospital Center	Mount Sinai Medical Center*+^	NY Downtown Hospital1	NYU Langone Tisch Medical Center*+^	NY Presbyterian University Hospital of Columbia and Cornell*+^	St. Luke's-Roosevelt Hospital Center*+
MetroPlus	HMO	$359 to $374	✓	✓	✓			✓			✓		
Health Republic	EPO	$367 to $387	✓	✓	✓		✓	✓	✓		✓	✓	✓
Oscar	EPO	$385 to $420	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
EmblemHealth	HMO	$385		✓		✓			✓				✓
Fidelis Care	HMO	$390	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
Empire Blue Cross	HMO	$418 to $439		✓		✓			✓	✓		✓	✓
Healthfirst	HMO	$440	✓	✓	✓	✓		✓	✓	✓			✓
Affinity	HMO	$440 to $442		✓		✓			✓		✓	✓	✓
United	EPO	$642	✓	✓	✓	✓		✓		✓	✓	✓	✓

Key
* *Top hospital*
\+ *Academic Medical Center*
^ *Hospital ranked equal to or higher than the state average for a patient experience measure: "percent of patients who reported they would definitely recommend the hospital." In New York, the state average is 65 percent.*
[a] *Patient experience data not available for most recent reporting period.*

Table 2d. General Acute-Care Hospital Networks for Marketplace Plans in Portland, Oregon

Insurer	Plan type	Premium range for 27 year-old	Adventist Medical Center^	Legacy Emanuel Hospital and Health System*^	Legacy Good Samaritan Hospital*^	Oregon Health and Science University*+^	Providence Portland Medical Center*^	Providence St. Vincent Medical Center*^
Moda	PPO	$159					✓	✓
	PPO	$165	✓	✓	✓	✓		
	PPO	$175 to $204	✓	✓	✓	✓	✓	✓
HealthNet	POS	$176 to $181	✓	✓	✓			
Providence	EPO	$191 to $232					✓	✓
PacificSource	PPO	$203 to $216		✓	✓	✓	✓	✓
LifeWise	PPO	$203 to $220				✓	✓	✓
Kaiser Permanente	HMO	$210 to $222				✓		✓
Health Republic	EPO	$210 to $221					✓	✓
Oregon's Health Co-op	PPO	$223 to $230	✓	✓	✓	✓	✓	✓
Bridgespan	PPO	$227.87	✓			✓		

Key
* *Top hospital*
\+ *Academic Medical Center*
^ *Hospital ranked equal to or higher than the state average for a patient experience measure: "percent of patients who reported they would definitely recommend the hospital." In Oregon, the state average is 72 percent.*

Table 2e. General Acute-Care Hospital Networks for Marketplace Plans in Providence, Rhode Island

Insurer	Plan type	Premium range for 27-year-old	Miriam Hospital*+^	Rhode Island Hospital*+^	Women & Infants Hospital*+^	Roger Williams Medical Center	St. Joseph's Health Services RI
Blue Cross Blue Shield Rhode Island	PPO	$225 to $246	✓	✓	✓	✓	✓

Key
* *Top hospital*
\+ *Academic Medical Center*
^ *Hospital ranked equal to or higher than the state average for a patient experience measure "percent of patients who reported they would definitely recommend the hospital." In Rhode Island, the state average is 72 percent.*

Table 2f. General Acute-Care Hospital Networks for Marketplace Plans in Richmond, Virginia

Insurer	Plan type	Premium range for 27-year-old	Virginia Commonwealth University Medical Center *+a^	Bon Secours St. Mary's Hospital*^	Bon Secours-Richmond Community Hospital^	Chippenham Hospital (Hospital Corporation of America)^	Johnston-Willis Hospital (Hospital Corporation of America)^	Henrico Doctors' Hospital (Hospital Corporation of America)^
CoventryOne	POS	$188	✓	✓	✓	✓	✓	✓
Anthem	HMO	$208 to $215				✓	✓	✓
Aetna	PPO	$260 to $284	✓	✓	✓	✓	✓	✓
Optima	HMO	$285	✓	✓	✓	✓	✓	✓

Key

* *Top hospital*

\+ *Academic Medical Center*

^ *Hospital ranked equal to or higher than the state average for a patient experience measure: "percent of patients who reported they would definitely recommend the hospital." In Virginia, the state average is 69 percent.*

[a] *VCU Medical Center includes Children's Hospital of Richmond.*

ENDNOTES

1. Holahan J and Blumberg L. *Marketplace Competition & Insurance Premiums in the First Year of the Affordable Care Act*. Washington: Urban Institute, 2014.
2. Blumberg L, Peters R, Wengle E and Arnesen R. *Physician Network Transparency: How Easy Is It for Consumers to Know What They Are Buying?* Washington: Urban Institute, 2014.
3. Olmsted MG, Murphy J, Geisen E, et al. *Methodology: U.S. News and World Report Best Hospitals 2013–14*. Research Triangle Park, North Carolina: RTI International, 2013, http://www.usnews.com/pubfiles/BH_Methodology_Report.pdf (accessed October 2014).
4. "Member Directory," Association of American Medical Colleges, https://members.aamc.org/eweb/DynamicPage.aspx?site=AAMC&webcode=AAMCOrgSearchResult&orgtype=Hospital/Health%20System (accessed October 2014).
5. "Survey of Patients' Experiences," Centers for Medicare and Medicaid Services, http://www.medicare.gov/hospitalcompare/Data/overview.html (accessed October 2014).
6. Olmsted et al., *Methodology: U.S. News and World Report Best Hospitals 2013–14*, p. 3.

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ISSUE BRIEF
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What Will Be the Impact of the Employer Mandate on the U.S. Workforce?

Sherry Glied and Claudia Solís-Román

Abstract The Affordable Care Act's employer mandate requires large firms to pay penalties unless they offer affordable health insurance coverage to full-time employees, raising concerns that employers might lay off workers or reduce hours. In this brief, we estimate the number of workers potentially at risk of losing their jobs or having hours reduced. Most workers near the thresholds—those in firms with around 50 full-time-equivalent employees or those working near 30 hours per week—are already insured or have been offered coverage. There are 100,000 full-time workers at the firm-size threshold and 296,000 at the hourly threshold who are uninsured. Fewer than 10 percent, less than 0.03 percent of the U.S. labor force, might see reductions in employment or hours in the short run. Over time, employment patterns might change, leading to fewer firm sizes and work schedules near the thresholds, potentially affecting up to 0.5 percent of the workforce.

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OVERVIEW

Under the Affordable Care Act (ACA), employers must offer health insurance to their employees or pay penalties.[1] Under this so-called employer mandate, firms with 50 or more full-time or full-time-equivalent employees may have to pay penalties if they do not offer health benefits and have workers with low enough incomes to qualify for federally subsidized coverage who are not otherwise insured. The law defines full-time employees as those who work 30 or more hours per week, while full-time-equivalent (FTE) is defined as the sum of part-time employee hours in a week divided by 30.[2,3]

The Obama administration suspended the mandate requirement in 2013 and incorporated a further delay for firms with 50 to 99 FTE employees in 2014 to give employers more time to comply with new requirements. Employers with 50 to 99 FTE employees have until 2016 to comply, and firms with 100 or more workers that provide insurance to 70 percent or more of their workforce will not face penalties in 2015.

To avoid being subject to this mandate—and thus avoid paying for either coverage or penalties—employers could choose to lay off workers or reduce worker hours. If employers go this route, more workers are likely to seek subsidized coverage in the marketplaces, increasing the federal cost of the health reform law. Avoiding the insurance mandate in such a way also may lead to distortions in the market and decreased productivity.

Prior research shows the changes mandated by the Affordable Care Act are most likely to affect workers near the regulatory thresholds at which penalties

are levied.[4,5] These workers are in firms with around 50 FTE employees or working close to 30 hours per week. Many employers of workers near these thresholds already meet the mandate standard because their employees hold employer-sponsored insurance, they have offered their workers insurance and been declined, or their workers have insurance coverage from another source.

Most firms subject to the employer mandate already comply with the requirement; among those that do not, most are likely to find compliance less expensive than mandate avoidance. Altering staff size is costly. Hiring and training costs are often substantial even for entry-level employees. Hiring two 20-hour/week employees often costs more in supervision, scheduling, and hiring costs than hiring a single 40-hour/week employee. Regulations also make it costly to substitute two part-time employees for one full-time employee. For instance, in some states, an employer will pay double the unemployment tax if she hires two workers and pays each $7,000 per year rather than paying a single employee $14,000.[6] Similarly, because overtime pay is higher than regular pay, it can be more costly to increase hours for existing workers rather than hiring an additional employee.

While there has been a lot of debate over the expected effects of the employer mandate, there is little evidence of the magnitude of its potential effect on workers' hours and employment. This issue brief estimates the number of workers most at risk of either layoff or a reduction in hours because of the employer mandate. It also examines current research to assess the long-term consequences of the mandate based on estimates of effects of similar government regulations implemented elsewhere.

We use data from the Small Business Administration and the Medical Expenditure Panel Survey to estimate the number of workers who may be at risk of losing hours or positions. We calculate employment levels near the Affordable Care Act thresholds for firm size and weekly hours worked.[7] See Appendix A for a detailed methodology.

HOW MANY WORKERS WORK AT JOBS NEAR THE MANDATE THRESHOLDS?

Employees in Firms with Just Over 50 Workers

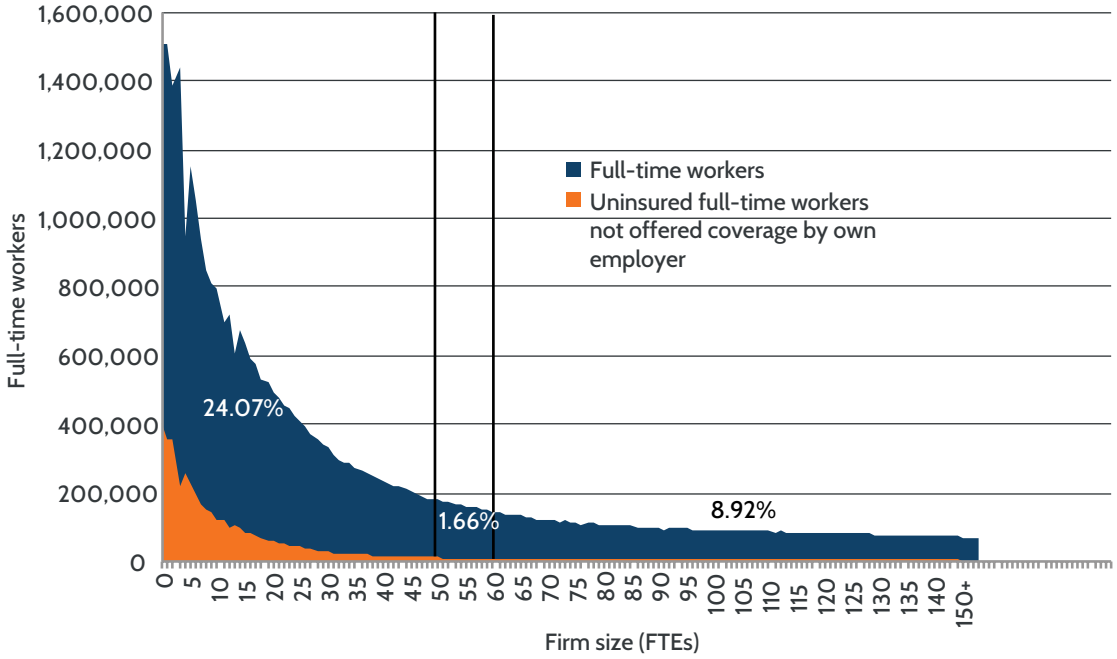
Exhibit 1 shows the distribution of full-year, full-time employment by firm size. About 24 percent of workers are employed in firms with fewer than 50 FTE employees. Relatively few are employed in firms that have 50 to 59 FTE employees—the range most likely to be affected by the mandate. About 1.66 percent of all U.S. employees work full time in firms near this employment threshold (Table 1, Column 2). If we looked at firms with 45 to 54 workers—or other nearby thresholds—it would not affect our estimates substantially.

Of the 1.66 percent of workers in firms near the 50-worker threshold, more than 71 percent already hold coverage through their own employers (Table 1, Column 3). An even larger share—more than 88 percent—either hold or have been offered employer-based coverage; just 11.56 percent of these workers have no offer of employer coverage from their own employer. Most of those who received an offer but declined it have insurance from an alternative source—usually as a dependent. The 11.56 percent who are employed in a firm near the threshold but are not already offered health insurance coverage by their employer constitutes 0.17 percent of all U.S. workers—a total of about 193,000 people. Of these, less than two-thirds are uninsured and might seek coverage in the marketplaces. In total, an estimated 100,000 workers, or about 0.09 percent of the labor force, work in firms that would be penalized under the mandate if their employers did not change their current offering behavior.

Employees Working Just Over 30 Hours per Week

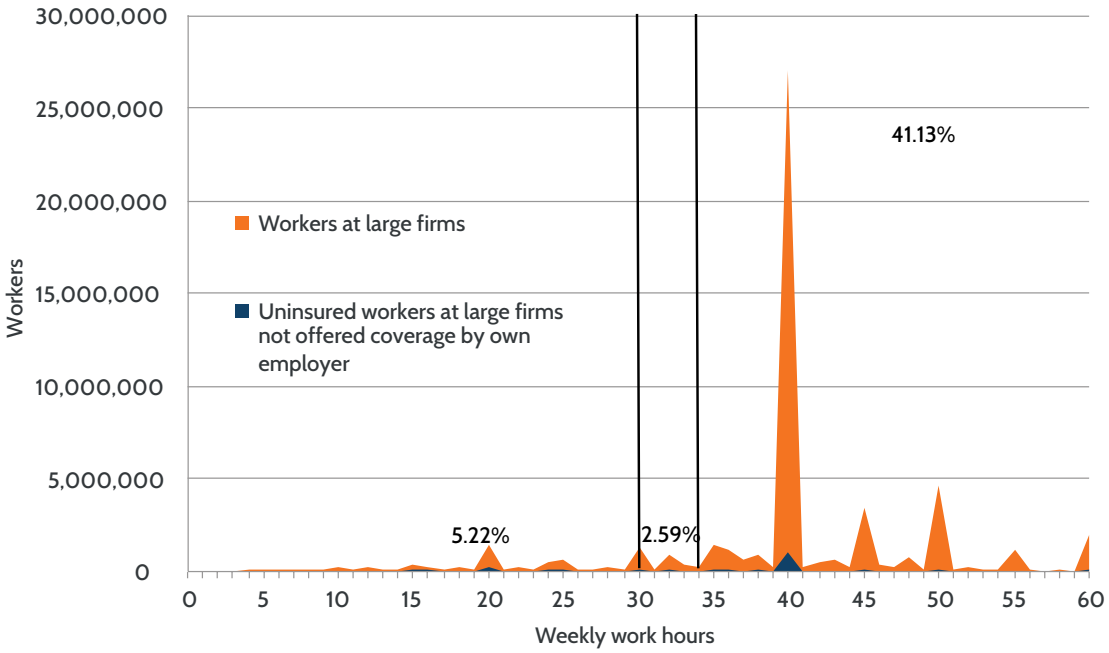
In Exhibit 2, we show the number of hours worked by full-year employed workers of large firms. About 5.22 percent of such workers work fewer than 30 hours per week. Relatively few workers (2.59% of all workers) have 30-to-34-hour work week schedules. If we looked at workers working 40 to 44 hours per week—a higher threshold currently under consideration—it would greatly increase the number of workers in the threshold range (from 2.9 million to 28.6 million; see Table 3).[8]

Exhibit 1. Employment by Firm Size (percentages of U.S. workforce)



In total, about 2.59 percent of the U.S. workforce is employed 30 to 34 hours per week in a firm with 50 or more FTE employees (Table 2). Slightly more than half of these workers already receive employer-sponsored insurance through their own employers (Table 2, Column 3). More than 70 percent have employer-sponsored coverage or have received an offer from their employers. In total, about 835,000 U.S. workers—about 0.75 percent of all U.S. workers—currently work hours near the mandate threshold and are not offered health insurance coverage by their employers. Among those without an offer of coverage, most have insurance through another source; fewer than 40 percent are uninsured—a total of about 296,000 workers. Many firms are unaware that their employees may have coverage from another source and make employment decisions based only on their own information about which workers hold employer-sponsored

Exhibit 2. Employment by Weekly Work Hours (percentages of U.S. workforce)



coverage. However, because firms can only be penalized if their full-time workers seek subsidized coverage in the exchanges, and most workers who already hold coverage as dependents are unlikely to seek such subsidized coverage, the number of employers who might wish to avoid the mandate by lowering hours would be much lower if employers were aware of which of their employees is currently uninsured.

The number of uninsured workers without an offer of coverage near the firm size and weekly hours thresholds (100,000 and 296,000, respectively) together comprise just over one-third of one percent (.09 and .26 percent, respectively) of the U.S. workforce. As we show below, the number of people likely to be affected by the mandate is much lower than this figure, as most employers would find the cost of adjusting firm size—by switching from full-time to part-time workers or reducing hours—greater than the cost of offering coverage.

HOW HAVE MANDATES AFFECTED WORKERS IN OTHER LOCALES?

Several recent studies examine the effects on the labor market of other similar provisions. After the implementation of an employer mandate in Massachusetts, both employer-sponsored coverage and employment increased. Employment patterns in both high- and low-wage industries in Massachusetts from 2001 to 2010 were similar to those in other states over the same period.[9,10] Since 1975, Hawaii has had a mandate requiring all employers, regardless of firm size, to provide health insurance to workers employed 20 hours per week or more. This provision had little effect on wages or employment, but it was associated with a statistically significant increase of about 1.4 percentage points in the share of workers working fewer than 20 hours.[11] Only workers with a very low probability (26%) of holding employer-sponsored insurance before the mandate were more likely to have low hours. No effect was observed among workers with higher initial rates of employer coverage.[12] The Hawaii results suggest that the ACA mandate would have very little effect, if any, because it affects only the workforce of larger firms, where the probability that workers already hold coverage is more than double the Hawaii figure (58%).

Another study focused on the effect of labor regulations in France, where regulatory requirements, such as requirements to negotiate with in-house workers' councils, sharply increase labor costs for firms with 50 or more employees. Researchers found that the share of firms with 49 to 57 workers (3.5% of all firms) in France is about 10 percent smaller than would have been expected in the absence of these laws, meaning that firms have either shrunk (laid off or failed to hire workers) or grown to avoid the regulatory threshold. The regulations in France require firms with over 50 workers to establish several committees, to report detailed information to the government monthly, and to face higher penalties for workplace infractions. Unlike the health insurance that firms will provide to their employees under the ACA, the French requirements provide few benefits to individual workers. Analyses suggests that French workers have been unwilling to accept lower wages in return for these regulations; in contrast, analyses from Massachusetts suggest that workers are willing to accept lower wages in exchange for newly mandated health insurance.[13,14,15] This suggests that employer responses under the ACA regulations would likely be substantially more limited than in France.

In the next few years, ACA-related changes in employment patterns would likely affect only uninsured workers without offers near the thresholds for firm size and hours worked. Estimates from the existing literature—including those based on Massachusetts's experiences—suggest the mandate will have little impact on behavior short term. Even estimates based on longer-run responses to much more onerous regulations in Hawaii and France suggest modest effects. In combination, the Massachusetts results and the findings from Hawaii and France adjusted for the differences between the ACA and these regulations suggest that from 0 percent to 10 percent of threshold-affected workers may experience reductions in employment or hours in the short run. This would mean 0 to 10,000 workers might be displaced because of firm-size reductions and 0 to 29,000 workers might see a reduction in hours.

In the longer run, firms will enter and exit the market, grow and shrink, and change their health insurance offering decisions. As new firms enter and hire workers, they will make decisions about offering health insurance and about

how many workers to employ. The evidence from Hawaii and France is particularly relevant, as these studies reflect long-term effects of mandates. The results suggest that in the long run, the effect of mandates might extend to all workers who would have been in the threshold range, whether or not they are currently offered coverage. If that were to occur, we would expect to see about 167,000 fewer workers employed at firms with 50 to 59 workers and about 290,000 fewer workers employed 30 to 34 hours per week. These changes would affect about one-half of 1 percent of the U.S. labor force. To put this in context, there were approximately 3.8 million job openings overall—including 391,000 openings in the accommodation and food services sector alone—on the last day of May 2013.[16]

DISCUSSION

Our results show that relatively few American workers are employed near the Affordable Care Act thresholds—that is, firm sizes of 50 FTE employees or working 30 weekly hours. Among those who are employed near the thresholds, the overwhelming majority (88 percent of those near the firm-size threshold and 71 percent of those near the hourly threshold) are employed by firms that already meet the mandate requirement by offering coverage to their employees. Among those workers who do not have an offer, many hold insurance coverage from an alternate source, and thus would not count toward an employer penalty. Less than one-half of 1 percent of workers (.09 percent of workers near the firm-size threshold and .26 percent of workers near the hourly threshold) work at firms that do not offer them coverage and are uninsured.

Experience from other settings suggests that even in the longer run, regulatory requirements have relatively modest effects on the distribution of firm sizes and hours worked across the labor market. Even if employers responded in the long run as they did in Hawaii or France, where regulatory costs were considerably higher, any effects would be very small—affecting less than one-half of 1 percent of all workers. Of course, in the United States, a relatively small effect translates into a sizable group of people.

Currently, Congress is being lobbied to raise the weekly hour threshold to 40 hours per week, so it is also useful to compare the labor market effects associated with the 30-hour threshold to what might occur if the threshold were raised.[17] Relative to other possible thresholds, the threshold of people working near 30 hours per week (in firms of around 50 full-time workers) would generate small labor market effects. Far more workers would be affected, in both the short run and the long run if the threshold were moved to 40 hours.[18]

Despite the likely small empirical effect of the employer mandate, it has caused a great deal of consternation among employers. One reason for this may be that employers do not routinely collect information on the alternative coverage available to their employees. Among the employees affected by the thresholds and included in our analyses, there are many more who have employer coverage than those who do not. In addition, there are others who have employer coverage from another source, usually as a dependent on a family member's plan. Employers are increasingly requiring higher employee contributions for family coverage to discourage workers from selecting family coverage when they have other options available. Despite these incentives, there are many reasons families choose to obtain coverage from a single employer rather than dividing family members among two or more plans. Families may choose to obtain coverage from the spouse with more stable employment or they may prefer coverage from a single managed care plan so they can get care from the same practice. Public policy should not discourage such family coverage decisions.

As the Obama administration develops strategies for implementing the employer mandate, it should take into consideration evidence available to employers about coverage alternatives used by their employees. Employers should not be penalized if they believe an employee holds coverage from an alternative source and therefore do not offer coverage. As reporting requirements for employer coverage are developed, the IRS also should consider ways to make information about whether employees have alternative sources of coverage more evident to employers.

Appendix A. Methodology

The majority of existing data sources do not provide sufficient detail on firm size, employer offers, and sources of insurance coverage to directly estimate the number of threshold-affected employees. As Garicano and colleagues show, regulations affecting firms at a 50-worker threshold are likely to affect the distribution of firms in a narrow range around 50. Large population data sources on health insurance coverage, however, classify firms into categories of, at best, 25 to 49 or 50 to 99 workers. Workers also may have difficulty precisely estimating the number of employees in their firm. Even data that do count workers do not account for full-time-equivalence standards employed as the metric for firm applicability in the employer mandate.

We therefore use a series of estimates based on multiple data sources. We build our analysis on data from the Medical Expenditure Panel Survey (MEPS), which provides detailed information on availability of employer-sponsored insurance plans, health insurance coverage, weekly work hours, as well as detailed firm size, but has relatively small samples. Employment estimates are calculated using small-firm size category employment data from the Small Business Administration (SBA), provided by the U.S. Census Bureau, Statistics of U.S. Businesses 2010. SBA data that provided employment levels at intervals as small as 45 to 49 and 50 to 74 was merged with MEPS firm size data at unit level, and smoothed using a negative binomial regression model over firm sizes 2 to 200. Public administration workers, self-employed individuals, agricultural workers, and most government businesses are excluded from MEPS employment levels for consistency with the definition of working population used by Statistics of U.S. Businesses. Using these data, we fit curves to smooth the distribution of employment, full-time-equivalents (FTEs), coverage, and offer rates by firm size and weekly hours. We calibrate our fitted data against the data on firm size from SBA and MEPS.

As the maximum suggested look-back period for the employer mandate is one year, employees averaging 30 hours over a full year are included in threshold estimates, and average hours of staff working seasonally or below an average of 30 hours per week are included in the calculation of FTE employees for firm size, as it pertains to categorizing applicable firms. Offer information not ascertained from full-time, full-year workers is predicted using a logit regression model including firm size, weekly hours, wage, marital status, industry category, and insurance coverage status.

Firm Size and Full-Time-Equivalence

To assess firm size as defined by the Affordable Care Act, FTE employees are calculated by prorating part-time work hours over number of employees at firms and dividing hours completed by part-time employees in a week by 30. (Guidance provides a means of counting part-time employees that includes a by-month measure of hours divided by 130, a calculation that generates slightly different results.) To generate the FTE scale, we produce a measure of the share of workers at each unit of firm size working below 30 hours per week by fitting a cubic logit regression. Average hours worked by part-time staff are generated by limiting the sample to employees averaging below 30 weekly hours and using a cubic logistic regression of hours by firm size.

Number of Employees Near the Firm-Size Threshold for Large Firms

Detailed information from MEPS about insurance coverage, employer offer of insurance, and worker status is used to calculate rates of characteristics of interest across firm size for employees near the threshold of the definition of large firm. Rates are predicted using cubic logit regression for holding employer-sponsored insurance (ESI) through own employer; having no employer offer; and having no employer offer of coverage and no other coverage (uninsured), then predicted by FTE firm size and summed across the threshold range.

Number of Employees Near the Hours Threshold for Full-Time Employment

Employment along the threshold of weekly hours is drawn from 2008–2011 MEPS data. Rates of coverage and coverage type are evaluated along weekly hours using a probit regression model. In this case, the sample is restricted to workers at large firms working 1 to 60 hours per week. Rates along the target range are calibrated against the number of workers at each unit of weekly hours worked to generate employment levels among workers working 30 to 34 hours per week.

Threshold-Affected Workers as a Share of the U.S. Workforce

The percent of the total workforce illustrated in Table 1 and Table 2 are taken from the SBA static national small firm size categories data, provided by the Census Bureau's Statistics of U.S. Businesses 2010 estimates. Exhibits describe employment by hours and firm size and show year-round employees.

Table 1. Full-Time Workers in Firms with 50 to 59 Full-Time-Equivalent Employees

	Employment	Percent of U.S. workforce	Percent of workers near threshold
Total workforce	**111,970,095**	**100.00%**	–
Full-time workers in firms with 50-59 FTE employees	1,670,000	1.66%	100.00%
Holding own ESI	1,199,000	1.07%	71.80%
Without own ESI	471,000	0.42%	28.20%
Not offered coverage by own employer	193,000	0.17%	11.56%
Uninsured and not offered coverage by own employer	100,000	0.09%	5.99%

Table 2. Workers at Firms with at Least 50 Full-Time-Equivalent Employees Working 30 to 34 Hours per Week

	Employment	Percent of U.S. workforce	Percent of workers at 30–34-hour threshold
Total workforce	**111,970,000**	**100.00%**	–
Large-firm workers working 30-34 hours per week	2,901,000	2.59%	100.00%
Holding own ESI	1,460,000	1.30%	50.33%
Without own ESI	1,441,000	1.29%	49.67%
Not offered coverage by own employer	835,000	0.75%	28.78%
Uninsured and not offered coverage by own employer	296,000	0.26%	10.20%

Table 3. Workers at Firms with at Least 50 Full-Time-Equivalent Employees Working 40 to 44 Hours per Week

	Employment	Percent of U.S. workforce	Percent of workers at 40–44-hour threshold
Total workforce	**111,970,000**	**100.00%**	–
Large-firm workers working 40-44 hours per week	28,626,000	25.57%	100%
Holding own ESI	21,712,000	19.39%	76%
Without own ESI	6,914,000	6.17%	24%
Not offered coverage by own employer	2,567,000	2.29%	9%
Uninsured and not offered coverage by own employer	1,148,000	1%	0%

Notes: Throughout the exhibits, ESI denotes employer-sponsored insurance holders with coverage through their own employer. In the MEPS data set, in cases where respondents estimate hours worked per week at 35 hours or more, hours are set to 40. Like the Small Business Administration, we exclude workers with inapplicable, unknown, or not ascertained hours or firm size. Statistics of U.S. Businesses (SUSB) data exclude self-employed persons and most government business establishments. "All U.S. business establishments with paid employees. The Statistics of U.S. Businesses (SUSB) covers all NAICS industries except crop and animal production; rail transportation; National Postal Service; pension, health, welfare, and vacation funds; trusts, estates, and agency accounts; private households; and public administration. The SUSB also excludes most government employees."

Notes

[1] It states: "If (1) any applicable large employer fails to offer to its full-time employees . . . minimum essential coverage under an eligible employer-sponsored plan for any month . . . and (2) at least one full-time employee has . . . enrolled for such month in a qualified health plan with . . . an applicable premium tax credit or cost-sharing reduction . . . then there is hereby imposed on the employer an assessable payment." Under this provision, employers must offer their employees plans which cover at least 60% of the cost of essential health benefits ("minimum value"), at a cost to employees that may not exceed 9.5% of household income ("affordable").

[2] As defined by regulations proposed by the Department of the Treasury on August 31, 2012.

[3] J. Mulvey, "Potential Employer Penalties Under the Patient Protection and Affordable Care Act (ACA)" (Washington, D.C.: Congressional Research Service, 2013); and Kaiser Family Foundation, "Employer Responsibility Under the Affordable Care Act," last modified July 15, 2013, http://kff.org/infographic/employer-responsibility-under-the-affordable-care-act/.

[4] T. C. Buchmueller, J. DiNardo, and R. G. Valletta, "The Effect of an Employer Health Insurance Mandate on Health Insurance Coverage and the Demand for Labor: Evidence from Hawaii," *American Economic Journal: Economic Policy,* Nov. 2011 3(4):25–51.

[5] L. Garicano, C. Lelarge, and J. van Reenen, "Firm Size Distortions and the Productivity Distribution: Evidence from France" (National Bureau of Economic Research, 2013).

[6] Tax Policy Center, "Payroll Taxes," Urban Institute and Brookings Institution, http://www.taxpolicycenter.org/taxtopics/Payroll-Taxes.cfm.

[7] As framed by the Congressional Research Service. Mulvey, "Potential Employer Penalties," 2013.

[8] S. Glied and C. Solís-Román, "Why Changing the Definition of Full-Time Work Under the ACA Will Put More Workers at Risk and Increase Federal Spending," *The Commonwealth Fund Blog,* Jan. 24, 2014.

[9] J. R. Gabel, H. Whitmore, J. Pickreign et al., "After the Mandates: Massachusetts Employers Continue to Support Health Reform as More Firms Offer Coverage," *Health Affairs,* Nov.–Dec. 2008 27(6):w566–w575.

[10] L. Dubay, S. K. Long, and E. Lawton, "Will Health Reform Lead to Job Loss? Evidence from Massachusetts Says No," in *Timely Analysis of Immediate Health Policy Issues* (Washington, D.C.: Urban Institute, 2012).

[11] Buchmueller, DiNardo, and Valletta, "Effect of an Employer Health Insurance Mandate," 2011.

[12] Thomas Buchmueller, email message to Sherry Glied, Sept. 16, 2013; Robert Valletta, email message to Sherry Glied, Sept. 19, 2013.

[13] Regulations include a requirement that firms establish a works council with a minimum budget of 0.3% of total payroll, a committee on health, safety and working conditions, a profit-sharing plan, and incur higher costs in the case of workplace accidents, among other duties.

[14] Garicano, Lelarge, and van Reenen, "Firm Size Distortions," 2013.

[15] J. T. Kolstad and A. E. Kowalski, "Mandate-Based Health Reform and the Labor Market: Evidence from the Massachusetts Reform" (Cambridge, Mass.: National Bureau of Economic Research, 2012).

[16] U.S. Bureau of Labor Statistics, "Table 1. Job Openings Levels and Rates by Industry and Region, Seasonally Adjusted" (Washington, D.C.: BLS, 2013).

[17] E. Viebeck, "Lobbyists Push to Change Obamacare's Definition of Full-Time Work," *The Hill,* Sept. 19, 2014, http://thehill.com/policy/healthcare/218325-big-k-street-push-to-change-o-care-30-hour-rule.

[18] Glied and Solís-Román, "Why Changing the Definition of Full-Time Work," 2014.

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ACA Implementation—Monitoring and Tracking

Analyzing Different Enrollment Outcomes in Select States That Used the Federally Facilitated Marketplace in 2014

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URBAN INSTITUTE
HEALTH POLICY CENTER

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. This report is one of a series of papers focusing on particular implementation issues in case study states. 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. For more information about the Robert Wood Johnson Foundation's work on coverage, visit **www.rwjf.org/coverage**.

INTRODUCTION

This report analyzes two pairs of states that achieved very different enrollment rates in the federally facilitated Marketplace (FFM) during the 2014 open enrollment period. We compare North Carolina with South Carolina and Wisconsin with Ohio. The report analyzes the factors that appear to have contributed to the different enrollment outcomes in the paired states and summarizes some of the lessons learned across all four states. These findings may help policymakers and stakeholders develop strategies to increase enrollment throughout the country in 2015.

Several reports focus on best practices and lessons learned from 2014 enrollment.[1] This study addresses enrollment experiences in states with similar characteristics that used the FFM in 2014 and that are not planning to develop their own state-based Marketplaces (SBMs). We focus solely on FFM states to control for important variables. In all four states, consumers experienced the same technical challenges with healthcare.gov and Navigators and community health centers received proportionately similar levels of federal funding for consumer outreach and assistance. All four states were also home to significant anti-Affordable Care Act (ACA) political activity. Ohio was the only one of the four states to retain control over health plan management in the FFM in 2014.

Neither North Carolina nor South Carolina expanded Medicaid in 2014. Ohio and Wisconsin, on the other hand, made significant changes to Medicaid eligibility. Ohio expanded Medicaid effective January 1, 2014. Wisconsin changed its Medicaid eligibility rules, opening coverage to childless adults below 100 percent of the federal poverty level (FPL) but eliminating coverage for tens of thousands of people at or above 100 percent of FPL who thus became eligible for Marketplace subsidies.

Demographic factors do not appear to explain the different enrollment outcomes in the four states, nor does the amount of federal funding. We find, however, that development of a strong collaborative infrastructure between and among diverse groups engaging in outreach and enrollment assistance was an important factor in both North Carolina and Wisconsin, the states with the higher enrollment rates of the pairs. Additionally, private contributions (charitable foundations and in-kind contributions from nonprofit organizations) and local government support appear to have enabled groups to devote the resources needed to coordinate their efforts and to help overcome anti-ACA political environments. Finally, we conclude that Medicaid changes in Wisconsin and Ohio probably had a significant effect on the different Marketplace enrollment outcomes in those two states.

DIFFERENT ENROLLMENT RATES FOR THE FOUR STUDY STATES

We focus on these two pairs of states because each pair differed significantly in 2014 enrollment rates, each pair is in the same general region of the country, and each pair has demographic similarities. Table 1 summarizes the enrollment rate in each state as a percentage of projected 2014 enrollment. It also shows the average Marketplace enrollment rates for all SBM states, for all FFM states, and for all states in 2014.

North Carolina and Wisconsin both had relatively high enrollment rates, compared not only with other FFM states but also with SBM states and the national average. According to the Urban Institute's analysis, North Carolina's enrollment was 145.3 percent of projected 2014 enrollment; this was second only to Florida among the 34 FFM states and sixth overall in the country.[2] Wisconsin was the fourth most successful FFM state and was among the top 10 in the country overall, reaching 130.3 percent of projected enrollment.

In contrast, both South Carolina and Ohio had enrollment rates below the average FFM enrollment rate of 112.5 percent of projections (101.3 percent and 75.3 percent, respectively).

Table 1. Preliminary Enrollment (as of April 2014) in Federally Facilitated Marketplace Health Plans as a Percentage of Projected 2014 Enrollment in Marketplace Plans

State	(1) Projected 2014 Marketplace enrollment	(2) Total Marketplace target population for 2016	(3) Projected 2016 Marketplace enrollment	(4) Latest Marketplace enrollment data	(5=4/1) Current enrollment as a percentage of projected 2014 enrollment	(6=4/2) Current enrollment as a percentage of the total target population
North Carolina	246,000	1,304,000	615,000	357,584	**145.3%**	**27.4%**
South Carolina	117,000	657,000	283,000	118,324	**101.3%**	**18.0%**
Wisconsin	107,000	444,000	269,000	139,815	**130.3%**	**31.5%**
Ohio	205,000	796,000	498,000	154,668	**75.3%**	**19.4%**
Total for federally facilitated Marketplace	4,745,000	24,142,000	11,773,000	5,338,000	**112.5%**	**22.1%**
Total for state-based Marketplaces	2,213,000	8,640,000	5,769,000	2,682,000	**121.2%**	**31.0%**
National	6,958,000	32,781,000	17,542,000	8,020,000	**115.3%**	**24.5%**

Source: Blumberg LJ, J Holahan, GM Kenney, M Buettgens, N Anderson, H Recht, and S Zuckerman, "Measuring Marketplace Enrollment Relative to Enrollment Projections: Update," The Urban Institute, 2014. http://www.urban.org/UploadedPDF/413112-Measuring-Marketplace-Enrollment-Relative-to-Enrollment-Projections-Update.pdf.

Notes: The Urban Institute first published this data in May 2014 for all 50 states and the District of Columbia based on preliminary enrollment totals released by the United States Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE). ASPE's preliminary enrollment totals include people who had started their applications by March 31, 2014, and completed them by April 19, 2014, and individuals who qualified for other types of special enrollment periods and were reported to have enrolled by April 19, 2014. ASPE's numbers do not consider people who signed up for a plan but did not pay their premium or people who have signed up since April 19, 2014, because they qualified for a special enrollment period. See Office of the Assistant Secretary for Planning and Evaluation. "Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period." Washington: US Department of Health and Human Services, 2014, http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf (accessed October 2014). Our May enrollment analysis compared HHS' reported enrollment totals to projected 2014 Marketplace enrollment based on the Urban Institute's Health Insurance Policy Simulation Model, using the Congressional Budget Office's initial projection of 7 million total enrollees nationwide for 2014. Urban also used the Health Insurance Policy Simulation Model to project the target population for 2016. Because total reported enrollment exceeded 8 million people, on average states using both state-based Marketplaces and the federally facilitated Marketplace exceeded their 2014 enrollment projections, although some individual states exceeded state-specific projections and others fell below.

METHODOLOGY

Several possible variables may have affected enrollment rates in the paired states. We analyzed demographic data, rates of uninsured, the insurance market, the political landscape, marketing, outreach and education efforts and enrollment assistance systems (including federal funding for outreach and enrollment assistance). To collect this data, we interviewed many sources in each of the study states, including Navigators, certified application counselors, consumer advocates, producers (brokers and agents), health insurance plans and health care providers.

Demographic Data

In table 2 (North Carolina and South Carolina) and table 3 (Wisconsin and Ohio), we compare population and socioeconomic data in each pair of study states. The nonelderly uninsured rates in North Carolina and South Carolina were very similar (19.2 percent and 19.6 percent respectively). North Carolina had a higher median income than South Carolina ($45,906 and $44,163, respectively). Wisconsin had a lower uninsured rate for the nonelderly (10.9 percent) than Ohio (13.5 percent). Wisconsin also had a higher median income than Ohio: $51,467 compared with $48,081, respectively. It is possible that the somewhat higher rates of uninsured could have made enrollment more challenging in Ohio than in Wisconsin, but the uninsured rate does not explain the different enrollment rates in North Carolina and South Carolina. In both pairs of states, the more successful Marketplace enrollment took place in the state with a higher median income.

We also compared the racial and ethnic makeup of the comparison states. North Carolina and South Carolina had comparable White populations as a percentage of their overall populations (62.1 percent and 61.9 percent, respectively), as did Wisconsin (81.1 percent) and Ohio (79.4 percent). But the paired comparison states differed in the composition of their minority populations. North Carolina and South Carolina had relatively large Black populations, but South Carolina had a significantly larger percentage of Blacks than North Carolina (28.5 percent versus 22.0 percent). North Carolina had a larger Hispanic population compared to South Carolina (9.8 percent versus 5.8 percent). Ohio had nearly twice the percentage of Blacks as Wisconsin (12.5 percent versus 6.3 percent), but Wisconsin had a larger percentage of Hispanics (7.0 percent) than Ohio (3.6 percent). It is possible that these racial and ethnic differences played a role in enrollment experiences in these states.

Table 2. Demographic and Socioeconomic Data for North Carolina and South Carolina

Population and demographics	North Carolina	South Carolina
Total population (2013)	9,848,060	4,774,839
Nonelderly uninsurance rate (2012)	19.2%	19.6%
Median household income	$45,906	$44,163
Total nonelderly population	8,254,072	3,948,252
Distribution of nonelderly population by race/ethnicity (2012)		
White (non-Hispanic)	62.1%	61.9%
Black	22.0%	28.5%
Hispanic	9.8%	5.8%
Asian	2.6%	1.4%
Percent rural (2010)	33.9%	33.7%

Sources: The United States Census Bureau, American Community Survey 2013, year 1 estimates, http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml (accessed October 2014); U.S. Census Bureau, "2010 Census Urban and Rural Classification and Urban Area Criteria," http://www2.census.gov/geo/ua/PctUrbanRural_State.xls (accessed October 2014); Urban Institute tabulations based on the 2012 Health Insurance Policy Simulation Model using data from the American Community Survey (HIPSM-ACS 2012).

Table 3. Demographic and Socioeconomic Data for Wisconsin and Ohio

Population and demographics	Wisconsin	Ohio
Total population (2013)	5,742,713	11,570,808
Nonelderly uninsurance rate	10.9%	13.5%
Median household income	$51,467	$48,081
Total nonelderly population	4,866,500	9,619,300
Distribution of nonelderly population by race/ethnicity (2013)		
White (non-Hispanic)	81.1%	79.4%
Black	6.3%	12.5%
Hispanic	7.0%	3.6%
Asian	2.8%	1.9%
Percent rural (2010)	29.9%	22.1%

Sources: The United States Census Bureau, American Community Survey, http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml (accessed October 2014); U.S. Census Bureau, "2010 Census Urban and Rural Classification and Urban Area Criteria," http://www2.census.gov/geo/ua/PctUrbanRural_State.xls (accessed October 2014); Urban Institute tabulations based on the 2012 Health Insurance Policy Simulation Model using data from the American Community Survey (HIPSM-ACS 2012).

We also consider whether states with higher percentages of rural populations had lower Marketplace enrollment rates in 2014. In all four study states—including the more successful states of North Carolina and Wisconsin—stakeholders reported challenges enrolling consumers in rural communities. But these state pairings suggest that having a larger rural population did not lead to lower Marketplace enrollment in 2014. According to Census Bureau data,[3] both North Carolina and South Carolina were just under 34 percent rural but had very different enrollment rates.[4] Ohio had significantly lower enrollment rates than Wisconsin (22.1 percent compared with 29.9 percent, respectively), despite Wisconsin being more rural than Ohio.[5]

Commercial Insurance Markets and Premium Rates

Tables 4 and 5 compare the private insurance markets in the FFM and in each pair of comparison states in 2012. There was one dominant carrier in both North Carolina and South Carolina, but South Carolina was somewhat more competitive than North Carolina during the open enrollment period, with three carriers offering plans on the FFM compared with two in North Carolina. In North Carolina, Blue Cross Blue Shield of North Carolina (BCBSNC) was the only carrier to offer plans statewide. Both Wisconsin and Ohio had a dozen carriers offering plans on the FFM.

We also considered whether the study states had different policies regarding availability of nongrandfathered individual health plans. In November 2013, President Obama announced that individual health plans that did not comply with ACA requirements could continue to be offered through 2014. (The Obama administration later extended this option through 2016.) States could decide whether to allow health insurance issuers to offer this option to their policyholders; all four of the study states authorized continuation of these policies in 2014.

Finally, we compared the second lowest cost silver premium rates in the largest metropolitan area of each state as an indicator of relative premium affordability. We looked at the second lowest cost silver premium because by law, that is the level to which advanced premium tax credits are attached. Though subsidized enrollees (composing the majority of Marketplace enrollment) pay a fixed percentage of their income (with the remainder paid by the federal government), unsubsidized enrollees must pay out of pocket the full premium of the chosen plan. In this way, subsidized enrollees are shielded from the premium differences across geographic areas as long as they choose a plan with a premium that is at or below the level of the second lowest cost silver plan. As shown in table 6, the premium rates were higher in both North Carolina and Wisconsin, the states with the higher enrollment rates of each pair. Though we did not compare all plan premiums throughout all rating regions in these states, this information suggests that during the first year of open enrollment, premiums were not a significant factor in explaining the different enrollment rates across the study states.

Table 4. Private Insurance Market Comparison of North Carolina and South Carolina before Implementation and on the Federally Facilitated Marketplace

	North Carolina	South Carolina
Market share		
Market share of largest carrier in individual (nongroup) market (2012)	85% BCBSNC	57% BCBSSC
Market share of largest carrier in small-group market (2012)	62% BCBSNC	70% BCBSSC
Federally facilitated Marketplace		
Number of statewide carriers on federally facilitated Marketplace	1 (BCBSNC, broad and narrow network plans)	2 (BCBSSC, Consumers' Choice)
Total number of carriers on federally facilitated Marketplace	2 (BCBSNC, Coventry of the Carolinas)	3 (BCBSSC, Consumers' Choice, Coventry of the Carolinas)

Sources: "Market Share and Enrollment of Largest Three Insurers- Individual Market," Kaiser Family Foundation, http://kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers-individual-market/ (accessed October 2014); "Get Health Care Premium Estimates and Preview Marketplace Plans," Healthcare.gov, https://www.healthcare.gov/find-premium-estimates/ (accessed October 2014).

Notes: BCBSNC = Blue Cross Blue Shield of North Carolina. BCBSSC = Blue Cross Blue Shield of South Carolina.

Table 5. Private Insurance Market Comparison of Wisconsin and Ohio before Implementation and on the Federally Facilitated Marketplace

	Wisconsin	Ohio
Market share		
Market share of largest carrier in individual (nongroup) market (2012)	Wisconsin Physicians Services (25%)	Wellpoint (36%)
Market share of largest carrier in small-group market (2012)	United Healthcare (29%)	Wellpoint (39%)
Federally facilitated Marketplace		
Number of statewide carriers on federally facilitated Marketplace	0	1 (Anthem Blue Cross Blue Shield)
Total number of carriers on federally facilitated Marketplace	13 (Anthem Blue Cross Blue Shield, Arise, Common Ground, Dean, Group Health Cooperative of South Central Wisconsin, Gunderson, Health Tradition, Medica, MercyCare, Molina of Wisconsin, Physicians Plus, Security of Wisconsin, Unity)	12 (Ambetter from Buckeye, Anthem Blue Cross Blue Shield, AultCare, CareSource, HealthAmericaOne, HealthSpan, Humana of Ohio, Kaiser of Ohio, MedMutual, Molina, Paramount, Summacare)

Sources: "Market Share and Enrollment of Largest Three Insurers- Individual Market," Kaiser Family Foundation, http://kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers-individual-market/ (accessed October 2014); "Get Health Care Premium Estimates and Preview Marketplace Plans," Healthcare.gov, https://www.healthcare.gov/find-premium-estimates/ (accessed October 2014).

Table 6. Comparison of Second Lowest Cost Silver Marketplace Plans for 2014, Largest Urban Area

State	Rating area	2014 second lowest cost silver premium for 27-year-old)	2014 second lowest cost silver premium for 50-year-old
North Carolina	Rating area 4: Charlotte	$251.35	$428.35
South Carolina	Rating area 40: Columbia	$220.32	$375.47
Ohio	Rating area 9: Columbus	$207.40	$353.45
Wisconsin	Rating area 1: Milwaukee	$258.39	$440.36

Source: "Get Health Care Premium Estimates and Preview Marketplace Plans," Healthcare.gov, https://www.healthcare.gov/find-premium-estimates/ (accessed October 2014).

Federal Funding for Outreach and Enrollment Assistance

SBMs and state–federal partnership Marketplaces were eligible to receive significant funding—including funding for marketing, outreach and education, and in-person enrollment assistance—from the US Department of Health and Human Services (HHS) to establish their marketplaces.[6] None of the study states received Exchange Establishment Grants for the 2014 open enrollment period. Although North Carolina received initial funding, sources reported that the funds were returned in early 2013 before they could be spent to support outreach and enrollment. Instead, organizations within each state received Navigator grant awards directly from the Centers for Medicare and Medicaid Services (CMS). CMS distributed the Navigator grants using a standardized formula, taking into account the number of uninsured within each state, with a minimum allotment of $600,000. HHS also hired national firms to conduct public relations and advertising campaigns in select FFM states. HHS targeted 13 states, including North Carolina and Ohio, but we could not determine how much was spent in those states or where the advertising ran.[7]

In addition, HHS' Health Resources and Services Administration (HRSA) made significant grant awards to community health centers in all 50 states to conduct consumer outreach and enrollment assistance. Grants awarded by HRSA in each FFM state were approximately twice the amount of Navigator grants awarded in those states. Thus, in all four study states, significantly more federal resources were available for community health centers to provide outreach and enrollment assistance than there were for Navigators. HRSA also awarded funding directly to state primary care associations throughout the country for additional outreach and enrollment activities.

CMS also provided funding to two national contractors, Cognosante and SRA International, to provide additional assistance in several states (including Wisconsin and North Carolina). According to a recent analysis of ACA implementation in Wisconsin, state-based organizations were unfamiliar with these organizations and unaware that they would be working in the state.[8]

States also were able to apply for funding from CMS for consumer assistance programs to help educate and assist consumers about new health insurance protections under the ACA. Three of the study states received consumer assistance program funding, but only North Carolina received a significant award. The North Carolina Department of Insurance, led by an independently-elected insurance commissioner, received $2,373,593 in consumer assistance program funding. It used the funding to establish Health Insurance Smart NC, which educates consumers on health insurance and helps them with complaints against insurance carriers.

Table 7 shows the total amount of direct federal funding for outreach and enrollment assistance in the four states. Wisconsin received the lowest amount of federal outreach and enrollment funding, which is consistent with it having relatively low uninsured rates. In table 7 we also compare direct federal funding for outreach and enrollment assistance as a percentage of Urban's 2014 projections of nonelderly uninsured and nonelderly uninsured eligible for financial assistance through both Medicaid and Marketplace subsidies in each state. These projections take into account Medicaid eligibility for 2014. North Carolina, which had the highest Marketplace enrollment in 2014, had the lowest funding per number of uninsured and per number of uninsured eligible for subsidies. As we will explain, however, there was significant private funding and support for outreach and enrollment assistance in North Carolina.

Table 7. Federal Funding for Outreach, Education, Marketing, Consumer Assistance Programs and Enrollment Assistance Leading up to and Including Open Enrollment for 2014

Funding	North Carolina	South Carolina	Wisconsin	Ohio
Total Navigator funding	$3,025,296	$1,953,615	$1,001,942	$2,998,930
Health Resources and Services Administration funding to health centers (includes supplemental fiscal year 2014 grants through July 2014)	$6,358,944	$3,664,091	$2,696,927	$5,943,337
Health Resources and Services Administration grants to state primary care associations	$162,597	$163,806	$105,053	$161,082
Total federal funding for outreach and enrollment assistance for first open enrollment	$9,546,837	$5,781,512	$3,803,922	$9,103,349
Consumer Assistance Program funding (as of fiscal year 2012)	$2,373,593	$18,500	$62,653	$0
Total direct federal funding for consumer outreach, education and enrollment assistance	$11,920,430	$5,800,012	$3,866,575	$9,103,349
Uninsured (nonelderly) without ACA	1,570,485	783,289	523,108	1,352,548
Uninsured (nonelderly) eligible for any financial assistance under current Medicaid expansion Decision[a]	704,549	371,227	387,856	1,095,719
Dollars of federal outreach and enrollment assistance funding per uninsured individual	$6.08	$7.38	$7.27	$6.73
Dollars of federal outreach and enrollment assistance funding available per individual eligible for financial assistance	$13.55	$15.57	$9.81	$8.31

Sources: Urban Institute projections based on the 2014 Health Insurance Policy Simulation Model using data from the American Community Survey (HIPSM-ACS 2014); Center for Consumer Information and Insurance Oversight, "Navigator Grant Recipients," Centers for Medicare and Medicaid Services, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/navigator-list-10-18-2013.pdf (accessed October 2014); "Outreach and Enrollment Assistance Awards to Health Centers," Health Resources and Services Administration, http://www.hrsa.gov/about/news/2013tables/outreachandenrollment/ (accessed October 2014); "Primary Care Association Outreach and Enrollment Awards," Health Resources and Services Administration, http://www.hrsa.gov/about/news/2013tables/outreachandenrollment/pcas.html (accessed October 2014); "Consumer Assistance Program Grants under the Affordable Care Act, as of FY 2012," Kaiser Family Foundation, http://kff.org/health-reform/state-indicator/consumer-assistance-program-grants/ (accessed October 2014).

[a] For Wisconsin this takes into account Medicaid eligibility changes in 2014.

SUMMARY OF CASE STUDY FINDINGS: NORTH CAROLINA AND SOUTH CAROLINA

We conclude that several important differences between North Carolina and South Carolina affected enrollment experiences with the FFM. North Carolina has a rich history of partnerships, coordination, and collaboration among diverse stakeholders around health care issues. This infrastructure, which was much less developed in South Carolina, helped to support outreach and enrollment efforts, create a state-wide message about the ACA, and develop systems—including a statewide scheduling system and toll free phone number—to facilitate enrollment on the Marketplace. The presence of foundation support in North Carolina, which appeared to be less substantial in South Carolina, also allowed assisters and advocates to mobilize efforts around outreach and enrollment.[9]

Coordinated Outreach Efforts

Perhaps the most significant difference between North Carolina and South Carolina was the organization and robustness of outreach efforts both before and after the passage of the ACA. Informants reported that North Carolina had a long-standing infrastructure of health and consumer advocates within the state and that partnerships, coordination, and collaboration among diverse stakeholders were common. Many of the informants with whom we spoke had worked together on health care consumer-related issues before the passage of the ACA; accordingly, there were pre-existing relationships and significant trust that helped to create a collaborative environment for ACA outreach and enrollment efforts. As one informant explained, "there was a history of action orientation."

In contrast to the collaborative atmosphere in North Carolina, there were notable conflicts in South Carolina. To the shock of many community-based organizations, the largest Navigator grant went to an out-of-state, for-profit agency, rather than to a consortium of highly recognized and collaborative community-based organizations. Informants reported that the out-of-state entity had no relationships within South Carolina, except with some hospitals where they conducted debt collection, which raised trust issues within local communities. Some informants also reported tension between some Navigator grantees and some members of the community-based consortium, leading to unproductive partnerships. These relationships appeared to improve over time, but recovery was difficult and collaboration and coordination dropped among South Carolina outreach and assistance organizations.

The partnership entities in North Carolina were galvanized into action after the state elected not to establish its own Marketplace. North Carolina initially planned to develop its own Marketplace. Many organizations, coordinated by the North Carolina Institute of Medicine, worked together on the development of the SBM. But in early 2013, after a new Republican governor took office and there were Republican majorities in both houses of the legislature, the governor signed into law a bill that prohibited any state agency from assisting in the establishment of a state-based or state–federal partnership Marketplace. Subsequently, the state returned all the federal funds it had received to establish its own Marketplace, and in response, private groups stepped in to fill the void. A cohort of 12 community-based organizations applied for and received what sources report was the fourth-largest federal Navigator grant in the country. The Navigator consortium worked to coordinate outreach and enrollment assistance. A much larger group of organizations, known as the Big Tent, also worked to coordinate education, outreach and enrollment activities. The Big Tent included members of the Navigator consortium, representatives of health plans and brokers, North Carolina's Primary Care Association, community health centers and other providers, and Enroll America.

Centralized Scheduling System and Statewide Toll-Free ACA Assistance Number

Nearly all the sources we spoke with in North Carolina emphasized the importance of the centralized assister scheduling system, operated by Legal Aid of North Carolina and initially funded by the North Carolina Primary Care Association with money the association had received from HRSA. Funded Navigators and HRSA grantees were able to use the centralized system to schedule appointments with consumers seeking enrollment assistance and paid a fee per full-time equivalent for use of the system. The system was password protected and not consumer-facing, so consumers could not sign up online themselves. The scheduling system tracked data on appointments, sometimes enabling organizations to deploy additional Navigator support in areas with high demand. There were limitations on the scheduling system—some reported that it did not work as well in some rural communities and for all assister entities—but Enroll America has taken the idea of a centralized scheduling system to create a nationwide scheduling system for 2015 open enrollment.

Legal Aid of North Carolina also developed a statewide hotline for consumer outreach and enrollment assistance. Staff on the hotline did not provide enrollment assistance, but were able to provide basic information about the FFM, refer people to local assisters, and set up appointments for consumers in their local communities. The establishment of a central toll-free number helped brand the Marketplace and create a unified message about where to go to obtain enrollment information.

Most of the sources we spoke to also emphasized the important role Enroll America played in North Carolina, both by developing and disseminating messaging strategies and by promoting the online scheduling system. Though Navigators and other certified assisters were limited in their ability to keep personal information about consumers, Enroll America only conducted outreach and education; thus, it was able to retain contact information from consumers interested in learning more about the Marketplace. Enroll America volunteers and staff had access to the scheduling system to schedule appointments for consumers and make calls to consumers to remind them of their appointments and of what documents to bring. Informants indicated that engaging consumers required multiple contacts and that the centralized scheduling system, combined with Enroll America's ability to collect consumer contact information and follow up with them, drove people toward the Marketplace enrollment assisters.

In contrast, there was no centralized coordination or branding in South Carolina, partly because the community-based consortium did not receive Navigator funding and also because they lacked the resources to sustain the coalition during open enrollment.

External Support

In addition to Enroll America's efforts, state-based philanthropies supported North Carolina's outreach and enrollment efforts. This nongovernmental funding helped create and sustain the infrastructure for cooperation and collaboration and fund direct consumer outreach and

assistance. Private nongovernmental support for outreach and enrollment assistance existed in South Carolina, but it appeared to be more limited and localized.

Insurance Market

Although not cited by many informants, it appeared to us that BCBSNC's dominance in the individual market may have contributed to higher enrollment by simplifying messaging and coordination in North Carolina and creating an incentive for BCBSNC to market heavily throughout the state. Outside the metropolitan areas, all FFM enrollment would come to BCBSNC rather than be dispersed among multiple carriers. Several sources reported that BCBSNC engaged in significant marketing and branding of its products through such avenues as mobile units and walk-in retail outlets.

As shown in table 4, BCBSNC had 85 percent of the individual market in North Carolina as of 2012. Moreover, there were only two issuers on the FFM in North Carolina in 2014 and only BCBSNC offered individual plans throughout the state. BCBSNC also participated regularly in the major coordinating group in the Big Tent. With only one issuer offering plans statewide, assisters, brokers, community advocates and the health plan often worked together.

Although Blue Cross Blue Shield of South Carolina also dominated the pre-ACA market in South Carolina, there were three carriers offering plans in South Carolina including a new cooperative, which informants reported was very competitive in certain parts of the state.

Anti-ACA Sentiment

Anti-ACA sentiment was substantial in both North Carolina and South Carolina, although informants indicated it was more consistent and intense in South Carolina. One study reports that there was considerable anti-ACA political advertising in North Carolina and some in South Carolina,[10] but the anti-ACA advertising did not seem to affect North Carolina enrollment.

South Carolina's intention to limit participation in the ACA was evident as early as August 2011, when Governor Nikki Haley signed a budget that stated that, if federal law permitted, South Carolina would opt out of such key ACA provisions as the individual mandate and Medicaid expansion.[11] The state house of representatives later passed a nullification law (the Freedom of Health Care Protection Act, H. 3101) that sought to void the ACA and penalize anyone assisting with enrollment and outreach activities.[12] Though the bill did not pass the state senate, it created considerable confusion among the public as to the legality of the health reform law, and also led to misperceptions about South Carolina's participation in the ACA, and how much Navigators and assisters were allowed to help consumers enroll into health coverage. Sources reported that some consumers thought it was illegal to sign up for "Obamacare" during open enrollment and that South Carolina had opted out of the law.

Additionally, the director of the South Carolina Department of Insurance was vocal in his concerns about fraud and misrepresentation by Navigators, further contributing to consumer wariness. Stakeholders reported that these anti-ACA messages created a need to reeducate consumers about enrolling through the federal Marketplace and led to significant barriers to effective outreach and enrollment in South Carolina. As reported by one informant, "state lawmakers just confused the heck out of people."

Navigator and Producer Collaboration

Though there appeared to be some tension between producers and Navigators in both states, there appeared to be more collaboration between these groups in North Carolina. The producer community in North Carolina participated in the Big Tent and enrollment events, including those they hosted themselves, and did not push for legislation requiring licensing of Navigators in North Carolina. In South Carolina, on the other hand, there were "no formal collaborations" between brokers and Navigators, and one informant we spoke with said that producers had been "frozen out" of the outreach and enrollment planning process. Producers in both states felt that, compared to Navigators, they had significantly more expertise about health insurance products. Some informants also reported that they believed CMS barred Navigators from collaborating with producers.

Overcoming Challenges in South Carolina

Although this study focuses on why one state had higher enrollment rates than another, South Carolina did very well in some ways despite the intense anti-ACA environment and lack of coordinated statewide efforts. It slightly exceeded projected enrollment rates for 2014, the market was more competitive in South Carolina than in North Carolina, and a new ACA health insurance cooperative was able to enter the market in its first year. By the end of open enrollment, many in the outreach and enrollment community had overcome initial obstacles and developed stronger working relationships. Additionally, several city and county officials and state legislators were openly supportive of the ACA, and their offices publicized and promoted outreach and enrollment opportunities for local residents.

Key Findings: North Carolina and South Carolina Open Enrollment in 2014

- Demographic factors, pre-ACA uninsured rates and Marketplace premium rates did not appear to play a significant role in the different enrollment outcomes.
- Partnerships, coordination and collaboration between diverse stakeholders, including Enroll America, a large Navigator consortium and a diverse group called the Big Tent, helped enrollment efforts in NC, as did a culture of collaboration that preceded the ACA.
- Private funding for planning, outreach and enrollment assistance, including the involvement of Enroll America, appeared to play a significant role in North Carolina and helped create and sustain the infrastructure for cooperation and collaboration.
- Coordinated efforts on messaging, a single statewide toll-free line and a statewide scheduling system helped enroll consumers in North Carolina.
- Anti-ACA sentiment was significant in both states but was more consistent and intense in South Carolina, creating greater enrollment challenges there.
- Outreach and enrollment efforts were more fragmented in South Carolina where a community-based nonprofit consortium applied for but did not receive Navigator funding and the largest grant went to an out-of-state for-profit agency.
- The dominance of BCBSNC and the fact that it was the sole carrier to offer plans statewide may have made it easier for assisters, brokers, community advocates and the insurer to collaborate in North Carolina than in South Carolina where three carriers competed on the FFM. As the only statewide carrier on the FFM, BCBSNC's marketing was more likely to drive enrollment toward its plans rather than to multiple carriers.
- The producer community in North Carolina did not press for legislation regulating Navigators and actively participated in statewide planning and enrollment coordination. Consumer advocates and assister groups worked with producers on enrollment events and strategies in North Carolina. In South Carolina, there was little (if any) collaboration between brokers and community-based organizations and assisters.
- The coverage gap was a challenge for assisters in both North Carolina and South Carolina, and assisters in both states described challenges in enrolling members of minority communities, particularly Latinos and other non-English-speaking consumers.

SUMMARY OF CASE STUDY FINDINGS: WISCONSIN AND OHIO

In Ohio and Wisconsin, we found that the story behind Marketplace enrollment was really a story about Medicaid, albeit for different reasons. Changes to the Medicaid programs in both states had a significant effect on consumer outreach and enrollment assistance.

Additionally, before the ACA's enactment, Wisconsin had a more cohesive network of consumer advocates and providers working to connect consumers to coverage. These partnerships evolved following the ACA's enactment and the state helped create regional networks to assist with enrollment. Ohio also had a coalition of advocates, assisters and providers, though their efforts appeared to be less focused and outcome-oriented than those in Wisconsin.

Political Context

Wisconsin and Ohio have similar political environments. Both states had Democratic governors when the ACA became law but elected Republican governors in November 2010. Both houses of the Wisconsin legislature and the Ohio General Assembly have Republican majorities, but the state senate in Wisconsin had a Democratic majority before the 2012 election. One study reports that nearly $800,000 was spent on anti-ACA political advertising in several cities in Ohio but relatively little was spent on anti-ACA political advertising in Wisconsin.[13]

The Effect of Medicaid on Marketplace Enrollment in Wisconsin and Ohio

As of 2010, Wisconsin had one of the most generous Medicaid plans in the country.[14] Wisconsin covered parents and caretaker relatives earning up to 200 percent of FPL. In 2009, it launched a new program to cover childless adults earning up to 200 percent of FPL. That program quickly exceeded enrollment projections and was capped within a few months of its launch.

In 2010, Republican Scott Walker was elected governor of Wisconsin, replacing Democrat Jim Doyle. A polarizing leader in his first two years, he faced and won a recall election in 2012. Governor Walker was a strong opponent of the ACA.[15] Yet, after he won the recall election, one of his major initiatives was to reform entitlement programs by relying heavily on the availability of private health insurance through the ACA-created Marketplace.

Through his "Entitlement Reform Plan,"[16] which was included in the state's 2013 to 2015 biennial budget, Walker restructured the BadgerCare program. While he rejected Medicaid expansion under the ACA, he eliminated the cap on enrollment of childless adults under 100 percent of FPL in BadgerCare, thereby opening enrollment to an estimated 82,000 low-income individuals as of April 2014.[17]

He also significantly cut eligibility for tens of thousands of Wisconsin residents, eliminating BadgerCare coverage for childless adults, parents and caretaker relatives who were at or above 100 percent of FPL. The theory was that these individuals would receive financial assistance to purchase private coverage on the FFM. The Wisconsin Department of Health Services (DHS) reported that as a result of Medicaid eligibility changes, nearly 63,000 people in Wisconsin lost their BadgerCare coverage in 2014.[18]

The Governor's reform plan and his decision not to expand Medicaid was met with significant opposition,[19] but Walker's plan was premised on *increasing* the number of insured in Wisconsin by 225,000 and moving people "from government dependence to independence."[20] Thus, the Walker administration was invested in increasing overall coverage rates, including through the federal Marketplace.

Sources reported that, following the troubled rollout of healthcare.gov, the Walker administration sent mixed signals in fall 2013 about delaying the BadgerCare changes, which were initially scheduled to take effect on January 1, 2014. Eventually the governor and the legislature delayed the changes until April 1, 2014, but by then many enrollees had already been told they would lose coverage at the end of 2013. Sources consistently reported that the confusion over the timing and content of the BadgerCare changes, combined with the huge IT problems on the FFM, had ripple effects throughout the enrollment community and among consumers. Nonetheless, diverse sources throughout Wisconsin told us that staff at DHS made significant efforts to educate people about the FFM and connect them with enrollment assistance.

DHS took several steps to help those losing BadgerCare transition to the private insurance market: sending several letters to those enrollees beginning in fall 2013 through spring 2014, calling them to inform them of the upcoming changes and their available options, and making available to health care providers a list of their Medicaid patients who would be losing coverage and would need assistance finding alternative coverage. DHS also organized and supported regional enrollment networks throughout the state and worked with a small group of stakeholders with enrollment experience and familiarity with the BadgerCare population to help develop enrollment strategies. Despite the governor's opposition to the ACA, the state made significant efforts to help those losing BadgerCare coverage transition into the private insurance market.[21] In the end, only about 19,000 of the consumers who lost BadgerCare reportedly signed up for a Marketplace plan,[22] but they were an identifiable set of consumers who needed insurance and were likely eligible for financial assistance on the FFM; as such, they were targeted for outreach and enrollment assistance.[23]

Ohio, on the other hand, expanded its Medicaid program, making 366,000 Ohioans newly eligible for Medicaid coverage.[24] Accordingly, much of the focus during open enrollment was on this newly eligible population. In late 2013, Ohio launched Benefits.Ohio.gov, an online portal that replaced a 30-year-old enrollment system. The new portal was implemented to handle the increase of applicants expected to apply for Medicaid coverage because of expansion. As of March 2014, more than 180,000 people had accessed the site and 115,000 Ohioans had enrolled in Medicaid through the portal, including the 54,000 who became eligible with the new income guidelines.[25] The portal also administers applications for other public benefits.[26]

Expanding Medicaid, however, occurred with considerable controversy. The Ohio General Assembly included a provision in the 2013 omnibus budget bill that would have barred the state Medicaid program from implementing the ACA Medicaid expansion, but Ohio Governor John R. Kasich line-item vetoed that provision and sought and received CMS approval to implement the expansion.[27] Defying the Ohio General Assembly, Governor Kasich pushed through the expansion of Medicaid using a little-known legislatively controlled entity called the Controlling Board. This entity, which normally oversees small adjustments to the state budget, facilitated Medicaid expansion by accepting approximately $2 billion in federal funds to cover the costs of expanding the Medicaid program in fiscal year 2014 to 2015 and was accused of acting illegally by state legislators. The Ohio Supreme Court upheld the Controlling Board's actions in December 2013.[28]

Sources in Ohio reported that enrollment efforts in Ohio focused particularly on Medicaid and that the majority of consumers seeking assistance were eligible for Medicaid. Based on those reports, we looked at Marketplace enrollment rates in other states that were on the FFM in 2014 and also expanded Medicaid. As shown in table 8, with the exception of Michigan, all states that expanded Medicaid and used the FFM in 2014 (Arkansas, Arizona, Delaware, Illinois, Iowa, New Jersey, New Mexico, North Dakota, Ohio and West Virginia) had enrollment rates well below the national average. This includes four states that were planning to build their own Marketplaces and received funding for in-person consumer assistance (Arkansas, Delaware, Illinois and New Mexico).[29] When compared to all of these states, Ohio did well, particularly considering that it relied solely on federal Navigator and HRSA grants for enrollment assistance.

Table 8. Current Enrollment as a Percent of Projected 2014 Enrollment of States Using the FFM for the Nongroup Market in 2014 by Medicaid Expansion Decision

State	Projected 2014 Marketplace enrollment	Projected 2016 Marketplace enrollment	Latest Marketplace enrollment data	Current enrollment as a percentage of projected 2014 enrollment
Florida	594,000	1,437,000	983,775	165.7%
North Carolina	246,000	615,000	357,584	145.3%
Michigan[a]	189,000	467,000	272,539	144.5%
Wisconsin	107,000	269,000	139,815	130.3%
New Hampshire[a]	31,000	79,000	40,262	128.8%
Maine	35,000	82,000	44,258	128.1%
Georgia	247,000	608,000	316,543	127.9%
Virginia	175,000	451,000	216,356	123.9%
Pennsylvania	267,000	677,000	318,077	119.3%
Total FFM	4,745,000	11,773,000	5,338,000	112.5%
Missouri	140,000	349,000	152,335	108.8%
Texas	696,000	1,683,000	733,757	105.4%
New Jersey	154,000	396,000	161,775	105.3%
Utah	83,000	208,000	84,601	101.6%
Tennessee	149,000	378,000	151,352	101.6%
South Carolina	117,000	283,000	118,324	101.3%
Delaware[a]	14,000	34,000	14,087	101.2%
Illinois[a]	215,000	566,000	217,492	101.0%
Alabama	100,000	252,000	97,870	97.4%
Montana	39,000	98,000	36,584	93.3%
Mississippi	68,000	162,000	61,494	91.1%
Indiana	150,000	369,000	132,423	88.5%
Kansas	66,000	169,000	57,013	86.7%
Nebraska	50,000	136,000	42,975	85.9%
Louisiana	122,000	305,000	101,778	83.3%
Ohio	205,000	498,000	154,668	75.3%
Arizona	160,000	391,000	120,071	75.0%
Arkansas[a]	61,000	147,000	43,446	71.5%
Oklahoma	97,000	235,000	69,221	71.5%
New Mexico[a]	46,000	112,000	32,062	69.8%
Wyoming	18,000	45,000	11,970	67.5%
West Virginia	30,000	68,000	19,856	67.3%
Alaska	22,000	51,000	12,890	58.2%
Iowa	54,000	145,000	29,163	53.8%
North Dakota	20,000	54,000	10,597	53.1%
South Dakota	25,000	66,000	13,104	51.9%

Source: Blumberg LJ, Holahan J, Kenney GM, Buettgens M, Anderson N, Recht H and Zuckerman S. Measuring Marketplace Enrollment Relative to Enrollment Projections: Update. Washington: Urban Institute, 2014, http://www.urban.org/UploadedPDF/413112-Measuring-Marketplace-Enrollment-Relative-to-Enrollment-Projections-Update.pdf (accessed October 2014).

[a] State Received additional federal funding to establish an In-Person Assister Program

Not expanding Medicaid

Expanding Medicaid

Federally facilitated Marketplace average

Unified Messaging and Statewide Coordination

The overarching theme heard in Ohio about outreach and enrollment on the FFM was that there was no statewide unifying message, and many sources reported that the lack of a statewide media and branding campaign was a major weakness. Although the largest Navigator grantee in Ohio engaged in media outreach, its efforts targeted certain geographic areas.

Another challenge identified by several sources in Ohio was that efforts across entities were fragmented. The Ohio Network for Health Coverage and Enrollment, a major convening body within the state, was described as a "loose network" of approximately 250 organizations that consisted primarily of Navigators, community health centers, consumer advocacy and community based organizations, and a few health plans and brokers. The Ohio Network for Health Coverage and Enrollment facilitated the exchange of information and best practices among the key players but did not have a strategic plan or enrollment objectives. Individual groups, including a large Navigator grantee with partners throughout the state, seemed to work effectively and believed they had significant success with their clients, but a collective outreach and enrollment strategy seemed absent. Though Enroll America had staff in Ohio, there was no strong statewide Marketplace enrollment system with which to coordinate.

There were similar challenges initially in Wisconsin, where a large statewide consortium called E4Health did not receive Navigator funding. Two factors, however, supported more-coordinated efforts in Wisconsin. First, the State Department of Health Services convened key stakeholders and helped organize regional enrollment networks (RENs), modeled on a successful network in Milwaukee. Second, the Wisconsin Primary Health Care Association provided funding and worked with Covering Kids and Families to maintain the E4Health website as a central, statewide source of information on the ACA and enrollment assistance.

Regional Networks

Regional assistance coalitions, which served as "idea forums" for Ohio Navigators and assisters, operated in pockets of the state, but it appeared that these coalitions were independent both from the statewide convening organization and from each other. Accordingly, their outreach and enrollment efforts were primarily focused in their immediate geographic areas. In contrast, the RENs in Wisconsin were developed and supported by DHS and were operational statewide, even if they did not coordinate their activities statewide.

The REN system was based on the Milwaukee Enrollment Network (MKEN), which sources consistently referred to as a successful local model. The state provided matching funds for AmeriCorps volunteers to help staff the RENs. MKEN grew out of a "pre-existing enrollment network" of providers, consumers and community groups that previously had worked together to increase access to health care in Milwaukee. Thus, they had strong established partnerships, trusting relationships and an organizational infrastructure that allowed them to develop and implement a strategic plan and goals for MKEN. Additionally, though they did not receive Navigator or other governmental funding to operate MKEN, they did receive some foundation funding and members received support from the county government. Other RENs did not have these same resources or experiences to draw on in for 2014, which made the MKEN model difficult to replicate in other regions. Sources also told us that in regions where local leaders strongly opposed the ACA, there was less support for the RENs, which may have contributed to the mixed experiences with RENs around the state.

In both states, many carriers offered individual plans before 2014 and on the FFM. Informants in Wisconsin described their insurance market as competitive and highly regionalized, and the FFM included several plans that were affiliated with regional hospital and provider systems. Thus, local coordination through the RENs in Wisconsin may have helped focus on the regional differences in available qualified health plans.

Anti-ACA Messaging

Given the controversial process under which Medicaid expansion in Ohio occurred, stakeholders reported substantial anti-ACA sentiment throughout the state, particularly outside the major urban hubs. The director of the Ohio Department of Insurance was an outspoken opponent of the ACA,[30] and informants noted that there was "a lot of noise to cut through" to educate consumers about the law.

Sources in Wisconsin also described the need to work through the anti-ACA backdrop (people had "political fatigue"). But the DHS leading the organization of the RENs and connecting people who were losing BadgerCare to the private market provided a significant counterweight to the anti-ACA messages.

Navigator Licensing Laws

Both Wisconsin and Ohio informants reported that state Navigator regulations had a chilling effect on outreach and enrollment efforts. Though these regulations may have had an effect on Navigators, the effect was comparable in both states and did not explain the different enrollment outcomes.[31]

Key Findings: Wisconsin and Ohio Open Enrollment in 2014

- Demographic factors, pre-ACA uninsured rates, and Marketplace premium rates did not appear to play a significant role in the different enrollment outcomes.
- Medicaid expansion in Ohio dominated open enrollment, leading to much less focus on Marketplace outreach and enrollment. Our analysis shows that 9 of the 10 other states that used the FFM and expanded Medicaid, like Ohio, also had below average rates of Marketplace enrollment in 2014.
- Over 60,000 people in Wisconsin lost Medicaid (BadgerCare) coverage in 2014, and another 20,000 lost coverage through the state's high-risk pool. These were identifiable populations that needed alternative coverage, were used to having insurance, and were therefore more likely to enroll. Approximately 19,000 former BadgerCare enrollees signed up for qualified health plans on the FFM, and an undetermined number of former high-risk pool members enrolled.
- Wisconsin officials made significant efforts to notify people that they were losing BadgerCare coverage and tried to link them to enrollment assistance. Because the governor's entitlement reform plan projected a large increase in coverage, officials were motivated to help people obtain coverage on the FFM.
- Despite significant opposition to Wisconsin Governor Scott Walker's decision not to expand Medicaid, consumer advocates and organizations engaged in outreach and assistance set aside those differences to develop pragmatic collaborative strategies to enroll consumers in the FFM.
- Anti-ACA sentiment was significant in both states but appeared more consistent and intense in Ohio.
- Sources in both states wanted more statewide coordination to develop a unified message, a centralized brand, and a single place to get information about the ACA and enrollment assistance. The regional enrollment networks in Wisconsin appeared to be more successful than the more ad-hoc regional groups in Ohio, where outreach and enrollment assistance efforts were more fragmented.
- In both states, groups that had worked together in the past, and had resources to support coordinating activities, appeared to be most successful.

CROSS-CUTTING OBSERVATIONS

In each state we studied, unique factors appeared to affect Marketplace enrollment experiences. The first open enrollment period was dominated by the troubled launch of healthcare.gov and a highly polarized and partisan backdrop of ACA debate, which affected states and communities differently. In all four study states, sources reported that the highest demand for coverage was from people with the lowest incomes. In part, this could be because federally funded assisters—particularly the community health centers and some of the community-based Navigator organizations—work with those populations and are trusted resources in their communities. But it also may reflect the composition of the uninsured and the greatest pent-up demand for coverage. In North Carolina and South Carolina, this meant that Navigators and certified application counselors spent substantial time with consumers in the coverage gap (those with low incomes who were not eligible for Medicaid or financial assistance on the Marketplace). In Wisconsin and Ohio, on the other hand, Medicaid changes played a significant role throughout open enrollment.

Our focus was on comparing each pair of FFM states, but themes emerged that transcended all of those states. Much of what we heard supports findings that have been reported by Kaiser Family Foundation, Enroll America and others[32] and is consistent with survey results from Urban Institute's Health Reform Monitoring Survey (HRMS). We have therefore included a summary of takeaways that we heard from multiple sources in all four states.

Outreach, Education and Consumer Understanding

- A centralized place to call for outreach and assistance information other than healthcare.gov is important in FFM states (a single toll-free number, branded assistance for the Marketplace and a one-stop place for information).
- More mass media can help educate consumers about the Marketplace and basics of insurance, and can include earned media, billboards, signs on buses and TV and radio advertisements.
- Start outreach and messaging early—waiting until the eve of open enrollment is too late to help educate consumers about the availability of private insurance coverage and subsidies.
- Television phone-a-thons (sponsored by local television media) are perceived as an effective strategy to connect consumers with enrollment assistance. Telethon staff answered general questions about health insurance and the ACA and referred consumers to in-person assisters for enrollment help at a later date.

Enrollment Assistance

- It often takes multiple contacts and meetings before a consumer enrolls.
- In-person meetings are the most effective way to help people enroll.[33]
- Trusted and known community leaders and members are the most effective at spreading the word and getting people to meet with an assister, especially with hard-to-reach populations.
- Reaching and enrolling members of racial minorities is more challenging, particularly in Hispanic and Latino communities and other communities where consumers have limited English proficiency.[34]
- Churches and libraries were frequently identified as successful venues for outreach and assistance.
- It takes a long time to enroll people and help them pick an appropriate plan, particularly if they are not familiar with private health insurance.
- City and county officials can provide important support for outreach and enrollment, particularly in states where state officials are hostile to the ACA.

Outreach and Enrollment Systems

- Coordinating plans and strategies between and among diverse organizations is particularly effective and requires resources and a coordinating entity to support the infrastructure.
- In FFM states, funding by private philanthropies and local government entities can significantly increase dissemination of coordinated messaging, identify the areas of need and organize and facilitate enrollment assistance.

Enrollment Barriers

- Lack of consumer understanding of the Marketplace, financial subsidies and basic health insurance terms and concepts remain a major barrier to enrollment, particularly in minority communities and hard-to-reach populations.[35]
- Affordability was consistently cited as a significant barrier to Marketplace enrollment among lower-income consumers.[36]
- Identity verification issues on healthcare.gov increased barriers for immigrants.
- More resources using trusted community members, particularly in Hispanic or Latino communities and in other communities with limited English proficiency, are needed to bring people to the Marketplace and provide help to enroll.[37]
- Consumers often select plans based solely on premium price, which may not be the most appropriate plan for them. A system that rewards quick enrollment may not adequately educate consumers.
- Significant tensions between brokers and Navigators or assisters were exacerbated by state Navigator licensing laws and by the perception that CMS rules barred collaboration between the two groups. Some assisters reportedly wanted to refer complex cases to brokers but believed that they were not allowed to do so.[38]

ENDNOTES

1. Volk, J, Corlette, S, Ahn S, Brooks T. Report from the First Year of Navigator Technical Assistance Project: Lessons Learned and Recommendations for the Next Year of Enrollment. Washington: Georgetown University Health Policy Institute, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf416166 (accessed October 2014); Enroll America. *State of Enrollment: Lessons Learned from Connecting America to Coverage, 2013–2014.* Washington: Enroll America, 2014, https://s3.amazonaws.com/assets.getcoveredamerica.org/20140613_SOEReportPDFlr.pdf (accessed October 2014); Artiga S, Stephens J, Rudowitz R, Perry M. *What Worked and What's Next? Strategies in Four States Leading ACA Enrollment Efforts*. Oakland, CA: Kaiser Family Foundation, 2014, http://kff.org/health-reform/issue-brief/what-worked-and-whats-next-strategies-in-four-states-leading-aca-enrollment-efforts/ (accessed October 2014); Pollitz K, Tolbert J and Ma R. *Survey of Health Insurance Marketplace Assister Programs: A first Look at Consumer Assistance under the Affordable Care Act.* Oakland, CA: Kaiser Family Foundation, 2014, http://kaiserfamilyfoundation.files.wordpress.com/2014/07/8611-survey-of-marketplace-assisters2.pdf (accessed October 2014); Tolbert J, Perry M, Dryden S, Perry K. *Connecting Consumers to Coverage: Lessons Learned from Assisters for Successful Outreach and Enrollment.* Oakland, CA: Kaiser Family Foundation, 2014, http://kff.org/health-reform/issue-brief/connecting-consumers-to-coverage-lessons-learned-from-assisters-for-successful-outreach-and-enrollment/ (accessed October 2014); Grob R, Schlesinger M, Pollitz K and Grubstein L. *Taking Stock and Taking Steps: A report from the Field after the First Year of Marketplace Consumer Assistance under the ACA.* Oakland, CA: Kaiser Family Foundation, 2014, http://kff.org/health-reform/report/taking-stock-and-taking-steps-a-report-from-the-field-after-the-first-year-of-marketplace-consumer-assistance-under-the-aca/ (accessed October 2014); Kingsdale J, Mazza KJ and Connolly K. *Boosting Enrollment: Lessons Learned from 2013–2014.* Princeton, NJ: Robert Wood Johnson Foundation, 2014, http://www.statenetwork.org/wp-content/uploads/2014/08/State-Network-Wakely-Boosting-Enrollment-August-2014.pdf (accessed October 2014); Goodwin K and Tobler L. *Medicaid and Marketplace Outreach and Enrollment Options for States*. Washington: National Conference of State Legislatures, 2014, http://www.ncsl.org/documents/health/MedicaidandMarketplaceOandEOptionsforStates514.pdf (accessed October 2014); Families USA. *Enrollment Momentum: Accelerating the Affordable Care Act's Enrollment Momentum: 10 Recommendations for Future Enrollment Periods.* Washington: Families USA, 2014, http://familiesusa.org/sites/default/files/product_documents/ENR_Enrollment_report_FINAL_032814_web.pdf (accessed October 2014).
2. Blumberg LJ, Holahan J, Kenney GM, Buettgens M, Anderson N, Recht H and Zuckerman S. *Measuring Marketplace Enrollment Relative to Enrollment Projections: Update*. Washington: Urban Institute, 2014, http://www.urban.org/UploadedPDF/413112-Measuring-Marketplace-Enrollment-Relative-to-Enrollment-Projections-Update.pdf (accessed October 2014).
3. Researchers at the Leonard Davis Institute of Health Economics compared premiums, issuers and plans offered to residents of urban and rural areas in all Marketplaces in 2014. The authors report what percentage of each state's population eligible to purchase plans in the Marketplace lived in rural areas. According to their analysis, the percentage of the Marketplace-eligible population living in rural communities in 2014 is 23 percent in North Carolina, 16 percent in South Carolina, 27 percent in Wisconsin, and 21 percent in Ohio. Based on these percentages, in both of our paired states, the state with the higher rural population had the higher enrollment rate. See Polsky DE, Weiner J, Nathenson RA, Becker N and M Kanneganti. *How Did Rural Residents Fare on the Health Insurance Marketplaces?* Philadelphia: Leonard Davis Institute of Health Economics, 2014.

4. U.S. Census Bureau, "2010 Census Urban and Rural Classification and Urban Area Criteria," http://www2.census.gov/geo/ua/PctUrbanRural_State.xls (accessed October 2014).
5. U.S. Census Bureau, "2010 Census Urban and Rural Classification and Urban Area Criteria."
6. CMS maintains an interactive map to show which states received exchange establishment grants. All four study states received an initial $1 million planning grant in 2010. North Carolina received significant establishment grant awards but did not move forward and returned unspent funds in 2013. Wisconsin received an Early Innovator grant from HHS in 2010 but returned the money after Governor Scott Walker was elected.
7. Burns A and Cheney K, "Obama Administration Plans $12M Ad Buy to Promote Health Law," *Politico,* September 15, 2013, http://www.politico.com/story/2013/09/obamacare-ad-buy-96339.html (accessed October 2014).
8. This analysis also provides more details regarding the political context and enrollment efforts in Wisconsin. Friedsam D, Kaplan T and Eskrich S. *Managing Health Reform Wisconsin: Round 1 – State-Level Field Network Study of the Implementation of the Affordable Care Act*. Albany, NY: Nelson A. Rockefeller Institute of Government, State University of New York, 2014. http://www.rockinst.org/aca/states/wisconsin/2014-08-Wisconsin_Round_One.pdf (accessed October 2014).
9. The Robert Wood Johnson Foundation, which provided funding for this report, funded Enroll America and assisters in North Carolina and Ohio.
10. Ellenberger H, "2013 Estimated Spending on Anti-ACA Political Advertising," Kantar Media Intelligence/CMAG, http://mycmag.kantarmediana.com/misc/Anti-ACA_political_advertising.html (accessed October 2014).
11. For a detailed description of the political backdrop in South Carolina and more details about the various enrollment efforts, see Andrews C and Yingling M. *South Carolina: Round 1 – State-Level Field Network Study of the Implementation of the Affordable Care Act*. Albany, NY: Nelson A. Rockefeller Institute of Government, State University of New York, 2014, http://www.rockinst.org/ACA/states/South_Carolina/2014-08-SCarolina_Round_One.pdf (accessed October 2014).
12. "South Carolina House Bill 3101," South Carolina General Assembly, http://legiscan.com/SC/bill/H3101/2013 (accessed October 2014).
13. Ellenberger H, "2013 Estimated Spending on Anti-ACA Political Advertising."
14. For a summary of BadgerCare before and after the ACA, see Gates A and Rudowitz R. *Wisconsin's BadgerCare Program and the ACA.* Oakland, CA: Kaiser Family Foundation, 2014. http://kff.org/medicaid/fact-sheet/wisconsins-badgercare-program-and-the-aca/ (accessed October 2014).
15. Jindal B and Walker S, "Jindal and Walker: Unworkable ObamaCare, Opaque Rules, Big Delays and Rising Costs: The Chaos is Mounting," *Wall Street Journal*, July 25, 2013, http://online.wsj.com/news/articles/SB10001424127887324110404578626452647631608 (accessed October 2014).
16. A description of the Entitlement Reform Plan and links to related documents are on the Wisconsin Department of Health Services website. "Governor Walker's Entitlement Reform Plan," Wisconsin Department of Health Services, http://www.dhs.wisconsin.gov/aboutdhs/initiatives/budget/initiatives/er/index.htm (accessed October 2014).
17. "April 2014 BadgerCare Plus – New Childless Adult Enrollment by (Admin) County," Wisconsin Department of Health Services, http://www.dhs.wisconsin.gov/badgercareplus/enrollmentdata/pdf/BadgerCarePlusNewChildlessAdultsApril2014.pdf (accessed October 2014).
18. Wisconsin Department of Health Services, http://www.dhs.wisconsin.gov/badgercareplus/enrollmentdata/pdf/BadgerCarePlusTransitioningMemberSummaryApril2014.pdf (accessed October 2014).
19. Friedsam D, Kaplan T, and Eskrich S, *Managing Health Reform Wisconsin: Round 1 – State-Level Field Network Study of the Implementation of the Affordable Care Act,* p. 4; Peacock J, "New DHS Data Confirm Our Fears: Most Adults Losing BadgerCare Aren't Insured in the Marketplace," *Wisconsin Council on Children and Families Blog,* July 16, 2014, http://www.w.org/new-dhs-data-confirm-fears-adults-losing-badgercare-arent-insured-marketplace/ (accessed October 2014).
20. Office of Governor Scott Walker, "Governor Scott Walker Announces Entitlement Reform: Rejects Federal Medicaid Expansion, Still Reduces Number of Uninsured by 224, 580," press release, February 13, 2013, http://walker.wi.gov/newsroom/press-release/governor-scott-walker-announces-additional-entitlement-reform (accessed October 2014).
21. There were two other sets of identifiable consumers that likely included large numbers of people eligible for financial assistance on the FFM. DHS had a list of consumers who had inquired about the program covering childless adults. Sources informed us that DHS also contacted those individuals, numbering in the tens of thousands, many of whom may have been eligible for the FFM. Some sources also reported that they believe Marketplace enrollment was also successful because the state's high-risk pool, the Health Insurance Risk-Sharing Plan, ended coverage as of April 1, 2014, and approximately 20,000 members of the Health Insurance Risk-Sharing plan needed new coverage. According to a chart published by the National Association of State Comprehensive Health Insurance Plans, as of December 31, 2011, Wisconsin had the third-largest number of enrollees among all the state high-risk insurance pools in the country. As of December 31, 2012, the Health Insurance Risk-Sharing Plan had nearly 22,000 members, only 2,000 of whom were federal high-risk pool enrollees. No one reported any specific outreach efforts to the members of HIRSP, but it is likely they were given notice and information about the FFM and how to obtain help enrolling. "Pool Membership – 2011," National Association of State Comprehensive Health Insurance Plans, September 2012, http://naschip.org/2012/Quick%20Checks/Pool%20Membership%202011.pdf (accessed October 2014); Health Insurance Risk-Sharing Plan. *2012 Annual Report.* Madison, WI: Health Insurance Risk-Sharing Plan, http://www.hirsp.org/pdfs/annual_2012.pdf (accessed October 2014).
22. In addition to the 18,800 consumers who signed up for Marketplace plans, another 5,000 were found eligible for Medicaid or BadgerCare. Wisconsin Department of Health Services, "Department Provides Update Regarding Operationalization of Governor Walker's Entitlement Reforms," press release, July 16, 2014, http://www.dhs.wisconsin.gov/News/PressReleases/2014/071614.htm (accessed October 2014).
23. Several sources told us that they believe Marketplace enrollment projections for Wisconsin did not consider the many people who had been covered by BadgerCare who lost coverage and became eligible for the Marketplace plans and thus understated the actual Marketplace-eligible population. These sources thought that this might have contributed to the reports of high enrollment rates in Wisconsin. This does not explain the enrollment rates reported by the Urban Institute in May 2014. In estimating projected target enrollment populations we considered the changes in BadgerCare.
24. Ohio Governor's Office of Health Transformation. *Extend Medicaid Coverage and Automate Enrollment*. Columbus, OH: Ohio Governor's Office of Health Transformation, http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=oid6Wo-y0gs%3d&tabid=156 (accessed October 2014).
25. Higgs R, "Medicaid Expansion Has Drawn About 54,000 Newly Eligible Applicants to Ohio's Program With 300,000 More Expected by Mid-2015," *Cleveland.com*, March 28, 2014, http://www.cleveland.com/open/index.ssf/2014/03/medicaid_expansion_has_drawn_a.html (accessed October 2014).
26. "Ohio Benefits," https://benefits.ohio.gov/ (accessed October 2014).
27. Gabriel T, "Medicaid Expansion Is Set for Ohioans," *New York Times*, October 21, 2013, http://www.nytimes.com/2013/10/22/us/medicaid-expansion-is-set-for-ohioans.html?_r=0 (accessed October 2014); Candisky C, "Ohio Supreme Court Upholds Kasich's Expansion of Medicaid," *The Columbus Dispatch*, December 21, 2013, http://www.dispatch.com/content/stories/local/2013/12/20/1220-Ohio-Supreme-Court-upholds-state-Medicaid-expansion.html (accessed October 2014).
28. *State ex rel. Cleveland Right to Life v. State of Ohio Controlling Bd.,* 138 Ohio St. 3d 57, 2013-Ohio-5632, http://www.supremecourt.ohio.gov/rod/docs/pdf/0/2013/2013-Ohio-5632.pdf (accessed October 2014).
29. New Mexico has an SBM but used the FFM in 2014 for the individual market. CMS did not award any Navigator grants to organizations in New Mexico, but the New Mexico Health Insurance Exchange awarded grants for in-person assisters.
30. "Ohio Lt. Gov. Mary Taylor Says There's Still 'Uncertainty in Insurance Market After ACA Deadline," *Ideastream.com,* April 4, 2014, http://www.ideastream.com/news/feature/with-end-of-aca-deadline-state-insurance-director-warns-of-uncertainty (accessed October 2014).
31. "Governor Kasich Signs Health Insurance Navigators Legislation," Ohio House of Representatives press release, April 30, 2013, http://www.ohiohouse.gov/stephanie-kunze/press/governor-kasich-signs-health-insurance-navigators-legislation (accessed October 2014); Nickel TK, "Insurance Statutory Provisions contained in the 2013–2015 Wisconsin State Budget, 2013 Wisconsin Act 20, Regarding Navigators and Nonnavigator Assisters," Wisconsin Office of the Commissioner of Insurance Bulletin to Insurers, July 26, 2013, http://oci.wi.gov/bulletin/0713navigator.htm (accessed October 2014).
32. Enroll America, *State of Enrollment*; Artiga et al., *What Worked and What's Next?*; Pollitz, Tolbert and Ma, *Survey of Health Insurance Marketplace Assister Programs*; Tolbert et al., *Connecting Consumers to Coverage*; Grob, Schlesinger and Grubstein, *Taking Stock and Taking Steps*; Kingsdale, Mazza and Connolly, *Boosting Enrollment*; Goodwin and Tobler, *Medicaid and Marketplace Outreach and Enrollment Options for States*; Families USA, *Enrollment Momentum*.

33. Sources consistently emphasized the importance of one-on-one direct assistance to help consumers enroll. This is consistent with findings from Urban Institute's June 2014 Health Reform Monitoring Survey. That survey found that, among adults who had been uninsured for some or all of the previous 12 months, those who were insured at the time of the survey were more likely to have used direct assistance than those who were uninsured. Zuckerman S, Karpman M, Blavin F, Shartzer A. *Navigating the Marketplace: How Uninsured Adults Have Been Looking for Coverage.* Washington: Urban Institute, 2014, http://hrms.urban.org/briefs/navigating-the-marketplace.html (accessed October 2014).
34. This is consistent with findings from Urban Institute researchers, using results from Urban Institute's HRMS, showing that health insurance literacy is lowest among racial minorities and particularly among Hispanics. Long SK and Goin D. *Large Racial and Ethnic Differences in Health Insurance Literacy Signal Need for Targeted Education and Outreach.* Washington: Urban Institute, 2014. http://hrms.urban.org/briefs/literacy-by-race.html (accessed October 2014).
35. Long and Goin, *Large Racial and Ethnic Differences in Health Insurance Literacy Signal Need for Targeted Education and Outreach*.
36. The June 2014 wave of the HRMS found that among adults who had been uninsured for some or all of the previous 12 months, 7 in 10 adults who remain uninsured cited financial barriers as a reason for not signing up for coverage. Zuckerman et al., *Navigating the Marketplace: How Uninsured Adults Have Been Looking for Coverage*.
37. This too is consistent with HRMS survey results. We reported that the March 2014 wave of the HRMS found that Hispanics used direct assistance and indirect or informal assistance at higher rates than non-Hispanics and that low-income adults were less likely to use the website and more likely to use direct and indirect or informal assistance. Blavin F, Zuckerman S and Karpman M, *Obtaining Information on Marketplace Health Plans: Websites Dominate but Key Groups Also Use Other Sources.* Washington: Urban Institute, 2014, http://hrms.urban.org/briefs/obtaining-information-on-marketplace.html (accessed October 2014).
38. In the March 2014 wave of the HRMS, respondents rated direct assistance and indirect or informal assistance as the most useful sources of information about the Marketplace. The highest ratings went to brokers and agents. Among respondents who had used brokers and agents, nearly 84 percent reported that they were very or somewhat helpful to use. Blavin, Zuckerman and Karpman, *Obtaining Information on Marketplace Health Plans*.

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Jane B. Wishner is a senior research associate, Anna C. Spencer is a research associate and Erik Wengle is a research assistant, all with the Urban Institute's Health Policy Center. The authors are grateful to John Holahan and Linda Blumberg for their input on this report, and to Sarah Gadsden, Rachel Arnesen, and Megan McGrath for research assistance.

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The COMMONWEALTH FUND

TRACKING TRENDS IN HEALTH SYSTEM PERFORMANCE

SEPTEMBER 2014

Are Americans Finding Affordable Coverage in the Health Insurance Marketplaces?

Results from the Commonwealth Fund Affordable Care Act Tracking Survey

Petra W. Rasmussen, Sara R. Collins, Michelle M. Doty, and Sophie Beutel

Abstract By the end of the first open enrollment period for coverage offered through the Affordable Care Act's marketplaces, increasing numbers of people said they found it easy to find a plan they could afford, according to The Commonwealth Fund's Affordable Care Act Tracking Survey, April–June 2014. Adults with low or moderate incomes were more likely to say it was easy to find an affordable plan than were adults with higher incomes. Adults with low or moderate incomes who purchased a plan through the marketplaces this year have similar premium costs and deductibles as adults in the same income ranges with employer-provided coverage. A majority of adults with marketplace coverage gave high ratings to their insurance and were confident in their ability to afford the care they need when sick.

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OVERVIEW

More than 8 million people have enrolled in health plans offered through the Affordable Care Act's marketplaces this year. Most people—about 8 million—signed up during the open enrollment period that began in October 2013 and ended in April 2014. Approximately 500,000 more joined during special enrollment periods triggered by job loss or other transitional life events.[1] In addition, more than 7 million people have signed up for Medicaid, which has ongoing enrollment.[2]

According to survey findings published by The Commonwealth Fund in July, this new enrollment is helping to reduce the number of people who are uninsured and is improving access to health care among people who are using their new coverage.[3] This issue brief focuses on findings from the survey regarding people's experiences enrolling in new coverage and

on whether they find their new coverage to be affordable. The Affordable Care Act Tracking Survey was conducted from April 9 to June 2, 2014. Where possible, results are compared to two surveys conducted by SSRS for The Commonwealth Fund during the first three months of open enrollment. (See About the Survey for more information.)

Findings from the survey include:

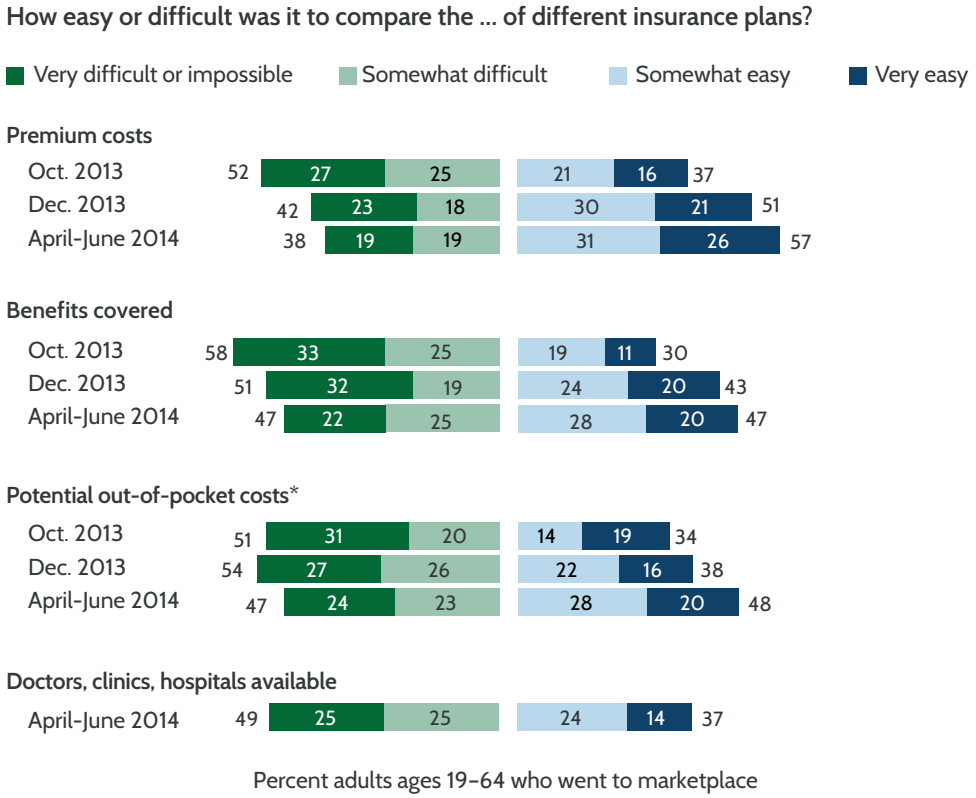
- Consumers experienced an improved ability to compare plans offered through the marketplaces on the basis of benefits and costs over the open enrollment period.
- Many people had difficulty comparing plans by the doctors or hospitals included in networks.
- More people who shopped for coverage found it easy to find a plan they could afford by June; although half still reported difficulty doing so. Adults with the lowest incomes were more likely to say it was easy to find an affordable plan than adults with higher incomes.
- More than three of five adults who tried to find out if they were eligible for financial assistance found it easy to do so.
- A majority of adults who visited the marketplace continued to rate their experience trying to get health insurance as fair or poor.
- Adults who had low or moderate incomes (i.e., those with incomes below 250 percent of the federal poverty level, or $28,725 for an individual and $58,875 for a family of four) and marketplace coverage paid monthly premiums comparable to those paid by adults with employer coverage.
- People with low or moderate incomes with marketplace coverage reported finding it easy to afford their premiums at similar rates to those in the same income range with employer coverage. Those with higher incomes in marketplace plans were significantly less likely than those in the same income range with employer coverage to say it was easy to afford their premiums.
- Adults with low or moderate incomes and marketplace coverage had deductibles comparable to those faced by adults with employer coverage in the same income range. Those with higher incomes had higher deductibles than adults with employer coverage.

SURVEY FINDINGS IN DETAIL

Adults who visited the marketplaces found it easier to compare plans and costs by the end of the open enrollment period.

People's ability to compare health plan benefits, out-of-pocket costs, and premiums improved over the course of the open enrollment period (Exhibit 1). By April through June 2014, over half of people who went to the marketplace (57%) said it was very or somewhat easy to compare the premium costs of different plans, an increase from 37 percent in October. About half (47%) of adults who shopped for coverage said it was easy to compare benefits of different plans. A similar percentage (48%) said it was easy to compare the potential out-of-pocket costs from deductibles and copayments of different insurance plans. In October, only about one-third of marketplace visitors reported that it was easy to perform these tasks.[4]

Exhibit 1. More Adults Who Visited the Marketplaces Found It Easy to Compare Benefits and Costs of Plans; Few Found It Easy to Compare Plans by Providers Available



Note: The sampling techniques for the October and December 2013 surveys were different from those in April-June 2014. Bars may not sum to 100 percent because of "don't know" responses or refusal to respond; segments may not sum to subtotals because of rounding.
* Potential out-of-pocket costs from deductibles and copayments.
Source: The Commonwealth Fund Affordable Care Act Tracking Surveys, Oct. 2013, Dec. 2013, and April-June 2014.

However, people had a more difficult time comparing plans in terms of providers included in the network. Thirty-seven percent of people who visited the marketplace said it was somewhat or very easy to compare the doctors, clinics, and hospitals available under different plans.

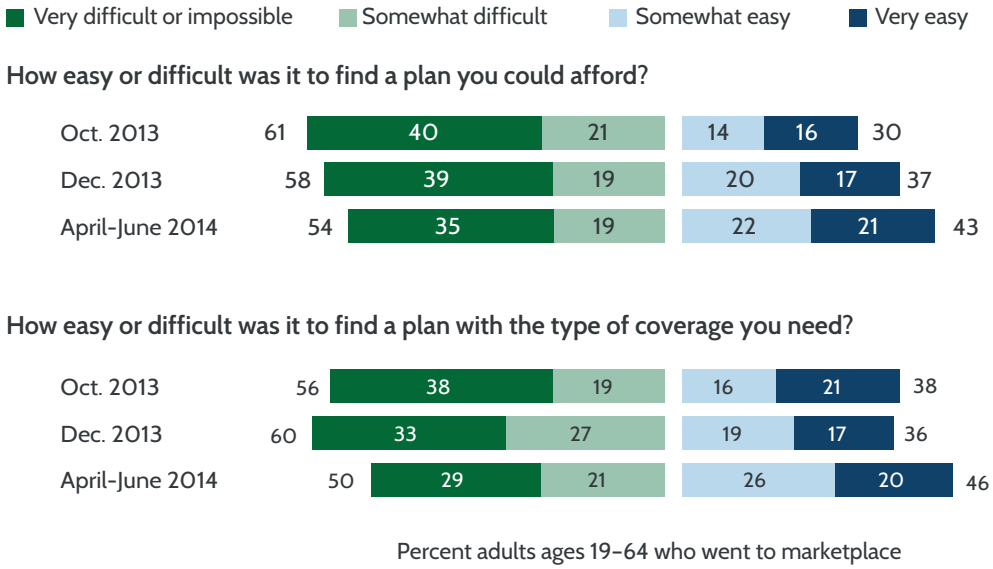
Compared with the beginning of open enrollment, more people who shopped for coverage found it easy to find a plan they could afford by the end of the period.

By June, 43 percent of adults who had visited the marketplace said they found it very or somewhat easy to find a plan they could afford (Exhibit 2, Appendix Table 1). While this was an improvement when compared with adults who had visited earlier in the enrollment period, more than half of adults reported difficulty finding an affordable plan.

There were significant differences by income. About half (49%) of adults with incomes under 138 percent of the federal poverty level ($15,856 for an individual and $32,499 for a family of four) who visited the marketplaces said it was very or somewhat easy to find a plan they could afford compared with about one-third (36%) of adults with incomes of 400 percent of poverty or higher ($45,960 for an individual and $94,200 for a family of four) (Exhibit 3).

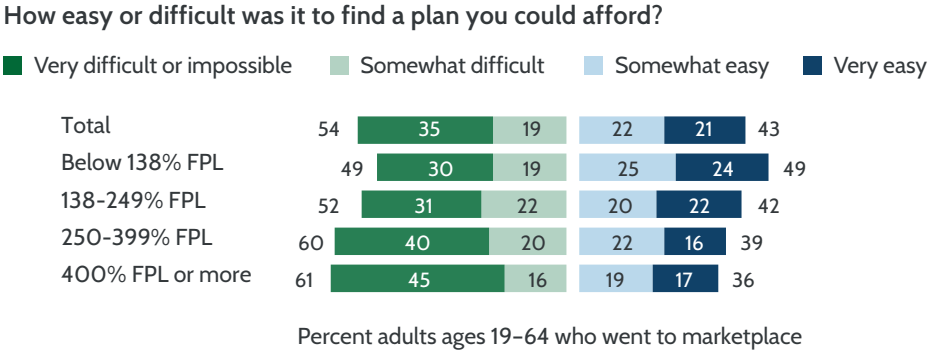
This difference is likely explained by the cost protections and improved affordability for adults with lower incomes, who may be eligible for Medicaid or receive premium and cost-sharing subsidies for health plans sold through the marketplaces. A majority of people who visited the

Exhibit 2. More Adults Found It Easy to Find Plans They Needed and Could Afford by End of Open Enrollment



Note: The sampling techniques for the October and December 2013 surveys were different from those in April–June 2014. Bars may not sum to 100 percent because of "don't know" responses or refusal to respond; segments may not sum to subtotals because of rounding.
Source: The Commonwealth Fund Affordable Care Act Tracking Surveys, Oct. 2013, Dec. 2013, and April–June 2014.

Exhibit 3. More Adults with Lower Incomes Found It Easy to Find an Affordable Plan Than Did Adults with Higher Incomes

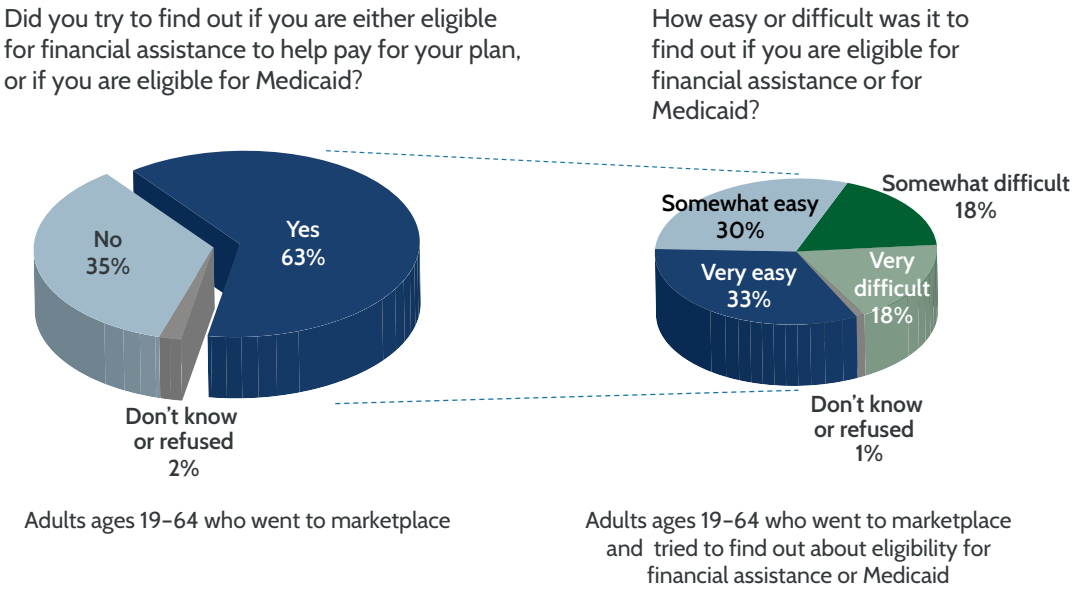


Notes: FPL refers to federal poverty level. Bars may not sum to 100 percent because of "don't know" responses or refusal to respond; segments may not sum to subtotals because of rounding.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, April–June 2014.

marketplaces tried to find out if they were eligible for financial assistance or Medicaid, with a majority reporting that it was easy to do so (Exhibit 4).

When looking at states that expanded eligibility for Medicaid, two-thirds of marketplace visitors who were eligible for the program (i.e., those with incomes below 138 percent of poverty) said it was easy to find a plan they could afford (data not shown). In states that had not expanded their Medicaid programs by the time of the survey, however, only 35 percent of adults in this same income range found it easy to find a plan they could afford (data not shown).[5]

Exhibit 4. More than Three of Five Adults Who Tried to Find Out About Their Eligibility for Financial Assistance or Medicaid Said It Was Easy to Do So



Note: Segments may not sum to 100 percent because of rounding.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, April–June 2014.

A majority of adults who visited the marketplace rated their experience trying to get health insurance as fair or poor.

When asked to rate their overall experience trying to get health insurance through the marketplace, fewer than two of five marketplace visitors (38%) said their experience was excellent or good (Exhibit 5). There were significant differences by political affiliation and age. Just under half of those who identify as Democrats (47%) rated their experience as good or excellent, compared with only a quarter (24%) of Republicans. Young adults were more likely than older adults to rate their experience as excellent or good (46% vs. 33%) (Appendix Table 2).

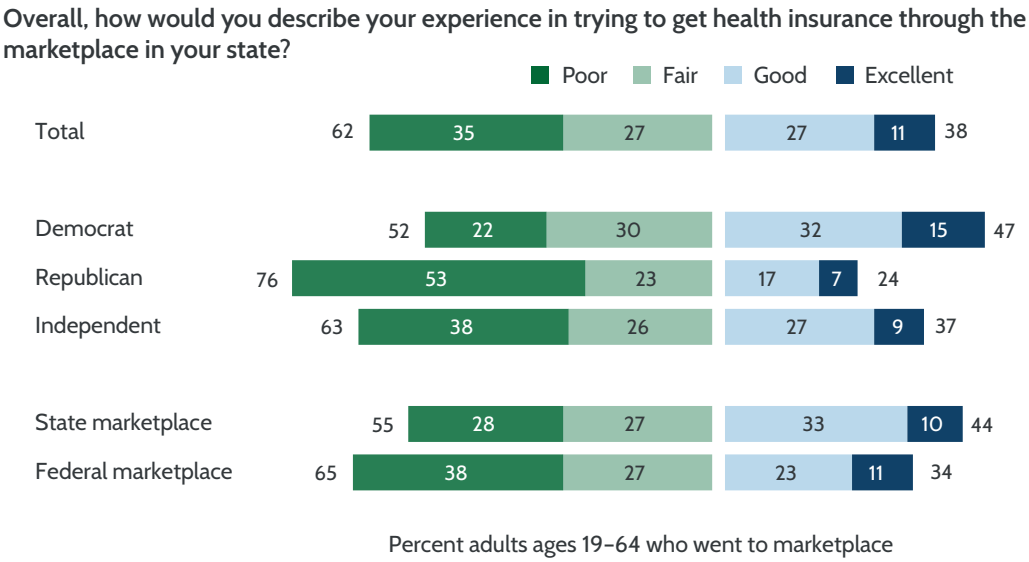
Premium payments and deductibles in marketplace plans are comparable to employer plans for people with low or moderate incomes.

Premiums and out-of-pocket costs figured most prominently in people's decisions about which plan to choose. Roughly equal shares of those who selected a private plan through the marketplace said premium amount and deductible and copayments sizes were the most important factors in their decision (Exhibit 6). A smaller share of adults (20%) said having their preferred doctor, health clinic, or hospital included in the plan's network was most important.

Premiums

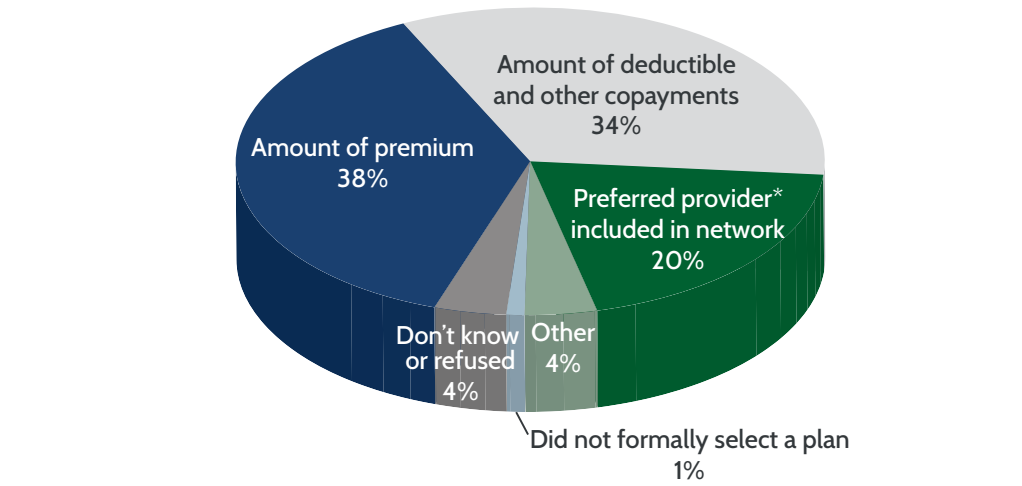
Among adults with insurance plans that only covered themselves (i.e., single policies), those with marketplace coverage reported premium costs similar to those with employer coverage. About 60 percent of adults with either marketplace or employer coverage paid nothing for their policies or less than $125 per month (Exhibit 7). A larger share of people with employer plans paid nothing for their policies compared to people with marketplace plans.

Exhibit 5. A Majority of Adults Who Visited the Marketplace Rated Their Experience as Fair or Poor



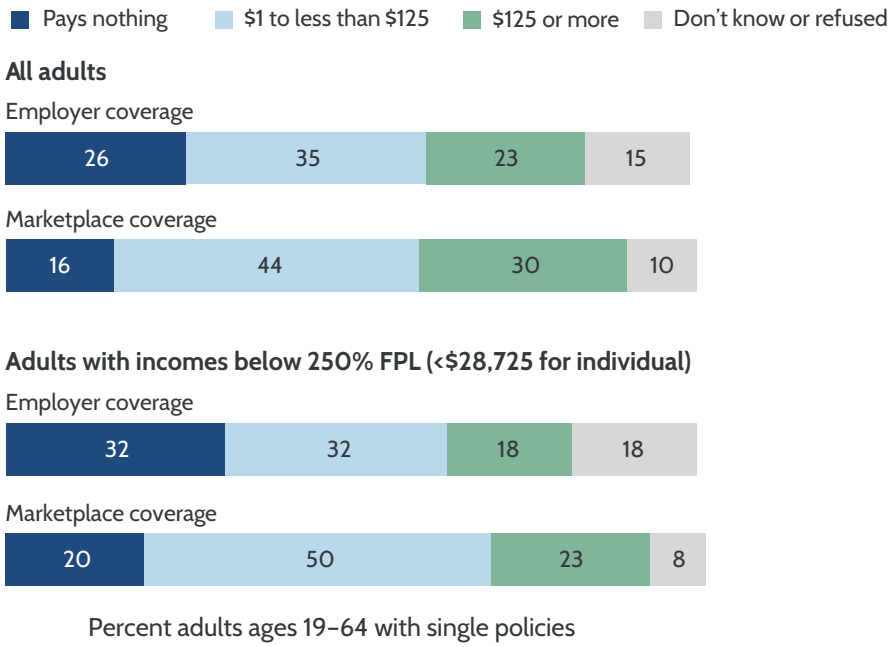
Notes: Bars may not sum to 100 percent because of "don't know" responses or refusal to respond; segments may not sum to subtotals because of rounding.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, April–June 2014.

Exhibit 6. Premiums and Cost Exposure Were the Most Important Factors in Plan Selection



* Actual question wording: preferred doctor, health clinic, or hospital included in plan's network.
Note: Segments may not sum to 100 percent because of rounding.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, April–June 2014.

Exhibit 7. Adults with Marketplace Coverage with Incomes Under 250 Percent of Poverty Paid Monthly Premiums Comparable to Those with Employer Coverage



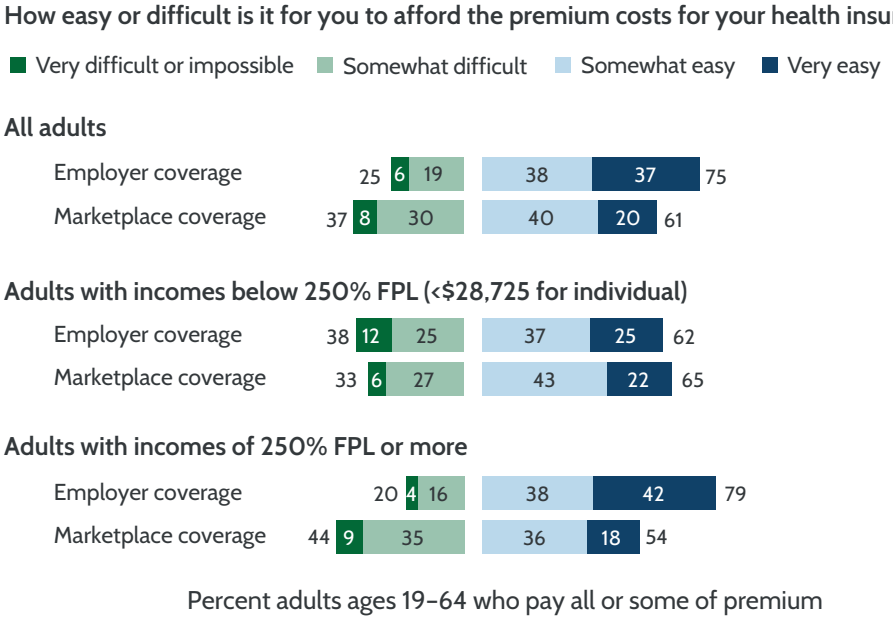
Note: FPL refers to federal poverty level. 250% of the poverty level is $28,725 for an individual or $58,875 for a family of four.
Bars may not sum to 100% because of rounding.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, April–June 2014.

These similarities reflect the fact that most people who purchased marketplace plans were eligible for a subsidy. In the survey, 64 percent of people with marketplace coverage had incomes under 250 percent of poverty, and were thus eligible for the most generous premium subsidies and cost-sharing protections under the law (data not shown). Consequently, about 70 percent of adults with marketplace coverage and incomes under 250 percent of poverty paid less than $125 a month toward their premiums, including 20 percent who paid nothing.

The experience for people with higher incomes is different. Because of sample size limitations, we could only look at adults with incomes above 250 percent of poverty with marketplace coverage by grouping adults with single policies and adults with family policies. Adults with higher incomes had much less premium protection in marketplace plans than those who were covered by an employer (data not shown). Most people in employer plans receive premium contributions from their employers regardless of income, whereas those with higher incomes in marketplace plans must pay the full premium.

These differences were reflected in people's assessments of the affordability of their health plans. Sixty-five percent of adults with low or moderate incomes with marketplace plans who pay a premium said it was very or somewhat easy to afford their premiums (Exhibit 8). About the same share of people with employer-based health benefits in that income range who pay a premium said it was very or somewhat easy to afford them. But only 54 percent of adults with incomes of 250 percent or higher with marketplace coverage said it was very or somewhat easy to pay their premiums compared with 79 percent of those with employer coverage.

Exhibit 8. Three of Five Adults with Marketplace Coverage Found It Easy to Pay Their Premiums



Note: FPL refers to federal poverty level. 250% of the poverty level is $28,725 for an individual or $58,875 for a family of four. Bars may not sum to 100% because of "don't know" responses or refusal to respond; segments may not sum to subtotals because of rounding.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, April–June 2014.

Deductibles

Adults with low or moderate incomes and marketplace plans had per-person deductibles comparable to the deductibles that adults in the same income range with employer-provided insurance have (Exhibit 9). About two of five people with incomes under 250 percent of poverty with either marketplace coverage or employer plans had either no deductible or a deductible of less than $500 per person.

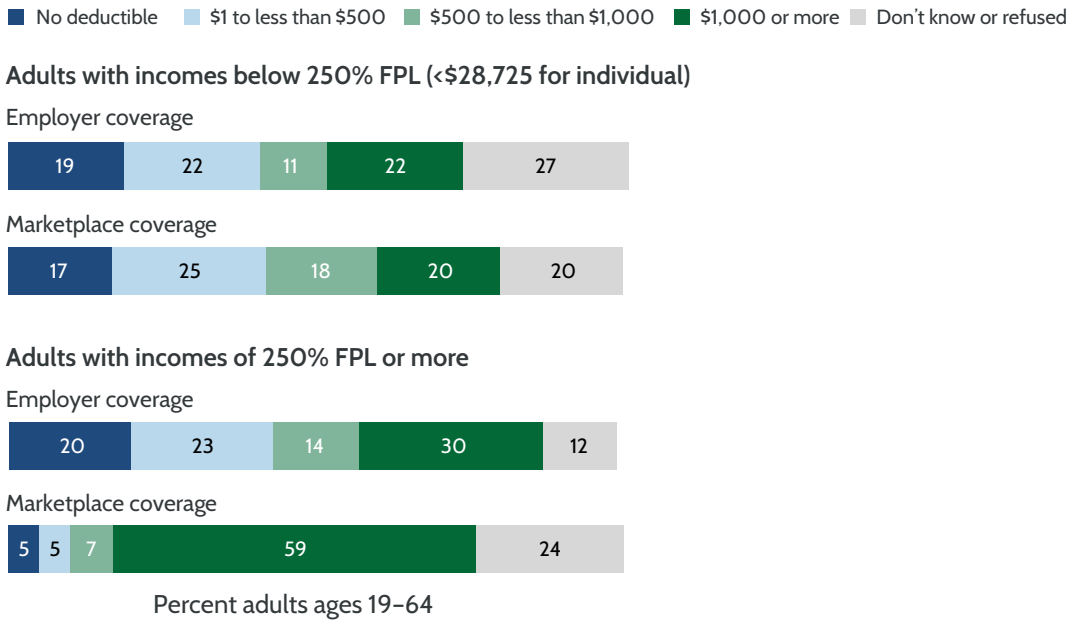
However, among adults with higher incomes, those with marketplace plans were more likely to have high per-person deductibles than those with employer coverage. Among those with incomes at 250 percent of the poverty level or more, 59 percent of adults with marketplace coverage had a deductible of $1,000 or more per person compared with 30 percent of those with employer coverage.

A majority of adults with marketplace coverage gave high ratings to their insurance and were confident in their ability to afford the care they need when sick.

Overall, a majority of people with marketplace coverage said their insurance was good, very good, or excellent (Exhibit 10). However, adults with employer coverage gave their health plans the highest ratings.

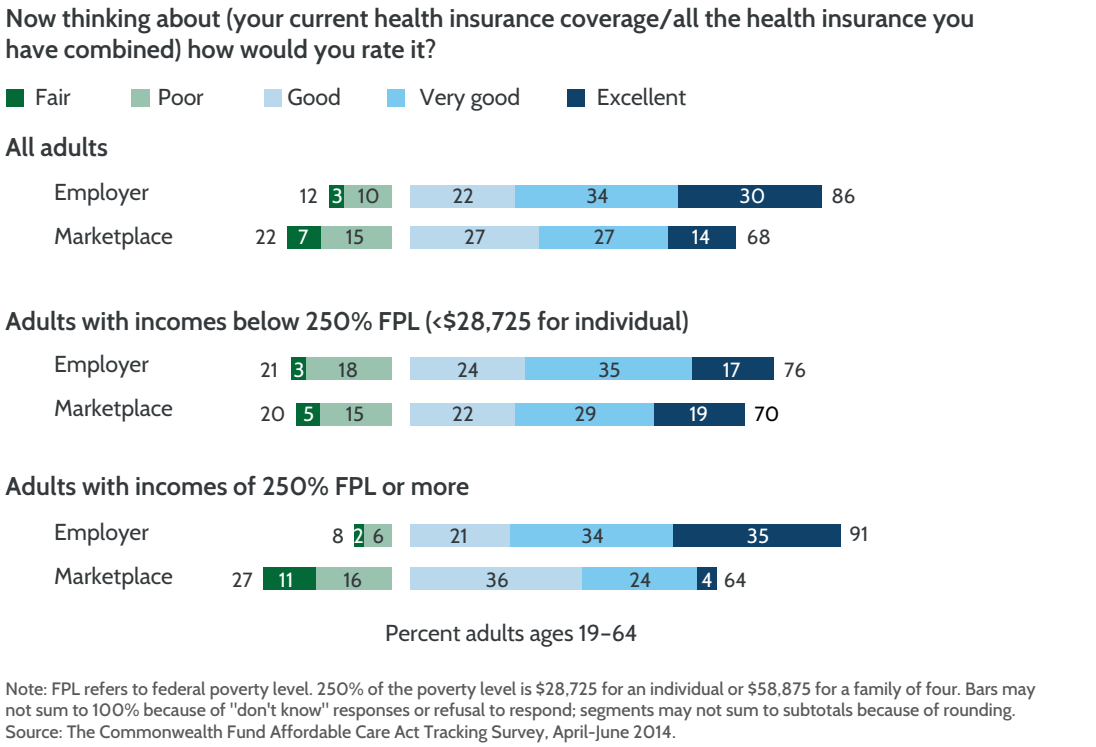
Ratings varied by income. Among adults with incomes below 250 percent of poverty, there was no significant difference in the views of those with employer-provided insurance and those with marketplace coverage. However, there were significant differences among higher-income adults, with more than nine of 10 adults with employer coverage rating their insurance highly compared with 64 percent of adults with marketplace coverage.

Exhibit 9. Adults with Low and Moderate Incomes Who Had Marketplace Coverage Had Deductibles Comparable to Those in Employer Plans



Note: FPL refers to federal poverty level. 250% of the poverty level is $28,725 for an individual or $58,875 for a family of four. Bars may not sum to 100% because of rounding.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, April-June 2014.

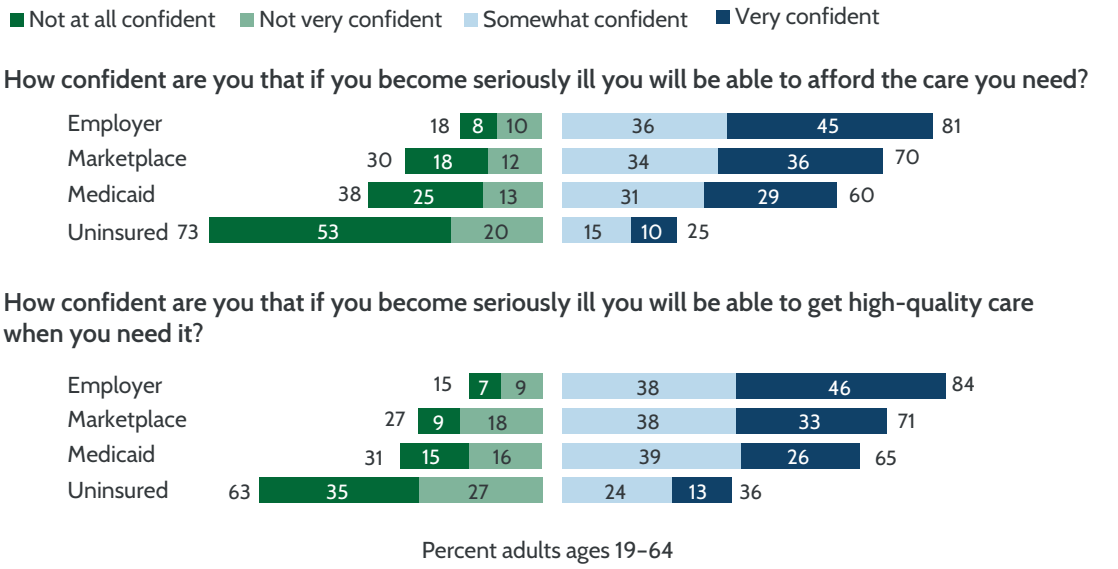
Exhibit 10. More Than Two-Thirds of Adults with Marketplace Coverage Rated Their Health Insurance as Excellent, Very Good, or Good



Note: FPL refers to federal poverty level. 250% of the poverty level is $28,725 for an individual or $58,875 for a family of four. Bars may not sum to 100% because of "don't know" responses or refusal to respond; segments may not sum to subtotals because of rounding.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, April-June 2014.

Seventy percent of people with marketplace plans and 60 percent of those with Medicaid said they were very or somewhat confident they could afford care when they were sick, compared with 81 percent of those with employer plans (Exhibit 11).[6] Similarly, large majorities of adults with marketplace coverage and employer insurance were confident in their ability to get access to high-quality care. Uninsured adults, in contrast, were substantially less confident they could afford or get high-quality care when sick.

Exhibit 11. A Majority of Adults with Marketplace Coverage Were Confident They Could Afford Care They Needed or Get High-Quality Care



Note: Bars may not sum to 100% because of "don't know" responses or refusal to respond; segments may not sum to subtotals because of rounding.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, April–June 2014.

CONCLUSION

By the end of the first open enrollment period, the Affordable Care Act helped reduce the number of uninsured working-age adults by 9.5 million, and it is improving access to health care both for people who were previously uninsured and for those with prior coverage.[7] The process of gaining new insurance was difficult for many people who visited the marketplaces during the open enrollment period, suggesting that federal and state officials will need to work hard to improve the marketplace enrollment experience in 2015. However, despite these difficulties, most adults surveyed gave marketplace plans high ratings and are confident in their ability to afford and gain access to high-quality care if they fall ill.

Subsidized coverage options for people with low or moderate incomes were effective in making individual market coverage comparable with employer-based health benefits in terms of affordability and protection from out-of-pocket costs. Adults in this income range have been most at risk of lacking insurance altogether or having such high out-of-pocket costs that they were effectively underinsured.[8]

The findings also show that employer-based coverage, on average, offers greater protection from premium and out-of-pocket costs for people with higher incomes. This is because most employers share those costs with their employees, regardless of their income. While the insurance market reforms have made it far easier for people without employer coverage to gain access to comprehensive benefits without being charged more based on their health status, employer-based insurance continues to be a better deal for people with higher incomes.

Notes

[1] *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period, October 1, 2013–March 31, 2014 (Including Additional Special Enrollment Period Activity Reported Through 4-19-2014),* ASPE Issue Brief (Washington, D.C.: U.S. Department of Health and Human Services, May 1, 2014), http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf; and C. Ornstein, "Even After Open Enrollment, Activity Remains Unexpectedly High on Federal Health Insurance Exchange," *ProPublica,* July 23, 2014, http://www.propublica.org/article/after-open-enrollment-activity-high-federal-health-insurance-exchange.

[2] C. Mann, "More Than 7.2 Million Additional Americans Covered Under Medicaid and CHIP," *U.S. Department of Health and Human Services Blog,* Aug. 8, 2014, http://www.hhs.gov/healthcare/facts/blog/2014/08/medicaid-chip-enrollment-june.html.

[3] S. R. Collins, P. W. Rasmussen, and M. M. Doty, *Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period* (New York: The Commonwealth Fund, July 2014).

[4] All reported differences are statistically significant at the $p \leq 0.05$ level or better, unless otherwise noted.

[5] In the 25 states that, as of April 2014, had not opted to expand their Medicaid programs or yet begun to enroll beneficiaries, adults with incomes between 100 percent and 138 percent of poverty are eligible for subsidized private plans offered through the marketplaces. But those with incomes below poverty are ineligible for premium tax credits, because Congress, not anticipating the 2012 Supreme Court decision that turned the law's Medicaid expansion into an option for states, assumed they would be eligible for Medicaid. The poorest families in these states thus would bear the entire cost of a private plan through the marketplace should they try to enroll. The states that expanded their Medicaid program by April 2014 include: AR, AZ, CA, CO, CT, DE, HI, IA, IL, KY, MA, MD, MI, MN, ND, NJ, NM, NV, NY, OH, OR, RI, VT, WA, WV, and the District of Columbia. New Hampshire expanded eligibility for Medicaid with coverage effective in August. Pennsylvania's section 1115 waiver for customized Medicaid expansion was approved in August 2014 and coverage will be effective in January 2015. Indiana has submitted a Section 1115 waiver to the federal government but has not yet been approved. See map at http://www.commonwealthfund.org/interactives-and-data/maps-and-data/medicaid-expansion-map.

[6] The difference between marketplace plans and Medicaid is not statistically significant.

[7] Collins, Rasmussen, and Doty, *Gaining Ground,* 2014.

[8] C. Schoen, S. L. Hayes, S. R. Collins, J. A. Lippa, and D. C. Radley, *America's Underinsured: A State-by-State Look at Health Insurance Affordability Prior to the New Coverage Expansions* (New York: The Commonwealth Fund, March 2014).

Appendix Table 1. Marketplace Visitors Finding a Plan with the Coverage They Need and That They Can Afford, by Demographics

(base: adults ages 19 to 64 who went to the marketplace)

		How easy or difficult was it to find . . .			
		A plan with the type of coverage you need?		A plan you could afford?	
	Total marketplace visitors	Somewhat or very easy	Somewhat or very difficult or impossible	Somewhat or very easy	Somewhat or very difficult or impossible
Percent distribution	100%	46%	50%	43%	54%
Unweighted n	1,103	501	565	460	613
Age					
19–34	33	55	41	46	52
35–49	30	42	56	40	57
50–64	35	41	52	43	53
Gender					
Male	46	46	51	43	54
Female	54	46	49	42	54
Race/Ethnicity					
White	64	42	53	38	59
African American	14	58	40	49	51
Latino	14	54	45	58	37
Income					
<250% FPL	63	50	47	46	50
250% FPL or more	37	39	55	37	60
Political affiliation					
Republican	16	34	62	37	61
Democrat	35	57	37	55	41
Independent	28	42	55	34	63
State Medicaid expansion decision					
Expanded Medicaid	50	50	45	52	44
Did not expand Medicaid	50	43	54	34	63

Note: FPL refers to federal poverty level. 250% of FPL is $28,725 for an individual or $58,875 for a family of four.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, April–June 2014.

Appendix Table 2. Rating of Marketplace Experience, by Demographics

(base: adults ages 19 to 64 who went to the marketplace)

		Overall, how would you describe your experience in trying to get health insurance through the marketplace in your state?			
	Total marketplace visitors	Excellent	Good	Fair	Poor
Percent distribution	100%	11%	27%	27%	35%
Unweighted n	1,103	136	271	284	406
Age					
19–34	33	12	34	26	27
35–49	30	11	22	28	39
50–64	35	9	24	29	38
Insurance status when visited marketplace					
Uninsured	56	11	25	26	38
Insured	44	11	28	30	30
Gender					
Male	46	12	25	29	34
Female	54	10	28	26	35
Race/Ethnicity					
White	64	10	27	26	37
African American	14	10	26	35	28
Latino	14	13	31	25	30
Income					
<250% FPL	63	12	27	28	32
250% FPL or more	37	8	26	27	39
Political affiliation					
Republican	16	7	17	23	53
Democrat	35	15	32	30	22
Independent	28	9	27	26	38
Marketplace type					
State-run marketplace	35	10	33	27	28
Federally run marketpalce	65	11	23	27	38

Note: FPL refers to federal poverty level. 250% of FPL is $28,725 for an individual or $58,875 for a family of four.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, April–June 2014.

ABOUT THE SURVEY

The Commonwealth Fund Affordable Care Act Tracking Survey, April–June 2014, was conducted by SSRS from April 9 to June 2. The survey consisted of 17-minute telephone interviews in English or Spanish, and was conducted among a random, nationally representative sample of 4,425 adults, ages 19 to 64, living in the United States. Overall, 2,098 interviews were conducted on landline telephones and 2,327 interviews on cellular phones, including 1,481 with respondents who live in households with no landline telephone access.

This survey is the fourth in a series of Commonwealth Fund surveys to track the implementation and effects of the Affordable Care Act. The first was conducted by SSRS from July 15 to September 8, 2013, by telephone among a random, nationally representative U.S. sample of 6,132 adults ages 19 to 64. The survey had an overall margin of sampling error of +/– 1.8 percent at the 95 percent confidence level.

The second and third surveys in the series were conducted by SSRS in October and December of 2013. Both were included as a series of questions on SSRS's nationally representative omnibus telephone survey. For these surveys, only those adults ages 19 to 64 who reported that they were uninsured or had purchased health insurance through the individual market were surveyed. The October survey was in the field October 9–27, 2013, and had a sample of 682 adults. The survey had an overall margin of sampling error of +/– 4.3 percent at the 95 percent confidence level. The December survey was in the field December 11–29, 2013, and had a sample of 622 adults. That survey had an overall margin of sampling error of +/– 4.6 percent at the 95 percent confidence level.

The sample for the April–June 2014 survey was designed to increase the likelihood of surveying respondents who were most likely eligible for new coverage options under the Affordable Care Act. In addition to the random sample of 19-to-64-year-olds, respondents in the July–September 2013 survey who said they were uninsured or had individual coverage were asked if they could be recontacted for the April–June 2014 survey. SSRS also recontacted households reached through their omnibus survey of adults who were uninsured or had individual coverage prior to open enrollment. The data are weighted to correct for the stratified sample design, the use of prescreened and recontacted respondents from earlier surveys, the overlapping landline and cellular phone sample frames, and disproportionate nonresponse that might bias results. The data are weighted to the U.S. 19-to-64 adult population by age, gender, race/ethnicity, education, household size, geographic division, and population density using the U.S. Census Bureau's 2011 American Community Survey, and weighted by household telephone use using the U.S. Centers for Disease Control and Prevention's 2012 National Health Interview Survey.

The resulting weighted sample is representative of the approximately 186.1 million U.S. adults ages 19 to 64. Data for income, and subsequently for federal poverty level, were imputed for cases with missing data, utilizing a standard regression imputation procedure.

The survey has an overall margin of sampling error of +/– 2.1 percentage points at the 95 percent confidence level. The landline portion of the main sample survey achieved a 19 percent response rate and the cellular phone main sample component achieved a 15 percent response rate. The overall response rate, including prescreened and recontacted sample, was 14 percent.

For more information on the July–September 2013 survey, please refer to: http://www.commonwealthfund.org/publications/issue-briefs/2013/sep/insurance-marketplaces-and-medicaid-expansion.

For more information on the October 2013 survey, please refer to: http://www.commonwealthfund.org/Publications/Data-Briefs/2013/Nov/Americans-Experiences-Marketplaces.aspx.

For more information on the December 2013 survey, please refer to: http://www.commonwealthfund.org/publications/data-briefs/2014/jan/experiences-in-the-health-insurance-marketplaces.

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REPORT

November 2014

Estimating Federal Payments and Eligibility for Basic Health Programs: An Illustrative Example

Prepared by:

Stan Dorn
The Urban Institute

and

Jennifer Tolbert
Kaiser Family Foundation

Table of Contents

Introduction

In some states, policymakers and stakeholders are considering adoption of the Basic Health Program (BHP) option permitted under the Patient Protection and Affordable Care Act (ACA). Federal regulations allow BHP implementation beginning in 2015. Through BHP, consumers with incomes at or below 200 percent of the federal poverty level (FPL) who would otherwise qualify for subsidized qualified health plans (QHPs) offered in health insurance marketplaces instead are offered state-contracting standard health plans that provide coverage no less generous and affordable than what have been provided in the marketplace. To operate BHPs, states receive federal funding equal to 95 percent of the premium tax credits (PTCs) and cost-sharing reductions (CSRs) that BHP enrollees would have received if they had been covered through QHPs. The rules governing BHP as well as its potential advantages and disadvantages are discussed elsewhere.[1]

This paper has a narrow, technical goal: to inform state-level analysts about the characteristics of BHP-eligible people in their state and how to use that information to estimate the approximate federal BHP payment amount per average BHP-eligible resident. The paper first describes how federal BHP payments are determined, under the final federal payment methodology for 2015. The next section explains how state officials can use information about the characteristics of BHP-eligible consumers to estimate average federal payment amounts, illustrating that explanation with an example from one state. The final section places such federal payment estimates in context, showing what they can and cannot contribute to a state's analysis of BHP's overall fiscal effects.

To assist policymakers and others with calculating average federal payments for BHP-eligible consumers, we provide detailed estimates of the characteristics of BHP-eligible people in each state in the Appendix and as a link to a downloadable Excel file. These estimates were developed using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM).

These estimates differ from many past state-level estimates of BHP-eligible consumers, in two ways. First, they avoid underestimating average federal BHP payments, because the estimates in the appendix take into account unaccepted offers of employer-sponsored insurance (ESI) that preclude BHP eligibility. The estimates here are based on data from the American Community Survey (ACS), and unaccepted ESI offers are imputed through statistical matches with non-ACS sources of data. Many past efforts to analyze the characteristics of BHP-eligible consumers did not go beyond Census data. They simply assumed that uninsured consumers and those with nongroup coverage are not offered ESI. In fact, a significant minority have access to ESI, with offers that grow increasingly common as incomes rise. Failing to exclude those consumers from counts of BHP-eligible consumers overestimates average income levels among those who qualify for BHP. Since QHP subsidies and federal BHP payments decline as incomes rise, this underestimates average federal BHP payments.

Second, the numbers in appendix table A4 were developed with the aid of small-area estimation techniques that allowed an estimate of multiple characteristics for BHP-eligible consumers. For example, they show the number of such consumers in a state who are age 35-44, in 2-person households, with incomes between 150 and 175 percent FPL, with 1 BHP-eligible member in each household. Estimates with such multi-characteristic

population sets greatly improve policymakers' ability to project federal payment amounts, because federal payments are based on the number of BHP enrollees with such multiple characteristics.

State-level observers interested in federal payments for BHP *enrollees* could add take-up assumptions or simulations to the eligibility estimates in appendix table A4 to project the number and characteristics of consumers who will sign up for BHP. Such an enrollment projection could be translated into a total federal funding estimate through the method described below, which develops federal payment amounts for BHP enrollees with each set of characteristics shown in appendix table A4. However, the main goal of this paper is more modest—namely, helping state analysts develop reasonable estimates of average federal payments per BHP-*eligible* consumer, without determining, among eligible consumers, those who will likely enroll.

How Federal BHP Payment Amounts are Determined

As noted earlier, the federal government pays 95 percent of what BHP enrollees would have received in marketplace subsidies, had the state not implemented BHP. To calculate that amount, the federal government puts each BHP enrollee into a federal payment cell, which is defined based on geography, income, and other personal characteristics. A specified federal payment applies to each enrollee in the cell. The payment is based on a reference premium and it includes a PTC component as well as a CSR component. Each of these factors—the cell definition, the reference premium, the PTC component, and the CSR component—is discussed in turn, below.

Note that this section describes the federal BHP payment methodology for 2015. CMS proposed the same methodology for 2016.[2] That methodology has not been finalized for 2016, however, and it may change for 2017 and beyond.

Federal payment cells

Each BHP enrollee falls within a "federal payment cell" that is defined by the following characteristics of its members:

- County of residence;
- Age range (0-20, 21-34, 35-44, 45-54, 45-54, or 55-64);
- Income range (0-50, 51-100, 101-138, 139-150, 151-175, or 176-200 percent FPL);
- Household size; and
- Coverage status (single BHP coverage, two-adult BHP coverage, etc.).

Reference premiums

To determine both the PTC and CSR component of the federal payment for a BHP enrollee, the starting point is the reference premium. The reference premium is the average premium that would have been charged by the second-lowest-cost silver plan in 2015 to non-smokers in the BHP beneficiary's county and age range if the state had not established a BHP program. Averages within the age range are calculated based on an assumed even age distribution.

In most counties, the same QHPs are offered to all residents. If a single county is split between QHPs so that different silver plans have the second-lowest premium in different portions of the county, the portion with the most residents determines the reference premium that is used to calculate BHP payments for all county residents. Premiums for non-tobacco-users apply, since such premiums determine PTC amounts.

Generally, reference premiums for 2015 will be based on 2015 premiums, once they become known. However, a state seeking predictable federal payments before 2015 premiums were known had the option of instead using 2014 marketplace premiums, updated using a Premium Trend Factor (PTF). Such a state was required to inform CMS by May 15, 2014, that it chose this option. The PTF seeks to capture the likely increase in marketplace premiums from 2014 to 2015, based on nationally applicable trends. For 2015, CMS set the PTF as increasing premiums by 8.15%. This reflected two factors: the average increase in private insurance costs from 2014 to 2015 forecast by the CMS Office of the Actuary; and CMS' estimates of the average impact on marketplace premiums of changes in the operation of the ACA's transitional reinsurance program.[3]

Determining the Premium Tax Credit Component

Once the reference premium is established, calculating the average PTC for BHP enrollees within the federal payment cell begins by determining the percentage of household income devoted to premium payment for enrollees in the "reference" or "benchmark" plan (that is, the second-lowest-cost silver QHP). In 2015, those percentages will be 2.01% for those with incomes below 133% FPL, 3.02% at 133% FPL, 4.02% at 150% FPL, and 6.34% at 200% FPL, with percentages set on linear, sliding scales between the last three FPL "anchor points." These percentages allow a calculation of the average (mean) payment amount, among households of a given size, for consumers within a particular federal payment cell enrolled in the benchmark plan, assuming an even distribution of households by FPL level. Subtracting that payment amount from the average reference premium for the payment cell yields an estimated average PTC.

That PTC must then be adjusted to reflect the average impact of income tax reconciliation, had BHP consumers claimed advance payment of tax credits (APTC) in the marketplace. To determine this Income Reconciliation Factor (IRF), CMS assumes that BHP eligibility will be continuous, based on household circumstances at the time of initial application, without adjustments to reflect mid-year income fluctuations. Modeling from the Department of the Treasury suggests that, across the entire caseload of BHP-eligible consumers, APTC amounts would be offset by a repayment to IRS that, on average, reduces such amounts by 5.08%. The PTC amount for each BHP payment cell is thus multiplied by an IRF of 94.92% for 2015. Finally, the resulting total is multiplied by 95% to determine the PTC component of the federal BHP payment.

Determining the Cost-Sharing Reduction Component

The value of the CSR component in the marketplace equals the total health care claims for essential health benefits (EHBs) paid by the increase in actuarial value resulting from the CSR. The first step in calculating this component is thus estimating the amount of total health care claims provided by the reference-premium plan.

Only some of the premium pays claims costs. To exclude administrative and other non-claims costs, the Factor for Removing Administrative Costs (FRAC) is set at 80%. Put differently, the federal payment methodology assumes that, on average, 80% of the reference premium is used to pay EHB claims. This is based on the approach taken by CMS in defining CSR advance payments for QHPs in 2015.

QHP enrollees will pay some EHB costs. With a silver-level plan, Actuarial Value (AV) is 70%, so consumers pay, on average, 30% of such claims costs. Accordingly, the total amount of EHB claims is the amount paid by the plan, divided by 70%. Put differently, it is the plan's EHB claims amount (that is, the reference premium times 0.8) multiplied by 1.43, which is referred to as the AV factor.

Unlike PTCs, which reflect the premium charged to non-smokers in states that permit higher QHP premiums for tobacco users, CSRs include claim costs that result from tobacco use. Accordingly, the reference premium calculated as described above must be increased to reflect the average effect of tobacco use on BHP claims. Such a Tobacco Rating Adjustment Factor (TRAF) takes into account tobacco utilization levels by BHP enrollees, shown by state-specific data from the Centers for Disease Control and Prevention (CDC), which includes information about tobacco use rates by age.[4] To estimate the average claims costs for tobacco use that are not included within the reference premiums charged to non-users, the TRAF also considers the weighted average difference, among benchmark plans, in premiums charged to tobacco users and non-users. For example, if in a particular state, benchmark plans charge 15 percent more, on average, for tobacco users than for non-users, and 10 percent of adults age 25-34 use tobacco, then the TRAF for BHP adults age 25-34 would increase EHB claims by .15 x .10 or .015.

If QHP enrollees with incomes at or below 200% FPL receive CSRs, they will pay less out-of-pocket for health care services. As a result, they will use more care, and their claims will increase. The Induced Utilization Factor (IUF) takes this effect into account. Based on CMS analysis, consumers who move from silver-level AV of 70% to either 87 or 94% AV—the two minimum AV levels BHP consumers would receive in the marketplace—increase average utilization by 12%. Accordingly, for BHP consumers, regardless of income, the IUF is 12% for 2015.

Taken together, these factors multiplied by the applicable reference premium determine the average claims costs that would have been incurred by BHP consumers, had they received CSRs in the marketplace. The value of the CSR in the marketplace would be the increased share of those claims paid by the federal government because of the CSR. For a consumer above 150% FPL, that share is 17% (that is, the difference between 87% AV provided by CSRs and the underlying 70% AV furnished by silver-level coverage). For a consumer below 150% FPL, it is 24% (the difference between 94% AV and 70% AV).

This penultimate factor—the Change in Actuarial Value—shows that income plays a much simpler role in determining the CSR component of federal BHP payments, compared to the PTC component. All that matters, for purposes of the CSR component, is whether the consumer's income is above or below 150% FPL. Neither household size nor precise FPL level matters, once that basic threshold question is resolved.

The number that results from the above calculations shows the value of the CSR that BHP enrollees would have received in the marketplace. To determine the CSR component of the federal BHP payment, that number must be multiplied by 95%.

Estimating Federal BHP Funding Levels

Our suggested approach

As explained earlier, the methodology for calculating actual federal BHP payments relies on determining a reference premium for each county in the state and applying it to each county's BHP enrollees. The approach we suggest to projecting federal BHP payments simplifies this process by calculating a statewide reference premium and applying it to estimates of the statewide BHP-eligible population.

As the first step in our proposed process, one averages the premium for the second-lowest-cost silver plans among the state's counties, weighted in proportion to the number of silver-plan enrollees or subsidized QHP enrollees in each county. The averages reflect non-smoker premium quotes for single adult enrollees of a particular age, such as 21-year-olds. The state's rating rules allow a derivation of premiums for other ages and for coverage of more than one person per household.[5]

In step two, one uses the statewide benchmark premium to build statewide federal payment cells. Each cell shows what the federal government would pay for BHP enrollees of the applicable age range, FPL range, household size, and number of BHP-eligible consumers per household, assuming the statewide reference premium.

In step three, one calculates the average federal payment per BHP-eligible consumer, using the estimates in appendix Table A4 showing the number of BHP-eligible consumers who are within each statewide federal payment cell. To obtain the average, one: (1) multiplies the federal payment amount in each cell by the number of eligible consumers in that cell and (2) divides the total by the number of BHP-eligible consumers in the state. The results also allow a determination of average federal payments per BHP-eligible consumers within various sub-populations, such as those with incomes or ages in various ranges.

An illustrative example: Washington State

Here, we show how the above method is used to find that federal payments for BHP-eligible residents in Washington State will average approximately $4,366 for 2015.[6]

Step One: Determine the weighted average benchmark premium

For the Washington illustration, we begin by calculating the weighted average "benchmark" premium—that is, the second-lowest-cost silver plan offered in Washington's marketplace—for 21-year-old non-smokers. Table 1 shows 2014 premiums and total enrollment for the benchmark plan in each Washington county.

Table 1. Benchmark monthly premiums and Total QHP enrollment in Washington, by county: 2014		
County	Monthly Benchmark Premium for 21-year old non-smoker	Total QHP Enrollment as of April 2014
Adams	$221.14	451
Asotin	$221.34	421
Benton	$220.50	3,039
Chelan	$221.14	2,319
Clallam	$226.87	2,072
Clark	$244.61	8,564
Columbia	$221.14	92
Cowlitz	$226.87	1,551
Douglas	$221.14	871
Ferry	$203.63	169
Franklin	$220.50	1,333
Garfield	$221.34	63
Grant	$221.14	1,443
Grays Harbor	$226.67	1,440
Island	$226.87	2,127
Jefferson	$226.87	1,332
King	$219.62	52,640
Kitsap	$226.87	4,940
Kittitas	$221.14	923
Klickitat	$226.87	756
Lewis	$226.87	1,538
Lincoln	$203.63	225
Mason	$226.87	1,121
Okanogan	$221.34	1,087
Pacific	$226.87	693
Pend Oreille	$203.63	255
Pierce	$226.87	12,748
San Juan	$226.87	1,248
Skagit	$226.67	2,949
Skamania	$226.87	224
Snohomish	$226.67	15,518
Spokane	$203.45	10,027
Stevens	$203.63	856
Thurston	$226.67	5,057
Wahkiakum	$226.87	113
Walla Walla	$220.50	1,132
Whatcom	$226.87	6,744
Whitman	$221.14	541
Yakima	$220.50	4,068

Source: Dirksen 2014[7] and Washington Health Benefits Exchange, April 2014.[8]

We average the county-specific premiums in proportion to each county's QHP enrollment. As a result, we find a weighted average benchmark premium for 21-year-old non-smokers of $222.86 a month in 2014.[9] According to the Washington State Office of the Insurance Commissioner, weighted average QHP rates are expected to rise approximately 8.25% from 2014 to 2015.[10] To estimate federal BHP payments for 2015, we therefore use a weighted-average benchmark premium of $241.25 for 21-year-old non-smokers, which is 8.25% above the 2014 level.

STEP TWO: CONSTRUCT FEDERAL PAYMENT CELLS

After calculating the weighted average benchmark premium, or "reference premium," for 21-year-old non-smokers in 2015, we construct federal payment cells by developing two components for each relevant combination of age range, FPL, household size, and number of BHP-eligible consumers per household: the PTC component and the CSR component of the federal BHP payment.

Premium Tax Credit Component

Premiums by age

In moving from the reference premium for 21-year-old non-smokers to the PTC component of federal BHP payments, the first step requires estimating the reference premiums that would be charged to BHP-eligible consumers of other ages. Like most states, Washington varies premiums by age using the so-called "HHS Default Standard Age Curve."[11] We apply the ratios of that curve to the $241.25 premium for 21-year-old non-smokers to derive the reference premiums for adults of other ages, as shown in Table 2.

Table 2. Weighted Average Monthly Reference Premiums for Washington Non-Smokers, by Age: 2015

Age	Premium Ratio	Weighted Premium	Age	Premium Ratio	Weighted Premium	Age	Premium Ratio	Weighted Premium
0-20	0.635	$153.19	35	1.222	$294.81	50	1.786	$430.87
21	1.000	$241.25	36	1.230	$296.74	51	1.865	$449.93
22	1.000	$241.25	37	1.238	$298.67	52	1.952	$470.92
23	1.000	$241.25	38	1.246	$300.60	53	2.040	$492.15
24	1.000	$241.25	39	1.262	$304.46	54	2.135	$515.07
25	1.004	$242.22	40	1.278	$308.32	55	2.230	$537.99
26	1.024	$247.04	41	1.302	$314.11	56	2.333	$562.84
27	1.048	$252.83	42	1.325	$319.66	57	2.437	$587.93
28	1.087	$262.24	43	1.357	$327.38	58	2.548	$614.71
29	1.119	$269.96	44	1.397	$337.03	59	2.603	$627.97
30	1.135	$273.82	45	1.444	$348.37	60	2.714	$654.75
31	1.159	$279.61	46	1.500	$361.88	61	2.810	$677.91
32	1.183	$285.40	47	1.563	$377.07	62	2.873	$693.11
33	1.198	$289.02	48	1.635	$394.44	63	2.952	$712.17
34	1.214	$292.88	49	1.706	$411.57	64+	3.000	$723.75

Source: CCIIO 2014. *Note*: The Premium Ratio is taken from the HHS Default Standard Age Curve.

As noted above, the federal payment methodology assumes an even distribution by age within each age range used to define federal payment cells. We apply that averaging methodology in using Table 2 to calculate reference premiums for each age range, with results shown in Table 3.

Table 3. Reference Premiums for Washington Non-Smokers, by Age Range: 2015

Age range	Premium
19-20	$153.19
21-34	$261.43
31-44	$310.18
45-54	$425.23
55-64	$639.31

Consumer payments for benchmark coverage

Estimating the PTC requires subtracting from the reference premiums shown in Table 3 the amounts that BHP-eligible consumers would pay for marketplace benchmark coverage, which vary based on FPL and household size. Table 4 shows those income-based amounts for households up to 5 people in size.[12]

Table 4. Monthly Payments Required for Benchmark Coverage, by FPL and Household Size: 2015

FPL	Required % of income	Household Size					FPL	Required % of income	Household Size				
		1	2	3	4	5			1	2	3	4	5
132	2.01%	$25.80	$34.78	$43.76	$52.73	$61.71	167	4.81%	$78.10	$105.27	$132.44	$159.61	$186.78
133	3.02%	$39.06	$52.65	$66.24	$79.83	$93.42	168	4.86%	$79.32	$106.92	$134.52	$162.12	$189.71
134	3.08%	$40.12	$54.08	$68.04	$82.00	$95.96	169	4.90%	$80.56	$108.59	$136.61	$164.64	$192.67
135	3.14%	$41.19	$55.52	$69.86	$84.19	$98.52	170	4.95%	$81.80	$110.26	$138.72	$167.18	$195.64
136	3.20%	$42.28	$56.98	$71.69	$86.40	$101.11	171	4.99%	$83.06	$111.95	$140.85	$169.74	$198.64
137	3.26%	$43.37	$58.46	$73.55	$88.64	$103.73	172	5.04%	$84.32	$113.65	$142.99	$172.32	$201.65
138	3.31%	$44.48	$59.95	$75.42	$90.90	$106.37	173	5.09%	$85.59	$115.36	$145.14	$174.92	$204.69
139	3.37%	$45.59	$61.46	$77.32	$93.18	$109.04	174	5.13%	$86.87	$117.09	$147.31	$177.53	$207.75
140	3.43%	$46.72	$62.98	$79.23	$95.49	$111.74	175	5.18%	$88.16	$118.83	$149.50	$180.17	$210.84
141	3.49%	$47.86	$64.52	$81.17	$97.82	$114.47	176	5.23%	$89.46	$120.58	$151.70	$182.82	$213.94
142	3.55%	$49.02	$66.07	$83.12	$100.17	$117.23	177	5.27%	$90.76	$122.34	$153.91	$185.49	$217.07
143	3.61%	$50.18	$67.64	$85.09	$102.55	$120.01	178	5.32%	$92.08	$124.11	$156.15	$188.18	$220.21
144	3.67%	$51.35	$69.22	$87.09	$104.95	$122.82	179	5.37%	$93.40	$125.90	$158.39	$190.89	$223.38
145	3.73%	$52.54	$70.82	$89.10	$107.38	$125.65	180	5.41%	$94.74	$127.70	$160.66	$193.61	$226.57
146	3.78%	$53.74	$72.43	$91.13	$109.82	$128.52	181	5.46%	$96.08	$129.51	$162.93	$196.36	$229.79
147	3.84%	$54.95	$74.06	$93.18	$112.29	$131.41	182	5.50%	$97.43	$131.33	$165.23	$199.12	$233.02
148	3.90%	$56.17	$75.71	$95.25	$114.79	$134.33	183	5.55%	$98.79	$133.16	$167.53	$201.90	$236.27
149	3.96%	$57.40	$77.37	$97.34	$117.31	$137.27	184	5.60%	$100.16	$135.01	$169.86	$204.70	$239.55
150	4.02%	$58.64	$79.04	$99.44	$119.85	$140.25	185	5.64%	$101.54	$136.87	$172.20	$207.52	$242.85
151	4.07%	$59.71	$80.49	$101.26	$122.04	$142.81	186	5.69%	$102.93	$138.74	$174.55	$210.36	$246.17
152	4.11%	$60.80	$81.95	$103.10	$124.25	$145.40	187	5.74%	$104.33	$140.62	$176.92	$213.22	$249.51
153	4.16%	$61.89	$83.42	$104.95	$126.48	$148.01	188	5.78%	$105.73	$142.52	$179.30	$216.09	$252.87
154	4.21%	$62.99	$84.90	$106.81	$128.72	$150.64	189	5.83%	$107.15	$144.43	$181.70	$218.98	$256.26
155	4.25%	$64.09	$86.39	$108.69	$130.99	$153.29	190	5.88%	$108.57	$146.35	$184.12	$221.89	$259.67
156	4.30%	$65.21	$87.90	$110.58	$133.27	$155.96	191	5.92%	$110.01	$148.28	$186.55	$224.82	$263.09
157	4.34%	$66.34	$89.42	$112.50	$135.57	$158.65	192	5.97%	$111.45	$150.22	$189.00	$227.77	$266.54
158	4.39%	$67.47	$90.95	$114.42	$137.89	$161.37	193	6.02%	$112.90	$152.18	$191.46	$230.74	$270.01
159	4.44%	$68.62	$92.49	$116.36	$140.23	$164.11	194	6.06%	$114.36	$154.15	$193.93	$233.72	$273.51
160	4.48%	$69.77	$94.04	$118.32	$142.59	$166.86	195	6.11%	$115.83	$156.13	$196.43	$236.72	$277.02
161	4.53%	$70.93	$95.61	$120.29	$144.97	$169.64	196	6.15%	$117.31	$158.12	$198.93	$239.74	$280.56
162	4.58%	$72.11	$97.19	$122.28	$147.36	$172.45	197	6.20%	$118.80	$160.13	$201.46	$242.78	$284.11
163	4.62%	$73.29	$98.78	$124.28	$149.77	$175.27	198	6.25%	$120.29	$162.14	$203.99	$245.84	$287.69
164	4.67%	$74.48	$100.39	$126.30	$152.21	$178.12	199	6.29%	$121.80	$164.17	$206.55	$248.92	$291.29
165	4.72%	$75.67	$102.00	$128.33	$154.66	$180.98	200	6.34%	$123.31	$166.21	$209.11	$252.02	$294.92
166	4.76%	$76.88	$103.63	$130.38	$157.12	$183.87							

Note: Calculations are based on FPL levels for 2014 for all states except Alaska and Hawaii, which will be in effect at the start of 2015 open enrollment.

As explained above, consumer payments, within each FPL range for each household size, are calculated based on averages, assuming that each FPL percentage is equally represented in the range. Table 5 shows those

averages.[13] Note that the same amounts would be paid for benchmark coverage in all states but Hawaii and Alaska, so Tables 4 and 5 can be used by analysts in any of the other 48 states and the District of Columbia.[14]

Table 5. Average monthly payments required for benchmark coverage, by FPL range and household size: 2015

FPL range	Household size				
	1	2	3	4	5
0-138% FPL	$14.16	$19.08	$24.00	$28.93	$33.85
139-150% FPL	$52.01	$70.11	$88.20	$106.30	$124.40
151-175% FPL	$73.52	$99.10	$124.68	$150.25	$175.83
176-200% FPL	$105.97	$142.84	$179.70	$216.57	$253.44

Note: Calculations are based on FPL levels for 2014 for all states except Alaska and Hawaii, which will be in effect at the start of 2015 open enrollment. Calculations for BHP consumers under 138% FPL assume even distribution by FPL percentage. If actual distribution between those within federally specified ranges (0-50, 51-100, and 101-138% FPL) is significantly different from the assumed distribution, average payments required for consumers under 138% FPL could differ from those shown.

PTC estimates, without considering tax reconciliation effects

The above analyses allow a calculation of PTC amounts, without considering tax reconciliation effects. The simplest case involves a household with one BHP-eligible member. Such a household's PTC is determined by subtracting the required payment for benchmark coverage, given the applicable FPL level and household size, as shown in Table 5, from the reference premium for the applicable age range, as shown in Table 3. Table 6 displays the results, by FPL level and household size.

Table 6. PTC amounts for households with one BHP-eligible member: 2015

Household size	FPL	Payment for benchmark plan	Age range and reference premium				
			19-20 $153.19	21-34 $261.43	35-44 $310.18	45-54 $425.23	55-64 $639.31
1	0-138% FPL	$14.16	$139.03	$247.27	$296.02	$411.07	$625.16
	139-150% FPL	$52.01	$101.18	$209.42	$258.16	$373.21	$587.30
	151-175% FPL	$73.52	$79.67	$187.91	$236.66	$351.71	$565.79
	176-200% FPL	$105.97	$47.22	$155.46	$204.21	$319.26	$533.34
2	0-138% FPL	$19.08	$134.11	$242.35	$291.10	$406.15	$620.23
	139-150% FPL	$70.11	$83.08	$191.32	$240.07	$355.12	$569.20
	151-175% FPL	$99.10	$54.09	$162.33	$211.08	$326.13	$540.21
	176-200% FPL	$142.84	$10.35	$118.59	$167.34	$282.39	$496.48
3	0-138% FPL	$24.00	$129.19	$237.43	$286.17	$401.22	$615.31
	139-150% FPL	$88.20	$64.99	$173.23	$221.97	$337.02	$551.11
	151-175% FPL	$124.68	$28.51	$136.75	$185.50	$300.55	$514.64
	176-200% FPL	$179.70	$0.00	$81.73	$130.48	$245.52	$459.61
4	0-138% FPL	$28.93	$124.26	$232.50	$281.25	$396.30	$610.38
	139-150% FPL	$106.30	$46.89	$155.13	$203.88	$318.93	$533.01
	151-175% FPL	$150.25	$2.94	$111.18	$159.92	$274.97	$489.06
	176-200% FPL	$216.57	$0.00	$44.86	$93.61	$208.66	$422.74
5	0-138% FPL	$33.85	$119.34	$227.58	$276.32	$391.37	$605.46
	139-150% FPL	$124.40	$28.79	$137.03	$185.78	$300.83	$514.92
	151-175% FPL	$175.83	$0.00	$85.60	$134.35	$249.40	$463.48
	176-200% FPL	$253.44	$0.00	$7.99	$56.74	$171.79	$385.88

Note: Calculations show estimated PTC amounts before considering reconciliation effects.

For households with more than one BHP-eligible member, the calculation is more complex. This issue requires careful attention; it is often mishandled in estimating federal BHP

payments. In Washington and almost all other states, family premiums are calculated by adding up the premiums charged to each enrollee within the family.[15] The family's required payment for benchmark coverage, however, is unaffected by the number of family members who receive such coverage. For purposes of estimating federal BHP payments per BHP-eligible consumer, the payment amount required from the entire family is divided among the BHP-eligible members of the family.

To illustrate, in a 4-person household between 139-150% FPL, the required household payment for benchmark coverage is $106.30. If that household has one BHP-eligible member in the 45-54 age range, the reference premium is $425.23. The PTC amount is the difference between the two numbers, or $318.93 (Table 6). If that household has two BHP-eligible members in the 45-54 age range, each is charged the $425.23 reference premium, but they "split" the household's required payment of $106.30. Each therefore receives a PTC of $372.08, calculated by subtracting $53.15 from $425.23.[16] Tables 7 and 8 show PTC amounts for individual consumers within households that have two and three BHP-eligible members. The calculations divide household income-based payments by 2 and 3, respectively, to determine individual (rather than household) PTC amounts.

Table 7. PTC amounts per eligible consumer in households with 2 BHP-eligible members: 2015

Household size	FPL	Payment for benchmark plan	Age range and reference premium				
			19-20 $153.19	21-34 $261.43	35-44 $310.18	45-54 $425.23	55-64 $639.31
2	0-138% FPL	$9.54	$143.65	$251.89	$300.64	$415.69	$629.77
	139-150% FPL	$35.05	$118.14	$226.38	$275.12	$390.17	$604.26
	151-175% FPL	$49.55	$103.64	$211.88	$260.63	$375.68	$589.76
	176-200% FPL	$71.42	$81.77	$190.01	$238.76	$353.81	$567.90
3	0-138% FPL	$12.00	$141.19	$249.43	$298.18	$413.22	$627.31
	139-150% FPL	$44.10	$109.09	$217.33	$266.08	$381.12	$595.21
	151-175% FPL	$62.34	$90.85	$199.09	$247.84	$362.89	$576.97
	176-200% FPL	$89.85	$63.34	$171.58	$220.33	$335.38	$549.46
4	0-138% FPL	$14.46	$138.73	$246.97	$295.71	$410.76	$624.85
	139-150% FPL	$53.15	$100.04	$208.28	$257.03	$372.08	$586.16
	151-175% FPL	$75.13	$78.06	$186.30	$235.05	$350.10	$564.19
	176-200% FPL	$108.28	$44.91	$153.15	$201.89	$316.94	$531.03
5	0-138% FPL	$16.93	$136.26	$244.50	$293.25	$408.30	$622.39
	139-150% FPL	$62.20	$90.99	$199.23	$247.98	$363.03	$577.12
	151-175% FPL	$87.92	$65.27	$173.51	$222.26	$337.31	$551.40
	176-200% FPL	$126.72	$26.47	$134.71	$183.46	$298.51	$512.60

Note: Display shows estimated PTC amounts before considering tax reconciliation effects.

Table 8. PTC amounts per eligible consumer in households with 3 BHP-eligible members: 2015							
Household size	FPL	Payment for benchmark plan	Age range and reference premium				
			19-20 $153.19	21-34 $261.43	35-44 $310.18	45-54 $425.23	55-64 $639.31
3	0-138% FPL	$8.00	$145.19	$253.43	$302.18	$417.23	$631.31
	139-150% FPL	$29.40	$123.79	$232.03	$280.78	$395.83	$609.91
	151-175% FPL	$41.56	$111.63	$219.87	$268.62	$383.67	$597.75
	176-200% FPL	$59.90	$93.29	$201.53	$250.28	$365.33	$579.41
4	0-138% FPL	$9.64	$143.55	$251.79	$300.53	$415.58	$629.67
	139-150% FPL	$35.43	$117.76	$226.00	$274.74	$389.79	$603.88
	151-175% FPL	$50.08	$103.11	$211.35	$260.09	$375.14	$589.23
	176-200% FPL	$72.19	$81.00	$189.24	$237.99	$353.04	$567.12
5	0-138% FPL	$11.28	$141.91	$250.15	$298.89	$413.94	$628.03
	139-150% FPL	$41.47	$111.72	$219.96	$268.71	$383.76	$597.85
	151-175% FPL	$58.61	$94.58	$202.82	$251.57	$366.62	$580.70
	176-200% FPL	$84.48	$68.71	$176.95	$225.70	$340.75	$554.83

Note: Display shows estimated PTC amounts before considering tax reconciliation effects.

Calculating the PTC component of federal BHP payments

To calculate the PTC component of federal BHP payments, the above PTC amounts are multiplied by .9492, reflecting the impact of tax reconciliation, according to the federal payment methodology for 2015; and .95, which converts the marketplace PTC into the federal BHP payment. The amounts in Tables 6 through 8 are multiplied by .90174, the product of these two factors. The results are shown in Table 9.

Table 9. PTC component of federal BHP payments: estimated Washington state averages, 2015																				
		1-person household				2-person household				3-person household				4-person household				5-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	$125.37	$91.24	$71.84	$42.58	$120.93	$74.92	$48.78	$9.34	$116.49	$58.60	$25.71	-	$112.05	$42.28	$2.65	-	$107.61	$25.97	-	-
	Age 21-34	$222.98	$188.84	$169.45	$140.19	$218.54	$172.52	$146.38	$106.94	$214.10	$156.20	$123.32	$73.70	$209.65	$139.89	$100.25	$40.45	$205.21	$123.57	$77.19	$7.21
	Age 35-44	$266.94	$232.80	$213.40	$184.14	$262.49	$216.48	$190.34	$150.90	$258.05	$200.16	$167.27	$117.66	$253.61	$183.85	$144.21	$84.41	$249.17	$167.53	$121.15	$51.17
	Age 45-54	$370.68	$336.54	$317.15	$287.89	$366.24	$320.22	$294.08	$254.64	$361.80	$303.91	$271.02	$221.40	$357.36	$287.59	$247.95	$188.16	$352.92	$271.27	$224.89	$154.91
	Age 55-64	$563.73	$529.59	$510.20	$480.94	$559.29	$513.27	$487.13	$447.69	$554.85	$496.96	$464.07	$414.45	$550.41	$480.64	$441.00	$381.21	$545.97	$464.32	$417.94	$347.96
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	$129.53	$106.53	$93.46	$73.74	$127.31	$98.37	$81.92	$57.12	$125.09	$90.21	$70.39	$40.49	$122.87	$82.05	$58.86	$23.87
	Age 21-34	-	-	-	-	$227.14	$204.13	$191.06	$171.34	$224.92	$195.97	$179.53	$154.72	$222.70	$187.81	$168.00	$138.10	$220.48	$179.66	$156.46	$121.48
	Age 35-44	-	-	-	-	$271.10	$248.09	$235.02	$215.30	$268.88	$239.93	$223.49	$198.68	$266.66	$231.77	$211.95	$182.06	$264.44	$223.61	$200.42	$165.43
	Age 45-54	-	-	-	-	$374.84	$351.83	$338.76	$319.04	$372.62	$343.68	$327.23	$302.42	$370.40	$335.52	$315.70	$285.80	$368.18	$327.36	$304.17	$269.18
	Age 55-64	-	-	-	-	$567.89	$544.88	$531.81	$512.09	$565.67	$536.73	$520.28	$495.47	$563.45	$528.57	$508.75	$478.85	$561.23	$520.41	$497.22	$462.23
3 BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	$130.92	$111.63	$100.66	$84.12	$129.44	$106.19	$92.97	$73.04	$127.96	$100.75	$85.29	$61.96
	Age 21-34	-	-	-	-	-	-	-	-	$228.53	$209.23	$198.27	$181.73	$227.05	$203.79	$190.58	$170.65	$225.57	$198.35	$182.89	$159.56
	Age 35-44	-	-	-	-	-	-	-	-	$272.48	$253.19	$242.22	$225.69	$271.00	$247.75	$234.54	$214.60	$269.52	$242.31	$226.85	$203.52
	Age 45-54	-	-	-	-	-	-	-	-	$376.23	$356.93	$345.97	$329.43	$374.75	$351.49	$338.28	$318.35	$373.27	$346.05	$330.59	$307.27
	Age 55-64	-	-	-	-	-	-	-	-	$569.28	$549.98	$539.02	$522.48	$567.80	$544.54	$531.33	$511.40	$566.32	$539.10	$523.64	$500.32

Cost-Sharing Reduction Component

CSR component before adjusting for tobacco use

Estimating the CSR's value for an individual consumer begins by calculating the amount of the consumer's expected EHB claims. As noted earlier, the total amount of EHB claims, without including those related to tobacco use, is determined by making the following adjustments to the reference premium for non-smokers:

- Multiplying the reference premium by 0.8, to eliminate administrative costs;
- Dividing it by 0.7, to add consumers' share of EHB claims; and
- Multiplying it by 1.12, to account for induced utilization resulting from lower out-of-pocket cost-sharing.

Combining these three factors means that the reference premium is multiplied by 1.28 to estimate the amount of EHB claims (other than those resulting from tobacco use). The value of the CSR, for consumers at or below 150% FPL, is the increase in AV resulting from the CSR, which equals 24% of EHB claims costs; for those between 151 and 200% of FPL, that increase equals 17%. The resulting value of the CSR in the marketplace is then multiplied by 95%, to calculate the CSR component of the federal BHP payment. Table 10 shows these calculations.

Table 10. Calculating the CSR component of the federal BHP payment, without the tobacco adjustment: 2015

Age range	Reference premium	EHB claims	CSR value in marketplace		CSR component of BHP payment	
			0-150% FPL	151-200% FPL	0-150% FPL	151-200% FPL
19-20	$153.19	$196.08	$47.06	$33.33	$44.71	$31.67
21-34	$261.43	$334.63	$80.31	$56.89	$76.30	$54.04
31-44	$310.18	$397.03	$95.29	$67.50	$90.52	$64.12
45-54	$425.23	$544.29	$130.63	$92.53	$124.10	$87.90
55-64	$639.31	$818.32	$196.40	$139.11	$186.58	$132.16

The tobacco adjustment

The tobacco adjustment is calculated based on two factors: the extent to which EHB claims for tobacco use are not included in the premium charged to non-smokers, which is estimated based on the weighted-average ratio of benchmark premiums for tobacco users to benchmark premiums charged to non-tobacco users; and the estimated prevalence of tobacco use among BHP enrollees.

For tobacco users age 21 and older, all but one of Washington's benchmark QHPs increase premiums by 7.5% above the rates charged to non-users.[17] The other QHP increases such premiums by 20%.[18] The latter plan is the benchmark QHP in counties with 41% of the state's QHP enrollees.[19] Weighting these tobacco-based premium increases by QHP enrollment, we find that, for the weighted-average tobacco user age 21-64 in Washington State, premiums rise by 12.6% because of tobacco use. Under the federal payment methodology, this is the measure of EHB tobacco-related claims that are not included in the reference premium charged to non-users.

According to data from the Centers for Disease Control and Prevention (CDC), 17.5% of all Washington adults smoked and 3.6 percent used smokeless tobacco in 2012, totaling 20.1 percent tobacco users. These percentages varied greatly by age, as shown in Table 11.

Table 11. Percentage of Washington residents who use tobacco, by age: 2012			
Age range	Percent of residents who use tobacco		
	Cigarettes	Smokeless Tobacco	Total
18-24	15.8%	4.1%	19.9%
25-44	22.9%	5.7%	20.0%
45-64	17.6%	2.4%	8.7%
65+	7.5%	1.2%	28.6%

Source: Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, 2013.[20]

By multiplying the 12.6% weighted average increase in health care costs resulting from tobacco use by the estimated rate of tobacco use among Washington residents within various age ranges, as shown in table 11,, we calculate the percentages by which CSR payments should increase to reflect tobacco-related EHB claims that are not included in premiums charged to non-smokers. The percentage increases that apply within the age ranges used by the CDC are set out in Table 12.

Table 12. Increases in CSR payments required to cover tobacco-related EHB claims, within CDC-reported age ranges	
Age range	Percent increase in CSR payments
18-24	2.5%
25-44	3.6%
45-64	2.5%

Table 13 shows how those increases would translate into the age ranges used for BHP payment.[21]

Table 13. Increases in CSR payments required to cover tobacco-related EHB claims, within age ranges used for federal BHP payments	
Age range	Percent increase in CSR payments
19-20	2.5%
21-34	3.3%
31-44	3.6%
45-54	2.5%
55-64	2.5%

Source: CMS 2014.[22]

While that calculation shows the generally applicable methodology, in Washington state no tobacco adjustment applies to BHP enrollees under age 21, because QHPs do not raise premiums for tobacco users under age 21.

Calculating the CSR component of federal BHP payments with tobacco adjustment

As the final step in calculating the CSR component, we increase the CSR component of federal BHP payment amounts, shown in Table 10, by the percentages shown in Table 13 (except for adults under age 21, whose CSRs are not adjusted based on tobacco use). The result is shown in Table 14.

Table 14. CSR component of federal BHP payments including tobacco adjustment: estimated Washington state averages, 2015		
Age range	CSR component of federal BHP payment	
	0-150% FPL	151-200% FPL
19-20	$44.71	$31.67
21-34	$78.81	$55.82
35-44	$93.78	$66.43
45-54	$127.20	$90.10
55-64	$191.24	$135.46

Federal payment cells

Table 15 combines the PTC components shown in Table 9 with the CSR components shown in Table 14. The combination represents the approximate average federal payment for all BHP-eligible Washington residents who share the displayed combination of household size, FPL, age, and number of BHP-eligible consumers per household. Unlike the dollar amounts shown above, those in the following table are stated in annual terms.

Table 15. Federal BHP annual payment amounts per consumer: estimated Washington state averages, 2015																				
		1-person household				2-person household				3-person household				4-person household				5-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	$2,041	$1,631	$1,242	$891	$1,988	$1,435	$965	$492	$1,934	$1,240	$689	$0	$1,881	$1,044	$412	$0	$1,828	$848	$0	$0
	Age 21-34	$3,621	$3,212	$2,703	$2,352	$3,568	$3,016	$2,426	$1,953	$3,515	$2,820	$2,150	$1,554	$3,462	$2,624	$1,873	$1,155	$3,408	$2,429	$1,596	$756
	Age 35-44	$4,329	$3,919	$3,358	$3,007	$4,275	$3,723	$3,081	$2,608	$4,222	$3,527	$2,804	$2,209	$4,169	$3,332	$2,528	$1,810	$4,115	$3,136	$2,251	$1,411
	Age 45-54	$5,975	$5,565	$4,887	$4,536	$5,921	$5,369	$4,610	$4,137	$5,868	$5,173	$4,333	$3,738	$5,815	$4,977	$4,057	$3,339	$5,761	$4,782	$3,780	$2,940
	Age 55-64	$9,060	$8,650	$7,748	$7,397	$9,006	$8,454	$7,471	$6,998	$8,953	$8,258	$7,194	$6,599	$8,900	$8,063	$6,918	$6,200	$8,846	$7,867	$6,641	$5,801
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	$2,091	$1,815	$1,501	$1,265	$2,064	$1,717	$1,363	$1,065	$2,038	$1,619	$1,225	$866	$2,011	$1,521	$1,086	$666
	Age 21-34	-	-	-	-	$3,671	$3,395	$2,963	$2,726	$3,645	$3,297	$2,824	$2,526	$3,618	$3,199	$2,686	$2,327	$3,591	$3,102	$2,547	$2,128
	Age 35-44	-	-	-	-	$4,379	$4,102	$3,617	$3,381	$4,352	$4,005	$3,479	$3,181	$4,325	$3,907	$3,341	$2,982	$4,299	$3,809	$3,202	$2,782
	Age 45-54	-	-	-	-	$6,025	$5,748	$5,146	$4,910	$5,998	$5,651	$5,008	$4,710	$5,971	$5,553	$4,870	$4,511	$5,945	$5,455	$4,731	$4,311
	Age 55-64	-	-	-	-	$9,110	$8,834	$8,007	$7,771	$9,083	$8,736	$7,869	$7,571	$9,056	$8,638	$7,731	$7,372	$9,030	$8,540	$7,592	$7,172
3 BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	$2,108	$1,876	$1,588	$1,389	$2,090	$1,811	$1,496	$1,257	$2,072	$1,745	$1,403	$1,124
	Age 21-34	-	-	-	-	-	-	-	-	$3,688	$3,456	$3,049	$2,851	$3,670	$3,391	$2,957	$2,718	$3,652	$3,326	$2,865	$2,585
	Age 35-44	-	-	-	-	-	-	-	-	$4,395	$4,164	$3,704	$3,505	$4,377	$4,098	$3,612	$3,372	$4,360	$4,033	$3,519	$3,239
	Age 45-54	-	-	-	-	-	-	-	-	$6,041	$5,810	$5,233	$5,034	$6,023	$5,744	$5,141	$4,901	$6,006	$5,679	$5,048	$4,768
	Age 55-64	-	-	-	-	-	-	-	-	$9,126	$8,895	$8,094	$7,895	$9,108	$8,829	$8,002	$7,762	$9,091	$8,764	$7,909	$7,629

Step Three: Calculate the average federal payment for BHP-eligible residents

Multiplying the number of BHP-eligible consumers in each category, shown in appendix table A4 for Washington State, by the federal payment per capita for each applicable statewide federal payment cell, as shown in Table 15, yields the federal payment totals shown in Table 16. For all BHP-eligible consumers statewide, these payments sum to $190.0 million. When we divide that total by the estimated 43,520 BHP-eligible state residents shown in the Appendix tables for Washington State, we find that federal payments for BHP-eligible state residents average approximately $4,366 for 2015.

Obviously, not all BHP-eligible consumers will enroll. But to the extent that eligible consumers of all types—income, age, household size, etc.—are equally likely to sign up, the average federal payment per enrollee will approximate the amount for all eligible consumers.

These estimates also allow a calculation of average federal payments for various subsets of BHP-eligible consumers, such as all consumers within particular age and FPL ranges. One can simply divide total federal payments for each subset by the number of included consumers. For example, Table 17 shows that:

- 2015 BHP payments in Washington State rise with age. They average $1,483 for BHP-eligible consumers age 19-20; 2,889 for those age 21-34; $3,421 for those age 35-44; $4,993 for those age 45-54; and $7,841 for those age 55-64. This pattern results from higher marketplace premiums (hence higher QHP subsidies, all else equal) for older adults.

- Within each individual age band, federal BHP payments are highest for the poorest consumers. For example, among adults age 19-20, federal payments average $2,015 for BHP-eligibles consumers at 0-138% FPL; $1,589 at 139-150% FPL; $1,216 at 151-175% FPL; and $860 at 176-200% FPL. This reflects higher marketplace subsidies (hence higher federal payments) for lower-income consumers.

- However, when one combines BHP-eligible consumers of all ages, the lowest average federal payments are for those with incomes below 138% FPL, because consumers in this group are poor immigrants disproportionately likely to be young adults. Above 138% FPL, federal payments are highest for those with the lowest income, even if one includes eligible consumers of all ages. Payments average $5,042 at 139-150% FPL, declining to $4,435 at 151-175% FPL and $4,132 at 176 to 200% FPL.

These sub-set averages can help state-level policymakers and stakeholders compare federal payments to health care costs that vary based on age (and income, if benefits and out-of-pocket cost-sharing differ based on BHP enrollees' income). Such averages can also help policymakers craft BHP rules that promote financial feasibility by encouraging the enrollment of eligible consumers with the most favorable fiscal relationship between federal funding amounts and average health care costs.

Table 16. Total Federal BHP annual amounts for eligible consumers, by category: 2015 (thousands)																				
		1-person household				2-person household				3-person household				4-person household				5-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	39-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	$1,648	$330	$501	$283	$280	$100	$100	$35	$165	$59	$42	$0	$94	$16	$7	$0	$95	$3	$0	$0
	Age 21-34	$11,546	$4,970	$8,917	$7,794	$2,258	$652	$1,052	$618	$1,099	$340	$552	$268	$569	$115	$130	$60	$419	$37	$50	$9
	Age 35-44	$1,924	$1,211	$2,186	$2,013	$517	$333	$580	$330	$368	$212	$424	$247	$217	$122	$136	$71	$205	$37	$54	$21
	Age 45-54	$1,891	$2,414	$4,354	$4,119	$500	$782	$1,283	$797	$227	$258	$483	$346	$150	$90	$125	$87	$110	$28	$39	$32
	Age 55-64	$2,649	$7,113	$13,602	$11,884	$954	$4,057	$7,285	$6,450	$278	$541	$952	$695	$133	$121	$194	$133	$290	$72	$113	$45
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	$86	$102	$147	$72	$32	$68	$115	$70	$21	$28	$36	$27	$21	$11	$16	$5
	Age 21-34	-	-	-	-	$464	$542	$857	$605	$297	$472	$967	$649	$240	$536	$867	$649	$164	$431	$672	$441
	Age 35-44	-	-	-	-	$114	$229	$423	$313	$177	$225	$535	$421	$208	$449	$772	$671	$184	$422	$800	$540
	Age 45-54	-	-	-	-	$302	$987	$1,756	$1,467	$216	$537	$1,046	$838	$157	$464	$726	$661	$131	$246	$505	$350
	Age 55-64	-	-	-	-	$707	$3,781	$7,759	$6,972	$135	$706	$1,491	$1,358	$115	$261	$488	$385	$131	$109	$145	$156
3 BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	$11	$27	$75	$58	$8	$37	$56	$38	$29	$40	$75	$41
	Age 21-34	-	-	-	-	-	-	-	-	$50	$61	$172	$136	$27	$104	$164	$122	$61	$73	$114	$78
	Age 35-44	-	-	-	-	-	-	-	-	$6	$24	$53	$41	$5	$31	$70	$65	$42	$67	$136	$103
	Age 45-54	-	-	-	-	-	-	-	-	$114	$98	$282	$228	$58	$162	$255	$240	$89	$127	$263	$179
	Age 55-64	-	-	-	-	-	-	-	-	$29	$200	$459	$447	$26	$165	$281	$216	$61	$86	$137	$114

Table 17. Average federal payments per BHP-eligible consumer, for various combinations of age and FPL: statewide estimates, 2015					
Age	Income Range				
	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	**Total (0-200% FPL)**
19-20	$2,015	$1,589	$1,216	$860	**$1,483**
21-34	$3,598	$3,177	$2,658	$2,307	**$2,889**
35-44	$4,292	$3,844	$3,260	$2,898	**$3,421**
45-54	$5,956	$5,549	$4,869	$4,522	**$4,993**
55-64	$9,037	$8,629	$7,728	$7,374	**$7,841**
Total (Age 19-64)	**$4,032**	**$5,042**	**$4,435**	**$4,132**	**$4,366**

Conclusion: placing federal payment estimates in context

The above process should provide a reasonable approximation of average federal payments per BHP-eligible consumer; however, actual federal payments could be different. For example, if the lowest-income BHP-eligible residents tend to live in a particularly low-cost or a particularly high-cost area of the state, then actual average federal payments may be lower or higher than the amount derived using the approach suggested here. That said, this method provides a good starting point for estimating the amount that a state would receive from the federal government, if all BHP-eligible consumers were equally likely to enroll. This should allow a comparison of federal payments to the cost of providing BHP coverage to the average eligible consumer.

The appendix tables should facilitate estimating BHP coverage costs by providing information about the characteristics of BHP-eligible consumers. However, BHP costs will depend on state decisions about covered benefits, out-of-pocket cost-sharing, premiums, and provider reimbursement. To estimate state costs, policymakers could begin with either average Medicaid costs for non-pregnant, non-disabled adults at relatively high income levels or average silver-level benchmark QHP costs for adults below 200 percent FPL. In either case, those initial cost figures would need to be adjusted to reflect differences between the coverage on which they are based (Medicaid or subsidized QHP coverage) and BHP.

It will also be important to estimate which consumers are likely to enroll. Only those who sign up will generate costs and yield federal payments. As suggested earlier, states may be able to influence the balance of BHP costs and revenues. For example, if the state designs BHP coverage so that the lowest-income BHP consumers are more likely to enroll because of minimal premiums and out-of-pocket costs, that may increase the average amount of federal BHP payments without a corresponding increase in average state BHP costs.

A BHP fiscal analysis also needs to consider potential state savings from BHP.[23] More fundamentally, federal BHP funding can vary based on year-to-year changes in QHP benchmark premiums. Over time, marketplace premiums should eventually stabilize. Moreover, CMS's publication of federal payment rates for a given year in February of the prior year gives states advance notice of changes, allowing time to plan. Predictability is further enhanced if a state decides to base a year's BHP payments, not on that year's QHP benchmark premiums, but on the previous year's premiums, updated based on CMS national projections. Notwithstanding these factors that can enhance a state's ability to predict future federal payments and thus to plan ahead, during BHP's early years states could consider attempting to retain a small surplus in BHP trust funds to guard against unforeseen drops in future QHP benchmark premiums or unexpected changes to federal BHP payment methodologies.

Appendix: The Characteristics of BHP Eligibles by State

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The federal BHP payment formula depends on applicable benchmark premiums and on four characteristics of BHP enrollees: age (within ranges specified by the BHP federal payment methodology), income (within FPL ranges specified by the BHP federal payment methodology), number of persons in the tax unit (the household unit, as defined for purposes of determining eligibility both for BHP and QHP subsidies), and number of BHP-eligible persons in the tax unit who receive coverage through BHP. In order to compute payments, the joint distribution of these four characteristics—in other words, the number of enrollees at each benchmark premium level who possess every possible combination of the above four characteristics—must be known. For each state, we estimated the number of the joint distribution of these characteristics among people who would be eligible for BHP in 2016.[24]

We did not model how many of those eligible for BHP would actually enroll in the program. This depends to a large extent on the BHP premiums and beneficiary cost sharing, and states have a lot of flexibility in setting these elements of BHP policy.

Methods

To produce these estimates, we began with the Urban Institute's Health Insurance Policy Simulation Model-American Community Survey (HIPSM-ACS). To obtain a large, representative sample population for each state, we pooled together the observations on the 2009, 2010, and 2011 American Community Surveys (ACS). Among national surveys conducted by the U. S. Census Bureau, the American Community Survey (ACS) has the largest state-specific samples and so is likely to provide the most reliable estimates. However, a limitation of both this data set and the other data set frequently used (the Current Population Survey-Annual Social and Economic Supplement) is that they do not include information about offers of employer-sponsored insurance (ESI), which almost always preclude subsidy eligibility.[25] States that fail to take such offers into account will overestimate the prevalence of relatively high-income BHP-eligible consumers, since ESI offers grow increasingly common as income rises.[26] As a result, such states will underestimate federal BHP funding per BHP enrollee, since QHP subsidies, hence BHP funding levels, decline as income rises. The estimates presented here do not share this problem, since HIPSM incorporates, via statistical matches with other data sources, information about unaccepted ESI offers.

Immigration Status. We impute documentation status for non-citizens in each year of survey data separately based on a year-specific model used in the CPS. Documentation status is imputed to immigrants in two stages, using individual and family characteristics, based on an imputation methodology that was originally developed by Passel, the most-used source of estimates of immigrants not lawfully present.[27] Undocumented immigrants and lawfully present non-citizens, including immigrant adults who have been U.S. residents for less than five years, are generally ineligible for Medicaid.

Tax units and filing. To model tax units and filing behavior, we use 2011 tax rules (including thresholds for tax filing requirements), Earned Income Tax Credit (EITC) eligibility guidelines, and poverty guidelines as defined by the U.S. Department of Health and Human Services. Baseline coverage and post-ACA eligibility are based on estimates from HIPSM-ACS.

Tax units and filing status are determined based on the IRS guidelines set forth by the 2011 1040 Instructions and the 2011 EITC eligibility guidelines. The primary tax filing unit for each family is defined as the head of the family, the spouse, and any qualifying children or qualifying relatives (as defined by the IRS). In multi-generational households, nuclear subfamilies are tested for their filing status. If they are not found to file as a unit themselves, they are tested to qualify as dependents of the head of the household.

Tax filing status is determined based on characteristics of the head of the tax unit and pooled income within the tax unit. Married couples are assumed to be filing jointly to qualify for tax credits. As support within the household is not captured by the ACS, any unmarried tax unit head with dependents is considered filing as a head of household. Any other unmarried person without dependents is tested as single. To determine requirement to file, individual Adjusted Gross Income (AGI) is pooled for each person within the tax unit and compared to the 2011 minimum mandatory filing threshold.

Due to limitations of the income that is captured by the ACS, some taxable income categories could not be included in total income. Capital gains are not reported as investment income in the ACS, so it was not counted. Paid alimony was also excluded; however, internal analysis based on CPS alimony data suggests this exclusion would not affect our results. The ACS does not collect data on unemployment compensation, but because this was likely an important form of income for people at the margin of the Medicaid and subsidy eligibility thresholds, it was imputed based on reported unemployment compensation from the 2008 CPS.

None of the adjustments needed to calculate AGI are reported by the ACS, so we therefore take total income as a proxy for AGI. Total income is calculated as the sum of wages, business income, farm income, rents, most forms of positive investment income, retirement income, unemployment compensation, and the taxable portion of social security income.

EITC eligibility is calculated in a slightly different way. AGI is pooled only among the head of the tax unit, the spouse (if filing as a married couple), and qualifying children. Qualifying dependents are not tested to file for EITC individually because they are either childless dependents (ineligible for EITC) or are found not to file in subfamily analysis. However, because they are claimed on the tax unit head's return, they take on the EITC eligibility status of their tax unit.

Once it was determined which tax units were required to file and which were eligible for EITC, units were assigned filing decisions. A 2005 Treasury Report estimated that about 7.4 million taxpayers who were required to file did not in Tax Year 2003.[28] That year, approximately 131 million individual tax returns were filed,[29] meaning the filing rate among those required to file was about 95%. A study by the IRS of Tax Year 2005 filings estimated the following EITC participation rates, by number of qualifying children: 55.6% among those without qualifying children, 73.6% among those with one qualifying child, and 85.9% among those with two or more qualifying children.[30] Based on these rates, tax units were randomly assigned their decision to file or not file.

Eligibility for Medicaid/CHIP, QHP subsidies, and BHP. Medicaid and subsidy eligibility are determined using MAGI, which adds nontaxable social security income to AGI. Unit-level MAGI is pooled among the unit head, the spouse (if married), and any qualifying children with an individual AGI above the single tax filing threshold. The income of other qualifying children and qualifying relatives is not included. This

is then used to calculate a ratio of MAGI to the applicable federal poverty level (FPL) of the unit. Special prorating of units that include undocumented parent(s) or childless spouses is used to scale the total AGI (including that of the undocumented family members) by a ratio of the FPLs including and excluding the undocumented family members.

Medicaid eligibility for some groups, particularly the blind and disabled, does not change under the ACA. We model their eligibility using pre-ACA rules. To determine Medicaid and CHIP eligibility for other groups, tax unit-level MAGI-as-a-percentage-of-FPL is assigned to the tax unit head, the spouse (if married), and qualifying children with individual AGI above the single tax filing threshold. Excluded qualifying children and qualifying relatives are automatically eligible for Medicaid under CMS regulations. Under the ACA, the children of non-filing qualifying dependents also automatically qualify for Medicaid. The remaining parents, childless adults, and children are then tested for Medicaid eligibility based on the corresponding eligibility threshold in their state of residence. Children who are found ineligible for Medicaid are tested for CHIP eligibility.

QHP subsidy eligibility is determined slightly differently. To be eligible for subsidies, one must have a MAGI-as-a-percentage-of-FPL between 100 and 400%. Eligibility for any public coverage precludes eligibility for subsidies, so subsidy-eligible consumers cannot be eligible for Medicaid or CHIP under the ACA, as determined above, nor can they currently be eligible for Medicare. Finally, no unit member can have an offer of single coverage that costs less than 9.5% of family MAGI. For this determination, we use the HIPSM-ACS imputation of employer offers and the affordability of those offers.

Those eligible for BHP are by definition those eligible for QHP subsidies who have incomes below 200% FPL.

Single Distributions of Each Characteristic. The resulting data allowed us to produce reliable estimates of the *single distributions* of BHP eligibles by state of age group, FPL income group, number of people in the tax unit, and number of BHP eligibles within the tax unit. These are Tables A1, A2, and A3.

Joint Distributions for Each State. As noted earlier, estimating federal BHP payments requires the joint distribution of all four characteristics by state. That is, one must know how many BHP-eligible residents of a state share a particular combination of age, FPL level, household size, and number of BHP-eligible household members. This would mean separating the BHP-eligible population for each state into 240 different groups.[31] To get reliable estimates for so many small groups of people would require a sample size for each state far larger than what our data provide. We overcame this difficulty using a standard small area estimation technique that relies on our data having a large enough sample size to estimate this four-trait joint distribution among BHP-eligibles *nationally*. For each state, we reweighted the national joint distribution to match the individual state's single distribution of age group, FPL income group, household size, and the number of BHP-eligible individuals per household.[32] Thus, we used estimates in which we had confidence—state-level single distributions of characteristics and the national joint distribution—to estimate the state-level joint distribution, which could not itself be tabulated directly from the data. The single distributions for each state are shown in tables A1-A3 and the final joint distribution estimates are shown in table A4. One additional single distribution, involving household size, is not included here, but is available upon request from the authors.

RESULTS

The following tables present the data on the characteristics of the BHP-eligible population by state. Tables A1-A3 provide summary-level statistics on age, income range, and the number of BHP-eligible people in the household unit for all 50 states and the District of Columbia. Table A4 provides detailed estimates of the joint distribution of BHP eligible consumers by the four characteristics listed above. These detailed estimated are not provided for several states (Alaska, Delaware, the District of Columbia, North Dakota, South Dakota, and Wyoming) due to small sample sizes in those states. Detailed estimates are also not provided for New York because more comprehensive Urban Institute estimates have already been incorporated into state budget projections. Because of sample size considerations, we did not distinguish between FPL income ranges below 138% FPL. The number of BHP-eligible persons in the household unit represents the maximum number of people in the household who can enroll in BHP. Because very few BHP-eligible people are in households with more than five members or in households with more than three BHP-eligible members, our largest listed categories included households with five or more members and with three or more BHP-eligible members. In Table A4, we present data for households with one to four members. You can access the complete data in a downloadable Excel file at https://kaiserfamilyfoundation.files.wordpress.com/2014/11/8665-appendix-table-a41.xlsx.

Table A1: BHP Eligibles by Age											
State	19-20		21-34		35-44		45-54		55-64		Total
	N	%	N	%	N	%	N	%	N	%	N
Alabama	4,042	5%	30,794	35%	16,405	19%	13,343	15%	22,587	26%	87,172
Alaska	730	4%	8,080	47%	2,040	12%	2,765	16%	3,744	22%	17,358
Arizona	4,614	4%	41,738	36%	20,834	18%	19,598	17%	29,125	25%	115,909
Arkansas	2,606	5%	19,441	35%	10,394	19%	9,470	17%	13,810	25%	55,720
California	46,615	6%	335,180	40%	154,246	19%	149,334	18%	147,330	18%	832,704
Colorado	4,900	5%	37,949	39%	16,602	17%	17,882	18%	20,136	21%	97,469
Connecticut	3,444	8%	17,814	41%	5,359	12%	6,128	14%	10,775	25%	43,520
Delaware	736	6%	4,909	39%	2,178	17%	1,800	14%	2,901	23%	12,523
DC	1,253	15%	3,065	38%	727	9%	843	10%	2,216	27%	8,103
Florida	23,137	5%	176,938	35%	98,005	20%	93,656	19%	107,119	21%	498,855
Georgia	10,465	5%	80,941	38%	41,128	20%	36,648	17%	41,607	20%	210,789
Hawaii	891	3%	8,720	34%	4,539	18%	5,365	21%	6,085	24%	25,600
Idaho	1,593	4%	15,628	41%	6,612	18%	5,537	15%	8,331	22%	37,701
Illinois	11,913	6%	81,309	38%	36,543	17%	38,332	18%	44,418	21%	212,515
Indiana	7,554	6%	50,822	38%	22,726	17%	21,858	16%	29,945	23%	132,905
Iowa	2,875	6%	18,301	41%	7,201	16%	7,370	17%	8,516	19%	44,263
Kansas	3,100	6%	19,360	39%	8,417	17%	9,056	18%	10,271	20%	50,203
Kentucky	2,982	4%	29,472	36%	13,878	17%	13,433	16%	22,069	27%	81,834
Louisiana	4,522	5%	36,219	39%	16,402	18%	14,606	16%	20,969	23%	92,717
Maine	945	4%	7,718	30%	3,491	14%	5,078	20%	8,189	32%	25,421
Maryland	4,455	5%	32,278	37%	16,674	19%	16,270	19%	17,541	20%	87,218
Massachusetts	5,941	8%	32,600	43%	11,939	16%	11,577	15%	13,413	18%	75,470
Michigan	8,396	4%	62,469	33%	29,357	16%	34,450	18%	52,527	28%	187,199
Minnesota	3,984	6%	25,776	37%	6,623	10%	10,723	15%	22,360	32%	69,466
Mississippi	2,189	4%	18,976	35%	10,368	19%	9,038	17%	13,971	26%	54,541
Missouri	5,343	4%	45,599	38%	22,000	18%	19,555	16%	26,792	22%	119,289
Montana	1,248	4%	11,455	39%	4,924	17%	5,102	18%	6,347	22%	29,075
Nebraska	1,232	4%	12,311	40%	5,552	18%	6,157	20%	5,243	17%	30,495
Nevada	2,224	4%	23,549	38%	11,811	19%	11,254	18%	13,012	21%	61,850
New Hampshire	1,193	5%	8,822	37%	3,779	16%	5,237	22%	4,715	20%	23,747
New Jersey	7,215	4%	61,796	38%	33,973	21%	28,459	18%	30,972	19%	162,416
New Mexico	2,239	5%	17,579	37%	8,649	18%	7,955	17%	10,740	23%	47,161
New York	23,288	6%	148,887	41%	67,099	18%	58,707	16%	66,749	18%	364,729
North Carolina	8,706	5%	65,002	35%	36,562	19%	32,422	17%	44,836	24%	187,528
North Dakota	575	4%	6,090	45%	1,910	14%	1,858	14%	2,967	22%	13,400
Ohio	8,202	4%	70,131	35%	35,944	18%	34,827	17%	51,463	26%	200,567
Oklahoma	3,498	5%	29,213	38%	14,672	19%	14,111	18%	16,101	21%	77,596
Oregon	3,959	5%	34,061	39%	15,765	18%	14,239	16%	19,600	22%	87,625
Pennsylvania	11,531	5%	77,880	34%	40,083	17%	42,014	18%	57,625	25%	229,132
Rhode Island	1,460	7%	8,172	40%	3,298	16%	3,407	17%	3,842	19%	20,179
South Carolina	5,488	6%	34,154	35%	16,509	17%	18,123	18%	23,826	24%	98,101
South Dakota	1,142	8%	5,731	39%	2,655	18%	1,980	14%	3,081	21%	14,588
Tennessee	5,369	4%	42,740	35%	21,458	18%	22,255	18%	29,572	24%	121,394
Texas	31,271	5%	231,706	41%	112,162	20%	94,753	17%	100,362	18%	570,254
Utah	3,547	6%	26,562	47%	9,865	18%	8,000	14%	8,142	15%	56,116
Vermont	788	6%	4,149	33%	2,245	18%	2,025	16%	3,402	27%	12,608
Virginia	7,742	6%	48,259	37%	24,876	19%	21,629	16%	28,898	22%	131,403
Washington	6,677	5%	53,526	41%	22,020	17%	23,129	18%	26,174	20%	131,526
West Virginia	899	3%	11,874	34%	5,037	14%	6,873	20%	10,174	29%	34,855
Wisconsin	5,119	6%	31,933	36%	15,401	17%	14,814	17%	22,402	25%	89,667
Wyoming	564	5%	3,593	35%	1,390	13%	1,672	16%	3,098	30%	10,318

* Data suppressed due to low sample size
** See the detailed estimates of BHP costs and savings in state budget projections, based on Urban Institute modeling
Source: Health Insurance Policy Simulation Model- American Community Survey, 2014

Table A2: BHP Eligibles by FPL									
State	Less than 138%		139-150%		151-175%		176-200%		Total
	N	%	N	%	N	%	N	%	N
Alabama	3,886	4%	17,145	20%	35,428	41%	30,712	35%	87,172
Alaska	951	5%	3,415	20%	6,239	36%	6,753	39%	17,358
Arizona	11,338	10%	18,931	16%	44,551	38%	41,089	35%	115,909
Arkansas	2,673	5%	11,373	20%	22,791	41%	18,882	34%	55,720
California	155,345	19%	124,611	15%	284,068	34%	268,680	32%	832,704
Colorado	8,803	9%	15,644	16%	37,503	38%	35,519	36%	97,469
Connecticut	8,211	19%	7,123	16%	14,854	34%	13,332	31%	43,520
Delaware	1,629	13%	1,839	15%	4,854	39%	4,202	34%	12,523
DC	1,253	15%	1,421	18%	2,063	25%	3,367	42%	8,103
Florida	82,116	16%	82,665	17%	175,162	35%	158,912	32%	498,855
Georgia	16,138	8%	35,579	17%	86,529	41%	72,543	34%	210,789
Hawaii	4,986	19%	4,192	16%	7,463	29%	8,960	35%	25,600
Idaho	1,685	4%	7,525	20%	13,914	37%	14,577	39%	37,701
Illinois	29,203	14%	36,676	17%	76,074	36%	70,562	33%	212,515
Indiana	9,717	7%	25,097	19%	50,598	38%	47,493	36%	132,905
Iowa	3,617	8%	7,287	16%	17,387	39%	15,972	36%	44,263
Kansas	4,218	8%	9,672	19%	20,045	40%	16,268	32%	50,203
Kentucky	6,125	7%	16,126	20%	32,247	39%	27,336	33%	81,834
Louisiana	4,675	5%	17,251	19%	37,264	40%	33,527	36%	92,717
Maine	370	1%	4,343	17%	10,734	42%	9,973	39%	25,421
Maryland	14,184	16%	12,562	14%	31,274	36%	29,198	33%	87,218
Massachusetts	18,102	24%	9,650	13%	24,250	32%	23,468	31%	75,470
Michigan	14,603	8%	33,357	18%	70,313	38%	68,926	37%	187,199
Minnesota	5,670	8%	12,507	18%	26,112	38%	25,178	36%	69,466
Mississippi	1,913	4%	10,908	20%	22,591	41%	19,129	35%	54,541
Missouri	8,456	7%	21,535	18%	45,324	38%	43,974	37%	119,289
Montana	720	2%	6,881	24%	11,339	39%	10,136	35%	29,075
Nebraska	2,702	9%	6,468	21%	10,360	34%	10,965	36%	30,495
Nevada	6,073	10%	9,055	15%	22,093	36%	24,628	40%	61,850
New Hampshire	1,629	7%	4,732	20%	7,943	33%	9,442	40%	23,747
New Jersey	32,395	20%	24,767	15%	55,651	34%	49,604	31%	162,416
New Mexico	3,620	8%	7,701	16%	17,630	37%	18,210	39%	47,161
New York	75,596	21%	58,100	16%	116,956	32%	114,077	31%	364,729
North Carolina	12,982	7%	34,247	18%	73,833	39%	66,465	35%	187,528
North Dakota	1,494	11%	1,869	14%	5,714	43%	4,324	32%	13,400
Ohio	12,274	6%	35,710	18%	79,895	40%	72,689	36%	200,567
Oklahoma	6,278	8%	12,899	17%	30,496	39%	27,923	36%	77,596
Oregon	6,508	7%	15,479	18%	32,799	37%	32,838	37%	87,625
Pennsylvania	17,804	8%	38,816	17%	88,365	39%	84,147	37%	229,132
Rhode Island	3,422	17%	3,034	15%	5,568	28%	8,155	40%	20,179
South Carolina	5,341	5%	18,444	19%	39,269	40%	35,046	36%	98,101
South Dakota	863	6%	2,376	16%	5,638	39%	5,712	39%	14,588
Tennessee	6,656	5%	25,992	21%	47,657	39%	41,089	34%	121,394
Texas	88,134	15%	99,013	17%	204,857	36%	178,251	31%	570,254
Utah	5,094	9%	9,483	17%	20,525	37%	21,014	37%	56,116
Vermont	502	4%	2,967	24%	5,045	40%	4,095	32%	12,608
Virginia	14,292	11%	20,550	16%	54,154	41%	42,407	32%	131,403
Washington	16,301	12%	20,672	16%	47,409	36%	47,144	36%	131,526
West Virginia	1,269	4%	6,799	20%	13,511	39%	13,275	38%	34,855
Wisconsin	4,959	6%	15,601	17%	37,217	42%	31,891	36%	89,667
Wyoming	481	5%	2,236	22%	4,598	45%	3,003	29%	10,318

* Data suppressed due to low sample size
** See the detailed estimates of BHP costs and savings in state budget projections, based on Urban Institute modeling
Source: Health Insurance Policy Simulation Model- American Community Survey, 2014

Table A3: BHP Eligibles in Tax Unit							
State	1		2		3+		Total
	N	%	N	%	N	%	N
Alabama	56,305	65%	27,988	32%	2,879	3%	87,172
Alaska	12,989	75%	4,202	24%	167	1%	17,358
Arizona	84,166	73%	28,859	25%	2,884	2%	115,909
Arkansas	35,385	64%	19,295	35%	1,040	2%	55,720
California	597,140	72%	198,287	24%	37,277	4%	832,704
Colorado	69,054	71%	26,906	28%	1,510	2%	97,469
Connecticut	36,893	85%	6,412	15%	214	0%	43,520
Delaware	9,451	75%	2,962	24%	110	1%	12,523
DC	7,360	91%	540	7%	203	3%	8,103
Florida	351,639	70%	124,291	25%	22,926	5%	498,855
Georgia	137,912	65%	62,847	30%	10,029	5%	210,789
Hawaii	20,086	78%	5,326	21%	188	1%	25,600
Idaho	22,092	59%	14,396	38%	1,213	3%	37,701
Illinois	155,046	73%	49,309	23%	8,160	4%	212,515
Indiana	86,382	65%	39,511	30%	7,012	5%	132,905
Iowa	31,612	71%	11,881	27%	771	2%	44,263
Kansas	33,461	67%	14,693	29%	2,049	4%	50,203
Kentucky	54,418	66%	26,073	32%	1,343	2%	81,834
Louisiana	62,935	68%	25,958	28%	3,824	4%	92,717
Maine	18,621	73%	6,408	25%	392	2%	25,421
Maryland	66,138	76%	19,184	22%	1,896	2%	87,218
Massachusetts	59,589	79%	13,715	18%	2,167	3%	75,470
Michigan	126,164	67%	55,244	30%	5,791	3%	187,199
Minnesota	54,391	78%	14,158	20%	916	1%	69,466
Mississippi	34,208	63%	18,456	34%	1,877	3%	54,541
Missouri	79,625	67%	35,647	30%	4,016	3%	119,289
Montana	17,601	61%	10,618	37%	857	3%	29,075
Nebraska	21,469	70%	8,531	28%	495	2%	30,495
Nevada	45,617	74%	14,956	24%	1,278	2%	61,850
New Hampshire	16,585	70%	6,208	26%	953	4%	23,747
New Jersey	116,794	72%	40,062	25%	5,560	3%	162,416
New Mexico	34,971	74%	10,710	23%	1,481	3%	47,161
New York	274,446	75%	79,740	22%	10,543	3%	364,729
North Carolina	129,275	69%	52,921	28%	5,332	3%	187,528
North Dakota	9,175	68%	4,022	30%	203	2%	13,400
Ohio	138,347	69%	57,442	29%	4,778	2%	200,567
Oklahoma	49,350	64%	24,731	32%	3,516	5%	77,596
Oregon	60,222	69%	24,456	28%	2,947	3%	87,625
Pennsylvania	151,848	66%	68,121	30%	9,163	4%	229,132
Rhode Island	14,947	74%	4,463	22%	769	4%	20,179
South Carolina	63,197	64%	29,718	30%	5,186	5%	98,101
South Dakota	9,103	62%	4,739	32%	747	5%	14,588
Tennessee	80,367	66%	36,806	30%	4,221	3%	121,394
Texas	381,480	67%	161,110	28%	27,664	5%	570,254
Utah	29,945	53%	22,363	40%	3,808	7%	56,116
Vermont	8,463	67%	4,067	32%	78	1%	12,608
Virginia	91,036	69%	34,880	27%	5,487	4%	131,403
Washington	90,448	69%	38,034	29%	3,045	2%	131,526
West Virginia	24,725	71%	9,950	29%	180	1%	34,855
Wisconsin	67,623	75%	20,248	23%	1,796	2%	89,667
Wyoming	6,004	58%	4,314	42%	-	0%	10,318

* Data suppressed due to low sample size
** See the detailed estimates of BHP costs and savings in state budget projections, based on Urban Institute modeling
Source: Health Insurance Policy Simulation Model- American Community Survey, 2014

Table A4. Estimated number of BHP-eligible people by state, household size, FPL, number of BHP-eligible people in household unit, and age

Alabama: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	264	317	626	475	46	107	159	106	27	75	94	74	16	23	27	24
	Age 21-34	1,454	3,445	7,248	7,030	287	482	955	668	141	269	565	364	78	98	153	111
	Age 35-44	342	1,176	2,433	2,427	93	340	712	460	67	230	572	408	40	140	204	144
	Age 45-54	158	1,058	2,140	2,104	41	355	670	446	19	121	269	214	13	44	74	61
	Age 55-64	134	1,846	3,886	3,425	48	1,077	2,158	1,966	15	147	293	225	*	34	62	46
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	16	98	172	96	*	73	153	113	*	30	54	55
	Age 21-34	-	-	-	-	57	359	649	479	37	326	781	563	31	389	744	616
	Age 35-44	-	-	-	-	16	184	385	292	27	186	502	419	33	406	796	752
	Age 45-54	-	-	-	-	24	414	813	691	17	232	503	419	13	213	375	356
	Age 55-64	-	-	-	-	35	969	2,159	1,926	*	184	426	389	*	70	142	116
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	27	87	76	*	40	75	60
	Age 21-34	-	-	-	-	-	-	-	-	*	41	128	103	*	71	124	100
	Age 35-44	-	-	-	-	-	-	-	-	*	16	40	30	*	20	53	51
	Age 45-54	-	-	-	-	-	-	-	-	*	39	119	98	*	64	111	106
	Age 55-64	-	-	-	-	-	-	-	-	*	50	126	118	*	41	77	58

Arizona: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	617	271	607	487	106	91	152	108	63	63	90	75	36	20	26	24
	Age 21-34	4,280	3,751	8,961	9,215	848	524	1,179	877	420	291	698	478	225	106	188	145
	Age 35-44	971	1,237	2,913	3,082	268	358	849	584	192	242	683	517	116	147	244	182
	Age 45-54	544	1,354	3,116	3,253	144	454	976	690	65	155	392	332	45	57	109	94
	Age 55-64	407	2,053	4,926	4,613	146	1,196	2,734	2,646	45	163	372	302	21	37	79	61
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	42	89	181	106	17	68	162	124	11	27	58	61
	Age 21-34	-	-	-	-	171	391	804	629	112	354	966	739	92	420	916	808
	Age 35-44	-	-	-	-	46	196	469	380	79	198	608	541	98	432	966	969
	Age 45-54	-	-	-	-	75	509	1,135	1,030	57	283	699	620	44	260	520	526
	Age 55-64	-	-	-	-	108	1,084	2,752	2,610	22	205	543	530	18	79	184	158
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	26	97	89	*	40	85	73
	Age 21-34	-	-	-	-	-	-	-	-	20	46	162	140	10	78	159	136
	Age 35-44	-	-	-	-	-	-	-	-	*	17	48	38	*	21	62	64
	Age 45-54	-	-	-	-	-	-	-	-	27	45	155	136	14	73	145	147
	Age 55-64	-	-	-	-	-	-	-	-	*	55	156	156	*	44	95	77

Arkansas: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	182	209	401	291	32	71	102	65	19	49	60	45	11	15	17	15
	Age 21-34	989	2,246	4,588	4,257	195	314	605	404	96	175	357	220	53	64	96	67
	Age 35-44	233	769	1,546	1,474	63	223	452	279	46	151	364	247	27	92	130	87
	Age 45-54	123	793	1,555	1,462	32	266	488	310	15	91	196	149	10	33	54	42
	Age 55-64	89	1,169	2,388	2,011	32	682	1,326	1,154	10	93	180	132	*	21	38	27
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	11	65	111	59	*	49	99	69	*	20	35	34
	Age 21-34	-	-	-	-	39	236	413	291	26	214	496	341	21	254	472	373
	Age 35-44	-	-	-	-	11	122	247	180	19	123	322	257	23	269	511	461
	Age 45-54	-	-	-	-	17	299	570	463	13	168	353	281	*	154	263	240
	Age 55-64	-	-	-	-	24	621	1,341	1,142	*	119	267	234	*	46	90	70
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	18	57	47	*	27	49	38
	Age 21-34	-	-	-	-	-	-	-	-	*	27	82	64	*	47	81	63
	Age 35-44	-	-	-	-	-	-	-	-	*	10	26	19	*	13	34	31
	Age 45-54	-	-	-	-	-	-	-	-	*	27	82	64	*	45	76	69
	Age 55-64	-	-	-	-	-	-	-	-	*	33	79	71	*	27	49	35

California: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	10,392	2,384	5,183	4,289	1,791	805	1,309	952	1,081	554	771	666	628	173	223	215
	Age 21-34	58,893	26,594	61,790	65,277	11,677	3,716	8,114	6,226	5,792	2,065	4,810	3,391	3,058	752	1,294	1,029
	Age 35-44	12,863	8,454	19,375	21,081	3,572	2,450	5,628	3,986	2,561	1,650	4,530	3,529	1,549	1,004	1,618	1,244
	Age 45-54	7,811	10,043	22,460	24,118	2,079	3,371	7,038	5,123	954	1,151	2,819	2,465	645	420	782	693
	Age 55-64	3,924	10,034	23,381	22,517	1,394	5,829	12,950	12,894	424	796	1,759	1,477	198	182	372	300
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	656	732	1,426	868	263	545	1,272	1,015	163	229	462	504
	Age 21-34	-	-	-	-	2,351	2,761	5,483	4,417	1,553	2,490	6,593	5,190	1,277	2,966	6,277	5,708
	Age 35-44	-	-	-	-	630	1,347	3,118	2,617	1,069	1,364	4,072	3,727	1,320	2,972	6,474	6,676
	Age 45-54	-	-	-	-	1,046	3,564	7,721	7,194	809	2,038	4,869	4,402	603	1,872	3,637	3,794
	Age 55-64	-	-	-	-	1,101	5,520	13,527	13,149	251	1,099	2,817	2,826	200	432	967	849
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	96	193	738	681	72	307	630	561
	Age 21-34	-	-	-	-	-	-	-	-	275	308	1,051	930	145	539	1,065	940
	Age 35-44	-	-	-	-	-	-	-	-	29	112	314	271	24	151	437	463
	Age 45-54	-	-	-	-	-	-	-	-	392	317	1,108	988	190	539	1,021	1,083
	Age 55-64	-	-	-	-	-	-	-	-	51	322	875	896	49	262	551	439

Colorado: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	596	300	687	569	103	101	174	127	61	70	103	89	36	22	30	29
	Age 21-34	3,417	3,401	8,304	8,785	676	475	1,094	837	334	265	647	457	179	96	175	139
	Age 35-44	667	959	2,306	2,511	183	278	671	475	131	187	540	421	79	114	193	148
	Age 45-54	432	1,224	2,878	3,093	114	411	903	658	52	140	362	316	36	51	100	89
	Age 55-64	241	1,364	3,346	3,224	86	793	1,855	1,848	27	108	252	212	12	25	53	43
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	37	92	189	115	15	68	167	134	*	29	60	66
	Age 21-34	-	-	-	-	135	351	735	593	88	317	881	694	72	377	837	761
	Age 35-44	-	-	-	-	33	157	382	320	56	159	499	457	68	342	785	809
	Age 45-54	-	-	-	-	59	440	1,004	935	45	250	628	569	33	228	465	485
	Age 55-64	-	-	-	-	67	742	1,918	1,868	15	146	394	394	12	57	134	118
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	24	98	90	*	38	82	73
	Age 21-34	-	-	-	-	-	-	-	-	15	39	141	125	*	68	141	125
	Age 35-44	-	-	-	-	-	-	-	-	*	14	40	34	*	18	55	58
	Age 45-54	-	-	-	-	-	-	-	-	22	40	145	130	11	67	134	141
	Age 55-64	-	-	-	-	-	-	-	-	*	42	121	125	*	34	76	61

Connecticut: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	807	202	404	318	141	70	103	72	86	48	61	50	50	15	18	16
	Age 21-34	3,188	1,547	3,299	3,314	633	216	434	317	313	120	257	172	164	44	69	52
	Age 35-44	444	309	651	669	121	89	188	126	87	60	151	112	52	37	54	39
	Age 45-54	317	434	891	908	85	146	278	193	39	50	112	93	26	18	31	26
	Age 55-64	292	822	1,756	1,607	106	480	975	922	31	65	132	105	15	15	28	21
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	41	56	98	57	16	40	84	66	10	17	29	31
	Age 21-34	-	-	-	-	126	160	289	222	82	143	343	257	66	167	323	279
	Age 35-44	-	-	-	-	26	56	117	93	41	56	154	132	48	115	231	225
	Age 45-54	-	-	-	-	50	172	341	299	36	95	209	178	26	84	149	146
	Age 55-64	-	-	-	-	78	428	969	897	15	81	189	179	13	30	63	52
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	14	47	42	*	20	38	30
	Age 21-34	-	-	-	-	-	-	-	-	14	18	57	48	*	31	56	45
	Age 35-44	-	-	-	-	-	-	-	-	*	*	14	12	*	*	19	19
	Age 45-54	-	-	-	-	-	-	-	-	19	17	54	45	*	28	50	49
	Age 55-64	-	-	-	-	-	-	-	-	*	23	57	57	*	19	35	28

Florida: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	4,763	1,266	2,560	2,026	818	425	643	447	493	293	378	313	285	91	110	101
	Age 21-34	29,220	15,358	33,132	33,544	5,788	2,144	4,346	3,191	2,870	1,192	2,575	1,737	1,524	435	693	527
	Age 35-44	7,705	5,927	12,603	13,135	2,150	1,716	3,670	2,484	1,541	1,160	2,951	2,198	934	705	1,055	777
	Age 45-54	4,572	6,881	14,263	14,667	1,216	2,309	4,473	3,112	558	788	1,792	1,499	379	288	496	421
	Age 55-64	2,658	8,010	17,306	15,956	949	4,663	9,594	9,142	287	636	1,304	1,044	136	145	276	212
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	328	413	756	437	133	314	681	512	81	129	248	257
	Age 21-34	-	-	-	-	1,195	1,631	3,019	2,315	787	1,477	3,628	2,728	649	1,747	3,436	2,986
	Age 35-44	-	-	-	-	360	927	1,996	1,601	627	936	2,579	2,269	777	2,059	4,139	4,095
	Age 45-54	-	-	-	-	588	2,470	4,954	4,438	468	1,391	3,083	2,690	353	1,287	2,314	2,307
	Age 55-64	-	-	-	-	722	4,324	9,849	9,183	159	835	1,987	1,918	127	329	683	575
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	51	116	409	364	39	186	356	305
	Age 21-34	-	-	-	-	-	-	-	-	145	198	621	529	77	339	621	528
	Age 35-44	-	-	-	-	-	-	-	-	15	76	197	158	13	96	263	265
	Age 45-54	-	-	-	-	-	-	-	-	215	209	659	568	104	347	609	614
	Age 55-64	-	-	-	-	-	-	-	-	30	228	577	566	27	182	357	279

Georgia: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	1,082	683	1,584	1,164	188	231	402	259	111	160	237	182	64	50	68	59
	Age 21-34	6,160	7,680	19,010	17,857	1,218	1,074	2,505	1,699	602	598	1,483	926	325	218	400	282
	Age 35-44	1,397	2,532	6,170	5,963	383	733	1,802	1,130	275	495	1,451	1,001	166	302	518	353
	Age 45-54	734	2,596	6,187	5,889	193	871	1,941	1,251	88	298	778	601	60	109	216	170
	Age 55-64	414	2,934	7,288	6,217	147	1,706	4,041	3,563	47	233	549	408	21	53	116	83
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	66	210	433	235	27	156	387	275	17	65	139	136
	Age 21-34	-	-	-	-	242	794	1,686	1,206	160	719	2,035	1,418	132	861	1,945	1,561
	Age 35-44	-	-	-	-	65	396	978	724	113	402	1,281	1,036	139	880	2,042	1,864
	Age 45-54	-	-	-	-	103	945	2,190	1,803	77	541	1,381	1,108	58	499	1,036	957
	Age 55-64	-	-	-	-	115	1,600	4,188	3,604	25	317	867	766	20	124	294	231
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	55	222	183	*	87	191	150
	Age 21-34	-	-	-	-	-	-	-	-	27	87	319	249	14	153	319	251
	Age 35-44	-	-	-	-	-	-	-	-	*	33	98	74	*	44	136	127
	Age 45-54	-	-	-	-	-	-	-	-	38	87	322	255	19	147	298	278
	Age 55-64	-	-	-	-	-	-	-	-	*	93	270	245	*	76	169	120

Hawaii: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	211	43	74	76	36	14	18	17	21	*	11	12	12	*	*	*
	Age 21-34	1,756	719	1,306	1,733	348	100	171	165	173	56	101	90	91	20	27	27
	Age 35-44	445	266	476	653	124	77	138	123	89	52	111	109	54	32	40	39
	Age 45-54	339	400	696	945	91	134	218	201	42	46	87	97	28	17	24	27
	Age 55-64	196	462	837	1,020	70	269	464	585	21	37	63	67	10	*	13	14
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	17	16	25	18	*	12	22	22	*	*	*	11
	Age 21-34	-	-	-	-	73	77	120	121	47	70	143	142	39	82	134	155
	Age 35-44	-	-	-	-	21	43	78	83	37	43	100	116	46	95	159	209
	Age 45-54	-	-	-	-	39	140	235	280	33	78	144	167	25	72	107	141
	Age 55-64	-	-	-	-	52	247	473	585	11	47	93	120	*	19	32	36
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	*	14	17	*	*	13	15
	Age 21-34	-	-	-	-	-	-	-	-	*	10	26	30	*	17	26	29
	Age 35-44	-	-	-	-	-	-	-	-	*	*	*	*	*	*	*	13
	Age 45-54	-	-	-	-	-	-	-	-	14	11	28	32	*	18	26	35
	Age 55-64	-	-	-	-	-	-	-	-	*	12	25	33	*	*	16	16

Idaho: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	100	127	226	206	17	43	57	46	10	30	34	32	*	*	*	10
	Age 21-34	698	1,797	3,391	3,960	138	252	447	378	68	141	265	206	37	51	71	63
	Age 35-44	129	478	887	1,067	35	138	259	203	25	94	208	179	15	57	74	63
	Age 45-54	62	446	810	960	16	150	253	204	*	51	101	98	*	19	28	28
	Age 55-64	46	686	1,292	1,376	17	400	717	790	*	55	97	91	*	12	21	18
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	*	40	62	43	*	30	56	49	*	12	20	24
	Age 21-34	-	-	-	-	26	182	293	263	17	165	353	309	14	199	338	340
	Age 35-44	-	-	-	-	*	76	143	131	10	77	188	189	13	168	296	337
	Age 45-54	-	-	-	-	*	172	303	311	*	98	189	190	*	89	140	162
	Age 55-64	-	-	-	-	13	365	726	783	*	71	147	162	*	27	49	48
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	11	32	33	*	16	28	27
	Age 21-34	-	-	-	-	-	-	-	-	*	19	53	52	*	33	52	50
	Age 35-44	-	-	-	-	-	-	-	-	*	*	15	13	*	*	20	23
	Age 45-54	-	-	-	-	-	-	-	-	*	17	46	46	*	28	43	50
	Age 55-64	-	-	-	-	-	-	-	-	*	20	46	52	*	17	28	26

Illinois: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	2,103	740	1,468	1,191	364	251	372	266	219	173	219	186	127	54	64	60
	Age 21-34	10,982	7,585	16,059	16,644	2,176	1,060	2,111	1,586	1,077	591	1,250	864	572	215	337	262
	Age 35-44	2,270	2,276	4,750	5,065	626	659	1,381	958	450	445	1,111	848	271	271	396	299
	Age 45-54	1,461	2,881	5,862	6,172	388	967	1,837	1,311	178	330	736	630	121	121	204	177
	Age 55-64	853	3,374	7,151	6,752	304	1,964	3,965	3,870	93	268	538	443	43	61	114	90
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	128	225	398	237	51	167	352	277	32	70	127	136
	Age 21-34	-	-	-	-	439	791	1,433	1,131	288	714	1,715	1,323	236	846	1,626	1,449
	Age 35-44	-	-	-	-	114	373	783	643	191	377	1,020	915	234	811	1,606	1,623
	Age 45-54	-	-	-	-	199	1,043	2,055	1,875	152	590	1,283	1,138	113	538	950	970
	Age 55-64	-	-	-	-	234	1,826	4,079	3,893	51	357	831	817	41	139	283	244
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	18	59	205	186	14	93	172	149
	Age 21-34	-	-	-	-	-	-	-	-	51	91	282	245	27	157	282	244
	Age 35-44	-	-	-	-	-	-	-	-	*	32	82	69	*	43	113	117
	Age 45-54	-	-	-	-	-	-	-	-	74	93	295	258	36	157	272	281
	Age 55-64	-	-	-	-	-	-	-	-	10	102	252	254	*	83	157	125

Indiana: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	765	566	1,094	899	134	193	279	202	79	134	164	141	46	42	48	46
	Age 21-34	3,723	5,398	11,116	11,671	736	755	1,464	1,112	363	421	866	606	196	154	234	184
	Age 35-44	737	1,543	3,128	3,380	201	447	912	640	145	302	734	567	86	184	261	200
	Age 45-54	416	1,709	3,382	3,606	109	574	1,059	766	50	196	425	368	34	72	118	104
	Age 55-64	284	2,374	4,890	4,676	102	1,383	2,713	2,683	32	189	368	307	15	43	78	62
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	43	167	284	173	17	122	251	202	11	52	89	98
	Age 21-34	-	-	-	-	146	559	983	788	96	505	1,178	922	79	601	1,121	1,010
	Age 35-44	-	-	-	-	37	252	514	426	61	255	673	610	74	548	1,054	1,079
	Age 45-54	-	-	-	-	61	643	1,234	1,136	45	364	771	691	33	331	569	588
	Age 55-64	-	-	-	-	77	1,271	2,762	2,671	16	247	559	554	13	95	187	165
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	43	142	131	*	66	119	103
	Age 21-34	-	-	-	-	-	-	-	-	16	62	189	166	*	108	187	163
	Age 35-44	-	-	-	-	-	-	-	-	*	22	55	47	*	30	76	79
	Age 45-54	-	-	-	-	-	-	-	-	22	61	187	165	11	102	172	180
	Age 55-64	-	-	-	-	-	-	-	-	*	71	172	176	*	58	107	86

Iowa: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	314	192	438	354	55	66	112	80	33	45	66	56	19	14	19	18
	Age 21-34	1,427	1,703	4,150	4,273	282	238	547	408	139	133	324	222	75	48	87	68
	Age 35-44	247	424	1,017	1,077	67	123	296	204	48	83	238	181	29	50	85	64
	Age 45-54	150	507	1,190	1,244	40	170	373	264	18	58	149	127	12	21	41	36
	Age 55-64	86	585	1,431	1,341	31	340	794	769	*	47	108	88	*	11	23	18
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	17	54	109	65	*	39	96	76	*	17	34	37
	Age 21-34	-	-	-	-	55	174	362	285	36	157	434	333	30	187	414	366
	Age 35-44	-	-	-	-	13	71	170	139	21	72	225	199	25	152	350	350
	Age 45-54	-	-	-	-	22	186	425	382	16	107	268	234	12	97	197	200
	Age 55-64	-	-	-	-	24	319	823	778	*	64	171	166	*	25	58	49
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	13	53	48	*	20	44	37
	Age 21-34	-	-	-	-	-	-	-	-	*	18	66	57	*	32	67	57
	Age 35-44	-	-	-	-	-	-	-	-	*	*	19	16	*	*	26	27
	Age 45-54	-	-	-	-	-	-	-	-	*	18	67	58	*	31	62	64
	Age 55-64	-	-	-	-	-	-	-	-	*	19	55	56	*	16	35	27

Kansas: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	351	234	465	332	61	80	119	74	37	55	70	52	21	17	20	17
	Age 21-34	1,603	2,085	4,418	4,024	317	292	582	383	156	163	344	208	84	59	93	63
	Age 35-44	308	580	1,210	1,132	84	168	353	214	61	113	284	190	36	69	101	67
	Age 45-54	198	736	1,499	1,384	52	247	471	294	24	85	189	141	16	31	52	40
	Age 55-64	112	832	1,763	1,458	40	484	978	835	13	66	133	96	*	15	28	19
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	20	68	120	63	*	50	105	73	*	21	37	36
	Age 21-34	-	-	-	-	63	216	392	271	41	195	469	317	34	232	446	347
	Age 35-44	-	-	-	-	16	96	202	145	26	98	265	207	32	208	414	365
	Age 45-54	-	-	-	-	28	267	528	420	21	152	332	256	15	138	244	219
	Age 55-64	-	-	-	-	31	453	1,012	844	*	90	209	179	*	35	71	53
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	17	60	47	*	27	49	37
	Age 21-34	-	-	-	-	-	-	-	-	*	24	75	57	*	42	76	57
	Age 35-44	-	-	-	-	-	-	-	-	*	*	22	16	*	12	30	28
	Age 45-54	-	-	-	-	-	-	-	-	10	25	79	60	*	42	73	66
	Age 55-64	-	-	-	-	-	-	-	-	*	26	65	58	*	22	41	28

Kentucky: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	313	213	408	301	54	71	102	67	32	49	60	46	18	15	17	15
	Age 21-34	2,367	3,239	6,589	6,234	469	453	868	592	232	253	513	323	125	92	139	98
	Age 35-44	499	989	1,980	1,924	137	286	578	364	98	194	464	322	59	118	166	114
	Age 45-54	283	1,103	2,156	2,067	75	370	676	438	34	126	271	211	23	46	75	59
	Age 55-64	234	1,856	3,778	3,248	84	1,083	2,098	1,863	26	148	285	213	12	34	60	43
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	22	72	124	67	*	55	111	78	*	22	39	38
	Age 21-34	-	-	-	-	94	336	589	423	61	306	706	496	50	363	670	541
	Age 35-44	-	-	-	-	24	160	323	240	41	161	419	342	50	349	662	609
	Age 45-54	-	-	-	-	39	422	798	665	30	233	488	398	23	213	361	335
	Age 55-64	-	-	-	-	61	972	2,095	1,825	12	182	408	366	10	70	138	108
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	21	67	56	*	33	59	46
	Age 21-34	-	-	-	-	-	-	-	-	11	40	118	94	*	67	115	90
	Age 35-44	-	-	-	-	-	-	-	-	*	14	34	24	*	17	43	40
	Age 45-54	-	-	-	-	-	-	-	-	14	38	109	88	*	61	102	94
	Age 55-64	-	-	-	-	-	-	-	-	*	48	116	107	*	39	71	53

Louisiana: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	322	339	700	551	56	115	178	123	33	80	105	86	19	25	30	28
	Age 21-34	1,846	3,852	8,480	8,534	365	539	1,119	812	180	301	662	444	98	110	179	135
	Age 35-44	367	1,103	2,388	2,473	99	319	697	469	72	216	561	415	43	131	200	147
	Age 45-54	188	1,108	2,347	2,395	49	372	735	509	22	127	295	244	15	46	82	69
	Age 55-64	135	1,613	3,556	3,255	48	940	1,974	1,868	16	128	268	214	*	29	57	43
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	19	103	188	109	*	76	167	128	*	32	59	62
	Age 21-34	-	-	-	-	71	395	745	573	47	358	895	671	38	428	855	737
	Age 35-44	-	-	-	-	17	177	387	306	30	179	508	439	36	388	799	782
	Age 45-54	-	-	-	-	28	421	867	764	20	239	541	466	15	218	401	397
	Age 55-64	-	-	-	-	36	861	2,004	1,855	*	167	405	384	*	64	135	114
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	27	95	85	*	42	81	67
	Age 21-34	-	-	-	-	-	-	-	-	*	43	140	117	*	75	138	115
	Age 35-44	-	-	-	-	-	-	-	-	*	15	40	32	*	20	55	55
	Age 45-54	-	-	-	-	-	-	-	-	10	40	131	112	*	67	122	121
	Age 55-64	-	-	-	-	-	-	-	-	*	48	125	122	*	39	77	60

Maine: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	23	65	153	124	*	22	39	28	*	15	23	19	*	*	*	*
	Age 21-34	135	763	1,912	1,979	26	106	252	188	13	59	149	103	*	22	40	31
	Age 35-44	27	210	518	551	*	61	151	104	*	41	122	93	*	25	43	33
	Age 45-54	22	360	869	913	*	121	273	194	*	41	110	93	*	15	30	26
	Age 55-64	17	570	1,439	1,355	*	333	799	778	*	45	109	89	*	10	23	18
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	*	21	46	27	*	16	40	31	*	*	14	15
	Age 21-34	-	-	-	-	*	81	176	138	*	73	208	160	*	85	194	172
	Age 35-44	-	-	-	-	*	37	92	75	*	37	118	106	*	77	182	184
	Age 45-54	-	-	-	-	*	132	311	284	*	72	188	168	*	65	136	138
	Age 55-64	-	-	-	-	*	298	797	762	*	55	153	150	*	21	51	44
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	*	25	23	*	*	21	18
	Age 21-34	-	-	-	-	-	-	-	-	*	11	39	34	*	18	37	32
	Age 35-44	-	-	-	-	-	-	-	-	*	*	10	*	*	*	13	13
	Age 45-54	-	-	-	-	-	-	-	-	*	11	40	35	*	18	37	38
	Age 55-64	-	-	-	-	-	-	-	-	*	14	41	42	*	11	25	21

Maryland: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	905	220	520	425	156	74	131	94	94	51	77	66	55	16	22	21
	Age 21-34	5,160	2,466	6,239	6,503	1,022	344	819	620	507	191	485	337	269	70	131	102
	Age 35-44	1,258	877	2,189	2,350	350	254	637	444	251	171	513	394	152	104	183	139
	Age 45-54	763	1,039	2,535	2,685	203	349	795	570	93	119	319	274	63	43	88	77
	Age 55-64	416	1,132	2,879	2,735	148	658	1,595	1,567	45	90	217	179	21	20	46	36
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	59	69	148	88	24	52	132	103	15	22	48	52
	Age 21-34	-	-	-	-	209	259	563	446	138	234	677	525	113	277	642	575
	Age 35-44	-	-	-	-	60	138	350	290	103	140	454	411	128	306	726	739
	Age 45-54	-	-	-	-	100	371	876	807	78	210	548	491	59	194	410	422
	Age 55-64	-	-	-	-	115	616	1,650	1,584	26	120	337	334	20	47	116	100
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	19	78	71	*	30	67	59
	Age 21-34	-	-	-	-	-	-	-	-	25	30	113	99	13	53	114	99
	Age 35-44	-	-	-	-	-	-	-	-	*	12	35	29	*	15	48	50
	Age 45-54	-	-	-	-	-	-	-	-	37	32	121	107	18	54	111	116
	Age 55-64	-	-	-	-	-	-	-	-	*	34	101	102	*	27	63	50

Massachusetts: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	1,627	262	627	533	282	89	160	119	172	61	95	83	100	19	27	27
	Age 21-34	6,992	2,188	5,608	6,072	1,387	306	736	581	688	170	437	316	361	62	117	96
	Age 35-44	1,234	558	1,414	1,574	340	162	409	297	244	109	329	263	147	66	117	93
	Age 45-54	762	673	1,666	1,833	203	226	521	389	93	77	209	187	62	28	58	53
	Age 55-64	463	821	2,116	2,091	166	477	1,173	1,198	49	65	159	137	23	15	34	28
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	88	73	156	98	34	53	136	114	22	23	48	55
	Age 21-34	-	-	-	-	277	225	491	407	182	202	587	475	149	239	558	521
	Age 35-44	-	-	-	-	66	93	236	203	107	94	311	291	130	199	483	510
	Age 45-54	-	-	-	-	113	249	597	567	83	142	376	346	61	128	276	294
	Age 55-64	-	-	-	-	129	445	1,208	1,205	28	88	249	255	23	34	84	76
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	11	18	75	72	*	27	62	55
	Age 21-34	-	-	-	-	-	-	-	-	31	24	92	83	16	42	93	82
	Age 35-44	-	-	-	-	-	-	-	-	*	*	26	23	*	12	37	40
	Age 45-54	-	-	-	-	-	-	-	-	43	24	94	85	21	41	86	93
	Age 55-64	-	-	-	-	-	-	-	-	*	26	79	84	*	22	50	41

Michigan: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	955	559	1,126	960	166	189	285	214	98	131	168	150	57	41	49	48
	Age 21-34	5,328	6,152	13,200	14,412	1,053	858	1,736	1,371	520	478	1,026	748	280	174	277	227
	Age 35-44	1,117	1,865	3,942	4,428	306	539	1,149	838	220	364	922	742	132	221	329	262
	Age 45-54	783	2,588	5,341	5,928	207	869	1,675	1,259	94	297	672	605	65	108	186	170
	Age 55-64	593	3,984	8,569	8,532	213	2,325	4,757	4,898	66	317	647	559	31	72	137	114
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	61	178	322	200	24	133	286	234	15	55	101	114
	Age 21-34	-	-	-	-	216	650	1,201	995	139	588	1,429	1,161	114	689	1,343	1,260
	Age 35-44	-	-	-	-	56	313	666	576	94	314	860	815	114	670	1,344	1,434
	Age 45-54	-	-	-	-	105	964	1,927	1,859	81	532	1,176	1,108	61	483	862	925
	Age 55-64	-	-	-	-	156	2,094	4,767	4,815	31	392	929	966	26	152	314	285
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	50	172	166	*	77	145	132
	Age 21-34	-	-	-	-	-	-	-	-	26	81	254	235	14	137	249	226
	Age 35-44	-	-	-	-	-	-	-	-	*	28	72	62	*	35	94	102
	Age 45-54	-	-	-	-	-	-	-	-	38	83	260	241	19	136	240	259
	Age 55-64	-	-	-	-	-	-	-	-	*	103	260	280	*	83	160	138

Minnesota: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	482	283	566	477	84	97	145	107	50	67	85	75	29	21	25	24
	Age 21-34	2,255	2,595	5,524	5,936	447	362	728	566	220	202	431	309	118	74	116	94
	Age 35-44	250	403	847	930	66	116	245	176	48	78	196	156	28	47	70	55
	Age 45-54	245	799	1,639	1,788	65	268	513	380	30	92	206	182	20	33	57	51
	Age 55-64	257	1,733	3,701	3,626	93	1,013	2,057	2,083	28	138	279	238	13	32	59	48
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	26	82	146	89	*	59	125	103	*	25	43	48
	Age 21-34	-	-	-	-	89	267	486	399	56	240	571	459	45	278	534	494
	Age 35-44	-	-	-	-	16	80	166	141	24	79	217	200	28	158	319	332
	Age 45-54	-	-	-	-	37	317	629	592	27	171	376	345	20	149	263	276
	Age 55-64	-	-	-	-	66	887	2,014	2,004	12	163	381	388	11	61	126	112
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	22	73	69	*	32	58	50
	Age 21-34	-	-	-	-	-	-	-	-	*	32	100	91	*	53	96	83
	Age 35-44	-	-	-	-	-	-	-	-	*	*	22	18	*	11	28	30
	Age 45-54	-	-	-	-	-	-	-	-	14	30	93	84	*	49	86	90
	Age 55-64	-	-	-	-	-	-	-	-	*	42	107	116	*	35	66	57

Mississippi: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	114	172	340	251	20	58	86	56	11	40	51	39	*	13	15	13
	Age 21-34	718	2,169	4,570	4,329	142	303	603	411	70	169	356	224	39	62	96	68
	Age 35-44	172	755	1,566	1,525	47	219	458	289	34	148	369	256	20	90	132	90
	Age 45-54	86	736	1,490	1,429	22	247	467	303	10	84	187	146	*	31	52	41
	Age 55-64	66	1,151	2,428	2,088	23	671	1,348	1,198	*	92	183	137	*	21	39	28
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	*	56	98	53	*	42	88	62	*	17	31	31
	Age 21-34	-	-	-	-	28	226	411	295	18	206	494	347	15	246	471	380
	Age 35-44	-	-	-	-	*	118	248	184	14	120	323	263	17	262	514	474
	Age 45-54	-	-	-	-	12	280	551	458	*	157	341	278	*	145	255	237
	Age 55-64	-	-	-	-	17	608	1,357	1,181	*	116	269	240	*	45	90	72
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	15	52	43	*	24	45	35
	Age 21-34	-	-	-	-	-	-	-	-	*	26	81	64	*	45	80	63
	Age 35-44	-	-	-	-	-	-	-	-	*	*	25	18	*	12	33	31
	Age 45-54	-	-	-	-	-	-	-	-	*	25	78	63	*	42	72	67
	Age 55-64	-	-	-	-	-	-	-	-	*	31	79	72	*	25	48	35

Missouri: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	523	371	747	632	91	125	189	141	53	87	111	98	31	27	32	32
	Age 21-34	3,286	4,638	9,944	10,768	650	649	1,310	1,026	321	362	775	560	173	132	209	170
	Age 35-44	706	1,445	3,048	3,400	193	418	889	644	139	282	716	571	83	172	255	201
	Age 45-54	367	1,465	3,021	3,323	96	492	946	706	44	168	379	339	30	61	105	96
	Age 55-64	251	2,031	4,360	4,302	89	1,183	2,419	2,468	28	162	329	282	13	37	70	57
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	33	117	209	131	13	87	187	153	*	36	67	75
	Age 21-34	-	-	-	-	129	478	879	727	85	434	1,058	854	69	519	1,009	938
	Age 35-44	-	-	-	-	33	229	487	416	57	231	637	596	71	505	1,011	1,068
	Age 45-54	-	-	-	-	53	550	1,099	1,048	39	311	686	638	29	285	511	546
	Age 55-64	-	-	-	-	68	1,086	2,461	2,457	14	211	497	509	12	81	167	152
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	31	108	104	*	49	94	84
	Age 21-34	-	-	-	-	-	-	-	-	14	53	168	152	*	92	166	150
	Age 35-44	-	-	-	-	-	-	-	-	*	19	50	42	*	25	67	73
	Age 45-54	-	-	-	-	-	-	-	-	19	51	160	147	*	85	149	160
	Age 55-64	-	-	-	-	-	-	-	-	*	59	151	158	*	48	93	78

Montana: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	44	119	188	147	*	40	48	33	*	28	28	23	*	*	*	*
	Age 21-34	291	1,568	2,644	2,643	58	220	349	251	28	123	206	137	16	45	56	42
	Age 35-44	54	416	690	709	14	121	202	135	10	82	162	119	*	50	58	42
	Age 45-54	32	494	798	809	*	166	250	172	*	57	100	82	*	21	28	23
	Age 55-64	20	607	1,021	927	*	354	566	532	*	48	77	61	*	11	16	12
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	*	38	53	30	*	28	47	35	*	12	17	17
	Age 21-34	-	-	-	-	11	160	231	177	*	146	278	206	*	175	265	227
	Age 35-44	-	-	-	-	*	69	114	90	*	69	150	129	*	150	235	228
	Age 45-54	-	-	-	-	*	181	284	249	*	103	178	152	*	94	131	129
	Age 55-64	-	-	-	-	*	328	581	534	*	65	119	112	*	25	40	33
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	*	27	24	*	16	23	19
	Age 21-34	-	-	-	-	-	-	-	-	*	18	43	36	*	31	43	36
	Age 35-44	-	-	-	-	-	-	-	-	*	*	12	*	*	*	16	16
	Age 45-54	-	-	-	-	-	-	-	-	*	17	42	35	*	28	39	38
	Age 55-64	-	-	-	-	-	-	-	-	*	19	37	36	*	15	23	17

Nebraska: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	141	95	147	135	24	32	37	30	14	22	22	21	*	*	*	*
	Age 21-34	1,077	1,458	2,392	2,819	213	204	315	269	106	114	186	147	56	42	50	45
	Age 35-44	217	425	687	835	60	123	200	158	43	83	161	140	26	51	57	49
	Age 45-54	146	566	889	1,067	39	190	279	227	18	65	112	109	12	24	31	31
	Age 55-64	61	465	760	817	21	270	420	468	*	37	57	54	*	*	12	11
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	*	31	43	29	*	24	39	34	*	*	14	17
	Age 21-34	-	-	-	-	42	149	210	189	28	136	252	222	23	163	241	245
	Age 35-44	-	-	-	-	11	69	112	105	18	70	146	149	22	153	233	268
	Age 45-54	-	-	-	-	18	194	295	308	14	112	187	189	11	103	139	163
	Age 55-64	-	-	-	-	17	261	446	485	*	53	95	106	*	21	33	32
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	*	23	24	*	14	20	21
	Age 21-34	-	-	-	-	-	-	-	-	*	17	39	39	*	29	40	40
	Age 35-44	-	-	-	-	-	-	-	-	*	*	11	10	*	*	15	18
	Age 45-54	-	-	-	-	-	-	-	-	*	17	41	41	*	29	38	45
	Age 55-64	-	-	-	-	-	-	-	-	*	16	30	34	*	13	19	17

Nevada: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	289	117	271	261	50	39	68	58	29	27	40	40	17	*	11	13
	Age 21-34	2,353	1,912	4,737	5,868	466	267	623	560	231	148	369	306	124	54	99	93
	Age 35-44	536	633	1,544	1,976	148	183	449	374	106	123	362	331	64	75	129	117
	Age 45-54	307	707	1,689	2,131	81	237	529	453	37	81	212	218	25	30	59	61
	Age 55-64	176	812	2,022	2,290	62	472	1,121	1,314	20	65	152	150	*	15	32	31
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	21	39	83	59	*	30	75	69	*	12	27	35
	Age 21-34	-	-	-	-	93	197	421	399	61	179	507	470	50	214	483	516
	Age 35-44	-	-	-	-	25	99	245	241	43	100	319	344	54	220	511	621
	Age 45-54	-	-	-	-	40	254	588	648	31	144	367	394	24	133	276	339
	Age 55-64	-	-	-	-	48	440	1,154	1,324	11	86	235	278	*	34	80	83
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	11	46	50	*	18	40	43
	Age 21-34	-	-	-	-	-	-	-	-	11	23	81	85	*	39	81	85
	Age 35-44	-	-	-	-	-	-	-	-	*	*	24	23	*	10	31	39
	Age 45-54	-	-	-	-	-	-	-	-	15	22	80	85	*	37	74	92
	Age 55-64	-	-	-	-	-	-	-	-	*	24	70	84	*	19	43	42

New Hampshire: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	114	92	149	154	20	31	38	35	12	22	22	24	*	*	*	*
	Age 21-34	619	985	1,697	2,244	122	138	223	214	60	77	132	117	32	28	36	36
	Age 35-44	116	266	451	615	32	77	131	116	23	52	105	103	14	32	37	36
	Age 45-54	98	449	740	1,000	26	151	232	213	12	52	93	102	*	19	26	29
	Age 55-64	42	387	664	803	15	225	368	461	*	31	50	53	*	*	11	11
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	*	28	41	31	*	21	36	36	*	*	13	18
	Age 21-34	-	-	-	-	25	103	151	153	16	93	180	178	13	110	170	195
	Age 35-44	-	-	-	-	*	46	77	82	*	46	100	116	12	98	157	204
	Age 45-54	-	-	-	-	12	153	245	287	*	87	153	174	*	80	113	148
	Age 55-64	-	-	-	-	12	215	387	475	*	43	81	102	*	17	28	31
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	*	22	25	*	12	18	20
	Age 21-34	-	-	-	-	-	-	-	-	*	12	30	34	*	21	30	34
	Age 35-44	-	-	-	-	-	-	-	-	*	*	*	*	*	*	11	15
	Age 45-54	-	-	-	-	-	-	-	-	*	13	34	38	*	22	31	42
	Age 55-64	-	-	-	-	-	-	-	-	*	12	25	32	*	10	16	16

New Jersey: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	1,691	351	749	584	289	117	187	128	174	80	110	90	101	25	32	29
	Age 21-34	11,873	4,891	11,173	11,117	2,355	683	1,466	1,058	1,170	380	869	576	619	138	234	175
	Age 35-44	3,176	1,916	4,317	4,423	889	555	1,256	837	637	375	1,011	740	387	228	362	262
	Age 45-54	1,666	1,955	4,296	4,339	443	656	1,346	920	203	224	539	444	138	82	149	125
	Age 55-64	935	2,190	5,015	4,544	333	1,273	2,779	2,601	100	174	378	298	47	40	80	60
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	120	116	225	129	49	89	204	151	30	36	75	76
	Age 21-34	-	-	-	-	480	514	1,006	759	318	465	1,215	898	263	555	1,158	988
	Age 35-44	-	-	-	-	143	292	667	525	255	295	866	747	318	657	1,400	1,360
	Age 45-54	-	-	-	-	218	704	1,496	1,317	173	399	938	804	131	371	710	696
	Age 55-64	-	-	-	-	257	1,189	2,870	2,626	58	232	586	556	45	92	202	167
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	19	33	122	107	14	53	108	91
	Age 21-34	-	-	-	-	-	-	-	-	57	59	198	165	30	103	199	166
	Age 35-44	-	-	-	-	-	-	-	-	*	23	63	50	*	29	85	85
	Age 45-54	-	-	-	-	-	-	-	-	81	61	202	172	39	101	188	186
	Age 55-64	-	-	-	-	-	-	-	-	11	65	175	167	*	52	108	82

New Mexico: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	239	141	309	278	41	48	78	62	25	33	46	43	14	10	13	14
	Age 21-34	1,377	1,610	3,750	4,319	272	225	494	412	135	125	292	225	73	46	79	68
	Age 35-44	303	513	1,177	1,398	83	149	343	265	60	100	276	235	36	61	98	83
	Age 45-54	164	542	1,216	1,424	43	182	381	303	20	62	153	145	13	23	42	41
	Age 55-64	110	739	1,726	1,814	39	430	957	1,041	12	59	130	119	*	13	28	24
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	15	44	85	57	*	33	76	66	*	14	27	33
	Age 21-34	-	-	-	-	54	167	334	294	36	151	401	345	29	180	382	378
	Age 35-44	-	-	-	-	14	82	189	172	25	82	247	246	30	179	391	440
	Age 45-54	-	-	-	-	23	202	440	447	17	114	274	272	13	105	204	232
	Age 55-64	-	-	-	-	30	395	974	1,037	*	76	197	215	*	30	66	64
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	12	44	45	*	18	38	36
	Age 21-34	-	-	-	-	-	-	-	-	*	19	65	63	*	33	64	62
	Age 35-44	-	-	-	-	-	-	-	-	*	*	19	18	*	*	26	30
	Age 45-54	-	-	-	-	-	-	-	-	*	19	64	62	*	31	59	68
	Age 55-64	-	-	-	-	-	-	-	-	*	21	59	66	*	17	37	33

North Carolina: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	854	607	1,251	984	148	205	317	219	88	142	186	154	51	44	54	50
	Age 21-34	4,720	6,629	14,547	14,639	932	927	1,915	1,392	460	516	1,132	759	250	188	305	231
	Age 35-44	1,189	2,436	5,260	5,450	327	705	1,537	1,033	235	477	1,236	915	141	291	441	323
	Age 45-54	616	2,463	5,196	5,306	162	826	1,629	1,126	74	283	653	541	51	103	181	153
	Age 55-64	424	3,442	7,565	6,926	151	2,006	4,198	3,973	48	274	571	454	22	63	121	92
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	53	191	351	203	22	143	314	238	13	59	112	118
	Age 21-34	-	-	-	-	189	698	1,315	1,005	124	633	1,583	1,183	102	752	1,504	1,295
	Age 35-44	-	-	-	-	55	380	831	659	95	384	1,080	940	117	843	1,723	1,692
	Age 45-54	-	-	-	-	86	920	1,884	1,669	65	518	1,171	1,014	49	478	877	867
	Age 55-64	-	-	-	-	114	1,835	4,261	3,946	24	353	853	813	19	137	288	243
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	52	183	163	*	81	158	132
	Age 21-34	-	-	-	-	-	-	-	-	22	82	264	222	12	141	260	220
	Age 35-44	-	-	-	-	-	-	-	-	*	32	84	67	*	41	113	113
	Age 45-54	-	-	-	-	-	-	-	-	31	82	266	227	15	137	246	245
	Age 55-64	-	-	-	-	-	-	-	-	*	97	252	245	*	78	155	121

Ohio: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	723	555	1,184	939	126	186	299	209	74	129	176	146	43	40	51	47
	Age 21-34	4,598	7,021	15,969	16,217	908	981	2,103	1,542	449	547	1,244	842	244	199	336	256
	Age 35-44	1,047	2,319	5,192	5,426	286	671	1,516	1,028	206	453	1,219	910	123	276	435	322
	Age 45-54	593	2,578	5,642	5,813	156	865	1,769	1,234	71	296	710	593	49	108	197	167
	Age 55-64	435	3,842	8,765	8,099	155	2,240	4,865	4,647	49	306	661	531	22	70	140	108
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	47	180	345	200	19	136	308	234	12	55	110	116
	Age 21-34	-	-	-	-	183	734	1,437	1,109	119	666	1,724	1,302	98	790	1,636	1,422
	Age 35-44	-	-	-	-	49	371	839	671	85	373	1,089	957	104	813	1,727	1,710
	Age 45-54	-	-	-	-	82	966	2,051	1,836	62	539	1,265	1,107	47	495	940	938
	Age 55-64	-	-	-	-	115	2,033	4,904	4,590	24	386	970	933	19	149	327	278
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	50	184	165	*	79	159	135
	Age 21-34	-	-	-	-	-	-	-	-	21	87	290	247	11	148	284	241
	Age 35-44	-	-	-	-	-	-	-	-	*	32	86	68	*	40	113	114
	Age 45-54	-	-	-	-	-	-	-	-	29	86	283	245	15	141	263	264
	Age 55-64	-	-	-	-	-	-	-	-	*	104	280	277	*	84	172	137

Oklahoma: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	384	220	495	396	66	74	125	88	39	51	74	62	23	16	21	20
	Age 21-34	2,393	2,716	6,534	6,685	473	380	860	636	234	211	509	347	126	77	137	106
	Age 35-44	538	887	2,101	2,214	148	257	613	419	106	173	494	371	64	106	176	131
	Age 45-54	308	994	2,301	2,390	81	333	722	508	37	114	289	244	25	42	80	69
	Age 55-64	174	1,124	2,714	2,527	62	654	1,505	1,449	20	89	204	166	*	20	43	34
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	25	70	141	83	10	52	126	97	*	22	45	48
	Age 21-34	-	-	-	-	95	281	582	453	62	255	701	533	51	304	668	586
	Age 35-44	-	-	-	-	25	140	336	272	44	142	439	388	54	311	699	697
	Age 45-54	-	-	-	-	42	359	806	726	32	204	505	444	24	188	378	381
	Age 55-64	-	-	-	-	48	611	1,554	1,463	11	120	319	309	*	47	108	93
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	19	74	66	*	30	64	55
	Age 21-34	-	-	-	-	-	-	-	-	11	32	112	96	*	55	112	96
	Age 35-44	-	-	-	-	-	-	-	-	*	12	34	28	*	15	46	47
	Age 45-54	-	-	-	-	-	-	-	-	15	32	114	99	*	54	106	108
	Age 55-64	-	-	-	-	-	-	-	-	*	34	97	96	*	28	61	47

Oregon: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	404	269	546	476	70	91	138	106	41	63	81	74	24	20	24	24
	Age 21-34	2,556	3,390	7,318	8,172	506	474	964	779	250	264	570	425	135	96	154	129
	Age 35-44	527	1,011	2,148	2,472	144	293	626	469	104	198	504	415	62	120	180	146
	Age 45-54	279	1,045	2,171	2,463	73	351	679	523	33	120	272	251	23	44	76	71
	Age 55-64	192	1,457	3,150	3,208	68	849	1,748	1,841	22	116	237	211	*	26	50	43
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	25	84	152	98	10	63	136	115	*	26	48	56
	Age 21-34	-	-	-	-	100	348	644	551	66	316	775	646	54	378	740	710
	Age 35-44	-	-	-	-	25	161	346	304	43	163	452	437	53	355	716	780
	Age 45-54	-	-	-	-	40	393	791	778	30	222	493	473	22	203	366	404
	Age 55-64	-	-	-	-	52	779	1,777	1,832	11	151	359	380	*	58	121	113
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	23	79	78	*	35	68	63
	Age 21-34	-	-	-	-	-	-	-	-	11	38	122	114	*	67	121	113
	Age 35-44	-	-	-	-	-	-	-	-	*	14	36	31	*	18	48	54
	Age 45-54	-	-	-	-	-	-	-	-	15	37	116	110	*	61	108	120
	Age 55-64	-	-	-	-	-	-	-	-	*	43	109	119	*	35	67	58

Pennsylvania: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	1,283	747	1,624	1,350	223	253	412	302	133	175	243	211	77	55	70	68
	Age 21-34	6,407	7,317	16,952	18,023	1,265	1,021	2,230	1,715	625	569	1,318	935	337	207	356	284
	Age 35-44	1,474	2,445	5,580	6,108	404	707	1,628	1,156	291	477	1,309	1,025	174	291	467	362
	Age 45-54	918	2,994	6,676	7,213	242	1,004	2,094	1,531	111	344	840	736	76	125	233	208
	Age 55-64	624	4,126	9,592	9,293	224	2,404	5,323	5,332	70	328	723	609	32	75	153	124
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	78	230	448	272	31	171	397	319	19	72	141	157
	Age 21-34	-	-	-	-	259	773	1,540	1,244	169	700	1,842	1,456	139	823	1,739	1,587
	Age 35-44	-	-	-	-	72	397	915	770	121	400	1,186	1,094	148	863	1,870	1,943
	Age 45-54	-	-	-	-	126	1,105	2,391	2,241	95	618	1,478	1,351	72	565	1,094	1,143
	Age 55-64	-	-	-	-	167	2,196	5,395	5,292	35	419	1,073	1,083	29	163	363	322
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	11	63	233	218	*	96	197	174
	Age 21-34	-	-	-	-	-	-	-	-	31	93	318	285	16	160	314	279
	Age 35-44	-	-	-	-	-	-	-	-	*	35	97	82	*	45	129	136
	Age 45-54	-	-	-	-	-	-	-	-	45	97	334	300	22	162	307	324
	Age 55-64	-	-	-	-	-	-	-	-	*	114	311	324	*	92	193	159

Rhode Island: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	308	81	143	182	54	28	36	41	32	19	21	29	19	*	*	*
	Age 21-34	1,293	661	1,244	2,022	256	92	163	194	127	51	96	106	67	19	26	32
	Age 35-44	242	179	333	559	67	52	96	106	48	35	77	94	29	21	28	33
	Age 45-54	155	225	407	677	41	76	127	144	19	26	51	69	13	*	14	19
	Age 55-64	89	259	487	729	32	151	269	418	*	21	37	48	*	*	*	*
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	17	23	35	34	*	17	31	40	*	*	11	19
	Age 21-34	-	-	-	-	52	69	109	137	34	62	130	160	28	73	124	176
	Age 35-44	-	-	-	-	13	30	55	72	21	30	72	103	25	64	113	181
	Age 45-54	-	-	-	-	22	82	143	207	17	47	90	126	12	42	66	107
	Age 55-64	-	-	-	-	25	141	278	422	*	28	58	90	*	11	19	27
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	*	17	25	*	*	14	19
	Age 21-34	-	-	-	-	-	-	-	-	*	*	21	29	*	13	21	29
	Age 35-44	-	-	-	-	-	-	-	-	*	*	*	*	*	*	*	14
	Age 45-54	-	-	-	-	-	-	-	-	*	*	22	30	*	13	20	33
	Age 55-64	-	-	-	-	-	-	-	-	*	*	18	29	*	*	11	14

South Carolina: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	435	415	845	661	76	141	216	148	45	98	127	104	26	31	37	34
	Age 21-34	1,949	3,621	7,868	7,861	384	506	1,036	747	189	282	612	408	103	103	165	124
	Age 35-44	413	1,108	2,371	2,436	112	321	692	461	81	217	557	409	48	132	198	144
	Age 45-54	266	1,416	2,956	2,997	70	475	928	637	32	163	372	306	22	59	103	86
	Age 55-64	172	1,854	4,035	3,666	62	1,081	2,239	2,103	20	148	304	241	*	34	65	49
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	25	123	223	128	*	91	196	150	*	39	70	73
	Age 21-34	-	-	-	-	78	381	710	539	51	344	848	629	42	406	802	686
	Age 35-44	-	-	-	-	21	184	395	312	34	185	514	444	42	396	805	783
	Age 45-54	-	-	-	-	37	520	1,056	925	28	293	656	560	21	267	483	474
	Age 55-64	-	-	-	-	47	993	2,282	2,098	*	192	459	432	*	74	154	129
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	32	113	99	*	49	94	78
	Age 21-34	-	-	-	-	-	-	-	-	*	45	144	121	*	78	142	119
	Age 35-44	-	-	-	-	-	-	-	-	*	17	43	35	*	22	58	58
	Age 45-54	-	-	-	-	-	-	-	-	13	47	153	128	*	79	140	139
	Age 55-64	-	-	-	-	-	-	-	-	*	54	137	133	*	44	85	65

Tennessee: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	423	440	775	584	74	149	196	130	43	104	115	91	25	32	34	29
	Age 21-34	2,491	5,153	9,648	9,301	492	721	1,271	883	243	403	751	482	132	147	203	147
	Age 35-44	551	1,654	3,046	3,019	150	479	890	572	108	324	715	506	65	198	255	179
	Age 45-54	335	1,986	3,565	3,485	88	667	1,119	740	40	228	448	355	28	83	124	100
	Age 55-64	219	2,634	4,924	4,313	78	1,537	2,733	2,474	25	210	371	283	11	48	79	58
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	27	141	220	121	11	105	196	142	*	43	70	70
	Age 21-34	-	-	-	-	99	540	868	635	64	490	1,040	743	53	582	986	813
	Age 35-44	-	-	-	-	26	268	497	378	45	271	646	538	55	587	1,022	958
	Age 45-54	-	-	-	-	46	731	1,271	1,077	34	410	787	651	26	376	584	553
	Age 55-64	-	-	-	-	59	1,409	2,780	2,464	12	271	556	507	10	105	188	151
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	38	116	99	*	61	100	80
	Age 21-34	-	-	-	-	-	-	-	-	11	64	174	141	*	110	172	139
	Age 35-44	-	-	-	-	-	-	-	-	*	23	52	39	*	30	68	66
	Age 45-54	-	-	-	-	-	-	-	-	16	65	177	144	*	107	164	156
	Age 55-64	-	-	-	-	-	-	-	-	*	74	163	153	*	60	101	75

Texas: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	5,902	1,927	3,811	2,908	1,019	652	964	646	613	450	568	452	356	141	165	146
	Age 21-34	33,797	21,763	45,950	44,758	6,700	3,046	6,042	4,264	3,320	1,697	3,580	2,321	1,760	619	964	705
	Age 35-44	7,639	7,176	14,924	14,963	2,119	2,080	4,345	2,832	1,520	1,405	3,499	2,506	920	856	1,249	884
	Age 45-54	3,933	7,188	14,586	14,411	1,043	2,413	4,567	3,059	477	824	1,829	1,471	323	301	507	415
	Age 55-64	2,121	7,744	16,353	14,489	752	4,502	9,062	8,297	231	615	1,230	952	107	140	260	193
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	363	589	1,035	584	147	438	924	683	92	183	335	338
	Age 21-34	-	-	-	-	1,335	2,248	4,053	3,009	886	2,034	4,892	3,544	730	2,441	4,681	3,908
	Age 35-44	-	-	-	-	361	1,118	2,348	1,805	625	1,135	3,077	2,583	772	2,494	4,914	4,659
	Age 45-54	-	-	-	-	553	2,612	5,134	4,391	417	1,500	3,251	2,705	313	1,384	2,443	2,346
	Age 55-64	-	-	-	-	594	4,248	9,436	8,428	135	850	1,971	1,813	106	332	671	546
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	52	153	527	450	39	242	454	370
	Age 21-34	-	-	-	-	-	-	-	-	150	242	754	611	79	428	763	618
	Age 35-44	-	-	-	-	-	-	-	-	16	91	232	184	14	123	326	318
	Age 45-54	-	-	-	-	-	-	-	-	207	241	761	625	102	410	705	686
	Age 55-64	-	-	-	-	-	-	-	-	27	252	623	584	27	205	391	286

Utah: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	405	245	509	457	71	84	130	103	42	58	77	72	24	18	22	23
	Age 21-34	2,151	2,563	5,676	6,506	426	360	749	622	211	201	443	340	112	73	120	103
	Age 35-44	353	605	1,319	1,559	96	176	384	296	69	118	310	262	41	72	110	92
	Age 45-54	168	560	1,194	1,390	44	188	373	296	20	64	149	142	14	23	42	40
	Age 55-64	86	572	1,268	1,324	30	332	702	759	*	45	95	88	*	10	20	18
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	21	69	125	84	*	50	109	98	*	21	39	48
	Age 21-34	-	-	-	-	81	255	480	425	54	230	579	498	44	280	560	553
	Age 35-44	-	-	-	-	18	97	213	192	29	99	285	280	36	214	446	497
	Age 45-54	-	-	-	-	27	208	430	430	19	122	278	269	14	111	206	234
	Age 55-64	-	-	-	-	25	319	742	780	*	67	162	173	*	25	54	52
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	16	59	59	*	25	50	47
	Age 21-34	-	-	-	-	-	-	-	-	*	24	79	75	*	43	80	76
	Age 35-44	-	-	-	-	-	-	-	-	*	*	22	21	*	12	32	38
	Age 45-54	-	-	-	-	-	-	-	-	10	22	73	70	*	38	68	79
	Age 55-64	-	-	-	-	-	-	-	-	*	22	56	63	*	18	36	31

Vermont: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	47	77	125	89	*	26	32	20	*	18	19	14	*	*	*	*
	Age 21-34	176	552	961	876	35	77	127	83	17	43	75	45	*	16	20	14
	Age 35-44	42	190	325	304	11	55	95	58	*	37	76	51	*	23	27	18
	Age 45-54	21	191	319	295	*	64	100	62	*	22	40	30	*	*	11	*
	Age 55-64	18	331	575	475	*	194	319	273	*	26	43	31	*	*	*	*
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	*	22	31	17	*	16	28	19	*	*	*	*
	Age 21-34	-	-	-	-	*	59	87	60	*	53	105	71	*	63	99	77
	Age 35-44	-	-	-	-	*	31	53	38	*	31	69	54	*	67	108	95
	Age 45-54	-	-	-	-	*	75	121	96	*	42	75	58	*	38	55	49
	Age 55-64	-	-	-	-	*	174	319	267	*	33	63	54	*	13	21	16
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	*	15	13	*	*	13	*
	Age 21-34	-	-	-	-	-	-	-	-	*	*	18	14	*	12	17	13
	Age 35-44	-	-	-	-	-	-	-	-	*	*	*	*	*	*	*	*
	Age 45-54	-	-	-	-	-	-	-	-	*	*	18	14	*	12	17	15
	Age 55-64	-	-	-	-	-	-	-	-	*	*	19	17	*	*	11	*

Virginia: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	1,125	459	1,149	791	195	156	293	176	118	107	173	124	68	33	50	40
	Age 21-34	5,221	4,149	11,109	9,767	1,032	579	1,463	929	510	322	866	506	273	117	234	154
	Age 35-44	1,225	1,419	3,746	3,382	338	410	1,093	640	243	277	880	567	146	169	314	200
	Age 45-54	634	1,427	3,686	3,280	168	478	1,156	696	77	164	463	334	52	60	128	95
	Age 55-64	428	1,950	5,253	4,190	153	1,135	2,915	2,401	47	155	396	275	22	35	84	56
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	65	136	302	153	26	100	268	179	16	42	95	88
	Age 21-34	-	-	-	-	209	434	998	665	138	392	1,201	782	113	465	1,142	856
	Age 35-44	-	-	-	-	59	224	598	413	100	226	781	590	123	491	1,237	1,056
	Age 45-54	-	-	-	-	92	535	1,344	1,033	68	303	841	630	51	278	627	539
	Age 55-64	-	-	-	-	116	1,045	2,973	2,391	25	203	602	497	20	78	203	149
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	35	152	117	*	54	128	93
	Age 21-34	-	-	-	-	-	-	-	-	24	49	196	143	13	86	195	142
	Age 35-44	-	-	-	-	-	-	-	-	*	19	62	44	*	25	86	75
	Age 45-54	-	-	-	-	-	-	-	-	34	49	199	147	17	83	184	160
	Age 55-64	-	-	-	-	-	-	-	-	*	58	183	155	*	47	113	76

Washington: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	1,063	386	845	733	184	130	214	163	110	90	126	114	64	28	36	37
	Age 21-34	6,450	4,629	10,819	12,002	1,279	647	1,423	1,145	633	360	843	625	337	131	227	190
	Age 35-44	1,205	1,250	2,879	3,289	331	362	836	622	238	244	673	551	143	148	240	194
	Age 45-54	772	1,574	3,542	3,996	205	528	1,110	849	94	180	445	408	63	66	123	115
	Age 55-64	438	1,785	4,187	4,237	156	1,038	2,321	2,429	48	142	315	278	22	32	67	57
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	66	119	233	149	27	88	206	173	17	37	74	85
	Age 21-34	-	-	-	-	253	475	950	806	166	428	1,139	944	136	511	1,084	1,036
	Age 35-44	-	-	-	-	61	205	477	419	102	208	624	599	125	447	981	1,061
	Age 45-54	-	-	-	-	106	568	1,240	1,212	81	323	777	737	60	294	574	629
	Age 55-64	-	-	-	-	121	970	2,397	2,452	27	191	493	518	21	74	168	155
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	31	120	117	*	49	102	95
	Age 21-34	-	-	-	-	-	-	-	-	29	52	180	168	15	91	180	167
	Age 35-44	-	-	-	-	-	-	-	-	*	18	50	45	*	24	68	76
	Age 45-54	-	-	-	-	-	-	-	-	40	52	180	169	20	87	167	185
	Age 55-64	-	-	-	-	-	-	-	-	*	55	152	165	*	45	95	81

West Virginia: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	49	63	120	101	*	21	30	22	*	14	17	16	*	*	*	*
	Age 21-34	499	1,323	2,675	2,919	99	185	352	277	49	103	208	152	27	38	56	46
	Age 35-44	92	349	694	778	25	101	202	147	18	68	162	130	11	41	58	46
	Age 45-54	74	564	1,096	1,215	19	190	344	258	*	65	138	124	*	24	38	35
	Age 55-64	53	822	1,664	1,654	19	480	924	950	*	65	126	108	*	15	27	22
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	*	23	41	25	*	18	37	29	*	*	13	15
	Age 21-34	-	-	-	-	20	137	240	199	13	125	286	232	10	147	269	252
	Age 35-44	-	-	-	-	*	60	120	103	*	60	154	146	*	128	242	257
	Age 45-54	-	-	-	-	*	205	386	374	*	112	234	221	*	102	171	184
	Age 55-64	-	-	-	-	14	432	926	936	*	80	179	187	*	31	61	55
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	*	24	23	*	12	21	20
	Age 21-34	-	-	-	-	-	-	-	-	*	17	50	47	*	29	49	45
	Age 35-44	-	-	-	-	-	-	-	-	*	*	13	10	*	*	15	17
	Age 45-54	-	-	-	-	-	-	-	-	*	17	48	45	*	27	45	48
	Age 55-64	-	-	-	-	-	-	-	-	*	20	49	52	*	16	30	26

Wisconsin: Estimated number of BHP-eligible people by household size, FPL, number of BHP-eligible people in household unit, and age

		1-person household				2-person household				3-person household				4-person household			
		0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL	0-138% FPL	139-150% FPL	151-175% FPL	176-200% FPL
1 BHP-eligible person in unit	Age 19-20	412	362	825	620	72	123	211	139	43	85	124	97	25	27	36	31
	Age 21-34	1,832	3,144	7,636	7,334	361	439	1,007	698	178	245	595	380	97	89	161	116
	Age 35-44	388	963	2,303	2,273	105	279	673	431	76	188	541	382	45	115	193	135
	Age 45-54	217	1,055	2,467	2,402	57	354	773	510	26	121	310	245	18	44	86	69
	Age 55-64	163	1,620	3,951	3,448	58	944	2,194	1,978	19	129	298	226	*	29	63	46
2 BHP-eligible people in unit	Age 19-20	-	-	-	-	23	106	214	118	*	78	188	139	*	33	66	67
	Age 21-34	-	-	-	-	73	329	685	500	47	297	820	585	39	351	778	638
	Age 35-44	-	-	-	-	19	157	379	286	32	158	494	409	39	339	773	722
	Age 45-54	-	-	-	-	32	402	914	767	23	226	567	465	17	205	418	393
	Age 55-64	-	-	-	-	44	858	2,214	1,953	*	165	441	399	*	63	147	118
3+ BHP-eligible people in unit	Age 19-20	-	-	-	-	-	-	-	-	*	28	107	91	*	42	89	70
	Age 21-34	-	-	-	-	-	-	-	-	*	38	136	109	*	65	134	106
	Age 35-44	-	-	-	-	-	-	-	-	*	14	41	32	*	18	56	53
	Age 45-54	-	-	-	-	-	-	-	-	12	37	137	110	*	63	126	119
	Age 55-64	-	-	-	-	-	-	-	-	*	46	132	124	*	38	82	61

Source: Health Insurance Policy Simulation Model-American Community Survey 2014

* - Data suppressed due to low sample size.

Notes

[1] Stan Dorn and Jennifer Tolbert. *The ACA's Basic Health Program Option: Federal Requirements and State Trade-Offs*, November 2014, Washington, DC: Kaiser Family Foundation and Urban Institute.

[2] CMS. "Basic Health Program: Federal Funding Methodology for Program Year 2016," *Federal Register,* October 23, 2014, Vol. 79, No. 205, pp. 63363- 63376, http://www.gpo.gov/fdsys/pkg/FR-2014-10-23/pdf/2014-25257.pdf.

[3] After a BHP program's first year, the federal government will need to make an additional adjustment to the reference premium, captured by the Population Health Factor (PHF). At that point, BHP enrollees will no longer be in the individual market. They may have a different average risk level than the remaining participants in the individual market. If so, premiums charged in the individual market without the participation of consumers under 200% FPL might be different than if BHP enrollees had stayed in the individual market. The PHF will adjust marketplace premiums to compensate for the change in risk levels made by the removal of BHP consumers so the reference premium reflects what would have been charged without BHP. If BHP consumers are healthier, on average, than individual market participants, the PHF will reduce the premium from levels observed in the marketplace. If they are less healthy, it will raise the premium.

In future years, it should not be difficult to determine the PHF. Each individual market participant's risk level will be measured as part of the risk adjustment system. If states gather similar information about BHP enrollees, actuaries should be able to estimate the impact on individual market premiums if BHP-eligible consumers were added to the individual market.

In most states today, the PHF is even easier to calculate for the first year of BHP program operation: it does not affect premiums at all. That is because, in 2014, BHP-eligible consumers are already in the individual market in most states. As a result, marketplace premiums are already based on the risk pool that would apply without the operation of BHP.

However, in 2014 a handful of states—especially Minnesota, which covers all BHP-eligible consumers through the state's longstanding "MinnesotaCare" program, now operating under a Medicaid waiver—serve numerous BHP-eligible consumers outside the individual market. No risk-adjustment system or comparable data-gathering mechanism allows a prospective comparison between the average risk level of such consumers and those who will enroll in the 2014 individual market. As a result, CMS is allowing states, for the 2015 BHP program year, to have the PHF determined retrospectively, after the conclusion of the 2015 BHP program year. A state choosing this option must, by August 1, 2014, have proposed a protocol to CMS for gathering the information needed to determine the PHF. CMS must approve the protocol by December 31, 2014. If information gathered through the protocol shows the need to change CMS' 2015 payments, adjustments would be carried out through increases or reductions to the state's later BHP payments.

[4] Links to such rates are available through the map at http://www.cdc.gov/tobacco/widgets/index.htm#widget.

[5] Most state individual markets, including QHPs, use HHS's default ratios between premiums charged to adults age 21-24 and individuals of other ages. If more than one person within a family enrolls in a plan, the family premium combines the premiums charged to each family member, based on their ages. A few states—the District of Columbia, Massachusetts, Minnesota, New Jersey, and Utah—depart from the HHS default ratios in varying premium charges based on age. These states still determine family premiums based on the combined age-specific premiums charged to each enrolling family member. For HHS's default ratios and the ratios used by the latter states, see Center for Consumer Information and Insurance Oversight (CCIIO). *State Specific Age Curve Variations*.August 9, 2013. http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/state-specific-age-curve-variations-08-09-2013.pdf. New York and Vermont do not permit premiums to vary based on age. Premiums vary based on family enrollment, depending on the characteristics of the enrolling family. In each state, coverage for two adults costs twice as much as coverage for one adult. For information about how premiums change when children are involved, see CCIIO, "State Specific Family Tier Ratios," *Market Rating Reforms: State Specific Rating Variations*. Updated: July 11, 2014. http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html#age.

[6] The purpose of this example is to illustrate our suggested approach to calculating federal BHP payments, not to provide up-to-the-minute, accurate estimates for Washington State. After this example was developed, final QHP premiums for 2015 were announced. To obtain more accurate and current estimates, Washington State officials and stakeholders would need to revise these calculations using actual 2015 premiums, rather than the projections we developed based on state insurance officials' analysis.

[7] Dekker Dirksen, Community Health Plan of Washington/Community Health Network of Washington, personal communication, July 2014.

[8] Washington State Health Benefits Exchange, April 23, 2014. *Health Coverage Enrollment Report: October 1, 2013 - March 31, 2014.* http://wahbexchange.org/files/2713/9888/1218/WAHBE_End_of_Open_Enrollment_Data_Report_FINAL.pdf.

[9] To derive the weighted average, we first multiple the premium in a county by the number of QHP enrollees in that county. For example, we multiply $221.14 in Adams County by the 451 QHP enrollees and obtain a product of $99,734.14. We combine such county-specific products for all counties, which equals $34,028,555.85, and divide by the total number of QHP enrollees statewide, which is 152,690. The resulting average is $222.86.

[10] Mike Kreidler, Washington state Insurance Commissioner, "Seventeen health insurers file more than 230 plans for 2015 - average proposed rate change 8%," *News Release,* May 13, 2014, http://insurance.wa.gov/about-oic/news-media/news-releases/2014/5-13-2014.html; Jeffrey Naas, Washington State Office of the Insurance Commissioner, personal communication, July 2014.

[11] For information about each individual state's approach to age rating, see CCIIO, *Market Rating Reforms: State Specific Rating Variations,* Updated July 11, 2014, http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-

rating.html; CCIIO, *State Specific Age Curve Variations,* August 9, 2013, http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/state-specific-age-curve-variations-08-09-2013.pdf.

[12] Very few BHP-eligible consumers live in households with more than five members.

[13] For BHP-eligible consumers under 138% FPL, sample size considerations prevented us from developing eligibility estimates within the smaller FPL ranges used by the federal payment methodology (0-50, 51-100, and 101-138% FPL). We assumed an even distribution of BHP enrollees by FPL income levels from 0 to 138% FPL, as provided by the federal payment methodology for narrower FPL ranges. If BHP-eligible consumers are unevenly distributed among the three federal-specified FPL ranges below 138% FPL, our estimated payment amounts for consumers under 138% FPL may be inaccurate. However, given the relatively small size of the under-138%-FPL population among BHP-eligible consumers, the impact on calculating a state's average federal payment per BHP-eligible consumer is likely to be modest.

[14] Hawaii and Alaska would be treated differently, because the FPL equals different income amounts in those states than in other states.

[15] The only exceptions are fully community-rated states, where family premiums vary based on the number of adults and children enrolled in coverage. CCIIO, *Market Rating Reforms: State Specific Rating Variations.*

[16] Put differently, the two BHP-eligible members receive family coverage for which a premium of $850.46 is charged, the household payment requirement is $106.30, and the household PTC is $744.16—precisely twice the $372.08 received by each BHP-eligible member.

[17] Premera Blue Cross, "Individual Filing – Effective 1/1/2014," *Exhibit 6.2 in Exchange Rates – Silver Plans;* LifeWise Health Plan of Washington, "Individual Filing – Effective 1/1/2014," *Exhibit 6.2 in Exchange Rates – Silver Plans.*

[18] Group Health Cooperative, 1/1/2014 *Individual Rate Filing, "*Exhibit 11 - Final Rates."

[19] These counties are Benton, Franklin, King, Walla Walla, and Yakima. Dirksen, op cit. For the distribution of enrollees by County, see Table 2.

[20] These numbers come from *Tobacco Control State Highlights 2012*, http://www.cdc.gov/tobacco/data_statistics/state_data/state_highlights/2012/zip_files/highlights.zip.

[21] As explained by CMS in its proposed 2016 BHP methodology, "For the BHP payment rate cell for persons ages 21-34, we would calculate the factor as (4/14 * the utilization rate of 18-24 year olds) plus (10/14 * the utilization rate of 25-44 year olds), which would be the weighted average of tobacco usage for persons 21-34 assuming a uniform distribution of ages; for all other age ranges used for the rate cells, we would use the age range in the CDC data in which the BHP payment rate cell age range is contained." CMS. Basic Health Program: Federal Funding Methodology for Program Year 2016.

[22] CMS, Basic Health Program: Federal Funding Methodology for Program Year 2016.

[23] Dorn and Tolbert 2014.

[24] These estimates will be almost the same as those for 2015, with very small changes reflecting population growth. A state analyzing BHP implementation for 2015 could use the tables in this appendix to develop the kind of fiscal analysis described in the body of this report.

[25] Among consumers with incomes between 139 and 400% FPL who are offered ESI, between 97% and 99.8% of such offers meet the ACA's definition of affordability. Even among consumers in this income range who do not accept ESI offers, between 87% and 99% of the rejected offers are affordable. See the U.S. panel in table 1 in Matthew Buettgens, Stan Dorn, Habib Moody. *Access to Employer-Sponsored Insurance and Subsidy Eligibility in Health Benefits Exchanges: Two Data-Based Approaches*. Washington, DC: Urban Institute (prepared for the California HealthCare Foundation), Dec. 2012, http://www.urban.org/UploadedPDF/412721-Access-to-Employer-Sponsored-Insurance.pdf.

[26] See Buettgens, Dorn and Moody, 2012.

[27] Passel, J. and D. Cohen. 2009. "A Portrait of Unauthorized Immigrants in the United States." Washington, DC: Pew Hispanic Center.

[28] Treasury Inspector General for Tax Administration, "The Internal Revenue Service Needs a Coordinated National Strategy to Better Address an Estimated $30 Billion Tax Gap Due to Non-filers," November 2005, Reference Number 2006-30-006.

[29] "Internal Revenue Service Data Book 2003," Internal Revenue Service, 2003.

[30] Plueger, D, "Earned Income Tax Credit Participation Rate for Tax Year 2005," Internal Revenue Service, 2009.

[31] For households with 1 BHP-eligible member, groups would include 5 age ranges, 4 FPL income ranges, and 5 household sizes (with households of 5 or more members constituting the largest household), for a total of 100 groups (5x4x5=100). Households with 2 BHP-eligible members have the same number of age and FPL income ranges, but only 4 household sizes, since a 1-person household cannot have 2 BHP-eligible members. Accordingly, this second set includes 80 groups (5x4x4=80). The final set, consisting of households with 3+ BHP-eligible members, has only 3 household sizes, so it includes 60 groups (5x4x3=60). Altogether, these three sets include 240 groups (100+80+60=240).

[32] Specifically, we reweighted by minimizing cross-entropy. Martin Wittenberg, An introduction to maximum entropy and minimum cross-entropy using Stata, *The Stata Journal* (2010) 10, Number 3, pp. 315-330.

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ENSURING CONSUMERS' ACCESS TO CARE:

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November 2014 | Health Management Associates

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Preface

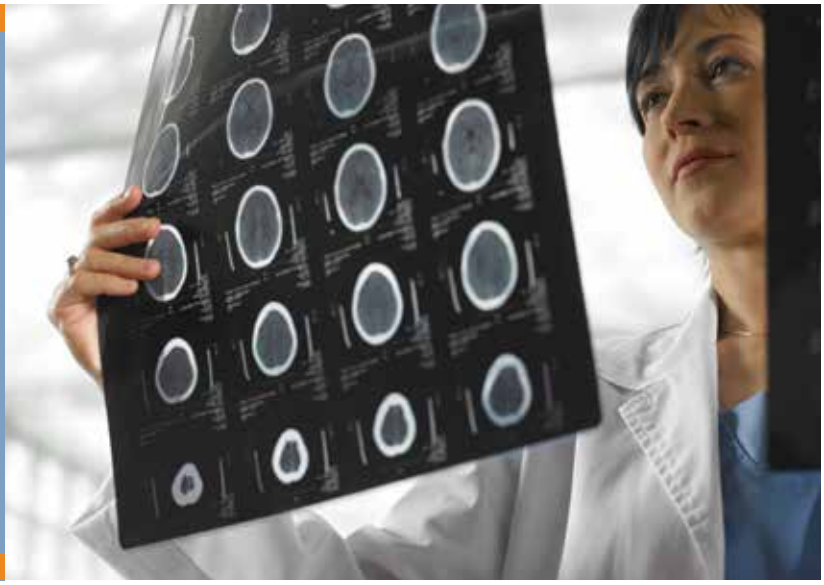
The Affordable Care Act (ACA) includes many reforms intended to make health care more affordable and accessible to consumers. Of note here, the ACA standardizes the list of covered benefits, sets a floor for the amount of financial coverage, and establishes a maximum limit for enrollees' annual out-of-pocket expenses. These reforms help consumers compare health plans and use their coverage, but they accelerated a trend towards tighter provider networks and tiered networks, as insurers turn to new levers to keep premium costs low. As a result, the issue of network adequacy is elevated. Health insurance coverage is meaningless if consumers cannot get the covered benefits promised to them due to network constraints.

To ensure that patients and consumers have access to the care they need in a changing health care environment, the Consumer Representatives to the National Association of Insurance Commissioners (NAIC) have for several years urged the NAIC to update its Managed Care Network Adequacy Model Act. We are pleased that the NAIC, through its Network Adequacy Model Review Subgroup, is now undertaking this important task. To help inform the NAIC's work, as well as the work of state and federal regulators, the consumer representatives offer this report, **"Ensuring Consumers' Access to Care: Network Adequacy State Insurance Survey Findings and Recommendations for Regulatory Reforms in a Changing Insurance Market."** To develop this report, the Consumer Representatives to the NAIC commissioned Health Management Associates to evaluate the current status of state requirements related to network adequacy, the challenges regulators face, and best practices for ensuring network access. We then make recommendations for revising the Network Adequacy Model Act. We hope these findings and recommendations will be helpful to regulators moving forward.

Acknowledgments

The Consumer Representatives to the NAIC would like to extend our deep and sincere appreciation to Dianne Longley, a respected former regulator at the Texas Department of Insurance, for her thorough and dedicated work in researching and writing this report. She currently works at Health Management Associates in the area of health policy. We would also like to thank Samia Abbass at Health Access California and Ashley Williams and Sarah Dash at Georgetown University's Center on Health Insurance Reforms for their tremendous support on this project. We also thank Stefanay Allen and DragoonStudios in Atlanta for their creative design for this paper. We would also like to express our heartfelt gratitude to the Robert Wood Johnson Foundation for their generous support for this project. And finally, as always, we are grateful to the NAIC for giving us the ongoing opportunity to provide consumer-focused input to insurance regulators on health policy issues, including implementation of the ACA.

Executive Summary



State and federal insurance regulators face new and complex challenges to ensuring that consumers' interests are monitored and protected in a rapidly evolving health insurance market. As consumers enter the insurance market in record numbers as a result of the Affordable Care Act (ACA), the increased competition and demand for health care services have created both new opportunities and new pressures for health plans and health care providers. Many insurers have responded by offering health plans with lower premiums in exchange for more limited access to health care providers. Although some reasonable trade-offs are necessary to ensure health coverage is affordable, the increasing use of "narrow networks" and tiered networks has focused additional attention on the regulation of health plan provider networks and the potential financial implications for consumers who receive out-of-network services.[1]

Historically, state oversight of network adequacy has varied significantly from state to state and, in many cases, has not kept up with changes in health plan designs. Recently, NAIC (National Association of Insurance Commissioners) president-elect Monica Lindeen noted in her testimony before the House of Representatives' Energy and Commerce Subcommittee on Health that older insurance statutes cannot fully accommodate the new health plan designs offered today, and that current state standards may need revisions to address network adequacy concerns. Commissioner Lindeen announced that in response to the changing market and concerns regarding regulatory standards, the NAIC has agreed to update its 1996 network adequacy model law, which is intended to establish requirements for health plans to assure adequacy, accessibility, transparency, and quality of health care services for consumers.[2]

In March of 2014, the NAIC Regulatory Framework (B) Task Force created the Network Adequacy Model Review Subgroup to develop recommendations for updating the Managed Care Plan Network Adequacy Model Act. Since May, the NAIC Subgroup has been holding weekly public conference calls and using the NAIC's open process to engage consumers, health care providers, business groups, insurers and other stakeholders in the review process. In response to the Subgroup's invitation to stakeholders to propose solutions, the NAIC Consumer Representatives offered to conduct a survey of all state Departments of Insurance (DOIs) to obtain information on statutory and regulatory requirements related to oversight of network adequacy, and to identify strategies used to monitor compliance with network adequacy requirements. Our goal through this effort was to identify challenges faced by regulators as well as "best practices" and successful initiatives used by states in order to develop recommendations for the NAIC's consideration. The survey was sent to DOIs in all 50 states and to regulators in Puerto Rico and the District of Columbia. The NAIC supported our efforts by encouraging states to respond to the survey and by allowing the Consumer Representatives to provide an overview of the survey project at the 2014 summer meeting. By September, DOIs had submitted a total of 38 completed surveys. The respondents represent states of varying sizes with different demographics, geographies, and health insurance exchange dynamics, providing excellent information on the current spectrum of regulatory approaches to network adequacy oversight and ensuring availability and transparency of information to enable consumers to make informed health plan purchasing decisions.

Survey Results

Not surprisingly, the survey results confirm that States do not take a "one size fits all" approach to network adequacy oversight. As the highlights in the table below indicate, different marketplace dynamics, varying levels of statutory authority, and other state-specific factors impact the tools regulators have available and the degree to which health plans must comply with specific requirements. Complete survey results are included later in this report.

SURVEY HIGHLIGHTS

- **Most states have not adopted the NAIC Managed Care Plan Network Adequacy Model Act.**
- **The primary tool regulators use to monitor network adequacy is complaint data. Almost all states track network adequacy-related complaints but vary in the level of detail they collect.**
- **DOIs consistently report that one of the biggest challenges they face as regulators is developing consumer-friendly information and resources for consumers to help them understand the risks and potential costs associated with out-of-network services. While they agree consumers need better information to make informed decisions, they struggle to provide information in a clear, easy-to-understand format that addresses the variations in requirements for different types of health plans.**
- **Just over a third of states have requirements that Preferred Provider Organizations (PPOs) update their provider directories on a regular basis, such as annually or semi-annually.**
- **Overall, respondents indicate more regulatory authority exists for health maintenance organizations (HMOs) than PPO plans and even less regulatory oversight is in place for newer managed care products, such as Exclusive Provider Organizations (EPOs).**
- **Less than half of states have provisions in place to prohibit or limit a situation in which a member receives services from an out-of-network provider (such as an anesthesiologist) when treated at an in-network hospital. However, those requirements are limited in many cases to specific situations such as emergency services, and the level of protection varies widely based on the type of plan (HMO or PPO).**
- **Enforcement actions are rarely taken based on violations related to network adequacy. Only four states reported they usually take enforcement actions against more than one health plan a year due to network adequacy violations.**

Recommended Changes to Managed Care Plan Network Adequacy Model Act

In addition to providing a broad overview of the variety of regulatory approaches currently in place related to network adequacy, the survey results also identify opportunities for improved regulations that more accurately reflect the complexities of today's health insurance market. While network adequacy oversight has evolved significantly in a few states, others have made little progress. To encourage states to consider opportunities for regulatory improvements, we have included in this report several recommendations for new state network adequacy oversight requirements and modifications to the NAIC Model Law based in part on responses and comments provided by survey respondents. Although these suggestions do not represent the only options for improving network adequacy, we hope the NAIC and state regulators will seriously consider integrating these ideas into the new Model Law requirements and in any legislative or regulatory changes states are considering.

- Expand the scope of existing network adequacy regulations to include all types of network plans, including HMOs, PPOs, Exclusive Provider Organizations (EPOs), and Point of Service (POS) plans, and plans with multi-tier provider networks. [3]
- DOIs should evaluate the methods used to educate consumers on the ability to file complaints with the Department and identify ways to improve outreach to consumers to ensure they are fully informed of the Department's complaint process. Because regulators rely heavily on complaints as an indicator of potential problems with a health plan's network, it is imperative that consumers are aware of the ability to file complaints with the DOI and the process for doing so. DOIs should also provide an on-line mail box for consumers to communicate problems or suggestions to the Department, even if the individual does not want to file an official complaint.

- Establish a process for regularly updating the NAIC Model Law to address oversight of new models of care, such as Accountable Care Organizations (ACOs) and other models that may evolve over time.
- Establish quantitative standards for meaningful, reasonable access to care, such as minimum provider-to-enrollee ratios, reasonable wait times for appointments based on urgency of the condition, and distance standards that require access to network providers within a reasonable distance from the enrollee's residence. While we recognize that geography and local market conditions make it challenging to set national quantitative standards that would be appropriate in every state, we believe it is important that states set such standards.
- Require health plans to submit and receive approval from DOI of access plans to ensure consumers are adequately protected from network deficiencies.
- Ensure consumers are provided sufficient information to identify and select between broad, narrow or ultra-narrow networks. In areas without sufficient choice, require health plans to offer at least one plan with a broad network or an out-of-network benefit, with limited exceptions to be determined by the Commissioner.
- Require all health plans, not just Qualified Health Plans (QHPs), to include access to Essential Community Providers.
- Require all network plans to include provisions that protect consumers from balance billing in all emergency situations and when receiving services from non-network facility-based providers in an in-network facility.
- Require providers to notify health plans and patients when leaving a network for any reason.
- Require health plan provider directories to be updated regularly, publicly available for both enrolled members and individuals shopping for coverage, and include standards for information that must be included to provide consumers with information on network differences and the potential financial impact on consumers depending on which plan they choose.
- Establish requirements guaranteeing continuity of care for individuals who are in the midst of an episode of care and their provider is dropped from or leaves the network or is moved to a higher cost tier.
- Create special enrollment periods to allow individuals to move to a new health plan when they rely on erroneous information published in a health plan's provider directory, their primary care provider becomes a non-participating provider, or a covered person is in the midst of a course of treatment and loses access to their specialty care provider or facility.
- Work with other state agencies to address balance billing concerns resulting from consumers needing to use out-of-network providers.
- Adopt standardized health plan reporting requirements to monitor frequency of out-of-network services and network adequacy, and identify circumstances where additional consumer protections or changes in regulatory processes are warranted. Require health plans to make information publicly available in a prominent position on their website. DOIs should also provide notice to consumers of the availability of such information and how it may be accessed.
- Establish a comprehensive, standardized list of complaint codes that all DOIs use to track consumer complaints related to network adequacy and access to care.
- Expand efforts to educate consumers on DOI complaint processes to ensure they are aware of their right to file a complaint and reduce any administrative barriers that may discourage consumers from filing complaints.
- States should not rely solely on health plan accreditation as a substitute for demonstrating network adequacy compliance, but should supplement accreditation with additional standards.

Network Adequacy and Financial Implications for Consumers

Network adequacy refers to a health plan's ability to meet the medical needs of its enrollees by providing reasonable access to a sufficient number of in-network primary care and specialty physicians, as well as all other health care services for which benefits are included under the terms of the insurance contract.[4] In the event an enrollee is unable to obtain covered services from an in-network health care provider and is treated by an out-of-network provider, the health plan may pay a much lower portion of the medical bill – or nothing at all – and the consumer may be faced with significantly higher cost-sharing that does not count toward their out-of-pocket limit. Depending on the circumstances, the provider may also then "balance bill" the patient for the remaining costs, which can be a significant amount of money depending on the services received and the payment provided by the insurer. While network adequacy is typically the primary focus of regulatory oversight, balance billing is directly linked to network access and creates additional challenges for regulators.

Although many states have struggled to determine how to best regulate provider networks in a way that ensures access to care while still allowing health plans flexibility in network design and network size in exchange for lower premiums, no single approach has evolved. Primary oversight of network adequacy for commercial benefit plans is delegated to state Departments of Insurance (DOIs) that have adopted varying approaches based, in part, on differences in statutory authority granted by their Legislature. In addition, the federal Department of Health and Human Services (HHS) also plays a role in network adequacy regulation in its oversight of requirements for Qualified Health Plans (QHPs) offered on state and federal health insurance exchanges.[5] While HHS has delegated network adequacy reviews to states in most cases, the requirements for QHP provider networks vary from those required of most commercial insurance plans, creating an additional complication for states in some cases. States that have created a separate entity to operate their exchange may also have a role in monitoring network adequacy of QHPs sold on the exchange.

The initial network adequacy regulatory requirements developed by states and the NAIC were designed for HMOs but have evolved over time to include other types of network plans including PPOs and, to a much lesser extent, EPOs.[6] In most if not all states, network adequacy regulations are more comprehensive for HMO plans than for PPOs due to the more restrictive HMO requirements that limit consumers' ability to use any provider other than those included in the HMO network except in emergency situations or in cases where an enrollee does not have access to covered services from a network provider. Generally, in an HMO health plan, the HMO must provide all covered services through a network provider, or arrange for an out-of-network provider to care for the enrollee at no additional cost if an in-network provider is not available. As long as the enrollee uses an in-network provider or receives approval for out-of-network services, the enrollee should not be balance billed for fees other than their standard co-payment.

However, network adequacy standards for PPOs are usually more complicated for regulators and consumers since PPOs do not provide prepaid care and benefits are included to allow enrollees to choose an out-of-network provider. Out-of-pocket costs for services are lower as long as the individual uses an in-network provider but may be significantly higher when receiving services from an out-of-network provider. While some state laws require PPOs to meet certain network adequacy standards, the criteria are frequently much less stringent than those for HMOs. As with HMOs, PPO enrollees are protected

from unexpected bills as long as they stay in their network or use out-of-network providers only when an in-network provider is unavailable and the PPO authorizes the use of a non-network provider. However, unlike HMOs, in the event a PPO enrollee is treated by an out-of-network provider, even when due to no choice of their own, the enrollee is responsible for the generally higher cost-sharing amounts and any remaining balance billed by the provider after the health plan has paid its portion of the bill.

Impact on Consumers of Inadequate Network Adequacy Regulatory Oversight

When a network plan enrollee does receive out-of-network services, the costs can be significant, even in cases where the enrollee had no control over the circumstances and did not knowingly choose to use an out-of-network provider. To better understand the need for improved consumer protections, a brief discussion of the circumstances created by inadequate networks helps to illustrate the frustrations of consumers who often have no control over the providers they see, even when "playing by the health plan rules" and making every effort to use only network providers. Following is a brief overview of situations in which consumers may receive treatment from out-of-network providers.

• Treatment by an Out-of-Network Provider During a Pre-Approved In-Network Hospital Admission

Consumers planning a hospital stay select an in-network hospital and an in-network provider for their primary services (such as surgery), but they must use the ancillary providers (e.g., anesthesiologists, radiologists, pathologists) with which the hospital contracts for other services received, such as lab work, anesthesiology, or imaging services. If those facility-based providers do not also contract with the patient's health plan, the patient is frequently billed for out-of-network charges their health insurer does not pay. Depending on the services, the out-of-network bill can amount to thousands of dollars that the patient did not anticipate or have any control over, despite their adherence to the health plan requirement that they use an in-network facility.[7] In many cases, consumers are not even aware they were treated by a non-network provider until they receive a "surprise" bill.

• Balance Billing in an Emergency

Under section 2719A of the Public Health Service Act, all non-grandfathered health plans are required to charge in-network cost-sharing for emergency services provided by an out-of-network emergency department (ED) physician or for emergency services provided by an out-of-network hospital. However, despite this consumer protection, consumers can still find themselves subject to high out-of-pocket costs. When a consumer visits an emergency room and is treated by an emergency room doctor who does not participate in their insurance network, they can still be balance billed by the doctor and the hospital. Because hospital-based physicians often decide which insurance plans to participate in, a visit to the emergency room can result in multiple separate bills from different providers. An Avalere Health study commissioned by the American Heart Association found that hospital-based diagnostic radiologists were less likely to be included in QHP networks, compared to cardiologists and neurologists. When hospital-based physicians do not contract with the same plans as the hospital, consumers end up receiving out-of-network services even if the hospital is an in-network facility. Depending on the level of the emergency, even an informed consumer may be unable to determine whether the contracted ED providers are in their network since provider directories do not typically list hospital-level participating providers. For emergency services, the patient's balance bill can be especially significant as the amount an insurance company pays a doctor (the contract amount) is often much lower than the provider's actual billed charge.[8] In addition, if a patient who is treated and stabilized at an out-of-network hospital ED needs to be admitted as an inpatient, they can then face the difficult choice of staying and being subject to out-of-network cost-sharing (which could be 100 percent, depending on the type of plan they have) and balance billing or being transferred to an in-network hospital, which may not be in their best medical interest.

• No Access to a Particular Type of Provider (e.g., Pediatric Orthopedist, Neonatologist)

Regional shortages of certain specialty providers limit access to specialty care and can inhibit the health plan's ability to develop adequate networks. Shortages occur in both rural and heavily populated urban areas and are most commonly seen for certain specialty services that may only be provided at a select group of facilities. While health plans are required to ensure access to necessary care within reasonable time frames, consumers may find themselves battling with health plans to obtain authorizations for out-of-network services when specialty providers are not included in the health plan's network. Members unwilling to wait for approval may seek care from an out-of-network provider that could result in balance billing if the health plan does not cover the full cost. Even when approval is issued, the health

plan's payment arrangement may still leave consumers with higher costs. Enrollees with uncommon health conditions are particularly vulnerable to these circumstances if the network does not provide access to highly specialized services available from only a limited number of providers.

- **Unreasonable Delays in Access to Care Due to an Insufficient Network**
  Consumers may also encounter delays in receiving services when a provider network is insufficient to meet the volume of services required by the enrollees they serve. Similar to the illustration above, consumers may choose to go to an out-of-network provider because they cannot find an in-network provider accepting new patients or because they do not believe they can wait for an available appointment from an in-network provider. If so, they will be responsible for costs not covered by the health plan.

- **No Access to a Particular Treatment Due to Lack of Providers Who Offer It**
  Consumers with chronic or serious medical conditions can be particularly impacted if a provider network does not include providers who can treat their particular condition. This is especially true for specialty providers at academic institutions or centers of excellence who offer services that are not available at another facility. An Avalere Health study commissioned by the American Heart Association found that inclusion of Comprehensive Stroke Centers (CSC) and specialty physicians affiliated with those facilities varied widely across 10 regions; however, the study found that 23 percent of the QHPs reviewed did not include a single CSC in their network and inclusion of select specialty physicians ranged from a low of 8 percent in Los Angeles to a high of 83 percent in Philadelphia. If the provider is not included in the enrollee's network, the enrollee may seek an authorization for services from the health plan, but may still be responsible for out-of-network costs or subject to balance billing. If they are unable to receive an authorization but decide to seek services anyway, the costs can be even higher.

Although consumers may be faced with these challenges in any network plan, individuals enrolled in "narrow networks" may bear an increased risk of encountering difficulties obtaining in-network services. In an effort to attract new consumers entering the health insurance market through the exchanges, both HMO and PPO health plans have increasingly turned to more limited "narrow networks" that offer fewer provider choices in exchange for lower premiums.[9] As this trend continues to grow more popular among health plans, consumers' access to and choice of providers may be severely limited, which may also lead to increased consumer complaints about lack of choice among providers or inability to access certain specialty providers in a timely manner. For consumers with limited financial resources who have chosen a narrow network plan due in part to the lower premium, the cost of unforeseen balance bills can create financial risks that are especially difficult for them to absorb. In some states, severely limited networks have left large numbers of doctors and hospitals completely out of the provider network, frustrating consumers who need, or would like, to receive care from the excluded providers. For example:

- California consumers recently filed lawsuits against insurance companies alleging they offered inadequate networks of doctors and hospitals and provided incorrect information about participating providers, often leaving consumers with large medical bills.[10] Consumers claim they did not find out the providers were out-of-network until after they received care and were forced to pay out-of-network charges. Claimants also report they were unable to switch health plans despite the fact that they selected the plan based on inaccurate provider information.
- In Washington, four of the seven health insurers selling plans in the health insurance exchange excluded several of the most prestigious Seattle hospitals, including Seattle Children's Hospital.[11] One plan included only one hospital in its network of hospital providers, and the hospital does not offer child delivery services. In response to complaints from providers and consumers that such networks do not provide reasonable access to necessary medical care, the Insurance Commissioner adopted more stringent network adequacy requirements for 2015 that require plans to ensure provider directories are accurate and clearly identify which providers participate in which network. Health plans must also include enough providers to meet time and/or distance requirements to ensure enrollees have a sufficient number of network providers to meet enrollees' needs in a reasonable time frame.
- In New Hampshire, the sole insurer participating in the health insurance exchange, Anthem, reduced the breadth of its provider network by excluding over 30 percent of the state's hospitals.[12] In response to complaints from consumer and provider groups, as well as federal and state policymakers, the New Hampshire Department of Insurance initiated a review of its network adequacy standards and has drafted new rules which, if adopted, will apply to plans offered in the plan year beginning January 2016. For 2015, four new insurers are entering the market, and all hospitals in the state will be included in at least one plan network.[13]

As network adequacy has received increased attention, regulators have begun to focus on improving the current regulatory framework for oversight of health plan networks and payment policies related to out-of-network bills. In doing so, some regulators have relied primarily on anecdotal data captured through complaints filed by consumers, which only identifies problems after-the-fact and relies on consumers' awareness of the complaint process. Because not all consumers affected by inadequate networks or balance billing actually file complaints with DOIs, the full extent of the problem is unknown. While most states have little data to confirm the extent to which health plan enrollees receive out-of-network services, and even less information on the frequency of balance billing, a few states have increased efforts to collect data to assist in their oversight activities and to inform the development of new regulatory options. For example:

- A Texas Department of Insurance (TDI) regulation that took effect in 2013 requires Texas PPOs to provide to TDI out-of network service data for hospital-based physician types, including emergency department (ED) doctors. Analysis of the data published by the Center for Public Policy Priorities shows that Texas consumers are at significant risk of being balance billed for services provided by non-network providers, even when using in-network hospitals. For example, two of the largest insurers in the state reported that 48 percent and 56 percent of their in-network hospitals had no in-network ED doctors. Out-of-network fees paid to ED physicians were more than twice as high as fees paid to other out-of-network hospital-based providers. One plan in particular reported significantly higher levels of hospitals with no in-network facility-based providers, including 56 percent of hospitals with no in-network ED physicians, 38 percent of hospitals with no in-network anesthesiologists, and 31 percent of hospitals with no in-network radiologists. [14]
- A review of consumer complaints related to health insurance reimbursements in New York revealed that more than 10,000 complaints related to balance billing were filed since 2008. In describing new legislation that will provide additional data on out-of-network services and authorizes regulations to improve network adequacy oversight, Benjamin Lawsky, Superintendent of Financial Services and the chief insurance regulator for the state of New York, noted, "The heart of the bill came out of the fact that the No. 1 complaint on health insurance issues we receive year after year is people who get stuck with surprise balance bills."[15]

While these examples of data collection by DOIs are a good beginning, they are still uncommon and represent the exception rather than the rule. We hope these and other activities states are pursuing will encourage the NAIC and other state DOIs to consider taking similar steps to improve protections for the consumers enrolled in network plans.

Current Federal Regulatory Structure

While states have historically been the primary regulators of health insurance, with the implementation of the ACA, health plans may be subject to oversight by not only the state DOI, but also the state Medicaid agency and the entity operating the health insurance exchange, which in some cases is the Centers for Medicare and Medicaid Services (CMS).[16] Since the adoption of the ACA and subsequent debate regarding the division of state and federal regulatory responsibilities, a number of states have consistently expressed concern regarding expansion of federal oversight of state insurance markets. In an April 2014 letter from officers of the NAIC to the Center for Consumer Information and Insurance Oversight, regulators state, "We believe federal regulation of network adequacy standards will lead to conflicting standards between state and federal requirements and that network adequacy regulation will be most effective at the state level where the needs of consumers, the cost of care, and the standards of the area, can best be evaluated."[17]

Despite the resistance from states, federal regulators have increasingly indicated a willingness to regulate network adequacy and access to care. For example, as will be discussed in greater detail later in this report, CMS has signaled plans for greater network adequacy oversight and regulation of qualified health plans (QHPs) certified for inclusion in federally facilitated exchanges. Similarly, the Departments of Health and Human Services, Labor, and Treasury recently issued a number of Frequently Asked Question guidance documents clarifying how a non-grandfathered health plan that "utilizes reference-based pricing (or similar network design)" will be evaluated to ensure that "it provides adequate access to quality providers".[18] This FAQ applies to all non-grandfathered health plans using reference-based pricing or a similar scheme. Its reasoning would apply to any restrictive network design.

To better understand the impact of the federal requirements and how state regulations can be effectively designed to meet both federal and state oversight requirements, the following section provides an overview of the federal statutory and regulatory requirements applicable to the networks of QHPs offered to exchange enrollees. The information includes comments provided in proposed and adopted regulations to provide the perspective of federal regulators and their expectations with regard to network adequacy oversight.

ACA Requirements Related to Network Adequacy

Section 1311(c) of the ACA requires the Secretary of Health and Human Services to adopt regulations establishing criteria for the certification of QHPs, including the following network adequacy requirements:

- Ensure a "sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c)[19] of the Public Health Service Act), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers", and
- Include within plan networks "essential community providers, where available, that serve predominantly low income, medically underserved individuals, such as health providers defined in Section 340B of the Public Health Service Act."

The ACA describes providers who are considered to be essential community providers through its reference to Section 340B of the Public Health Service Act (PHSA), which guarantees access to discounted drugs for certain healthcare providers that serve low income populations. In addition, ACA Section 1311 also requires the Secretary to establish criteria for all QHPs to obtain accreditation by a recognized entity on the basis of local performance in several categories, including consumer access and network adequacy.

Also of note, Section 2707(b) limits consumers' annual out-of-pocket costs (i.e., cost-sharing) paid for covered health plan services, but Section 1302(c) of the ACA does not require insurers to count costs paid by consumers to out-of-network providers towards their annual out-of-pocket limit. The Department of Health and Human Services subsequently adopted federal rules consistent with this restriction. As noted above, a recent tri-agency Frequently Asked Questions guidance suggests that network designs (including some reference-based pricing programs) may be a subterfuge for evading the out-of-pocket limit, however, and thus be illegal.[20]

U.S. Health and Human Services Regulations Related to Network Adequacy

On March 12, 2012, HHS issued a final rule to implement the provisions related to establishment of health insurance exchanges under the ACA.[21] The rule finalized two separate proposed rules issued in 2011:

- Establishment of Exchanges and Qualified Health Plans (July 15, 2011); and
- Exchange Functions in the Individual Market: Eligibility Determinations and Exchange Standards for Employers (August 17, 2011).

In the preamble, HHS states that while it recognizes that national standards are appropriate in some circumstances, states are "best equipped to adapt the minimum Exchange functions to their local markets and the unique needs of their residents." The intent is to provide states "substantial discretion" in the design and operation of an exchange.

HHS Regulatory Impact Analysis of Final Exchange Rule

In the regulatory impact analysis of the final rule, HHS included explanations regarding its rationale for network adequacy requirements.[22] HHS restates that the rule permits state discretion in setting network adequacy standards. An exchange may determine that existing state requirements for commercial providers is sufficient for QHPs, provided that QHPs will be required to maintain a network that is sufficient in number and types of providers so that services will be provided without unreasonable delay. If states use that approach, HHS reports that this regulatory provision will have no cost impact on premiums. HHS also says that, "While it is not expected, the Exchange could set additional standards in accordance with current provider market characteristics and consumer needs, which could have a minimal cost impact."

If a state exchange sets QHP network adequacy standards that go beyond what is currently required in the market, HHS acknowledges that health plans may need to contract with additional providers at higher rates. If that is the case, premium rates are also likely to be higher. HHS says that the network adequacy standards are designed to maintain a "basic level of consumer protection," while allowing QHP issuers to compete for business based on their networks, quality of coverage, and premiums.

HHS also notes that the final rule "permits QHP issuers to contract with a sufficient number and geographic distribution of essential community providers to provide timely access to services for low-income and medically underserved individuals. QHP issuers are not required to contract with all essential community providers and, except for certain limited categories of providers, the issuer is not required to contract with an essential community provider if the provider does not accept the issuer's generally accepted rates for participating providers."

Final Rule Requirements Related to Network Adequacy

Network adequacy and related requirements are included in both Section 155 related to responsibilities of the exchange and Section 156 related to requirements for issuers of QHPs. Following is a summary of those provisions as stated in the final rule.

Establishment of Exchange Network Adequacy Standards (45 CFR §155.1050)

This section of the rule requires the exchange to ensure that the provider network of each QHP offers a sufficient choice of providers for enrollees to meet the standards for network adequacy specified in §156.230.

Final Rule Provisions:

- The exchange must ensure that the provider network of each QHP meets the standards described in §156.230 (i.e., includes a sufficient number and type of providers, includes essential community providers, requires plans to provide provider directories, and allows plans to limit enrollment if they do not have the capacity to serve additional enrollees);
- The U.S. Office of Personnel Management will oversee network adequacy standards and compliance for multi-State plans;
- The exchange cannot prohibit a QHP issuer from contracting with any essential community provider as designated in §156.235(c).

Network Adequacy Standards (45 CFR §156.230)

This section provides network adequacy standards required of QHPs. In the preamble response to comments, HHS notes there are several competing goals in establishing requirements for adequate networks. In balancing the varying perspectives, HHS modified the language in the proposed rule to more closely align with the NAIC Managed Care Plan Network Adequacy Model Act. HHS notes that the revised language better conveys their expectations concerning the number and variety of providers that are required in a QHP's network. The revisions also establish a baseline – "All services… without reasonable delay" – for determining whether a network meets the required standard. HHS states that the revised language provides states with the discretion needed to ensure network adequacy standards within the exchange are consistent with standards applied outside the exchange, and reflect local conditions. The rule also says that "….placing the responsibility for compliance on QHP issuers rather than directing the Exchange to develop standards, is more consistent with current State practice."

In response to recommendations that the rule prohibit a network from being deemed inadequate in a professional shortage area, HHS repeats that states should have flexibility to develop local solutions to ensure access. Further, HHS believes that the standards for inclusion of essential community providers in networks will help strengthen access in medically-underserved areas.

In response to comments suggesting that the rule require the inclusion of specific provider types and that networks meet a "uniform growth standard" to ensure they are able to accept new enrollees, HHS states that the final rule is modified to require that networks include sufficient numbers and types of providers, including providers specializing in mental health and substance abuse services, to ensure appropriate access to care. HHS also reiterates comments made in the proposed rule preamble, urging states to consider local demographics and availability of providers when developing network adequacy standards.

Several commenters suggested the rules impose more stringent standards for network directories. The final rule notes that exchanges will be given discretion regarding the information included in the directory and frequency of required updates, but HHS expects directories to include information on each provider's licensure or credentials, specialty and contact information, and to consider the information needs of both current and potential enrollees. The rule requires that provider directories comply with the requirements in §155.230, which includes accommodations for individuals with limited English proficiency and/or disabilities.[23]

HHS also declined to establish a uniform standard for patient notifications when a provider leaves a network. The rule states that such a requirement may not be consistent with the non-exchange market, and might raise QHP administrative costs. Finally, the preamble addresses comments suggesting that QHPs are obligated to include health programs operated by or on behalf of Indian tribes based on section 408 of the Indian Health Care Improvement Act (IHCIA). HHS responds that the intent of section 408 is to confirm that Indian providers are eligible to receive payment from Federal Health Care Programs if certain standards are met. Section 26 of IHCIA provides that Indian providers are entitled to third party payments, including

QHPs, up to the reasonable charges or the highest amount an insurer would pay to other providers eligible for payment. HHS declined to require QHPs to include Indian providers/programs but points out that Section 26 of IHCIA will foster network participation because it benefits QHPs to contract with Indian providers in order to establish the provider payment terms.

Final Rule Provisions:

- QHP networks must include essential community providers as described in §156.235 (see discussion below);
- QHP networks must include a sufficient number and types of providers, including mental health and substance abuse specialists, to ensure all services are available without unreasonable delay;
- QHP networks must meet the provisions of Section 2702(c) of the PHS Act (which allows QHPs to limit their enrollment to individuals who live, work, or reside within their service areas, and to close enrollment if they do not have the capacity to serve additional members.);
- QHPs must make its provider directory available to the exchange for online publication, and provide hard copies to potential enrollees upon request. The directory must identify providers that are not accepting new patients.

Essential Community Providers (45 CFR §156.235)

This section of the rule requires a QHP issuer to include within its network a sufficient number of essential community providers (ECPs) who serve predominantly low-income, medically underserved individuals. The proposed rule uses a definition of ECPs that is consistent with the ACA, which includes all health care providers defined in section 340B(a)(4) of the PHS Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Act.

Section 340B(a)(4) refers to the Drug Discount Program that serves vulnerable patient populations and identifies covered entities.[24] Section 1927 of the PHS Act allows the Secretary of HHS to identify any "safety net facility or entity" that would benefit from nominal drug pricing under the Medicaid program.[25]

Final Rule Provisions:

- QHP issuers must have a sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of providers for low-income, medically underserved individuals;
- QHP issuers that employ their own physicians or contract with a single medical group to serve enrollees are required to have a sufficient number and geographic distribution of either employed or contracted providers and hospitals to ensure reasonable and timely access to care for low-income, medically underserved enrollees;
- Essential Community Providers are defined as those serving predominantly low-income, medically underserved individuals, including providers defined in section 340B(a)(4) of the PHS Act and providers described in section 1927(c)(1)(D)(i)(IV) of the PHS Act;
- No QHP issuer is required to contract with an ECP if the provider refuses to accept the generally applicable payment rates of the issuer;
- FQHCs are entitled to payments at least equal to what would have been paid under the applicable Medicaid Prospective Payment System (PPS) rate, or may accept a mutually agreed upon rate, as long as the payment rate is at least equal to the payment rate other providers would receive for the same service.

Accreditation Requirements (45 CFR §156.275) and Accreditation Timeline (45 CFR §155.1045)

The ACA requires accreditation of all QHPs as a way to ensure plans meet a minimum level of quality of care and patient satisfaction. This requirement is important to the discussion of network adequacy requirements because accreditation organizations include access to care or network adequacy standards as one criteria for certification.

Final Rule Provisions:

- QHP Issuers must be accredited in the following categories:
  - o Clinical quality measures;
  - o Patient experience rating on a standard CAHPS survey;
  - o Consumer access;
  - o Utilization management:
  - o Quality assurance;
  - o Provider credentialing;
  - o Complaints and appeals;
  - o Network adequacy and access; and
  - o Patient information programs.
- QHPs must authorize the accrediting entity to release to the exchange and HHS a copy of its most recent accreditation survey, along with any additional survey-related information HHS may require.
- QHPs must be accredited within the timeframe established by the exchange, and maintain accreditation as a condition of being certified as a QHP.

The exchange will establish a time frame in which a QHP must be accredited. The OPM determines the accreditation time period for multi-state plans.

State vs. Federal Regulatory Authority over Network Adequacy

With the passage of the ACA and the dual regulatory oversight of network adequacy requirements, state and federal regulators have at least initially addressed some issues related to coordination of network adequacy oversight. The majority of states are enforcing ACA health insurance market reforms and have worked with federal regulators to develop processes and procedures that more clearly define and coordinate state and federal roles. However, some states have determined they lack either the authority, the ability, or, in some cases, both to enforce ACA market reform provisions. CMS agreed to enter into collaborative agreements with any state willing and able to perform regulatory functions for federal regulations, allowing the state to use the same regulatory framework used to ensure compliance with state law. However, in 2013, six states – Arizona (for the group PPO market only), Alabama, Missouri, Oklahoma, Texas, and Wyoming – determined they did not have the authority to enforce ACA provisions. Those states have worked with CCIIO and health plans to implement processes to delegate certain oversight functions to the appropriate federal agency. Arizona subsequently notified CMS the state would assume full enforcement responsibilities as of January 1, 2014.[26]

As it did in 2013, in March 2014, CMS released a letter to issuers (*Final 2015 Letter to Issuers in the Federally-facilitated Marketplaces*[27]) to clarify the federal regulatory approach and requirements for issuers applying for QHP certification and provide additional regulatory guidance to issuers selling products in FFMs beginning in January 2015. States performing plan management functions in an FFM have more flexibility in evaluating compliance with some certification standards and, in some cases, are allowed to adjust processes.

In the March 2014 letter, CMS articulated a different approach it would take to assuring network adequacy standards were met in FFMs for QHPs undergoing approval in 2014 for sale in 2015. States performing plan management functions in an FFM may use a similar approach, but are not required to do so. For certification as a QHP in the 2015 benefit year, CMS stated it would **not** use issuer accreditation status to determine network adequacy requirements are met. Instead, provider networks will be assessed using a "reasonable access" standard. In its evaluation of network adequacy in QHPs for the 2015 benefit year, CMS focused on those areas it stated have most typically raised network adequacy concerns:

- Hospital systems;
- Mental health providers;
- Oncology providers; and
- Primary care providers.

If an inadequate network is identified through the QHP certification process, CMS stated it would notify the issuer of the problem and would consider the issuer's response in its final assessment. CMS also will share information and analysis and coordinate with states conducting network adequacy reviews.

In addition, CMS indicated it will include time and distance or other standards for FFM QHP networks in future rulemaking. Information gathered during the 2015 benefit year QHP certification process will be used to develop this analysis. Beyond QHP certification, CMS said it also intends to monitor network adequacy via complaint tracking to determine whether QHPs continue to meet network adequacy certification standards.

CMS also stated it will evaluate whether QHPs sufficiently incorporate ECPs into their networks by using a general ECP enforcement guideline requiring plans to include at least 30 percent of available ECPs in each plan's service area in order to participate in the provider network. In addition, the issuer must offer contracts in good faith to:

- All available Indian health providers in the service area; and
- At least one ECP in each ECP category in each county in the service area, where an ECP in that category is available.

NAIC Managed Care Plan Network Adequacy Model Act

As previously discussed, in 1996, the NAIC adopted the Managed Care Plan Network Adequacy Model Act to "establish standards for the creation and maintenance of networks by health carriers and to assure the adequacy, accessibility and quality of health care services offered under a managed care plan…."[28] The Model Act provides regulatory guidance to state insurance departments and other agencies with oversight responsibilities for managed health care regulation. The Model was drafted to apply generally to all types of managed care plans, including both HMOs and PPOs, with state regulators/legislators responsible for making modifications as necessary to conform to specific state regulatory structure. Drafting notes are included throughout the document to advise states of specific revisions for consideration.

Earlier this year, the NAIC acknowledged the need to modernize the Model Act and created the NAIC subgroup to work with stakeholders to develop recommendations for consideration by the NAIC. The NAIC stated it intends to "fast track" the process for revising the Model law, with the expectation of completing its work by the end of this year so that it will be available to state and federal policymakers as they consider regulatory changes for the 2016 plan year. Following is an overview of the current Model Act. However, note that while some states have enacted requirements that are similar to provisions included in the Model, very few states have enacted the Model in its entirety.

Network Adequacy Standards

The Model Act includes the following standards for network adequacy:

- Health carriers must maintain a network that provides a sufficient number of providers to ensure services are accessible without unreasonable delay.
- Emergency services must be available 24 hour a day, 7 days a week.
- Sufficiency may be determined by the carrier based on (but not limited to) the following criteria:
  - o Provider-to-enrollee ratios for primary care and/or specialty care;
  - o Geographic accessibility;
  - o Waiting times for appointments;
  - o Hours of operation;
  - o Volume of technological and specialty services available to meet enrollee needs.
- If a carrier's network does not have a sufficient number or type of providers to provide a covered benefit, the carrier must work with the enrollee to obtain the care elsewhere at no greater cost to the enrollee. As an alternative, the health plan can make other arrangements acceptable to the regulatory agency.

- Enrollees must have access to providers that are within a reasonable proximity to their business or personal residence. Regulators are instructed to give consideration to the availability of providers within the service area in determining compliance with this provision.
- Health carriers are required to continually monitor their ability – including clinical capacity – to furnish all contracted benefits to enrollees.
- Carriers must file an access plan with the regulatory agency, in a form defined by the regulator. The plan must be updated when the carrier makes any material change to the plan. The plan must include:
  - The carrier's network;
  - Procedures for making referrals within and outside the network;
  - The process for monitoring network sufficiency;
  - How the carrier will address needs of enrollees with limited English proficiency, cultural and ethnic diversities, and individuals with physical or mental disabilities;
  - A process for assessing the ongoing needs of enrollees and customer satisfaction;
  - A process for informing enrollees of plan benefits and requirements, such as grievance procedures; the process for choosing and changing providers; and the process for providing and approving emergency and specialty care;
  - A system for ensuring coordination and continuity of care for enrollees referred to specialty physicians and persons using ancillary services (including social services and other community resources) and for discharge planning;
  - The health plan's process for allowing enrollees to select and change primary care providers;
  - A continuity of care plan when a participating provider's contract is terminated for any reason, or if the health carrier becomes insolvent or is unable to continue operations for any reason;
  - Any other information required by the regulating entity.

Health Carrier and Participating Provider Requirements

The Model Act includes the following requirements for health carriers and participating providers:

- Contracts between carriers and providers must include a hold harmless provision that prohibits the provider from seeking payment for services from an enrollee if the health carrier fails to pay the provider for covered services provided to an enrollee. The restriction does not apply to coinsurance, deductibles or copayments or costs for uncovered services delivered on a fee-for-service basis to an enrollee, provided the enrollee is clearly informed that the carrier may not cover the specific service and agrees prior to treatment to pay for the services;
- The carrier's selection standards for including providers in the network must meet requirements equivalent to the Health Care Professional Credentialing Verification Model Act and cannot:
  - Allow a carrier to avoid high-risk enrollees by excluding providers located in areas that serve populations with a risk of higher than average claims, losses or health care utilization, or
  - Exclude providers solely because they treat patients with a risk of higher care costs or health care utilization.[29]
- The carrier must provide the regulating entity a copy of its selection standards for participating providers.[30]
- The carrier may not prohibit providers from discussing any treatment options with the enrollee, or from advocating on behalf of the patient in a utilization review or grievance process;
- Provisions regarding contract terminations, including at least 60 days notice to either party before terminating the contract without cause.
- Carriers must provide notice to enrollees when terminating a primary care provider.
- Providers may not assign or transfer their rights and responsibilities under a contract without consent of the carrier.[31]
- Providers are obligated to provide covered services regardless of whether the plan is a public program or private plan.

The Model Act includes a number of additional administrative and contractual obligations designed to protect both the carrier and the provider, including notification of the provider's administrative and financial responsibilities, prohibition against penalizing providers for reporting carrier activities that jeopardize a patient's health, and dispute procedures between carriers and providers.

Requirements for Intermediary Arrangements

The Model Act also includes requirements for agreements between health carriers and intermediaries who are authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network. The provisions are primarily administrative responsibilities related to documentation, maintenance and availability of information and records. The Model Act also allows the carrier to approve or disapprove participation of a subcontracted provider in its own or a contracted network. Intermediaries must comply with all of the requirements outlined above and included in Section 6 of the Model Act.

State Filing and Contracting Requirements

The Model Act includes several additional procedural or administrative provisions under Section 8 and 9, including a requirement that carriers file sample provider contracts with the state and a statement that the execution of a contract with a provider does not relieve the carrier of its responsibilities or liabilities under state law.

Enforcement

If the Commissioner or regulating entity determines a carrier has failed to meet the network adequacy standards or violates another provision of the Model Act, a corrective action plan should be developed by the carrier, or other appropriate enforcement action should be taken to ensure compliance.

The Model Act also prohibits the regulatory agency from acting to arbitrate, mediate or settle disputes regarding a carrier's decision not to include a provider in the network, or any other dispute regarding provider contracts or termination.

Survey of State Regulators' Network Adequacy Oversight Activities and Regulations

Although states have taken a range of approaches to network adequacy oversight based on variations in statutory authority, local market conditions, geographic factors and managed care prevalence rates, all states share common problems and concerns and have successfully used the NAIC as a forum to discuss aligning regulatory requirements across states when appropriate. The appointment and subsequent activities of the NAIC Network Adequacy Model Review Subgroup is an excellent example of the NAIC's efforts to include stakeholders in the development of solutions to problems associated with Network Adequacy, and the Consumer Representatives welcome the opportunity to participate in this initiative.

In May 2014, the NAIC Consumer Representatives sent a letter to the DOIs of each state, Puerto Rico and the District of Columbia, requesting completion of a survey to help identify current standards for regulating network adequacy, the challenges regulators face, and some of the tools they have developed to assist them in their oversight of network adequacy. The survey is included as Appendix A. The intent of the survey is to identify various ways regulators monitor and review network adequacy and creative solutions states have developed that could be replicated or reflected in modifications to the Model Law.

The survey questions were divided into two sections. The first section requested information regarding general approaches states have taken to regulating network adequacy in their health insurance market. States were also asked to indicate to what extent they had adopted the NAIC Network Adequacy Model Law. The second section asked for more specific information about how states have operationalized their network adequacy oversight, specifically asking them to distinguish differences in the oversight of network adequacy as it relates to 1)PPOs and 2)HMOs.

To encourage participation and in recognition of the sensitivity of the issue, states were assured their individual responses would be kept confidential. States that share managed care oversight with an agency other than the DOI were asked to submit responses from both agencies. Over a three month period, we received 38 surveys, including responses from the District of Columbia and Puerto Rico. Following is a summary of the survey results.

Survey Part One: General Approaches to Regulating Network Adequacy

Use of NAIC Model Act

States were asked whether they had adopted the NAIC Model Act, and if so, whether it was adopted in its entirety or modified. Of the 38 respondents, seven indicated that the NAIC Managed Care Plan Network Adequacy Model Act was adopted as written, while two indicated they had adopted portions of the Act, but with significant revisions. The remaining 29 respondents indicated they had not adopted the NAIC Model Act.

TABLE 1: STATE ADOPTION OF NAIC MODEL ACT

	Adopted Model Act	Adopted Model Act, with Significant Revisions	Have Not Adopted Model Act
Percentage of Respondents	18%	5%	76%

Use of Network Adequacy Complaint Codes

The inclusion in state DOI complaint tracking systems of complaint codes specifically related to network adequacy indicates to what extent regulators are able to identify complaints related to network adequacy or access to care. Because complaint data is an important enforcement mechanism for regulators, more detailed data will better equip states to monitor health plan compliance and identify potential problems in their earliest stages. Survey respondents were provided 10 specific complaint codes and asked to identify those that are included in their complaint tracking systems:

a. Inadequate Provider Network

b. Network Adequacy

c. Access to Care

d. Timely Access to Care

e. Inaccurate Provider Directory

f. Out-of-Network Claim Dispute/Resolution

g. Out-of-Network Services

h. Formulary Restrictions

i. Balance Billing

j. Other

Almost all respondents indicated that one or more of the listed complaint codes related to network adequacy or access to care are included in their current complaint tracking systems. Only one of the 38 respondents indicated they did not include any complaint codes related to network adequacy or access to care in their complaint tracking systems. On average, states include five of the 10 complaint codes listed above. Table 2 summarizes the percentage of states indicating they use a particular complaint code, or one with a very similar description, in their tracking systems.

TABLE 2: DOI USE OF NETWORK ADEQUACY COMPLAINT TRACKING CODES

Complaint Code Option	Adopted Model Act
a. Inadequate Provider Network	63%
b. Network Adequacy	34%
c. Access to Care	76%
d. Timely Access to Care	29%
e. Inaccurate Provider Directory	50%
f. Out-of-Network Claim Dispute/Resolution	47%
g. Out-of-Network Services	66%
h. Formulary Restrictions	21%
i. Balance Billing	34%
j. Other	42%

In addition to the codes listed in the table, respondents reported using the following additional "other" codes for tracking network adequacy or access to care complaints:

- Provider availability;
- Choice of primary care provider;
- Provider listing dispute;
- Pharmacy benefits (similar to formulary restrictions);
- Essential community providers;
- Appointment availability;
- Out-of-Network emergency care;
- Access to OB/GYN;
- Network denial/termination of provider;
- Claims reimbursement/balance billing issuers;
- Out-of-Network referral;
- Inadequate network rates;
- Primary care physician referral;
- Closed network/provider discrimination;
- Credentialing delay;
- Delayed authorization issue; and
- Access to fee schedule rates.

Biggest Challenges Faced in Oversight of Network Adequacy

Respondents were asked to rate the challenges they face in the regulation and oversight of network adequacy. Options included:

a. Maintaining adequate trained staff for network analysis activities

b. Obtaining complete and accurate network adequacy data files from health plans and conducting a thorough review at licensure

c. Monitoring and identifying network adequacy problems on an ongoing basis once the initial plan has been filed and approved

d. Ensuring health plan enrollees have sufficient information to understand the risks and potential costs associated with receiving out-of-network services

e. Lack of authority to exercise increased oversight and impose enforcement actions and penalties

f. Additional challenges encountered

Respondents were asked to rate these challenges on a scale of 1 to 5 (with 1 as the least significant and 5 as the most significant). Respondents were instructed to rate each challenge individually rather than rating them in relation to one another. Of the 38 responses, eight did not rate the challenges. Of the respondents that did rate these challenges, the highest rated challenge was "Ensuring health plan enrollees have sufficient information to understand the risks and potential costs of receiving out-of-network services." On average, the other regulatory and oversight activities related to network adequacy were scored equally challenging by respondents. See Table 3 for a summary of results.

TABLE 3: NETWORK ADEQUACY REGULATORY CHALLENGES

Challenge to Regulating Network Adequacy	Average rating (1 is least significant and 5 is most significant)
a. Maintaining adequate trained staffing levels for network analysis activities	3
b. Obtaining complete and accurate network adequacy data files from health plans and conducting a thorough review at licensure	3
c. Monitoring and identifying network adequacy problems on an ongoing basis once the initial plan has been filed and approved	3
d. Ensuring health plan enrollees have sufficient information to understand the risks and potential costs associated with receiving out-of-network services	4
e. Lack of authority to exercise increased oversight and impose enforcement actions and penalties	3

Other challenges identified by respondents include:

- Insufficient funding/resources
- Lack of providers and significant unwillingness of specialty providers to contract with insurers
- Issues of disclosure for nonparticipating facility-based providers

- Geographic challenges
- Educating consumers about the shift to EPOs
- Ensuring network adequacy throughout the year
- Different requirements and/or regulatory authority for HMOs vs PPOs
- Oversight bifurcated between different regulatory entities
- Confusion among health plans around provider contracts, including which providers they contract with, what services those providers perform and what networks those providers are a part of; additionally on the provider side, providers are unclear about which health plans they contract with and in which networks they are a participating provider.

Role of State Regulators in Ensuring Consumers Are Informed about the Impact of Seeing Out-of-Network Providers

The survey asked regulators to indicate whether they have any requirements for health plans to include notifications to members to ensure they are adequately informed of the circumstances in which a member may see an out-of-network provider and how to avoid doing so. The majority of respondents (61 percent) indicated they do have requirements, but the provisions vary. States report health plans must use one or more of the following documents for notification requirements:

- Evidence of coverage documents;
- Plan description;
- Health care contracts;
- Marketing documents;
- Policy forms and certificates of coverage;
- Member handbooks; and
- Separate disclosure notices related specifically to balance billing.

Transparency Requirements to Protect Consumers When Facility-Based Physicians Providing Care in an In-Network Hospital are Out-of-Network

Respondents were asked whether there were any "transparency" requirements in place designed to prohibit or limit circumstances when a facility-based physician (e.g., anesthesiologist, radiologist, ER physician) is unavailable to the patient, even when the facility is in the patient's network. Of the 37 responses, the states were almost evenly split with 51 percent reporting they have no transparency requirements and 49 percent that do.

TABLE 4: TRANSPARENCY REQUIREMENTS REGARDING SERVICES OF OUT-OF-NETWORK PROVIDERS

	Yes	No
Does your state have "transparency" requirements or network adequacy provisions in place to prohibit or limit circumstances when no facility-based physician is available, even though the hospital/facility is in the patient's network?	49%	51%

In the detailed information they provided, respondents report using a variety of strategies to ensure consumers are protected in these types of situations, including:

- Require health plans to provide benefits at in-network cost sharing levels for out-of-network facility-based providers or to hold consumers harmless for charges over and above the in-network rates
- Require health plans to comply with claims payment standards for determining payment amounts for non-network providers for HMO plans
- Require health plans to track and report to DOI the amount of out-of-network claims submitted for services provided at in-network facilities

- Require health plans and providers to participate in mandatory arbitration to negotiate and resolve out-of-network balance bills
- Require health plans to hold consumers harmless for any costs for out-of-network emergency services that exceed what the consumer would have paid to an in-network provider.

In addition, some states also require facilities to notify the health plan when a surgery is scheduled for which an in-network provider may not be available. Others reported that the burden is on the consumer who is required to contact the anesthesiologist, radiologist, pathologist, facility, clinic, or laboratory when scheduling appointments or elective procedures to determine whether the provider is in-network.

Reporting Requirements for Network Adequacy Oversight

Respondents were asked to rate the extent to which they believe a list of current requirements for regular reporting of the following health plan data are important, or would help in the oversight and monitoring of network adequacy if they were required. Respondents were asked to separately rate each provision on a scale of 1 to 5 (with 1 as the least significant and 5 as the most significant). Of the 38 respondents, six did not respond to the question. Of the remaining 32 responses, the three highest rated responses (e, f, g) indicate regulators highly value consumer complaint data as a mechanism for monitoring network adequacy. Complete results are included in the following table.

TABLE 5: IMPORTANCE OF HEALTH PLAN DATA REPORTING REQUIREMENTS

Importance of requirement for regular reporting of health plan data (either existing or hypothetical) for regulating network adequacy	Average rating (1 is least significant and 5 is most significant)
a. Aggregated data on number/percentage of out-of-network claims	3
b. Data on number/percentage of out-of-network claims by service area	3
c. Claims value of out-of-network claims	2
d. Reimbursement rate payments for in-network claims vs. out-of-network claims	2
e. Number of complaints filed with health plan regarding problems accessing care, receipt of care by out-of-network providers, or claims payment of out-of-network services	4
f. Number of complaints filed with health plan regarding inaccurate provider directory information	4
g. Number of complaints filed with health plan regarding restriction of provider access due to enrollment in a narrow network	4

Survey Part Two: Operational Processes Related to Regulatory Oversight of Network Adequacy

This section of the survey requested information on the processes regulators use to review and monitor network filings and other information used to evaluate compliance with network adequacy requirements. Because requirements frequently vary for HMO and PPO plans, respondents were instructed to provide separate responses for the two types of plans. Following are the results of these questions.

Health Plan Network Review

Respondents were asked to identify at which of the times provided below they review a health plan's network for compliance:

a. Upon application for licensure

b. When adding a new service area or expanding an existing area

c. Regularly scheduled periodic review (i.e., annually, semiannually, biennially, etc.)

d. When complaints or other market conduct oversight activities indicate a potential problem

e. Routinely required as part of a market conduct examination

f. When a health plan files a notice of significant change to their network

g. Other

Of the 38 survey respondents, five did not identify any circumstances under which they review HMO or PPO networks. Of the remaining 33, as expected, the responses in Table 6 indicate regulators are much more likely to review HMO networks than PPO networks both initially and as part of ongoing oversight activities. Consistent with other information provided by respondents, regulators typically rely on complaint data for both HMOs and PPOs to trigger a review of the network.

TABLE 6: CIRCUMSTANCES REQUIRING HEALTH PLAN NETWORK REVIEWS

Circumstance under which Department reviews health plan network	HMOs	PPOs
a. Upon application for licensure	85%	36%
b. When adding a new service area or expanding an existing area	73%	36%
c. Regularly scheduled periodic review	42%	36%
d. When complaints or other market conduct oversight activities indicate a potential problem	85%	67%
e. Routinely required as part of a market conduct examination	39%	27%
f. When a health plan files a notice of significant change to their network	70%	42%
g. Other	9%	6%

One state that reported "Other" noted that the DOI may initiate a review of an HMO's network based on complaints. However, for PPOs, the DOI's investigations are limited to transparency issues, communications provided to PPO members and how information is different from care received, or how the information was provided. The state does not have network adequacy requirements for PPOs.

GEO-Access Maps

In answering whether GEO-Access maps are required as part of the provider network filing, 45 percent of the 38 respondents indicated that GEO-Access maps or their equivalent are required of HMO plans, compared to 29 percent who have similar requirements for PPOs.

TABLE 7: HEALTH PLAN GEO-ACCESS MAPPING REQUIREMENTS

	Yes for HMOs	Yes for PPOs
Does your Department require plans to submit GEO-Access maps or equivalent as part of their provider network filing?	45%	29%

Use of Vendors in the Review and Analysis of Provider Network File Submissions.

Respondents were also asked whether their Department contracts with a vendor for the review and analysis of provider network file submissions. Of the 38 respondents, four (11 percent) reported they use vendors to review and analyze provider network file submissions for both HMO and PPO plans.

Initial Provider Network Review

Respondents were asked to identify the types of information reviewed as part of the initial provider network review process. A list of seven common types of data was included and are listed in Table 8 below. Of the 38 total survey respondents, 28 responded to the question. Consistent with other survey responses, regulators report that HMOs are more likely than PPOs to be subject to more extensive reviews in all categories listed.

TABLE 8: DATA REVIEWED DURING INITIAL NETWORK ADEQUACY REVIEW

Information reviewed as part of initial provider network review process	HMOs	PPOs
a. The entire filing is reviewed in detail and tested against GEO Access standards to determine full compliance	50%	36%
b. A sample of the network data files are reviewed in lieu of a full, comprehensive assessment of the network	11%	4%
c. The state accepts the health plan's attestation that the network filing complies with the Department's requirements	39%	29%
d. Department staff perform "secret shopper" calls to confirm providers are in the network and accepting new patients	11%	0%
e. Medical care referral patterns and hospital admission privileges are reviewed to ensure participating providers have admitting privileges at in-network facilities	11%	7%
f. Department staff verifies whether in-network hospitals contract with facility-based providers (i.e., radiologists, pathologists, anesthesiologists, emergency room physicians) who are in the health plan's network	21%	14%
g. Network providers are reviewed to determine whether the network includes access to centers of excellence for transplants, cancer, and other critical services	36%	29%

Ongoing Network Adequacy Oversight

To further evaluate regulatory approaches for ensuring network adequacy once a health plan's network has been filed and reviewed, respondents were asked to identify from a list of options which activities the Department uses to monitor network adequacy on an ongoing basis. Twenty-seven of the 38 survey respondents provided an answer. Survey responses indicate that most Departments monitor ongoing compliance with network adequacy requirements by evaluating trends or particular issues identified through complaint data. Again, consistent with previous information, regulators report that they commonly rely on complaint data to identify network adequacy issues in both HMO and PPO markets. Regulators also indicate they are slightly more likely to exercise more stringent oversight of narrow networks in PPO plans than in HMO plans, but even so, only three states use this tool to conduct additional oversight of PPOs.

TABLE 9: INFORMATION USED BY REGULATORS TO MONITOR ONGOING NETWORK ADEQUACY

Information used to monitor ongoing network adequacy	HMOs	PPOs
a. Department collects out-of-network data from health plans to identify the extent to which members use out-of-network services	15%	11%
b. Department exercises more stringent oversight and monitoring of "Narrow Networks" that offer a more restricted network in exchange for reduced premium rates	7%	11%
c. Department monitors health plan members' ER utilization as a possible indicator of an inadequate network	4%	4%
d. Department reviews health plan consumer satisfaction surveys to identify the extent to which enrollees report dissatisfaction with the network or access to care	19%	11%
e. Department performs random survey of providers to confirm providers are in network, accepting new patients, confirm appointment availability timeframes, or other relevant information	19%	19%
f. Department monitors complaints to identify trends or concerns that could indicate potential problems with network adequacy	85%	70%
g. Department requires health plans to report complaint information on volume of complaints related to network adequacy/access to care	30%	26%

Several states provided information describing additional monitoring activities they use, including:

- Health plans are required to become reaccredited with any service area expansion or material change in the provider network (HMOs).
- Some components of network adequacy are reviewed annually or semi-annually, including:
  - o Provider directory (both printed and web-based) updates to determine accuracy, and
  - o Data related to access and availability of appointments.
- Network adequacy is sometimes reviewed as part of market conduct exams.

Protecting Consumers from Out-of-Network Charges

To evaluate how consumers are protected from out-of-network charges or balance billing, we asked respondents to identify whether they have adopted certain regulatory requirements for either HMO or PPO plans. Thirty of the 38 respondents identified one or more provisions are applicable in their state.

The most commonly used strategy requires plans to pay for out-of-network emergency services in a way that protects enrollees from costs that would exceed the cost of care provided by an in-network facility. However it should be noted that some states interpreted this question differently than others. Several responded "Yes" to the question but pointed out that they require plans to pay out-of-network claims in a way that limits the percentage of an enrollee's co-insurance payment, but not the total amount of the coinsurance. For example, a 20 percent coinsurance on a $500 in-network claim is $100. If the service is out-of-network and the fee is $1,000, the consumer still must pay the 20 percent coinsurance on a $1,000 charge, or $200 instead of the $100 required for an in-network provider. Although not all states that responded affirmatively to this question provided clarification, based on other responses in the survey, it appears likely that this practice is common in other states.

TABLE 10: STATE REGULATION OF OUT-OF-NETWORK CHARGES

What strategies apply to protect consumers from out-of-network charges?	HMOs	PPOs
a. Plans are required to resolve/pay claims for out-of-network emergency services in a way that ensures enrollees' costs are no more than what they would be for in-network services	83%	60%
b. Plans are required to calculate claims payments for emergency out-of-network services based on specific criteria or a formula specified by statute or regulation	33%	30%
c. Plans are required to calculate claims payments for non-emergency out-of-network services based on specific criteria or a formula specified by statute or regulation	13%	17%
d. Health plans are required to comply with general criteria (such as usual, customary and reasonable) in the calculation of out-of-network claims payments	43%	47%
e. Consumers are entitled to an independent arbitration process for negotiating health plan payments for out-of-network services	7%	13%

Provider Directory Oversight

Respondents were asked to provide information about oversight mechanisms used to ensure accuracy of provider network directories. Respondents were asked to choose any that apply from the following list:

a. Printed network directories must be updated at least semi-annually

b. Printed network directories must be updated at least annually

c. On-line directories must be updated at least monthly

d. On-line directories must be updated at least quarterly

e. For health plans that offer tiered or narrow networks that include a subset of providers, directories must clearly identify which providers participate in the restricted/narrow network

f. If a consumer relies on inaccurate information in a directory and is balance billed as a result, the health plan is responsible for resolving the claim in a way that holds the patient harmless

Twenty-one respondents answered this question. Compared to other types of regulatory oversight identified in the survey, states appear to more consistently apply similar criteria for both HMOs and PPOs.

TABLE 11: NETWORK DIRECTORY REQUIREMENTS

Network directory requirements	HMOs	PPOs
a. Printed network directories must be updated at least semi-annually	14%	5%
b. Printed network directories must be updated at least annually	48%	38%
c. On-line directories must be updated at least monthly	29%	24%
d. On-line directories must be updated at least quarterly	14%	14%
e. For health plans that offer tiered or narrow networks that include a subset of providers, directories must clearly identify which providers participate in the restricted/narrow network	62%	62%
f. If a consumer relies on inaccurate information in a directory and is balance billed as a result, the health plan is responsible for resolving the claim in a way that holds the patient harmless	43%	43%

Network Adequacy Enforcement Actions

Respondents were asked to identify the average annual number of enforcement actions (e.g., fines, penalties, cease and desist, enrollment freeze, licensure revocation) taken in response to network adequacy violations. Five respondents did not answer this question. Responses of the remaining 33 respondents are provided in Table 10. On average, most respondents report the number of enforcement actions related to network adequacy is very low, with 88 percent of respondents indicating 0-1 enforcement actions are pursued on average each year for HMOs, and 73 percent indicating 0-1 enforcement actions are pursued on average each year for PPOs.

TABLE 12: AVERAGE NUMBER OF ENFORCEMENT ACTIONS TAKEN IN RESPONSE TO NETWORK ADEQUACY CONCERNS

Average annual number of enforcement actions related to network adequacy violations	HMOs	PPOs
a. 0-1	88%	73%
b. 2-3	3%	0%
c. 4-5	0%	0%
d. 5-10	0%	3%
e. 11 or more	3%	3%
f. Do not know	6%	6%

Network Adequacy Requirements for POS and/or EPO Plans

Given the increasing use of different types of network plans to keep premium costs low, respondents were asked to provide information about how network adequacy is regulated for Point of Service (POS) plans and/or EPOs.[32] Twenty-five states replied to the question. In the majority of states, both POS plans and EPOs are subject to some level of oversight, but the approach varies among states. POS plans are more likely to be subject to HMO than PPO standards for regulatory purposes, while EPOs are equally likely to be subject to either PPO or HMO standards, depending on the state. However, five states reported POS plans are not subject to any network adequacy requirements, and four states have no network adequacy requirements for EPOs. Of the states that reported "Other," two noted that EPOs are not allowed and one state noted that network adequacy requirements do not apply to POS plans or EPOs. One other state noted that all plans (HMOs, PPOs, EPOs, POS) are subject to the same network adequacy standards as outlined in the ACA market reforms.

TABLE 13: HOW STATES REGULATE POS AND EPO PLANS

Regulatory approach for POS and/or EPO benefit plans	Percentage indicating regulatory approach is taken
a. POS plans are not subject to network adequacy requirements	20%
b. EPOs are not subject to network adequacy requirements	16%
c. POS plans are subject to the same network adequacy requirements that apply to PPOs	56%*
d. POS plans are subject to the same network adequacy requirements that apply to HMOs	76%*
e. POS plans are subject to separate network adequacy requirements that are different than those applicable to HMOs or PPOs	4%
f. EPOs are subject to the same network adequacy requirements that apply to PPOs	44%
g. EPOs are subject to the same network adequacy requirements that apply to HMOs	44%
h. EPOs are subject to separate network adequacy requirements that are different than those applicable to HMOs or PPOs	4%
i. Other (please describe)	20%

*Some states responded that POS and EPO plans are subject to the same standards as both PPOs and HMOs, which results in responses that total more than 100%. Based on additional information provided by several states, requirements vary depending on whether the POS or EPO plan is offered by an HMO or a PPO. If offered by a PPO, the plan is subject to the PPO standards. If offered by an HMO, the plan is subject to the HMO standards.

Survey Highlights and Recommendations for Improving Network Adequacy Oversight

In addition to providing a better understanding of the tools states use – or don't use - to regulate network adequacy, the survey results identify opportunities for improved regulations and suggest revisions to include in the NAIC Model Act update to improve network adequacy oversight and consumer protections. While several recent studies provide a good overview of existing statutory or regulatory provisions adopted by states, this survey looks beyond the regulations to obtain regulators' perspectives on how the provisions work in "the real world," challenges they face in their efforts to oversee network adequacy, and ideas for improvements. Although not all states participated in the survey, the responses represent states of varying sizes, from all regions of the country, and with varying levels of network plan penetration rates. While the identities of the responding states are not being made publicly available in order to encourage states to provide honest, frank answers, the 73 percent response rate is a testament to the importance of this issue and the interest states have in contributing to the NAIC's efforts to improve the Model Act.

Key findings include:

- Most states have not adopted the NAIC Managed Care Plan Network Adequacy Model Act.
- States place a high value on consumer complaint data and commonly rely on complaint data as a tool for identifying potential problems and monitoring health plan compliance. However, the codes they use for identifying network adequacy complaints vary widely. Only three of the complaint code options provided in the survey are used by more than half of the surveyed states. As such, the ability to share information with neighboring states, where consumers may also seek care and file complaints regarding access problems, is limited. In addition, the more restrictive codes used by some states may fail to fully identify the types of problems consumers have and could limit the usefulness of the information.
- States identified several common challenges in their efforts to oversee network adequacy. While the challenge most commonly identified is ensuring health plan enrollees have sufficient information to understand the risks and potential costs associated with receiving out-of-network services, other objectives pose equal challenges for some states (maintaining adequate staffing levels, obtaining complete and accurate data files from health plans, monitoring and identifying network adequacy problems, lack of authority to exercise increased oversight and take enforcement action). Four states reported all five areas of oversight at the highest level of challenge; two other states identified four of the five areas at the highest level. These data seem to confirm that disparate approaches to regulation and the varying degrees to which states have access to common regulatory tools create inconsistencies in the protections available to consumers based in part on where they live.

- More than half of the states do not prohibit or limit a situation in which a member receives services from an out-of-network provider when being treated at an in-network hospital.
- While HMO and PPO benefit plans have distinct coverage provisions that justify some differences in regulatory oversight, states consistently exercise much more stringent oversight of HMO plans than PPO plans. For example, while 24 states require HMO plans to resolve or pay claims for out-of-network emergency services in a way that protects enrollees from balance billing, only 16 states impose similar requirements on PPO plans. Seven states indicated such protections do not exist for either PPO or HMO plans.
- Information included in regulators' review of network filings also varies significantly. Only 14 states review the entire filings for HMO plans and 10 do so for PPOs. States that do not perform comprehensive reviews miss important opportunities to identify problems up front, before they become a problem.

Recommendations

Based on these findings, as well as information provided in other relevant studies, we have included the following recommendations for updating the NAIC Model Act, as well as for consideration by states as they evaluate their own legal framework for overseeing network adequacy. Please note that these recommendations are limited to only those requirements that are within the jurisdiction and control of regulators and network plans. However, the problems of network adequacy and balance billing are not solely attributed to health plans but are shared by providers, including hospitals and other facilities and practitioners. Until collaboration among all parties occurs, regulators must rely on the enforcement and regulatory authority they have to ensure consumers receive the services they are entitled to under the terms of their insurance contracts and have the information they need to make informed decisions regarding the health plan they purchase and health care services they receive.

Expand Scope of Regulations to Include All Network Plans

To most effectively regulate network adequacy across all products currently available to consumers, the Model Act and state regulations should broadly apply to health benefit plans using any type of requirement or incentive for enrollees to choose certain providers over others (e.g., HMOs, EPOs, PPOs, POS, accountable care organizations), and any other new model of care delivery. The NAIC and DOIs should also establish a process for regularly reviewing existing standards and make necessary revisions to ensure they are applicable to new managed care models that evolve over time.

Quantify Reasonable Access Standards

To ensure a meaningful and transparent network adequacy "floor", network adequacy regulations should include meaningful quantitative provider-to-enrollee, travel time and distance, and appointment wait time standards as benchmarks for measuring network adequacy. Health plans should also be required to meet a minimum cultural appropriateness standard that ensures enrollees of different ethnic and cultural backgrounds have access to a diverse group of providers. The Model Act should incorporate flexibility to allow states to include standards that take into account their particular geographic factors, regional provider workforce shortages, and market conditions. While variations from state to state are necessary in the current environment, many states do not have even minimum standards, but instead allow health plans to self-define what they consider to be reasonable access. As a general rule, network access standards should ensure that all covered benefits can be provided through an in-network provider without an unreasonable delay and that health plans meet a standard for providing access to a culturally diverse network of providers. Limited exceptions may be included to address cases where sufficient numbers of certain types of health care providers are not available due to workforce shortages, the use of Centers of Excellence or similar types of arrangements for elective procedures, or to care for patients with particularly complex medical conditions. However, in such cases, provisions must also be included to ensure enrollees have access to non-network providers at no increased cost.

Ensure Consumer Choice between Broad, Narrow, or Ultra-Narrow Networks

A state regulatory agency should have discretion to determine whether consumers have adequate choice between broad, narrow, or ultra-narrow networks and, in areas where sufficient choice is not available, require a carrier to offer at least one plan with a broad network or an out-of-network benefit, unless the carrier can demonstrate good cause that such an option is not feasible. Furthermore, consumers must be provided with information that conveys, in a consumer-tested standardized way, the narrowness or broadness of a provider network at the point of shopping. The accuracy of these summary measures must be audited by the regulator.

Include Essential Community Providers

All plans should be required to include access to Essential Community Providers to increase consistency with ACA requirements, prevent adverse selection, and to support continuity of care for those new enrollees who already have an existing relationship with an ECP.

Expand Access Plan Filing Requirements to Improve Transparency

Carriers should be required to submit access plans to the regulating entity for prior approval and post approved plans on a public website for review by consumers. In addition to requirements in the current Model Act for access plans, the following components should also be added using a uniform format to ensure transparency and comparability among plans:

- Carrier's criteria for selecting network providers, including measures related to standards for quality of care and health outcomes;
- Carrier's protocol for maintaining, updating, and publicly posting its directory of participating providers specific to each network plan, including whether providers are accepting new patients, languages spoken in each provider office, and provider office hours and locations; and
- Carrier's method for publicly conveying breadth or narrowness of the provider network and the method of selecting network providers for each network plan. Information must be displayed in a standardized manner that allows consumers to compare provider networks across carriers and benefit plans.

These requirements may be adjusted to reflect any minimum standards the DOI has established related to each of these provisions.

Protect Consumers from Balance Billing

In all network plans, require carriers to include a provision in network provider contracts to protect consumers from balance billing under certain conditions, including for any services provided in a facility that is a network provider but uses out-of-network health care professionals to provide patient services. To accommodate exceptions for consumers who choose an out-of-network provider, health plan enrollees should be allowed an opportunity to authorize – in writing and in advance of receipt of services – that they have **knowingly chosen** to be treated by an out-of-network provider and have been informed of the potential costs of doing so.

In addition (or in lieu of for any state that fails to enact a prohibition against balance billing), require health plans and providers to participate in mandatory arbitration to reach agreement on a reasonable payment for out-of-network services. Under arbitration, consumers should be held harmless for any costs that exceed what they would have paid if the provider had been in-network.

Work with Other Agencies to Address Balance Billing

While we recognize that DOIs may not have the authority to regulate providers that do *not* have a contract with a health plan, we encourage DOIs to work with other state agencies that do regulate providers to put in place greater transparency and additional balance billing protections for consumers. In the event a DOI is unable to enact regulations protecting consumers from balance billing (see previous recommendation), if a health plan enrollee is balance billed for out-of-network services, a mandatory binding mediation process should be required to resolve bills that exceed a certain threshold. Mediation attendees should include the provider and a health plan representative. States should establish a reasonable threshold for consumers to request mediation when bills exceed a certain level. New York's new "surprise bills" law and Texas' mediation requirements can serve as a model for other states on this important concern.

Require Providers to Notify Health Plans when Leaving a Network for Any Reason

To ensure health plans have accurate information on the status of network providers, require health plans to include in all provider contracts a requirement that providers notify the plan and their patients when they are leaving a network for any reason. This may include but is not limited to a decision to retire or stop practicing medicine for other reasons, relocating to an area outside the health plan's service area, leaving a group practice that is included as a participant in the network, or withdrawing from a network for any other reason. Health plans should be required to update electronic provider directories at least monthly to reflect these and other changes in provider availability.

Ensure Continuity of Care

In situations where a carrier and a participating provider terminate their contract or the provider is assigned to a different cost-sharing tier, the carrier and provider should be required to provide continuing coverage for a covered person who is pregnant, terminally ill, or in the midst of an active course of treatment for a serious medical condition for 90 days, or until the course of treatment is completed, whichever is longer, under the same cost-sharing rules and provider negotiated rate that would apply if the contract or tier placement was still in force.

In addition, circumstances for special enrollment periods should be expanded to allow enrollees to switch health plans when any of the following triggering events occur:

- An individual's enrollment or non-enrollment in a plan is the result of a material error, inaccuracy, or misrepresentation in the provider directory, including but not limited to a provider being listed as a participating provider that is not part of the network or a provider incorrectly being listed as accepting new patients;
- A covered person's primary care provider becomes a non-participating provider during a plan year or policy year; or
- A covered person who is in the midst of a course of treatment for pregnancy or a serious medical condition loses access to their specialty care provider or facility because the provider becomes a non-participating provider or is moved to a higher cost-sharing tier during the plan or policy year.

Increase Transparency Requirements

DOIs should require that health plan provider directories be made publicly available and ensure that consumers can easily understand which provider directory applies to which network plan, if a carrier maintains more than one network. The provider directory should be available online to both enrollees and consumers shopping for coverage without requirements to log on or enter a password or a policy number and should include the following general information about the plan:

- The type of plan (e.g., HMO, PPO, EPO) and whether there is any coverage for services provided by out-of-network providers;
- The methodology used, if any, to determine the payment amount for out-of-network services;
- The breadth of the network, as defined by the commissioner or NAIC model (i.e., broad, narrow, or ultra-narrow);
- The standards or criteria for including or tiering a participating provider and the cost-sharing and out-of-pocket limit differentials that may result from using a non-participating provider or a provider in a tier other than the lowest cost-sharing tier; and
- The plan's protocol for using out-of-network providers with in-network cost sharing for situations where a suitable in-network provider is not available on a timely basis.

Health plans should also include transparency information in the Member handbook and on the health plan's public website in a location and format to be determined by the Insurance Commissioner.

Adopt Health Plan Reporting Requirements to Monitor Frequency of Out-of-Network Services

Regulators should adopt standard reporting requirements for all network plans to obtain data on out-of-network claims and more accurately measure network adequacy. For each service area in which the health plan operates, minimum data elements should include the number of out-of-network claims by type of provider, dollar value of total claims, average value per claim, total amount paid by the health plan, average amount paid per claim, total unpaid claim balances and average unpaid claim balance per claim. These data will allow regulators to identify types of providers and/or services that are most frequently the source of out-of-network claims, the adequacy of reimbursement amounts paid by health plans, and the potential financial impact on consumers if the provider balance-bills for the difference between the cost of the service and the amount paid by the health plan. Information should be publicly available on the DOI's website and the health plan's website.

Increase Utility of Complaint Data and Visibility of Complaint Process

Regulators should identify the most complete and useful set of complaint codes, learning from the wide variety of experience identified by the survey. In addition, regulators need to assess how many consumer problems actually make it into their complaint system. Unfortunately, many consumers don't realize they have a department of insurance and that the department can help resolve their insurance issues. The visibility of this process must be raised via marketing, mandatory notices on provider bills and health plan Explanations of Benefits, and other means. Further, this process must take into account complaint data received by other agencies such as the health insurance exchange, or consumer ombudsman program.

Monitor Reliance on Health Plan Accreditation as a Substitute for Confirming Compliance with Network Adequacy Standards

The NAIC and DOIs should monitor the practice of relying on health plan accreditation as an option for health plans to demonstrate compliance with network adequacy standards. While accreditation standards can play a meaningful role in states that have minimal network adequacy requirements or can supplement information DOIs rely on for confirming network adequacy, accreditation should not be viewed as a substitute for meaningful network adequacy and access to care standards. States that accept accreditation should clearly identify additional requirements for demonstrating network adequacy and should not rely solely on self-attestation by health plans

Recommendations for Amending the NAIC Managed Care Plan Network Adequacy Model Act

Based on the recommendations noted above, we have included suggestions for amending the Managed Care Plan Network Adequacy Model Act. Our suggested edits, as submitted to the NAIC's Network Adequacy Model Review Subgroup on July 3, are included in Appendix B. Revisions are provided in tracked change mode in order to assist the Subgroup in its development of proposed changes to the Model.

Finally, we want to reiterate our appreciation to the NAIC for its support of our survey project and development of this report. With continued concerns about the rising costs of health care, the use of provider networks will continue to be an important issue, and we are pleased to see the NAIC's commitment to updating the Model Act. We realize regulators are faced with many critical concerns and growing pressure from many fronts, and are grateful for the opportunity to participate in the development of new network adequacy regulations and solutions.

Appendix A: Insurance Department Survey of Network Adequacy Regulatory Requirements and Oversight.

Insurance Department Survey of Network Adequacy Regulatory Requirements and Oversight

May 28, 2014

Please Note That All Survey Responses Are Confidential.

State:_____ Survey Respondent Name:_____ Title:_____
Email Address:_____

Section A: Please answer each of the following questions as it applies to your Department's activities related to network adequacy regulatory oversight.

1. Has your state adopted the NAIC Managed Care Plan Network Adequacy Model Act (Model #74)?

a._____ Yes, we have adopted the NAIC Model Act as written, or with minor revisions.

b._____ Yes, we have adopted portions of the NAIC Model Act, but with significant revisions.

c._____ No, we have not adopted the NAIC Model Act.

d._____ Uncertain of our state's status.

2. Indicate which of the following complaint codes, or codes with very similar descriptions, are included in your complaint tracking system to enable the identification of complaints related to network adequacy or access to care:

a._____ Inadequate Provider Network

b._____ Network Adequacy

c._____ Access to Care

d._____ Timely Access to Care

e._____ Inaccurate Provider Directory

f._____ Out-of-Network Claim Dispute/Resolution

g._____ Out-of-Network Services

h._____ Formulary Restrictions

i._____ Balance Billing

j._____Other (Please describe) _____

3. On a scale of 1 to 5 (1 is the least significant, 5 is the most significant), how significant are the following challenges in the regulation and oversight of network adequacy?

a._____ Maintaining adequate trained staffing levels for network analysis activities

b._____ Obtaining complete and accurate network adequacy data files from health plans and conducting a thorough review at licensure

c._____ Monitoring and identifying network adequacy problems on an ongoing basis once the initial plan has been filed and approved

d._____ Ensuring health plan enrollees have sufficient information to understand the risks and potential costs associated with receiving out-of-network services

e._____ Lack of authority to exercise increased oversight and impose enforcement actions and penalties

f._____Please identify any additional challenges you have encountered: _____

_____

_____

4. Does your state have any required provisions/notifications in health plan member handbooks, disclosure document requirement for enrollment, or other documents distributed by health plans, that are designed to ensure consumers are adequately informed of the circumstances in which a member may see an out-of-network provider, and how to avoid doing so?

a._____ No

b._____ Yes; Please describe _____

_____

_____

5. Does your state have any "transparency" requirements or network adequacy provisions designed to prohibit or limit circumstances when no facility-based physician (i.e., anesthesiologist, pathologist, radiologist, ER physician, etc.) is available to a patient, even though the hospital/facility is in the patient's network? If so,please describe

_____

_____

_____

6. On a scale of 1 to 5 (1 is low, 5 is high), indicate the extent to which you believe your state's current requirement for regular reporting of the following health plan data is important (or you believe it would assist your Department in the oversight/monitoring of network adequacy, if it were required):

a._____ Aggregated data on number/percentage of out-of-network claims

b._____ Data on number/percentage of out-of-network claims by service area

c._____ Claims value of out-of-network claims

d._____ Reimbursement rate payments for in-network claims vs. out-of network claims

e._____ Number of complaints filed with health plan regarding problems accessing care, receipt of care by out-of-network providers, claims payment of out-of-network services

f._____ Number of complaints filed with health plan regarding inaccurate provider directory information

g._____ Number of complaints filed with health plan regarding restriction of provider access due to enrollment in a narrow network

Please identify any additional data or information that would be helpful:

_____

_____

_____

***Section B:* Please complete the table below by placing an X in the corresponding column to indicate the response is applicable to requirements for HMOs and PPOs. If the response is not applicable, leave the column blank. If you do not know the answer, please enter NR.**

	HMOs	PPOs
1. Under what circumstances does the Department review a health plan's network? (Check all that apply).		
a. Upon application for licensure		
b. When adding a new service area or expanding and existing area		
c. Regularly Scheduled Periodic Review (i.e., annually, semiannually, biennially, etc.)		
d. When complaints or other market conduct oversight activities indicate a potential problem		
e. Routinely required as part of a market conduct examination		
f. When a health plan files a notice of significant change to their network		
g. Other (describe)		
2. Does the Department require plans to submit GEO-Access maps or equivalent as part of their provider network filing? Check box if Yes.		
3. Does the Department contract with a vendor for the review and analysis of provider network file submissions? Check box if yes.		
4. Which of the following describes information that is reviewed <u>as part of the initial provider network review process</u>? Check all that apply.		
a. The entire filing is reviewed in detail and tested against GEO Access standards to determine full compliance		
b. A sample of the network data files are reviewed in lieu of a full, comprehensive assessment of the network		
c. The state accepts the health plan's attestation that the network filing complies with the Department's requirements		
d. Department staff perform "secret shopper" calls to confirm providers are in the network and accepting new patients		
e. Review medical care referral patterns and hospital admission privileges to ensure participating providers have admitting privileges at in-network facilities		
f. Verify whether in-network hospitals contract with facility-based providers (i.e., radiologists, pathologists, anesthesiologists, emergency room physicians) who are in the health plan's network		
g. Determine whether the network includes access to centers of excellence for transplants, cancer, and other critical services		
5. Which of the following describes activities the Department uses to monitor network adequacy on an ongoing basis once a health plan's network has been filed and approved?		
a. Department collects out-of-network data from health plans to identify the extent to which members use out-of-network services.		
b. Department exercises more stringent oversight and monitoring of "Narrow Networks" that offer a more restricted network in exchange for reduced premium rates		
c. Department monitors health plan members' ER utilization as a possible indicator of an inadequate network		
d. Department reviews health plan consumer satisfaction surveys to identify the extent to which enrollees report dissatisfaction with the network or access to care		
e. Department performs random survey of providers to confirm providers are in network, accepting new patients, confirm appointment availability timeframes, or other relevant information		

	HMOs	PPOs
f. Department monitors DOI complaints to identify trends or concerns that could indicate potential problems with network adequacy.		
g. Department requires health plans to report complaint information on volume of complaints related to network adequacy/access to care.		
Please describe any additional monitoring activities used:		
6. Which of the following are applicable in your state?		
a. Plans are required to resolve/pay claims for out-of-network emergency services in a way that ensures enrollees' costs are no more than what they would be for in-network services		
b. Plans are required to calculate claims payments for emergency out-of-network services based on specific criteria or a formula specified by statute or regulation		
c. Plans are required to calculate claims payments for non-emergency out-of-network services based on specific criteria or a formula specified by statute or regulation		
d. Health plans are required to comply with general criteria (such as usual, customary and reasonable) in the calculation of out-of-network claims payments		
e. Consumers are entitled to an independent arbitration process for negotiating health plan payments for out-of-network services		
Please describe any other requirements that apply to health plan payments for out-of-network services		
7. Which of the following applies to network directory requirements?		
a. Printed network directories must be updated at least semi-annually.		
b. Printed network directories must be updated at least annually.		
c. On-line directories must be updated at least monthly.		
d. On-line directories must be updated at least quarterly.		
e. For health plans that offer tiered or narrow networks that include a subset of providers, directories must clearly identify which providers participate in the restricted/narrow network.		
f. If a consumer relies on inaccurate information in a directory and is balance billed as a result, the health plan is responsible for resolving the claim in a way that holds the patient harmless.		
Please describe any additional requirements related to provider network directories:		
8. Within the past 5 years, what is the annual average number of enforcement actions (fines, penalties, cease and desist, enrollment freezes, licensure revocation, etc.) the Department has taken based on violations related to network adequacy?		
a. 0-1		
b. 2-3		
c. 4-5		
d. 5-10		
e. 11 or more		
f. Do not know		

	HMOs	PPOs
9. Please indicate below how your state address network adequacy requirements for Point of Service (POS) plans and/or Exclusive Provider Organizations (EPOs). Please check all that apply.		
a. POS plans are not subject to network adequacy requirements.		
b. EPOs are not subject to network adequacy requirements.		
c. POS plans are subject to the same network adequacy requirements that apply to Preferred Provider Organizations (PPOs).		
d. POS plans are subject to the same network adequacy requirements that apply to Health Maintenance Organizations (HMOs)		
e. POS plans are subject to separate network adequacy requirements that are different than those applicable to HMOs or PPOs.		
f. EPOs are subject to the same network adequacy requirements that apply to PPOs.		
g. EPOs are subject to the same network adequacy requirements that apply to HMOs.		
h. EPOs are subject to separate network adequacy requirements that are different than those applicable to HMOs or PPOs.		
i. Other (please describe)		

If your state has existing regulations and/or statutory provisions related to network adequacy requirements for managed care plans, please provide the appropriate citation/s below.

HMO Network Adequacy Statutory or Regulatory citation/s:

_____

_____

_____

PPO Network Adequacy Statutory or Regulatory citation/s:

_____

_____

_____

Thank you for your assistance! Please return the completed survey to: **dlongley@healthmanagement.com**. Questions may also be submitted to this address, or by calling Dianne Longley at 512-473-2626.

Appendix B: Proposed Modifications to the NAIC Managed Care Plan Network Adequacy Model Act

These recommended modifications were submitted by Consumer Representatives to the NAIC to the NAIC's Network Adequacy Model Review Subgroup on July 3, 2014.

~~MANAGED CARE~~ HEALTH BENEFIT PLAN NETWORK ~~ADEQUACY~~ ACCESS MODEL ACT

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the ~~Managed Care~~ Health Benefit Plan Network ~~Adequacy~~ Access Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in regulation form. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as regulations.

Section 2. Purpose

The purpose and intent of this Act are to establish standards for the creation and maintenance of networks by health carriers and to assure the transparency, adequacy, accessibility and quality of health care services offered under a ~~managed care~~ network plan by establishing requirements for written agreements between health carriers offering ~~managed care~~ network plans and participating providers regarding the standards, terms and provisions under which the participating provider will provide services to covered persons.

Drafting Note: In states that regulate prepaid health services, this model may be modified for application to contractual arrangements between prepaid limited health service organizations that provide a single or limited number of health care services and the providers that deliver services to covered persons ~~enrollees~~.

Section 3. Definitions

For purposes of this Act:

A. ~~"Closed plan" means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan.~~ "Balance billing" means the practice by a provider, who is not a participating provider in a covered person's health benefit plan network, of charging the covered person the difference between the provider's fee and the sum of the amount the covered person's health benefit plan pays and what the covered person is required to pay in applicable deductibles, co-payments, coinsurance or other cost-sharing amounts as required by the health benefit plan.

B. "Commissioner" means the insurance commissioner of this state.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

C. "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

D. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

E. "Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

F. "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

G. "Essential community provider" means providers that serve predominantly low-income, medically underserved individuals, including providers defined in section 340B(a)(4) of the Public Health Services Act and tax exempt entities that meet the requirements of that standard except that they do not receive funding under that section.

G. "Facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

H. "Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

I. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not corporate "persons."

J. "Health care provider" or "provider" means a health care professional or a facility.

K. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

L. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

M. "Health indemnity plan" means a health benefit plan that does not use a network arrangement to deliver health benefits or services.

N. "Intermediary" means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network.

O. ~~"Managed care plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.~~ "Network plan" means a health benefit plan issued by a health carrier under which the financing and delivery of health care services, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.

Drafting Note: The definition of "~~managed care~~ network plan" is intentionally broad in order to apply to health benefit plans using any type of requirement or incentive for enrollees to choose certain providers over others, such as HMOs, EPOs, PPOs, POS and including accountable care organizations (ACOs) and other new models of care delivery. ~~Some states may wish to limit the definition by regulation to exclude plans having broad-based provider networks that meet specified standards. The standards could include minimum network participation requirements (e.g., at least 90% of the providers in the service area participate in the plan) and maximum payment differentials (e.g., the providers in the plan accept a discount of no more than 5% below reasonable and customary charges). The purpose of the exclusion is to exempt health benefit plans that are primarily fee-for-service arrangements, that do not purport to manage the utilization of health care services, and that do not require the safeguards provided to consumers under this Act.~~

P. "Network" means the group of participating providers or preferred providers providing services to covered persons through a ~~managed care~~ network plan that either requires a covered person to use or creates incentives, including financial incentives, for a covered person to use participating providers managed, owned, under contract with or employed by the health carrier or a preferred provider organization.

Q. ~~"Open plan" means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.~~

R. "Participating provider" means a ~~provider~~ facility or health care professional who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

S. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

T. "Preferred provider" means a participating provider.

U. "Primary care professional" means a participating ~~health care professional~~ provider ~~designated by the health carrier to~~ who supervises, coordinates or provides initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

V. "Tiered provider network" means a network that identifies and groups participating providers into specific groups that reflect different provider reimbursement, require different cost-sharing by a covered person, or feature different provider access requirements, or any combination, thereof, apply as a means to manage cost, utilization, quality, or to otherwise incentivize covered person or provider behavior.

Section 4. Applicability and Scope

This Act applies to all health carriers that offer ~~managed care~~ network plans.

Drafting Note: States may wish to consider accreditation by a nationally recognized private accrediting entity, with established and maintained standards that are substantially similar to the standards required under this Act, as evidence of meeting some or all of this Act's requirements. Under such an approach, the accrediting entity should make available to the state its current standards to demonstrate that the entity's standards are comprehensive and meet or exceed the state's requirements. Accreditation should not rely exclusively on health plan self-attestation or a review of the carrier's policies and procedures and should include independent confirmation of network adequacy. Further, retrospective analyses of consumer complaint data should demonstrate that the accreditation standard results in adequate networks for covered persons. The private accrediting entity shall file or provide the state with documentation that a network plan has been accredited by the entity. A health carrier accredited by the private accrediting entity would then be deemed to have met the requirements of the relevant sections of this Act where comparable standards exist, except that accreditation should never exempt a health carrier from filing an access plan as required by Section 5. States should periodically review a health carrier's private certification and eligibility for deemed compliance. A health plan should be required to notify States upon loss of accreditation or a change in accreditation status to a lower level, at which time the State would initiate an immediate review of the health plan's network to determine whether the plan meets the State's network adequacy requirements.

Section 5. Network Adequacy

A. A health carrier providing a ~~managed care~~ network plan shall maintain a network that is sufficient in numbers and types of providers to assure that all covered benefits, including primary, specialty, institutional, and ancillary services to covered persons will be accessible without unreasonable travel or delay. In the case of emergency services, covered persons shall have access within a reasonable proximity of xx miles twenty-four (24) hours per day, seven (7) days per week. ~~Sufficiency shall be determined in accordance with the requirements of this section, and may be established by reference to any reasonable criteria used by the carrier, including but not limited to: provider covered person ratios by specialty; primary care provider covered person ratios; geographic accessibility; waiting times for appointments with participating providers; hours of operation; and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.~~

(1) For the purposes of this section, a carrier's network is sufficient if the carrier:

(a) Demonstrates that for primary care:

(i) The ratio of primary care providers to enrollees within the carrier's service area as a whole meets or exceeds the average ratio for the state for the prior plan year;

(ii) xx percent of covered persons within the service area are within xx miles of a sufficient number of primary care providers in an urban area and xx miles of a sufficient number of primary care providers in a rural area; and

(iii) Covered persons have access to an appointment with a primary care provider within xx days of requesting one.

(b) Demonstrates that for specialty care:

(i) Covered persons have access to an adequate range of specialists sufficient to deliver services covered under the policy or contract and located within xx miles in an urban area and within xx miles in a rural area.

(ii) Covered persons have access to any needed specialist necessary to deliver services covered under the policy or contract within xx days of referral or requesting of an appointment for non-urgent services.

(c) Demonstrates that for general hospital facilities with emergency care, each covered person in the network has access within xx minutes (or miles) in an urban area or xx minutes (or miles) in a rural area.

(d) Demonstrates that for essential community providers, at least the percent of essential community providers located in the plan's service area participate in the provider network as is required for qualified health plans in the state.

(e) Demonstrates that for other covered services, the network is sufficient to meet any other standards set by the commissioner.

Drafting Note: Quantitative regulatory standards should establish a floor of consumer protection to ensure adequate access to covered benefits, but we recognize that geography and local market conditions make it challenging to set a national standard that would be appropriate in every state. Therefore, each state should determine the appropriate quantitative standards. States may wish to look to the Medicare Advantage program, which establishes time and distance limits that vary based on five different types of geographic areas, as a model for establishing its standards.

(2) In any case where the health carrier has an insufficient number or type of participating provider with the training and experience necessary to provide a covered benefit within a reasonable proximity or timeframe, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, ~~or shall make other arrangements acceptable to the commissioner.~~

~~(2) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of covered persons. In determining whether a health carrier has complied with this provision, the commissioner shall give due consideration to the relative availability of health care providers in the service area under consideration.~~

(3) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, financial capability and legal authority of its providers to furnish all contracted benefits to covered persons.

B. If at the determination of the commissioner, there is not adequate choice between plans using broad and narrow or ultra-narrow networks in a service area, a health carrier offering a network plan in that area that provides coverage through a narrow or ultra-narrow network of participating providers, as defined by the commissioner, shall also offer at least one health benefit plan with a broad network of participating providers or an out-of-network benefit in that service area, unless the carrier can demonstrate good cause to the commissioner that such a plan is not feasible.

C. Beginning [insert effective date], a health carrier shall ~~file with~~ submit to the commissioner for approval prior to or at the time it files a newly offered network plan, in a manner and form defined by rule of the commissioner, an access plan meeting the requirements of this Act for each of the ~~managed care~~ network plans that the carrier offers in this state. ~~The health carrier may request the commissioner to deem sections of the access plan as proprietary or competitive information that shall not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information would cause the health carrier's competitors to obtain valuable business information.~~ The health carrier shall make the access plans, ~~absent proprietary information,~~ available on a publicly accessible website, ~~its business premises,~~ and shall provide them to any interested party upon request. The carrier shall prepare an access plan prior to offering a new ~~managed care~~ network ~~plan~~, and shall update an existing access plan within 15 business days of any ~~whenever it makes any~~ material change to an existing ~~managed care~~ network access plan. Each network access plan shall describe or contain at least the following:

Drafting Note: Different states will set different requirements for the access plan. This model requires a health carrier to ~~file~~ submit the plan with the insurance commissioner ~~but does not require the commissioner to take action on the plan~~ for prior approval. Some ~~states may want to require the commissioner's approval of access plans; other~~ states may prefer that a health carrier not file the access plan with the commissioner but ~~instead maintain the plan on file at the carrier's place of business and make it accessible to the commissioner and others specified by the commissioner~~ not require the commissioner to take action on the plan. Some states may also specify an agency other than the insurance department as the appropriate agency to receive or approve access plans.

(1) The health carrier's network, including how the use of telehealth or other technology may be used to meet network access standards;

(2) The health carrier's procedures for making and authorizing referrals within and outside its network, if applicable;

(3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in ~~managed care~~ network plans, including the use of evening and weekend hours for non-emergency care;

(4) The health carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(5) The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;

(6) The health carrier's method of informing covered persons of the plan's services and features, including but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

(7) The health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(8) The health carrier's process for enabling covered persons to change primary care professionals;

(9) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transferred to other providers in a timely manner; ~~and~~

(10) The health carrier's efforts to ensure the providers in its network report on and meet standards for quality of care and health outcomes.

(11) The health carrier's protocol for maintaining, updating and publicly posting its network directory of participating providers specific to each network plan, including whether accepting new patients, languages spoken, and office hours and locations;

(12) The health carrier's method for publicly conveying the overall breadth or narrowness of the provider network, along with the method used to select providers for the network, for each network plan; this public information should be sufficient to signal to consumers at a summary level how provider networks compare across health benefit plans; and

(13) Any other information required by the commissioner to determine compliance with the provisions of this Act.

Section 6. Requirements for Health Carriers and Participating Providers

A health carrier offering a ~~managed care~~ network plan shall satisfy all the requirements contained in this section.

A. A health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on services.

B. Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for covered persons. This requirement shall be met by including a provision substantially similar to the following:

"Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy."

C. Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, covered services to covered persons will continue through the period for which a premium has been paid to the health carrier on behalf of the covered person or until the covered person's discharge from an inpatient facility, whichever time is greater. Covered benefits to covered persons

confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary.

D. The contract provisions that satisfy the requirements of Subsections B and C shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and shall supersede any oral or written contrary agreement between a provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered services provisions required by Subsections B and C of this section.

E. In no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the health carrier.

F. (1) Health carrier selection standards for selecting or tiering of participating providers shall be developed for primary care professionals and each health care professional specialty. The standards shall be used uniformly in determining the selection or tiering of health care professionals by the health carrier, its intermediaries and any provider networks with which it contracts. The standards shall meet the requirements of [insert reference to state provisions equivalent to the Health Care Professional Credentialing Verification Model Act]. Selection or tiering criteria shall not be established in a manner:

(a) That would allow a health carrier to avoid high risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health services utilization;

(b) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health services utilization; or

(c) That does not take into account provider performance on quality metrics and patient outcomes.

(2) Paragraphs (1)(a), ~~and~~ (1)(b) and (1)(c) shall not be construed to prohibit a carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the carrier developed in compliance with this Act.

(3) The provisions of this Act do not require a health carrier, its intermediaries or the provider networks with which they contract, to employ specific providers or types of providers that may meet their selection criteria, or to contract with or retain more providers or types of providers than are necessary to maintain an adequate network.

Drafting Note: This subsection is intended to prevent health carriers from avoiding risk by excluding either of two types of providers: (1) those providers who are geographically located in areas that contain potentially high risk populations; or (2) those providers who actually treat or specialize in treating high risk populations, regardless of where the provider is located. Exclusion based on geographic location may discourage individuals from enrolling in the plan because they would be required to travel outside their neighborhood to obtain services. Exclusion based on the provider's specialty or on the type of patient contained in the provider's practice may discourage a person unwilling to change providers in the course of treatment from enrolling in the plan. For example, if a carrier were permitted to exclude physicians whose practices included many patients infected with HIV, the carrier could avoid enrolling these persons in its plan, since those persons would probably not want to change physicians in the course of treatment. This subsection does not prevent health carriers from requiring all providers that participate in the carrier's network to meet all the carrier's requirements for participation.

G. A health carrier shall make its ~~selection~~ standards for selecting or tiering participating providers available for review and approval by the commissioner.

Drafting Note: The disclosure of a health carrier's selection standards to providers and consumers is an important issue to be considered by states and could be addressed in this Act or in another law. The NAIC is considering developing such a model.

H. A health carrier shall ensure via contract with a facility that is a network provider that a covered person will not be subject to balance billing for services rendered in that facility by an out-of-network health care professional, unless the covered person authorizes in writing and in advance of receipt of services that he/she has chosen to be treated by an out-of-network health care professional and is aware of the additional costs applicable as a result of selecting an out-of-network provider.

I. A health carrier shall notify participating providers of the providers' responsibilities with respect to the health carrier's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state programs.

J. A health carrier shall not offer an inducement or a financial penalty under the ~~managed care~~ provider network ~~plan~~ contract to encourage a provider to provide less services or less costly services than are ~~than~~ medically necessary ~~services~~ to a covered person.

K. A health carrier shall not prohibit or discourage a participating provider from discussing treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance processes established by the carrier or a person contracting with the carrier.

L. A health carrier shall require a provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

M. (1) A health carrier shall post the current provider directory for each network plan online and must make a printed copy of the current provider directory available to a covered person or prospective covered person upon request. Provider directories must be updated at least monthly and must be offered in a manner to accommodate individuals with limited-English proficiency or disabilities.

(2) For each network plan, the associated provider directory must include in plain language, as clearly as possible, the following general information about the plan:

(a) The type of plan (i.e. HMO, PPO, EPO, etc.) and whether there is any coverage for services provided by out-of-network providers;

(b) The methodology used, if any, for determining the payment amount for out-of-network services;

(c) Detailed, consumer-oriented explanation of the risks and potential costs associated with receiving out-of-network services;

(d) The breadth of the network, as defined by the commissioner (i.e. broad, narrow, or ultra-narrow);

(e) The standards or criteria used for including or tiering a participating provider and the cost-sharing and out-of-pocket limit differentials that may result from using a non-participating provider or a provider in a tier other than the lowest cost-sharing tier;

(f) The health benefit plan's protocol for using out-of-network providers but with in-network cost-sharing for situations where a suitable in-network provider is not available on a timely basis; and

(g) Identification of any in-network facilities at which there are no contracts with a class of facility-based providers, specifying the particular provider class.

(3) For each health benefit plan, the associated provider directory must include the following information for each provider:

(a) The specialty area or areas for which the provider is licensed to practice and included in the network;

(b) Location and contact information;

(c) Any in-network institutional affiliations of the provider, such as hospitals where the provider has admitting privileges or provider groups with which a provider is a member;

(d) Whether the provider may be accessed without referral;

(e) If applicable, whether the provider is assigned to a specific tier, and if so, to which tier each participating provider is assigned;

(f) Education and board certification information;

(g) Whether the provider is currently accepting new patients;

(h) Any languages, other than English, spoken by the provider; and

(i) Accommodations made by the provider for persons with disabilities; and

(j) Provider quality of care information.

(4) If an issuer maintains more than one provider network, it should be clear to covered persons and prospective covered persons what provider directory applies to which network plan and covered persons or prospective covered persons may not be required to log on or enter a policy number in order to access the applicable provider directory.

N. A health carrier and participating provider shall provide at least sixty (60) days written notice to each other before terminating the contract without cause. The health carrier and participating provider shall make a good faith effort to provide written notice of a termination within fifteen (15) working days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. Where a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. Within five (5) working days of the date that the provider either gives or receives notice of termination, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier. In the case of a termination of a contract or assignment of a provider to a different cost-sharing tier, a health carrier and participating provider shall agree to provide continuing coverage for a covered person who is pregnant, terminally ill, or in the midst of an active course of treatment for a serious medical condition for 90 days or until the course of treatment is completed, whichever is longer, under the same cost-sharing rules that would apply if the contract or tier placement was still in force.

O. The rights and responsibilities under a contract between a health carrier and a participating provider shall not be assigned or delegated by the provider without the prior written consent of the health carrier.

Drafting Note: In order to assure continued provider participation, a state may wish to restrict the right of a health carrier to assign or delegate its contract with a provider without prior written notice to the provider.

P. A health carrier is responsible for ensuring that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions.

Q. A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from covered persons pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.

R. A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

S. A health carrier shall establish a mechanism by which the participating providers may determine in a timely manner whether or not a person is covered by the carrier.

T. A health carrier shall establish procedures for resolution of administrative, payment or other disputes between providers and the health carrier.

U. A contract between a health carrier and a provider shall not contain definitions or other provisions that conflict with the definitions or provisions contained in the ~~managed care~~ network plan or this Act.

Section 7. Special Enrollment Periods

A health carrier must provide special enrollment periods for the following triggering events:

(1) An individual's enrollment or non-enrollment in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in the provider directory, including but not limited to a provider being listed as a participating provider that is not part of the network or a provider incorrectly being listed as accepting new patients;

(2) A covered person's primary care provider becomes a non-participating provider during a plan year or policy year;

(3) A covered person who is in the midst of a course of treatment for pregnancy or a serious medical condition loses access to their specialty care provider or facility because the provider becomes a non-participating provider or is moved to a higher cost-sharing tier during the plan year or policy year.

Section 8. Intermediaries

A contract between a health carrier and an intermediary shall satisfy all the requirements contained in this section.

A. Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of Section 6.

B. A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.

C. A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.

D. A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from the health carrier.

E. If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons.

F. If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to covered persons at its principal place of business in the state and preserve them for [cite applicable statutory duration] in a manner that facilitates regulatory review.

G. An intermediary shall allow the commissioner access to the intermediary's books, records, financial information and any documentation of services provided to covered persons, as necessary to determine compliance with this Act.

H. A health carrier shall have the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services.

Section 9. Filing Requirements and State Administration

A. Beginning [insert effective date], a health carrier shall file with the commissioner sample contract forms proposed for use with its participating providers and intermediaries.

B. A health carrier shall submit material changes to a contract that would affect a provision required by this statute or implementing regulations to the commissioner for approval [cite period of time in the form approval statute] days prior to use. Changes in provider payment rates, coinsurance, copayments or deductibles, or other plan benefit modifications are not considered material changes for the purpose of this subsection, unless such changes may impact a covered person's access to covered services from a contracted provider in a timely manner.

C. If the commissioner takes no action within sixty (60) days after submission of a material change to a contract by a health carrier, the change is deemed approved.

D. The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon twenty (20) days prior written notice from the commissioner.

Section 10. Contracting

A. The execution of a contract by a health carrier shall not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable regulations.

B. All contracts shall be in writing and subject to review.

Drafting Note: Each state should add provisions that are consistent with that state's current regulatory requirements for the approval or disapproval of health carrier contracts, documents or actions. For example, a state may want to add a provision requiring a health carrier to obtain prior approval of contracts, or requiring a health carrier to file a contract before using it, or requiring a health carrier to certify that all its contracts comply with this Act.

C. All contracts shall comply with applicable requirements of the law and applicable regulations.

Section 11. Enforcement

A. If the commissioner determines that a health carrier has not contracted with a sufficient number of ~~enough~~ participating providers to assure that covered persons have accessible health care services in a geographic area, or that a health carrier's network access plan does not assure reasonable access to covered benefits, or that a health carrier has entered into a contract that does not comply with this Act, or that a health carrier has not complied with a provision of this Act, the commissioner shall institute a corrective action that shall be followed by the health carrier, or may use any of the commissioner's other enforcement powers to obtain the health carrier's compliance with this Act.

Drafting Note: In addition to the prior approval of network access plans, the commissioner should use other tools at his/her disposal to ensure ongoing compliance with the Act's requirements, including but not limited to data collection on use of out-of-network services, consumer surveys, unscheduled audits, secret shopper surveys, and/or tracking of consumer complaints. In addition, data collection on the following elements directly from network plans would be useful: number of complaints filed regarding problems accessing care, receipt of care by out-of-network providers, claims payment of out-of-network providers; number of complaints regarding inaccurate provider directory information; number of complaints filed regarding restriction of provider access due to enrollment in a narrow framework

B. The commissioner will not act to arbitrate, mediate or settle disputes regarding a decision not to include a provider in a ~~managed care~~ network plan or in a provider network or regarding any other dispute between a health carrier, its intermediaries or a provider network arising under or by reason of a provider contract or its termination, unless such action violates a requirement of this Act.

Section 12. Regulations

The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 13. Penalties

A violation of this Act shall [insert appropriate administrative penalty from state law].

Section 14. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 15. Effective Date

This Act shall be effective [insert date].

A. All provider and intermediary contracts in effect on [insert effective date] shall comply with this Act no later than eighteen (18) months after [insert effective date]. The commissioner may extend the eighteen (18) months for an additional period not to exceed six (6) months if the health carrier demonstrates good cause for an extension.

B. A new provider or intermediary contract that is issued or put in force on or after [insert a date that is six (6) months after the effective date of this Act] shall comply with this Act.

C. A provider contract or intermediary contract not described in Subsection A or Subsection B shall comply with this Act no later than eighteen (18) months after [insert effective date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1996 Proc. 2nd Quarter 10, 30, 732, 767, 770-777 (adopted).

Appendix C: Definition of Terms

The following terms are used frequently throughout this report. These definitions are provided to help the reader understand the distinctions between the various types of health plans that use networks of providers. The definitions are from the Glossary of Insurance Terms available at: ***https://www.healthcare.gov/glossary/***.

Exclusive Provider Organization (EPO)

A managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network (except in an emergency).

Health Maintenance Organization (HMO)

A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Point of Service Plan (POS)

A type of plan in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans also require you to get a referral from your primary care doctor in order to see a specialist.

Preferred Provider Organization (PPO)

A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Notes

[1] Note, the scope of this report is limited to the inclusion of health care providers, including pharmacists, in health plans' networks; the inclusion or exclusion of specific pharmaceuticals in health plan formularies is beyond its scope.

[2] Testimony of Monica J. Lindeen, Montana Commissioner of Securities and Insurance Before the House Energy and Commerce Subcommittee on Health, June 12, 2014; available at:

[3] See Appendix C for definition of terms.

[4] "Report of the Health Network Adequacy Advisory Committee," Texas Department of Insurance, January 2009. Available at: http://www.tdi.texas.gov/reports/life/documents/hlthnetwork09.doc

[5] Both Medicaid and Medicare managed care plans are also subject to network adequacy requirements, but are not included in this report due to the additional complexities and unique program requirements of these benefit programs.

[6] See Appendix C for definitions of terms.

[7] See http://www.tdi.texas.gov/reports/life/documents/hlthnetwork09.doc http://www.tdi.texas.gov/reports/life/documents/hlthnetwork409b.doc for two reports prepared by the Texas Department of Insurance (TDI) to better inform Texas Legislature as it discussed network adequacy as it relates to facility-based providers and out-of-network balance billing. TDI issued an initial report based on preliminary data submitted voluntarily by a small number of health plans, and a subsequent report that included the results of a statewide data call. Also see http://www.governor.ny.gov/assets/documents/DFS%20Report.pdf for a report on balance billing and network adequacy problems identified by the New York Department of Financial Services.

[8] See Surprise Medical Bills Take Advantage of Texans by Stacey Pogue, Center for Public Policy Priorities, found at http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf and http://www.nytimes.com/2014/09/29/us/costs-can-go-up-fast-when-er-is-in-network-but-the-doctors-are-not.html?emc=edit_tnt_20140928&nlid=58462464&tntemail0=y&utm_campaign=KHN%3A+Daily+Health+Policy+Report&utm_source=hs_email&utm_medium=email&utm_content=14297537&_hsenc=p2ANqtz--LsZED-GqhN_mP3Jl34plPaW3jypRREnEnXW7N72CJctYD8F9NlvWI__QMmm8Vf9NKz6yEauOXRSSjoVssGw4Rxq8Ls_KmDHFFI7jXMCn0qc6q6Hg&_hsmi=14297537&_r=1

[9] Corlette S, Lucia K, Ahn S, Implementation of the Affordable Care Act: Six-State Case Study on Network Adequacy, the Urban Institute, Sep. 2014. Available from http://www.rwjf.org/content/dam/farm/reports/reports/2014/rwjf415649.

[10] http://capsules.kaiserhealthnews.org/index.php/2014/09/consumer-groups-sue-2-more-calif-plans-over-narrow-networks/ and http://www.latimes.com/business/la-fi-0928-obamacare-doctors-20140928-story.html?utm_campaign=KHN%3A+Daily+Health+Policy+Report&utm_source=hs_email&utm_medium=email&utm_content=14297537&_hsenc=p2ANqtz-8LXMMPVLWAFREzBxZUUEAN--Ok2tIogb2nzi5xtQ6lapLnFnEdcpkDQoRO8bo6qH2l9FqibK_PZLBBsQzOlAmZn0Cnt7Jli5MncGhYTJ1kjp-46xc&_hsmi=14297537#page=1

[11] "State network regulation dispute portends national challenges," Healthcare Payer News, April 24, 2014. Available at: http://www.healthcarepayernews.com/content/state-network-regulation-dispute-portends-national-challenges

[12] http://www.kaiserhealthnews.org/stories/2013/november/25/states-balk-at-narrow-networks.aspx

[13] http://www.concordmonitor.com/news/12412914-95/qa-what-changes-are-coming-to-the-new-hampshire-insurance-marketplace-in-2015. Additional information on changes included in the new rule is available at: http://www.nh.gov/insurance/legal/documents/na_presentation_07.24.14.pdf

[14] Stacey Pogue, "Surprise Medical Bills Take Advantage of Texans: Little-known practice creates a "second emergency" for ER patients," Center for Public Policy Priorities, September 15, 2014. Available at: http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf

[15] "An Unwelcome Surprise: How New Yorkers are Getting Stuck with Unexpected Medical Bills from Out-of-Network Providers," New York State Department of Financial Services. Available at: http://www.governor.ny.gov/assets/documents/DFS%20Report.pdf

[16] Note that this report only addresses network adequacy requirements in the commercial market and does not include separate requirements applicable to Medicaid managed care plans.

[17] http://www.naic.org/documents/index_health_reform_comments_140423_naic_letter_cciio_network_adequacy.pdf

[18] "FAQs about Affordable Care Act Implementation (Part XXI)." October 10, 2014. Accessed online at: http://www.dol.gov/ebsa/faqs/faq-aca21.html

[19] Section 2702(c) of the Public Health Service Act allows plans using provider networks to limit their enrollment to individuals who live, work, or reside within their service areas. In addition, plans may close enrollment to additional members demonstrate they are applying their capacity measures uniformly and not selectively, and can demonstrate they do not have the capacity to serve additional enrollees.

[20] http://www.dol.gov/ebsa/faqs/faq-aca21.html

[21] 45 CFR Parts 155,156,157, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers". Department of Health and Human Services.

[22] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Exchange Standards for Employers (CMS-0090-FWP) and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (CMS-9975-P), Regulatory Impact Analysis; Center for Consumer Information and Insurance Oversight. March, 2012. Available at: http://cciio.cms.gov/resources/files/Files2/03162012/hie3r-ria-032012.pdf

[23] In the preamble Section II A(1)(b) related to definitions, HHS states that several commenters suggested HHS define "limited English proficient." HHS reports they plan to issue future guidance that will include best practices and advice related to meaningful access standards for limited English proficient individuals.

[24] U.S. Department of Health and Human Services, Health Resources and Services Administration, "Introduction to 340B Drug Pricing Program". Available online at: http://www.hrsa.gov/opa/introduction.htm

[25] "Essential Community Providers – Health Reform GPS: Navigating Implementation," George Washington University's Hirsch Health Law and Policy Program and the Robert Wood Johnson Foundation.

[26] See updated reference to state compliance activities at: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/compliance.html

[27] http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf

[28] "Managed Care Plan Network Adequacy Model Act," National Association of Insurance Commissioners, Model Regulation Service – October 1996. 1996 Proceedings of the NAIC, 2nd Quarter, 770-777.

[29] The drafting note points out that this provision is designed to prohibit plans from creating a network that avoids risk by excluding providers who are located in areas that contain high-risk populations or providers who have a history of treating high-risk populations, such as individuals with HIV.

[30] The drafting note states this requirement is an important issue for states and could be enacted in another law.

[31] Drafting note suggests the states may want to consider a similar restriction against health carriers to ensure continued provider participation.

[32] Please see Appendix C for additional information on Point of Service plans.

Around the Network

Promising Practices:

OE2 Outreach and Enrollment

Issue 9
November 2014

Building off of lessons learned during the first open enrollment period (OE1), states are now in the early stages of the second open enrollment period (OE2), which began November 15, 2014. Their planning and preparation efforts included trying to enhance consumer education and outreach methods to reach the uninsured, increasing IT system and call center capacity, and introducing new tools to make it easier to shop for insurance online. In this month's *Around the Network: Promising Practices*, we present information on some states' plans to improve consumer outreach and enrollment during OE2 based on information gathered during NASHP's State Health Policy Conference held in October and several recent Exchangers calls.

Call Centers

Several states are planning to increase call center capacity to meet anticipated volume or to take on additional duties:

- **Kentucky** is increasing their call center capacity to lower the consumer call-in abandonment rate, which was 40 percent during OE1. The exchange has 400 representatives for OE2, with 300 on average at any given point taking calls.
- The **Federally facilitated marketplace (FFM)** call center for non-SBM states is also increasing its capacity from 13,000 agents during OE1 to 14,000 agents. Agents have increased availability during evening and weekend hours as well as on Thanksgiving and Christmas. The FFM call center is also increasing training, including in specific areas such as enrollment for immigrant populations and renewals.
- In OE1, **Illinois'** "Helpdesk" (call center) took only inbound calls. With additional data about consumers available to the Helpdesk this year, the state plans to make outbound calls, as well.
- **The District of Columbia, Connecticut,** and the **FFM** are planning for increased call center volume during 'tax season,' from February to April. Although outside the scope of call center agent responsibilities, the FFM and CT are training their agents to answer basic tax filing questions. In addition, the FFM is planning to make agents available during March and April to accommodate call volume regarding issues such as alignment of health insurance advanced premium tax credits (APTC) with tax filing documents. A continuation from OE1, DC plans to place assisters in various tax sites across the District and enable call center agents to connect consumers to tax filing services.

Agents, Navigators, and Assisters

States are also planning to make changes to assister programs, as well as continue to work with agents:

- In **Illinois**, unlike last year, the exchange requires full-time outreach and enrollment navigator staff. This decision was made based on efficacy of full-time staff compared to part-time staff. The state also identified a need for navigators to fill gaps, especially around key deadlines. IL has a roaming navigator team that goes where the need is greatest. To ensure navigator accountability, Illinois' marketplace, Get Covered Illinois, is implementing an enhanced scheduling system that enables the marketplace to know when navigators are available, whom they are reaching, and how they are reaching consumers. IL will also continue to hold navigator

webinars that showcase data on which groups have the highest enrollment numbers. This strategy served as a positive motivator among assisters during OE1.
- **Kentucky** formed an agent/navigator subcommittee that meets once a month to work through issues, form a partnership between the agent and navigator communities, and incorporate their advice into marketplace changes.

Outreach Strategies that Target the Uninsured

States are planning to employ new strategies and target new areas to reach the remaining uninsured:

- **Delaware** is placing consumer "ballot boxes" throughout the state in locations such as hospitals, schools, and churches. Consumers can leave cards in these boxes with limited identifiable information, and an assister will contact each consumer to help them enroll or learn about coverage options.
- **Illinois** plans to expand outreach to uninsured populations through text message alerts to better reach those that do not have smart phones**.**
- **The District of Columbia** is strategically placing its bus and metro ads on routes that travel through neighborhoods that have high rates of uninsured individuals.

System Enhancements and Web Tools

States are also making improvements to IT systems, both to enhance functionality with consumer web tools and to ensure that IT systems operate smoothly during OE2.

- **Kentucky** is working on improving its SHOP functionality. In the past, agents and brokers were unhappy with this functionality because there was no easy rate quoting tool. For OE2, agents do not have to log-in or create an account to browse plans and get a quote. They are able to get a quote for up to five groups at a time.
- **Kentucky** is also increasing its server capacity and IT system capabilities. In OE1, the state's QHP browse feature did not take APTC into consideration. Now, in OE2, the QHP browse tool allows consumers to view calculated premiums after APTC is applied, if consumers enter their income.
- **Kansas** is continuing its consumer assistance website, which includes a 2015 tax credit calculator.
- **Kentucky's** Kynect app is able to locate an agent or kynector in an individual's county. The 2.0 version of the app will include a feature that allows consumers to browse plans and take photos of requested documentation and submit them via the app itself. It is particularly targeted to the young invincible population.
- **Colorado** is employing decision support tools, like an avatar named "Kyla," to help consumers shop for and purchase a plan on its exchange website.

Around the Network: Promising Practices is intended for distribution through Exchangers to state officials and exchange staff only. If you have questions or ideas for future topics, please e-mail tkramer@nashp.org.

Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

Resolving Enrollment Conflicts as States Expand Medicaid

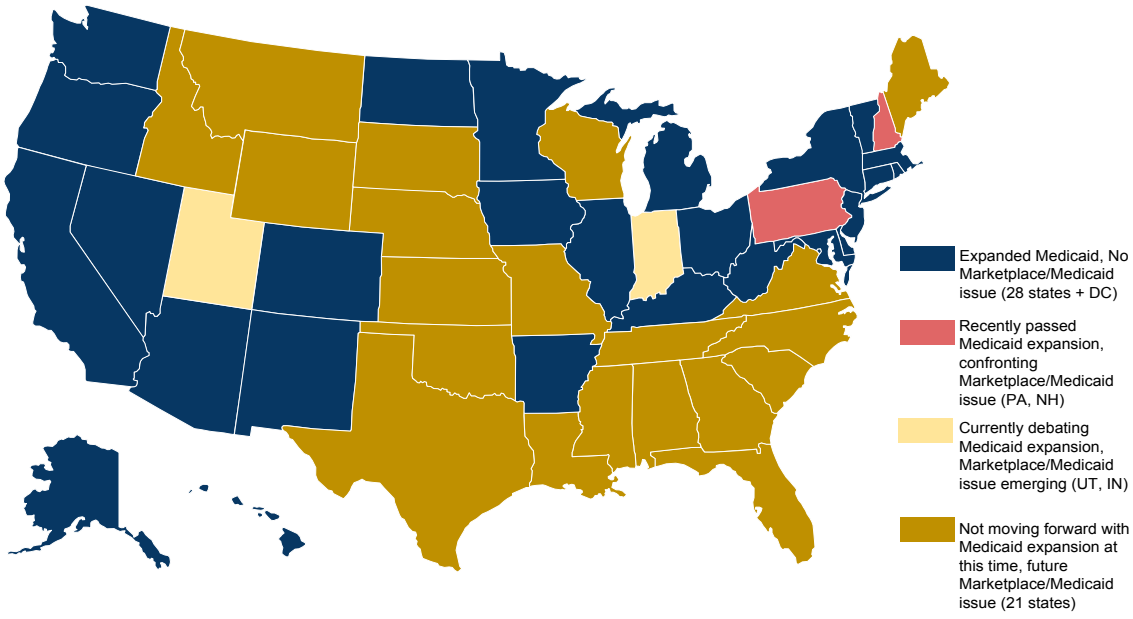
by Adam Searing

Federal approval[1] of Pennsylvania's new plan to expand Medicaid coverage under the Affordable Care Act (ACA) on January 1, 2015 has brought urgency to an obscure but important issue. States that expand Medicaid after the initial start of the ACA's coverage expansions on January 1, 2014 face a special problem regarding newly eligible adults with incomes between 100 percent and 138 percent of the federal poverty level (FPL).

Many people in this narrow income range in non-expansion states have enrolled in private health plans with significant subsidies through the state and federal health insurance marketplaces. Why? The ACA provides tax credits to lower the cost of purchasing a marketplace qualified health plan for people with income between 100 percent and 400 percent FPL. But financial assistance is only available to people who lack access to other coverage that meets minimum standards in the

States enacting delayed Medicaid expansions under the Affordable Care Act face transition issues with newly eligible low-income residents already in current health care marketplace plans

States Facing Marketplace/Medicaid Enrollment Issue



As states such as Pennsylvania, Utah and others move toward actual or potential Medicaid expansions these are the key issues for the group of marketplace-insured newly Medicaid eligible adults.

ACA, including Medicaid or affordable employer based coverage.[2]

In contrast, in states that expanded Medicaid under the ACA as of January 1, 2014, this problem did not exist since newly eligible adults with income under 138 percent FPL would have been enrolled in Medicaid and not offered financial assistance to purchase marketplace coverage.

Therefore, in states like Pennsylvania that did not initially expand Medicaid under the ACA, a significant number of people with incomes between 100 percent and 138 percent of the FPL are currently enrolled in subsidized marketplace plans. Once a state expands Medicaid, this group of people must be transitioned to their state's Medicaid program since they are no longer eligible to receive financial assistance through the marketplace. This problem was never contemplated under the ACA since the law did not anticipate that the United States Supreme Court would effectively give states the option of declining to expand Medicaid coverage.

As Pennsylvania plans for the launch of its Medicaid expansion on January 1, 2015, and Utah and other states continue to weigh their options to expand Medicaid, there are key transition issues that may affect this group of marketplace-insured newly Medicaid eligible adults:

1.No immediate loss of coverage. In general, the ACA does not allow individuals to continue to receive financial assistance to purchase private health plans through the federal or state health marketplaces if they become eligible to enroll in their state's Medicaid program.[3] Therefore, adults who are newly eligible for Medicaid must enroll, or obtain other coverage, if they want to meet the mandate for health coverage. However, the law is not as cut and dried as it appears. Recognizing the ACA's goal of continuity of health care coverage, newly enacted federal rules regarding marketplace renewals allow flexibility for most individuals receiving tax subsidized health plans through the state or federal health marketplaces to continue that coverage.[4] If a state's expansion of Medicaid coincides with open enrollment, the option to be auto-renewed will impact current enrollees who are newly eligible for Medicaid. Specifically, under this guidance from the Centers for Medicare and Medicaid Services (CMS),[5] most adults receiving tax credits in the marketplaces (including adults with incomes between 100 percent and 138 percent FPL) who do not contact the state or federal marketplace will simply continue their current health plan coverage and 2014 level of financial assistance. Only people who did not authorize the marketplace to check their latest tax data or those whose tax data indicates their income is greater than 500 percent FPL are required to contact the marketplace to determine if they remain subsidy eligible. All enrollees are being encouraged to contact the marketplace to update their eligibility based on their projected income for 2015. Those who do will have their eligibility evaluated for Medicaid.

2.We know the people to contact. The federal marketplace (which operates in the majority of non-expansion states) will provide to states implementing the Medicaid expansion the contact information of enrollees with incomes between 100 percent and 138 percent FPL.

3.No state outreach requirement. There is no specific federal requirement for states to directly contact current marketplace enrollees in this income category to notify them of their new eligibility for Medicaid.

4.Michigan experience. After Michigan expanded Medicaid on April 1, 2014, the state sent letters informing potentially eligible adults who submitted an application through the federal marketplace of the likelihood that they would now qualify for Medicaid. These individuals were then asked to complete a new application for

The federal or state marketplace should revaluate the Medicaid coverage option for people where, because of marketplace plan enrollment, the marketplace already has existing income, family size and contact information.

the Healthy Michigan Plan. Michigan's expansion was planned early enough in 2014 that the state was able to train navigators to inform marketplace applicants that they would have to cancel their marketplace plans after they received confirmation of their Medicaid enrollment.

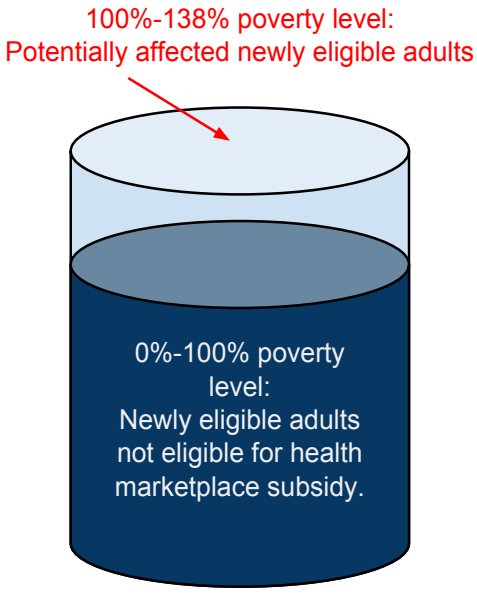
5.New Hampshire experience. After state policymakers expanded Medicaid on August 15, 2014, the federal government and New Hampshire's Department of Health and Human Services worked together to draft a letter[6] and accompanying guidance[7] that notified marketplace enrollees in the 100 percent to 138 percent FPL income range of the need to switch to Medicaid. It was made clear that enrollees could either apply immediately to Medicaid or – if they didn't apply to Medicaid – they would keep their marketplace tax-subsidized coverage through the end of 2014 without any penalty. However, the state indicated there could be potential tax complications for people now eligible for Medicaid who stayed in marketplace plans in 2015. Without additional outreach to remind any residual marketplace enrollees of their likely eligibility for Medicaid, enrollees who do not update their applications may be auto-renewed based on the current renewal process. To what extent these enrollees will be at risk for payback of tax credits received into 2015 remains to be seen.

Federal/State marketplace solution?

Overall this should be a fairly simple problem to fix. A list of newly eligible adults with incomes between 100 percent and 138 percent FPL who enrolled in marketplace health plans can be created so contacting them to get them to switch into Medicaid would seem straightforward. But should the marketplace do more than simply provide a list to states for outreach purposes? There are opportunities to streamline the process but the best way to coordinate coverage may differ if a state's Medicaid expansion coincides with open enrollment when people are more apt to return to the marketplace to update their eligibility.

If a current enrollee with income between 100 percent and 138 percent FPL contacts the marketplace during open enrollment to update their eligibility, they will be automatically evaluated for Medicaid eligibility in an expansion state based on their projected income for the upcoming year. To provide extra encouragement to current enrollees who fall into the expanded Medicaid income range, the federal marketplace could develop specific income-based outreach notices at renewal similar to the process that it uses to for enrollees that fit other specific circumstances. While the current regulations allow for auto-renewal, the federal government could change the rules to require enrollees with income between 100 percent and 138 percent FPL in an expansion state to contact the marketplace to retain financial assistance as it does for enrollees who latest tax data indicates their income is over 500 percent FPL.

Outside open enrollment, one option would be for



the marketplace to send electronic accounts for this group of current enrollees to the state to review their eligibility for Medicaid based on current income. This would take advantage of the current process for coordinating coverage between Medicaid and the marketplace for new applicants, or when current enrollees report a change or renew their eligibility, if they are assessed as Medicaid eligible.

Any steps that states and the marketplaces can take to streamline the process will help assure the success of transitioning newly eligible individuals to Medicaid. In addition to adopting streamlined procedures, clear communications with current enrollees are key to a successful transition. All letters and other forms of communication should be clearly express the likelihood of Medicaid eligibility and explicitly detail what actions the consumer must take. Follow-up reminders by mail, email, and/or phone will increase the probability that enrollees will take any necessary steps to initiate their Medicaid eligibility.

State outreach?

States expanding Medicaid may not see it as their responsibility to contact this group and may ask the federal government to do this outreach directly – a task that so far the federal government has indicated it lacks the resources to accommodate. Even though states do not have to pay any of the cost for newly eligible Medicaid enrollees through 2016 and a minimal cost thereafter, they may resist conducting additional outreach to boost Medicaid enrollment. Nonetheless, it is only fair that consumers be well informed of their options, particularly when they could be at risk for paying back premium tax credits if they take no action and are automatically renewed for coverage in the marketplace.

Despite the jurisdictional and political barriers, it is important that outreach and enrollment of the Medicaid expansion population take place to ensure no one is left out of health coverage, particularly in states that have delayed expanding Medicaid. New Hampshire and Michigan have some early experience at working together with the federal government to ensure no newly eligible adults lose health coverage at a time when a state is expanding Medicaid. These cooperative, good faith efforts should provide lessons learned and inform best practices as other states move forward to expand coverage.

Endnotes

1. Press release: "CMS Statement on Approval of Medicaid Expansion in Pennsylvania," Centers for Medicare and Medicaid Services, 8/28/2014. See: http://www.cms.gov/Newsroom/MediaRelease-Database/Press-releases/2014-Press-releases-items/2014-08-28.html

2. An overview of this issue is provided at HealthCare.gov. See: https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/

3. Eligibility for premium tax credit, 26 CFR 1.36B-2. See: http://www.gpo.gov/fdsys/pkg/CFR-2013-title26-vol1/pdf/CFR-2013-title26-vol1-sec1-36B-2.pdf

4. 45 CFR §155.335(a)(2)(ii), effective Oct. 6, 2014. See: http://www.gpo.gov/fdsys/pkg/FR-2014-09-05/pdf/2014-21178.pdf

5. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Guidance on Annual Redeterminations for Coverage for 2015, June 26, 2014. See: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-on-annual-redetoption-2015-6-26-14.pdf

6. New Hampshire Health Protection Program. See: http://ccf.georgetown.edu/wp-content/uploads/2014/10/NH-Med-Exp-transition-Letter.pdf

7. New Hampshire Health Protection Program. See: http://ccf.georgetown.edu/wp-content/uploads/2014/10/NH-Med-Exp-Transition-QA.pdf

THE HENRY J. KAISER FAMILY FOUNDATION

REPORT

November 2014

The ACA's Basic Health Program Option: Federal Requirements and State Trade-Offs

Prepared by:

Stan Dorn
The Urban Institute

and

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Kaiser Family Foundation

Table of Contents

Executive Summary

The Patient Protection and Affordable Care Act (ACA) gives states the option to implement a Basic Health Program (BHP) that covers low-income residents through state-contracting plans outside the health insurance marketplace, rather than qualified health plans (QHPs). In March 2014, the Centers for Medicare & Medicaid Services (CMS) issued final regulations on the requirements for a BHP and the methodology for calculating federal payments to states. States can choose to implement BHP beginning in 2015.

BHP Requirements

In a state implementing this option, BHP is available to consumers with incomes up to 200% of the federal poverty level (FPL) who would otherwise qualify for subsidies in the marketplace. Most are adults with incomes between 133 and 200% FPL, but some are lower-income consumers ineligible for federal Medicaid funding because of immigration status. In addition to meeting income requirements, BHP-eligible consumers must be state residents, age 64 or younger, U.S. citizens or lawfully present immigrants, and ineligible for other minimum essential coverage, including Medicaid, CHIP, and affordable insurance offered by an employer. Although any state can implement BHP, only those that also expand Medicaid are likely to do so.

BHP must be at least as comprehensive and affordable as subsidized coverage in the marketplace. BHP consumers are enrolled in "standard health plans" that cover the ten Essential Health Benefits required of QHPs in the marketplace. At state option, such plans may cover additional benefits as well. BHP premiums and out-of-pocket cost-sharing may not exceed what would have been charged by the benchmark plan (second-lowest cost silver plan) in the marketplace, taking into account premium tax credits (PTCs) and cost-sharing reductions (CSRs) for which consumers would have qualified. Standard health plans may be sponsored by state-contracting HMOs, insurers, Medicaid or CHIP managed care organizations, provider networks, or other qualified entities.

States can choose between Medicaid rules and rules that apply in the marketplace for most aspects of BHP. The flexibility to choose between these existing administrative structures applies to such BHP features as the rules for verifying and redetermining eligibility, effective dates of eligibility, criteria for plan network adequacy, grace periods for late payment of premiums, and enrollment opportunities—either continuous enrollment (as under Medicaid) or open and special enrollment periods (as in the marketplace). This flexibility simplifies state administration and facilitates continuity of coverage for consumers.

Federal Funding of State BHPs

The federal government pays 95% of what BHP enrollees would have received in marketplace subsidies. The federal payment for each enrollee includes two components: one reflecting the PTC and another reflecting the CSR the enrollee would have received in the marketplace. The same amount is paid for all enrollees within each federal payment cell, which is defined based on county of residence, age range, income range, household size, and type of BHP coverage (single, couple, etc.). These per capita amounts are set prospectively for each year. When BHP is first implemented, the state's initial payments are based on projected enrollment into each payment cell. After the program starts, payments are adjusted to reflect actual enrollment

within each cell. The final payment methodology for 2015 was published in March 2014; in subsequent years, final payment methodologies will be published each February prior to the beginning of the BHP program year.

Why states have considered BHP

States considering BHP seek to achieve multiple goals, including providing more affordable coverage and reducing "churning" between Medicaid and marketplace plans. Many of the states actively debating BHP envision providing coverage similar to that offered through existing Medicaid or Children's Health Insurance Programs. If structured in this manner, BHP would give consumers more affordable coverage than what is offered in marketplaces, even with federal subsidies. The result would likely be higher levels of enrollment and greater access to care for the lowest-income group of subsidy-eligible consumers. Recent research suggests that the perceived unaffordability of coverage is a major obstacle to enrollment among the remaining uninsured. In addition, some states that had previously expanded coverage through a Medicaid waiver or through state-funded coverage would achieve savings by shifting those beneficiaries into a federally-funded BHP without reducing benefits or increasing costs for affected consumers. Finally, serving all residents with incomes up to 200% FPL through the same Medicaid-based health plans, with cost-sharing amounts changing but other coverage remaining constant as income rises and falls, would likely reduce the amount of "churning" (that is, involuntary movement between plans in response to income fluctuation). Churning would be further reduced under the final regulations' option to provide BHP enrollees with 12-month, continuous eligibility.

BHP would also avoid the need for consumers to reconcile advance premium tax credits on federal income tax returns. Since BHP enrollees do not receive tax credits, they would not face the risk of losing tax refunds or owing tax debts if they turn out to receive excess subsidies during the year.

State cost issues

States evaluating whether to implement BHP must compare expected federal funding to projected costs, factoring in potential offsetting savings, to determine BHP's financial feasibility. States need to compare federal BHP funding, which will reflect marketplace benchmark premiums, to state BHP costs in assessing the amount (if any) that states need to contribute.

Enrollment patterns influenced by state policy choices will affect the relationship between federal funding levels and state costs. For example, states that encourage enrollment of the lowest-income BHP-eligible consumers by greatly lowering or eliminating their premium charges may see average federal funding per beneficiary increase, since the lowest-income consumers qualify for the highest QHP subsidies.

Potential state budget savings could also affect BHP's fiscal impact. In addition to shifting enrollees in state-funded programs to federally-funded BHP, some states might achieve savings by using BHP's negotiating leverage to lower plan and provider bids for both BHP and Medicaid and by structuring BHP benefits to substitute for state-funded services—for example, certain mental health and substance abuse treatment—that fall outside QHPs' commercial coverage.

States must also decide how to finance BHP administrative costs, which cannot be directly paid with federal BHP funds. However, states can fund these expenses by surcharging BHP plans and using federal BHP funds to

cover the resulting premium escalation, just as many marketplaces fund administrative costs by surcharging QHPs and using PTCs to cover much of the consequent premium increase.

States concerned about BHP costs exceeding federal funding can lower BHP costs or "hedge" financial risks. A state can lower BHP costs by increasing consumer out-of-pocket cost-sharing, limiting benefits, or raising premiums (so long as BHP coverage remains at least as generous and affordable as QHP plans). States can also adjust plan payments and associated provider reimbursement levels to reduce BHP costs. BHP plan and provider payments are likely to be set at least somewhat below QHP levels, but cutting payments even further will reduce the state's costs, albeit by potentially narrowing the provider networks available to beneficiaries.

States can also adopt strategies that hedge financial risks, rather than lower costs. They can share risks with health plans by holding back a small proportion of payments until the end of the year. Once uncertainties are resolved, those "hold-backs" can be disbursed. States can also retain a small percentage of federal payments as reserves, to help pay future years' BHP costs if unforeseen contingencies materialize and federal BHP funds fall unexpectedly short of covering state BHP costs.

BHP AND THE MARKETPLACE SIZE

Although implementing BHP will reduce the size of a state's marketplace, smaller marketplaces are likely to remain stable in most states. Implementing BHP will lead to a smaller marketplace as consumers with incomes under 200% FPL move out of the marketplace and into the BHP. However, the ACA's insurance market reforms will promote stability in marketplaces with fewer enrollees. Those reforms base marketplace premiums on the risk level of the individual market as a whole, not solely on the risk level of enrollees within the marketplace or plan. This requirement, along with other premium stabilization mechanisms, should prevent spikes in premiums that might otherwise occur, as illustrated by a very small but stable marketplace in Massachusetts, operating under rules like the ACA's. Massachusetts' Commonwealth Choice exchange, which serves only unsubsidized residents above 300% FPL, has remained stable since its 2007 launch, even though fewer than one-half of 1% of non-elderly residents enrolled during Commonwealth Choice's first three years.

However, a smaller marketplace could reduce competition and would need alternative sources of revenue. Fewer covered lives could make the marketplace less attractive to carriers. In response, carriers might reduce the number of plan options offered to consumers or avoid the marketplace. Moreover, many states are planning to fund marketplaces through assessments on participating plans. In those states, the administrative costs that are fixed—that is, those that are unchanged even if fewer people enroll—would be spread across a smaller base if fewer consumers receive marketplace coverage. However, BHP could help pay marketplace administrative costs that benefit BHP, such as for eligibility determination, compensating for lost QHP assessments.

BHP AND MARKETPLACE RISK LEVELS AND PREMIUMS

Implementing BHP could potentially alter the risk level of enrollees in the individual market; however, a state-based risk adjustment system that includes BHP plans could both prevent this change and lead to modest individual market premium reductions. If BHP enrollees have different

average costs than other marketplace enrollees, moving them into BHP would change the risk level of the individual market, hence the premiums charged by marketplace plans. At income levels low enough for subsidies, premium payments are determined primarily by household income, with tax credits absorbing overall changes to premium levels. If premiums rise or fall, the consumers most affected are those with incomes too high to qualify for subsidies.

A state can address those concerns by administering a risk-adjustment system that combines BHP plans with individual market carriers, thereby including BHP consumers in the individual market's risk pool. If such a state's BHP makes coverage more affordable, it will attract some healthier consumers than would have enrolled into the marketplace. The risk adjustment system will share those better risks with the individual market. The result would likely be modest reductions to individual market risk levels and marketplace premiums.

Minnesota's 2014 experience with a BHP–like option

Minnesota did not provide marketplace coverage to residents with incomes at or below 200% FPL in 2014 because it was planning to implement BHP in 2015. Instead, these consumers were covered through a reconfigured version of the state's Medicaid waiver program, MinnesotaCare (MNCare). Removing all residents under 200% FPL from the state's marketplace did not appear to create any of the problems described above:

- **QHP enrollment was robust, albeit reduced because of MNCare.** By the end of open enrollment, 47,902 consumers joined QHPs, and 37,985 signed up for MNCare. As of July 2014, enrollment totals reached 52,233 in QHPs and 54,154 in MNCare.
- **Five participating carriers offered consumers numerous marketplace options, and benchmark premiums were the lowest in the country.** Thirty-three QHPs were offered in the median county in the state, including ten silver, ten bronze, eight gold, two platinum, and three catastrophic plans. In addition, benchmark QHP premiums in Minnesota were at least 17% lower than in any other state. For 2015, although the low-cost carrier that covered the most QHP members has withdrawn from the Minnesota marketplace, another carrier has taken its place. The total number of QHP options rose from 78 to 84, and state officials project urban benchmark premiums will remain the country's lowest.
- **The marketplace reports that it can cover its administrative costs, despite a smaller base of QHP enrollment on which to levy premium surcharges.** MNCare pays its proportionate share of marketplace costs related to eligibility and enrollment, replacing at least some of the lost premium surcharge revenue. The marketplace's capacity for self-support is also enhanced by the projected 69% decline in administrative costs in 2015 as work transitions from building infrastructure towards ongoing operations.

Alternative approaches to improving affordability

States may consider alternatives to BHP, which include state-funded subsidies to supplement PTCs and CSRs in the marketplace and, in the future, more comprehensive approaches through state innovation waivers. Starting in 2017, broad state innovation waivers may allow states to develop methods bolder than BHP for making coverage affordable to low-income consumers. These waivers allow far-reaching (albeit budget-neutral to the federal government) restructuring of the ACA's fundamental architecture. In the meantime, the most plausible alternative to BHP for states interested in improving affordability involves supplementing PTCs and CSRs. That approach imposes state costs, even if the federal

government continues to provide Medicaid matching funds for state-furnished PTC supplements. Moreover, such supplementation will not shield consumers from income-tax reconciliation, and it may not let states achieve some of BHP's potential cost savings. On the other hand, a state that supplements PTCs and CSRs does not shrink its marketplace, is not at risk for costs other than those involving supplemental subsidies in the marketplace, and can help residents with incomes above 200% FPL. A state committed to improving affordability needs to carefully consider the many trade-offs inherent in these various alternative approaches.

Conclusion

BHP offers the prospect of improved affordability for low-income residents, fiscal gains for some states, and reduced churning. However, it also poses financial risks for states and has implications for state marketplaces. In the coming years, some states may investigate a range of approaches to improving affordability of coverage for their low-income residents. Which approach is best—BHP, state supplementation of marketplace subsidies, or bolder alternatives permitted under state reform waivers that begin in 2017—will depend greatly on the unique circumstances facing each individual state.

Introduction

Beginning in 2015, states have the option to implement a Basic Health Program (BHP) providing low-income consumers with coverage outside health insurance marketplaces, which are sometimes called "exchanges." The BHP option, provided by the Patient Protection and Affordable Care Act (ACA), permits a state to contract with "standard health plans" that serve consumers with incomes at or below 200% of the federal poverty level (FPL) (about $39,500 for a family of three in 2014) who would otherwise qualify for subsidized marketplace coverage.[1] States opting for BHP receive federal funding equal to 95% of what the federal government would have paid in marketplace subsidies for BHP enrollees. BHP beneficiaries must receive coverage at least as affordable and comprehensive as what they would have obtained from a qualified health plan (QHP) participating in a marketplace.

Most states considering BHP have sought to provide low-income consumers with more affordable coverage than will be offered in marketplaces, using models provided by Medicaid or the Children's Health Insurance Program (CHIP). These models lower the overall cost of coverage by reducing provider payments below levels in the private market and using state leverage to negotiate aggressively with health plans, thereby permitting nominal premiums and cost-sharing. Early microsimulation modeling estimated that such savings would let states use 95% of marketplace subsidies to provide consumers with substantially more affordable coverage than would be available from subsidized QHPs.[2]

Medicaid expansion and BHP eligibility

For citizens and qualified immigrants, BHP is not available below 133% FPL. If a state implements BHP without expanding Medicaid eligibility, such consumers between 100 and 133% FPL qualify for marketplace subsidies, those between 133 and 200% FPL can be eligible for the BHP but not marketplace subsidies, and those above 200% FPL can again qualify for marketplace subsidies. Such "stop-and-start" eligibility for marketplace subsidies makes it unlikely that states will implement BHP without a Medicaid expansion, even though they have the legal right to do so.

If a state expands Medicaid to 138% FPL, citizens and qualified immigrants are ineligible for BHP at or below 138% FPL, because they will be eligible for minimum essential coverage through Medicaid.

In March 2014, the Centers for Medicare & Medicaid Services (CMS) published final BHP regulations[3] and a final methodology for calculating state BHP payments in calendar year 2015,[4] the first year when states will be allowed to operate BHP. This paper begins by summarizing these federal policies, including the requirements for BHP as well as the methodology for determining federal BHP payments. It then analyzes the key trade-offs facing states as they decide whether and, if so, how to implement BHP, with a particular focus on the impact of BHP on state budgets and the size, stability, and risk level of state marketplaces.

Requirements for a State BHP

Eligibility

As envisioned by states considering BHP, this option would provide more affordable coverage for low-income consumers than what they would obtain in the marketplaces. BHP is available to consumers with incomes at or below 200% FPL who would otherwise qualify for marketplace subsidies. Eligible consumers include those who:

- Are state residents;

- Are age 64 or younger;
- Are U.S. citizens or legally residing immigrants;
- Either have income between 133 and 200% FPL or have income below 133% FPL but are not eligible for federally-matched Medicaid because of their immigration status;
- Are not eligible for other forms of minimum essential coverage, including CHIP and Medicaid (other than for pregnant women's coverage or a form of Medicaid that offers less than full scope benefits, such as coverage limited to family planning services); and
- Are not offered affordable coverage from an employer.

A state must cover all eligible consumers, statewide. A BHP cannot cap enrollment, use a waiting period for those with prior coverage, set an upper income limit on eligibility below 200% FPL, or otherwise fail to enroll eligible applicants. However, to promote the smoother transition of individuals from marketplace coverage to BHP, a state can implement alternative initial enrollment strategies on a transitional basis during 2015 with CMS approval.[5]

Covered services and consumer costs

A standard health plan provided through BHP must cover all ten Essential Health Benefits (EHBs) that are required for QHPs nationally. States adopting BHP have the flexibility to use a combination of more than one base benefit option. A BHP may cover additional services, but not fewer services, than those required for QHPs. Several specific benefit requirements for QHPs also govern BHP, including the following:

- Each plan must provide the state with its list of covered prescription drugs and meet prescription drug coverage requirements applicable to QHPs;
- Benefit design may not be discriminatory; and
- Federal funds may not be used for abortion services, except in the case of rape, incest, or danger to the woman's life.[6]

BHP premiums[7] and out-of-pocket cost-sharing levels[8] may not exceed the amounts that would have been charged if BHP beneficiaries had enrolled in the so-called "reference" or "benchmark" plan—that is, the second-lowest cost silver-level QHP. These costs take into account the premium tax credits and cost-sharing reductions for which enrollees would have qualified. Accordingly, BHP premiums cannot exceed the percentages of household income shown in Table 1, which reflect the structure of premium tax credits. The cost-sharing reductions available in the marketplaces raise the actuarial value of plans to lower deductibles, co-payments, and out-of-pocket maximums. To meet these requirements, BHP actuarial values (AV) cannot fall below the levels shown in Table 2. In addition, American Indians and Alaska Natives (AI/AN) cannot be charged any cost-sharing—put differently, their standard health plans must have an actuarial value of 100%.[9] While BHP consumers may not be charged more than they would have been charged in the marketplace, states can set lower premium payments and cost-sharing requirements.

As an additional protection, any BHP variations of premiums and out-of-pocket cost-sharing based on income cannot favor higher-income beneficiaries.[10] Other QHP safeguards also apply, such as the prohibition against cost-sharing for preventive services.[11] As with QHPs, BHP plans must accept premium and cost-sharing payments made by Ryan White programs, AI/AN organizations, and state and federal government programs.[12]

Table 1. Maximum Permitted Premium Charges to BHP Consumers in 2015	
Income (FPL)	Maximum permitted premium
<133%	2% of household income
133-149%	3% to 4% of household income (on a linear sliding scale)
150-200%	4% to 6.3% of household income (on a linear sliding scale

Source: CMS 2014. *Note:* These income contribution amounts do not reflect the slight increases recently announced by the IRS, which are described below.[13]

Table 2. Minimum Required Actuarial Value for BHP Consumers	
Consumer Characteristics	Actuarial Value
Up to 150% FPL	94%
151-200% FPL	87%
American Indian/Alaska Native (up to 200% FPL)	100% (no cost-sharing is permitted)

Source: CMS 2014

In one important respect, BHP consumers are exempt from a cost that can apply in marketplaces. QHP enrollees who claim advance payment of premium tax credits (APTCs) must reconcile those payments on their federal income tax returns. APTC claims, which are based on projected income for the year, are compared to PTCs based on the taxpayer's final annual income. If the APTCs turn out to have been too high, consumers must repay some or all of the excess, through taxes owed or a reduced refund. If APTCs were too low, taxpayers can claim an additional credit on their return. Since BHP enrollees do not receive APTCs, they are not subject to tax reconciliation.

Health plans

In states adopting BHP, BHP-eligible consumers cannot receive subsidized coverage through the marketplace, and are instead covered through a "standard health plan."[14] States may contract with the following types of entities to offer standard health plans:

- Licensed health maintenance organizations (HMO);
- Licensed health insurers, in which case the plan's medical loss ratio must be at least 85%;[15]
- Non-licensed HMOs participating in Medicaid or CHIP; or
- Networks of health care providers demonstrating the capacity to meet the state's minimum required negotiating criteria for its competitive contracting process. Such networks must be "capable of meeting the provision and administration of standard health plan coverage, including but not limited to, the provision of benefits, administration of premiums and applicable cost sharing and execution of innovative features, such as care coordination and care management" and "may include but [are] not limited to: Accountable Care Organizations, Independent Physician Associations, or a large health system [sic]."[16] This provider network category could allow BHP plans to include innovative health care delivery systems with alternative financing methods that seek to improve population health and quality while slowing cost growth.

As a general rule, states must assure CMS that each BHP enrollee will have a choice of standard health plans from at least two offerors. However, a state may request an exception by demonstrating that it has reviewed (1) whether it is insisting on contractual requirements beyond those needed under federal law; (2) whether additional negotiating flexibility would be consistent with statutory requirements and available funding for the BHP; and (3) whether potential bidders have received enough information to participate in the BHP.[17]

BHP programs must meet competitive contracting requirements, except in 2015 for states that show they are unable to do so. [18] Those requirements include standard state procurement procedures for federal grants.[19] They also entail negotiation of premiums, cost-sharing, and benefits and include innovative features, such as:

- Care coordination and care management for enrollees (especially those with chronic conditions);
- Incentives for using preventive care; and
- Strategies to maximize patient involvement in health care decision-making, including through incentives for appropriate utilization and provider choices.

In clarifying the meaning of "negotiation," CMS explained that "nothing precludes a state from establishing standards that will serve as the starting point for negotiations with standard health plans offerors." That approach would leave room for negotiation around such elements as "price [paid by the state], the provision of benefits in addition to those specified in the state's solicitation, lower premium and cost-sharing amounts than those specified in the state's solicitation, or any other aspects of the state's program…"

In its plan procurement process, the state must also consider additional criteria that ensure:

- Consideration of enrollees' health care needs;
- Provider networks that meet applicable standards (discussed below);
- Managed care or similar processes to improve quality, accessibility, appropriate utilization, and efficiency of service provision;
- Performance measures and standards related to quality and improved outcomes;
- Coordination with other insurance affordability programs to ensure continuity of care; and
- Fraud prevention while ensuring consumer protection.

Much like marketplace contracts with qualified health plans, state contracts with standard health plan offerors must address "network adequacy, service provision and authorization, quality and performance, enrollment procedures, disenrollment procedures, noticing and appeals, [and] provisions protecting the privacy and security of personally identifiable information." Such contracts also need to address other requirements specified by HHS, including those involving "service delivery model[s that] further… the objectives of the program."[20]

States have the option to enter into multi-state compacts to jointly contract with standard health plan offerors that serve BHP beneficiaries in more than one state. Such contracts may cover either statewide areas or specific areas within states.[21]

State Interactions with Consumers

In promulgating BHP rules, CMS gave states the option to use existing administrative structures whenever possible, to promote continuity of coverage for consumers and to simplify program administration. Accordingly, for most aspects of BHP, a state can choose between its Medicaid rules and the rules that apply in the marketplace. This flexibility applies to:

- Criteria for health plan network adequacy, mentioned above;
- Rules and procedures for verifying eligibility;[22]
- Rules and procedures for redetermining eligibility (except as described below);[23]
- Standards for authorized representatives (if the state permits their use for BHP);[24]
- Standards and procedures for certified application counselors (if the state permits their use for BHP);[25]
- Effective dates of eligibility;[26]
- Appeals rules and procedures;[27]
- Enrollment opportunities (that is, either continuous enrollment, as under Medicaid, or open and special enrollment periods no more restrictive than those used in the marketplace);[28] and
- Grace periods for late payment of premiums and coverage lock-out periods for non-payment of premiums that either (1) meet marketplace requirements, if the state uses marketplace enrollment procedures for BHP, or (2) provide grace periods lasting at least 30 days and meet CHIP lock-out requirements, if the state uses Medicaid enrollment procedures for BHP.[29]

Other specific consumer provisions apply to all BHPs. For example:

- Eligibility must be redetermined every 12 months, unless it is redetermined earlier based on information received from beneficiaries or third-party data sources. Although enrollees must report changes in circumstances as if they were receiving marketplace subsidies, states have the option to provide BHP eligibility continuously based on circumstances at the time of initial application. Such continuous eligibility remains in effect regardless of changed household conditions, so long as the beneficiary remains under age 65, a state resident, and not enrolled in another form of minimum essential coverage.[30] As explained below, federal BHP allotments are based on the assumption that all BHPs provide continuous eligibility.
- States must inform potential applicants and enrollees about the BHP, including benefits, any coverage tiers used by the state, and eligibility criteria. States must require health plans to provide clear information about premiums, cost-sharing, covered services (including amount, duration, and scope limits); to make available and update at least quarterly information about currently participating providers; and to meet other consumer information requirements that apply to QHPs.[31]
- States may not "discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation."[32]
- BHPs must use the same streamlined application form and meet the same eligibility coordination requirements that apply to other insurance affordability programs.[33]
- Consumers must receive the same opportunity to apply and to receive assistance with their application that extends to Medicaid applicants.[34] As with Medicaid, BHP eligibility must be determined by the state or

another governmental entity to which the state delegates the authority to determine eligibility,[35] and takes place within the single eligibility service that is used for all insurance affordability programs.

- American Indian and Alaska Native consumers must receive the benefit of specified safeguards that apply to marketplaces.[36]

State interactions with the federal government

BHP Blueprint

States interested in establishing BHP must furnish CMS with a comprehensive Blueprint describing the structure and administration of the program. The BHP Blueprint provides the roadmap for how the program will operate and documents compliance with federal legal requirements. In addition to specifying the BHP's components, the Blueprint must also include a description of how the state will ensure program integrity, an operational assessment documenting agency readiness, a transition plan if the state is proposing an alternative enrollment strategy for 2015, and a description of the qualifications and responsibilities of the BHP Trust Fund trustees and the method of their appointment. In concert with the Blueprint, states must submit a funding plan that includes enrollment and cost projections for the first year, along with any sources of funding beyond the BHP Trust Fund.[37]

States must seek public comment on the initial Blueprint and any significant revisions to the Blueprint prior to submission to CMS. Public comment is required for revisions that alter core program functions or make changes to the benefit package or enrollment/disenrollment policies. States are required to provide federally recognized tribes with an opportunity to provide input.[38] To further promote transparency and allow public input, HHS will post the submitted Blueprint online.[39]

States have the option, as an initial step before submitting a complete Blueprint, to provide a more limited Blueprint that describes the BHP's basic elements. CMS can grant interim certification of this more limited document to provide states with some certainty as they continue program development and procurement.[40]

States may not begin enrolling consumers into the BHP or receive federal payment until CMS provides full certification. This requires the Blueprint to provide a complete description of the program and its operations, document compliance with federal requirements, and demonstrate the integration of BHP with other insurance affordability programs to ensure seamless and coordinated coverage.[41]

Federal review

States operating BHPs must submit annual reports to HHS that discuss any evidence of fraud and demonstrate compliance with requirements related to:

- Eligibility verification;
- Limitations on the use of federal funds; and
- Collection of quality and performance measures from all standard health plans.

The report must also address requirements specified by the Secretary and list any recommendations identified through an HHS audit or evaluation that the state has not yet implemented.[42]

HHS may conduct annual reviews or audits of state BHPs to identify if states have violated any BHP requirements, including those that may lead to withdrawal of the Blueprint certification. Such oversight will also assess whether any BHP trust fund monies were improperly spent.[43]

BHP Trust Fund

A BHP state must establish a BHP trust fund as an independent entity or as a segregated account within the state's General Fund. All federal BHP payments must be deposited into the BHP trust fund, along with non-federal funds. The trust fund must be overseen by a Board of Trustees and only allowable expenditures—payments to standard health plans that reduce premiums or cost-sharing or provide essential or additional benefits for BHP enrollees—are permitted. [44]

Sound fiscal policies must ensure accountability in the receipt and expenditures of trust fund monies, including:

- Maintaining accounting records, including retaining records for at least three years;
- Obtaining annual certification that BHP trust funds are being used in accordance with federal requirements;
- Conducting an independent audit of expenditures; and
- Publishing annual reports of BHP trust fund expenditures.[45]

The BHP trustees and the state must also develop policies and procedures to ensure restitution, within two years, of any BHP trust funds that may not have been properly spent. If no provision is made to restore improperly spent funds, states may be required to return those funds to HHS.[46]

Withdrawal and Termination of BHP

A BHP may be terminated by a state or HHS. A state deciding to end BHP must submit written notice to HHS no later than 120 days before termination and include a proposed plan for transitioning consumers to other insurance affordability programs. Once a state receives approval, it is required to inform consumers and standard health plan offerors of its intention at least 90 days before the termination date. To ensure continuity of coverage, the state must transfer eligibility and verification information electronically to the marketplace or the Medicaid agency and inform consumers of their assessed eligibility for other insurance affordability programs.[47]

HHS may withdraw certification of a BHP Blueprint if it determines the Blueprint no longer meets applicable requirements. A state must develop a transition plan for consumers within 30 days of the withdrawal of certification by HHS.[48]

Federal Funding of State BHPs

As noted earlier, the federal government pays 95% of what BHP enrollees would have received in marketplace subsidies, had the state not implemented BHP. To calculate that amount, the federal government puts each BHP enrollee into a federal payment cell, which is defined based on county of residence, income, and other consumer characteristics. Before the year begins, the federal government announces the per enrollee amount it will pay for BHP enrollees in each payment cell.

When a state is about to start its BHP, the state projects quarterly enrollment levels in each cell. If those projections are deemed reasonable, CMS makes corresponding deposits into the state's BHP Trust Fund. Once actual enrollment data become available, CMS adjusts payment amounts so that, over time, the funding received by a state reflects actual rather than projected enrollment within each federal payment cell.

This section begins by explaining how federal payment cells are defined. It then touches on the timing for setting federal payment amounts. Finally, it uses one example to illustrate how CMS determines payment rates for each cell.

Federal payment cells

Each BHP enrollee falls within a "federal payment cell" that is defined by the following characteristics of its members:

- County of residence;
- Age range (0-20, 21-34, 35-44, 45-54, 45-54, or 55-64);
- Income range (0-50, 51-100, 101-138, 139-150, 151-175, or 176-200% FPL);
- Household size; and
- Coverage status (single BHP coverage, two-adult BHP coverage, etc.).

The timing for defining federal payments

As a general rule, the federal payment amounts for each cell—that is, the amount the federal government will pay for each BHP enrollee who fits within the cell—will be set prospectively, before the start of a BHP program year. The only uncertainty facing a state is thus the number of enrollees in each cell. This policy seeks to offer states fiscal predictability. If CMS changes its methodology for determining federal payment, those changes will be implemented only prospectively, for years after the change is made; they will not put into question funds already claimed by a state.

The precise methodology for calculating payments per cell may vary from year to year as CMS gathers experience with the operation of marketplaces and can better predict the subsidies that consumers would have received there. Proposed annual methodologies will be published in October, 15 months before the January start of the applicable BHP program year. The following February, 11 months before the BHP program year begins, annual methodologies will be finalized and federal payment amounts will be published, providing some lead time for state budget planning.

For 2015, the first year of potential BHP operation, the final payment methodology was published in early March, slightly later than is expected for future years. The timing of CMS publication of 2015 payment amounts will depend on various state choices, as explained in below. In the meantime, CMS will provide states with technical assistance to help project federal payment levels.

There are two exceptions to the general rule that federal payment amounts for each cell are not adjusted retrospectively. First, if a federal payment amount reflects an arithmetic error, the error will be corrected. Second, for 2015, a state can request a retrospective adjustment that, after the end of 2015, will change

marketplace premiums to compensate for the impact of BHP on the risk level within the individual market. This option reflects unique circumstances. Marketplaces and BHPs have not operated before, which makes it impossible for CMS to prospectively adjust for this factor. Such retrospective, population-wide risk adjustments are only provided for in the 2015 payment methodology, and CMS has not announced whether or not they will be allowed in future years.

Determining the Payment Amount for Each Cell

The federal government pays the same amount for each BHP enrollee within a federal payment cell. That amount includes a premium tax credit (PTC) component plus a cost-sharing reduction (CSR) component. Those components equal 95% of what the average BHP beneficiary in the cell would have received in PTCs and CSRs, respectively, if the state had not implemented BHP and the beneficiary had enrolled in the second-lowest cost silver QHP rather than BHP.

Throughout the rest of this section, we will use an example payment cell to illustrate CMS' calculations. The illustrative payment cell includes all BHP enrollees with the following characteristics:

- Residence in Peoria County, IL;
- Age 45-54;
- Income between 139 and 150% FPL, inclusive;
- One-person household size; and
- Enrollment in single BHP coverage.

We explain below how the federal payment for each BHP enrollee within this payment cell is calculated to equal $432 a month, combining a $290 PTC component and a $142 CSR component. At the conclusion of the section, we review all calculations in a text box, so readers can see how they all fit together.

The Reference Premium

The starting point for defining the federal payment is the reference premium—that is, the average premium that would have been charged by the second-lowest-cost silver plan in 2015 to non-smokers in the BHP beneficiary's county and age range if the state had not established a BHP program. The average is calculated assuming that enrollees are evenly distributed by age within the payment cell. Premiums for non-smokers are used because PTCs are based on such premiums.

A BHP state makes two choices in deciding how CMS will determine its reference premiums in 2015:

1. As its first choice, a state could either:
   - Begin its calculations with actual marketplace premiums for the 2015 program year; or
   - Begin its calculations with 2014 marketplace premiums, trended forward to 2015 based on expected national changes to marketplace premiums from 2014 to 2015. CMS projects that national marketplace premiums will rise 8.15%, reflecting increased private insurance costs and changes in the ACA's transitional reinsurance program. To elect this second option, however, a state was required to inform CMS by May 15, 2014—a date that has now passed.

2. For its second choice, a state can either:
   - Submit a protocol proposing a method for adjusting marketplace premiums retrospectively, after the end of 2015, to compensate for the impact of BHP implementation on average risk levels in the 2015 individual market; or
   - Not adjust marketplace premiums to reflect the impact of BHP implementation on average risk levels in the individual market.

In our example, we assume that Illinois chooses to use 2014 marketplace premiums trended forward to 2015 and not to adjust marketplace premiums to reflect the effect of BHP on insurance risk levels. Calculation of the reference premium thus begins with 2014 QHP premiums. In 2014, the second-lowest-cost silver QHP in Peoria County, Illinois, charges non-smoking adults age 45-54 an average of $345 a month for single coverage (Table 3). Increasing the $345 premium for 2014 by 8.15% yields a 2015 reference premium of $373.[49]

Table 3. Monthly Premiums for Benchmark QHP in Peoria County, IL, for non-smoking, single adults ages 45–54, 2014

Age	Premium
45	$282
46	$293
47	$306
48	$320
49	$334
50	$349
51	$365
52	$382
53	$399
54	$417
Average 45–54	**$345**

Source: Premium quotes from Healthcare.gov as of March 30, 2014. Averages are calculated assuming an even age distribution, as described in March 2014 BHP federal payment notice.

Determining the PTC component

The next step is determining the percentage of household income QHP enrollees would spend on premiums for the "reference" or "benchmark" plan (that is, the second-lowest-cost silver QHP). For example, those percentages will be 3.0% at 133% FPL and 4.0% at 150% FPL in 2015, varying on a sliding scale between those "anchor points." The average payment amount is then calculated for people in the federal payment cell, assuming an even distribution of households by FPL level. Subtracting that payment from the average reference premium yields an average PTC amount, approximating what consumers would have received in the marketplace.[50] Note: the Internal Revenue Service recently released updated percentages for 2015, which are slightly higher than those used for 2014—for example, consumers at 133% FPL must pay 3.02% of income,

rather than 3.0%, for benchmark coverage, and the contribution for those at 150% FPL has gone from 4.0% to 4.02% of income.[51] For clarity's sake, the body of this paper will continue to use the simpler percentages that applied in 2014.

Here is how that calculation works in our example. For one-person adult households between 139-150% FPL, the average enrollee share of the premium payment for a benchmark plan is $52, assuming the adults are evenly distributed by FPL level (Table 4). The resulting advance PTC for our group of middle-aged adults in Peoria County is $321. That is the difference between the reference premium of $373, which reflects the average cost of coverage based on the group's age and geography, and the average payment amount for benchmark coverage of $52, which reflects their FPL and household size.

Table 4. Monthly premium payments required for the benchmark plan from single adults who have various incomes as a percentage of FPL: 2015

FPL	Monthly Income	Monthly Payment	
		Share of Income	Dollars
139%	$1,352	3.4%	$45
140%	$1,362	3.4%	$46
141%	$1,371	3.5%	$48
142%	$1,381	3.5%	$49
143%	$1,391	3.6%	$50
144%	$1,400	3.6%	$51
145%	$1,410	3.7%	$52
146%	$1,420	3.8%	$53
147%	$1,430	3.8%	$55
148%	$1,439	3.9%	$56
149%	$1,449	3.9%	$57
150%	$1,459	4.0%	$58
		Average, 139–150% FPL	**$52**

Notes: Assumes 2014 FPL levels, which will apply during the start of open enrollment for 2015. Premium payment levels for benchmark coverage are calculated as described in March 2014 BHP federal payment notice (3% of household income at 133% FPL, 4% of household income at 150% FPL, with premium payments increased on an even linear scale between those income levels). Averages assume an even distribution of income among households within each payment cell, by FPL level, as described in CMS payment notice.

The PTC is then adjusted to reflect the average impact of income tax reconciliation, had BHP consumers claimed advance payment of tax credits in the marketplace. CMS estimates that, for the average BHP enrollee nationally, such reconciliation would reduce PTCs by 5.08%. (This finding reflects CMS' assumption that BHP eligibility will not change at all during the year, regardless of actual income fluctuations.)

Finally, the resulting PTC amount is multiplied by 95% to determine the PTC component of the federal payment for each BHP enrollee in this cell.

> In our example, making that 5.08% reduction to the $321 PTC amount yields $305. This is the estimated average amount that, after adjustment for tax reconciliation effects, individuals within this payment cell would have received in premium tax credits per month, if they had enrolled in QHPs rather than BHP in 2015. Illinois's federal payment amount for this cell thus includes a PTC component equal to 95% of $305, or $290.[52]

Determining the CSR component

The value of the CSR in the marketplace equals the portion of the total EHB health care claims for BHP enrollees that is paid by the increase in actuarial value resulting from the CSR. The CSR component of the federal BHP payment is then set to equal 95% of the value of the CRS in the marketplace. We describe each of these steps below.

The calculation of CSR value begins with an estimation of the average EHB health care claims covered by a silver-level plan charging the reference premium. To exclude administrative and other non-claim costs, CMS estimates that 80% of the reference premium is used to pay BHP claims, so 20% is subtracted from the reference premium.

Consumers also share in paying EHB claims through deductibles, copayments, and other cost sharing. Silver-level plans have an actuarial value of 70%, which means that, for an average population, the plans pay 70% of all covered claims. To add the amount of claims paid by the plan and consumers, the adjusted reference premium (less the 20% reduction for non-claims costs) is then divided by 70%.

> As noted earlier, the reference premium amount in the payment cell used in our example is $373 per month. Excluding the 20% of the premium related to administrative and other non-claim costs results in an average EHB claims amount of $298.40. To determine the total amount of all covered claims, including payments from both the plan and the consumer, we divide $298.40 by 70%, resulting in a total EHB claims amount of $426.29.

These claims estimates are based on the reference premium that is charged for non-smokers. However, CSRs, unlike PTCs, pay the costs of tobacco-related care. CMS therefore increases the claims amount to reflect both the percentage of BHP enrollees who use tobacco (as shown by data from the Centers for Disease Control and Prevention, taking into account age and state)[53] and the estimated impact of tobacco use on health care costs (as shown by the difference between weighted average QHP benchmark premiums charged to tobacco users and non-users).[54]

> For purposes of our example, let us assume that, for Illinois residents age 45-54, CMS sets this tobacco adjustment to require a 30% average increase in EHB claims above the amount for non-tobacco users. Adding 30% to $426.29 (that is, multiplying it by 1.3) results in a total average EHB claims amount of $554.17.

One final adjustment is made to reflect the increased utilization resulting from the reduced cost-sharing faced by BHP enrollees. The calculations above reflect utilization of silver-level coverage, with 70% actuarial value. However, the federal payment cell in our example consists of consumers with incomes between 139 and 150% FPL, who will receive CSRs that raise the actuarial value of their coverage to 94%. This will reduce their cost-sharing, which in turn will increase their utilization. CMS estimates that such increased utilization will increase total claims by an average of 12%. Accordingly, the claims cost estimate for silver coverage must be increased by 12%, to reflect induced utilization.

> Increasing the total claims amount in our example by 12%, to account for induced utilization resulting from lower cost-sharing, raises the average EHB claims per consumer to $620.67.

As stated earlier, the value of the CSR component equals the increased share of health care claims paid by the federal government as a result of the CSR. The CSR increases the actuarial value of the reference plan by 24% for BHP enrollees with incomes at 133-150% FPL (AV = 94%) and by 17% for BHP enrollees with incomes at 150-200% FPL (AV = 87%). For those two groups the EHB claims costs estimates developed as described above are thus multiplied by 24% and 17%, respectively, to determine the CSR's value, had BHP enrollees received QHP coverage in the marketplace.

Finally, the resulting estimate of CSR value is multiplied by 95% to determine the CSR component of the federal payment for each BHP enrollee in this cell.

> Our example involves BHP enrollees at or below 150% FPL. Accordingly, CSRs in the marketplace would have increased actuarial value from 70% to 94%, paying 24% of total claims. The average EHB claims amount in the marketplace for consumers in this payment cell is $620.67 per month. The CSR's value in the marketplace would thus be 24% of such claims, or $148.96 per month. The CSR component of the BHP payment is 95% of that CSR value, or $141.51 a month—$142, rounded off to the nearest dollar.
>
> The total monthly federal BHP payment for each enrollee in this example payment cell equals the $290 PTC component plus the $142 CSR component, or $432.

Calculating the Federal BHP Payment: A Recap

Reference premium for 2015

1. The average 2014 premium for non-smoking adults age 45-54 in Peoria County's second-lowest cost silver QHP ($345) increased by the projected national average QHP premium increase for 2015 (8.15%) = $373

Premium Tax Credit Component

2. Reference premium for 2015 ($373) minus the average payment for benchmark plan in one-person households in this FPL range ($52) = expected advance PTC amount ($321)
3. Reduce expected advance PTC amount ($321) by average tax reconciliation percentage assuming no mid-year eligibility adjustments (5.08%) = average PTC, post-tax reconciliation ($305)
4. Multiply average PTC, post-tax reconciliation ($305) by 95% for PTC component of BHP payment ($290)

Cost Sharing Reduction Component

5. To determine EHB claims paid by silver-level QHP charging reference premium, exclude administrative costs (20%) from reference premium ($373) = $298.40
6. To add EHB claims paid by consumer, divide plan-paid claims ($298.40) by silver level AV (70%) =$426.29 in total EHB claims, including plan-paid claims plus consumer cost-sharing
7. Increase to add average claims costs for BHP smokers, as estimated by CMS. Assume CMS publishes 30% tobacco factor for BHP enrollees in this age group, raises EHB claims to $554.17.
8. Increase claims (12%) to reflect greater utilization because of lower cost-sharing due to CSR. EHB claims = $620.67.
9. In this FPL range, CSR in the marketplace would raise AV from 70 to 94%, so value of CSR is 24% of EHB claims ($620.67) = $148.96.
10. Multiply CSR value in the marketplace ($148.96) by 95% to obtain CSR component of BHP payment ($141.51, or $142, rounded off to the nearest dollar)

Total Monthly Federal BHP Payment for Enrollees in Payment Cell

11. Add PTC component ($290) and CSR component ($142) = $432

Key State Policy Questions

In this section of the paper, we begin by discussing the reasons some states have considered implementing BHP. We then explore the two main areas of concern that have been raised as arguments for not moving forward: namely, BHP's fiscal risks for states and BHP's potential adverse effects on marketplaces.

Rationale for BHP

Several states have seriously considered BHP. Depending on the state, the objectives prompting consideration have included the following:

Increasing the affordability of coverage for low-income adults. One analysis attempting to quantify the potential gains in this area found that providing BHP coverage like that offered by many state CHIP programs would lower monthly premiums for the average eligible adult under 200% FPL from $100 a month, in subsidized marketplace plans, to $8 a month.[55] It also found that average annual out-of-pocket costs would fall from $434, in subsidized marketplace plans, to $96. Making coverage more affordable could increase low-income consumers' willingness to enroll and, once enrolled, to obtain necessary non-emergency care.

Experience with 2014 QHP enrollment reinforced the importance of these goals. An inability to afford coverage was the most commonly reported reason consumers remained uninsured as of June 2014, according to the Health Reform Monitoring Survey, a quarterly survey of the nonelderly that monitors ACA implementation. Among the uninsured with incomes between 139 and 400% FPL—the main target group for marketplace subsidies—52% cited financial reasons for not enrolling.[56] However, within that group, 40 percent had heard "little or nothing" about subsidies; and even among the remainder, who reported hearing "some" or "a lot" about subsidies, the perceived unaffordability of QHP coverage may not reflect accurate and complete information about available assistance.

Reducing "churn" between health plans. If Medicaid, CHIP, and BHP were combined so that the same health plans served all residents with incomes at or below 200% FPL, the total amount of "churning" between Medicaid plans and marketplace plans would decline by 16%, according to the only published analysis that took into account unaccepted offers of employer-sponsored insurance.[57] Moreover, final BHP regulations permit states to provide BHP enrollees with continuous, 12-month eligibility, based on household circumstances at the time of application, regardless of later, mid-year changes. In fact, federal BHP funding is premised on such continuous BHP eligibility, as noted earlier.[58] Implementing such continuous eligibility could greatly reduce mid-year transitions between insurance affordability programs.

Protecting consumers from the risk of tax reconciliation. As noted earlier, BHP consumers do not receive APTCs and so are not subjected to tax reconciliation. Shielding uninsured consumers from this risk could increase their willingness to enroll into subsidized coverage. Once the APTC reconciliation requirements become widely understood, some consumers who qualify for APTCs could choose to remain uninsured rather than risk losing tax refunds or owing money to the federal government due to tax reconciliation.

Achieving significant state budget savings while preserving existing access to care for beneficiaries of pre-ACA state programs. Before the ACA, some states covered low-income adults

through Medicaid waiver programs or using state-only funding. This coverage was typically much more affordable for consumers and, in some cases, offered more generous benefits than subsidized marketplace insurance. BHP lets states continue pre-ACA coverage for these groups, while substituting federal for state funding. Otherwise, such states face the dilemma of either: (1) moving their residents into the marketplace—thus saving state money but increasing residents' health care costs and potentially reducing their access to care—or (2) continuing to provide low-income residents with state-funded help—thereby preserving their pre-ACA access to care but persisting with state expenditures not paid by other states for similar populations.

Providing coverage that reflects state rather than federal policy preferences. Some state officials expressed interest in using BHP to provide low-income consumers with coverage like that furnished to children at similar income levels under state CHIP programs. They sought to use approaches preferred by state policymakers, rather than providing subsidies defined in federal laws governing marketplace coverage. In other states, officials felt that objectives related to delivery system reform might be better achieved with direct state control through BHP rather than through marketplace QHPs, particularly in federally facilitated marketplaces.

State Fiscal Issues

While BHP offers states federal funding that can be used to provide low-income consumers with more affordable coverage, its financing structure creates fiscal issues for states. Federal BHP funding equals 95% of what the federal government would have paid in premium and cost-sharing subsidies for BHP enrollees. If that funding proves insufficient to cover program costs, states will be responsible for covering any shortfalls. States must thus carefully compare BHP costs to available federal funding, taking into account any state savings created by BHP. This section explores these fiscal issues and discusses strategies for mitigating state risks.

Estimating Total Federal Funding and State BHP Costs

A critical step in assessing the financial feasibility of BHP and estimating available federal funding is to identify the characteristics of BHP-eligible consumers. Previous sections of this report explain how CMS will set federal funding amounts for particular BHP consumers, but to project total federal funding levels, states will need to estimate the distribution of BHP-eligible consumers, by geography, age, and income. Among surveys conducted by the U.S. Census Bureau, the American Community Survey (ACS) has the largest state-specific samples and so is likely to provide the most reliable estimates. However, a limitation of this data set is that ACS data do not include information about offers of employer-sponsored insurance (ESI), which almost always preclude subsidy eligibility.[59] States that fail to take such offers into account will overestimate the prevalence of relatively high-income BHP-eligible consumers, since ESI offers grow increasingly common as income rises.[60] As a result, such states will underestimate federal BHP funding per BHP enrollee, since QHP subsidies, hence BHP funding levels, decline as income rises.

State BHP rules will affect federal funding. A state could structure its BHP program to boost the enrollment of consumers who qualify for particularly high federal funding levels. A state might encourage the enrollment of low-income BHP consumers, for example, by entirely or almost entirely eliminating premium charges for enrollees below a specified FPL level. Such consumers receive particularly large QHP subsidies and so would draw down particularly high federal BHP payments. Increased enrollment of low-FPL consumers, relatively to those with somewhat higher FPL levels, would likely increase the overall ratio of federal funding to state BHP costs, perhaps by non-trivial amounts.

States must carefully estimate BHP costs, exploring mechanisms to reduce those costs, if needed. Medicaid expenditures per member per month for healthy adults, increased to furnish provider reimbursement and associated plan payments to somewhere between Medicaid and QHP levels, can represent a useful starting point for estimating the cost of BHP adult coverage.[61] A state can lower those costs by increasing out-of-pocket cost-sharing above Medicaid levels, which lowers utilization. Along similar lines, varying the scope of covered benefits can affect BHP coverage costs.[62] The state could also impose or raise consumer premium charges.[63]

Provider reimbursement and associated plan payment levels also influence BHP coverage costs. A state that further raises these amounts above Medicaid levels will increase BHP costs. If that increase would cause state costs to exceed federal funding levels or state policymakers' fiscal targets, offsetting program changes may be needed, such as benefit reductions or increases in consumer cost-sharing (so long as they do not violate the baseline federal requirement that BHP consumers must receive at least the covered benefits and cost-sharing protections that would have been available in the marketplace).[64] On the other hand, a state could reduce BHP costs by lowering provider and plan payments towards Medicaid levels, but that would limit provider networks, with potentially adverse effects on access to care, depending on the state.

States can finance BHP administrative costs through assessments on BHP participating plans. As explained earlier, federal BHP dollars cannot directly pay for BHP administration. However, states can leverage BHP's new infrastructure to obtain administrative funding. As CMS explained, "states have the option to establish sources of non-federal funding to help offset administrative costs associated with BHP. Non-federal resources can include assessments imposed on BHP participating plans."[65]

A BHP can thus fund administrative costs by surcharging BHP-participating plans. The resulting revenues are non-federal resources, which can pay BHP administrative expenses. Those assessments are part of standard health plans' costs, funded through premiums. The premiums, in turn, are paid using federal BHP funds. Many marketplaces use a similar strategy by raising administrative funds through QHP assessments. QHPs incorporate those assessments into higher premiums, which federal PTCs help pay.

POTENTIAL STATE BUDGET SAVINGS

States assessing their potential financial exposure could also consider potential sources of state budget savings that might result from BHP implementation.

State-funded populations could be shifted into BHP. Depending on state circumstances, the resulting state savings may involve the following groups:

- Lawfully present pregnant non-citizen women whose incomes are at or below 138% FPL receive, in many states, optional Medicaid coverage under Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 or CHIP coverage. No maintenance-of-effort requirement applies to such women over age 18. A state implementing BHP could move them into federally-funded BHP without reducing their benefits or increasing their costs.
- Other lawfully present non-citizens whose incomes are at or below 138% FPL and who are ineligible for federal Medicaid funds because of immigration status receive state-financed health coverage in some states. Without BHP, such immigrants could receive subsidized QHP coverage, which may be significantly less

affordable than what the state previously furnished. BHP would let the state continue providing those immigrants with coverage along pre-ACA lines while shifting the cost of their care to the federal government.

- Pregnant women with incomes between 138 and 200% FPL receive optional Medicaid coverage in most states. A state implementing BHP could move such women who are over age 18 (to whom maintenance-of-effort requirements do not apply) into federally-funded BHP while preserving all the benefits and cost-sharing protections formerly provided by Medicaid. In some states, when women in this income range become pregnant, they must move from QHPs to Medicaid plans if they want to access Medicaid's additional services and cost reductions. If BHP is provided through the same plans that serve Medicaid beneficiaries, women could stay with the same plan and provider when they get pregnant without surrendering Medicaid's services and cost-sharing protections. Preserving continuity of care during pregnancy would ameliorate this potentially important form of churning, affecting low-income pregnant women, not discussed above.

BHP "covered lives" may give states additional negotiating leverage to obtain lower bids from plans or providers seeking to serve both Medicaid and BHP consumers. Even a small percentage reduction in Medicaid's per member per month costs could yield significant savings, given the total size of Medicaid managed care contracts in most states. Savings might also result from lower per unit costs if BHP is added to administrative services contracts that benefit multiple, state-administered health programs.

BHP benefits could be structured to substitute for state-funded services. For example, BHP could provide coverage for services such as mental health and substance abuse treatment of an amount, duration, and scope that exceeds the commercial benefits covered by QHPs. BHP provider networks could also be structured to assure or increase state fiscal gains in these areas.

Limiting State Financial Risks

As noted earlier, a state that implements BHP assumes the risk of a larger-than-anticipated gap between state BHP costs and federal BHP funds. Policymakers may be concerned that more than an expected amount of state general funds could ultimately be required to cover any resulting shortfall. Despite the efforts by federal officials to ensure a predictable level of federal funding, states face some inevitable uncertainties. The most important such uncertainties may involve fluctuating QHP benchmark premiums during the early years of marketplace operations, which directly influence federal BHP funding amounts. Such uncertainties are mitigated by CMS's publication of BHP payment amounts for each year in February of the previous calendar year and state options to base a year's BHP payments on the previous year's QHP benchmark premiums, trended forward based on CMS national projections. These two policies give states time to respond when QHP benchmark premiums change in surprising ways.

To limit fiscal uncertainties associated with the BHP, states can explicitly share risks with health plans through contractual contingencies. For example, a small proportion of payments to health plans could be held back until after the end of the year. Along similar lines, health plan contracts could reserve the right for states to reduce payment amounts if unforeseen shortfalls emerge. Similar contract language is already standard in many states for Medicaid and other programs.

States can maintain modest funding reserves to cover future shortfalls. CMS has made clear that a state is not required to spend all of its federal BHP funding during the year in which such funding is provided.

One year's funds can be retained and used for future BHP consumers.[66] A state BHP could thus carry over modest reserves to guard against future contingencies.

States must carefully consider the trade-offs of any strategies to mitigate financial risks. If a state uses its leverage with health plans to ask them to share risks, the state will have less leverage to obtain other desired concessions. And if for a given year a state holds some federal BHP funds in reserve, such a decision could translate into fewer covered services, higher costs for beneficiaries, or lower reimbursement levels for plans (and hence providers) during that particular year.

Impact of BHP on a State's Marketplace

Implementing BHP will reduce the size of the state's marketplace and potentially change its risk pool. This section explores those effects.

A Smaller Marketplace

BHP will reduce marketplace size. Microsimulation estimates of the impact of BHP on the marketplace conducted before the start of open enrollment in October 2013 suggested that, in the average state under full ACA implementation, BHP would reduce the number of APTC-recipient marketplace enrollees by about half, from 3.1% to 1.6% of residents under age 65. Adding unsubsidized enrollees, the average marketplace was projected to shrink by 20% under BHP, from 6.5% to 5.2% of non-elderly residents.[67] Now that the open enrollment period has ended, policymakers should be able to determine the percentage of marketplace enrollees whose incomes are at or below 200% FPL and who would leave the marketplace if their state implemented BHP. New York is the only state to publish income tabulations describing QHP enrollment. There, 39% of QHP beneficiaries are under 200% FPL and would leave the marketplace following BHP implementation; 35% qualify for subsidies with incomes between 200 and 400% FPL; and 26% of QHP enrollees are unsubsidized, with incomes above 400% FPL.[68]

A smaller marketplace is highly unlikely to become unstable, in most states. Before the ACA, purchasing pools could become dangerously unstable and experience so-called "death spirals" when small size made them vulnerable to adverse selection. Prior to the ACA's insurance market reforms, a pool's premiums were based on risk levels within the pool. As a result, a few costly enrollees in a small pool could raise premiums significantly. Healthy consumers could then buy the identical coverage for a much lower cost outside the pool. Many healthy consumers would leave the pool, further raising the average risk level within the pool, further raising premiums, causing an exodus of the healthiest remaining consumers, etc.

This is highly unlikely to happen with the ACA's insurance reforms and market stabilization mechanisms, which share risk across the entire individual market. Insurance rating rules, risk-adjustment mechanisms, pooling requirements, and reinsurance seek to make the cost of coverage reflect the risk level of the individual market as a whole, rather than the risk level of enrollees within a particular plan or within the marketplace. Consequently, even if a relatively small marketplace attracts members who are comparatively unhealthy, marketplace premiums are unlikely to rise above the level charged outside the marketplace by more than a small amount. Moreover, the healthiest marketplace enrollees cannot purchase the identical coverage elsewhere for a substantially lower cost. At the same time, a coverage mandate brings healthy enrollees into the individual market, lowering the overall risk level. Illustrating the stability yielded by ACA-like insurance reforms, Massachusetts's Commonwealth Choice marketplace, which was limited to unsubsidized consumers

above 300% FPL, remained perfectly stable even though, during its first three years, it served less than one-half of one percent of non-elderly residents (see text box).[69]

A smaller marketplace may need to charge higher amounts to cover administrative costs. Some administrative costs vary with size and will decline if a marketplace shrinks. Other costs are fixed, however. The latter will need to be spread across a smaller base if a state implements BHP. Accordingly, if a marketplace relies on QHP assessments to fund administrative costs, the amount charged per plan will rise. If the result is higher QHP premiums, consumers who qualify for tax credits will be largely unaffected, but unsubsidized consumers would face a somewhat higher cost for coverage inside the marketplace than outside.[70] To address this problem, BHP could help pay marketplace administrative costs, in proportion to benefits received, as is taking place in Minnesota (described below); or the marketplace could apply surcharges to BHP standard health plans.

A smaller marketplace may have less appeal to carriers. With fewer covered lives in the marketplace, carriers may be less interested in offering coverage. As a result, marketplace consumers could have fewer plan options. While this would simplify consumer choice, some consumers may have valued the options that are lost. Moreover, it is not clear whether carriers would have the same incentives to lower premiums and maximize market share if fewer covered lives are at stake.

A Tiny but Stable Health Insurance Marketplace: The Massachusetts Experience

The much greater stability of purchasing pools under reform has already been observed in Massachusetts, which implemented policies like those the ACA has put in place nationwide. That state's Commonwealth Choice program began in July 2007, functioning as a health insurance marketplace serving individuals with incomes above 300% FPL and some small firms. By the end of 2007, slightly fewer than 15,000 people received individual coverage.[71] Enrollment was still under 20,000 by the end of 2008.[72] By July 2010, several programs for small employers were added, and total enrollment reached approximately 35,000, of whom nearly 27,000 received individual coverage.[73] At no point did the small number of people receiving individual coverage through the exchange cause its destabilization.

If anything, greater challenges faced Commonwealth Choice than marketplaces in states that implement BHP. The Massachusetts program was limited to consumers over 300% FPL. More importantly, Commonwealth Choice offered no subsidies. By contrast, even in a state that implements BHP, marketplaces will be the only place where consumers with incomes between 200 and 400% FPL can obtain subsidized coverage, providing a force for stability and enrollment of healthy consumers that was not present with Commonwealth Choice.

Effect on the Marketplace Risk Pool

BHP's impact on the risk pool will depend on state circumstances and should not be exaggerated. The health status of BHP-eligible consumers will affect the risk pool of the marketplace. While lower income is associated with poorer health status, BHP-eligible consumers are more likely to be young adults, who are typically healthier, compared to others in the individual market. Analysts using the Urban Institute's Health Insurance Policy Simulation Model found, for example, that because many Utah adults below

200% are relatively young, BHP implementation in that state would raise premiums in the individual market, hence in the marketplace, by approximately 2%; but in Washington State, where low-income adults tend to be older than in the country as a whole, BHP implementation would not change the individual market's risk level.[74]

Regardless of the state, however, the magnitude of BHP's impact should not be exaggerated. As noted earlier, marketplace enrollees are pooled together with other participants in the individual market. Accordingly, if consumers under 200% FPL move from marketplace to BHP, the risk pool of the entire individual market will be affected, not just the smaller pool within the marketplace. The proportionate impact on risk levels, hence premiums, will thus be smaller than is sometimes envisioned.

The effect of the BHP on the marketplace risk level also depends on the extent to which a state's Medicaid program covers high risk individuals, including pregnant women and people with disabilities between 138 and 200% FPL.[75] A state with broad Medicaid eligibility in this income range has fewer high-risk individuals whom BHP would shift out of the marketplace. How low-income adult demographics and Medicaid coverage play out—and so how BHP implementation would affect the individual market's risk pool—vary greatly by state.

BHP can be structured to improve the individual market risk pool. If BHP is more affordable than subsidized marketplace coverage, BHP will likely attract some healthy consumers who would not enroll into the marketplace. CMS has made clear that federally-operated risk-adjustment systems cannot include BHP. However, a state-operated risk-adjustment system can combine BHP standard health plans with individual market carriers.[76] That would keep consumers below 200% FPL within the individual market's risk pool while adding to that pool the better risks attracted by BHP's more affordable cost structure. The result would likely be a modest reduction to individual premiums charged both within and outside marketplaces.

Notwithstanding its appeal, this approach has trade-offs. Establishing and operating a risk adjustment system could require significant effort from state officials, even if much of the information technology infrastructure and methodologies required for such a system will already be in place because of the federal system. Moreover, BHP standard health plans will either receive or make risk-adjustment payments, modestly increasing the uncertainties such plans face at initial BHP implementation.

The impact on Minnesota's marketplace of BHP-like coverage in 2014

Minnesota policymakers plan to implement BHP starting in 2015. As a transition policy for 2014, consumers with incomes at or below 200% FPL do not receive QHP subsidies in Minnesota's marketplace. Instead, they are covered through the state's preexisting (but reconfigured) Medicaid waiver program, MinnesotaCare (MNCare). Excluding consumers under 200% FPL from the state's marketplace has not yet appeared to create significant problems along the lines suggested above.

- **QHP enrollment is reduced but remains robust**. According to the first data available after the end of open enrollment, 47,902 consumers had enrolled in QHPs by April 13, 2014, and 37,985 had joined MNCare.[77] Since then, MNCare enrollment has remained unconstrained, but only those qualifying for special enrollment periods have been able to sign up for QHPs. Accordingly, as of July 10, 2014, 52,233 consumers were covered through QHPs and 54,154 had joined MNCare.[78] Approximately half of all consumers who

applied for QHP subsidies were found eligible. These results were achieved despite significant problems with the marketplace's early rollout.

- **Broad carrier participation provides consumers with numerous QHP options**. Five different carriers, contracting with ten different provider networks, sponsored Minnesota QHPs in 2014. In the median county, consumers could choose from among 33 QHPs, including ten silver, ten bronze, eight gold, two platinum, and three catastrophic plans.[79] While this range of choices was significant, it was somewhat narrower than in the average marketplace rating area nationally, where five carriers offered 47 QHPs.[80] For 2015, although the low-cost carrier that covered the most QHP members has withdrawn from the Minnesota marketplace, another carrier has taken its place, and the total number of QHP options rose from 78 to 84.[81]
- **QHP reference premiums are very low, and the marketplace appears stable.** Rather than experiencing adverse selection that raised QHP premiums and risked a potential death spiral, Minnesota had the country's lowest benchmark QHP premiums in 2014, at least 17% below those in the second least-expensive state;[82] and Minnesota's marketplace showed no signs of instability.[83] Even though the lowest-cost carrier has left the marketplace for 2015, average premium increases are forecast at 4.5 to 12 percent.[84] State officials characterize 2015 benchmark premiums in Minnesota's urban areas as continuing to be the lowest in the country.[85]
- **The marketplace reports that it can cover its administrative costs, despite a smaller base of QHP enrollment on which to levy premium surcharges.** The marketplace has proposed a balanced budget for 2015, without requiring additional resources from the state or federal governments. Officials anticipate receiving $11 million from a 3.5% "withhold" of premium revenues from QHPs, along with $22 million from the Medicaid program—including MNCare. Marketplace operations involving enrollment and eligibility determination help achieve the purposes of MNCare and the underlying Medicaid program. The latter programs contribute to those functions in proportion to the benefits they receive. In effect, MNCare's implementation shifted some of funding of marketplace administration from health plan assessments to Medicaid. Another factor facilitating financial feasibility is that the marketplace's annual administrative costs are projected to fall by 69% in 2015 as the bulk of its work transitions away from initial infrastructure development and towards ongoing operations.[86]

While serving consumers under 200% FPL through a separate system of coverage has not yet created significant problems for Minnesota's marketplace, problems might develop in the future.

Alternative State Options to Making Coverage More Affordable for Low-Income Consumers

States may consider state innovation waivers beginning in 2017. Broad state innovation waivers, which can go into effect starting in 2017, may allow bold approaches that combine federal resources offered by the ACA and, in ways that are budget-neutral to the federal government, provide low-income consumers with more affordable coverage than they would obtain in marketplaces with standard ACA subsidies.[87] However, CMS has not yet promulgated substantive guidelines, although Vermont long ago announced its plan to use such a waiver to implement a state-based single-payer system.

Until states can adopt innovation waivers, the most plausible alternative state-level method of improving affordability involves supplementing subsidies offered in the marketplace. For example, Massachusetts and Vermont, which used pre-ACA Medicaid waivers to provide subsidized coverage

to adults with incomes above 138% FPL, are lowering the cost of marketplace coverage by supplementing PTCs and CSRs for residents with incomes up to 300% FPL. A Medicaid waiver provides federal matching funds for PTC supplements;[88] but federal matching funds are not available for CSR supplements, which these states are therefore funding with state-only dollars.[89]

The ACA permits states to supplement marketplace subsidies.[90] However, it is not clear that states with pre-ACA coverage less generous than that offered by Massachusetts and Vermont can obtain Medicaid waivers to help pay the cost of PTC supplements, since such states cannot argue that waivers are needed to prevent their low- and moderate-income residents from suffering harm. With or without such waivers, a state supplementation strategy involves state budget costs that need to be compared against potential costs under BHP.

A state supplementation approach has other important differences from BHP:

- It does not shield low-income residents from the tax reconciliation risks of losing tax refunds or incurring federal income tax debts if they inaccurately project annual income when they enroll.
- It would likely not provide the same reduction in "churning," since most consumers would need to change plans when their income moves above or below 139% FPL, and since 12-month continuous eligibility will not be available.
- It may or may not provide the same opportunities for state budget savings, depending on state circumstances.
- It keeps consumers below 200% FPL in the marketplace, incorporating the healthier risks attracted by lower premiums into the individual market without requiring the state to administer risk adjustments.
- Consumers between 138 and 200% FPL will retain access to marketplace networks, rather than Medicaid provider networks, which may improve their access to care.
- It lets the state make coverage more affordable for residents with incomes above 200% FPL. For a BHP state to help such residents, it would need to combine BHP for consumers up to 200% FPL with marketplace supplements for consumers above that income level.

How Would a Rise in Risk Levels within a Marketplace Affect Consumers?

Increased risk levels within a marketplace are shared throughout a state's individual market. Each carrier pools all individual market enrollees, within and outside the marketplace. Moreover, risk-adjustments and reinsurance payments combine risks among all carriers' individual market plans. As a result, if marketplace risk levels rise, marketplace premiums will increase by less than would be the case without market-wide risk sharing, but premiums will also rise for individual plans outside marketplaces.

To illustrate the impact of higher risk on various consumers, suppose average risks inside a marketplace rise by 10%, risks outside the marketplace do not change, the marketplace includes half of all individual market enrollees within a state, and the ACA's risk-sharing mechanisms are fully effective. Individual market premiums will rise by 5%, both inside and outside the marketplace. Effects will vary among consumers, depending on whether they receive tax credits and which plan they choose, as follows.

1. **Individual market enrollees, both within and outside the marketplace, who do not receive tax credits will see their premiums rise based on the average change in market-wide risk.** In this example, their premiums will increase 5%.

2. **Tax credit beneficiaries who enroll in benchmark coverage will be unaffected**. If a tax credit beneficiary selects the second-lowest cost silver plan in the marketplace, his or her premium payment depends entirely on income. The plan's 5% premium increase will be paid entirely by higher tax credits.

3. **Tax credit beneficiaries who enroll in coverage more expensive than the benchmark plan will pay slightly more in premiums**. They pay both their income-based amount and the difference between the benchmark premium and the higher premium charged by their chosen plan. If all marketplace premiums rise by 5%, that difference increases by 5%. For example, a single adult earning $25,000 a year who chooses the benchmark plan pays 6.92% of income in premiums, or $144 a month.[91] If that adult instead enrolls in a plan that costs $50 more than the benchmark plan, the consumer's monthly payments are $194. If all premiums rise by 5%, the differential between the consumer's plan and the benchmark plan will be $52.50, rather than $50, so the consumer's monthly payment will be $196.50—a 1.3% net increase.

4. **Tax credit beneficiaries who enroll in coverage less expensive than the benchmark plan will pay slightly less in premiums**. They pay their income-based amount minus the difference between the benchmark premium and the lower premium charged by their chosen plan. If all marketplace premiums rise by 5%, that difference increases by 5%. To continue with the prior example, if a consumer earning $25,000 a year picks a plan costing $50 less than the benchmark, the consumer pays $94 a month. If all premiums rise by 5%, the difference between the consumer's plan and the benchmark plan will be $52.50, rather than $50, so the consumer's monthly payment will be $91.50—a 2.7% net decrease.

Conclusion

BHP offers prospects of improved affordability for low-income residents, fiscal gains for some states, and reduced churning. Structured carefully to attract good risks and share them with the rest of the individual market via state-administered risk-adjustment systems, BHP could improve the individual market's overall risk level, modestly lowering marketplace premiums. On the other hand, BHP would reduce marketplace size, potentially narrowing the range of QHP options and raising marketplace administrative charges.

In the coming years, some states may investigate a range of approaches to improving affordability of coverage for their low-income residents. Which approach is best—BHP, state supplementation of marketplace subsidies, or bolder alternatives permitted under state reform waivers that begin in 2017—will depend greatly on the unique circumstances facing each individual state.

Acknowledgements

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Notes

[1] Technically, a state contracts with a "standard health plan offeror" that sponsors a "standard health plan."

[2] See, e.g., Stan Dorn, Matthew Buettgens, Caitlin Carroll. *Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States*. Washington, DC: Urban Institute, Sept. 2011, http://www.urban.org/UploadedPDF/412412-Using-the-Basic-Health-Program-to-Make-Coverage-More-Affordable-to-Low-Income-Households.pdf.

[3] CMS. "Basic Health Program: State Administration of Basic Health Programs; Eligibility and Enrollment in Standard Health Plans; Essential Health Benefits in Standard Health Plans; Performance Standards for Basic Health Programs; Premium and Cost Sharing for Basic Health Programs; Federal Funding Process; Trust Fund and Financial Integrity." *Federal Register*. Vol. 79, No. 48 (March 12, 2014): 14112-14151, http://www.gpo.gov/fdsys/pkg/FR-2014-03-12/pdf/2014-05299.pdf.

[4] CMS: "Basic Health Program; Federal Funding Methodology for Program Year 2015." *Federal Register*. Vol. 79, No. 48 (March 12, 2014): 13887 -13906, http://www.gpo.gov/fdsys/pkg/FR-2014-03-12/pdf/2014-05257.pdf.

[5] 42 CFR 600.305.

[6] 42 CFR 600.405.

[7] 42 CFR 600.505.

[8] 42 CFR 600.520(c).

[9] 42 CFR 600.520(b).

[10] 42 CFR 600.520(a).

[11] 42 CFR 600.510(b).

[12] 42 CFR 600.520(d). In addition, the state must provide consumers with access to information about premiums and cost-sharing at different income levels as well as the consequences if premiums are not paid. Such information must be made available upon request or through an Internet web site and at various key junctures, such as at enrollment and redetermination. 42 CFR 600.515.

[13] IRS. *Revenue Procedure 2014-37*. http://www.irs.gov/pub/irs-drop/rp-14-37.pdf.

[14] 42 CFR 600.415(a).

[15] 42 CFR 600.415(b)(3).

[16] 42 CFR 600.5

[17] 42 CFR 600.420(a).

[18] 42 CFR 600.410.

[19] See 45 CFR 92.36 (b) through (i).

[20] 42 CFR 600.415(b)(1). These contracts must also include the provisions required for all state contracts that use federal grant funds, under 45 CFR 92.36(i).

[21] 42 CFR 600.420(b).

[22] 42 CFR 600.345.

[23] 42 CFR 600.340(c) and (d).

[24] 42 CFR 600.310(c).

[25] 42 CFR 600.315.

[26] 42 CFR 600.320(c).

[27] 42 CFR 600.335.

[28] 42 CFR 600.320(d).

[29] 42 CFR 600.525.

[30] 42 CFR 600.340.

[31] 42 CFR 600.150.

[32] 45 CFR 155.120(c)(2), cited in 42 CFR 600.165

[33] 42 CFR 600.310(a), 42 CFR 600.330.

[34] 42 CFR 600.310(b).

[35] 42 CFR 600.320(a).

[36] 42 CFR 600.160.

[37] 42 CFR 600.110.

[38] 42 CFR 600.115 (c).

[39] 42 CRF 600.110 (c).

[40] 42 CFR 600.110; 42 CFR 600.120 (a).

[41] 42 CFR 600.120.

[42] 42 CFR 600.170.

[43] 42 CFR 600.200.

[44] 42 CFR 600.705.

[45] 42 CFR 600.710.

[46] 42 CFR 600.715.

[47] 42 CFR 600.140.

[48] 42 CFR 600.142.

[49] These calculations assume that, in each case, premiums are rounded off to the nearest dollar. If instead calculations did not use rounding, the 2014 average premium would be $344.70, and the 2015 reference premium would be $372.79.

One other comment is appropriate. Illinois might seek to apply a retrospective adjustment to premiums based on the state's Medicaid coverage of pregnant women, outside the marketplace, to 200 percent FPL (and slightly higher). After the end of the 2015 BHP program year, actuaries could estimate the impact on Illinois's individual market risk pool if pregnant women covered through BHP in 2015 had instead received coverage in the individual market. The result could be a slight increase in reference premiums, hence federal BHP funding for 2015. We could not estimate the amount of that increase here, however, and assume that Illinois opts not to make this retroactive adjustment.

[50] FPL levels are based on the thresholds for calendar year 2014, since those will be in effect at the November 2014 start of 2015 open enrollment.

[51] IRS. *Revenue Procedure 2014-37*. http://www.irs.gov/pub/irs-drop/rp-14-37.pdf.

[52] As before, these numbers round off each product to the nearest dollar. Without such rounding, the PTC amount, before application of the IRF, would be $321.06; the IRF would reduce that amount to $304.75; and the final PTC component would 95 percent of the latter figure, or $289.51.

[53] For an example of state-specific 2012 smoking rates by age, see Illinois's rates as reported by CDC: http://apps.nccd.cdc.gov/brfss/age.asp?cat=TU&yr=2012&qkey=8161&state=IL.

[54] To be more precise, the ratio between premiums charged to tobacco users and non-users shows the effect of tobacco use in raising claims costs above those that were covered by the premiums charged to non-tobacco users.

[55] Dorn, Buettgens, Carroll, op cit.

[56] Adele Shartzer, Genevieve M. Kenney, Sharon K. Long, Katherine Hempstead, and Douglas Wissoker. *Who Are the Remaining Uninsured as of June 2014?* July 29, 2014. Washington, DC: Urban Institute, http://hrms.urban.org/briefs/who-are-the-remaining-uninsured-as-of-june-2014.pdf.

[57] Matthew Buettgens, Austin Nichols, and Stan Dorn. *Churning Under the ACA and State Policy Options for Mitigation*. Washington, DC: Urban Institute (prepared for the Robert Wood Johnson Foundation), June 2012, http://www.urban.org/UploadedPDF/412587-Churning-Under-the-ACA-and-State-Policy-Options-for-Mitigation.pdf. Other studies, which did not consider the impact of unaccepted offers of employer coverage, reached mixed results. Graves, John, Rick Curtis, and Jonathan Gruber, "Balancing Coverage Affordability and Continuity under a Basic Health Program Option," *New England Journal of Medicine*. Vol. 365, no. 24 (2011): e44. Hwang, Ann, Sara Rosenbaum, and Benjamin D. Sommers, "Creation of State Basic Health Programs Would Lead to 4 Percent Fewer People Churning between Medicaid and Exchanges," *Health Affairs*. Vol. 31, no. 6 (2012): 1314-20.

This is a key methodological issue. In effect, BHP can raise the threshold of transition between Medicaid plans and marketplace plans from 138 percent FPL to 200 percent FPL. The impact of BHP on churning is thus greatly affected by the number of subsidy-eligible households near those two thresholds. Studies that fail to fully consider offers of employer coverage, which are more frequent at higher income levels, understate the potential impact of BHP in reducing churning.

[58] A state might adjust BHP eligibility mid-year, based on new information from enrollees or reliable third-party data sources. Such adjustments do not increase the PTC component of federal BHP payments on the theory that mid-year adjustments of APTC claims would reduce tax-reconciliation offsets, thus increasing the PTC amounts received by BHP consumers had they enrolled in QHPs in the marketplace. Instead, as noted earlier, the tax reconciliation reduction to the PTC component is calculated based on the assumption that BHP eligibility is continuous so, in effect, APTCs would not have been modified mid-year.

As a result, a state that chooses to implement 12-month continuous eligibility for BHP will not suffer any adverse effects in its receipt of federal funding. Costs would rise for a state that pays part of BHP expenses, however. Such a state would experience increased enrollment, hence increased expenditures, as a result of continuous eligibility. By the same token, increased enrollment would bring such a state a corresponding increase in federal BHP payments.

[59] Among consumers with incomes between 139 and 400 percent FPL who are offered ESI, between 97 percent and 99.8 percent of such offers meet the ACA's definition of affordability. Even among consumers in this income range who do not accept ESI offers, between 87 percent and 99 percent of the rejected offers are affordable. See the U.S. panel in table 1 in Matthew Buettgens, Stan Dorn, Habib Moody. *Access to Employer-Sponsored Insurance and Subsidy Eligibility in Health Benefits Exchanges: Two Data-Based Approaches*. Washington, DC: Urban Institute (prepared for the California HealthCare Foundation), Dec. 2012, http://www.urban.org/UploadedPDF/412721-Access-to-Employer-Sponsored-Insurance.pdf.

[60] See Buettgens, Dorn and Moody, 2012.

[61] An alternative approach would begin with QHP costs. For example, a recent BHP analysis for the state of Oregon took that approach. In extrapolating to the cost of using a Medicaid-based infrastructure, this analysis discounted QHP costs based on the estimated average difference between QHP and Medicaid provider reimbursements. Tim Courtney, Julia Lerche, Patrick Holland, Karan Rustagi, Matthew Buettgens, Stan Dorn, Jay Dev, and Hannah Recht. *Oregon Basic Health Program Study,* prepared for the Oregon Health Authority, Oregon Health Policy Research. October 2014, Clearwater, FL: Wakely Consulting Group and the Urban Institute.

[62] For an example of how varying the details of BHP coverage can affect likely costs, see Matthew Buettgens, Stan Dorn, Jeremy Roth, Caitlin Carroll. *The Basic Health Program in Utah*. Washington, DC: Urban Institute, Nov. 2012, http://www.urban.org/UploadedPDF/412695-The-Basic-Health-Program-in-Utah.pdf.

[63] Such premium increases could deter participation by healthier consumers, increasing average risk levels and the costs of those who do enroll. However, so long as BHP premiums remain significantly below those charged in the marketplace, this effect is likely to be much less significant than the fiscal contributions resulting from consumer premium payments.

[64] If states believe that they can likely increase plan payments (and ultimately the associated provider reimbursements) above Medicaid levels but there is some uncertainty as to the amount that federal funding will support, some of the increase could be held back and paid as a bonus after the end of the year. The total statewide payment amount would be based on how the relevant uncertainties were resolved, and the amount received by each plan (and ultimately provider) would be in proportion to the total amount of care furnished to BHP consumers.

[65] 79 Federal Register at 14133.

[66] 42 CFR 600.705(e).

[67] Dorn, Buettgens, Carroll, op cit.

[68] Authors' calculations, New York Department of Health. "2014 Open Enrollment Report," *NY State of Health: The Official Health Plan Marketplace,* June 2014, Albany, NY.

[69] For an estimate of the state's non-elderly population, see U.S. Census Bureau, "Massachusetts," *State & County Quick Facts,* Last Revised: Thursday, 27-Mar-2014 09:55:43 EDT, http://quickfacts.census.gov/qfd/states/25000.html.

[70] A smaller marketplace also has less leverage to change health care delivery and financing to improve population health and quality while slowing cost growth. However, those important goals need not be compromised if the state acting as purchaser uses BHP among other state programs to accomplish those same objectives. In fact, if the marketplace is federally facilitated, BHP could enhance a state's ability to implement delivery system and payment reforms, as noted in the text.

[71] Massachusetts Commonwealth Connector (Connector). *Commonwealth Choice Progress Report*. December 13, 2007.

[72] Connector. *Connector Summary Report*. December 11, 2008. https://www.mahealthconnector.info/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/2008/2008-12-11/Connector%2520Summary%2520Report%2520-%252012%252011%252008.xls.

[73] By July 2010, enrollment was approximately 36,000-37,000, of which 75 percent was in the non-group portion of the program. Connector. *Report to the Massachusetts Legislature: Implementation of Health Care Reform, Fiscal Year 2010*. November 2010. Total enrollment, in both small group and non-group portions of the program combined, has now levelled off at slightly higher than 40,000. Connector. *Report to the Massachusetts Legislature: Implementation of Health Care Reform, Fiscal Year 2012*. December 2012.

[74] Matthew Buettgens, Stan Dorn, Jeremy Roth, Caitlin Carroll. "The Basic Health Program in Utah." Washington, DC: Urban Institute, November 2012, http://www.urban.org/UploadedPDF/412695-The-Basic-Health-Program-in-Utah.pdf; Matthew Buettgens, Caitlin Carroll. "The ACA Basic Health Program in Washington State." Washington, DC: Urban Institute, April 2012, updated August 2012, http://www.urban.org/UploadedPDF/412572-The-ACA-Basic-Health-Program-in-Washington-State.pdf.

[75] Depending on the details of Medicaid coverage, it can either preclude BHP eligibility or, as a practical matter, make BHP enrollment less likely. As noted earlier, one can simultaneously qualify for (1) pregnancy-related Medicaid or categories of Medicaid eligibility that provide less than minimum essential coverage and (2) BHP or marketplace subsidies. However, enrollment in BHP or marketplace coverage is much less likely to take place, as a practical matter, with someone who is receiving Medicaid than with someone who is uninsured or previously paid for individual insurance.

[76] States may also have the authority, in their role as regulators of insurance markets, to require carriers that serve the individual market and BHP to pool both sets of enrollees.

[77] MNsure. *MNsure Metrics Dashboard: Prepared for Board of Directors Meeting, April 16, 2014*, https://www.mnsure.org/images/bd-2014-04-16-dashboard.pdf.

[78] MNsure. *MNsure Metrics Dashboard: Prepared for Board of Directors Meeting, July 16, 2014*, https://www.mnsure.org/images/bd-2014-04-16-dashboard.pdf.

[79] Authors' calculations, MNSure. *Provider Networks.* (undated) https://www.mnsure.org/images/Individual-ServiceAreas-ProviderLook-up.xls.

[80] Amy Burke, Arpit Misra, and Steven Sheingold. "Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014." *ASPE Research Brief,* June 18, 2014, Washington, DC: Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (ASPE/HHS).

[81] MNSure. "Health Care Coverage and Plan Rates for 2015." October 1, 2015, https://www.mnsure.org/images/2015-10-1-MNsure-healthcare-coverage-plan-rates.pdf.

[82] According to HHS estimates of weighted average premiums by state, Minnesota's premiums for the lowest-cost silver plan, second-lowest cost silver plan, and lowest-cost bronze plan were $192, $192, and $144 a month, respectively, well below those in any other state among the 48 (including the District of Columbia) for which data were reported. The state with next lowest such premiums for silver plans was Tennessee, with $235 and $245 weighted average premiums for the lowest and second-lowest-cost silver plans, respectively, 18 percent and 22 percent above Minnesota's corresponding averages. The state with the second-least-expensive weighted-average lowest-cost bronze plan was Oklahoma, with $174 monthly premiums that exceeded Minnesota's levels by 17 percent. Authors' calculations. ASPE Office of Health Policy. "Table 4: Weighted Average Premiums, 48 States," *Health Insurance Marketplace Premiums for 2014*. September 25, 2013, http://aspe.hhs.gov/health/reports/2013/marketplacepremiums/ib_premiumslandscape.pdf.

[83] James Nord. "MNsure claims success in first year sign-ups." *Politics in Minnesota*. April 4, 2014. http://politicsinminnesota.com/2014/04/mnsure-claims-success-in-first-year-sign-ups/.

[84] Christopher Snowbeck. "MNsure: Twin Cities' rates still look cheaper, but gap is shrinking in Minnesota," *Star Tribune,* October 4, 2014, http://www.startribune.com/business/278072961.html.

[85] Minnesota State Department of Commerce. "Commerce Announces Minnesota Health Insurance Rates – Lowest Rates in Nation for Second Year," October 1, 2014, http://mn.gov/commerce/insurance/media/newsdetail.jsp?id=209-143493.

[86] The other major source of funding is $5 million in unspent federal exchange grant funds from 2013. MNsure. "Preliminary MNsure Budget for Calendar Year 15," March 12, 2014, http://www.lcc.leg.mn/mnsure/meetings/04092014/Bd-2014-03-12-Prelim2015Budget.pdf; Christopher Snowbeck, "MNsure board OKs 3.5 percent premium withholding," *TwinCities Pioneer Press.* May 14, 2014, http://www.twincities.com/politics/ci_25762410/mnsure-board-oks-3-5-percent-premium-withholding; James Nord. "MNsure enrolls 170,000 Minnesotans as insurance deadline passes." *Politics in Minnesota*. April 1, 2014, http://politicsinminnesota.com/2014/04/mnsure-enrolls-170000-minnesotans-as-insurance-deadline-passes/.

[87] ACA Section 1332 permits state innovation waivers that allow major changes to ACA's architecture, including marketplaces, PTCs, and CSRs. Such changes must be cost-neutral and may not increase consumer costs or reduce benefits, compared to the ACA without a waiver. These waivers may not be into effect until 2017.

In this context, they might allow a state to use 100 percent, rather than 95 percent, of PTCs and CSRs to serve consumers through state-sponsored coverage that makes coverage more affordable for low-income consumers who include and potentially go beyond those who qualify for BHP. For the final regulation concerning the process for obtaining such waivers, see CMS, Department of the Treasury. "Application, Review, and Reporting Process for Waivers for State Innovation." *Federal Register*. Vol. 77, No. 38, 11700-11721, Monday, February 27, 2012, http://www.gpo.gov/fdsys/pkg/FR-2012-02-27/pdf/2012-4395.pdf, promulgating 31 CFR 33.100 et seq., 45 CFR 155.1300, et seq.

[88] Massachusetts Executive Office of Health and Human Services (EOHHS). *MassHealth: Roadmap to 2014*. Revised May 2013, http://www.mass.gov/eohhs/docs/eohhs/cms-waiver/aca-transition-plan-draft.pdf; Letter from CMS Administrator Marilyn Tavenner to EOHHS Secretary John Polanowicz, October 1, 2013, http://www.mass.gov/eohhs/docs/eohhs/cms-waiver/ma-1115-amendment-approval-oct-1-2013.pdf. For Vermont's premium costs, see Vermont Health Connect Subsidy Calculator, http://info.healthconnect.vermont.gov/tax_credit_calculator.

[89] Brian Rosman, Health Care for All Massachusetts, personal communication, 2013.

[90] ACA §1412(e).

[91] Results from Kaiser Family Foundation Subsidy Calculator, http://kff.org/interactive/subsidy-calculator/.

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November 2014 | Issue Brief

The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update

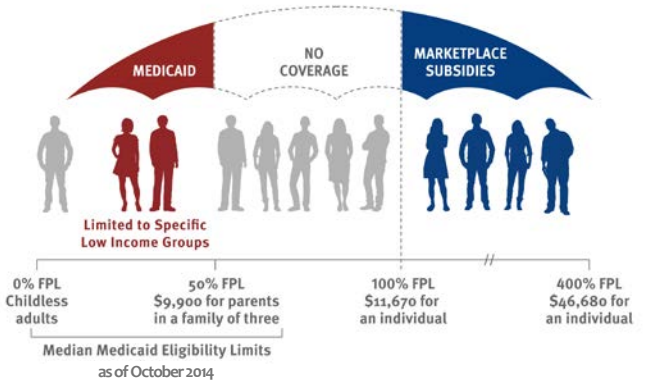
Rachel Garfield, Anthony Damico, Jessica Stephens, and Saman Rouhani

One of the major coverage provisions of the 2010 Affordable Care Act (ACA) is the expansion of Medicaid eligibility to nearly all low-income individuals with incomes at or below 138 percent of poverty ($27,310 for a family of three[1]). This expansion fills in historical gaps in Medicaid eligibility for adults and was envisioned as the vehicle for extending insurance coverage to low-income individuals, with premium tax credits for Marketplace coverage serving as the vehicle for covering people with moderate incomes. While the Medicaid expansion was intended to be national, the June 2012 Supreme Court ruling essentially made it optional for states.

As of October 2014, 23 states were not expanding their programs. Medicaid eligibility for adults in states not expanding their programs is quite limited: the median income limit for parents in 2014 is just 50% of poverty, or an annual income of $9,893 a year for a family of three, and in nearly all states not expanding, childless adults will remain ineligible.[2] Further, because the ACA envisioned low-income people receiving coverage through Medicaid, it does not provide financial assistance to people below poverty for other coverage options. As a result, in states that do not expand Medicaid, many adults will fall into a "coverage gap" of having incomes above Medicaid eligibility limits but below the lower limit for Marketplace premium tax credits (Figure 1).

Figure 1

In states that do not expand Medicaid under the ACA, there will be large gaps in coverage available for adults.



This brief presents estimates of the number of people who fall into the coverage gap, describes who they are, and discusses the implications of them being left out of ACA coverage expansions. An overview of the methodology underlying the analysis can be found in the Methods box at the end of the report, and more detail is available in the Technical Appendices available here, here, and here.

How Many People Are in the Coverage Gap?

Nationally, nearly four million poor uninsured adults fall into the "coverage gap" that results from state decisions not to expand Medicaid, meaning their income is above current Medicaid eligibility but below the lower limit for Marketplace premium tax credits. These individuals would have been newly-eligible for Medicaid had their state chosen to expand coverage.

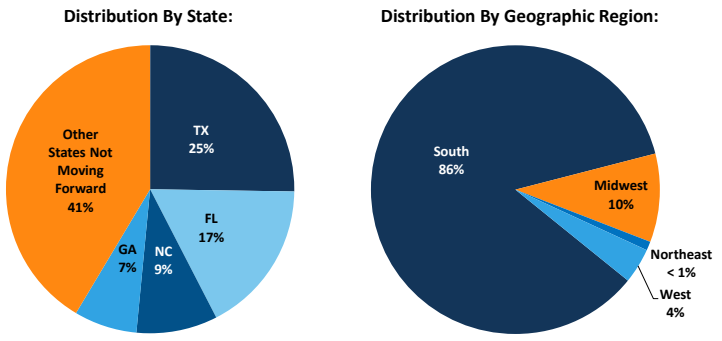
In the past year, the number of people falling into the coverage gap has declined as more states have taken up the Medicaid expansion. Since September 30, 2013, three states (Ohio, New Hampshire, and Pennsylvania) have opted to expand their Medicaid programs, extending ACA-related assistance to approximately 600,000 uninsured nonelderly adults.

Adults left in the coverage gap due to current state decisions not to expand Medicaid are spread across the states not expanding their Medicaid programs but are concentrated in states with the largest uninsured populations (Table 1). A quarter of people in the coverage gap reside in Texas, which has both a large uninsured population and very limited Medicaid eligibility (Figure 2). Seventeen percent live in Florida, nine percent North Carolina, and seven percent in Georgia. There are no uninsured adults in the coverage gap in Wisconsin because the state is providing Medicaid eligibility to adults up to the poverty level.

The geographic distribution of the population in the coverage gap reflects both population distribution and regional variation in state take-up of the ACA Medicaid expansion. As a whole, more people—and in particular more poor uninsured adults— reside in the South than in other regions.[3] Further, the South has higher uninsured rates and more limited Medicaid eligibility than other regions. Southern states also have disproportionately opted not to expand their programs, and nearly half (11 out of 23) of the states not expanding Medicaid are in the South. These factors combined mean 86% of people in the coverage gap reside in the South (Figure 2).

Figure 2

Distribution of Adults in the Coverage Gap, by State and Region



Notes: Excludes legal immigrants who have been in the country for five years or less and immigrants who are undocumented. The poverty level for a family of three in 2014 is $19,790. Totals may not sum to 100% due to rounding.
Source: Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels and 2014 Current Population Survey.

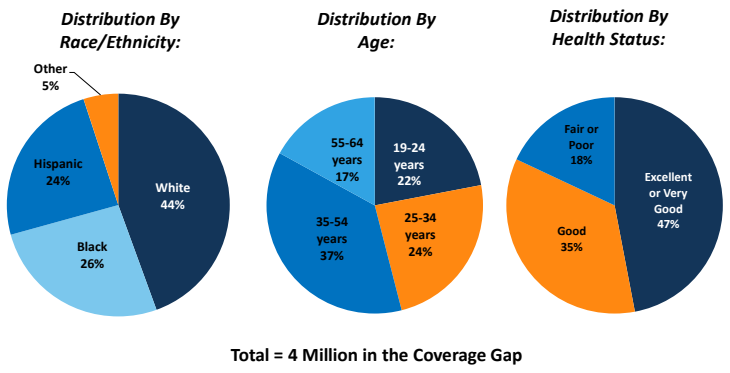
What Are Characteristics of People in the Coverage Gap?

The characteristics of the population that falls into the coverage gap largely mirror those of poor uninsured adults. For example, because racial/ethnic minorities are more likely than White non-Hispanics to lack insurance coverage and are more likely to live in families with low incomes, they are disproportionately represented among poor uninsured adults and among people in the coverage gap. Nationally, 44% of uninsured adults in the coverage gap are White non-Hispanics, 24% are Hispanic, and 26% are Black (Figure 3). However, the race and ethnicity of people in the coverage gap also reflects differences in the racial/ethnic composition between states moving forward with the Medicaid expansion and states not planning to expand.

Several states that have large Hispanic populations (e.g., California, New York, and Arizona) are moving forward with the expansion, while other states with large Black populations (e.g., Florida, Georgia, and Texas) are not. As a result, Blacks account for a slightly higher share of people in the coverage gap compared to the total poor adult uninsured population, while Hispanics account for a slightly lower share. The racial/ethnic characteristics of the population in the coverage gap vary widely by state, mirroring the underlying characteristics of the state population.

Figure 3

Demographic Characteristics of Adults in the Coverage Gap



Total = 4 Million in the Coverage Gap

Notes: Excludes legal immigrants who have been in the country for five years or less and immigrants who are undocumented. Totals may not sum to 100% due to rounding.
Source: Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels and 2014 Current Population Survey.

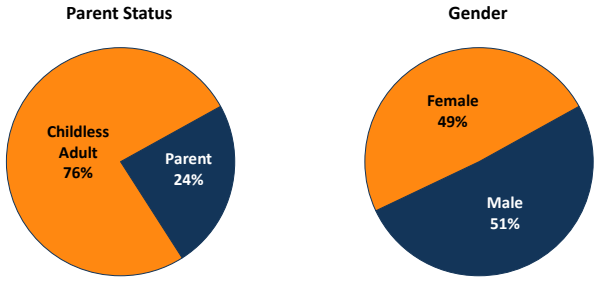
Nonelderly adults of all ages fall into the coverage gap (Figure 3). Notably, over half are middle-aged (age 35 to 54) or near elderly (age 55 to 64). Adults of these ages are likely to have increasing health needs, and research has demonstrated that uninsured people in this age range may leave health needs untreated until they become eligible for Medicare at age 65.[4]

While nearly half of people in the coverage gap report that their health is excellent or very good, nearly a fifth (18%) report that they are in fair or poor health (Figure 3). These individuals have known health problems that likely require medical attention. Studies repeatedly demonstrate that the uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases.[5] When they do seek care, the uninsured often face unaffordable medical bills.[6]

The characteristics of people in the coverage gap also reflect Medicaid program rules in states not expanding their programs. Because non-disabled adults without dependent children are ineligible for Medicaid coverage in most states not expanding Medicaid, regardless of their income, adults without dependent children account for a disproportionate share of people in the coverage gap (76%) (Figure 4). Still, nearly a quarter (24%) of people in the coverage gap are poor parents whose income places them above Medicaid eligibility levels. The share of people in the coverage gap who are parents with dependent children varies by state (see Table 1) due to variation in current state eligibility. For example, Alaska, Maine, and Tennessee will cover parents up to at least poverty as of 2014, so all people in the coverage gap in those states are adults without dependent children.

Figure 4

Parent Status and Gender of Adults in the Coverage Gap



Total = 4 Million in the Coverage Gap

Notes: Excludes legal immigrants who have been in the country for five years or less and immigrants who are undocumented.
Source: Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels and 2014 Current Population Survey.

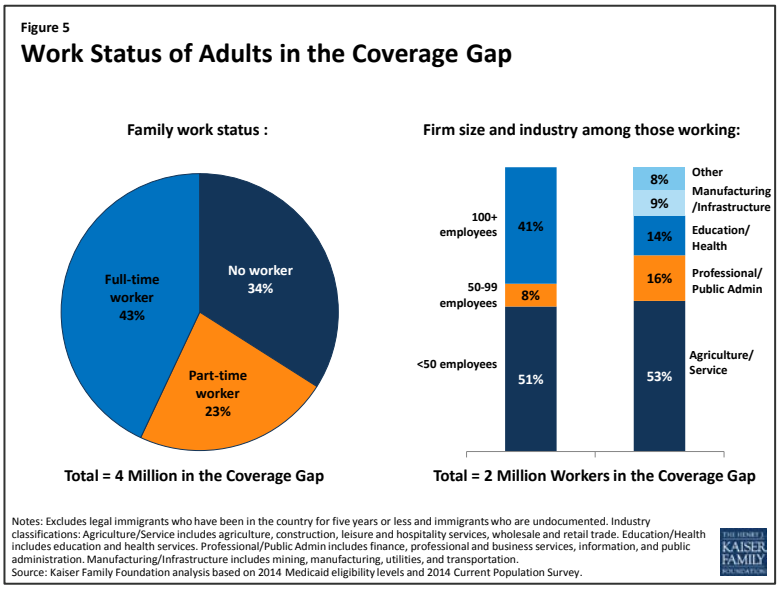
Women account for just under half (49%) of adults in the coverage gap (Figure 4). Women actually make up the majority of poor uninsured adults in states not expanding their program but are more likely than men to qualify for Medicaid under current rules. As a result, the gender split actually indicates a disproportionate share of men falling into the coverage gap. Of poor adults in non-expansion states who would have been eligible for Medicaid had their state expanded, 86 percent of males land in the gap, compared to 78 percent of females (data not shown). This disproportionate gender pattern occurs because men are much less likely than women to meet current Medicaid eligibility in states not expanding their programs.

The work status of people in the coverage gap indicates that there are limited coverage options available for people in this situation. Two-thirds (66%) of people in the coverage gap are in a family with a worker, and 54% are working themselves (Figure 5). While workers could potentially have an offer of coverage through their employer, the majority of workers in the coverage gap (51%) work for small firms (<50 employees) that will not be subject to ACA penalties for not offering coverage. Further, many firms do not offer coverage to part-time workers. A majority of workers in the coverage gap also work in industries with historically low insurance rates, such as the agriculture and service industries.

More than a third (34%) of adults in the coverage gap are in a family with no workers. Since the Medicaid expansion was designed to reach those left out of the employer-based system, and because people in the coverage gap by definition are poor, it is not surprising that most are unlikely to have access to health coverage through a job.

Figure 5

Work Status of Adults in the Coverage Gap



Notes: Excludes legal immigrants who have been in the country for five years or less and immigrants who are undocumented. Industry classifications: Agriculture/Service includes agriculture, construction, leisure and hospitality services, wholesale and retail trade. Education/Health includes education and health services. Professional/Public Admin includes finance, professional and business services, information, and public administration. Manufacturing/Infrastructure includes mining, manufacturing, utilities, and transportation.
Source: Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels and 2014 Current Population Survey.

Conclusion

The ACA Medicaid expansion was designed to address the high uninsured rates among adults living below poverty, providing a coverage option for people who had limited access to employer coverage and limited income to purchase coverage on their own. However, with many states opting not to implement the Medicaid expansion, millions of adults will remain outside the reach of the ACA and continue to have limited, if any, options for health coverage: they are ineligible for publicly-financed coverage in their state, most do not have access to employer-based coverage through a job, and all have limited income available to purchase coverage on their own.

The majority of people in the coverage gap are working poor—that is, employed either part-time or full-time but still living below the poverty line. Given the characteristics of their employment, it is likely that many will continue to lack access to coverage through their job even after the ACA provisions for employer responsibility for coverage are effective in 2015.[7] Further, even if they do receive an offer from their employer that meets ACA requirements, many will find their share of the cost to be unaffordable. Because this population is generally

exempt from the individual mandate, and because firms will not face a penalty for these workers remaining uninsured, they will continue to fall between the cracks in the employer-based system.

It is unlikely that people who fall into the coverage gap will be able to afford ACA coverage without financial assistance: in 2014, the national average premium for a 40-year-old individual purchasing coverage through the Marketplace was $270 per month for a silver plan and $224 per month for a bronze plan,[8] which equates to about half of income for those at the lower income range of people in the gap and about a quarter of income for those at the higher income range of people in the gap. Further, people in the coverage gap are ineligible for cost-sharing subsidies for Marketplace plans and could face additional out-of-pocket costs up to $6,350 a year if they were to purchase Marketplace coverage. Given the limited budgets of people in the coverage gap, these costs are likely prohibitively expensive. Thus, it is most likely that adults in the coverage gap will remain uninsured, even after the ACA is fully implemented.

If they remain uninsured, adults in the coverage gap are likely to face barriers to needed health services or, if they do require medical care, potentially serious financial consequences. Many are in fair or poor health or are in the age range when health problems start to arise, but lack of coverage may lead them to postpone needed care due to the cost. While the safety net of clinics and hospitals that has traditionally served the uninsured population will continue to be an important source of care for the remaining uninsured under the ACA, this system has been stretched in recent years due to increasing demand and limited resources.

Further, the racial and ethnic composition of the population that falls into the coverage gap indicates that state decisions not to expand their programs disproportionately affect people of color, particularly Black Americans. This disproportionate effect occurs because the racial and ethnic composition of states not expanding their Medicaid programs differs from the ones that are expanding. As a result, state decisions about whether to expand Medicaid have implications for efforts to address disparities in health coverage, access, and outcomes among people of color.

Last, the population in the coverage gap shows that, as a result of state decisions not to expand their Medicaid programs, many remaining uninsured under the ACA will reflect the legacy of the system linking Medicaid coverage to only certain categories of people. Many people who fall outside these categories—specifically men and adults without dependent children—still have a need for health coverage. The ACA Medicaid expansion was designed to end categorical eligibility for Medicaid, but in states not implementing the expansion, the vestiges of categorical eligibility will remain.

Table 1: Number and Characteristics of Poor Uninsured Nonelderly Adults in the ACA Coverage Gap, by State				
State	Number in Coverage Gap	Share in Coverage Gap who Are:		
		Adults without Dependent Children	Female	In a Working Family
All states not expanding Medicaid*	**3,846,000**	**76%**	**49%**	**66%**
Alabama	176,000	70%	52%	63%
Alaska	10,500	100%	NA	NA
Florida	669,000	79%	50%	64%
Georgia	282,000	76%	52%	57%
Idaho	51,000	81%	50%	72%
Indiana	138,000	67%	50%	66%
Kansas	60,000	83%	33%	78%
Louisiana	166,000	82%	46%	68%
Maine	22,000	100%	NA	53%
Mississippi	107,000	90%	48%	67%
Missouri	147,000	63%	55%	67%
Montana	35,000	82%	NA	67%
Nebraska	31,000	86%	50%	80%
North Carolina	357,000	75%	47%	62%
Oklahoma	104,000	88%	50%	58%
South Carolina	178,000	83%	49%	48%
South Dakota	NA	NA	NA	NA
Tennessee	142,000	100%	NA	NA
Texas	948,000	68%	51%	76%
Utah	30,000	75%	NA	NA
Virginia	171,000	79%	44%	70%
Wyoming	14,000	69%	58%	78%

NOTES: Excludes undocumented immigrants and legal immigrants who have been in the US for <5 years.
* Wisconsin is not included in Table 1 because the state is providing Medicaid eligibility to adults up to the poverty level under a Medicaid waiver. As a result, there is no one in the coverage gap in Wisconsin.
NA: Sample size too small for reliable estimate.
SOURCES: KFF analysis of March 2014 CPS and Medicaid MAGI eligibility levels.

Methods

This analysis uses data from the 2014 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC). The CPS ASEC provides socioeconomic and demographic information for the United Sates population and specific subpopulations. Importantly, the CPS ASEC provides detailed data on families and households, which we use to determine income for ACA eligibility purposes (see below for more detail). Notably, with the 2014 ASEC, Census implemented a fundamental redesign of the health insurance coverage questions. This redesign aimed both to address longstanding issues with measurement of insurance coverage in the ASEC and to capture new coverage categories available under the ACA. The redesigned insurance questions lead to a lower estimate of the uninsured rate compared to the previous approach, addressing a longstanding issue of under-reporting of coverage in the ASEC. As a result of these changes, health coverage data for the 2014 release (reflecting coverage in calendar year 2013) are not comparable with estimates from previous years.

Medicaid and Marketplaces have different rules about household composition and income for eligibility. For this analysis, we calculate household membership and income for both Medicaid and Marketplace premium tax credits for each person individually, using the rules for each program. For more detail on how we construct Medicaid and Marketplace households and count income, see the detailed technical Appendix A available here.

Undocumented immigrants are ineligible for Medicaid and Marketplace coverage. Since CPS data do not directly indicate whether an immigrant is lawfully present, we draw on the methods underlying the 2013 analysis by the State Health Access Data Assistance Center (SHADAC) and the recommendations made by Van Hook et. al.[9],[10] This approach uses the Survey of Income and Program Participation (SIPP) to develop a model that predicts immigration status; it then applies the model to CPS, controlling to state-level estimates of total undocumented population from Department of Homeland Security. For more detail on the immigration imputation used in this analysis, see the technical Appendix B available here.

Individuals in tax-filing units with access to an affordable offer of Employer-Sponsored Insurance are still potentially MAGI-eligible for Medicaid coverage, but are ineligible for advance premium tax credits in the Health Insurance Exchanges. Since CPS data do not directly indicate whether workers have access to ESI, we draw on the methods comparable to our imputation of authorization status. For more detail on the offer imputation used in this analysis, see the technical Appendix C available here. As of January 2014, Medicaid financial eligibility for most nonelderly adults is based on modified adjusted gross income (MAGI). To determine whether each individual is eligible for Medicaid, we use each state's MAGI eligibility level that was effective as of July 2014.[11] Some nonelderly adults with incomes above MAGI levels may be eligible for Medicaid through other pathways; however, we only assess eligibility through the MAGI pathway.[12]

An individual's income is likely to fluctuate throughout the year, impacting his or her eligibility for Medicaid. Our estimates are based on annual income and thus represent a snapshot of the number of people in the coverage gap at a given point in time. Over the course of the year, a larger number of people are likely to move and out of the coverage gap as their income fluctuates.

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[1] The 2014 federal poverty guideline for a family of three was $19,790. See: http://aspe.hhs.gov/poverty/14poverty.cfm.

[2] Of the states not moving forward with the expansion, only Wisconsin provides full Medicaid coverage to adults without dependent children as of 2014.

[3] Stephens, J., S. Artiga, and J. Paradise. Health Coverage and Care in the South in 2014 and Beyond. (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured), April 2014, available at: http://kff.org/report-section/health-coverage-and-care-in-the-south-in-2014-and-beyond-health-coverage-and-care-in-the-south-today/

[4] McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ. "Use of Health Services by Previously Uninsured Medicare Beneficiaries." *New England Journal of Medicine.* 2007 July 12, 357(2): 143-53.

[5] For a review of findings on access to care for the uninsured, see: Kaiser Commission on Medicaid and the Uninsured. *The Uninsured: A Primer- Key Facts About Health Insurance on the Eve of Coverage Expansions.* (Washington, DC: Kaiser Family Foundation),

October 23, 2013. Available at: http://www.kff.org/uninsured/report/the-uninsured-a-primer-key-facts-about-health-insurance-on-the-eve-of-coverage-expansions/.

[6] Ibid.

[7] See http://www.kff.org/infographic/employer-responsibility-under-the-affordable-care-act/ for a review of these requirements.

[8] The methods for arriving at this estimate can be found on the Kaiser Family Foundation Subsidy Calculator, (available here: http://www.kff.org/interactive/subsidy-calculator/). The calculator is based on Congressional Budget Office (CBO) projections from July 2012 (Available here: http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf)

[9] State Health Access Data Assistance Center. 2013. "State Estimates of the Low-income Uninsured Not Eligible for the ACA Medicaid Expansion." Issue Brief #35. Minneapolis, MN: University of Minnesota. Available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf404825.

[10] Van Hook, J., Bachmeier, J., Coffman, D., and Harel, O. "Can We Spin Straw into Gold? An Evaluation of Immigrant Legal Status Imputation Approaches" *Demography*. Forthcoming.

[11] Kaiser Commission on Medicaid and the Uninsured. *Fact Sheet: Medicaid Eligibility for Adults as of January 1, 2014.* (Washington, DC: Kaiser Family Foundation), October 1, 2014. Available at: http://www.kff.org/medicaid/fact-sheet/medicaid-eligibility-for-adults-as-of-january-1-2014/.

[12] Non-MAGI pathways for nonelderly adults include disability-related pathways, such as SSI beneficiary; Qualified Severely Impaired Individuals; Working Disabled; and Medically Needy. We are unable to assess disability status in the CPS sufficiently to model eligibility under these pathways. However, previous research indicates high current participation rates among individuals with disabilities (largely due to the automatic link between SSI and Medicaid in most states, see Kenney GM, V Lynch, J Haley, and M Huntress. "Variation in Medicaid Eligibility and Participation among Adults: Implications for the Affordable Care Act." *Inquiry*. 49:231-53 (Fall 2012)), indicating that there may be a small number of eligible uninsured individuals in this group. Further, many of these pathways (with the exception of SSI, which automatically links an individual to Medicaid in most states) are optional for states, and eligibility in states not implementing the ACA expansion is limited. For example, the median income eligibility level for coverage through the Medically Needy pathway is 15% of poverty in states that are not expanding Medicaid, and most states not expanding Medicaid do not provide coverage above SSI levels for individuals with disabilities. (See: O'Mally-Watts, M and K Young. *The Medicaid Medically Needy Program: Spending and Enrollment Update.* (Washington, DC: Kaiser Family Foundation), December 2012. Available at: http://www.kff.org/medicaid/issue-brief/the-medicaid-medically-needy-program-spending-and/. And Kaiser Commission on Medicaid and the Uninsured, "Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities," February 2010. Available at: http://www.kff.org/medicaid/issue-brief/medicaid-financial-eligibility-primary-pathways-for-the-elderly-and-people-with-disabilities/.

The COMMONWEALTH FUND

Tracking Trends in Health System Performance

NOVEMBER 2014

Too High a Price: Out-of-Pocket Health Care Costs in the United States

Findings from the Commonwealth Fund Health Care Affordability Tracking Survey, September–October 2014

Sara R. Collins, Petra W. Rasmussen, Michelle M. Doty, and Sophie Beutel

Abstract Whether they have health insurance through an employer or buy it on their own, Americans are paying more out-of-pocket for health care now than they did in the past decade. A Commonwealth Fund survey fielded in the fall of 2014 asked consumers about these costs. More than one of five 19-to-64-year-old adults who were insured all year spent 5 percent or more of their income on out-of-pocket costs, not including premiums, and 13 percent spent 10 percent or more. Adults with low incomes had the highest rates of steep out-of-pocket costs. About three of five privately insured adults with low incomes and half of those with moderate incomes reported that their deductibles are difficult to afford. Two of five adults with private insurance who had high deductibles relative to their income said they had delayed needed care because of the deductible.

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

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OVERVIEW

Over the past decade, Americans—whether they receive health insurance from their employers or purchase it on their own—have seen a substantial increase in the amount of money they pay when they go to a doctor or fill a prescription.[1] The share of workers covered by employer-based health plans who faced a deductible climbed from 55 percent in 2006 to 80 percent in 2014, according to the Kaiser Family Foundation.[2] In 2014, the average deductible for a single policy in an employer plan was $1,217, more than double the 2006 average of $584. More than two of five covered workers—up from 10 percent in 2006—have deductibles of $1,000 or more.

Because median family income has grown very slowly over the past decade, these trends mean that the amount U.S. families spend on health has

grown as a share of income. For some families, this has led to underinsurance—their insurance coverage does not provide adequate protection from the costs of health care. Prior research by The Commonwealth Fund has found that when people are underinsured they delay getting needed care at similar rates as adults who lack coverage altogether.[3] This is why the Affordable Care Act requires health insurance policies sold in the individual and small-group markets to cover a comprehensive set of health benefits, and why it provides greater financial protection for lower-income people who buy plans through the marketplaces. But the law's reach is limited. More than 150 million Americans get their health insurance through an employer; 7.1 million bought plans through the marketplaces this year.

This issue brief assesses the financial protectiveness of health insurance coverage in the United States by examining survey results from The Commonwealth Fund that track the affordability of health insurance and health care among the nation's adult population. Between September 10 and October 5, 2014, the Commonwealth Fund Health Care Affordability Tracking Survey interviewed a nationally representative sample of 2,751 adults ages 19 to 64 about the costs of their health insurance and health care.

THE COMMONWEALTH FUND'S MEASURE OF UNDERINSURANCE

In 2003, Cathy Schoen developed a measure of underinsurance for the Commonwealth Fund Biennial Health Insurance Survey that takes into account an insured adult's reported out-of-pocket costs over the course of a year, not including premiums, and their health plan deductible. These actual expenditures and the potential risk of expenditures, as represented by the deductible, are then compared with household income. Specifically, someone who is insured all year is underinsured if:

- out-of-pocket costs, excluding premiums, over the prior 12 months are equal to 10 percent or more of household income; or
- out-of-pocket costs, excluding premiums, are equal to 5 percent or more of household income if income is under 200 percent of the federal poverty level ($22,980 for an individual and $47,100 for a family of four); or
- the deductible is 5 percent or more of household income.

The Commonwealth Fund has reported changes in this measure every year it has fielded the biennial survey. We will report an update of this measure in January 2015. With this smaller and shorter tracking survey, we aim to periodically check in on what Americans are spending out-of-pocket on their health care, their views of these costs, and how costs are affecting their medical decisions.

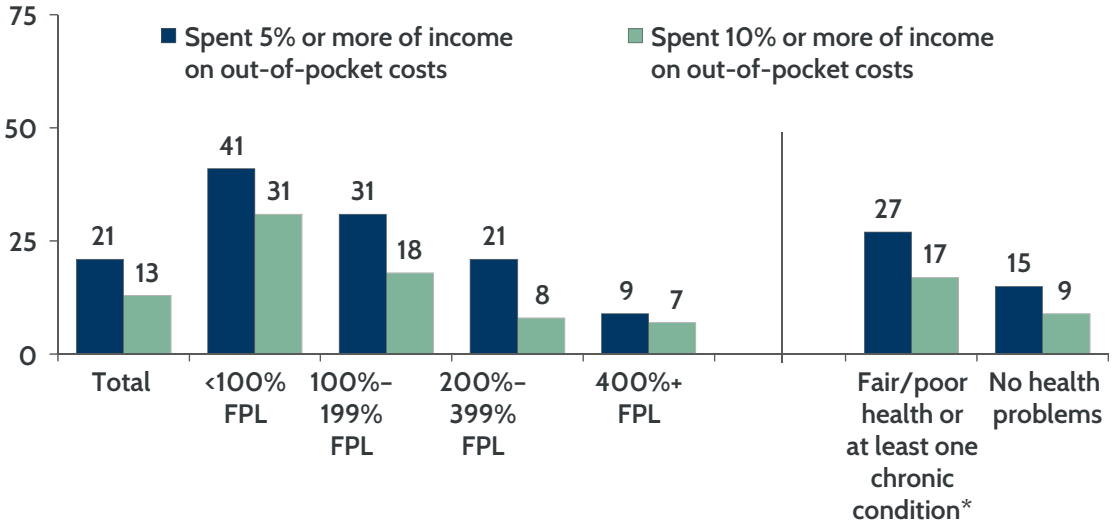
SURVEY FINDINGS

Low-Income Adults Are the Most Likely Among Those Insured All Year to Spend Large Shares of Their Income on Health Care

In the survey, people were asked how much they spent out-of-pocket for medical treatments and services that were not covered by their health insurance over the prior 12 months. They were asked to think of all their expenditures, including copayments, when they went to the doctor or hospital, as well as their costs for prescriptions and vision and dental care. We then calculated their estimates as a share of their income. Among adults who had had health insurance for the full 12 months, more than one of five (21%) spent 5 percent or more of their income on out-of-pocket costs and 13 percent spent 10 percent or more (Exhibit 1).

Exhibit 1. Two of Five Insured Adults with Incomes Below the Federal Poverty Level Spent 5 Percent or More of Their Income on Medical Out-of-Pocket Costs

Percent of adults ages 19–64 who were insured all year



Note: FPL refers to federal poverty level. * Respondent reported having at least one of the following chronic conditions: hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease; high cholesterol; or depression or anxiety.
Base: Respondents who were insured all year and reported their income level and out-of-pocket costs.
Source: The Commonwealth Fund Health Care Affordability Tracking Survey, September–October 2014.

Adults with low-incomes were the most likely to spend a large share of their income on uncovered health care costs.[4] Two of five (41%) adults with incomes under 100 percent of poverty ($11,490 for an individual and $23,550 for a family of four) who had insurance for the full year spent 5 percent or more of their income on out-of-pocket medical costs and 31 percent spent 10 percent of their income. In the next-higher income category, 100 percent to 199 percent of poverty ($22,980 for an individual and $47,100 for a family of four), 31 percent of adults spent 5 percent or more of their income on medical services not covered by their health plans.

People with health problems have higher costs than those who are healthier, and the survey finds that some of that extra cost is shouldered by patients and their families. Insured adults in fair or poor health or those who reported at least one chronic condition were more likely to spend large shares of their income on medical costs not covered by their insurance than insured adults in better health.[5]

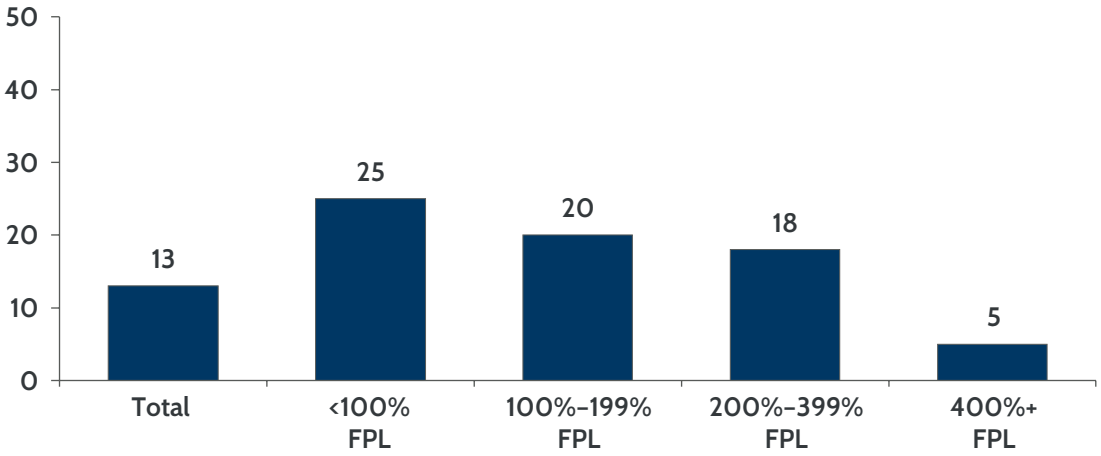
Thirteen Percent of Privately Insured Adults Have Deductibles Equal to 5 Percent or More of Income

When people use their health insurance, they incur out-of-pocket costs. A health plan's deductible provides an indicator of the financial protection a plan offers and the risk of incurring costs even before a person uses their plan. Adults in the survey were asked whether their plan had a per-person deductible and, if so, what the size of the deductible was. We then calculated the deductible as a share of their income.

Since few people with Medicaid have deductibles, we looked at adults' experience with deductibles among those who reported having a private plan at the time of the survey. Among adults with private insurance, 13 percent had a deductible of 5 percent or more of income (Exhibit 2). Adults with low and moderate incomes were the most likely to have deductibles that were high

Exhibit 2. Privately Insured Adults with Low Incomes Were the Most Likely to Have Deductibles That Could Potentially Use 5 Percent or More of Their Annual Income

Percent of privately insured adults ages 19–64 whose deductible is 5% or more of income*



Note: FPL refers to federal poverty level.
* Base: Respondents who reported their income level and deductible for their private insurance plan (includes those who are currently covered by employer-provided insurance, a marketplace plan, or a plan they purchased through the individual market outside of the marketplaces).
Source: The Commonwealth Fund Health Care Affordability Tracking Survey, September–October 2014.

relative to their income: one-quarter of privately insured adults with incomes under poverty and about one of five with incomes between 100 percent and 399 percent of poverty had deductibles that equaled 5 percent or more of income.

Many Adults Say Their Deductibles Are Unaffordable

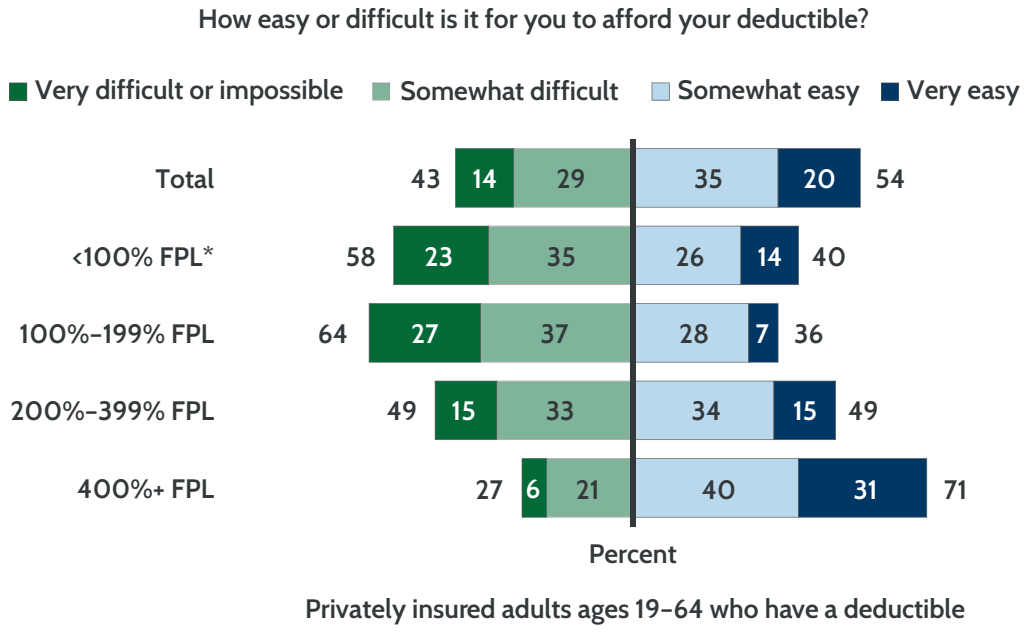
When we asked privately insured adults with deductibles if they could afford them, more than two of five (43%) said their deductible was somewhat, very difficult, or impossible to afford (Exhibit 3). People with low and moderate incomes were more likely to report difficulties. Nearly three of five (58%) adults with incomes under 100 percent of poverty and two-thirds (64%) of those with incomes between 100 percent and 199 percent of poverty reported it was difficult to afford their deductibles. About half (49%) of adults with incomes in the next higher income category—200 percent to 399 percent of poverty—reported difficulty affording deductibles, compared with one-quarter (27%) of those with incomes above 400 percent of poverty.

Adults with High Deductibles Report Delaying Needed Health Care

One rationale for adding deductibles to health plans is that they will create disincentives for consumers to use health care that might be of limited value, thereby lowering costs and limiting premium growth over time. But the survey finds evidence that deductibles also create disincentives for people to get needed care.

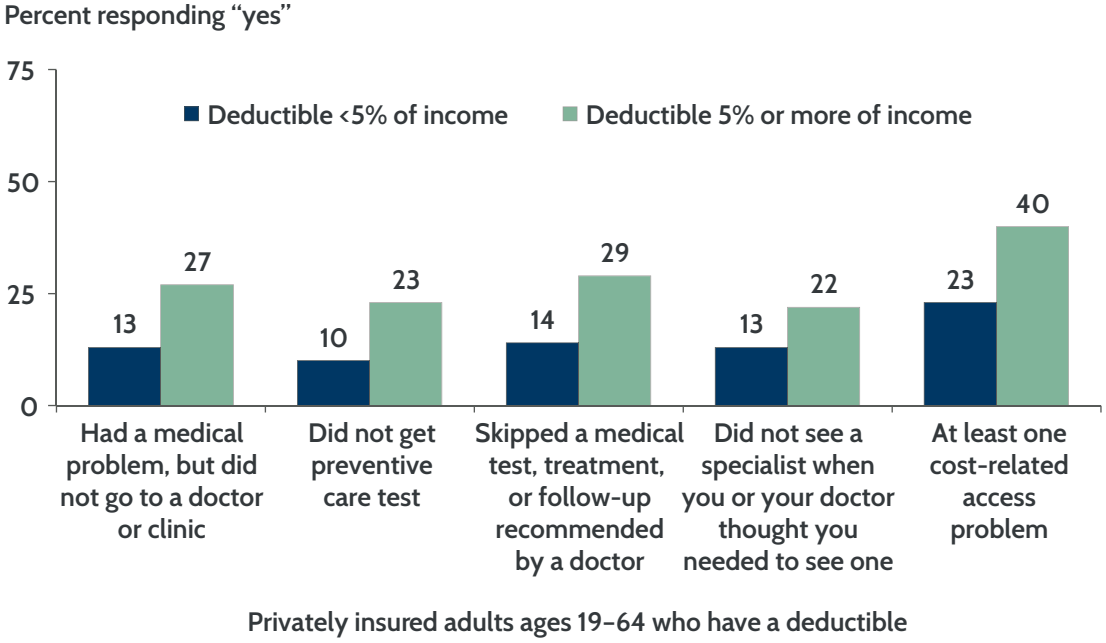
Privately insured adults with high deductibles relative to their income were significantly more likely to report delaying or avoiding needed health care than those with lower deductibles. Two of five (40%) adults with deductibles of 5 percent or more of income reported that because of their deductible, they had not gone to the doctor when sick, did not get a preventive care test, skipped a recommended follow-up test, or did not get needed specialist care (Exhibit 4). Adults who had deductibles that were smaller relative to income reported avoiding care at lower rates. Still, nearly one-quarter (23%) of privately insured adults who had deductibles that were less than 5 percent of income said they did not get needed care because of their deductible.

Exhibit 3. About Three of Five Privately Insured Adults with Low Incomes Reported That It Was Difficult or Impossible to Afford Their Deductible



Notes: FPL refers to federal poverty level. Bars may not sum to 100% because of "don't know" responses or refusal to respond; segments may not sum to subtotals because of rounding.
* Sample size n=94.
Source: The Commonwealth Fund Health Care Affordability Tracking Survey, September–October 2014.

Exhibit 4. Two of Five Privately Insured Adults with Deductibles That Comprise 5 Percent or More of Their Income Reported Delaying or Avoiding Needed Health Care Because of Their Deductible



Base: Respondents who reported their income level and deductible for their private insurance plan (includes those who are currently covered by employer-provided insurance, a marketplace plan, or a plan they purchased through the individual market outside of the marketplaces).
Source: The Commonwealth Fund Health Care Affordability Tracking Survey, September–October 2014.

WHY THE AFFORDABLE CARE ACT IS EXPECTED TO REDUCE THE NUMBER OF UNDERINSURED AMERICANS

The Affordable Care Act aims to improve the quality of health insurance sold in the individual and small-group markets and expand eligibility for Medicaid, which includes little or no cost-sharing.

The law improves the comprehensiveness of coverage by requiring that health plans sold in the individual and small-group markets cover an essential health benefits package, which may vary only by the degree of cost-sharing consumers bear–for example, the size of deductibles, copayments, and coinsurance. To further protect consumers and help them understand the costs they might be responsible for, the law requires insurance plans to be sold at four distinct levels in those markets: bronze, silver, gold, and platinum. Bronze plans cover an average of 60 percent of the medical costs incurred by enrollees in a plan; silver plans cover 70 percent; gold plans cover 80 percent; and platinum plans cover 90 percent. This is also known as the actuarial value of a plan. The law also provides cost-sharing subsidies for people with incomes under 250 percent of poverty ($28,725 for an individual and $58,875 for a family of four) who enroll in silver plans through the marketplaces.

Prior to the Affordable Care Act, as many as half of plans sold in many state individual insurance markets had actuarial values of less than 60 percent.[6] In addition, health insurers in most states excluded conditions they expected would be costly, such as maternity care, or limited what health plans would pay in a year and over a lifetime. The law has banned all of these practices.

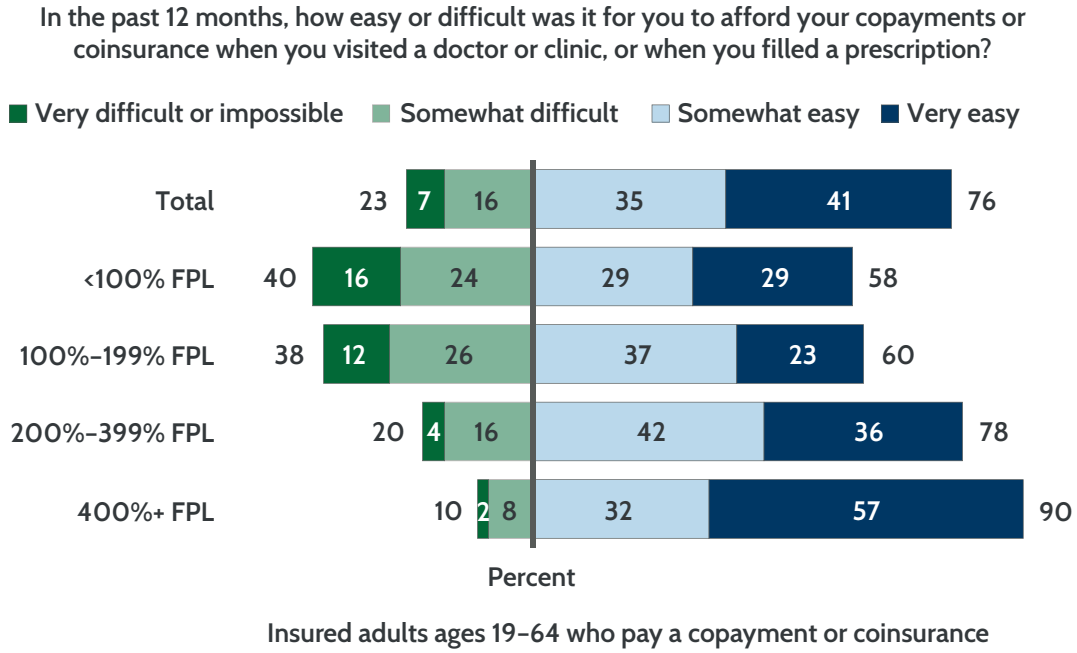
Employer plans have traditionally been far more comprehensive than individual market plans.[7] But the law includes provisions aimed at protecting people with employer coverage. Workers with incomes under 400 percent of poverty are eligible for tax credits for plans purchased in the marketplaces if they are offered a plan by their employer that has an actuarial value of less than 60 percent, and large employers that do this will pay a penalty. In addition, employers are now required to provide all federally recommended preventive care services without cost-sharing.

Lower-Income Adults Report Difficulty Affording Copayments, Delaying Needed Care

In addition to deductible size, another indicator of the financial protection a health plan offers is the amount of copayments or coinsurance a health plan requires when people go to the doctor or fill a prescription. The survey asked people whether their health plan included copayments or coinsurance and, if so, how easy or difficult it was for them to afford these potential costs. In this analysis, we include all insured adults because people with Medicaid and other public insurance plans also may have copayments. Three-quarters (76%) of insured adults who have copayments or coinsurance said it was very or somewhat easy to afford them (Exhibit 5). Adults with lower incomes were significantly more likely to say it was difficult to afford their copayments or coinsurance than were adults with higher incomes.

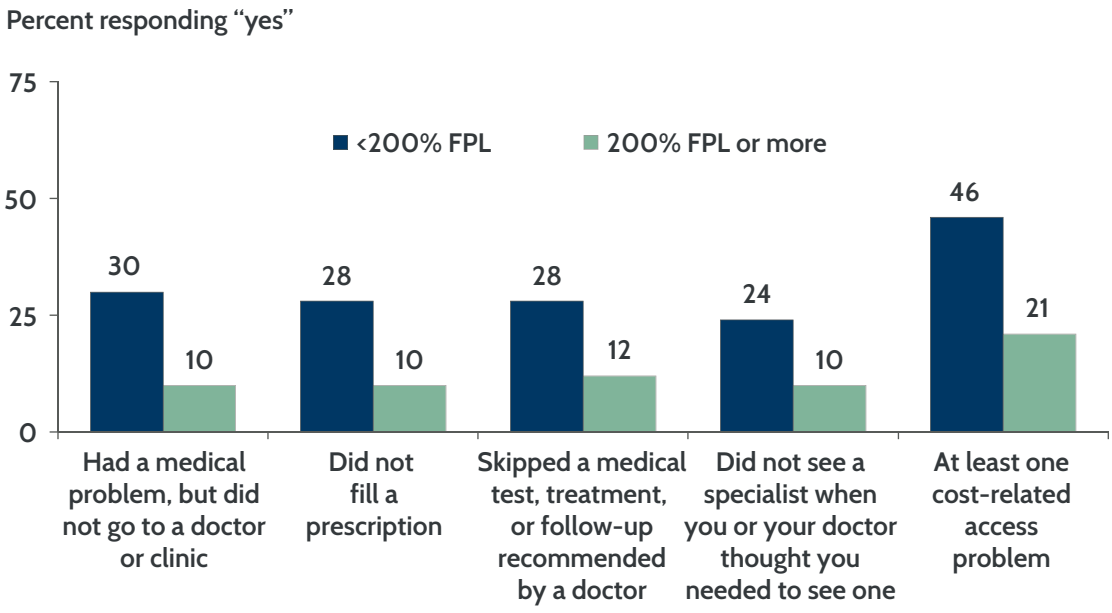
Difficulty in affording copayments appears to affect people's health care decisions. People with low incomes who had copayments or coinsurance were more likely to say they had delayed or avoided needed care because of these costs than were those with higher incomes. Nearly half (46%) of insured adults with incomes under 200 percent of poverty said that because of their copayments or coinsurance, they had either not filled a prescription, not gone to the doctor when they were sick, skipped a medical test or follow-up visit recommended by a doctor, or not seen a specialist when they or their doctor thought they needed one (Exhibit 6). Overall, lower-income adults delayed or avoided care because of their copayments at twice the rate of adults with higher incomes. However, adults with relatively higher incomes also reported issues: one of five (21%) adults with incomes of 200 percent of poverty or more reported not filling a prescription or delaying care because of copayments.

Exhibit 5. Most Insured Adults with Plans That Require a Copayment or Coinsurance Said It Was Somewhat or Very Easy to Afford Them



Notes: FPL refers to federal poverty level. Bars may not sum to 100% because of "don't know" responses or refusal to respond; segments may not sum to subtotals because of rounding.
Source: The Commonwealth Fund Health Care Affordability Tracking Survey, September–October 2014.

Exhibit 6. Insured Adults with Lower Incomes Were More Likely to Report They Had Delayed or Avoided Getting Care Because of Their Copayments or Coinsurance



Note: FPL refers to federal poverty level.
Source: The Commonwealth Fund Health Care Affordability Tracking Survey, September–October 2014.

CONCLUSION AND POLICY IMPLICATIONS

Changes in health benefit design over the past decade across all forms of insurance have emphasized greater consumer cost-sharing through higher deductibles, copayments, and coinsurance. Recently, some policymakers have suggested that insurers should be allowed to sell health plans in the Affordable Care Act's marketplaces that require even greater cost-sharing than the least protective bronze-level plans.[8]

The results of this survey show that these trends toward greater cost-sharing, combined with little or no growth in median family income, have left many working Americans in the middle and lower end of the income distribution with large health care cost burdens. About three of five adults with low incomes and half of those with moderate incomes say that their deductibles are difficult or impossible to afford.

Cost-sharing in health plans is affecting people's medical decisions in ways that should be of concern to policymakers and the medical community. Two of five adults who had deductibles that were high relative to their income said they had delayed or avoided needed care because of the deductible. Nearly one-quarter of people with high deductibles cited them as the reason they had not gotten a preventive care test, even though by law these tests are excluded from deductibles.

The Affordable Care Act has the potential to reduce the number of Americans who are underinsured though reforms aimed at improving the comprehensiveness of coverage in the individual and small-group markets. But the underlying rate of growth in health care costs relative to income growth also will have an impact on the number of underinsured people in the coming years. More than 400 pages of the Affordable Care Act are devoted to new programs and payment methods aimed at improving the quality of health care and lowering costs. While these provisions are directed at Medicare, it is expected they will stimulate change throughout the delivery system, and there is evidence this is occurring. A systemwide effort to reduce health care cost growth will be needed to ensure the affordability of both insurance and health care for working Americans over time. Future waves of this survey, along with other Commonwealth Fund surveys, will help gauge the nation's progress on these efforts through the eyes of consumers in the years to come.

Notes

[1] G. Claxton, M. Rae, N. Panchal et al., "Health Benefits in 2014: Stability in Premiums and Coverage for Employer-Sponsored Plans," *Health Affairs,* Oct. 1, 2014 33(10):1851–60; and C. Schoen, J. Lippa, S. Collins, and D. Radley, *State Trends in Premiums and Deductibles, 2003–2011: Eroding Protection and Rising Costs Underscore Need for Action* (New York: The Commonwealth Fund, Dec. 2012).

[2] Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits: 2014 Annual Survey* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Sept. 10, 2014), http://ehbs.kff.org/.

[3] C. Schoen, M. M. Doty, R. H. Robertson, and S. R. Collins, "Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 Percent," *Health Affairs,* Sept. 2011 30(9):1762–71; C. Schoen, S. R. Collins, J. L. Nicholson, and M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008, w298–w309; C. Schoen, M. M. Doty, S. R. Collins, and A. L. Holmgren, "Insured But Not Protected: How Many Adults Are Underinsured?" *Health Affairs* Web Exclusive, June 14, 2005, w5-289–w5-302; and S. R. Collins, R. H. Robertson, T. Garber, and M. M. Doty, *Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act* (New York: The Commonwealth Fund, April 2013).

[4] All reported differences are statistically significant at the p<= 0.05 level or better unless otherwise noted.

[5] Chronic conditions included hypertension or high blood pressure; heart disease; diabetes; asthma, emphysema or lung disease; high cholesterol; or depression or anxiety.

[6] J. R. Gabel, R. Lore, R. D. McDevitt et al., "More Than Half of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold Through Exchanges as of 2014," *Health Affairs* Web First, May 23, 2012.

[7] Ibid.

[8] Senator Mark Begich (D-Alaska) and six cosponsors, S.1729, "A bill to amend the Patient Protection and Affordable Care Act to provide further options with respect to levels of coverage under qualified health plans," introduced on November 11, 2013, https://www.congress.gov/bill/113th-congress/senate-bill/1729/all-info; and America's Health Insurance Plans, *Continuing Our Commitment to Consumers: Solutions That Will Enhance Affordability, Stability and Accessibility in the New Health Care Marketplace* (Washington, D.C.: AHIP, June 2014), http://www.ahip.org/News/Press-Room/2014/Policy-Solutions/.

SURVEY METHODOLOGY

The Commonwealth Fund Health Care Affordability Tracking Survey, September–October 2014, was conducted by SSRS from September 10 to October 5, 2014, as a part of SSRS' weekly nationally representative omnibus survey. The survey consisted of a 15-minute telephone interviews in English or Spanish and was conducted among a random, nationally representative sample of 2,751 adults ages 19 to 64 living in the continental United States. Overall 1,127 interviews were conducted with respondents on landline telephones and 1,624 interviews were conducted on cellular phones, including 1,012 with respondents who live in households with no landline telephone access.

The data are weighted to adjust for the fact that not all survey respondents were selected with the same probabilities, the overlapping landline and cellular phone samples, and disproportionate nonresponse that might bias results. Data are weighted to the U.S. 19-to-64 adult population by age, race, gender, region, marital status, education, and population density, based on the U.S. Census Bureau's 2014 March Supplement to the Current Population Survey (CPS) and household telephone use using the CDC's National Health Interview Survey. The resulting weighted sample is representative of the approximately 190.7 million U.S. adults ages 19 to 64.

The survey has an overall margin of sampling error of +/–2.1 percentage points at the 95 percent confidence level. The landline portion of the survey achieved a 9.9 percent response rate and the cellular phone sample achieved a 5.7 percent response rate. The overall response rate was 7.3 percent.

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Health Policy Brief

NOVEMBER 10, 2014

The Family Glitch. Some low-to-moderate-income families may be locked out of receiving financial assistance to purchase health coverage through the Marketplaces.

WHAT'S THE ISSUE?

The Affordable Care Act's (ACA's) "family glitch" bears no relationship to the early technology deficiencies that dominated the news and plagued the rollout of healthcare.gov and the state-based Marketplaces. Instead, it refers to how some low-to-moderate-income families may be locked out of receiving financial assistance to purchase health coverage through the new health insurance Marketplaces.

Eligibility is not solely determined by income. It is also subject to whether a family has access to affordable employer-sponsored insurance. The problem is that the definition of "affordable"—for both an individual employee and a family—is based only on the cost of individual-only coverage and does not take into consideration the often significantly higher cost of a family plan.

This shortcoming is a trouble spot in how the ACA is being implemented. As its name clearly conveys, the law was intended to make coverage more affordable, and for millions of Americans, it has. Families caught up in this glitch, however, cannot qualify for premium tax credits to reduce the cost of a Marketplace plan or for cost-sharing reductions to lower their out-of-pocket payments for health services, even if the family cannot afford coverage otherwise.

While a large number of children in these families are eligible for coverage through Medicaid or the Children's Health Insurance Program (CHIP), spouses and some children will remain uninsured without a path to affordable insurance if the family glitch is not fixed. However, many more children could be affected if Congress does not act to extend funding for CHIP after the current appropriation ends in September 2015.

WHAT'S THE IMPACT?

Under the ACA, an individual worker and family members who can enroll in "affordable" job-based health insurance cannot get financial help to lower the costs of Marketplace coverage. Based on the way eligibility for premium tax credits is determined under current Internal Revenue Service (IRS) regulations, employer-sponsored insurance, for both the employee and his or her family members, is deemed affordable if the cost of self-only coverage—that is, a plan that covers only the individual worker—is less than 9.50 percent of household income. This measure is adjusted annually and will increase to 9.56

10.1377/hpb2014.23

percent of household income in 2015. Defining eligibility in this way ignores the cost of a family plan, which is frequently much more expensive than self-only coverage.

In 2013 the average worker contribution for self-only, employer-sponsored coverage was $999 annually, while the average contribution for family coverage was $4,565, although there is considerable variation in both single and family plans. Therefore, the employer-sponsored coverage would be considered affordable for a family of four with a household income of $33,000 (just over 140 percent of the federal poverty level), even though buying a plan for the entire family would cost 13.8 percent of their household income, well above the current 9.5 percent threshold.

$4,565

In 2013 the average worker contribution for self-only, employer-sponsored coverage was $999 annually, while the average contribution for family coverage was $4,565.

In contrast, this same family, if all members were eligible for premium tax credits, would pay 3.4 percent of household income as their premium contribution toward the second-lowest-cost silver plan in the Marketplace. (Policies offered through the Marketplaces are divided into four tiers—bronze, silver, gold, and platinum—based on the actuarial value of the coverage they offer. Silver plans, on average, cover 70 percent of a patient's costs, with the enrollee responsible for the remaining costs in the form of deductibles, copays, and coinsurance. Actual cost sharing varies based on individual health care needs, and income-eligible families may qualify for higher-value coverage through cost-sharing subsidies.)

In the situation described above, none of the family members qualify for premium tax credits or cost-sharing reductions; however, they may be exempt from the individual mandate—that is, the ACA requirement to purchase insurance—if the lowest-price coverage available to them costs more than 8 percent of their household income. Although the penalty (called the individual responsibility payment) for being uninsured may be waived for these families, a large number of people are at risk of being uninsured.

"The cost of a family plan is frequently much more expensive than self-only coverage."

Estimates of the number of dependents (spouses and children) affected vary widely from two to four million, so additional research is needed to more accurately assess the impact. One fact is clear—many more low-to-moderate-income children would be affected if not for Medicaid and CHIP. Still, despite the availability of public coverage, the family glitch affects nearly half a million children, according to estimates by the Government Accountability Office (GAO).

Low-income families are hit the hardest by this glitch. Workers in the lowest 25 percent wage category contribute a much higher proportion of their income to secure coverage. What is more, their compensation in general, including employer-provided coverage, is typically less generous. They pay a higher monthly premium and larger percentage of the cost of employer coverage than workers in the highest 25 percent wage category. On average, workers in the lower-wage group are required to pay 44 percent of the cost of employer-based coverage, or an annual average of $6,324, while higher-wage earners pay only 30 percent, or $4,980.

The number of adults affected will be even higher in the twenty-three states that have yet to take advantage of federal funding to expand Medicaid to low-income people. In these states, people with a household income just above the poverty level (100–138 percent) will not have access to Medicaid or to premium tax credits if they fall into the family glitch. While children with family income in this range qualify for Medicaid in all states, their parents will be faced with paying the full premium for a Marketplace or private plan or going without coverage.

WHAT'S THE BACKGROUND?

This issue is a consequence of how the eligibility provisions related to the premium tax credits are being implemented for families that are offered employer-based coverage. While rooted in the ambiguity of the ACA with respect to affordability for family members, the problem emerges from a narrow interpretation of "affordable" by the Joint Committee on Taxation (JCT) and adopted in regulations issued by the IRS.

The definition of "affordable employer coverage" applies to two different provisions of the law, both intended to support the continuation of a strong private employer–based insurance market. First, the law encourages employers with more than fifty workers to offer affordable coverage to employees by assessing a fee (called the employer shared responsibility payment) on firms that do not offer coverage. Second, it blocks people from opting for tax-funded subsidies by limiting financial assistance to only those who do not have access to affordable employer coverage.

While the law sets a clear standard for affordable employee coverage and requires employers to allow dependent children to enroll

0.5 million

The family glitch affects nearly half a million children, according to estimates by the Government Accountability Office.

in a family plan, Congress deferred to business interests in limiting an employer's responsibility for providing "affordable" coverage to individual workers. As a result, there is no explicit standard of affordability for family members of an employee offered job-based family coverage. Moreover, the law neglects to clearly spell out how family members should be treated for purposes of eligibility for premium tax credits or the individual mandate.

The IRS initially proposed regulations using the cost of self-only coverage to define "affordability" for the other family members with respect to premium tax credits, primarily referencing the JCT's interpretation in its original analysis of the ACA. After receiving dissenting comments on the proposed rule, the IRS delayed the final regulation as it relates to family members.

During that time the GAO urged the Department of Treasury and the IRS to examine the impact of its proposed rule on eligible family members and determine whether it would be consistent with the ACA to adopt an approach that would consider the cost of family-based coverage. Given that the law set no standard requiring employers to offer affordable coverage to a worker's family or pay a penalty, the potential cost to the federal government emerged as the key determinant in limiting access to premium tax credits for family members.

The primary concern was that employers would raise the employee's share of family coverage, driving even more families to opt for premium tax credits. Ultimately, these concerns overrode other legal interpretations and fairness arguments when the IRS finalized the rule as proposed and actualized the family glitch.

"Without either congressional or administrative action, many low-income families are likely to remain uninsured."

WHAT'S THE DEBATE?

Legal and health policy experts believe there is a better reading of the law, which would align the definition of "affordability" with respect to both the individual penalty and access to premium tax credits for family members. The statute includes a special rule stating that the determination of affordability "shall be made by reference to the required contribution of the employee," which has been interpreted to mean "the required contribution of the employee for coverage of family members." The IRS regulations apply this special rule to the individual penalty but ignore it for the purposes of determining eligibility for premium tax credits for dependents who lack access to reasonably priced employer coverage.

Whether an oversight or a drafting error, experts at every point along the political spectrum agree that the current interpretation unfairly penalizes families. However, there is no consensus on fixing the problem. Few legislative proposals are perfect, and technical corrections are a common part of the process of fine-tuning laws, particularly when there are unintended consequences such as the family glitch.

Unfortunately, the current political polarization in Washington calls into question the probability of such action, especially when it comes to the highly contentious health reform law. While a statutory change would send a clear message to the administration to take action through rulemaking or guidance, legal and policy experts believe the problem can be addressed by the administration without amending the law.

WHAT'S NEXT?

Sen. Al Franken (D-MN) has introduced legislation (S. 2434), the Family Coverage Act, to ensure that working families have access to affordable health insurance coverage. The bill would amend the underlying law to determine affordability based on the cost of family-based (and not self-only) coverage with respect to a worker's family members.

However, the act also conveys the "sense of Congress" that the secretary of health and human services and the secretary of the treasury have the administrative authority to apply the affordability provision fairly as it relates to working families without a statutory change. Whether Congress will pass the bill or the administration will act remains to be seen. As is often the case, fixing the problem through the legislative process comes with a price tag, which would further fuel political rancor over the health reform law.

Without either congressional or administrative action, many low-income families are likely to remain uninsured. Currently, a much larger number of adults are affected than children, because Medicaid and CHIP offer a strong foundation of children's coverage. The median income eligibility level for Medicaid and CHIP coverage for children is 255 percent of poverty, about $60,000 for a family of four, and nineteen states provide CHIP up to 300 percent of poverty.

23 states

The number of adults affected will be even higher in the twenty-three states that have yet to take advantage of federal funding to expand Medicaid to low-income people.

However, Congress must act to extend CHIP funding past September 2015, or that option may no longer be available to families as states quickly run out of the annual allotment of federal matching funds that sustain at least two-thirds of the cost of CHIP coverage. Although states could choose to fund CHIP on their own, it is not likely that they would do so without the federal match, which covers a minimum of 65 percent of the cost of CHIP.

If the family glitch remains unresolved, it is likely to become a critical issue as Congress considers the future of CHIP. Without CHIP, the GAO ups the number of children impacted by the family glitch from its estimate of 460,000 to 1.9 million. The Medicaid and CHIP Payment and Access Commission (MACPAC), which provides policy and data analysis and advises Congress and the secretary of health and human services, estimated the impact on children to be even higher. It projects that more than half (56 percent) of the 5.3 million children enrolled in separate CHIP programs could be subject to the family glitch.

In its June 2014 report to Congress, MACPAC recommended funding CHIP for two additional years but cautioned that further extensions will be necessary if crucial reforms, including fixing the family glitch, are not enacted. Legislation recently filed in both houses of Congress would extend CHIP for four years, a provision that is strongly supported by children's advocates and the pediatric community.

The scope of the problem may also be highlighted in an upcoming report, as the ACA requires the US Comptroller General to conduct a study on the affordability of health insurance coverage no later than March 23, 2015 (five years after the law's enactment). The study is expected to look specifically at whether the percentage of household income used to determine the affordability of employer-sponsored insurance is appropriate.

Families that are affected and cannot afford coverage will have a last opportunity to claim an exemption from the tax penalty if they have not already done so when they file taxes for 2014. If the issue remains unsettled after the 2014 tax-filing period, there should be a concerted effort to measure and publicly report the full impact of the family glitch by conducting an independent analysis of the exemptions granted and commissioning additional studies such as surveys and focus groups of affected people.

Those who support a more equitable definition of "affordability" emphasize that the current interpretation is inconsistent with the ACA's goal of increasing access to affordable health insurance, as it does not consider the much higher cost of family coverage. Although fewer children are impacted (as long as they can get CHIP), leaving parents and spouses uncovered prevents these families from realizing the broader benefits that result from health coverage.

Insured adults have greater access to needed care and better health than uninsured adults do, which enhances their ability to work, support their families, and care for their children. Moreover, insured families have enhanced economic security by minimizing the financial impact of an injury or illness. Almost a quarter of uninsured people have medical bills they are unable to pay, and medical debt contributes to half of the bankruptcies in the United States.

"The notion that Congress wrote the law in a manner that would exclude many families from access to more affordable coverage…is simply incongruent," is often quoted from a letter sent to the Department of Treasury from lawmakers who played key roles in drafting and passing the law.

No one seems to disagree with this. Nonetheless, policy makers have yet to find consensus on fixing the problem. ■

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RESOURCES

Bureau of Labor Statistics, The Editor's Desk: Employer Premiums and Employee Contributions for Family Medical Care Benefits (Washington, DC: BLS, March 2013).

Congressional Budget Office, Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision (Washington, DC: CBO, July 2012).

Editorial, "A Glitch in Health Care Reform," *New York Times*, August 25, 2012.

Georgetown University Health Policy Institute Center for Children and Families, Medicaid Expansion: Good for Parents and Children (Washington, DC: Georgetown University CCF, January 2014).

Government Accountability Office, Children's Health Insurance: Opportunities Exist for Improved Access to Affordable Insurance (Washington, DC: GAO, June 2012).

Government Printing Office, Electronic Code of Federal Regulations: Title 26: Internal Revenue, Part I—Income Tax: Computing the Premium Assistance Credit Amount (Washington, DC: GPO, as of October 22, 2014).

Health Reform GPS, When Should Uninsured Family Members of Employees with Access to Affordable Self-Only Employer Coverage Qualify for Premium Tax Credits? (Princeton, NJ: Robert Wood Johnson Foundation, February 1, 2013).

Kaiser Family Foundation, 2013 Employer Health Benefits Survey: Summary of Findings (Menlo Park, CA: KFF, August 20, 2013).

Genevieve M. Kenney, Matthew Buettgens, Jocelyn Guyer, and Martha Heberlein, "Improving Coverage for Children under Health Reform Will Require Maintaining Current Eligibility Standards for Medicaid and CHIP," *Health Affairs* 30, no. 12 (2011):2371–81.

Larry Levitt and Gary Claxton, Measuring the Affordability of Employer Health Coverage (Menlo Park, CA: Kaiser Family Foundation, August 24, 2011).

Avik Roy, "Obama Bombshell: 4 Million People Who Thought They Were Gaining Coverage, Won't," *Forbes*, August 10, 2011.

New Survey Results Released on AAPI Small Businesses and Health Care

November 25, 2014

WASHINGTON—Ahead of this year's Small Business Saturday, the Asian & Pacific Islander American Health Forum (APIAHF) released topline survey findings on Asian American and Pacific Islander (AAPI) small businesses in California. The survey consisted of focus groups and key informant interviews that shed light on how small business owners and employees are faring under the Affordable Care Act (ACA). The survey builds on earlier research by APIAHF, which found that AAPI small businesses in California were largely not aware of the ACA and their coverage options and furthermore, anticipated barriers to getting enrolled.

"Outreach and enrollment efforts must effectively target AAPI small businesses who are over a million strong," said Kathy Ko Chin, APIAHF president and CEO. "These efforts must be informed by community needs. As our research shows, we have considerable work ahead to tackle the gaps in knowledge, challenges in enrollment and difficulties connecting people to care."

Asian Americans account for over 1.5 million minority-owned businesses in the nation, represent nearly 6 percent of all U.S. businesses and employ close to 3 million people. Research indicates a correlation between small business ownership and uninsurance, effectively limiting the ability of these employers and employees to access routine, quality and affordable health care.

The focus group and survey found that most of those eligible for coverage who eventually enrolled did so via California's Medicaid Program (Medi-Cal), instead of seeking private coverage though Covered California's marketplace. AAPI small business employees relied heavily on community health centers and community-based organizations to guide them through the Medicaid application process. In addition, regardless of the type of coverage obtained, all participants expressed difficulties finding culturally and linguistically appropriate providers and accessing care.

Based on these findings, APIAHF recommends that policy makers and in-person assistors in California take into account the following to ensure that small businesses know about their coverage options and are able to enroll:

- **Understand the role of community organizations vs. brokers**: Community health organizations and health centers play a crucial role in reaching AAPI small business owners, who, in contrast to other business owners, may be more likely to rely on these groups over insurance brokers as their main source of information.

- **Couple enrollment with facilitated connections to care**: Half of new participants in the study were covered by Medi-Cal, but did not understand how to use this coverage to access care.

- **Develop in-language resources**: AAPI small businesses need clear information about the ACA, in plain language, and in Asian and Pacific Islander languages. Many are still confused about the law's options and requirements.

APIAHF conducted the focus groups and survey in four California counties: Alameda, Fresno, Long Beach and Los Angeles. Participants included Bangladeshi, Hmong, Korean, Laotian, Vietnamese, Chamorro, Tongan and Samoan communities and were polled in both English and Asian languages.

This research was supported by grants from The California Endowment and The California Wellness Foundation.

APIAHF
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

The **Asian & Pacific Islander American Health Forum** influences policy, mobilizes communities, and strengthens programs and organizations to improve the health of Asian Americans, Native Hawaiians, and Pacific Islanders. Learn more at http://www.apiahf.org/.

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Affordability of Marketplace Coverage: Challenges to Enrollment and State Options to Lower Consumer Costs

December 2014

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The Urban Institute

Robert Wood Johnson Foundation

URBAN INSTITUTE
HEALTH POLICY CENTER

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. This report is one of a series of papers focusing on particular implementation issues in case study states. 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. For more information about the Robert Wood Johnson Foundation's work on coverage, visit **www.rwjf.org/coverage**.

EXECUTIVE SUMMARY

Open enrollment in 2014 exceeded expectations for consumer participation. Even at this early stage, the Patient Protection and Affordable Care Act (ACA) has significantly reduced the number of uninsured. Nevertheless, many consumers remain without coverage despite eligibility for Medicaid or subsidies to lower the cost of qualified health plans (QHPs) offered in health insurance marketplaces.

One serious obstacle to enrollment is many consumers' belief that QHP coverage, even with federal subsidies, is not affordable. In early June 2014, this was by far the most frequent reason that uninsured adults who visited a health insurance marketplace gave for not enrolling in marketplace coverage. According to the Urban Institute's Health Reform Monitoring Survey (HRMS), 58 percent of these adults cited their inability to afford coverage as a reason for failing to enroll, compared with 29 percent and 20 percent who mentioned ineligibility for financial assistance and technical or time barriers to participation, respectively—the second and third most frequently cited reasons. These findings are consistent with our interviews with application assisters from multiple states, who reported that even with subsidies, many uninsured found coverage too expensive to purchase.

Most uninsured adults who visited a marketplace (64 percent) reported hearing "some or a lot" about subsidies. On the other hand, some concerns about affordability may reflect a lack of information. Most uninsured consumers who did *not* visit a marketplace (72 percent) heard "little or nothing" about subsidies.

Altogether, 68 percent of the consumers who remained uninsured after open enrollment in 2014 had not visited a marketplace. It may therefore be important for states to address not just the actual affordability of coverage, but also public education about available subsidies. The latter topic is not explored here, but it is addressed as part of another paper in this series.

To improve QHP affordability for low- and moderate-income consumers, several states appeared to achieve success taking two distinct approaches:

- *Minnesota uses a Medicaid waiver to provide more affordable coverage outside the marketplace* to consumers with incomes up to 200 percent of the federal poverty level (FPL). An adult with income at 170 percent of FPL, for example, pays $33 a month for MinnesotaCare (MNCare), compared with $80 that would be charged for subsidized QHP coverage. Based on several projections, MNCare has achieved more than two or three times the level of enrollment, relative to its target population (eligible consumers with incomes under 200 percent of FPL), that was achieved by QHP subsidies, relative to their target population (eligible consumers with incomes above 200 percent of FPL). However, factors other than greater affordability may have contributed to

MNCare's high enrollment levels, such as many consumers' greater familiarity with and positive regard for MNCare than QHP coverage. One cannot conclusively declare MNCare to be a success until several other states have reported detailed enrollment information for comparison.

Minnesota plans to convert MNCare into a Basic Health Program (BHP) in 2015, the first year BHPs are allowed. This will increase the state's federal funding, but Minnesota will still need to contribute significant amounts. New York is also planning to implement a BHP.

- *Vermont supplements federal subsidies inside the marketplace* to improve affordability for consumers with incomes up to 300 percent of FPL. For example, single adults with incomes of 170 percent of FPL pay $60 in premiums rather than $80 a month; and those at 250 percent of FPL pay $161 instead of $193. Vermont's enrollment of subsidy recipients as a percentage of QHP-eligible consumers exceeds every other state's enrollment of subsidized and unsubsidized QHP enrollees combined. However, high enrollment resulted from factors in addition to greater affordability, such as the state's ability to shift numerous eligible consumers from pre-ACA Medicaid coverage into subsidized QHPs.

Massachusetts is taking an approach like that used by Vermont. Both states fund subsidies with a combination of state dollars and federal matching payments through Medicaid waivers. It is not clear whether other states can obtain similar waivers; if not, any new supplementation efforts will be entirely state-funded.

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) created two insurance affordability programs to help the low- and moderate-income uninsured obtain coverage:

- Expanded Medicaid eligibility to serve adults with incomes up to 138 percent of the federal poverty level (FPL), which the Supreme Court effectively changed into a state option; and
- A combination of premium tax credits and cost-sharing reductions to subsidize the purchase of private, qualified health plans (QHPs) in health insurance marketplaces. Subsidies are available to consumers who
  - are ineligible for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP);
  - are not offered employer-sponsored insurance the ACA classifies as affordable; and
  - have incomes between 100 and 400 percent of FPL. In states with expanded Medicaid eligibility, the lower income bound rises to 138 percent of FPL for most consumers.[1]

The end of the ACA's first open enrollment period has seen better-than-expected participation[2] and a significant drop in the number of uninsured, particularly in states that expanded Medicaid.[3] However, many eligible uninsured have not yet signed up. Based on the country's experience with CHIP, years may be needed to accomplish the ACA's enrollment goals as states learn from each other's successes and failures, eventually migrating toward a general consensus about effective practice.[4]

This paper focuses on one factor that has emerged as a challenge to marketplace enrollment: namely, consumers' perception that, even with federal subsidies, QHPs are not affordable. We begin by analyzing how this factor played out during the open enrollment season for 2014, relying on two primary sources of information:

- *Health Reform Monitoring Survey (HRMS) results from the first two quarters of 2014.* HRMS is a quarterly national survey of the nonelderly population conducted to analyze the ACA's effects. Funding for the core HRMS is provided by the Robert Wood Johnson Foundation (RWJF), the Ford Foundation, and the Urban Institute. For further information, see http://hrms.urban.org/.
- *State-level interviews* with policy-makers, consumer advocacy groups, navigators, application assisters and insurance brokers and agents. Based on semistructured interview protocols, researchers from the Urban Institute and, in some cases, Georgetown

University's Health Policy Institute and the Institute for Health Policy Solutions spoke with stakeholders in 22 states with state-based or partnership marketplaces, as well as several states with federally facilitated marketplaces (namely, Alabama and Virginia).

After exploring affordability issues that emerged during the 2014 open enrollment period, the report describes promising practices implemented by particular states to improve the affordability of coverage.

AFFORDABILITY OF QHPS AS AN OBSTACLE TO PARTICIPATION

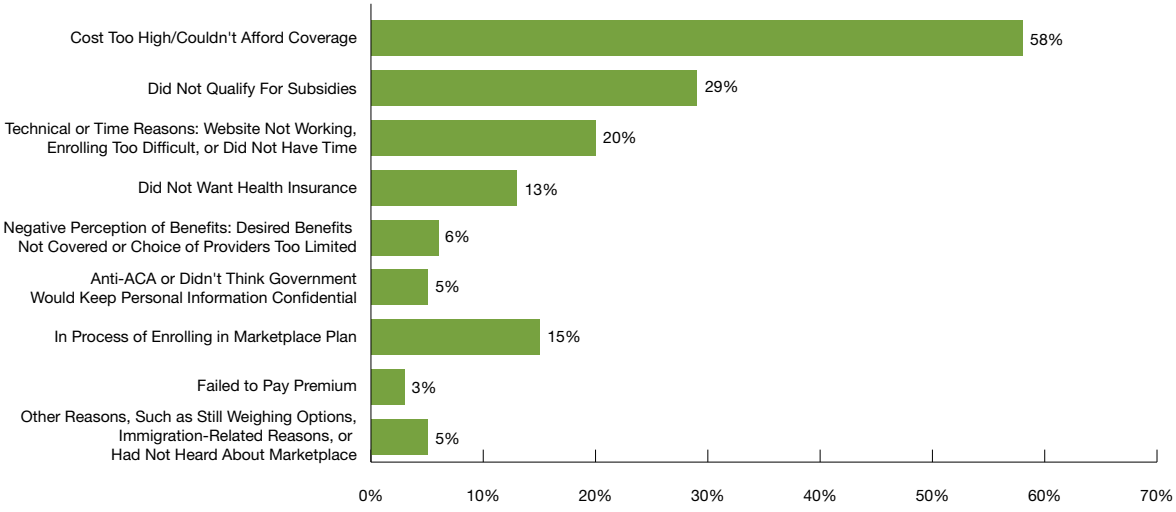
One of the most serious obstacles to enrollment in QHPs is the perceived cost of coverage, even taking into account available federal subsidies. According to HRMS results for the second quarter of 2014, financial barriers were the most frequent reason that uninsured adults who visited the marketplace gave for not enrolling. Unaffordable costs were mentioned by 58 percent of such adults, compared with 29 percent and 20 percent who cited ineligibility for financial assistance and technical or time barriers to participation, respectively the second and third most common reasons for not enrolling in marketplace coverage (Figure 1).

Unfamiliarity with subsidies did not appear to be the main reason why consumers who visited the marketplace found coverage unaffordable. Among those who visited the marketplace but remained uninsured, nearly two-thirds (64 percent) reported hearing "some or a lot" about subsidies, according to HRMS data for June 2014.

By contrast, among the uninsured who had not visited a marketplace, only 26 percent had heard "some or a lot" about subsidies; 72 percent had heard "little or nothing." Altogether, 68 percent of consumers who had been uninsured at some point during the previous 12 months and who remained uninsured in June 2014 did not visit a marketplace during 2014 open enrollment. This suggests that, in addition to addressing the actual affordability of QHP coverage, policy-makers seeking to increase enrollment levels could consider public education strategies. The latter topic is not addressed here, but it is included as part of another paper in this series.

The HRMS survey results showing that consumers familiar with marketplace coverage frequently chose not to enroll because they viewed costs as unaffordable are consistent with our interviews in many states. Application assisters and navigators often reported that many consumers who had not previously purchased individual coverage found subsidized QHP coverage very costly. Sometimes these consumers enrolled in plans with higher out-of-pocket cost-sharing levels than they would

Figure 1. Why Uninsured Adults Who Visited the Marketplace Did Not Enroll in Marketplace Coverage: June 2014



Source: HRMS, Quarter 2, 2014.
Note: Respondents could give more than one answer, so total answers exceed 100 percent.

have preferred, but many simply did not enroll. On the other hand, consumers who had previously purchased individual coverage were often pleased with the options made available by QHP subsidies, according to our interviewees. The same was true of consumers who had attempted to buy individual coverage in the past but could not do so because of preexisting conditions.

Premium charges can vary for many reasons.[5] When a subsidy beneficiary buys so-called "benchmark coverage"—that is, the second-lowest-cost silver plan—FPL and household size determine the consumer's payments. At the same time, out-of-pocket costs grow along with income as cost-sharing subsidies diminish in value. A single adult enrolling in benchmark silver-level coverage would pay the following annual amounts:

- At 150 percent of FPL, $684 in premiums for a plan with 94 percent actuarial value (AV). Using QHPs available in Vermont as examples, plans with such AV could have annual deductibles of $100 or $450.[6]

- At 200 percent of FPL, $1,452 in premiums for a plan with 87 percent AV, which could involve annual deductibles of $750 or $1,000.[7]

- At 250 percent of FPL, $2,328 in premiums for a plan with 73 percent AV, which could involve annual deductibles of $1,400 or $1,900.[8]

These are significant costs for people earning $17,505, $23,340 and $29,175, respectively, in annual pretax income.

STATE STRATEGIES TO IMPROVE AFFORDABILITY

The first year of full ACA implementation saw a few states appear to achieve success using two very different strategies to improve the affordability of QHP coverage for low- and moderate-income consumers.

Option 1: Providing low-income consumers with more affordable coverage outside the marketplace

Minnesota sidestepped affordability problems for consumers with incomes at or below 200 percent of FPL. Rather than QHP subsidies, such consumers received coverage through a modified version of the state's longstanding MinnesotaCare (MNCare) program.[9] Funded through a Medicaid waiver, MNCare charges much less than subsidized QHPs. For example, a single adult at 170 percent of FPL

- pays premiums of $33 a month for MNCare, compared with $80 that would have been charged for subsidized QHP coverage at that same FPL level;[10] and

- has coverage with a $2.75 monthly deductible and $3 office visit copays.[11] In the marketplace, a typical plan for such an adult receiving cost-sharing subsidies might have, for example, a $750 annual deductible and office copays of $10 and $30 for primary and specialty care office visits, respectively.[12]

Navigators and consumer groups reported that, because of MNCare's greater affordability, it received a much more positive response than subsidized QHP coverage. Many who qualified for the latter found coverage unaffordable and chose to pay the penalty for being uninsured; no such responses were reported for consumers who qualified for MNCare.[13] (Of course, Minnesota navigators could not describe consumers' reactions to QHP subsidies below 200 percent of FPL, since Minnesota consumers with incomes below 200 percent of FPL were not offered QHPs.)

From the start of open enrollment on October 1, 2013, through June 10, 2014,

- 51,558 individuals enrolled in Minnesota QHPs, of whom 41 percent (approximately 21,000) purchased coverage with the aid of premium tax credits; and

- 49,115 individuals enrolled in MNCare.[14]

These enrollment results can be compared to forecasts from several microsimulation models, which estimated Minnesota's participation levels once coverage transitions are complete and enrollment reaches steady-state levels. Such models distinguished (1) enrollment in subsidized QHP coverage below 200 percent of FPL, the income level served by MNCare; from (2) enrollment between 200 and 400 percent of FPL, the income level served by subsidized QHPs. Jonathan Gruber of MIT and Bela Gorman of Gorman Actuarial, LLC, estimated that, at steady-state levels, 153,000 tax credit recipients

below 200 percent of FPL would enroll in QHPs, as would 217,000 recipients with incomes between 200 and 400 percent of FPL.[15] Urban Institute researchers using the Health Insurance Policy Simulation Model (HIPSM) projected enrollment of approximately 138,000 and 125,000 tax credit recipients with incomes below and above 200 percent of FPL, respectively.[16]

The actual June 2014 enrollment levels of roughly 49,000 and 21,000 in those two income categories equal 32 percent and 10 percent, respectively, of the expected, final, steady-state levels forecast by Gruber and Gorman and 36 and 17 percent of such levels estimated by HIPSM.[17] Accordingly, if projected QHP participation within each income range is used to provide relative benchmarks for comparison, MNCare achieved more than two or three times the enrollment success attained by QHP subsidies.

MNCare thus enjoyed an apparent success, relative to expectations defined by HIPSM and the Gruber/Gorman estimates. MNCare's greater affordability, relative to subsidized QHPs, may have been one cause of that apparent success, as suggested by the application assisters we interviewed. However, other factors may have also contributed, such as low-income consumers' prior familiarity with and generally high regard for MNCare. Moreover, until information about the income distribution of subsidized QHP enrollment in a number of other states can be compared with enrollment patterns in Minnesota,[18] the judgment of MNCare's apparent success needs to be somewhat tentative, rather than conclusive.

State officials view the current Medicaid waiver as a bridge to Minnesota's implementation of the Basic Health Program (BHP) option under the ACA, which will start in 2015, the first year that federal regulations allow BHP implementation. With BHP, states cover consumers with incomes at or below 200 percent of FPL through state-contracting plans, rather than the marketplace. The federal government provides funding equal to 95 percent of what it would have spent on tax credits and cost-sharing reductions for BHP consumers if they had enrolled in QHPs.[19]

State officials expect BHP to significantly increase the state's receipt of federal funding, compared with the current Medicaid waiver, which provides Minnesota's standard federal medical assistance percentage (FMAP).[20] However, Minnesota's combination of low benchmark QHP premiums (the basis on which federal BHP funding is determined), high per capita Medicaid costs, and policy-makers' determination to keep consumer costs low will likely mean significant (albeit reduced) state costs under BHP. New York also plans to implement BHP, anticipating that it will achieve net state budget savings by transferring state-funded health care costs for indigent immigrant adults to federally funded BHP, without the affected consumers losing services or incurring increased costs.[21]

Option 2. Supplementing subsidies in the marketplace

Taking a different approach to improving affordability, Vermont supplements exchange subsidies for consumers with incomes up to 300 percent of FPL. For example:

- Single adults with incomes at 170 percent of FPL pay $60 in monthly premiums rather than the $80 that would ordinarily be charged at that income level, those at 200 percent of FPL pay $96 rather than $121, and those at 250 percent of FPL pay $161 instead of $193.[22]

- Vermont does not reduce out-of-pocket cost-sharing for consumers with incomes below 200 percent of FPL. Instead, the state modestly increases AV for consumers between 200 and 300 percent of FPL, smoothing out what would otherwise be an abrupt drop in AV. Between 201 and 250 percent of FPL, the state's supplement could lower an individual deductible, for example, from $1,900 to $1,500; and between 251 and 300 percent of FPL, it might reduce the out-of-pocket maximum for medical care from $5,100 to $4,000.[23]

Vermont achieved remarkably high QHP enrollment levels. April 2014 QHP participation in Vermont exceeded by 9.8 percent the final, steady-state levels forecast by HIPSM for 2016. Vermont's tax credit beneficiaries by themselves represented 73.6 percent of all QHP enrollees HIPSM forecast for 2016, subsidized and unsubsidized combined. By contrast, in the second-highest state, Florida, all QHP participants, with and without tax credits, together reached just 68.5 percent of forecast 2016 levels—well below the enrollment achieved in Vermont by tax credit beneficiaries alone.[24]

The generosity of subsidized coverage in Vermont likely played a role contributing to such high participation levels among Vermont's subsidy-eligible consumers. However, other factors may have been involved as

well—notably, the state's pre-ACA coverage, through its "Catamount Health" Medicaid waiver, of adults with incomes up to 300 percent of FPL. This existing coverage facilitated enrollment by providing a "target list" of consumers who typically qualified for subsidized QHP coverage, many of whom had current contact information on file, and who were already known to want subsidized health insurance.

The ACA specifically permits states to supplement federal QHP subsidies.[25] In the case of Vermont, the federal government, via Medicaid waiver, has gone further and shares the cost of supplementing tax credits, paying standard FMAP.[26] This waiver does not, however, contribute to the cost of supplementing cost-sharing reductions. Massachusetts, which also covered adults with incomes up to 300 percent of FPL before the ACA, is now implementing a policy like Vermont's, supplementing both premium tax credits and cost-sharing reductions in the marketplace. As in Vermont, Massachusetts's federal Medicaid waiver helps cover the cost of the former (but not the latter).

It is not at all clear that the federal government would grant similar waivers to other states that did not cover adults with incomes above 138 percent of FPL in the past and so do not need supplemental QHP subsidies to shield consumers from increased health care costs under the ACA. Without such a waiver, a state that supplements federal QHP subsidies would need to finance its supplement with state-only dollars.

Comparing the two options

Both approaches increased participation by making coverage more affordable. However, in neither case can one be certain about causation, since other factors were also in play.

One difference between these approaches is that Minnesota provides more affordable coverage by moving low-income consumers outside the marketplace into more affordable plans, which means that its marketplace contains fewer participants. Vermont keeps consumers within the marketplace and increases subsidy levels, lowering consumer costs while they remain enrolled in QHPs.

Also, Minnesota's approach is limited to consumers with incomes up to 200 percent of FPL. This limitation likely results from the state's intent to transition to BHP, which is not available above that income threshold. By contrast, Vermont's Medicaid waiver extends to consumers with incomes up to 300 percent of FPL.

Minnesota's approach brings in a greater total amount of federal funding, which lets the state provide more affordable coverage. On the other hand, the state's financial responsibility is potentially greater and less defined under Minnesota's approach:

- Minnesota furnishes all care. Under BHP, federal funding will be based on subsidies that would have been furnished in the marketplace, so the extent (if any) to which the state is ultimately responsible for paying health care costs will largely reflect the relationship between benchmark QHP premiums and the cost of state-furnished BHP coverage.

- Vermont's approach limits the state's financial responsibility to supplementing QHP subsidies.

These states have been willing to commit resources to making coverage more affordable to their low- and moderate-income residents. Before other states embrace similar efforts, they would need to carefully consider what costs might be involved, what offsets might be available, and what gains and trade-offs might result.

CONCLUSION

With insurance affordability programs starting in January 2014, the ACA's main coverage expansion has just begun. The cost of QHP coverage, even with federal subsidies, appears to be deterring many uninsured consumers from enrollment. Several states offer promising examples that suggest contrasting strategies for overcoming this obstacle.

These conclusions are necessarily somewhat preliminary at this early point in ACA implementation. The coming years will provide more experience with the ACA, and more data documenting its effects will become available. Observers will gain an increased capacity to definitively assess the significance of QHP costs as a barrier to enrollment as well as the impact of alternative state strategies aimed at making coverage more affordable for the low- and moderate-income uninsured.

ENDNOTES

1. In states that expand Medicaid, the lower threshold of financial eligibility for QHP subsidies generally rises to 138 percent of FPL because consumers with incomes at or below that level qualify for Medicaid, with one exception. Certain lawfully present noncitizens are ineligible for Medicaid because of their immigration status and so qualify for QHP subsidies, notwithstanding income below the ordinarily applicable lower-income threshold for such subsidies.
2. Blumberg LJ, Holahan J, Kenney GM, Buettgens M, Anderson N, Recht H and Zuckerman S. *Measuring Marketplace Enrollment Relative to Enrollment Projections: Update.* Washington, D.C.: Urban Institute, May 1, 2014, http://www.urban.org/UploadedPDF/413112-Measuring-Marketplace-Enrollment-Relative-to-Enrollment-Projections-Update.pdf.
3. Long SK, Kenney GM, Zuckerman S, Wissoker D, Shartzer A, Karpman M, Anderson N and Hempstead K. *Taking Stock at Mid-Year: Health Insurance Coverage under the ACA as of June 2014.* Washington, D.C.: Urban Institute, 2014, http://hrms.urban.org/briefs/taking-stock-at-mid-year.pdf.
4. Along with Medicaid coverage of children, CHIP is now one of the country's most successful need-based programs, reaching an estimated 87 percent of its target population. (Kenney GM, Anderson N and Lynch V. "Medicaid/CHIP Participation Rates among Children: An Update." Washington, D.C.: Urban Institute, 2013, http://www.urban.org/uploadedpdf/412901-%20Medicaid-CHIP-Participation-Rates-Among-Children-An-Update.pdf [accessed February 7, 2014].). During its first few years, however, CHIP was viewed with "general disappointment … due to low enrollment rates," according to the Congressional Research Service (Herz E and Baumrucker EP. "Reaching Low-Income, Uninsured Children: Are Medicaid and SCHIP Doing the Job?" Washington, D.C.: Congressional Research Service, 2001, http://www.policyarchive.org/handle/10207/bitstreams/1043.pdf [accessed February 7, 2014].).
5. According to the U.S. Department of Health and Human Services, the average premium paid by subsidy recipients in federally facilitated marketplaces is $82 a month, or $984 a year. (Burke A, Misra A and Sheingold S. *Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014.* Washington, D.C.: Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, 2014, http://aspe.hhs.gov/health/reports/2014/Premiums/2014MktPlacePremBrf.pdf.). However, we do not know what premiums were charged to consumers who chose not to enroll. Premiums charged to nonenrollees are presumably higher, on average, than for those who sign up for coverage, since higher premiums are associated with a reduced likelihood of taking up insurance. See, for example, Gresenz CR, Edgington SE, Laugesen MJ and Escarce JJ. "Income Eligibility Thresholds, Premium Contributions, and Children's Coverage Outcomes: A Study of CHIP Expansions." *Health Services Research* 48(2) 884–904, April 2013; Guy GP, Adams EK and Atherly AJ. *The Impact of Public and Private Health Insurance Premiums on the Health Insurance Status of Low Income Childless Adults*, Washington, D.C.: AcademyHealth, 2011, http://www.academyhealth.org/files/2011/monday/guy.pdf; and Dushi I and Honig M. "Price and Spouse's Coverage in Employee Demand for Health Insurance." *The American Economic Review*, 93(2): 252–256, May 2013.
6. See Vermont Health Connect, *Cost-Sharing Reduction (CSR) Tier I (94% AV) Silver Plans.*
7. See Vermont Health Connect, *Cost-Sharing Reduction (CSR) Tier II (87% AV) Silver Plans.*
8. See Vermont Health Connect, *Cost-Sharing Reduction (CSR) Tier IV (73% AV) Silver Plans.*
9. Although Minnesota's coverage was provided pursuant to state waiver, Medicaid coverage for adults over 138 percent of FPL can also be implemented through state plan amendment, pursuant to 42 CFR 435.21.
10. At 140 percent of FPL, MNCare premiums are $21 per adult, compared with $46 and $94 in subsidized QHP coverage for 1- and 4-person households, respectively; at 150 percent of FPL, MNCare premiums are $25, compared with $57 and $118; and at 200 percent of FPL, a MNCare adult pays $50 a month, compared with $121 and $247 for a subsidy-eligible QHP enrollee in a 1- and 4-person household, respectively. *MinnesotaCare Premium Estimator Table, Effective January 1, 2014 – December 31, 2014.* https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4139A-ENG.
11. Minnesota Department of Human Services. Minnesota Health Care Programs: Summary of Coverage, Cost Sharing and Limits (Effective January 1, 2014). DHS-3860-ENG.
12. See, for example, Vermont Health Connect. *Cost-Sharing Reduction (CSR) Tier II (87% AV) Silver Plans.*
13. Several broker interviewees suggested that some consumers, such as those with serious health problems who were formerly covered by the state's high-risk pool, would be better off in QHPs than in MNCare because of broader provider networks in QHPs. However, this concern was not reported by consumer advocacy groups, navigators or application assisters we interviewed; brokers receive commissions for QHP enrollees but not for MNCare enrollees, raising questions about their objectivity.
14. MNsure. "MNsure Metrics Dashboard: Prepared for Board of Directors Meeting, June 18, 2014." https://www.mnsure.org/images/bd-2014-06-18-dashboard.pdf.
15. Gruber J, Gorman B, Gorman D and Smagula J. "The Impact of the ACA and Exchange on Minnesota: Updated Estimates." St. Paul, MN: prepared for the State of Minnesota, February 2013, https://www.mnsure.org/images/Report-GruberGormanUpdate-2013-02-28.pdf.
16. See table 3 in Buettgens M, Holahan J and Carroll C. *Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid.* Washington, D.C.: Urban Institute 2011, http://www.urban.org/UploadedPDF/412310-Health-Reform-Across-the-States.pdf. The estimates in the text result from multiplying the projected number of marketplace participants statewide by the estimated percentage of such participants with incomes at applicable levels.
17. If one analyzes enrollment estimates available soon after the March conclusion of open enrollment, rather than enrollment estimates as of mid-June, similar conclusions follow. As of April 13, 2014—the earliest date following the end of open enrollment for which enrollment estimates are available—37,985 individuals had enrolled in MNCare and 47,902 in QHPs (MNsure. "MNsure Metrics Dashboard: Prepared for Board of Directors Meeting, April 16, 2014." https://www.mnsure.org/images/bd-2014-04-16-dashboard.pdf.). These estimates did not state the percentage of QHP enrollees receiving tax credits, which is why the text uses the June estimates. Applying to these mid-April results the June 2014 finding that 41 percent of Minnesota's QHP enrollees received tax credits, approximately 19,640 tax credit beneficiaries above 200 percent of FPL would be estimated to have enrolled in QHPs by mid-April. Using the Gruber/Gorman estimates of "steady state" QHP enrollment, MNCare had reached 25 percent of target levels by the end of open enrollment, compared with 9 percent of tax credit beneficiaries enrolling into QHP coverage. Using HIPSM estimates as the benchmark, MNCare enrolled 19 percent, and QHP subsidies 9 percent, of projected steady-state enrollees by the end of open enrollment.

18. The only state to report the income distribution of subsidy-eligible QHP enrollees is New York. There, 53 percent of such enrollees had incomes at or below 200 percent of FPL (NY State of Health: The Official Health Plan Marketplace. *2014 Open Enrollment Report*, Albany, NY: New York Department of Health, June 2014.). In Minnesota, by contrast, MNCare enrollees made up 70 percent of all mid-June enrollees who otherwise may have qualified for QHP subsidies (that is, 70 percent of all consumers who received either MNCare or subsidized QHP coverage). If one uses the method described above to estimate QHP-subsidy eligibility for the end of Minnesota open enrollment, then MNCare enrollees made up 66 percent of all such subsidy-eligible enrollees—well above New York's 53 percent level.
19. For more information about the BHP option, see Dorn S and Tolbert J. *The ACA's Basic Health Program Option: Federal Requirements and State Trade-Offs*. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured (publication pending). Beginning in 2017, states interested in this general approach may be able to go beyond BHPs by implementing broad state innovation waivers under ACA Section 1332, which will let states rearrange the ACA's architecture of federal health spending and coverage. This is the section that has authorized Vermont's implementation of a single payer system, which the state plans to begin implementing in 2017. A state implementing a Section 1332 waiver must ensure that, compared with standard ACA implementation, total federal spending does not increase and consumers neither lose benefits nor are charged higher premiums or out-of-pocket cost-sharing. Such a waiver might allow a state to implement a BHP-like approach while gaining access to more generous federal funding—providing 100 percent rather than 95 percent of subsidies that would otherwise have been paid. A waiver approach could also let consumers with incomes above 200 percent of FPL enroll in state-contracting plans outside the marketplace. However, no federal guidance or regulations have defined the substantive ground rules for such waivers, so whether and, if so, under what terms such a "BHP-plus" approach will be allowed is currently unknown.
20. Schwartz, S. "Two States on the Path to the Basic Health Program." *CHIRblog*, Georgetown University Health Policy Institute, Center for Health Insurance Reform, April 4, 2014, http://chirblog.org/two-states-on-the-path-to-the-basic-health-program/.
21. Affected adults in New York are lawfully present immigrants with incomes below 138 percent of FPL who are ineligible for federally matched Medicaid that goes beyond emergency services.
22. At 140 percent of FPL, single adults in Vermont pay $30 rather than $46; at 150 percent, they pay $39 rather than $57 (Vermont Health Connect Subsidy Calculator, http://info.healthconnect.vermont.gov/tax_credit_calculator).
23. Between 201 and 250 percent of FPL, Vermont's supplements increase AV from 77 to 73 percent, and between 251 and 300 percent of FPL, the state boosts AV from 70 to 73 percent. See Vermont Health Connect. Cost-Sharing Reduction (CSR) Tier III (77% AV) Silver Plans; *Cost-Sharing Reduction (CSR) Tier IV (73% AV) Silver Plans; Vermont Health Connect Silver Plans*.
24. This analysis is premised on the fact that 67 percent of Vermont's QHP enrollees receive tax credits. *Vermont Health Connect. Vermont Health Connect Update, Medicaid and Exchange Advisory Board, Monday, May 12*, May 12, 2014, http://info.healthconnect.vermont.gov/sites/hcexchange/files/Vermont%20Health%20Connect%20Update_MEAB_5%2012%2014.pdf. For interstate comparisons, see Blumberg LJ, Holahan J, Kenney GM, Buettgens M, Anderson N, Recht H, and Zuckerman S. *Measuring Marketplace Enrollment Relative to Enrollment Projections: Update*. Washington, D.C.: Urban Institute, 2014, http://www.urban.org/UploadedPDF/413112-Measuring-Marketplace-Enrollment-Relative-to-Enrollment-Projections-Update.pdf. The same results follow when other metrics are used to compare states. For example, one can compare April 2014 enrollment to the total population eligible to enroll in QHPs, defining the latter to include (1) people who qualify for tax credits, (2) the uninsured who are ineligible for IAPs, and (3) the individually insured who are ineligible for insurance affordability programs. Using this metric, Vermont enrolled 73.5 percent of QHP-eligible consumers by April 2014, compared with 42.2 percent in California, the second-highest state; the national average was 24.5 percent. Among tax credit beneficiaries alone, Vermont's enrollees represented 49.2 percent of the state's entire QHP-eligible population—still higher than California's 42.2 percent level, which counts both subsidized and unsubsidized enrollees as participants.
25. ACA §1412(e).
26. The total amount of federal payments for this purpose is capped, and these payments fall within the Vermont global waiver's total budget neutrality requirements.

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ACA Implementation—Monitoring and Tracking

Marketplace Enrollment Procedures: Early Barriers to Participation and Options for Surmounting Them

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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. This report is one of a series of papers focusing on particular implementation issues in case study states. 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. For more information about the Robert Wood Johnson Foundation's work on coverage, visit **www.rwjf.org/coverage**.

EXECUTIVE SUMMARY

Open enrollment in 2014 exceeded expectations for consumer participation. Even at this early stage, the Patient Protection and Affordable Care Act (ACA) has significantly reduced the number of uninsured. Nevertheless, numerous consumers remain without coverage despite eligibility for Medicaid or subsidies to lower the cost of qualified health plans (QHPs) offered in health insurance marketplaces. Several features of the marketplace enrollment process made it difficult for many eligible uninsured to receive coverage, in both state-administered systems and marketplaces run by the federal government:

- **Disconnection between marketplaces and Medicaid.** In many states, uninsured consumers who apply to marketplaces and are classified as eligible for Medicaid must wait months for coverage after their applications are forwarded to state Medicaid agencies for further processing. One survey found that, as of late May, 2.9 million people were stuck in such backlogs. More recent reports indicate that such problems are persisting, albeit at a reduced magnitude, and they could spike again with marketplace enrollment opening again on November 15.
- **Procedural challenges facing special populations.** Immigrants, people with limited English proficiency and nontraditional households often faced technical obstacles to enrollment. Barriers described by application assisters in numerous states included Web site eligibility rules that incorrectly sorted low-income immigrants between Medicaid and QHP subsidies, an identity-proofing system that relied on the kind of credit history that many immigrants and low-income consumers lack, a failure to make marketplace information linguistically accessible to non-English speakers, and Web site business rules that assume traditional family structure (e.g., that minor children live with their parents).
- **Difficulty with plan selection.** In geographic areas with numerous QHP options, consumers sometimes found it so difficult to pick a plan that QHP selection could take twice as long as the entire subsidy application process, according to application assisters in multiple states. Many uninsured were unfamiliar with basic insurance concepts. Few if any Web sites provided reliable information about QHP provider networks.

To address these challenges, some states have implemented effective practices that warrant consideration by policy-makers in other states. Those practices, along with other promising strategies not used during the first

year of open enrollment, are described for each of the three barriers identified above:

To prevent Medicaid backlogs

- *New York and Kentucky each use a single eligibility system for all insurance affordability programs.* Administering their marketplaces through public agencies, these states each operated a single system that gave most applicants real-time eligibility determinations that sorted each family member into the applicable program, whether Medicaid, CHIP or QHP subsidies.
- *Washington uses the Medicaid agency's computerized system to make eligibility decisions within the marketplace's eligibility service.* Using a quasi-public agency to administer its marketplace, Washington has Medicaid's computerized system make a final eligibility determination for Medicaid based on attestations and data matches, whenever possible. As in New York and Kentucky, most eligible applicants qualify while they are still online at the marketplace.
- *States can operate freestanding computerized systems for Medicaid eligibility determination that reduce the need to manually process applications coming from the marketplace.* Even before the ACA, Oklahoma used such a system to automate verification for half of Medicaid applications. Now, under the ACA, data from federal and state sources could similarly verify many applicants' sworn attestations of current income at Medicaid levels. Automated verification based on records showing such things as prior-year income, participation in the Supplemental Nutrition Assistance Program, and quarterly wages could greatly reduce the need for manual processing, preventing large Medicaid backlogs.

To help disadvantaged populations overcome technical barriers to enrollment

- *Application assisters in multiple states have helped consumers overcome such barriers.* By providing extra application assistance resources to disadvantaged communities, states could give more consumers the benefit of such expert aid.
- *States could address particular barriers.* As suggested by application assisters, state-based marketplaces (SBMs) and federally facilitated marketplaces (FFMs) could modify eligibility rules for immigrants, add methods for identity proofing that incorporate the observations of certified navigators and brokers, and prioritize the translation of forms and notices that require an appropriate response to prevent a denial or termination of coverage.
- *SBMs could partner with community-based organizations* to analyze obstacles and develop solutions that take into account the circumstances disadvantaged populations face. Such collaboration could both promote effective policy and build community buy-in.
- *State Medicaid and CHIP programs have analyzed samples of applications that were incomplete or rejected for procedural reasons,* learning where consumers got stuck and which procedural requirements led to denials. Similar efforts by SBMs and FFMs could identify underlying policies and practices that hinder enrollment under the ACA.

To make QHP choices manageable for consumers

- *California and Connecticut focus default plan views on the options likely to be of greatest interest to consumers,* even though consumers can opt to see other plans. Plans shown by default to subsidy-eligible consumers are at the silver level and in the coverage category requested by the consumer (e.g., single adult coverage). The default view automatically shows the effect of subsidies on premiums, deductibles and other out-of-pocket costs, including when consumers are browsing anonymously.
- *California, Connecticut, Maryland, Michigan, New York and Oregon also standardize QHP designs within each metal tier.* This has avoided the confusion that was sometimes observed in other states when, within a single tier, numerous plan options were offered with small, relatively inconsequential differences that few consumers readily understood.

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) created two insurance affordability programs to help the low- and moderate-income uninsured obtain coverage:

- Expanded Medicaid eligibility to serve adults with incomes up to 138 percent of the federal poverty level (FPL), which the Supreme Court changed into a state option; and
- A combination of premium tax credits and cost-sharing reductions to subsidize the purchase of private, qualified health plans (QHPs) in health insurance marketplaces. Subsidies are available to consumers who
  - are ineligible for Medicare, Medicaid and the Children's Health Insurance Program (CHIP);
  - are not offered employer-sponsored insurance the ACA classifies as adequate and affordable; and
  - have incomes between 100 and 400 percent of FPL. In states with expanded Medicaid eligibility, the lower income bound rises to 138 percent of FPL for most consumers.[1]

The end of the ACA's first open enrollment period has seen participation in marketplace coverage that was greater than expected[2] and a significant drop in the number of uninsured, particularly in states that expanded Medicaid.[3] However, many eligible uninsured have not yet enrolled. Based on the country's experience with CHIP, years may be needed to accomplish the ACA's enrollment goals as states learn from each other's successes and failures, eventually migrating toward a general consensus about effective practice.[4]

This paper seeks to inform that long-term process while helping state policy-makers and stakeholders refine their plans for the open enrollment period that runs from mid-November through mid-February. State decisions not to expand Medicaid eligibility to 138 percent of FPL have received considerable analysis elsewhere and are not the subject of discussion here. Our focus is on enrollment that takes place through the marketplaces, including through marketplace Web sites, whether consumers wind up in QHPs, Medicaid or CHIP. Here, we analyze what happens to consumers once they arrive at a marketplace, using whatever application assistance their marketplace makes available. An accompanying report examines marketplace decisions about public education and application assistance, which can have an equally important effect on enrollment levels.

This report begins begin by analyzing some of the most important obstacles to participation that emerged in the procedures that were used during open enrollment season for 2014. That analysis relies on two primary sources of information:

- *Health Reform Monitoring Survey (HRMS) results from the first two quarters of 2014.* The HRMS is a quarterly national survey of the nonelderly population conducted to analyze the ACA's effects. Funding for the core HRMS is provided by the Robert Wood Johnson Foundation, the Ford Foundation and the Urban Institute. For further information, see http://hrms.urban.org/.
- *State-level interviews* with policy-makers, consumer advocacy groups, navigators, application assisters and insurance brokers and agents. Based on semistructured interview protocols, researchers from the Urban Institute and, in some cases, Georgetown University's Health Policy Institute and the Institute for Health Policy Solutions spoke with stakeholders in 22 states with state-based or partnership marketplaces, as well as two states with federally facilitated marketplaces (namely, Alabama and Virginia).

After analyzing obstacles to participation, the report describes promising practices implemented by particular states as well as other potential options for overcoming those obstacles.

ENROLLMENT PROCEDURES THAT OBSTRUCTED PARTICIPATION

Barriers that inhibit enrollment vary by state and population group. Here, the paper focuses on obstacles in three categories that, based on interviews, appeared particularly significant in many states, including those with state-based marketplaces (SBMs) and federally facilitated marketplaces (FFMs): disrupted linkages between marketplaces and Medicaid programs, procedural problems experienced by disadvantaged groups, and challenges in plan selection.

Disconnection between marketplaces and Medicaid

In many states, significant problems emerged when uninsured consumers who applied for coverage through a marketplace and were classified as eligible for Medicaid had their applications forwarded to the Medicaid program for further processing. Many consumers waited months before hearing from Medicaid. When word came, Medicaid often requested information that consumers had already provided to the marketplace. Sometimes Medicaid caseworkers used pre-ACA verification methods, denying coverage unless consumers furnished pay stubs or other documentation without first assessing whether available data was reasonably compatible with attestations of financial eligibility. A number of interviewees believed that such procedural obstacles may have prevented some eligible uninsured consumers from receiving coverage.

To assess this problem's magnitude, Congressional Quarterly Roll Call surveyed Medicaid programs in all 50 states and the District of Columbia. The 41 responding states reported that at least 2.9 million pending Medicaid applications had not yet been processed as of late May 2014. The states with the largest backlogs were California (900,000 applications), Illinois (330,000), North Carolina (at least 298,840), Ohio (212,090), Virginia (183,643), Georgia (at least 159,313), Michigan (at least 123,381) and South Carolina (at least 113,429).[5] Backlogs have diminished since May but have not disappeared,[6] and they could once again grow during 2015 open enrollment unless connections between marketplaces and Medicaid programs improve.

In states with FFMs, these backlogs resulted, in part, from the limited ability of federal Web sites to transfer full electronic case files to state Medicaid programs. However, a number of SBMs— including those in California, Colorado, Maryland and Minnesota—also experienced significant disconnections and backlogs.

This problem has both legal and technological roots. Under Centers for Medicare and Medicaid Services (CMS) regulations, an SBM run by a quasi-public agency or non-profit corporation must let its state Medicaid program make the final determination of Medicaid eligibility.[7] Further, most states with FFMs have the marketplace make preliminary rather than final determinations of Medicaid eligibility. This means the marketplaces forward applications to state Medicaid agencies for further analysis and conclusive findings of whether consumers qualify.

In states that use outdated information technology (IT) for Medicaid eligibility purposes, the handoff from the marketplace to Medicaid can involve computer systems from different generations that do not communicate with each other. As a result, Medicaid staff may need to manually input information from the marketplace, ask consumers for information they have already given the marketplace, or take other time-consuming steps to complete eligibility determination.

It is striking that the four states with the largest backlogs all determine Medicaid eligibility at the county rather than the state level. This adds an additional layer of intergovernmental relationships that must be successfully managed for low-income consumers to receive coverage.

Procedural challenges for disadvantaged populations

Interviewees in most states reported particularly troublesome technical barriers to enrollment for immigrants, people with limited English proficiency, and people with complex family situations. Marketplace enrollment systems did not appear designed with such consumers in mind. For example:

- Applicants' identities were verified via the Federal Data Services Hub using Experian, one of the country's major credit agencies. This made it hard to verify identities for low- and moderate-income consumers who lacked significant credit history, including many immigrants. Their applications were often stymied at the very start. Skilled application assisters could frequently overcome these obstacles through manual work-arounds, but many disadvantaged consumers did not receive such help.
- In some states that expanded Medicaid eligibility, FFMs and SBMs would automatically classify lawfully present immigrants with incomes at or below 138 percent of FPL as Medicaid-eligible. In fact, because of restrictions enacted as part of federal welfare reform legislation, federal Medicaid match is denied to many lawfully resident immigrants, such as non-pregnant, nondisabled adults whose lawful status was granted within the past five years. Such adults are eligible for QHP subsidies, not Medicaid. Fixing these errors was a high priority for application assisters and community groups, as the wrongful receipt of Medicaid, even if caused by an innocent mistake, can endanger an immigrant's ability to remain in the U.S.

- Linguistic access posed a problem in many states. Web sites were typically unavailable in languages other than English and Spanish. In some states, informants reported that Spanish versions of Web sites were poorly translated. Moreover, forms and notices were often written in English only, even if they were essential to enrollment. For example, such notices might inform an applicant that coverage would be denied unless the applicant provided certain information to the marketplace. Consumers who did not understand those notices and did not take the requested steps could remain uninsured, even if they qualified for insurance affordability programs (IAPs).
- Applicants with complex or unusual family situations were sometimes ill-served by program business rules. For example, those rules in many states assumed that children under age 18 lived with their parents. In some cases, this made it difficult to enroll homeless children and foster children.

Difficulty choosing a QHP

Many application assisters reported that after qualifying for QHP subsidies, consumers in areas with numerous options often found it difficult to select a plan. It was not unusual for QHP selection to take twice as long as completing the IAP application process, according to interviewees in multiple states.

Plan selection was further complicated by many consumers' unfamiliarity with such basic financial health insurance terms as "premiums," "deductibles," and "coinsurance," as well as such basic nonfinancial terms as "provider network" and "covered services." Before the start of open enrollment, HRMS data confirmed this lack of knowledge. They showed, for example, that simple financial vocabulary words for health insurance were confidently understood by only 36 percent of white uninsured, 15 percent of Hispanic uninsured, and 26 percent of other uninsured consumers.[8]

The difficulty of understanding plan descriptions that use these terms was amplified by the multiplicity of plan choices in much of the country. According to the U.S. Department of Health and Human Services, consumers in the average rating area must choose from among 47 QHPs offered by five carriers.[9] Often, our interviewees reported that consumers were stymied when presented with numerous options within a single metal tier without meaningful plan variations between those choices.

Web site displays of plan information sometimes worsened plan selection challenges. Some consumers could not eliminate irrelevant plan views. For example, in one state, applicants seeking single adult coverage could not remove listings of plans that offered child-only coverage (although they could ask to have such plans listed last). In almost every state, assisters reported that consumers could not obtain comprehensive, current information about QHP provider networks from the marketplace Web site. Instead, they had to go to plan Web sites, and even there often could not distinguish between providers included in insurers' pre-ACA networks and those participating in new QHP networks.[10]

OVERCOMING THESE OBSTACLES TO PARTICIPATION

Disconnection between marketplaces and Medicaid

New York and Kentucky avoided significant Medicaid backlogs and delays. In each of these states, one state agency administers both Medicaid and the state's marketplace. Each state used a single eligibility system for all IAPs. Online applicants' eligibility for Medicaid, CHIP and QHP subsidies was usually determined in real time—that is, while applicants were still online. New York and Kentucky thus avoided the kind of backlogs and bifurcated enrollment consumers faced in other states. However, FFM states and states with SBMs that are not run by state agencies may have difficulty using a single eligibility system for all IAPs.

Like Kentucky and New York, Washington state largely avoided backlogs and delays. However, unlike Kentucky and New York, Washington uses a quasi-public entity to administer the marketplace. As a result, the marketplace cannot make the final determination of Medicaid eligibility. Washington's Medicaid program built a rules engine—a computer-operated system to make eligibility decisions. The rules engine automatically qualifies consumers for Medicaid whenever, based on the state's business rules, data matches have sufficiently verified applicant attestations to establish eligibility. In Washington, Medicaid lends its rules engine to the shared eligibility service that evaluates IAP applications in the marketplace. As a result, if the rules engine finds an applicant eligible for Medicaid, such

a finding constitutes a final determination by the Medicaid program. No further referrals to Medicaid are required.[11] In Washington, most Medicaid-eligible applicants have relatively straightforward circumstances and qualify in real time, without the need for manual processing. Often, applicants qualify based on attestations, pending data matches completed soon thereafter.

Some FFM states have decreased Medicaid backlogs by using marketplaces to make a final determination of Medicaid eligibility rather than a preliminary assessment, followed by a referral to the state Medicaid agency, which makes the final decision. However, approaches to tightening the connection between FFMs and state Medicaid programs need to account for state concerns about the quality of federal eligibility data. For example, some states report that, for financial eligibility, they may receive from the FFM nothing more than the applicant's attestations and selected elements from federal income tax returns, which the state may not consider sufficiently recent and detailed to provide satisfactory verification. Numerous Medicaid programs have thus resorted to manual verification, causing backlogs and increased administrative costs. Eventually, an approach like Washington's may be possible with FFMs, where a state's Medicaid rules engine operates inside a federally managed eligibility service, providing final determinations of Medicaid eligibility to applicants in real time. This strategy is not currently feasible, however, given other pressing IT issues facing FFMs.

In the meantime, states could consider developing Medicaid rules engines to process applications received from marketplaces, replacing manual eligibility determinations with data-based determinations whenever possible. Oklahoma's pre-ACA experience illustrates the potential offered by this approach. Beginning in September 2010—years before the ACA's new procedural requirements went into effect—Oklahoma's Medicaid program was already encouraging applicants to apply online. Oklahoma used a rules engine with data matches to replace manual verification for approximately 50 percent of applicants.[12]

Under the ACA's new approach, Medicaid rules engines could specify the circumstances under which the previous year's tax return and the applicant's sworn attestations about current monthly income, under penalty of perjury, combine to establish eligibility without any need for further application processing. Such an engine would also define the circumstances under which (1) information received from the FFM is not sufficient to verify eligibility and specific state data sources are "pinged" to obtain additional information; and (2) the combination of state and federal data provides sufficient verification of sworn attestations to qualify an applicant. For adults in states that have expanded Medicaid eligibility and for children in all states,[13] the following examples illustrate the kinds of data that, under a state's business rules, could automatically verify sworn attestations of current monthly income at Medicaid levels:[14]

- *During January through August, data from prior-year tax returns showing modified adjusted gross income (MAGI) at or below 138 percent of FPL.*[15] Such income establishes an 85 percent likelihood of current monthly income at Medicaid levels in January through April and an 80 percent likelihood in May through August.
- *During September through December, a combination of (1) prior-year tax returns showing MAGI at or below 138 percent of FPL and (2) state quarterly wage records from earlier in the current year showing earnings at or below 80 percent of FPL.* That combination establishes an 85 percent likelihood of current monthly income at Medicaid levels.[16]
- *Data showing the current receipt of benefits from means-tested human services programs.* For example, among beneficiaries of the Supplemental Nutrition Assistance Program (SNAP)[17] and Temporary Assistance for Needy Families,[18] 95 percent have MAGI at or below 138 percent of FPL. The same is true of 86 percent of recipients of housing subsidies, 78 percent of participants in the low-income home energy assistance program, and 75 percent of individuals in families receiving child care subsidies. CMS has made clear that, even without an attestation of income at Medicaid levels, SNAP receipt can establish Medicaid eligibility in the context of targeted enrollment efforts,[19] which a number of states have already used to substantially increase Medicaid take-up.[20] Combining the receipt of SNAP or other means-tested benefits with attestations of income at Medicaid eligibility levels could potentially be used more broadly to expedite Medicaid enrollment and prevent backlogs in FFM states and elsewhere.[21]

This strategy's greatest effect on backlogs would result from using automated rules engines to verify eligibility. However, as an initial transition phase, states can achieve useful progress without full automation. For example, granting Medicaid caseworkers rights to look up information in an applicant's human services case file to supplement information received from the marketplace or Federal Data Services Hub can reduce the need for further manual verification. To illustrate, Alabama implemented Express Lane Eligibility (ELE) to automatically qualify children for

Medicaid based on SNAP and TANF data. In its initial approach to ELE, the state had caseworkers look up SNAP and TANF records, after which Alabama transitioned to automated data matching. The initial look-up approach achieved administrative savings, although the automated system yielded greater gains.[22]

Addressing challenges that face disadvantaged populations

Interviewees in multiple states reported that skilled application assisters provided intensive support, sometimes including translation or interpretation services, to help immigrants, people in complex or nontraditional households, and people with limited English proficiency overcome the barriers described above. If marketplaces target additional application assistance resources to such populations, more people could benefit from expert help. However, our informants also suggested several approaches that SBMs or FFMs could use to lower barriers themselves:

- To reduce the burdens experienced by immigrant applicants, eligibility rules that automate the treatment of immigrants with incomes at or below 138 percent of FPL could incorporate the immigration status characteristics that distinguish Medicaid from QHP-subsidy eligibility. This will require some customization to reflect state variations, such as the extent to which particular states have implemented available options to qualify children and pregnant women for CHIP and Medicaid based on lawful presence in the U.S. without satisfying such additional requirements as residence for at least five years.
- Marketplace procedures could add methods of verifying identity that do not depend on credit history. Such methods could incorporate the observations of certified navigators, brokers and other assisters when they work with applicants in person.
- Marketplace administrators understand that their Web sites need to be translated into languages other than English and Spanish that are spoken by significant numbers of low- and moderate-income residents. However, an equally urgent if not more pressing priority involves translating forms and notices that, without an appropriate response, can prevent eligible consumers from enrolling in coverage.

Going beyond individual barriers, two additional steps could address a range of problems. First, many informants strongly urged SBM leaders to engage seriously with community-based organizations that, during prior open enrollment periods, worked closely with immigrants and low-income households. Such organizations can provide useful information about the specific glitches that created problems, analyze proposed solutions to identify potentially unrealistic expectations about the circumstances facing disadvantaged populations, and jointly develop effective strategies to overcome key challenges. Such engagement can also increase community groups' buy-in and enhance their commitment to helping the marketplace achieve its participation goals.

Second, SBMs and FFMs could carefully examine application procedures to answer two questions:

1. At what points during the application process did consumers frequently give up and abandon their applications?

2. What were the main *procedural* defects that led to the rejection of IAP applications without the marketplace being able to determine applicants' actual eligibility for assistance?

For current purposes, it does not matter whether a marketplace has the data systems required for quantified, reliable answers to these two questions. Officials can simply collect samples from two sets of applications—those that were abandoned before completion, and those that were rejected for procedural reasons. Officials are likely to see the places where applicants frequently gave up and the common reasons for procedural denial. In most cases, officials will be able to identify the policies and practices that were probably responsible for those trends and decide whether to modify them. In the past, similar efforts have helped Medicaid and CHIP programs identify and overcome procedural obstacles that needlessly inhibited enrollment of eligible consumers.

Facilitating QHP choice

California and Connecticut took two steps that made it much easier for consumers to choose between available QHP options. First, marketplace Web sites in both states showed subsidy-eligible consumers default views that were limited to silver plans offering the type of coverage requested by the consumer, displaying the effect of subsidies on premiums, deductibles and other out-of-pocket costs. Such displays were even shown to anonymous browsers, whose subsidy eligibility was calculated based on their rough, unverified income estimates. Consumers could opt to see other available plans, but the initial, default view made decisions more

manageable by showing the relatively small number of options that were likely to be most relevant.

Second, plan design was standardized within each metal tier. Maryland, Michigan, New York and Oregon also took this approach. As a result, consumers were not asked to compare multiple insurance products with minor differences that were bewilderingly hard to assess. Behavioral economics research suggests that such simplification can make it easier for most people to understand available options and decide which choice best fits their needs.[23] Our interviewees confirmed that, as a practical matter, most consumers in these states did not have difficulty with plan selection—a very different report than we received in other states.

SBMs and partnership marketplaces could pursue a more modest standardization strategy that requires insurers to meet a high threshold for proving that plan variations within a single tier offer significantly different choices. For example, carriers could offer (1) closed-panel HMOs; and (2) preferred provider organizations that provide access, with different cost-sharing amounts, to both network and non-network providers.

Carriers could likewise offer plans that offer significantly different trade-offs between (1) up-front cost-sharing via deductibles and copayment or coinsurance levels; and (2) back-end cost-sharing via out-of-pocket cost-sharing maximums, to the extent allowed by the statute. Plan options offering less significantly different tradeoffs would not be allowed under this approach.

Eliminating insignificant plan variations within metal tiers would prevent a kind of carrier "gaming" that has emerged as a problem in some states, where insurers offer numerous plans that only vary slightly from one another. If a consumer asks to see available silver-level plans ranked based on premium cost, all the plans shown on the first browser screen—or even the first several screens—can be sponsored by a single carrier, even if only a few dollars separate the price of those plans from those of other carriers. As a practical matter, consumers wind up choosing from among a single insurer's plans without seeing significant differences between the options presented to them. This can inhibit rather than facilitate robust competition between insurers and meaningful consumer choice.

As policy-makers consider narrowing the range of options within each metal tier, it is important to remember that such steps will not take away consumers' choices among plans offered in different metal tiers. Choices in different tiers necessarily involve substantially different plan designs.

Another approach being explored in a number of states involves developing tools that help consumers sort through available choices and make good decisions. Time will be required to evaluate the effectiveness of such tools with marketplaces' key target audiences and to compare these strategies with approaches that make choices more manageable by reducing their number. Ultimately, many states may wind up balancing both general strategies, combining some limits on plan options with improved decision supports for consumers.

CONCLUSION

With insurance affordability programs having started in January 2014, the ACA's main coverage expansion has just begun. Based on the country's prior experience with the successful CHIP program, it will take years before the ACA's new systems operate smoothly and effectively in the majority of states. Achieving such progress will require careful, patient attention to enrollment obstacles. A number of states offer promising examples suggesting how such obstacles can be overcome. Other states and the federal government can build on these examples, improving the enrollment process for 2015 and beyond.

ENDNOTES

1. In states that expand Medicaid, the lower threshold of financial eligibility for QHP subsidies generally rises to 138 percent of FPL, because consumers with incomes at or below that level qualify for Medicaid, with one exception. Certain lawfully present noncitizens are ineligible for Medicaid because of their immigration status and so qualify for QHP subsidies, notwithstanding income below the ordinarily applicable lower income threshold for such subsidies.
2. Blumberg LJ, Holahan J, Kenney GM, Buettgens M, Anderson N, Recht H and Zuckerman S. *Measuring Marketplace Enrollment Relative to Enrollment Projections: Update.* Washington, DC: Urban Institute, 2014, http://www.urban.org/UploadedPDF/413112-Measuring-Marketplace-Enrollment-Relative-to-Enrollment-Projections-Update.pdf.
3. Long SK, Kenney GM, Zuckerman S, Wissoker D, Shartzer A, Karpman M, Anderson N and Hempstead K. *Taking Stock at Mid-Year: Health Insurance Coverage under the ACA as of June 2014.* Washington, DC: Urban Institute, 2014, http://hrms.urban.org/briefs/taking-stock-at-mid-year.pdf.
4. Along with Medicaid coverage of children, CHIP is now one of the country's most successful need-based programs, reaching an estimated 87 percent of its target population. Kenney GM, Anderson N and Lynch V. "Medicaid/CHIP Participation Rates among Children: An Update." Washington, DC: Urban Institute, 2013, http://www.urban.org/uploadedpdf/412901-%20Medicaid-CHIP-Participation-Rates-Among-Children-An-Update.pdf. (accessed February 7, 2014). During its first few years, however, CHIP was viewed with "general disappointment … due to low enrollment rates," according to the Congressional Research Service. Herz E and Baumrucker EP. "Reaching Low-Income, Uninsured Children: Are Medicaid and SCHIP Doing the Job?" Washington, DC: Congressional Research Service, 2001. http://www.policyarchive.org/handle/10207/bitstreams/1043.pdf (accessed February 7, 2014).
5. Adams R. "How Website Woes Foiled Obamacare a Second Time." *Roll Call*, June 3, 2014, http://www.rollcall.com/news/how_website_woes_foiled_obamacare_a_second_time-233507-1.html.
6. For example, Anderson V. "One-Third Of Georgia's Medicaid Applicants Still In Limbo." *Atlanta Journal Constitution/Kaiser Health News*, August 27, 2014, http://www.kaiserhealthnews.org/Stories/2014/August/27/OneThird-Of-Georgias-Medicaid-Applicants-Still-In-Limbo.
7. 42 CFR 431.10(c)(2) requires eligibility decisions to be made by "a government agency which maintains personnel standards on a merit basis."
8. In the income range for QHP subsidy eligibility (138 to 400 percent of FPL), only 55 percent of white adults (including both insured and uninsured), 36 percent of Hispanics and 43 percent of other adults were confident in their understanding of all simple financial health insurance terms. Long S and Goin D. "Large Racial and Ethnic Differences in Health Insurance Literacy Signal Need for Targeted Education and Outreach." Washington, DC: Urban Institute, 2014, http://hrms.urban.org/briefs/literacy-by-race.html.
9. Burke A, Misra A and Sheingold S. "Premium Affordability, Competition, and Choice in the Health Insurance marketplace, 2014." *ASPE Research Brief*. Washington, DC: Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (ASPE/HHS), 2014.
10. For more detailed information about the information that marketplaces make available about provider networks, see Blumberg LJ, Peters R, Wengle E and Arnesen R. *Physician Network Transparency: How Easy Is It for Consumers to Know What They Are Buying?* Washington, DC: Urban Institute, 2014. http://www.urban.org/UploadedPDF/1001746-Physician-Network-Transparency.pdf.
11. Janet Varon, Northwest Health Law Advocates, personal communication, 2014. In cases where the rules engine does not definitively establish Medicaid eligibility, the Medicaid program conducts further work to determine eligibility.

    Other strategies are available to limit the need for Medicaid to process applications after the initial evaluation by FFMs or SBMs. Even if a marketplace takes the most minimal of roles, simply assessing rather than determining Medicaid eligibility, so long as the marketplace uses the state's eligibility rules and verification procedures, the state Medicaid program does not revisit the conclusions reached through such assessments. CMS, Center for Medicaid and CHIP Services. *Medicaid and CHIP FAQs: Coordination between Medicaid/CHIP and the Federally Facilitated Marketplace.* Originally released May 2012 and April 2013. http://www.medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-Implementation/Downloads/FAQs-by-Topic-Coordination-with-Marketplace.pdf. In effect, a duplicate of the Medicaid program's rules engine would be incorporated into the marketplace rules engine. Only if the application of the state's eligibility rules and procedures via that "shadow Medicaid rules engine" leaves an uncertain outcome would the state Medicaid agency need to further determine eligibility, other than to formally affirm the marketplace's finding.
12. CMS State Resource Center. Simplified, Real-Time Verification Issue Brief. Washington, DC: Medicaid and CHIP Learning Collaboratives, 2013, http://www.medicaid.gov/State-Resource-Center/MAC-Learning-Collaboratives/Downloads/Realtimebrief.pdf.
13. In all but 17 states, Medicaid eligibility for children extends above 138 percent of FPL, defined in terms of modified adjusted gross income. CMS. *State Medicaid and CHIP Income Eligibility Standards (For MAGI Groups, based on state decisions as of April 1, 2014)*.
14. States are not required to verify sworn attestations of financial eligibility. The only eligibility requirements that require verification involve citizenship and immigration status. If verification is required by state policy choice or federal law, ACA regulations require verification by data matches whenever available data are "reasonably compatible" with attestations.
15. Tax return data are available for numerous Medicaid-eligible applicants. More than 64 percent of Medicaid-eligible children live in families who file federal income tax returns; and in states that have expanded Medicaid eligibility, more than 59 percent of Medicaid-eligible adults file tax returns. Unpublished findings from Dorn S, Buettgens M and Dev J. Tax Preparers Could Help Most Uninsured Get Covered. Washington, DC: Urban Institute, 2014, http://www.urban.org/UploadedPDF/413029-Tax-Preparers-Could-Help-Most-Uninsured-Get-Covered.pdf.
16. Both this finding and that in the previous bullet are based on longitudinal data following consumers over time. Those data show, among consumers whose income during the prior calendar year was at specified levels, the percentage whose income during specified months of the current calendar year was at or below 138 percent of FPL; and among those with prior-year income at certain levels and wages during the first months of the current year at specified levels, the percentage whose income during the final months of the current year was at or below 138 percent of FPL. For technical reasons related to the survey data, wage information from four rather than three months was used as a proxy for quarterly wage records. Dorn S, Buettgens M, Moody H and Hildebrand C. Using Past Income Data to Verify Current Medicaid Eligibility. Washington, DC: Urban Institute, 2013, http://www.urban.org/UploadedPDF/412920-Using-Past-Income-Data-to-Verify-Current-Medicaid-Eligibility.pdf.

17. This percentage applies to Medicaid coverage of adults, assuming that states cover adults up to 138 percent of FPL. The same is true with the following estimates for other human services programs. Dorn S, Wheaton L, Johnson P and Dubay L. *Using SNAP Receipt to Establish, Verify, and Renew Medicaid Eligibility*. Washington, DC: Urban Institute, 2013, http://www.urban.org/UploadedPDF/412808-Using-SNAP-Receipt-to-Establish-Verify-and-Renew-Medicaid-Eligibility.pdf.

    One issue regarding SNAP is important to address. Ordinarily, SNAP eligibility is limited to households with gross incomes (as calculated by SNAP) at or below 130 percent of FPL. However, some states have implement broad-based categorical eligibility that extends SNAP to recipients of noncash TANF services with gross incomes up to 185 percent of FPL or higher. In the latter states, 91 percent of adults receiving SNAP have MAGI at or below 138 percent of FPL; this percentage never dips below 89 percent for any state. If an adult in one of the latter states attests, under penalty of perjury, to income at Medicaid levels, and the state Medicaid program verifies that the adult has an open SNAP case, state policy-makers could potentially find that information sufficient to verify the attestation, given these high percentages.

18. Dorn S, Isaacs J, Minton S, Huber E, Johnson P, Buettgens M and Wheaton L. *Overlapping Eligibility and Enrollment: Human Services and Health Programs Under the Affordable Care Act*. Washington, DC: Urban Institute. 2013, http://www.urban.org/UploadedPDF/413028-Overlapping-Eligibility-and-Enrollment-Human-Services-and-Health-Programs-Under-the-Affordable-Care-Act.pdf. This same source applies to all benefit programs cited here, except for SNAP, where the previously cited paper provides more updated estimates.

19. "Facilitating Medicaid and CHIP Enrollment and Renewal in 2014," Center for Medicare and Medicaid Services (CMS), Department of Health and Human Services (HHS), May 17, 2013. http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-003.pdf.

20. Within six weeks (by November 15, 2013), the four states that first implemented these strategies—Arkansas, Illinois, Oregon and West Virginia—had enrolled approximately 63,000, 36,000, 70,000 and 54,000 people, respectively. Guyer J, Schwartz T and Artiga S, Fast Track to Coverage: Facilitating Enrollment of Eligible People into the Medicaid Expansion, Manatt Health Solutions and the Kaiser Commission on Medicaid and the Uninsured, 2013, http://kaiserfamilyfoundation.files.wordpress.com/2013/11/8517-fast-track-to-coverage-facilitating-enrollment-of-eligible-people-into-the-medicaid-expansion1.pdf. Since the initial implementation of these targeted enrollment strategies, the number enrolled has increased. For example, Oregon reached more than 123,000 people by February 6, 2014. "Legislature Aimed at Improving Access to Cover Oregon, IT Oversight Bills." Cascade Business News, Feb 18, 2014, http://www.cascadebusnews.com/news-pages/e-headlines/4982-legislature-aimed-at-improving-access-to-cover-oregon-it-oversight-bills.

21. States have typically used human services case records to verify attestations about particular types of income. CMS has not formally approved using the final income findings of human services programs that are reflected in their eligibility determinations as verifications of MAGI attestations by applicants for Medicaid and CHIP, but indications are promising for states to pursue this approach.

22. Hoag S et al. *CHIPRA Mandated Evaluation of Express Lane Eligibility: Final Findings*. Washington, DC: ASPE/HHS, 2013, http://aspe.hhs.gov/health/reports/2013/ELE/ELE%20Final%20Report%20to%20ASPE%2012%2011%2013.pdf.

23. See, for example, Johnson E, Hassin R, Baker T, Bajger A and Treuer G. *Can Consumers Make Affordable Care Affordable? The Value of Choice Architecture*, New York, NY: Columbia Business School, 2013; Ericson KM and Starc A, "Heuristics and Heterogeneity in Health Insurance Exchanges: Evidence from the Massachusetts Connector," *American Economic Review* 102, no. 3: 49 3–97, 2012; Kuye IO, Frank RG and McWilliams JM, "Cognition and Take-Up of Subsidized Drug Benefits by Medicare Beneficiaries," *JAMA Internal Medicine* 173, no. 12: 110 0–1107, 2013; and Barnes AJ, Hanoch Y, Martynenko M, Wood S, Rice T and Federman AD. "Physician Trainees' Decision Making and Information Processing: Choice Size and Medicare Part D." *PLoS ONE* 8(10): e77096.

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Marketplace Insurance Premiums in Early Approval States: Most Markets Will Have Reductions or Small Increases in 2015

Revised, December 2014

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URBAN INSTITUTE
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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. This report is one of a series of papers focusing on particular implementation issues in case study states. 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. For more information about the Robert Wood Johnson Foundation's work on coverage, visit **www.rwjf.org/coverage**.

INTRODUCTION

Despite marketplace insurance premiums in 2014 being surprisingly modest in many areas, some people feared that large increases would occur in 2015—with significant implications for premiums of unsubsidized individuals and for government subsidy costs.[1] The positive experience with premiums in 2014 may well have resulted from the pressure to gain early market share by being one of the two lowest cost silver plans because federal subsidies are tied to the second-lowest cost premium in each rating area.[2]

Under the Affordable Care Act (ACA), premium costs for individuals who are eligible for marketplace nongroup subsidies are limited to a percentage of their incomes, assuming they choose the second-lowest cost silver plan or a less expensive plan. They must pay the full marginal cost for a higher cost plan. Insurers, understanding those incentives, have strong reasons to set premiums as aggressively as possible while protecting themselves against losses.[3]

This report analyzes the relative growth in marketplace premiums in 2015 compared to 2014. We draw premiums from rate filings for each carrier's lowest cost silver plan offering in select rating areas in states that have finalized, approved premiums. We find that consumers in most of the areas studied will be able to obtain 2015 silver-level coverage at lower rates than were available in 2014 or at premium increases of less than 5 percent. Frequently for 2015, a different carrier from the one in 2014 offers the lowest priced silver option in a rating area.

BACKGROUND

The ACA's incentives, centered on the silver plan premiums in an area, resulted in healthy competition over rates in many markets in 2014, particularly in urban areas. Markets generally saw a large number of competing carriers offering several plans. Many insurers limited their provider networks, thereby generally excluding higher cost providers, or negotiated competitively with physicians and hospitals to accept lower rates in order not to be excluded from the plan's network.[4]

National commercial plans, particularly Blue Cross Blue Shield (BCBS) plans, as well as local carriers, entered the health insurance marketplaces in 2014. Plans previously providing coverage only for Medicaid beneficiaries and co-ops also entered the marketplaces in a number of areas. As a result of competition, premiums were surprisingly modest in many areas, particularly in comparison with benchmarks such as small group market premiums.[5]

Some markets were less competitive, however, particularly in states—or less populated parts of states—where a BCBS carrier was dominant and had few significant competitors. Rates in those markets were somewhat higher but not dramatically so. Some states highly dominated by BCBS plans still had quite modest premiums for marketplace plans.[6]

Premiums in 2014 may have been artificially low because insurers did not adequately understand the health status of individuals who would enter the markets. Having seen that they had priced too aggressively, insurers may have increased premiums to adjust for underestimating enrollee risk profiles. Insurers may have to broaden their provider networks to some extent to meet the demands of the increased enrollment expected in 2015; broadening networks may necessitate somewhat higher payment rates to certain providers. Finally, underlying health care costs are beginning to trend upward, which could also affect 2015 premiums.

On the other hand, the pressure to be one of the lowest cost plans remains intact. Large premium increases likely would mean a reduced market share. Insurers could not recoup 2014 losses by setting premiums high in 2015 if doing so reduces enrollment.[7] Further, marketplace enrollment is expected to grow in 2015. The Congressional Budget Office estimates that an additional 7 million people will purchase health insurance through the marketplaces in 2015.[8] Higher marketplace enrollment should improve the overall mix of healthy and sick individuals within the risk pool, assuming that those with the highest expected costs would have been the first to enroll. The ACA-compliant plans' risk pools should also improve in the coming years, as more individuals move into those plans from the remaining noncompliant plans.

Many insurers allowed their pre-ACA enrollees to renew their plans early in order to lengthen the time before those enrollees would move into the new options, and the federal government extended the time period during which individuals could re-enroll in their pre-ACA plans. Both of those moves likely reduced the number of healthy individuals enrolling in marketplace and other ACA-compliant plans in the early years of reform, conditions that will change in the coming years. The cost-sharing requirements of silver plans should also dampen utilization because sizable deductibles, for example, tend to decrease use of services. Insurer efforts to reduce costs by limiting networks or reducing provider payments are also likely to reduce premium growth.

Several studies have already been released that provide some information about 2015 marketplace premiums.[9] This study offers a more in-depth look at the dynamics in a broad array of markets with finalized rates. Unlike the other studies, this one provides data at the carrier level in each area studied, which then allow us to more clearly understand the competitive forces at play. Additionally, we include the calculated change in the lowest price silver plan premium available each year, which no other studies provide and which allows us to understand how the price of entering the silver tier of coverage is changing across the first two years of reform. Finally, this analysis includes data from several states that have not been reported in other studies, including Delaware, South Dakota and Montana.

SUMMARY OF FINDINGS

In this paper, we present data on how premiums are changing between 2014 and 2015 in nongroup marketplace plans; we focus on 17 states and the District of Columbia, which were the first to complete their rate review and approval processes. In each rating area studied, we report the relative difference between the lowest cost silver plans in 2014 and in 2015. In addition, we show the average percentage change in the lowest cost silver marketplace premiums across all carriers in the marketplace. Tables 1 and 2 provide the summarized results.

The key findings of this paper are as follows:

- Premium increases will be quite low between 2014 and 2015. In the rating areas we examine in the 17 states plus the District of Columbia, ten states will have average premium reductions across the carriers' lowest cost silver plans, seven will have small premium increases (defined as 5% or less), and one will have an increase greater than 5 percent. Across the 39 rating regions studied within those states, 25 will have average premium reductions across their carriers' lowest cost silver plans, 9 will have small increases, and five will have larger increases (greater than 5%).[10]
- Many of the small increases or reductions in 2015

premiums will occur in large cities, including Baltimore, Cincinnati, Cleveland, Denver, Detroit, the District of Columbia, Minneapolis, New York City, Portland (Oregon), and Seattle.

- There is no consistent pattern of differences in rate increases between urban and rural areas. For example, the rural counties studied in Tennessee will see a 0.7 percent increase in the average lowest cost silver premiums offered by carriers in 2015, compared to 2.7 percent in Nashville. Premiums will increase in the study's selected rural counties in Michigan by 1.1 percent and will decrease in Oregon by 1.8 percent. On the other hand, premiums in rural parts of New York and West Virginia each increase by 9 percent.
- Of the 39 rating regions, 26 will see a change from 2014 in the carrier offering the lowest cost silver premium in 2015. As a result, the lowest cost silver option available to consumers in 17 of the rating regions will be lower in 2015 than in 2014. Those changes reflect that many of the lowest cost carriers in 2014 have fairly low premiums and believe that they can increase those rates, while other carriers are responding to competitive pressure in the marketplaces and will reduce their premiums in 2015. This change is a desirable and direct outcome of market competition, but individuals will need to change plans to minimize their share of their premium payments.
- Finally, we saw that price competition is driven by different carriers in different states. BCBS-associated plans are highly competitive and will remain so in Delaware, the District of Columbia, Maine, Maryland, Michigan, Tennessee, Virginia, and West Virginia. They are less competitive in Colorado, Ohio, Minnesota, Montana, and New York. Medicaid-only plans that entered the marketplace will play an important role in keeping premiums low in states such as New York, Ohio, Rhode Island, and Washington. Kaiser Permanente generally will have premium reductions or small increases in 2015 and will become more competitive in Colorado, the District of Columbia, Maryland, and Virginia. Co-ops are extremely competitive in Colorado, Maine, Maryland, Montana, New York, Oregon, Tennessee and West Virginia.

Table 1. Changes in Lowest Cost Silver Premiums, in Selected Rating Areas in 18 States, 2014 to 2015

State	Lowest Cost Silver Plan, 2015 Premium for a 40-Year-Old[a]	Average Percentage Change in Lowest Cost Silver Premiums Across All Carriers[a,b]	Percentage Change in Lowest Cost Silver Plan Available on Marketplace[a,b]
Colorado	$231	-8.0%	-10.9%
Connecticut	$351	-2.4%	0.4%
Delaware	$300	3.7%	5.0%
District of Columbia	$242	2.4%	1.3%
Maine	$275	-4.0%	-3.1%
Maryland	$230	0.1%	3.4%
Michigan	$253	-1.4%	11.9%
Minnesota	$193	0.2%	7.2%
Montana	$238	-1.2%	-5.4%
New York	$304	1.9%	-6.3%
Ohio	$239	-3.0%	2.7%
Oregon	$202	-3.0%	-0.3%
Rhode Island	$244	-3.6%	-10.8%
South Dakota	$257	-12.4%	1.6%
Tennessee	$205	1.2%	5.8%
Virginia	$263	4.9%	3.9%
Washington	$235	-3.0%	-5.8%
West Virginia	$298	9.0%	8.3%

[a] *Data are based on selected rating areas (see Table 2).*
[b] *Percentage changes are not weighted by enrollment.*

Table 2. Changes in Lowest Cost Silver Premiums, in Selected Rating Areas in 18 States, 2014 to 2015

State	Rating Area	Lowest Cost Silver Plan, 2015 Premium for a 40-Year-Old[a] (US)	Average Percentage Change in Lowest Cost Silver Premiums Across All Carriers[a,b]	Percentage Change in Lowest Cost Silver Plan Available on Marketplace[a,b]	
Colorado	Rating Area 3: Denver, Aurora, Lakewood	$207	-4.0%	-15.7%	*
	Rating Area 5: Grand Junction	$293	-10.2%	2.7%	
	Rating Area 2: Colorado Springs	$194	-9.8%	-19.7%	*
Connecticut	Rating Area 1: Bridgeport, Stamford	$380	-3.1%	-0.8%	*
	Rating Area 2: Hartford	$321	-1.7%	1.5%	
Delaware	Rating Area 1: Entire State	$300	3.7%	5.0%	
District of Columbia	Rating Area 1	$242	2.4%	1.3%	*
Maine	Rating Area 1: Portland	$275	-4.0%	-3.1%	*
Maryland	Rating Area 1: Baltimore	$226	-1.8%	-0.7%	*
	Rating Area 3: Washington DC Suburbs	$226	-1.1%	-0.9%	*
	Rating Area 2: 12 Rural Counties	$237	3.3%	11.7%	*
Michigan	Rating Area 1: Detroit	$219	-3.9%	15.2%	
	Rating Area 7: Lansing	$269	-1.5%	9.8%	*
	Rating Area 15: 13 Rural Counties	$271	1.1%	10.6%	*
Minnesota	Rating Area 8: Minneapolis	$181	1.3%	17.9%	*
	Rating Area 2: Duluth	$206	-0.9%	-3.4%	*
Montana	Rating Area 1: Billings	$238	-1.2%	-5.4%	*
New York	Rating Area 4: New York City	$372	-2.4%	3.5%	*
	Rating Area 2: Buffalo	$262	-0.8%	-4.8%	
	Rating Area 7: 13 Rural Counties	$278	9.0%	-17.5%	*
Ohio	Rating Area 9: Columbus	$249	-5.1%	2.3%	
	Rating Area 4: Cincinnati	$232	-3.7%	7.4%	*
	Rating Area 11: Cleveland	$242	-0.1%	-1.7%	*
Oregon	Rating Area 1: Portland	$196	-5.1%	1.3%	*
	Rating Area 3: Salem	$202	-2.0%	0.6%	*
	Rating Area 6: 15 Rural Counties	$207	-1.8%	-2.9%	
Rhode Island	Rating Area 1: Entire State	$244	-3.6%	-10.8%	*
South Dakota	Rating Area 2: Sioux Falls	$257	-12.4%	1.6%	
Tennessee	Rating Area 4: Nashville	$194	2.7%	7.2%	*
	Rating Area 6: Memphis	$184	0.3%	-0.1%	*
	Rating Area 8: 16 Rural Counties	$238	0.7%	10.2%	*
Virginia	Rating Area 7: Richmond	$241	3.0%	5.2%	
	Rating Area 9: Virginia Beach, Norfolk	$273	5.7%	1.3%	*
	Rating Area 10: Washington D.C. Suburbs	$273	5.9%	5.1%	*
Washington	Rating Area 1: Seattle	$235	-3.2%	-4.2%	
	Rating Area 4: Spokane	$219	-5.3%	-6.9%	
	Rating Area 5: 14 Rural Counties	$251	-0.6%	-6.2%	
West Virginia	Rating Area 2: Charleston	$314	9.0%	9.0%	
	Rating Area 9: 9 Rural Counties	$282	9.0%	7.6%	*

[a] *Data are based on selected rating areas.*

[b] *Percentage changes are not weighted by enrollment.*

* *Indicates change in carrier with lowest cost silver plan available, from 2014 to 2015.*

METHODS

Our analysis focuses exclusively on comparing each carrier's lowest cost silver marketplace plan premium for a 40-year-old in chosen rating areas within 17 states and the District of Columbia in 2014 and 2015. Relative changes in premiums for a 40-year-old are identical to those for any other age because of the fixed-age rating curves required under the ACA. We gathered 2015 premium data for the study states and regions from publicly available rate filings posted on the websites of state departments of insurance. We obtained the 2014 premiums from a combination of the websites of state departments of insurance (some posted the rates in easily accessible tables), the 2014 rate-filing documents, or the respective marketplace websites.

In some instances, publicly available filings do not include complete rate tables; however, the rates of interest can be calculated from the plan specific base value (i.e., the consumer adjusted index rate) and applying the provided rate factors (geographic rating area, age rating factor, and tobacco usage factor). We selected only states that, as of early October 2014, had completed the rate review process and closed the filings for all of the carriers participating on the marketplace for 2015. We updated the analysis by re-checking marketplace websites after the start of open enrollment on November 15.

For most of the selected states, we studied multiple rating areas: one to two major metropolitan areas and one rural rating area. In the cases of Maine, Montana, and South Dakota, small population size and population concentration in the largest metropolitan area led us to include only one rating area. Two of our study states—Delaware and Rhode Island—plus the District of Columbia have only one rating area, which spans the entire marketplace. The analysis focuses on silver level plans because that tier of coverage is used to determine the size of advanced premium tax credits available to the modest income population to support the purchase of health insurance coverage under the ACA through the marketplaces.

We do our analysis on the silver plans as these are the most frequently purchased and are the only options that allow subsidized individuals to utilize available cost-sharing reductions. We study the lowest cost silver option offered by each carrier as these are their most competitive plans in this tier and best allow an analysis of competitive dynamics in the market. Of course, price is not the only factor on which carriers compete. Others of importance to consumers include provider networks, deductibles, and out-of-pocket limits.

We compiled the premium price for the lowest cost silver plan available from each carrier for a 40-year-old nonsmoker for 2014, along with the lowest cost silver plan premiums approved for each carrier participating in 2015. We then calculated the percentage change in the lowest monthly premium price from the 2014 plan year to the 2015 plan year for each carrier. In some cases, we were unable to calculate the percentage change for one of the following reasons: (a) the carrier was a new entrant to the marketplace in 2015, (b) the carrier expanded its service into a new rating area in 2015, (c) the carrier left the marketplace, or (d) part of the filing was incomplete or missing (technical issue). In some cases, particular plans may only be offered in a portion of a rating area; this is not taken into account in the calculations provided.

Some carriers introduced new products for 2015, often a health maintenance organization (HMO) or exclusive provider organization (EPO) to lower premium costs and to become more competitive in a particular area. Unless the new products were filed under separate subsidiaries, such a change may manifest as a significant decrease in the lowest cost option offered by a carrier; we have noted such changes where possible.

We computed the relative changes in lowest cost silver plans between 2014 and 2015, by rating area and across all rating areas selected in a state. We also calculated the relative change in the carriers' lowest cost silver plan premium that is available on the marketplace in 2014 to the lowest cost silver plan that will be available in 2015, ignoring possible changes in the carrier that offers the lowest cost option. This latter calculation provides an indicator of whether the silver tier of coverage is getting more or less expensive in a particular area. We do not have the enrollment data necessary to calculate weighted averages, however.

In the tables that follow, all monthly premiums are rounded to the nearest dollar and relative changes are rounded to the nearest one-tenth percent.

STATE-BY-STATE FINDINGS IN SELECTED RATING AREAS

As described in the methods section, we have identified and are reporting on only the lowest cost silver plan premium offered by each insurance carrier participating in each rating area studied in 17 states plus the District of Columbia. Thus, any references to premium changes, average premiums, or relative changes in average premiums refer to the carriers' lowest cost silver plan premiums in a given year or years. At times, reported premium changes reflect a change in the price being charged for the same plan offered by the carrier in both years; at other times, a carrier introduces an additional or replacement plan in 2015.

All premiums reported are monthly premiums prior to any applied subsidy for a 40-year-old single adult; relative changes between the two years will be identical for all ages, however, because of fixed premium ratios between adults of each age under the law. In addition, averages at the state level include data only on the rating areas studied.

Colorado

Between 2014 and 2015, Colorado changed the definitions of some of its premium rating areas. We report only on three markets that remained the same across the two years; the changes in areas are the reason we do not include a rural rating region for the state.

Colorado has had considerable competition in each of the three markets we examined. Overall, carriers' lowest cost silver plan premiums fell across the state by 8.0 percent, on average, for 2015 (see Table 3). In the Denver region, intense competition among 10 carriers in 2014 caused premiums to fall by 4.0 percent for 2015. In 2014, Kaiser Permanente and Humana have the lowest cost premiums; most other plans have considerably higher premiums. Both Kaiser and Humana are lowering their premiums by about 2.0 percent for 2015, to $240 and $244 respectively. But Colorado HealthOP, a co-op, chose to aggressively market for 2015 and is lowering its monthly premiums from $273 in 2014 to $207 in 2015, a 24.3 percent reduction. The co-op will be the lowest cost carrier in Denver for the 2015 plan year.

The premium for the lowest cost silver plan offered in Denver in 2015 will be 15.7 percent lower (see Table 2) than the lowest cost plan offered in 2014 ($245 offered by Kaiser Permanente in 2014, compared to $207 offered by the Colorado HealthOP in 2015). Access Health Colorado, also known as New Health Ventures, reduced its lowest cost silver premium by about 40 percent in 2015 by introducing an EPO plan into the market for the first time, but its lowest cost silver premium is still more expensive than the equivalent plans from the co-op, Kaiser, and Humana in the second year. HMO Colorado, a product of Anthem, lowered its premiums slightly, but it is still more expensive than many of its competitors.

In Grand Junction, premiums are falling by 10.2 percent, primarily because of premium reductions of more than 20 percent by both Colorado HealthOP and Access Health Colorado. Rocky Mountain Health Plan, a large carrier based in Grand Junction, will increase the premium of its lowest priced silver plan by 2.7 percent, but it will remain the lowest cost carrier in this region.

In Colorado Springs, Humana is the lowest cost carrier in 2014 by a considerable margin. It will reduce its premiums for 2015 by 3.9 percent. Colorado HealthOP and New Health Ventures are each introducing an EPO plan into the market for 2015, thereby reducing the premiums for its lowest cost silver offerings (previously PPO plans) by almost 40 percent. Colorado HealthOP will offer the lowest cost silver plan in 2015, with premiums significantly below those of the lowest cost carrier in 2014 ($194 per month in 2015 versus Humana's $242 per month in 2014). Kaiser Permanente is also extremely competitive in this market in 2014 and will remain so in 2015. Overall, the Colorado Springs market will see an average reduction of 9.8 percent in its carriers' lowest cost silver plans.

Thus, the Colorado market, led by two carriers that set premiums very aggressively, will see considerable premium reductions in 2015.

Connecticut

Among all of the states we examined, Connecticut has the highest average premiums across its carriers' lowest cost silver plans (see Table 1); however, premiums will fall in 2015 in the two rating areas we studied by an average of 2.4 percent. The lowest cost carrier in Connecticut in 2014 in Bridgeport and Hartford, the two rating regions studied, is ConnectiCare Benefits Inc. (see

Table 3. Lowest Cost Silver Plan Premiums for a 40-Year-Old, by Carrier, in Selected Rating Areas, in 2014 and 2015 in Colorado

Issuer Name	2014 Lowest Cost Silver Plan Premium (US)	2015 Lowest Cost Silver Plan Premium (US)	Percentage Change, 2014 to 2015
Rating Area 3: Denver, Aurora, Lakewood			
Kaiser Permanente	$245	$240	-1.9%
Humana	$250	$244	-2.4%
Colorado HealthOP	$273	$207	-24.3%
Denver Health Medical Plan	$275	$318	15.9%
Colorado Choice Health Plan	$294	$308	4.4%
Rocky Mountain Health Plans	$309	$345	11.4%
Cigna	$318	$339	6.4%
HMO Colorado (Anthem)	$320	$316	-1.0%
All–Savers	$381	$349	-8.4%
New Health Ventures (Access Health Colorado)[b]	$454	$274	-39.7%
Rating Area Average[a]			**–4.0%**
Rating Area 5: Grand Junction			
Rocky Mountain Health Plans	$285	$293	2.7%
HMO Colorado (Anthem)	$359	$359	-0.1%
Colorado HealthOP	$408	$317	-22.4%
New Health Ventures (Access Health Colorado)[b]	$503	$396	-21.2%
Rating Area Average[a]			**-10.2%**
Rating Area 2: Colorado Springs			
Humana	$242	$233	-3.9%
Colorado Choice Health Plan	$264	$276	4.4%
Kaiser Permanente	$270	$257	-4.6%
Rocky Mountain Health Plans	$274	$312	13.6%
HMO Colorado (Anthem)	$300	$296	-1.3%
Colorado HealthOP[c]	$309	$194	-37.0%
New Health Ventures (Access Health Colorado)[b]	$416	$251	-39.7%
Rating Area Average[a]			**-9.8%**
Average of Select Rating Areas[a]			**-8.0%**

[a] Percentage changes are not weighted by enrollment.
[b] Access Health Colorado is a subsidiary of New Health Ventures. New Health Ventures introduced an exclusive provider organization (EPO) product for 2015. This table compares the 2014 preferred provider organization (PPO) product to the 2015 EPO product.
[c] Colorado HealthOP expanded its EPO product into Rating Area 2; the comparison is 2014 PPO to 2015 EPO.

Table 4). Anthem Blue Cross Blue Shield is the largest carrier in the state and has the second lowest cost marketplace premiums in those rating areas in 2014. For 2015, Anthem will keep its lowest cost silver premiums in Bridgeport essentially fixed, but it will become the highest cost carrier. HealthyCT Inc., the state's co-op, reduced its lowest cost silver plan premiums by 12.8 percent in Bridgeport. As a result of those reductions and because ConnectiCare is increasing its rates very modestly, the ordering of carriers by their lowest cost silver offerings changed. For 2015, HealthyCT's lowest silver plan is more competitive than ConnectiCare's yet the 2015 premiums across those two carriers are much closer to each other than was the case in 2014.

Table 4. Lowest Cost Silver Plan Premiums for a 40-Year-Old, by Carrier, in Selected Rating Areas, in 2014 and 2015 in Connecticut

Issuer Name	2014 Lowest Cost Silver Plan Premium (US)	2015 Lowest Cost Silver Plan Premium (US)	Percentage Change, 2014 to 2015
Rating Area 1: Bridgeport, Stamford			
ConnectiCare Benefits Inc.	$383	$395	3.2%
Anthem Blue Cross Blue Shield	$421	$422	0.4%
HealthyCT Inc.	$436	$380	–12.8%
Rating Area Average[a]			**-3.1%**
Rating Area 2: Hartford			
ConnectiCare Benefits Inc.	$316	$321	1.5%
Anthem Blue Cross Blue Shield	$328	$334	1.7%
HealthyCT Inc.	$363	$333	-8.4%
Rating Area Average[a]			**-1.7%**
Average of Select Rating Areas[a]			**–2.4%**

[a] *Percentage changes are not weighted by enrollment.*

A similar pattern occurred in Hartford. ConnectiCare has the lowest cost silver plan premium for 2014, but a premium decrease by HealthyCT and small (less than 2 percent) increases by ConnectiCare and Anthem in 2015, mean that the premium spread has tightened. For 2015 Anthem's and HealthyCT's lowest cost silver offerings will be almost identical and much closer to ConnectiCare's than in 2014.

Within and across the two rating areas, the substantial reduction by HealthyCT has demonstrated a competitive response to ConnectiCare's aggressive first-year premiums. Premiums for the lowest cost carrier in 2015 will be less than those of the lowest cost carrier in 2014 by 0.8 percent in Bridgeport and will increase by only 1.5 percent in Hartford (see Table 2).

Delaware

Delaware is a small state without many marketplace competitors; nonetheless, the 2015 premium increases for the lowest cost silver offerings will be low, averaging less than 4 percent (Table 5). Highmark Blue Cross Blue Shield is the primary insurer in Delaware. Aetna Health, having recently merged with Coventry, is the only other competitor in the state's marketplace, which has one rating area for the entire state. Highmark offers the lowest cost silver plan in the state's marketplace in both 2014 and 2015. The gap between Highmark's and Aetna/Coventry's lowest cost silver plans will be closing slightly for 2015, however, because Highmark is increasing its lowest cost silver premium by 5 percent while Aetna/Coventry is increasing its by less than 3 percent.

Table 5. Lowest Cost Silver Plan Premiums for a 40-Year-Old, by Carrier, in 2014 and 2015 in Delaware

Issuer Name	2014 Lowest Cost Silver Plan Premium (US)	2015 Lowest Cost Silver Plan Premium (US)	Percentage Change, 2014 to 2015
Rating Area 1: Entire State			
Highmark Blue Cross Blue Shield Delaware	$286	$300	5.0%
CoventryOne/Aetna Health[b]	$319	$327	2.4%
Aetna Life Insurance Co.[b]	N/A	$337	N/A
State Average[a]			**3.7%**

[a] *Percentage changes are not weighted by enrollment.*

[b] *Aetna purchased Coventry in late 2012. For the 2014 plan year, plans are filed under CoventryOne. For 2015, the filing will be under Aetna Health and Aetna Life Insurance. Aetna Life Insurance offers PPOs, while Aetna Health offers HMOs. N/A indicates "not applicable."*

District of Columbia

In Washington, D.C., another marketplace with a single rating area, the lowest cost silver plan premiums are relatively low for 2014 and will remain so in 2015 (see Table 6), increasing by an average of 2.4 percent. CareFirst Blue Shield has the lowest cost silver plan offering in 2014, followed by Kaiser and then Aetna. CareFirst Blue Shield will increase the premiums for its lowest cost silver plan by 7.4 percent for 2015, while Kaiser will reduce its by 0.5 percent. The result is that Kaiser's 2015 option will be about 6 percent less than CareFirst's alternative ($242 vs. $256). Aetna's lowest cost silver option premium remains significantly higher than the other two, despite virtually no increase in premium for 2015. Overall, the increase in the lowest cost silver option available in the District of Columbia is only 1.3 percent between 2014 and 2015 (see Table 2).

Maine

The Portland market in Maine has two competitors in 2014, with the Maine Community Health Options' (co-op) lowest cost silver plan having slightly lower premiums than Anthem (see Table 7). For 2015, Anthem will reduce its premium by 7.5 percent and become the lowest cost plan. On average, carriers' least expensive premiums in the Portland region will fall by 4.0 percent in 2015 compared to 2014. Harvard Pilgrim is the one new entrant for the marketplace's second year. Anthem, a participant in 2014, will introduce a multistate plan, but each of these plans will have higher premiums than the incumbents.

Maryland

All three Maryland rating areas studied—Baltimore; the suburbs of Washington, D.C.; and 12 rural counties in the southern part of the state—have significant carrier marketplace participation in 2014, and participation in all of them will increase in 2015 (see Table 8). Across all three rating regions, carriers' lowest cost premiums will stay virtually constant, increasing by only an average of 0.1 percent. Two of the carriers participating in the Maryland marketplace have multiple subsidiaries listing separate plans and premiums. CareFirst subsidiaries include CareFirst of Maryland, d.b.a. Blue Cross Blue Shield; BlueChoice, Inc., d.b.a. CareFirst BlueCross BlueShield; and Group Hospital and Medical Services (the latter is not included in our table because its plans and premiums are identical to those of CareFirst of

Table 6. Lowest Cost Silver Plan Premiums for a 40-Year-Old, by Carrier, in 2014 and 2015, in the District of Columbia

Issuer Name	2014 Lowest Cost Silver Plan Premium (US)	2015 Lowest Cost Silver Plan Premium (US)	Percentage Change, 2014 to 2015
Rating Area 1: Entire District			
CareFirst BlueCross BlueShield	$238	$256	7.4%
Kaiser Permanente	$243	$242	–0.5%
Aetna	$306	$306	0.2%
District Average[a]			**2.4%**

[a] *Percentage changes are not weighted by enrollment.*

Table 7. Lowest Cost Silver Plan Premium, for a 40-Year-Old, by Carrier, in 2014 and 2015 in Maine

Issuer Name	2014 Lowest Cost Silver Plan Premium (US)	2015 Lowest Cost Silver Plan Premium (US)	Percentage Change, 2014 to 2015
Rating Area 1: Portland			
Maine Community Health Options (Co-op)	$283	$282	–0.5%
Anthem	$297	$275	–7.5%
Harvard Pilgrim[b]	N/A	$366	N/A
Anthem (multistate plan)[c]	N/A	$305	N/A
Rating Area Average[a]			**–4.0%**

[a] *Percentage changes are not weighted by enrollment.*
[b] *Harvard Pilgrim did not offer marketplace plans in 2014.*
[c] *No multistate plan was offered in 2014. N/A indicates "not applicable."*

Maryland). United Healthcare of the Mid-Atlantic is a new entrant in the Maryland marketplace in 2015. However, its subsidiary, All-Savers, participated in 2014 and will continue in the marketplace in 2015 alongside United Healthcare.

Blue Choice, which offers the CareFirst Blue Cross Blue Shield HMO, has the lowest cost silver premium in Baltimore in 2014, followed by the CareFirst PPO (also its multistate plan offering), the Evergreen Cooperative, and Kaiser Permanente. CareFirst Blue Choice also has the lowest cost 2014 silver plan in the other two rating areas studied.

Table 8. Lowest Cost Silver Plan Premiums for a 40-Year-Old, by Carrier, in Selected Rating Areas, in 2014 and 2015 in Maryland

Issuer Name	2014 Lowest Cost Silver Plan Premium (US)	2015 Lowest Cost Silver Plan Premium (US)	Percentage Change, 2014 to 2015
Rating Area 1: Baltimore			
BlueChoice, Inc., d.b.a. CareFirst BlueCross BlueShield[b]	$228	$244	7.0%
CareFirst of Maryland, d.b.a. Blue Cross Blue Shield (MSP)[b]	$240	$274	14.1%
Evergreen Cooperative	$252	$235	–6.9%
Kaiser Permanente	$270	$226	–16.1%
All-Savers[c]	$339	$315	–7.0%
Cigna	N/A	$340	N/A
United Healthcare of the Mid-Atlantic[d]	N/A	$253	N/A
Rating Area Average[a]			**–1.8%**
Rating Area 3: D.C. Suburbs			
BlueChoice, Inc., d.b.a CareFirst BlueCross BlueShield[b]	$213	$227	6.6%
CareFirst of Maryland, d.b.a. Blue Cross Blue Shield (MSP)[b]	$223	$255	14.3%
Evergreen Cooperative	$239	$231	–3.3%
Kaiser Permanente	$270	$226	–16.1%
All-Savers[c]	$339	$315	–7.0%
Cigna	N/A	$345	N/A
United Healthcare of the Mid-Atlantic[d]	N/A	$259	N/A
Rating Area Average[a]			**–1.1%**
Rating Area 2: 12 Rural Counties in the Southern Part of the State			
BlueChoice, Inc., d.b.a. CareFirst BlueCross BlueShield[b]	$224	$239	6.6%
CareFirst of Maryland, d.b.a. Blue Cross Blue Shield[b]	$235	$268	14.2%
Evergreen Cooperative	$239	$237	–0.8%
All-Savers[c]	$339	$315	–7.0%
Cigna	N/A	$345	N/A
Rating Area Average[a]			**3.3%**
Average of Select Rating Areas[a]			**0.1%**

[a] *Percentage changes are not weighted by enrollment.*
[b] *Carefirst-owned companies submitted three separate filings for 2015: Carefirst of Maryland, Carefirst BlueChoice, and Group Hospitalization and Medical Services (GHPS). GHPS filing has the same plan names and premium prices as Carefirst and is therefore not included.*
[c] *All-Savers is a subsidiary of United Healthcare.*
[d] *United Healthcare and Cigna are new entrants to the market for 2015. N/A indicates "not applicable."*

In 2015, CareFirst's Blue Choice HMO products in each of the three rating areas will be about 7 percent more expensive than the carrier's 2014 offerings. The CareFirst PPO product, by comparison, will experience a premium increase of about 14 percent in all three rating regions. Evergreen Cooperative will reduce its lowest cost silver premiums by 6.9 percent in Baltimore, 3.3 percent in the D.C. suburbs, and 0.8 percent in the rural areas. Kaiser Permanente will lower its lowest cost silver premiums by 16 percent in Baltimore and the D.C. suburbs (the carrier does not participate in the state's southern rural counties). As a result, both Evergreen and Kaiser will have lower premiums than Blue Choice in Baltimore, Kaiser will be on par with BlueChoice in the D.C. suburbs, and Evergreen will also be quite competitive.

Evergreen will have a slightly lower premium than Blue Choice in the rural regions in southern Maryland in 2015, just edging Blue Cross out as the lowest cost carrier. All-Savers and Cigna premiums will be well above the Evergreen and Carefirst options in 2015, despite All-Savers premium decrease.

Thus, the state's dominant carrier, CareFirst, no longer offers the lowest cost silver plan through its Blue Choice subsidiary. Kaiser and Evergreen, the state's co-op, offer less expensive products in Baltimore. Kaiser offers a less expensive product in the D.C. suburbs, and Evergreen is becoming increasingly competitive in the D.C. suburbs. Evergreen's 2015 lowest cost premium will be slightly less than that of CareFirst Blue Choice in the rural areas included in the study.

Michigan

In Michigan, we studied three rating areas: Detroit, Lansing, and the rating area that includes 13 rural counties in the northern mainland of the state (see Table 9). The average premium decrease across all three rating regions will be 1.4 percent in 2015. All three rating areas have a large number of carriers in the 2014 marketplace (10 in Detroit, five in Lansing, and seven in the rural area). Blue Cross offers plans through a subsidiary (Blue Care Network) throughout the state.

In the Detroit market, the carriers' lowest cost silver premium will fall by 3.9 percent on average in 2015. In 2014, Humana and Total Healthcare's lowest cost silver premium offerings are the most competitive, followed closely by the Blue Care Network of Michigan and the McLaren Health Plan. Humana will increase its premiums by 15.2 percent for 2015 and Total Healthcare will increase its premiums by 8.5 percent. The Blue Care Network and Blue Cross Blue Shield of Michigan will decrease premiums in 2015 by about 3 percent. As a result, Humana's lowest cost silver plan will remain the lowest cost silver offering in the Detroit market.

In Lansing and the rural area in the northern mainland, all carriers remaining in the marketplace will increase premiums for their lowest cost silver plans in 2015, with the exception of Consumers Mutual. Despite significant decreases, Consumers Mutual will remain a very high cost option in the rural region. Physicians Plus will enter the Lansing Market in 2015 and will be the lowest cost option available there. The largest increases in these areas reflect the market power of the Blue Cross plans in those regions, which gives them significant leverage in negotiating with providers. The Blue Care Network of Michigan and the Blue Cross Blue Shield plans are increasing their 2015 premiums of their lowest cost silver option by 12.9 percent and 10.6 percent respectively in Lansing and 11.1 percent and 10.7 percent in the rural area. Their competitors, with the exception of Alliance Health and Life in the rural area, will increase their premiums by considerably less. Despite its large increases the Blue Care Network will remain the lowest cost carrier in the rural area in 2015.

Minnesota

Minnesota's rating areas of Minneapolis and Duluth will experience very little change in average premiums for their carriers' lowest cost plans in 2015, and the state's premiums will remain among the lowest in the country (see Table 10). However, a significant shake-up will occur for many Minneapolis area marketplace enrollees in the second year of reform. The region's lowest cost carrier, PreferredOne, will leave the marketplace in 2015, despite having obtained a large market share in 2014; the carrier will also dramatically increase premiums for its off-marketplace individual market enrollees, citing high claims costs.[11]

The next lowest cost plan in 2014, HealthPartners, will increase its premiums in 2015 by 9.4 percent but will be the area's lowest cost carrier for 2015. UCare will have virtually identical premiums to HealthPartners in 2015, following a 10 percent reduction from its 2014 lowest silver premium option. Blue Cross Blue Shield has three subsidiaries participating in the Minneapolis region: BCBS Minnesota, BCBS Minnesota (a multistate plan, or MSP), and Blue Plus—the latter two are newly entering the market in 2015. Although still competitive, the Blue

Table 9. Lowest Cost Silver Plan Premiums for a 40-Year-Old, by Carrier, in Selected Rating Areas, in 2014 and 2015 in Michigan

Issuer Name	2014 Lowest Cost Silver Plan Premium (US)	2015 Lowest Cost Silver Plan Premium (US)	Percentage Change, 2014 to 2015
Rating Area 1: Detroit			
Humana Medical Plan of Michigan, Inc.	$190	$219	15.2%
Total Health Care USA, Inc.	$224	$243	8.5%
Blue Care Network of Michigan	$242	$234	-3.4%
McLaren Health Plan, Inc.	$288	$309	7.3%
Health Alliance Plan (HAP)	$302	$266	-11.9%
Blue Cross Blue Shield of Michigan	$311	$301	-3.3%
Priority Health	$313	$285	-9.1%
Molina Marketplace	$327	$252	-23.1%
Alliance Health and Life	$337	$338	0.3%
Consumers Mutual Insurance of Michigan	$433	$348	-19.7%
Rating Area Average[a]			**-3.9%**
Rating Area 7: Lansing			
Blue Care Network of Michigan	$245	$277	12.9%
McLaren Health Plan, Inc.	$278	$296	6.7%
Blue Cross Blue Shield of Michigan	$311	$344	10.6%
Priority Health	$326	$303	-7.0%
Consumers Mutual Insurance of Michigan	$440	$306	-30.5%
Physicians Plus	N/A	$269	N/A
Rating Area Average[a]			**-1.5%**
Rating Area 15: 13 Rural Counties in the Northern Mainland			
Blue Care Network of Michigan	$245	$272	11.1%
McLaren Health Plan, Inc.	$266	$274	2.8%
Priority Health	$276	$271	-1.8%
Blue Cross Blue Shield of Michigan	$277	$307	10.8%
Alliance Health and Life	$370	$371	0.3%
Health Alliance Plan (HAP)[b]	$370	N/A	N/A
Consumers Mutual Insurance of Michigan	$411	$343	-16.6%
Rating Area Average[a]			**1.1%**
Average of Select Rating Areas[a]			**-1.4%**

[a] *Percentage changes are not weighted by enrollment.*
[b] *Health Alliance Plan (HAP) is not participating in rating area 14 for 2015. N/A indicates "not applicable."*

Table 10. Lowest Cost Silver Plan Premiums for a 40-Year-Old, by Carrier, in Selected Rating Areas, in 2014 and 2015 in Minnesota

Issuer Name	2014 Lowest Cost Silver Plan Premium (US)	2015 Lowest Cost Silver Plan Premium (US)	Percentage Change, 2014 to 2015
Rating Area 8: Minneapolis, St. Paul, Bloomington			
PreferredOne[b]	$154	N/A	N/A
HealthPartners	$166	$181	9.4%
Blue Cross Blue Shield Minnesota	$201	$201	0.0%
UCare	$203	$183	–10.0%
Medica	$211	$222	5.6%
Blue Cross Blue Shield Minnesota (MSP)[d]	N/A	$249	N/A
Blue Plus[d]	N/A	$205	N/A
Rating Area Average[a]			**1.3%**
Rating Area 2: Duluth			
HealthPartners	$213	$235	10.5%
UCare	$233	$206	–11.9%
Blue Cross Blue Shield Minnesota	$235	$232	–1.4%
Medica[c]	N/A	$254	N/A
Blue Cross Blue Shield Minnesota (MSP)[d]	N/A	$289	N/A
Rating Area Average[a]			**–0.9%**
Average of Select Rating Areas[a]			**0.2%**

[a] Percentage changes are not weighted by enrollment.
[b] PreferredOne has left the Marketplace for 2015.
[c] Medica has entered rating area 2 for 2015.
[d] BCBS MN (MSP) and Blue Plus are subsidiaries of BCBS MN and are new entrants in 2015. N/A indicates "not applicable."

Cross Blue Shield subsidiaries have prices at the higher end of the spectrum.

In Duluth, average premiums will fall by about 1.0 percent in 2015. UCare will displace HealthPartners as the lowest cost option in the area, resulting from the former's significant price cut and the latter's significant price increase.

Thus, overall, the selected Minnesota metropolitan areas will continue to have low-cost options available from a range of competing carriers and will experience little change in average premiums. However, significant numbers of 2014 enrollees in the Minneapolis area will be required to change their insurance carrier in 2015 because of the exit of PreferredOne, that region's lowest priced carrier. Also because of the exit, 2015 premiums for the lowest cost silver option will be about 18 percent higher than the least expensive 2014 option in the Minneapolis area (see Table 2).

Montana

In Montana, we examined only one rating area, Billings, because of the small size and geographic concentration of the state's population (see Table 11). Overall, Billings' premiums will fall by 1.2 percent on average in 2015. The three carriers in this region are Blue Cross Blue Shield of Montana, Montana Health Co-op, and PacificSource Health Plans. PacificSource has the lowest silver plan premium for a 40-year-old in 2014 ($251), and Blue Cross Blue Shield has the highest premium of each carrier's lowest cost offering ($274), but the premiums for all three carriers' lowest cost plans are quite close in 2014. In 2015, the Montana Health Co-op's lowest cost silver plan will have a large premium decrease (11.2%), giving the co-op a competitive price edge over PacificSource. In fact, premiums for the lowest cost Montana Health Co-op silver plan in 2015 will be less than all of the carriers' 2014 silver premiums. Because of the significantly lower co-op premium in 2015, the premium for Billings' lowest cost silver option will fall by 5.4 percent in 2015 relative to the lowest cost option available in 2014 (see Table 2).

Table 11. Lowest Cost Silver Plan Premiums for a 40-Year-Old, by Carrier, in Selected Rating Areas, in 2014 and 2015 in Montana

Issuer Name	2014 Lowest Cost Silver Plan Premium (US)	2015 Lowest Cost Silver Plan Premium (US)	Percentage Change, 2014 to 2015
Rating Area 1: Billings			
PacificSource Health Plans	$251	$266	5.8%
Montana Health Co-Op	$268	$238	–11.2%
Blue Cross and Blue Shield of Montana	$274	$279	1.9%
Rating Areas Average [a]			**–1.2%**

[a] Percentage changes are not weighted by enrollment.

New York

We present data from three rating areas in New York: New York City, Buffalo, and 13 rural upstate counties (see Table 12). Overall, premiums will increase in the three rating regions by an average of 2.7 percent in 2015. Strong competition across multiple carriers in New York City has held premium growth to relatively low levels, with an average reduction in each carriers' lowest cost silver offering of 2.4 percent. The lowest cost silver plan in the city's rating area in 2014 is from Metro Plus; the carrier's lowest cost silver premium in 2015 will be 6.5 percent higher than in 2014.

However, five of the 10 carriers participating in 2014 will have lower premiums in 2015 compared to 2014; New York Fidelis by 1.7 percent, North Shore LIJ by 6.1 percent, Healthfirst by 11.9 percent, United by 15.2 percent, and Affinity by 15.6 percent. As a result, Affinity will replace Metro Plus with the lowest cost silver plan offered in 2015, followed closely by Health Republic and then Metro Plus. For the five carriers charging higher premiums in 2015 than in 2014 for their lowest cost silver plans, increases range from 2.5 percent (Oscar) to 7.3 percent (Empire Blue Cross). The state's co-op, Health Republic, which offers very low premiums for its products in 2014, will increase the price of its lowest cost silver offering by 4.0 percent in New York City in 2015. United, which charged much higher rates than the other carriers in 2014, will reduce the price of its lowest cost silver option by 15.2 percent for 2015. Although United will remain the most expensive of the silver tier options, the adjustments from 2014 levels will compress rates for carriers' lowest cost silver options in New York City in 2015 compared with 2014. Two new entrants into this marketplace in 2015 are MVP Health and Wellcare HMO, both toward the more costly end of the distribution of offerings.

In Buffalo, Health Republic, the lowest cost silver plan carrier in 2014, will remain so in 2015, with the premium for its lowest cost option 4.8 percent lower in the coming year. Fidelis will keep its lowest cost silver option premium roughly constant for the new plan year, keeping it as the second lowest cost carrier. BCBS of Western New York and Independent Health Benefits Corporation (IHBC) will both offer a lower cost premium in 2015 than they did in 2014, while Univera's lowest cost silver premium will be more than 10 percent higher in 2015, keeping it the most expensive carrier in this rating area. The overall average premium in Buffalo for the lowest cost silver plans offered by carriers will be about the same as in 2014.

In the upstate rural counties, premiums for the lowest cost silver plans will increase from 1.1 percent to 15.6 percent depending on the carrier, with an overall average increase of 9.0 percent. Fidelis offers the lowest priced silver option in 2014 and will increase its lowest premium by 5.6 percent for 2015. Interestingly, Health Republic will enter the rating region in 2015 with a premium ($278) far less than Fidelis's 2014 rates, making it the most price competitive option in 2015 by a significant margin. Several commercial plans in the region have substantially higher premiums than do either Health Republic or Fidelis. Because of the entry of Health Republic, the lowest silver premium in the area will decrease by 17.5 percent in 2015 (Table 2).

Ohio

We studied three rating areas in Ohio: Columbus, Cincinnati, and Cleveland. In those three metropolitan areas, carriers' lowest cost offerings will decrease, on average, by 3.0 percent in 2015. All three markets are highly competitive in 2014, and an additional carrier—

Table 12. Lowest Cost Silver Plan Premiums for a 40-Year-Old, by Carrier, in Selected Rating Areas, in 2014 and 2015 in New York

Issuer Name	2014 Lowest Cost Silver Plan Premium (US)	2015 Lowest Cost Silver Plan Premium (US)	Percentage Change, 2014 to 2015
Rating Area 4: New York City			
Metro Plus	$359	$383	6.5%
Health Republic Insurance of New York—Freelancers	$365	$380	4.0%
Oscar	$385	$394	2.5%
Emblem	$385	$407	5.7%
New York Fidelis	$390	$384	-1.7%
Empire BlueCross BlueShield	$418	$448	7.3%
Northshore LIJ	$420	$394	-6.1%
Healthfirst	$440	$387	-11.9%
Affinity—All Standard Benefits	$440	$372	-15.6%
United Health	$642	$545	-15.2%
Wellcare HMO[b]	N/A	$472	N/A
MVP Health[c]	N/A	$417	N/A
Rating Area Average[a]			**–2.4%**
Rating Area 2: Buffalo			
Health Republic Insurance of New York—Freelancers	$275	$262	-4.8%
New York Fidelis	$338	$337	-0.3%
BlueCross BlueShield of Western New York	$372	$342	-8.1%
Univera	$430	$474	10.3%
IHBC	$432	$428	-1.0%
MVP Health[c]	N/A	$365	N/A
Rating Area Average[a]			**-0.8%**
Rating Area 7: 13 Rural Counties Upstate			
New York Fidelis	$337	$356	5.6%
MVP Health	$373	$431	15.6%
Excellus	$443	$488	10.3%
CDPHP	$493	$499	1.1%
BlueShield of Northeastern NY	$505	$568	12.4%
Emblem[d]	N/A	$488	N/A
Health Republic Insurance of New York—Freelancers[d]	N/A	$278	N/A
Rating Area Average[a]			**9.0%**
Average of Select Rating Areas[a]			**2.7%**

[a] *Percentage changes are not weighted by enrollment.*
[b] *Wellcare HMO entered rating area 4 for 2015.*
[c] *MVP Health entered rating areas 2 and 7 for 2015.*
[d] *Emblem, and Health Republic entered rating area 7 for 2015.*

Table 13. Lowest Cost Silver Plan Premiums for a 40-Year-Old, by Carrier, in Selected Rating Areas, in 2014 and 2015 in Ohio

Issuer Name	2014 Lowest Cost Silver Plan Premium (US)	2015 Lowest Cost Silver Plan Premium (US)	Percentage Change, 2014 to 2015
Rating Area 9: Columbus			
CareSource	$298	$244	2.3%
Paramount Insurance Company	$317	$282	-5.4%
Anthem BlueCross BlueShield (community insurance)	$354	$353	11.3%
MedMutual	$418	$352	-0.8%
Molina Marketplace	N/A	$281	-32.9%
InHealth	N/A	$307	N/A
HealthAmericaOne (Aetna Life Insurance Company)[c]	N/A	$303	N/A
Rating Area Average[a]			**-5.1%**
Rating Area 4: Cincinnati			
Humana	$216	$252	16.7%
CareSource	$238	$232	-2.6%
Ambetter	$262	$236	-9.9%
HealthSpan	$274	$268	-2.2%
Anthem BlueCross BlueShield	$294	$319	8.5%
MedMutual	$359	$353	-1.8%
Molina Marketplace	$431	$281	-34.8%
InHealth	N/A	$300	N/A
Rating Area Average[a]			**-3.7%**
Rating Area 11: Cleveland			
Kaiser Foundation Health Plan of Ohio[b]	$246	$268	9.1%
CareSource	$249	$252	1.4%
MedMutual	$286	$301	5.4%
HealthSpan[b]	$299	$268	-10.5%
Paramount Insurance Company	$316	$302	-4.3%
Anthem BlueCross BlueShield	$320	$346	8.2%
SummaCare	$321	$373	15.9%
Molina Marketplace	$377	$278	-26.4%
HealthAmericaOne (Aetna Life Insurance Company)[c]	N/A	$283	N/A
Ambetter	N/A	$242	N/A
InHealth	N/A	$325	N/A
Rating Area Average[a]			**-0.1%**
Average of Select Rating Areas[a]			**-3.0%**

[a] *Percentage changes are not weighted by enrollment.*
[b] *Kaiser Foundation Health Plan merged with HealthSpan; Kaiser plans are now administered by HealthSpan.*
[c] *Aetna is a new entrant to the market for 2015; plans will be administered by HealthAmericaOne. N/A indicates "not applicable."*

HealthAmericaOne—will enter the Columbus and Cleveland marketplace regions in 2015. The presence of previously Medicaid-only plans, including CareSource, resulted in fairly low premiums in 2014 relative to the other markets studied (see Table 2), while stability or premium decreases in a number of plans will lead to low average premium growth in 2015.

CareSource has by far the lowest premiums in Columbus in 2014. Moreover, its lowest cost 2015 silver offering will be 2.3 percent more than its 2014 option, but keeping CareSource the lowest cost carrier. Molina, which began 2014 with very high premiums, will have a 2015 option that costs 32.9 percent less, which will make it the second-lowest cost carrier in the area. Anthem Blue Cross Blue Shield will increase the premiums for their most competitive option considerably.

Cincinnati insurers have strong competition in 2014 from Humana and two Medicaid plans, CareSource and Ambetter (a product of Centene Corporation). The latter two will lower their 2015 premiums, while Humana will increase its by 16.7 percent. Combined with a very large (34.8 percent) decrease in Molina's premium and a modest decrease in HealthSpan's premium, overall, premiums in Cincinnati will fall by an average 3.7 percent across the carriers' lowest cost silver premiums.

A similar pattern can be seen in Cleveland. Kaiser Permanente has the lowest cost silver premium option in 2014, followed closely by CareSource. Kaiser merged with HealthSpan, and the newly combined firm's lowest cost option will be 9.1 percent more expensive than Kaiser's 2014 offering and 10.5 percent less than HealthSpan's. CareSource will increase its 2015 premium modestly by 1.4 percent, making it the lowest cost carrier, followed by the combined Kaiser/HealthSpan venture. Molina will reduce its lowest cost premium by 26.4 percent, making it a strong competitor.

Oregon

We studied three rating areas in Oregon: Portland, Salem, and the 15 rural counties in the northeast part of the state (see Table 14). On average, premiums for the carriers' lowest cost options will fall by 3.0 percent between 2014 and 2015 in the areas we examined. All three regions have large numbers of participating insurers. Moda Health has the lowest premium silver option in each of those three areas in 2014 but will increase the premiums by about 10 percent in the Portland and Salem rating areas in 2015. Meanwhile, in both of those areas, the Providence Health Plan will come into 2015 more aggressively, lowering its lowest cost silver option prices by 16.1 percent in Portland and by 22.1 percent in Salem, making Providence the lowest price carrier in these rating areas for 2015.

In fact, most of the carriers in all three of the rating areas studied are lowering the cost of their most competitively priced silver options in 2015. BridgeSpan, a Regence Blue Shield subsidiary, will reduce the premium for its lowest cost silver plan by 14.2 percent in Portland, 10.1 percent in Salem, and 11.2 percent in the rural counties. In the rural market in Oregon, Moda Health will reduce its premiums by 2.9 percent and will remain the lowest cost carrier for 2015. A notable exception to the premium-lowering trend is Health Republic, which is a co-op that also sells coverage in New York and which will increase its lowest cost plan premiums in Salem and in the rural area by 23.6 percent and 17.5 percent, respectively. On average, however, low-cost premiums in the rural region will fall by 1.8 percent. As a result of the widespread premium decreases, those areas will see compression in the range of carriers' lowest cost silver offerings, which is an outcome of the highly competitive insurance markets.

Rhode Island

Rhode Island (see Table 15) has one rating area spanning the entire state and three carriers participating in its marketplace in 2015, up from two in 2014.[12] BlueCross BlueShield of Rhode Island has the lowest premium silver plan in 2014, but its 2015 lowest cost option will be priced 10.4 percent higher. Meanwhile, Neighborhood Health Plan will offer a silver option that costs 17.6 percent less than its least expensive offering in 2014, allowing it to gain a significant competitive edge over BlueCross BlueShield of Rhode Island in 2015. United Healthcare enters the nongroup marketplace in 2015, setting its premiums between its two competitors. Taken together, in 2015, consumers in Rhode Island will be able to obtain a silver tier plan option that costs 10.8 percent less than the least expensive option they could purchase in 2014 (see Table 2).

South Dakota

We examined the Sioux Falls rating area in South Dakota, which has three marketplace participating carriers in 2014 (see Table 16). South Dakota's BlueCross BlueShield plan does not participate in the marketplace. Two smaller plans—Avera Health Plans and Sanford Health Plan, together with DAKOTACARE—offer plans in the marketplace in 2014. Avera has, by far, the lowest

Table 14. Lowest Cost Silver Plan Premiums for a 40-Year-Old, by Carrier, in Selected Rating Areas, in 2014 and 2015 in Oregon

Issuer Name	2014 Lowest Cost Silver Plan Premium (US)	2015 Lowest Cost Silver Plan Premium (US)	Percentage Change, 2014 to 2015
Rating Area 1: Portland, Gresham, Hillsboro			
Moda Health	$194	$213	10.1%
Health Net Health Plan of Oregon, Inc.[b]	$215	N/A	N/A
Providence Health Plan	$234	$196	–16.1%
LifeWise Health Plan of Oregon	$248	$227	–8.4%
PacificSource Health Plans	$248	$272	9.9%
Health Republic Insurance	$256	$249	–2.7%
Kaiser Permanente	$256	$245	–4.3%
Oregon's Health CO-OP	$271	$231	–14.8%
BridgeSpan Health Company	$278	$238	–14.2%
Rating Area Average[a]			**–5.1%**
Rating Area 3: Salem			
Moda Health	$201	$221	9.7%
Health Republic Insurance	$223	$276	23.6%
PacificSource Health Plans	$248	$272	9.9%
LifeWise Health Plan of Oregon	$254	$232	–8.7%
Kaiser Permanente	$256	$245	–4.3%
Providence Health Plan	$260	$202	–22.1%
Oregon's Health CO-OP	$271	$261	–4.0%
ATRIO Health Plans	$278	$246	–11.7%
BridgeSpan Health Company	$296	$266	–10.1%
Rating Area Average[a]			**–2.0%**
Rating Area 6: 15 Rural Counties in the Northeast Part of the State			
Moda Health	$213	$207	–2.9%
Health Republic Insurance	$231	$272	17.5%
LifeWise Health Plan of Oregon	$254	$232	–8.7%
PacificSource Health Plans	$293	$302	3.3%
Oregon's Health CO-OP	$331	$302	–9.0%
BridgeSpan Health Company	$338	$300	–11.2%
Rating Area Average[a]			**–1.8%**
Average of Select Rating Areas[a]			**-3.0%**

[a] Percentage changes are not weighted by enrollment.
[b] Health Net Plan of Oregon is not on the marketplace for 2015. N/A indicates "not applicable."

Table 15. Lowest Cost Silver Plan Premiums for a 40-Year-Old, by Carrier, in 2014 and 2015 in Rhode Island

Issuer Name	2014 Lowest Cost Silver Plan Premium (US)	2015 Lowest Cost Silver Plan Premium (US)	Percentage Change, 2014 to 2015
Rating Area 1: Entire State			
Blue Cross & Blue Shield of Rhode Island	$274	$302	10.4%
Neighborhood Health Plan of Rhode Island	$296	$244	–17.6%
United Healthcare[b]	N/A	$284	N/A
State Average[a]			**–3.6%**

[a] Percentage changes are not weighted by enrollment.
[b] United Healthcare entered the market for 2015. N/A indicates "not applicable."

cost silver premium in 2014, the first year of reform. Its premium is 61 percent of Sanford Health Plan's lowest cost silver option and 78 percent of DAKOTACARE's lowest priced silver offering. In 2015, Avera will increase the premium for its lowest cost silver plan by 1.6 percent and Sanford will lower the cost of its least expensive silver option by 1.0 percent, still leaving Avera as the lowest cost carrier. DAKOTACARE will significantly lower its lowest cost silver plan premiums for 2015, by 37.7 percent, allowing it to be almost identical in premium to Avera's lowest cost offering.

Tennessee

We studied three rating areas in Tennessee's marketplace: Nashville, Memphis, and 16 rural counties in the middle-southern part of the state (see Table 17). BlueCross BlueShield of Tennessee and Community Health Alliance sell coverage in all three of those rating areas, whereas Cigna Health and Humana participate in the Nashville and Memphis areas. Premium increases in 2015 for those regions of Tennessee are modest, on average 1.2 percent, (Table 17), due to large decreases by Community Health Alliance. However, BlueCross BlueShield and Humana will increase their lowest cost option premiums significantly in 2014.

BlueCross BlueShield is by far the lowest cost carrier in all three of those rating areas in 2014, but the price of its lowest cost silver offerings will increase substantially in the second year of the marketplaces, going up by 21.7 percent in Nashville, 15.1 percent in Memphis, and 19.9 percent in the rural area studied. But even with such large relative increases in 2015, BlueCross BlueShield will still be very competitive in each of the three rating areas in 2015, and Tennessee premiums remain low by national standards (see Table 1). Community Health Alliance, the state's co-op, will lower the premiums it charges for its lowest cost silver offerings by 35.2 percent in Nashville, 37.2 percent in Memphis, and 18.6 percent in the rural counties, becoming the lowest cost carrier

Table 16. Lowest Cost Silver Plan Premiums for a 40-Year-Old, by Carrier, in 2014 and 2015 in South Dakota

Issuer Name	2014 Lowest Cost Silver Plan Premium (US)	2015 Lowest Cost Silver Plan Premium (US)	Percentage Change, 2014 to 2015
Rating Area 2: Sioux Falls			
Avera Health Plans	$252	$257	1.6%
Sanford Health Plan	$322	$319	-1.0%
DAKOTACARE	$414	$258	-37.7%
Average of Select Rating Areas[a]			**-12.4%**

[a] Percentage changes are not weighted by enrollment.

Table 17. Lowest Cost Silver Plan Premiums for a 40-Year-Old, by Carrier, in Selected Rating Areas, in 2014 and 2015 in Tennessee

Issuer Name	2014 Lowest Cost Silver Plan Premium (US)	2015 Lowest Cost Silver Plan Premium (US)	Percentage Change, 2014 to 2015
Rating Area 4: Nashville, Clarksville			
BlueCross BlueShield of Tennessee	$181	$220	21.7%
Humana Insurance Company	$248	$292	17.8%
Cigna Health and Life Insurance Company	$283	$301	6.5%
Community Health Alliance	$299	$194	-35.2%
Rating Area Average[a]			**2.7%**
Rating Area 6: Memphis			
BlueCross BlueShield of Tennessee	$186	$214	15.1%
Humana Insurance Company	$214	$240	12.0%
Cigna Health and Life Insurance Company	$267	$298	11.3%
Community Health Alliance	$294	$184	-37.2%
Rating Area Average[a]			**0.3%**
Rating Area 8: 16 Rural Counties in the Middle-Southern Part of the State			
BlueCross BlueShield of Tennessee	$216	$259	19.9%
Community Health Alliance	$293	$238	-18.6%
Rating Area Average[a]			**0.7%**
Average of Select Rating Areas[a]			**1.2%**

[a] Percentage changes are not weighted by enrollment.

across the board. Cigna and Humana will increase the premiums of their lowest cost silver plans in 2015 in both of the urban areas studied, but Humana's pricing will remain more competitive than Cigna in both regions.

Tennessee will see modest increases for the lowest cost silver options in those three rating areas. And, on average, as shown in Table 2, the levels of premiums in those areas remain quite low relative to those across the nation.

Virginia

We examined the rating areas of Richmond; Virginia Beach and Norfolk; and the Washington, D.C., suburbs in the Virginia marketplace (see Table 18). Those three markets have considerable carrier participation. Overall, 2015 premium increases in the participating carriers' lowest cost silver options will be fairly low, at 4.9 percent.

In the Richmond market, CoventryOne, the carrier offering the lowest cost silver option in 2014, will increase its premium by 5.2 percent in 2015 but will remain the most price-competitive option. Anthem HealthKeepers' lowest cost option will increase modestly as well, by 4.3 percent in 2015. Aetna and Kaiser Permanente's lowest cost silver plans will be slightly less expensive in 2015 than in 2014, whereas Optima, the least price competitive of the silver plans in 2014, will increase its lowest cost option by 6.9 percent for 2015, putting it further beyond the rest of the pack.

In the Tidewater area of Virginia Beach and Norfolk, Aetna and Optima Health offer the lowest cost silver plans in 2014. In 2015, however, Kaiser Permanente is entering that market and will then have the lowest cost silver plan. Optima Health will increase its premium for its least expensive plan by only 3.6 percent over 2014, but the cost of that plan will still be slightly higher than Kaiser's. Anthem

and Aetna's lowest cost options will be priced only slightly above Optima in a very competitive market.

In the Washington, D.C., suburbs, the Innovation Health Insurance Company, which is a product of Aetna and the Inova Hospital System (a dominant system of hospitals in Northern Virginia), offers the lowest cost silver plan in 2014. But although Innovation's lowest cost silver plan in 2015 will be 8.6 percent higher than in 2014, Kaiser Permanente will keep the premium for its lowest cost silver plan essentially fixed, allowing it to become the lowest cost silver carrier in 2015. Optima and CareFirst will both be increasing premiums for their least expensive silver offerings (Optima by 6.8% and CareFirst by 18.9%), making both less price competitive in that market. Anthem HealthKeepers remains in the mix, however, a result of lowering its lowest cost silver option premium by more than 5 percent for 2015.

Table 18. Lowest Cost Silver Plan Premiums for a 40-Year-Old, by Carrier, in Selected Rating Areas, in 2014 and 2015 in Virginia

Issuer Name	2014 Lowest Cost Silver Plan Premium (US)	2015 Lowest Cost Silver Plan Premium (US)	Percentage Change, 2014 to 2015
Rating Area 7: Richmond			
CoventryOne	$230	$241	5.2%
Anthem HealthKeepers	$253	$264	4.3%
Anthem Health Plans of Virginia (MSP)	$269	$280	3.8%
Kaiser Permanente	$275	$273	-0.7%
Aetna	$317	$312	-1.6%
Optima Health	$348	$372	6.9%
Piedmont Community Health Care[c]	N/A	$324	N/A
Rating Area Average[a]			**3.0%**
Rating Area 9: Virginia Beach/Norfolk			
Aetna	$270	$305	13.1%
Optima Health	$272	$281	3.6%
Anthem Health Keepers	$278	$287	3.2%
Anthem Health Plans of Virginia (MSP)	$296	$304	2.9%
Kaiser Permanente[c]	N/A	$273	N/A
Rating Area Average[a]			**5.7%**
Rating Area 10: Washington, D.C. Suburbs			
Innovation Health Insurance Company	$260	$282	8.6%
CareFirst BlueChoice, Inc.	$272	$323	18.9%
Kaiser Permanente	$275	$273	-0.7%
Anthem Health Plans of Virginia (MSP)	$289	$309	7.0%
CareFirst BlueCross BlueShield (MSP)[b]	$301	N/A	N/A
Anthem HealthKeepers	$301	$292	-3.1%
Optima Health	$333	$355	6.8%
Rating Area Average[a]			**6.1%**
Average of Select Rating Areas[a]			**4.9%**

[a] *Percentage changes are not weighted by enrollment.*
[b] *CareFirst is a multistate plan for which planned premiums are not available through the Virginia Bureau of Insurance for 2015. Thus N/A indicates "not available."*
[c] *Piedmont Community Health Care is a new entrant. Kaiser Permanente entered rating area 9 for 2015. N/A here indicates "not applicable."*

All in all, the Virginia markets remain price competitive going into 2015, adding carriers in at least some markets.

Washington

For Washington state, we examined premium rates in three areas: Seattle, Spokane, and 14 rural counties (see Table 19). The Washington markets are highly competitive and premiums on average will be 3.0 percent lower for 2015, with some much larger decreases.

Coordinated Care, part of the Centene Corporation – a national Medicaid carrier – offers the lowest cost silver plan in all three of those regions in 2014 and will decrease its lowest cost silver premiums in each area (-4.2 percent in Seattle, -6.9 percent in Spokane and -6.2 percent in the rural counties) in 2015. BridgeSpan, a Blue Shield plan with relatively high premiums in 2014, will

Table 19. Lowest Cost Silver Plan Premiums for a 40-Year-Old, by Carrier, in Selected Rating Areas, in 2014 and 2015 in Washington

Issuer Name	2014 Lowest Cost Silver Plan Premium (US)	2015 Lowest Cost Silver Plan Premium (US)	Percentage Change, 2014 to 2015
Rating Area 1: Seattle, Bellevue			
Coordinated Care	$245	$235	-4.2%
Group Health	$281	$281	0.1%
Premera	$283	$291	2.9%
Lifewise	$283	$291	2.8%
BridgeSpan Health Company	$300	$254	-15.6%
Molina HealthCare	$311	$277	-11.0%
Community Health Plans	$335	$343	2.5%
Moda[b]	N/A	$284	N/A
Rating Area Average[a]			**-3.2%**
Rating Area 4: Spokane			
Coordinated Care	$235	$219	-6.9%
Premera	$260	$267	2.9%
Lifewise	$260	$267	2.8%
Group Health	$268	$269	0.1%
BridgeSpan Health Company	$295	$255	-13.5%
Community Health Plans	$322	$332	3.0%
Molina HealthCare	$357	$265	-25.7%
Moda[b]	N/A	$284	N/A
Rating Area Average[a]			**-5.3%**
Rating Area 5: 14 Rural Counties			
Coordinated Care	$267	$251	-6.2%
Group Health	$282	$282	0.1%
Premera	$283	$291	2.9%
Lifewise	$283	$291	2.8%
Community Health Plans	$369	$360	-2.3%
BridgeSpan Health Company[c]	N/A	$263	N/A
Molina HealthCare[c]	N/A	$304	N/A
Moda[b]	N/A	$284	N/A
Rating Area Average[a]			**-0.6%**
Average of Select Rating Areas[a]			**-3.0%**

[a] Percentage changes are not weighted by enrollment.
[b] Moda entered the Washington market for 2015.
[c] Molina and BridgeSpan entered rating area 5 for the 2015 plan year. N/A indicates "not applicable."

reduce the prices for its lowest cost silver options and will become the second most competitive carrier in all three markets for the coming year (it will be entering the rural area marketplace for the first time in 2015), just behind Coordinated Care.

Molina, also a national Medicaid plan, has relatively expensive silver plan offerings in 2014 in Seattle and Spokane but will lower the premiums of its least costly options for 2015 in those areas, making the company significantly more competitive in the second year. It also will enter the rural market for the first time in 2015, although with relatively high premiums. The other carriers in those highly competitive markets are increasing the premiums for their lowest cost options very modestly (by 3% or less). Moda, the lowest premium carrier in Oregon in 2014, will also enter all three of those Washington markets in 2015 with quite competitive rates.

West Virginia

We examined the Charleston area and nine rural counties in the central eastern part of West Virginia (see Table 20). Highmark BlueCross BlueShield is the dominant carrier in West Virginia and the only carrier participating in those markets in 2014. The carrier—listed here twice because of its offerings of state-specific and multistate plans—has fairly high premiums, by national standards, for its lowest cost silver plan in 2014. Highmark Blue Cross Blue Shield, West Virginia's lowest cost silver plan, will cost 9 percent more in 2015 than it did in 2014, reflecting both the lack of competition in the insurance market and the plan's limited negotiating leverage over reimbursement rates with small-town providers. Highmark's 2015 premium rates for its multistate plan are identical.

The West Virginia Health Cooperative, a spin-off of the Kentucky Health Cooperative, will enter the rural market in 2015. The co-op's lowest cost silver offering will be almost the same as Highmark's. The introduction of marketplace competition may compel Highmark to lower its premiums in the 2016 plan year, depending on the extent to which the co-op is successful in capturing market share in 2015.

Table 20. Lowest Cost Silver Plan Premiums for a 40-Year-Old, by Carrier, in Selected Rating Areas, in 2014 and 2015 in West Virginia

Issuer Name	2014 Lowest Cost Silver Plan Premium (US)	2015 Lowest Cost Silver Plan Premium (US)	Percentage Change, 2014 to 2015
Rating Area 2: Charleston			
Highmark Blue Cross Blue Shield (MSP)[b]	$288	$314	9.0%
Highmark Blue Cross Blue Shield West Virginia	$288	$314	9.0%
Rating Area Average[a]			**9.0%**
Rating Area 9: 9 Rural Counties in the Central Eastern Part of the State			
Highmark Blue Cross Blue Shield (MSP)[b]	$262	$286	9.0%
Highmark Blue Cross Blue Shield West Virginia	$262	$286	9.0%
West Virginia Health Cooperative[c]	N/A	$282	N/A
Rating Area Average[a]			**9.0%**
Average of Select Rating Areas[a]			**9.0%**

[a] Percentage changes are not weighted by enrollment.

[b] Highmark Blue Cross Blue Shield is the multistate plan, and its rates are not available through the West Virginia Department of Insurance for 2015 at the time of this writing. Thus N/A here indicates "not available."

[c] West Virginia Health Cooperative is the Kentucky co-op that has entered the West Virginia market for 2015. N/A indicates "not applicable."

DISCUSSION

The ACA's insurance regulatory reforms to the nongroup market created four actuarial value tiers of insurance coverage, with advanced premium tax credits for the modest income pegged to the silver (70 percent actuarial value level) plans offered within the new marketplaces. Silver is also the only level of coverage to which cost-sharing subsidies may be applied. As a consequence of the centrality of silver tier coverage under the ACA, we analyzed 2015 changes to the lowest cost premium for silver coverage offered by each carrier in an array of markets in 17 states plus the District of Columbia, all of which have finalized premium rates for 2015, the second full year of health care reform.

The lowest cost silver premium for a carrier is the least expensive entry to the tier of coverage to which marketplace financial assistance is oriented. Premiums in those states and the rating regions studied within them, although not necessarily representative of the rates to be released in the remaining states for 2015, span the array of different market types, including urban areas of various sizes and rural communities in many geographic regions of the United States. Their insurance markets range from highly competitive to those strongly dominated by one or two carriers.

Our analysis indicates that, over all, premium increases for carriers' lowest cost silver plans offered through the nongroup marketplaces will be modest in 2015. Changes from 2014 in the vast majority of markets studied include many carriers that are lowering their lowest cost silver premiums; many others are increasing the premiums of their lowest cost silver offerings by modest amounts or holding them virtually constant. New competitors entering the marketplaces—including large insurers such as Aetna and United, along with some expansion of co-ops to additional states—also are evident in a number of markets. Exceptions exist, however, with some marketplace participants increasing the premium associated with their lowest cost options by double-digit percentages, but those cases often involve carriers whose 2014 rates were substantially lower than the rates of their local competitors. Those relatively large increases at times result in the carriers still having the lowest cost silver option in the market.

Competitive responses often can be observed in the carrier-specific changes between years one and two of marketplace implementation. Carriers whose lowest cost silver premiums are significantly higher in 2014 than premiums of their competitors frequently will lower their entry-level prices for 2015, sometimes by double-digit percentages. Often such adjustments lead to a different carrier from the one in 2014 offering the lowest cost silver option in 2015. Markets with multiple competitors clustered closely in price in 2014 often will reduce their premiums or increase them very little for the coming year. New 2015 entrants into a market tend to set premiums that indicate that the insurers have learned lessons by studying the 2014 levels in their area. In certain markets, large insurers may retain substantially higher prices even for their lowest premium silver product, but they likely offer a broader provider network than do their competitors and thus appeal to a particular segment of potential enrollees.

Some caution, however, ought to be observed when evaluating the predictive power of 2015 premium changes for future years because those markets remain in transition in a number of respects. In addition, as we have shown elsewhere,[13] average premiums vary considerably over the course of a 10-year-period.

First, plan years 2014 and 2015 both required insurers to set premiums with very little information about the characteristics of marketplace enrollees. Premiums were set in mid-2013 for 2014 with no postreform experience on which to rely. Premiums set in mid-2014 for 2015 had very little data about enrollees and their use of services, given that the 2014 open enrollment period did not end until late March of 2014. Thus, many enrollees were not able to access coverage under their new policies until sometime in April. The 2016 plan year will be the first in which insurers' actuaries will have had an entire year of experience from which to set premiums.

Second, premiums set for 2014 and 2015 were determined assuming potential payment from the temporary risk corridor and reinsurance programs. Some carriers may have set premiums aggressively (that is, low), presuming that at least a percentage of any possible error they made in predicting average costs to be incurred would be compensated by those programs. Both programs are set to expire after the 2016 plan year, with the size of potential reinsurance program outlays declining in both 2015 and 2016 relative to 2014.

Third, implementation of the permanent risk adjustment

program has introduced another level of uncertainty into appropriate insurer pricing in those early postreform years. At the time they were submitting premium rates for approval, insurers did not know how their enrollees' average risk compared to that of their competitors' enrollees. As such, insurers did not know whether they could expect to be paying out to the program or receiving payments from it. Because risk adjustment payments for the 2014 plan year will not be made until some months into 2015, those payments could not be confidently incorporated into premium setting. The extent to which the particular risk adjustment formulas will compensate for differential risk, as well as the practical opportunities for gaming the risk adjustment process—for example, by carriers using upcoding strategies—is yet to be determined as well. Those realities may significantly affect future pricing decisions.

Although significant uncertainties remain, however, the dark predictions of widespread, quickly escalating premiums appear not to have materialized for 2015. Outliers exist, to be sure, but those tend to be found in areas characterized prior to reform as noncompetitive insurance markets dominated by one or two insurers or a single hospital system that prevents carriers from negotiating effectively over provider payment rates or from limiting provider networks. More frequently, particularly in urban areas, effective price competition can be seen in private nongroup insurance markets for the first time, with premiums for entry-level silver coverage growing quite slowly or even decreasing.

ENDNOTES

1. See, for example, Abelson R. "Health Insurers Raise Some Rates by Double Digits." *New York Times*, January 5, 2013, http://www.nytimes.com/2013/01/06/business/despite-new-health-law-some-see-sharp-rise-in-premiums.html?pagewanted=all; Norman B, "Solving a 2014 Obamacare Problem Pushes Premium Hikes in 2015," *Politico*, August 13, 2014, www.politico.com/story/2014/08/obamacare-premium-increase-2015-109979.html (accessed September 2014); and Chang D and Madigan N. "Proposed Prices for Health Plans in 2015 Unveiled." *Miami Herald*, August 4, 2014, www.miamiherald.com/2014/08/04/4271376/proposed-prices-for-health-plans.html (accessed September 2014).
2. Holahan J and Blumberg LJ. "Marketplace Competition & Insurance Premiums in the First Year of the Affordable Care Act." August 2014, www.urban.org/UploadedPDF/413203-Marketplace-Competition-and-Insurance-Premiums-in-the-First-Year-of-the-Affordable-Care-Act.pdf.
3. Some people suggest, however, that some large, well-established carriers may have intentionally set premiums low, dipping into reserves, in an effort to gain an early market share.
4. Holahan and Blumberg, "Marketplace Competition."
5. Holahan J, Peters R, and Lucia K. "The Launch of the Affordable Care Act in Selected States: Insurer Participation, Competition, and Premiums." 2014, www.urban.org/UploadedPDF/413040-The-Launch-of-the-Affordable-Care-Act-in-Selected-States-Insurer-Participation-Competition-and-Premiums.pdf; and Skopec L and Kronich R. "Market Competition Works: Silver Premiums in the 2014 Individual Market Are Substantially Lower than Expected." ASPE Issue Brief, August 9, 2013, http://aspe.hhs.gov/health/reports/2013/MarketCompetitionPremiums/rb_premiums.pdf.
6. Holahan and Blumberg, "Marketplace Competition."
7. Holahan J. "Will Premiums Skyrocket in 2015? Timely Analysis of Immediate Policy Issues." May 2014, www.urban.org/UploadedPDF/413126-Will-Premiums-Skyrocket-in-2015.pdf.
8. Congressional Budget Office. "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act." April 2014, www.cbo.gov/sites/default/files/45231-ACA_Estimates.pdf.
9. Cox C, Levitt L, Claxton G, et al. "Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces." Kaiser Family Foundation, September 2014, http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-Marketplaces/; Health Research Institute, PriceWaterhouseCoopers (PWC). "A Look at 2015 Individual Market Health Insurance Rate Filings," 2014, www.pwc.com/us/en/health-industries/health-research-institute/aca-state-exchanges.jhtml; and McKinsey Center for US Health System Reform. "2015 OEP: Emerging Trends in the Individual Exchanges." McKinsey and Company, October 2014, http://healthcare.mckinsey.com/sites/default/files/2015%20OEP%20Emerging%20Trends%20-%20McK%20Reform%20Center_0.pdf.
10. The percentage changes in lowest cost silver offerings do not necessarily, however, apply to the second lowest cost premium across all participating carriers available in a given rating area. As such, they should not be used to compute changes in the reference premiums for these regions nor to compute premium tax credits.
11. Snowbeck C. Big Jump for PreferredOne Premiums. *Star Tribune*. October 16, 2014, www.startribune.com/business/279332032.html.
12. Neighborhood Health Plan offered Marketplace coverage only to low-income purchasers in 2014, but the carrier will offer coverage to all Marketplace enrollees in the state for 2015.
13. Blumberg LJ and Holahan J. "Year-to-Year Variation in Small-Group Health Insurance Premiums: Double-Digit Annual Increases Have Been Common Over the Past Decade." 2014, www.urban.org/UploadedPDF/413235-Year-to-Year-Variation-in-Small-Group-Health-Insurance-Premiums.pdf.

About the Authors and Acknowledgements

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Marketplace Renewals: State Efforts to Maximize Enrollment into Affordable Health Plan Options

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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. This report is one of a series of papers focusing on particular implementation issues in case study states. 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. For more information about the Robert Wood Johnson Foundation's work on coverage, visit **www.rwjf.org/coverage**.

INTRODUCTION

The stakes are high for the second year of health coverage enrollment under the Affordable Care Act. Though enrollment in the first year exceeded expectations, with just under 7 million enrolled,[1] most experts predict that the remaining uninsured will be harder to reach and less motivated to sign up for coverage. The Congressional Budget Office has projected that the health insurance marketplaces will have 13 million people enrolled in 2015, but more recent estimates from the U.S. Department of Health and Human Services project only up to 9.9 million people will be enrolled.[2] If either target is met, the majority of enrollees will be people who were covered in 2014 and re-enrolled. Though the marketplaces must make a significant investment to reach out to and enroll the uninsured, they must also focus on retaining those already enrolled.

For 2015, marketplaces' ability to conduct an effective renewal process for current enrollees is constrained by their information technology (IT) capacity, the short time period for open enrollment (November 15, 2014, through February 15, 2015) and limited resources for outreach and consumer assistance. All marketplaces must annually redetermine individuals' eligibility for enrollment and financial assistance,[3] but that redetermination may take place automatically in the federally facilitated marketplace (FFM) and some state-based marketplaces (SBM) to reduce demands on IT and support infrastructure and maximize retention.[4] Federal law also requires insurance companies to renew policies for enrollees, with few exceptions.[5] Thus, even if a marketplace is unable to conduct an automatic redetermination for marketplace and subsidy eligibility, and the consumer takes no action, many enrollees' coverage will still be renewed. All marketplaces have communicated with consumers about their options, are ramping up call center and consumer assistance capacity, and are finalizing the testing of IT systems.

The FFM and SBMs are taking different approaches in their efforts to maximize enrollment among current marketplace policyholders, including the use of automatic renewals (auto-renewals). In the federal approach to auto-renewals, the FFM is extending the same absolute dollar amount of an enrollee's 2014 premium subsidy to their 2015 coverage. Some SBMs are following the federal approach; others are diverging from it. Some SBMs are not using auto-renewals, instead requiring all enrollees to actively update their accounts and select a plan to maintain coverage and premium subsidies in 2015. Others are improving on the federal framework for auto-renewal to help ensure consumers receive a more accurate amount of financial assistance in 2015. In all marketplaces, officials recognize the considerable benefit for consumers that revisit the marketplace, update their account information and shop for new health plan options, as well as the financial risk for enrollees who fail to do so.

In this paper we evaluate six SBMs' efforts to maximize

enrollment through the redetermination and renewal process. Through a review of federal and state policy decisions we selected six states (California, Colorado, Kentucky, Maryland, Rhode Island and Washington) for an in-depth case study of their approach to re-enrollment. The states were selected because their SBM approaches to re-enrollment differ from the FFM approach. Our case studies include analysis of marketplace policies toward re-enrollment and interviews with marketplace officials, health insurance company representatives and consumer assisters. We conducted 23 interviews from September 2014 to October 2014. We attempt to (1) describe the general consumer experience during the re-enrollment process, (2) understand the role of the SBM in shaping that experience, and (3) share emerging opportunities and challenges for future enrollment periods.

UNDERSTANDING THE RE-ENROLLMENT EXPERIENCE

Consumer Behavior in Insurance Markets

Most health insurance markets that offer a choice of plans, such as the marketplaces created by the Affordable Care Act, involve an annual opportunity for enrollees to change plans. In Medicare (Medicare Advantage and Part D) and most employer-sponsored systems (including the Federal Employees Health Benefits Program), the enrollee's plan is typically automatically renewed: plan enrollees who take no action retain their current insurance and those who wish to make a change must take proactive steps to do so.

When auto-renewal is available, enrollees tend not to switch plans. In Medicare Part D, about 87 percent of all enrollees in stand-alone drug plans remained in the same plan from one year to the next, even though most had cheaper options available.[6] Over a five-year period, 72 percent of Part D enrollees never made a voluntary switch of plans. This low rate of plan switching is matched in other settings that involve a full array of health services and affiliations to preferred doctors and hospitals. For example, in the Federal Employees Health Benefits Program, about 12 percent of federal employees switched plans annually between 1996 and 2001.[7] A similar rate of switching (13 percent) has been reported for all nonelderly Americans with employer-sponsored health insurance, though that rate includes involuntary switching caused by changes in jobs or employer plan offerings.[8] In some other settings, switching rates have been lower. In Massachusetts' Commonwealth Care (the Massachusetts Health Connector), no more than 7 percent of enrollees switched plans in any year from 2009 to 2013.[9]

Most likely, a larger number of people in these programs shopped during the open enrollment periods but did not switch plans. For example, a survey of Medicare beneficiaries found that 60 percent said they review or compare their options at least once a year.[10] But in focus groups, many Medicare beneficiaries reported that they preferred not to switch plans because the initial process of picking a plan was "so frustrating."[11]

In both Medicare and Federal Employees Health Benefits Program, enrollees were more likely to switch when their current plans were making large premium increases or reducing benefits. But even in these circumstances, switching was infrequent. In Medicare Part D, 28 percent of those facing a premium increase of $20 per month or more made a switch, compared with 7 percent to 8 percent of those with premium decreases or small increases.[12]

The marketplace context and population are different than in these other settings, and the situation is complicated by subsidies. Marketplace enrollees are more likely to have lower incomes, meaning the dollar impact of not shopping for alternative plans may be greater for them. The complexity of returning to the marketplace after the challenges of the 2013-14 experience, however, will be a deterrent.

The Only Constant is Change

In most marketplaces across the country, consumers that enrolled in 2014 are facing a different landscape in 2015. In many areas, new insurance companies are competing for their business.[13] In a few others, insurers have dropped out.[14] Further, many participating insurers have changed the plans they offer. Some are being discontinued; others are being added. Some plans are being continued but with important changes to benefits, networks, or cost-sharing. As one insurer put it, "our

policies have changed so much that they are cancelled, effectively."

Almost universally, insurers are changing premiums for their 2015 plans. In some markets, premiums are rising; in others they are falling. In markets in which the average premium is unchanged or changed only modestly, there can be considerable premium volatility among plans.[15] The degree of premium changes may also vary considerably among rating areas within a state.[16] Thus, even consumers content with their 2014 plan are likely to learn about plan or premium changes that will affect their finances and potentially their access to care.

Changes in the Value of Premium Tax Credits

Because of premium changes for other plans sold in the marketplace, subsidy-eligible enrollees in plans without a change to their base premium may still face a change in the amount they pay for 2015. Financial assistance through the marketplace comes in the form of premium tax credits (PTCs)[18] that are tied to the price of the second–lowest-cost silver plan available in a given area. This is known as the "benchmark" plan. Consumers receiving PTCs can "buy up" from the benchmark to obtain a more expensive plan. When they do, they pay the difference. Similarly, they can "buy down" from the benchmark by buying a cheaper plan, allowing their PTC to go farther.

Data suggest that the benchmark plan has changed from 2014 to 2015 in most markets.[19] That is, a consumer enrolled in the benchmark plan in 2014 would need to switch to the new benchmark plan to get the maximum value of the premium tax credit. Also, even in markets in which the benchmark plan remains the same from 2014 to 2015, its price relative to other plans in the market is likely to be different. Though notices from the FFM and FFM insurers give enrollees general information about the possibility of a better deal if they return to the marketplace and shop, enrollees are not specifically told when there is a new benchmark plan with a lower price in their area.[20]

Changes in Age and Federal Poverty Level Guidelines

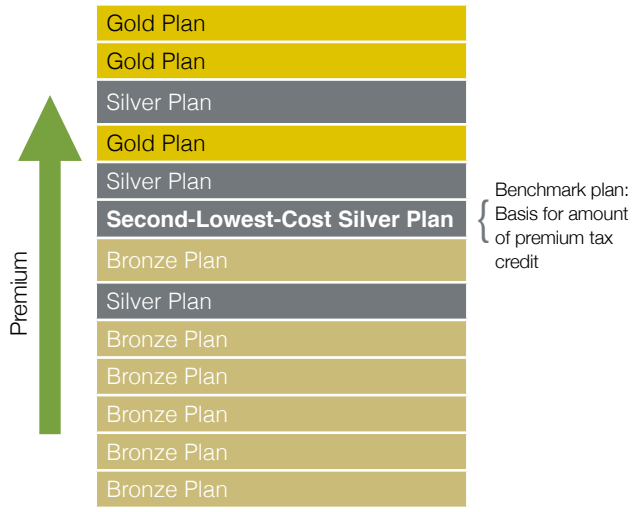
Most enrollees will also face premium increases based on age because insurers are allowed to implement age-related premium increases. These increases may be large or small, according to a standardized age-rating curve.[21] For example, an enrollee who has turned 21 will face a bigger jump in premiums than an enrollee who has turned 27. For those who are automatically renewed into coverage through the FFM, their PTC amount will not be adjusted to reflect this age-based increase in their premium. Also, an enrollee receiving PTCs and cost-sharing subsidies could be affected by the annual update to the federal poverty level (FPL), especially if his or her income crosses one of the income thresholds for reductions in their plan cost-sharing.[22] PTCs and cost-sharing subsidies in 2014 were based on 2013 FPL guidelines. Consumers who actively enroll in a 2015 plan and update their marketplace accounts will have their information updated to reflect the 2014 FPL guidelines, but those whose plans are automatically renewed through the FFM will not. Consequently, they could end up receiving less in PTCs and cost-sharing subsidies than the amount they are entitled to. And though missed PTCs can be recouped when filing taxes in the following year, missed cost-sharing subsidies are never reconciled, so any missed support will never be recouped.

Exhibit 1.
Refresher: How Are Premium Tax Credits Determined?[17]

$450	Cost of silver benchmark plan (for age and service area)
-$75	Minus expected "premium contribution" (calculated as a sliding scale percentage of federal poverty level income)
=$375	Equals premium tax credit (the amount a consumer receives to apply towards the cost of coverage he/she selects)

If a higher or lower cost plan is selected, the actual premium will be higher or lower than the expected premium contribution.

Exhibit 2. Plans Offered in Hypothetical Marketplace, Sorted by Premium



Source: Authors' analysis

Change in Plan Eligibility

Some enrollees will have other changes that affect their eligibility for certain plans. For example, individuals enrolled in catastrophic plans may no longer be eligible for those plans once they turn 30.[23] Young adults insured under a family plan may no longer be eligible for coverage with that plan if they turn 26 in 2014.[24]

Change in Family or Income Circumstances

Many enrollees will have changes to their projected 2015 income or household composition that will affect their eligibility for financial assistance. Though some will have already reported income or household changes that occurred during 2014 and received a corresponding adjustment to their level of financial assistance, others may not have done so. Reporting the most up-to-date information to the marketplace is important. For those who have not updated their family or income information, the marketplaces will assess income and household information based on the projected income data in their 2014 marketplace application, which many enrollees completed in late 2013. Consequently, these data could be out of date, leading to lower or higher subsidy amounts that would later need to be reconciled when filing tax returns.[25]

Risks and Benefits of Auto-Renewal

The FFM and some SBMs have created auto-renewal processes designed for individuals and families whose income or household circumstances have not changed their eligibility for financial assistance, whose plans are being continued in 2015, and who gave permission to the marketplace to access their tax information for renewal purposes. The benefit of auto-renewal is that eligible individuals will not need to revisit the marketplace to be re-enrolled into their plan. Most of those receiving financial assistance will continue to receive it. Auto-renewal is designed to maximize retention of current enrollees, ensure greater continuity of coverage, and relieve some of the pressure on the marketplace IT and consumer-assistance infrastructure.

However, auto-renewal carries the risks of significant premium increases for some consumers and tax liability for others. For those whose plans are automatically renewed, the FFM will provide the same absolute dollar amount of PTCs they received in 2014, without accounting for changes to the enrollee's plan, the benchmark plan, income or household size, age of enrollees or FPL.[26] Thus, few people whose plans are automatically renewed through the FFM will receive

Exhibit 3. What happens to the PTC under auto-renewal in two different scenarios?[28]

Mary Scenario 1: Mary's plan premium stays the same; benchmark plan premium decreases in 2015. Mary's income is just below 150 percent of FPL and has not changed from 2014 to 2015. She does not plan to shop for a new plan, so her plan will be automatically renewed by the FFM. Her plan was the benchmark plan in 2014 and has a $400 monthly premium. Mary received $343 of PTC each month in 2014. In 2015, Mary's plan does not change, but a new plan with a $300 monthly premium enters the market and becomes the benchmark plan. Mary is still eligible for a PTC, but this amount is pegged to the new benchmark plan premium, minus her contribution at 4 percent of her income. Her PTC for 2015 should be $243 per month, based on the new lower benchmark. But because her old plan is automatically renewed in the FFM, she will still receive the same 2014 PTC of $343. If she does not return to the FFM and update her information, she will pay $57 a month, though she should be paying $157 a month. She will owe the difference of about $1,200 ($100 per month) on her 2015 tax filing, though her actual liability would be capped based on her income (in this case the cap is $300). If she had returned to the marketplace and received an updated redetermination, she would have received the correct 2015 PTC of $243 a month and would have had the opportunity to select a cheaper plan.

Mary Scenario 2: Mary's plan premium stays the same; benchmark plan premium increases in 2015. Mary's income and other circumstances are the same as in Scenario 1. But her plan is now the lowest-cost plan instead of the second lowest, and the new benchmark is a plan with a $450 monthly premium. Mary's 2015 PTC should be $393 a month, based on the higher benchmark. But if her plan is automatically renewed in the FFM, she will receive her 2014 monthly PTC of $343, or $50 less per month than she is eligible for in 2015. She will thus pay $57 each month for her plan, though she should be paying just $7. Though she can recover the difference during next year's tax reconciliation, she will face higher costs in 2015 unless she goes to the marketplace to get an eligibility redetermination.

Table 1. Mary's PTCs and Premium Payments Under Two Scenarios

	2014	2015: Scenario 1	2015: Scenario 2
Mary's monthly income	$1,425	$1,425	$1,425
Mary's expected monthly premium contribution (4 percent of income)	$57	$57	$57
Mary's PTC based on a 2014 benchmark premium of $400 a month (FFM approach)	$343	$343	$343
Mary's PTC based on the 2015 benchmark premium of $300 in Scenario 1 and $450 in Scenario 2	N/A	$243	$393
Mary's total premium for her current plan if it is automatically renewed with 2014 PTC	$57	$57	$57
Mary's total premium for her current plan, redetermined with 2015 information	$57	$157	$7

Note: N/A = not applicable.

the correct level of PTCs or cost-sharing reductions in 2015, as illustrated in Exhibit 3.[27] Even those enrollees who have no personal changes in circumstances are likely to live in areas in which there have been premium increases or decreases and a change in the benchmark plan. The FFM approach also does not consider changes in enrollees' age and annual changes to the FPL guidelines. Individuals who receive less in PTCs than they are eligible for (and must thus pay commensurately more in premiums) may be unable to afford their 2015 premium, and some may therefore drop coverage. Those who receive more PTCs than they are eligible for will be required to pay the extra amount back during the tax reconciliation process. In some cases, these amounts could be significant.

For the marketplaces, auto-renewal is a double-edged sword. It is attractive because it can help maintain overall enrollment numbers and reduce strain on marketplace and insurer customer support capacity (such as IT, call centers and in-person assistance). Many consumers, however, are likely to be re-enrolled in a plan that is suboptimal for them; this may be financially risky. As described, other health insurance programs' auto-renewals have implicitly discouraged shopping and caused most people to stay in the same plan they had in the previous year.

Further, there is potential for error with auto-renewal because the marketplace draws on old income and household information that may not reflect enrollees' current status. Consumers that do shop for a new plan are likely to find one that offers a better overall value; in each market there will always be at least one plan a subsidy-eligible consumer can purchase to keep their net premium the same. As one insurance company official put it, "The cynical part of me likes [auto-renewal] and the crusader part of me says that you have to get into the best coverage that you and your family need."

RE-ENROLLMENT: STATE AND FEDERAL APPROACHES

SBMs have flexibility, within federally set boundaries, to develop their own processes for renewing enrollees.[29] Even as they exercised that flexibility, however, SBMs faced uncertainty over the capability of their IT systems, the number and variety of plans insurers would offer and final approved premiums for the 2015 benchmark plans. This uncertainty made decision-making about the renewal process more difficult.

The FFM will renew enrollees into their current plan if it is available and if they do not take action to review their account information and select a plan. The FFM will apply enrollees' 2014 PTC dollar amount to their 2015 coverage. Several SBMs have adopted this federal approach; others are able to adjust PTCs for auto-renewals to reflect 2015 plan prices, changes in age and the new FPL guidelines. But other SBMs are requiring all enrollees to return to the marketplace to update their account and select a plan. For some SBMs in this latter category, failure to return to the marketplace will lead to enrollees being re-enrolled in their plan without PTCs and cost-sharing reductions. In other SBMs, an enrollee's failure to act will lead to the loss of both financial assistance and health insurance coverage. Of our six study states, all are pursuing an alternative process to the one the FFM uses.

States Requiring Active Re-Enrollment

Among our six study states, Maryland and Rhode Island both require current enrollees to return to the marketplace to review their information, check their eligibility, and actively re-enroll in a health plan. The consequences of inaction, however, are different. In Maryland, enrollees who take no action will still be renewed into health coverage but will not receive PTCs or cost-sharing reductions in 2015; they can receive these if they re-enroll. If Rhode Island enrollees do not return to the marketplace, however, their coverage stops after December 31, 2014.

In Maryland, which experienced significant IT problems in the marketplace's first year and is switching to a new IT system, auto-renewal is not feasible. The marketplace was not able to transfer enrollees' data from the old IT system to the new one. In Rhode Island, the marketplace is not able to implement auto-renewal because it did not obtain consent from applicants to allow access to enrollees' income information for the 2015 redetermination process. But Rhode Island officials and stakeholders alike assert that given dramatic changes in plans and prices offered through the Rhode Island marketplace, requiring active renewals may be optimal

Table 2. State and Federal Approaches to Auto-Renewal*

Automatic Renewal	Financial Assistance	Marketplaces in Our Study
Yes	PTC adjusted for 2015 with available premium, age and FPL guideline data	CA, CO, KY, WA
Yes	2014 PTCs applied unless consumer updates account and selects plan	FFM
Yes	No PTCs unless consumer updates account and selects plan	MD
No	Not provided unless consumer re-enrolls	RI

**Source: Authors' review of FFM and SBM published materials.*

for Rhode Island consumers. For example, premiums for some plans fell significantly, but the premium for the 2014 benchmark plan went up. Consequently, there is now a new benchmark plan available at a lower price than the 2014 benchmark plan. One insurer respondent told us that their data show that a subsidy-eligible enrollee remaining in the 2014 benchmark plan "could experience [as much as] a 100 percent premium increase" if he or she stayed in the same plan and did not shop for new coverage. Similarly, Maryland officials noted significant rate competition among participating insurers in 2015 and a resulting change in the benchmark plan. They concluded that by requiring renewing individuals to return to the marketplace for redetermination, "folks may be better off because they'll get accurate eligibility [determinations]."

Officials and stakeholders in both states recognize that requiring active renewals could lower overall enrollment numbers. National studies have shown that Medicaid programs, including the Medicare Savings Programs, in which Medicaid provides supplemental assistance to low-income Medicare beneficiaries, experience reduced participation when they require enrollees to take an active step to renew eligibility.[30] Consequently, the marketplaces in Maryland and Rhode Island are conducting proactive outreach to enrollees using email, telephone, regular mail and social media. By the end of the open enrollment period, enrollees will have received several rounds of communications from the marketplace and their insurance companies, urging them to return to the marketplace to ensure they continue receiving subsidies. But even repeated notices may not reach everyone.

Further, Maryland officials are concerned that consumers will be discouraged from taking steps to complete an active renewal because of user experience and IT system problems experienced during the last open enrollment period. "The biggest issue is changing perceptions of the…experience... [We] don't want people to not come into the system because it was so bad last year." Stakeholders confirmed this, reporting that the biggest obstacle to maximizing re-enrollment is concerns about system proficiency among Marylanders who used the marketplace last year. Consequently, the marketplace has planned an aggressive, multiphase communications campaign for current enrollees:

- July-August: work with insurers to build a database of enrollees' contact information.
- September: contact enrollees via email, mail and phone about the redetermination process.
- October: begin media campaign to supplement direct outreach.
- November: insurers send enrollees a renewal notice; brokers and assisters initiate contacts with enrollees to encourage renewal.
- December: enrollees receive a reminder and "call to action" regarding the deadline to enroll in coverage effective January 1; additional outreach for those who have not yet obtained a redetermination.
- January–February: begin additional outreach to people that have not yet received a redetermination and chosen a new plan.

Maryland officials recognize that even with an extensive outreach effort, their requirement of an active redetermination for financial assistance will likely lead to a cohort of enrollees without PTCs in 2015. As one official put it, some enrollees will get "their first bill in January and ask, 'What happened?'" after they are renewed into a plan without the PTCs they had received in 2014. Many of these individuals are likely to experience significant "sticker shock" when asked to pay their premium without a PTC. Though they can visit the marketplace and gain a redetermination of eligibility for PTCs, they may have to pay one or two months' premiums without financial assistance.

Rhode Island's outreach to enrollees started slightly later than Maryland's; Rhode Island began sending renewal packets in early November. But the state developed a detailed plan to coordinate the timing and content of the marketplace's messaging with that of insurers. The marketplace's broad-based marketing campaign involves paid and earned advertising as well as several walk-in centers for assistance with enrollment. Rhode Island's call center operators received specific training focused on renewals, and the marketplace developed a "consumer friendly" packet to explain the complex factors affecting enrollees' plans, premiums and subsidies. Because all current enrollees will need to actively re-enroll, the marketplace is allowing consumers to begin the re-enrollment process as early as November 7, 2014. Consumers will also have a few extra days—until December 31, 2014—to select a plan for coverage effective January 1, 2015. Though officials believe they are doing everything they can to educate enrollees, they remain concerned about "waking up January 2 to customers who are very angry and potentially in a bad spot because they didn't do what they needed to get coverage by January 1…there's always a risk when asking consumers to take an active effort to do something." After February 15, 2015, state officials hope to use a flexible approach to special enrollment periods to address the needs of enrollees who did not take action within the open enrollment period, consistent with federal and state regulations.

Auto-Renewal: State Efforts to Maximize Renewals and Improve the Renewal Process

Four of the six study states—California, Colorado, Kentucky, and Washington—can offer automatic redeterminations and renewals for enrollees who do not actively re-enroll. Further, all four states can adjust consumers' PTCs to reflect changes in 2015 premiums, something the FFM and several states following the FFM approach are not able to do this year. California also opened its marketplace up for renewals a month early, in mid-October 2014.[31] As one respondent noted, with 1.4 million people enrolled through their marketplace, the state needed to "smooth out the volume" and avoid "straining the back end of customer service and distribution capacity."

All four states are investing heavily in marketing and outreach campaigns to educate consumers about the open enrollment opportunity. The California marketplace, for example, will spend more on outreach during this open enrollment period than it did during the first one.[32] The Kentucky marketplace launched a mobile tour; has a shopping mall storefront; and is advertising on radio, TV, and social media. But the states are emphasizing somewhat different messages.

Some California respondents minimized the potential risks of auto-renewal, asserting that because rates are stable in the state and because the marketplace will adjust PTCs to reflect 2015 prices, most consumers will be content if their plan is automatically renewed. However, marketplace officials say that notices and marketing materials sent to enrollees encourage them to return, shop and compare plans.

Colorado, Kentucky and Washington are also, to varying degrees, encouraging enrollees to come back to the marketplace and shop for a new plan, even if they are eligible for auto-renewal. Officials in Kentucky report that they are encouraging consumers eligible for auto-renewal to shop because they have two new insurers and want consumers to see the new plans. Officials there also acknowledge that even though the state will adjust consumers' PTCs to reflect the cost of the 2015 benchmark plan, some enrollees whose plans are automatically renewed could still face premium changes because their current plan may have a higher cost relative to the 2015 benchmark plan. Shopping for alternative plans will allow them to save money.

The marketplaces in Colorado and Washington shifted their messaging strategy around renewals after they gained better information about changes to plans and plan premiums for 2015. Early on, Washington reported they were not "going so strong on the shop around message," but were providing a "softball pitch" of checking out other options and shopping. But after receiving an internal analysis of premium and benchmark plan changes, Washington officials adjusted their messaging to include a stronger push for consumers to return, review their account information and shop.[33] Similarly, Colorado officials initially reported that they hoped to maximize the number of people who auto-renewed to reduce demands on their IT and customer support capacity. "For the population that's eligible for the [auto-renewal] option, we'll be pushing it," officials said. However, shortly before the start of open enrollment, the marketplace received a rate and PTC impact analysis showing that almost all of their enrollees live in an area where the premium for the benchmark plan is decreasing, substantially for most of those enrollees. With this new information, the marketplace adjusted its messaging to enrollees to emphasize shopping and the new, lower-priced plan options available.

Washington may be unique among our six states in that marketplace officials estimate 20 percent of enrollees did not provide consent for the marketplace to access their income information for renewals. One respondent pointed out that some in this category have incomes well beyond subsidy eligibility, so renewal could have been done without income verification. Further, the plans of another 20 percent of enrollees are being discontinued because of changes to benefits and other factors.[35] Most of these enrollees, however, will be transitioned into similarly structured plans; this is part of the auto-renewal process in Washington. The state's Office of the Insurance Commissioner worked closely with participating insurers to smooth this process. Nevertheless, insurer respondents in Washington predict "lots of chaos" because of well-intentioned but perhaps confusing communications from the marketplace and their health plan. Individuals are receiving notices from their plan, the content of which is prescribed the Office of the Insurance Commissioner. The letter informs them of their 2015 plan information, such as the plan name and ID, but does not include information about their estimated premium or 2015 PTC. Consumers will receive separate letters from the marketplace, referred to as "open enrollment renewal letters" by marketplace officials, that inform them of the amount of their PTC. Insurer respondents believe this is a recipe for "total confusion" on the part of consumers. Other marketplaces, such as those in California, Colorado and Kentucky, are "co-branding" their notices with participating insurers so consumers receive the same messages from both entities.

Barriers to Re-Enrollment

Information Technology

All six states identified IT capacity and functionality as a top barrier to maximizing re-enrollment for 2015. Insurer respondents noted that many SBMs were behind on testing important components of the renewal system and worried about readiness for launch on November 15, 2014. One plan respondent reported that testing had not been possible as late as 20 days before the start of open enrollment. Further, stakeholders in Washington and Colorado noted that the marketplaces are still resolving billing and reconciliation problems from 2014, leaving them skeptical of system capacity for another round of open enrollment. As one insurer put it, "If we enroll people with bad data, then the reconciliation process will be a hole we don't ever come out of."

Stakeholders also identified a technical glitch that could anger consumers who change their plan selection during the renewal process. According to insurer respondents, the FFM does not have the technical capability to notify an enrollee's previous insurer when they switch to a new insurer.[36] Consequently, enrollees will have to proactively disenroll themselves from their old plan to avoid duplicate coverage (and therefore extra premium payments). Some states, such as Washington and California, report that they are able to send termination notices to insurers, but insurers say those notices are not always timely.

Insufficient Consumer Support Infrastructure

Another challenge is the limited amount of resources for marketplace consumer support, including call centers, Navigators and in-person assisters. "[T]he biggest challenge is spreading out the workforce for renewing customers," one marketplace official told us; another reported she was primarily concerned with call centers' ability to handle an expected high volume of consumer questions. An assister noted that because consumers "will wait for the very end" to either renew or enroll into coverage, the workforce's capacity will be stretched to help renewing and newly enrolling customers. Another barrier that many assisters are up against is their inability to contact enrollees they helped during the last open enrollment period: assisters were prohibited from keeping records of their clients' contact information.

Messaging

Other stakeholders identified communications and messaging to enrollees as a primary barrier; they are concerned that different messages are coming from different actors and creating confusion about deadlines. A Rhode Island assister told us: "We are fully expecting people to come through the door, confused by these notice letters [from their insurers and the marketplace]." Many respondents across the six study states also remarked that the volume of notices is adding to consumer confusion regarding what to do and when to do it. One assister noted that letters telling consumers to take action arrived two weeks before those consumers could take any action; consequently, "they'll forget to do something." The confusion about what to do, when to do it, and why they should do it could lead some enrollees to choose inaction, even if it is financially disadvantageous. In California, assisters report that enrollees "call and ask, 'Do I have to come in?' When I tell them they can be automatically enrolled, they are happy about that and take the path of least resistance." Insurers expect widespread confusion, and some report they have prepared their own call center operators to answer questions arising because of the notices.

Marketplace officials and those working directly with consumers also cited concerns about their ability to

effectively explain how changes in plans and premiums, including changes to the benchmark plan, could affect enrollees. Because these changes could leave enrollees with higher premiums or potential tax liabilities and thus lead to frustrated and angry customers, conveying this information correctly and clearly is important.

Short Time Frame

Enrollees who want to actively renew their coverage and implement a plan change by January 1, 2015, for continuous coverage have a short window in which to do so: just 30 days, from November 15, 2014 to December 15, 2014. Most respondents are concerned about this tight time frame. "This is a daunting task," said one insurance company observer. "Even if every state did what California did [opened early for renewals] and we staffed 24/7, we'd have to process 7,000 [renewals] per day [if everyone decided to get actively renewed]."

CONCLUSION

The eligibility redetermination and renewal process for current marketplace enrollees is a significant technical and policy hurdle to a successful enrollment season for health insurance marketplaces. Marketplaces are under pressure to boost their enrollment numbers and make the process as simple and streamlined as possible to limit the number of consumers who fail to renew their coverage. Experience in the Medicare program has demonstrated that when auto-renewal is available, most consumers will not take active steps to shop for a new plan, even if it is in their financial interest to do so. The FFM and many SBMs will help ensure continuity of coverage for consumers and maximize re-enrollment by allowing many consumers who take no action to automatically renew into the same or a similar plan. The auto-renewal option, however, will likely leave many consumers with ongoing insurance coverage but in a suboptimal situation. Some will be paying higher premiums than they should, some will be enrolled in a suboptimal plan, and some will face tax liability because they will have received more in financial assistance than the amount for which they are eligible. For many, the financial costs could be significant.

To help mitigate these problems, four SBMs we studied used their flexibility to improve on the FFM's auto-renewal process by adjusting enrollees' financial assistance to reflect the updated cost of the 2015 benchmark plan in each enrollee's area, enrollees' current age and updated FPL guidelines. Consequently, enrollees in these states will have a more accurate determination of their PTCs and cost-sharing subsidies than many residents of FFM states. But these enrollees still need to consider the potential value of shopping for a plan that better fits their needs, particularly because subsidy amounts may be a function of premium changes in other plans offered in the enrollee's area. All six states we studied, and particularly the two SBM states that are not offering auto-renewal, are investing heavily in outreach and communication to enrollees to ensure they understand what they need to do and when they need to do it. At least two marketplaces, Colorado and Washington, changed their messaging strategy to de-emphasize auto-renewal and encourage enrollees to return to the marketplace and shop; these changes came after those states received data on changes to 2015 plans and prices. In all states, communications about renewals present a significant challenge: they require consumers to wade through many pages of technical and legal notices to understand the benefits and risks associated with re-enrolling through the marketplace.

Consequently, enrollees in these states will have a more accurate determination of their PTCs and cost-sharing subsidies than many residents of FFM states.

Marketplaces will not know whether their plan-renewal processes have been successful in both maximizing coverage and enrolling consumers in optimal coverage until later in 2015. Either way, the policy, technical, and communication choices they have made will likely provide important lessons for state and federal officials responsible for future open enrollment periods.

ENDNOTES

1. Tavenner, M. Letter to the Honorable Darrell Issa, Chairman, Committee on Oversight and Government Reform, U.S. House of Representatives, Washington: U.S. Department of Health and Human Services, 2014. http://oversight.house.gov/wp-content/uploads/2014/11/Issa-Final-Signed.pdf (accessed November 2014).
2. Congressional Budget Office. *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act.* Washington: Congressional Budget Office, 2014. http://www.cbo.gov/sites/default/files/45231-ACA_Estimates.pdf (accessed November 2014); Assistant Secretary for Planning and Evaluation, *How Many Individuals Might Have Marketplace Coverage After the 2015 Open Enrollment Period?*
3. 45 C.F.R. § 155.335.
4. 79 Fed. Reg. 37262 at 37263 (July 1, 2014).
5. 45 C.F.R. § 147.106.
6. Hoadley J, Hargrave E, Summer L, et al. *To Switch or Not to Switch: Are Medicare Beneficiaries Switching Drug Plans To Save Money?* Menlo Park, CA: Kaiser Family Foundation, 2013. http://kff.org/report-section/to-switch-or-not-to-switch-issue-brief/ (accessed November 2014).
7. Atherly A, Florence CS and Thorpe KE, "Health Plan Switching Among Members of the Federal Employees Health Benefits Program." *Inquiry*, 42(3): 255–65, 2005.
8. Many employers do not offer a choice of health plans; those that do often include only a few options. Cunningham PJ. *Few Americans Switch Employer Health Plans for Better Quality, Lower Costs.* Research brief no. 12. Washington: National Institute for Health Care Reform, 2013.
9. These rates also include some who switched because their plan exited the market. "Commonwealth Care Quarterly Update" Presented at the Health Connector Commonwealth Care Board of Directors Meeting, September 2011. https://www.mahealthconnector.info/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/2011/2011-9-8/5.Sept2011CommCareUpdate.pdf (accessed November 2014).
10. Kaiser Family Foundation. *Seniors' Knowledge and Experience with Medicare's Open Enrollment Period and Choosing a Plan: Key Findings from the Kaiser Family Foundation 2012 National Survey of Seniors.* Menlo Park, CA: Kaiser Family Foundation, 2012. http://kff.org/medicare/issue-brief/seniors-knowledge-and-experience-with-medicares-open/ (accessed November 2014).
11. Jacobson G, Swoope C, Perry M, et al. *How Are Seniors Choosing and Changing Health Insurance Plans?* Menlo Park, CA: Kaiser Family Foundation, 2014. http://kff.org/medicare/report/how-are-seniors-choosing-and-changing-health-insurance-plans/ (accessed November 2014).
12. Hoadley et al., *To Switch or Not to Switch.*
13. Assistant Secretary for Planning and Evaluation. *Health Insurance Issuer Participation and New Entrants in the Health Insurance Marketplace in 2015.* Washington: U.S. Department of Health and Human Services, 2014. http://aspe.hhs.gov/health/reports/2014/NewEntrants/ib_NewEntrants.pdf (accessed November 2014).
14. Crosby J, "Top Selling Insurer on MNSure Won't Be Back This Year," *Star Tribune*, Tuesday, September 16, 2014. http://www.startribune.com/politics/statelocal/275305421.html (accessed November 2014).
15. Holahan J, Blumberg LJ, Wengle E, McGrath M and Hayes E. *Marketplace Insurance Premiums in Early Approval States: Most Markets Will Have Reductions or Small Increases in 2015.* Washington: Urban Institute, 2014. http://www.urban.org/publications/413287.html (accessed November 2014).
16. Colorado Department of Regulatory Agencies. "Division of Insurance Approves 2015 Health Insurance Rates." Press release. Denver: Colorado Department of Regulatory Agencies, September 22, 2014. Available from http://cdn.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%22News%3A+-DOI+Approves+1%2C072+Plans+for+2015+%2B+Infographic.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1252034762120&ssbinary=true (accessed November 2014); "90 Health Plans Approved for Next Year's Exchange With a Record Low 1.9 Percent Rate Change." Press release. Olympia: Washington State Office of the Insurance Commissioner, August 27, 2014. http://www.insurance.wa.gov/about-oic/news-media/news-releases/2014/8-27-2014.html (accessed November 2014); "A Look at 2015 Individual Market Health Insurance Rate Filings." Last updated November 11, 2014. London: PricewaterhouseCoopers LLP. http://www.pwc.com/us/en/health-industries/health-research-institute/aca-state-exchanges.jhtml (accessed November 2014).
17. Although enrollees can choose to receive their PTCs as a lump sum payment at the end of the year (as part of a tax refund), the majority of enrollees receive their PTCs in advance to defray their premium each month. When provided this way, they are referred to as "advanced premium tax credits." For this report, we refer generally to both PTCs and advanced premium tax credits as PTCs.
18. The authors thank Tricia Brooks of Georgetown University's Center for Children and Families for providing this example of the PTC at work.
19. Carpenter E, "Exchange Plan Renewals: Many Consumers Face Sizeable Premium Increases in 2015 Unless They Switch Plans." *Avalere Health*, Thursday, June 26, 2014. http://avalere.com/expertise/managed-care/insights/exchange-plan-renewals-many-consumers-face-sizeable-premium-increases-in-20/ (accessed November 2014); Holahan et al., Marketplace Insurance Premiums in Early Approval States.
20. Centers for Medicare and Medicaid Services. "Insurance Standards Bulletin Series – INFORMATION." Baltimore, MD: Centers for Medicare and Medicaid Services, 2014. http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Renewal-Notices-9-3-14-FINAL.PDF (accessed November 2014); "Marketplace Open Enrollment and Annual Redetermination Notice." Baltimore, MD: Centers for Medicare and Medicaid Services. https://marketplace.cms.gov/technical-assistance-resources/training-materials/training.html (accessed November 2014).
21. Centers for Medicare and Medicaid Services. "Sub-Regulatory Guidance Regarding Age Curves, Geographical Rating Areas and State Reporting." Baltimore, MD: Centers for Medicare and Medicaid Services, 2013. http://www.cms.gov/CCIIO/Resources/Files/Downloads/market-reforms-guidance-2-25-2013.pdf (accessed November 2014).
22. Though the effect of changes to the FPL guidelines on PTCs may be modest, the effect on people eligible for cost-sharing subsidies could be significant. For example, an individual earning $23,000 in 2014 would be considered above 200 percent of FPL. This would make him or her eligible for cost-sharing reductions that would increase the actuarial value of a silver plan to 73 percent. However, if his or her income did not change, he or she would drop below 200 percent of FPL in 2015, based on the recent update to the FPL tables. This would make him or her eligible for cost-sharing reductions that increase the actuarial value of their silver plan to 87 percent.
23. 45 C.F.R. § 156.155.
24. 45 C.F.R. § 147.120.
25. There is no tax reconciliation process for cost-sharing reductions. Eligible individuals who receive more in cost-sharing reductions than they are entitled to (based on actual income) will not be required to pay the

difference when filing taxes; individuals who receive less in cost-sharing reductions than what they are entitled to will not be able to recover those.
26. Centers for Medicare and Medicaid Services. "Guidance on Annual Redeterminations for Coverage for 2015." Baltimore, MD: Centers for Medicare and Medicaid Services, 2014, p. 5. http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014-0626-Guidance-on-annual-redet-option-2015-FINAL.pdf (accessed November 2014).
27. All enrollees receiving PTCs will go through the tax reconciliation process when they file their 2015 tax returns. Based on their actual 2015 income, those receiving too little in PTCs will be paid back via a tax refund and those receiving too much will be required to pay that assistance back.
28. Adapted from Colorado Department of Regulatory Agencies. "2015 Health Insurance Plans and Rates – Division of Insurance Rate Review FAQ." Denver: Colorado Department of Regulatory Agencies, Division of Insurance, 2014. http://cdn.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%22FAQ+-+2015+Plans+%26+Rates.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1252034650492&ssbinary=true (accessed November 2014).
29. 45 C.F.R. § 155.335(a).
30. Summer L, Hoadley J and Hargrave E. *The Medicare Part D Low-Income Subsidy Program: Experience to Date and Policy Issues for Consideration*. Menlo Park, CA: Kaiser Family Foundation, 2010. http://kff.org/medicare/issue-brief/the-medicare-part-d-low-income-subsidy/ (accessed November 2014); Summer L. Increasing Participation in Benefit Programs for Low-Income Seniors. Washington: Commonwealth Fund, 2009. http://www.commonwealthfund.org/publications/fund-reports/2009/may/increasing-participation-in-benefit-programs-for-low-income-seniors (accessed November 2014).
31. "Plan Management and Delivery System Reform Advisory Committee." PowerPoint presentation. West Sacramento: Covered California, 2014. http://hbex.coveredca.com/stakeholders/plan-management/PDFs/FINAL.PPT.Plan.Mgmt.Aug.15.2014.pdf (accessed November 2014).
32. California Health Benefit Exchange Board. "Meeting Minutes." August 21, 2014. http://board.coveredca.com/meetings/2014/9-18/PDFs/August%2021%202014%20Minutes.pdf (accessed November 2014).
33. Washington Health Benefit Exchange. "Washington Healthplanfinder Urges Renewing Customers to Review Their Tax Credit Amounts." November 7, 2014. http://wahbexchange.org/news-resources/press-room/press-releases/tax-credit-amounts (accessed November 2014).
34. Connect for Health Colorado. "Connect for Health Colorado Offers Guidance for Open Enrollment." October 28, 2014. http://connectforhealthco.com/2014/10/connect-health-colorado-offers-guidance-open-enrollment/.
35. Arnette D, "QHP Renewal Update." Presented at the Washington Health Benefit Exchange Operations Committee meeting, September 17, 2014. http://www.wahbexchange.org/files/3414/1097/9428/Sept_Operations_Committee_-_QHP_Renewal_Process_Update_v2.pdf (accessed November 2014).
36. Radnofsky L, "More Problems Expected on Federal Health-Insurance Site in New Year," *Wall Street Journal*, Tuesday, November 4, 2014. http://online.wsj.com/articles/more-problems-expected-on-federal-health-insurance-site-in-new-year-1415147396 (accessed November 2014).

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ISSUE BRIEF
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National Trends in the Cost of Employer Health Insurance Coverage, 2003–2013

Sara R. Collins, David C. Radley, Cathy Schoen, and Sophie Beutel

Abstract Looking at trends in private employer-based health insurance from 2003 to 2013, this issue brief finds that premiums for family coverage increased 73 percent over the past decade—faster than median family income. Employees' contributions to their premiums climbed by 93 percent over that time frame. At the same time, deductibles more than doubled in both large and small firms. Workers are thus paying more but getting less protective benefits. However, the study also finds that while premiums continued to rise through 2013, the rate of growth slowed between 2010 and 2013, following implementation of the Affordable Care Act. While families experienced slower growth in premium contributions and deductibles over this period, sluggish growth in median family income means families are paying more in premiums and deductibles as a share of their income than ever before.

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OVERVIEW

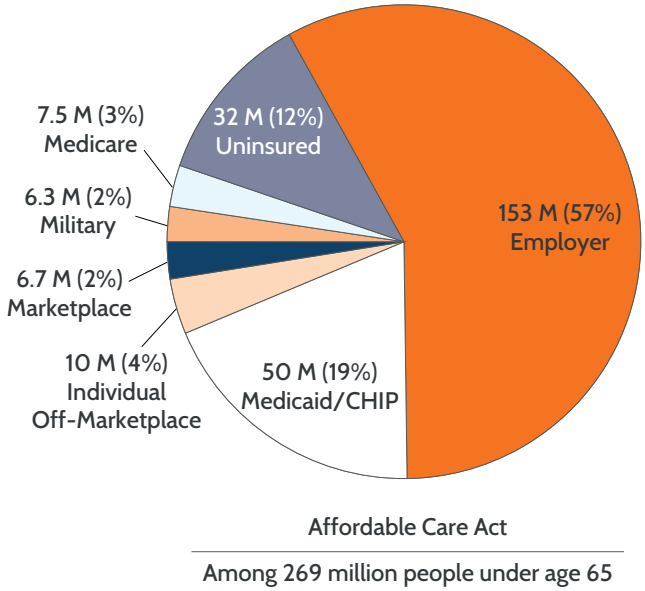
Recent news has focused on the cost of health insurance plans in the Affordable Care Act's marketplaces, but only 6.7 million people—or 2 percent of the population—are currently covered by marketplace plans. While the number of people enrolled in marketplace plans will climb to an estimated 9 million to 9.9 million in 2015 and eventually to 25 million over the next four years, people with marketplace coverage will still comprise only about 9 percent of the nonelderly population.[1] When we look at changes in the cost of health insurance and the implications for U.S. families, it is therefore important to examine trends in employer plans. About 57 percent of the under-65 population—or more than 150 million people—have insurance through employers (either their own or that of a family member) in 2014 (Exhibit 1).

This issue brief looks at national trends in employer-sponsored insurance from 2003 to 2013, the latest federal data available. Total insurance premiums paid by employers and employees rose much faster than median household income over that time. In addition, the amount that workers contributed to their premiums also climbed. At the same time, people with job-based insurance paid more out of pocket when they got health care: more plans have deductibles and the size of those deductibles has more than doubled over the decade.

There is, however, cause for optimism. While premiums continued to rise through 2013, the rate of growth slowed between 2010 and 2013, the years following implementation of the Affordable Care Act. This slowdown occurred both nationally

and, as we will describe in a forthcoming report on state trends, in 31 states and the District of Columbia. During this period, provisions of the law that apply to employer health insurance went into effect.

Exhibit 1. Estimated Source of Insurance Coverage, 2014



Note: The number of uninsured in 2014 was calculated using CPS estimates for 2013 minus an estimated 9.5 million fewer uninsured in 2014. The number of people enrolled in Medicaid/CHIP in 2014 includes the approximately 9.1 million new Medicaid enrollees in 2014. Estimate of individual o -marketplace is midrange of ASPE 2014 estimate.
Sources: Analysis of 2014 Current Population Survey by Sherry Glied and Claudia Solis-Roman of New York University for The Commonwealth Fund; ASPE, How Many Individuals Might Have Marketplace Coverage After the 2015 Open Enrollment Period? Nov. 2014; Centers for Medicare and Medicaid Services, Medicaid and CHIP: September 2014 Monthly Application, Eligibility Determinations, and Enrollment Report, Nov. 2014; The Commonwealth Fund A ordable Care Act Tracking Survey, April–June 2014.

FINDINGS

Employer Health Insurance Premiums at a 10-Year High, with Slower Growth After 2010

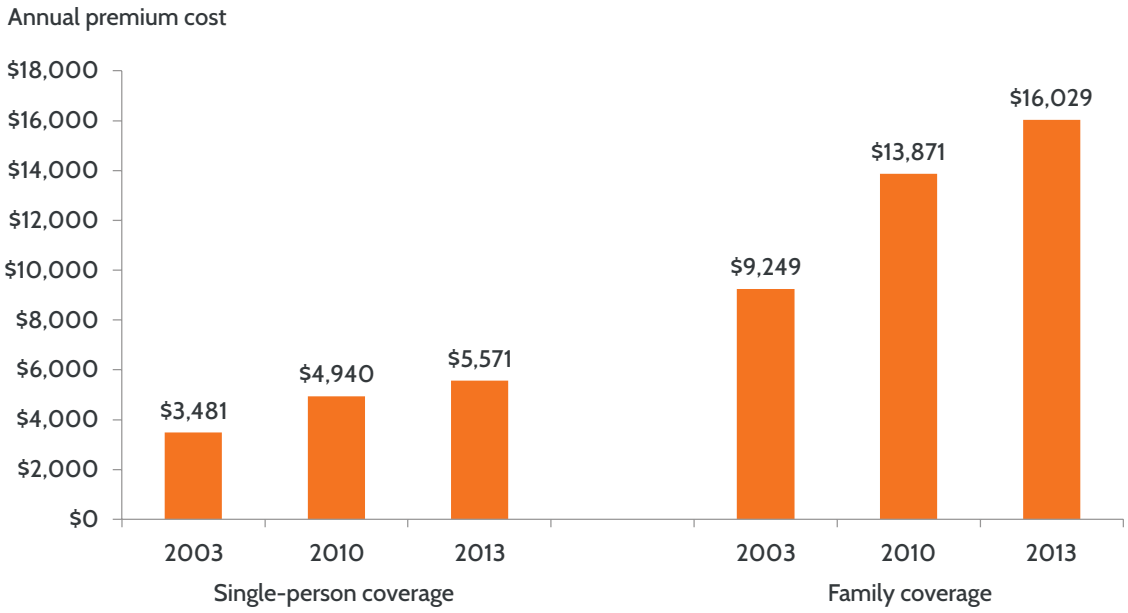
Average annual health insurance premiums for employer-sponsored family coverage reached $16,029 in 2013, up from $9,249 in 2003, an increase of 73 percent (Exhibit 2). Premiums for single coverage also rose markedly over the period, climbing from $3,481 to $ 5,571, or 60 percent.

Because the Affordable Care Act, which went into effect in 2010, included provisions that applied to employer plans beginning that year, we looked at trends in premiums before and after 2010. All nongrandfathered plans (i.e., health plans that were not in existence when the ACA was signed into law on March 23, 2010) are required to allow young adults to remain on or enroll in a parent's plan to age 26 and include recommended preventive services without cost-sharing. Both these provisions were expected to modestly increase premiums.[2] In addition, health insurers were required to spend at least 80 percent or 85 percent of premiums on medical costs for small and large employer health plans, or pay rebates to employers and covered employees. This provision has been found to have a mild decreasing effect on premiums.[3]

The analysis shows that the rate of growth in premiums after the passage of health reform slowed, compared with the average annual growth rate in the seven years prior to the law. From 2003 to 2010, premiums for employee-only plans grew at an average annual rate of 5.1 percent (Exhibit 3). In the three years since the ACA was enacted (2010–2013), growth in premiums slowed to 4.1 percent per year.

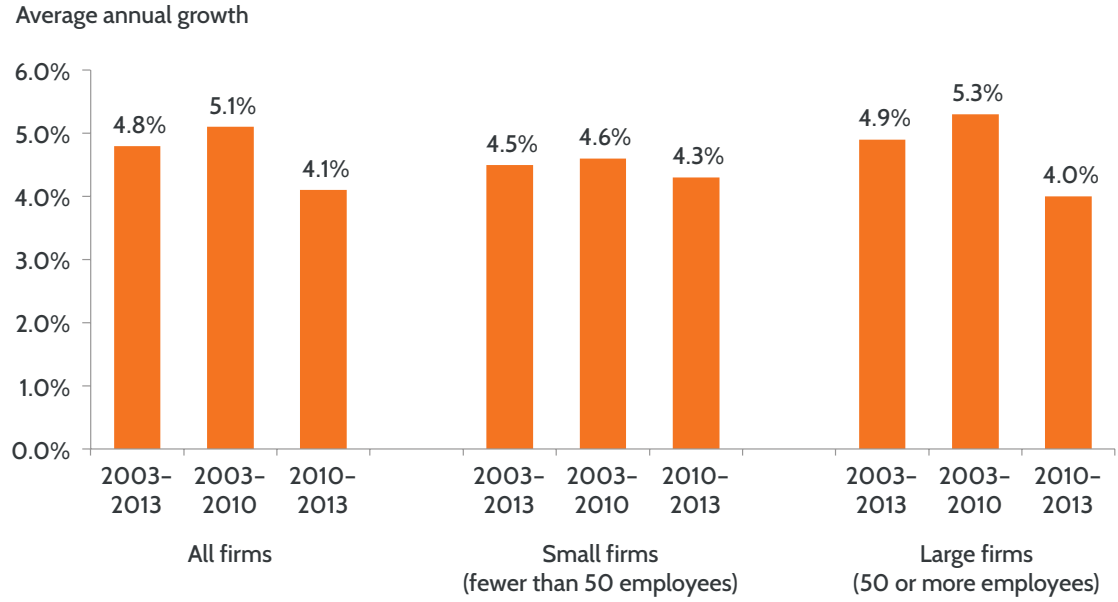
The reduced rate of premium growth was more pronounced in large employer plans than in small employer plans, primarily because premiums in large employer plans grew at a faster rate in 2003–2010 than did those in small employer plans. Premium growth after the passage of the Affordable Care Act was about the same for both large and small employers.

Exhibit 2. Average Premiums for Employer-Sponsored Single-Person and Family Health Insurance Plans, 2003, 2010, and 2013



Source: Medical Expenditure Panel Survey–Insurance Component, 2003–2013.

Exhibit 3. Average Annual Rate of Growth for Employer-Sponsored Single-Person Health Insurance Plans in All, Small, and Large Firms

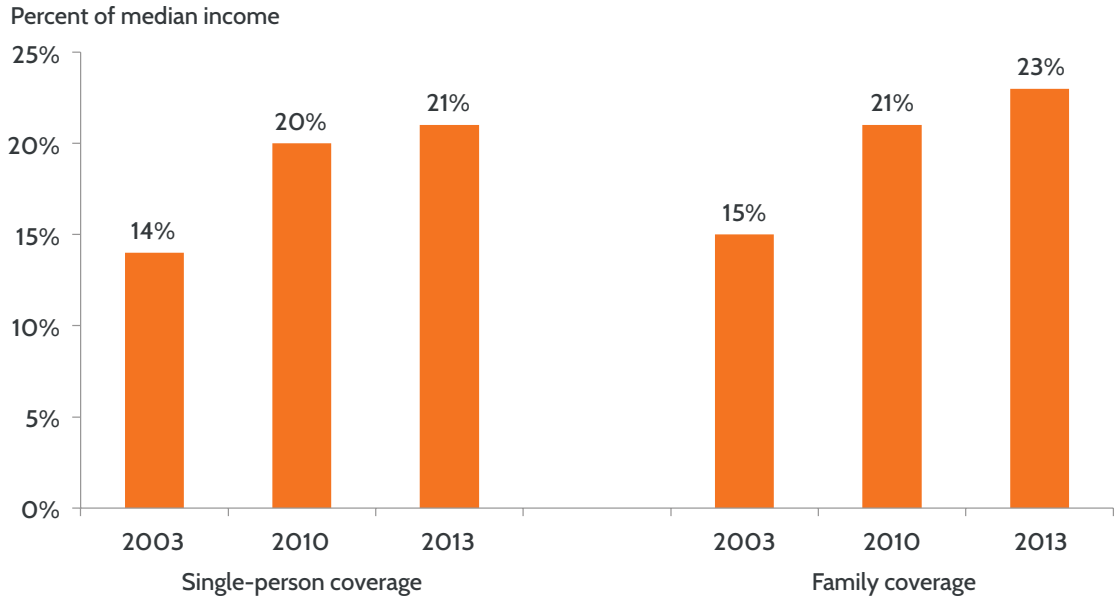


Source: Medical Expenditure Panel Survey–Insurance Component, 2003–2013.

Premium Increases Outpace Growth in Family Income

Despite the recent slowdown in growth, insurance premiums have risen faster than median incomes for the under-65 population. While average family premiums have climbed by 73 percent since 2003, median family income has risen by 16 percent over the same time period (data not shown). As a result, total premiums (including the employer and employee shares) relative to income have continued to climb for middle-income working-age families. In 2013, average annual family premiums were 23 percent of median family income, up from 15 percent in 2003 and 21 percent in 2010 (Exhibit 4). There are similar trends in premiums for single coverage: average premiums have climbed 60 percent over the decade, while median income for single-person households has grown by only 11 percent.

Exhibit 4. Average Health Insurance Premiums as Percent of Median Income, 2003, 2010, and 2013



Analysis of 2003–2014 Current Population Surveys by Sherry Glied and Claudia Solis-Roman of New York University for The Commonwealth Fund.
Source: Medical Expenditure Panel Survey–Insurance Component, 2003–2013.

Annual Employee Premium Contributions Have Grown, But Rate of Growth Has Slowed in Recent Years

In an effort to reduce their costs of providing health insurance, employers over the past decade have increased the amount that workers contribute to their premiums and to their health care, through higher deductibles and copayments. As a result, employees are paying more for plans that provide less financial protection.

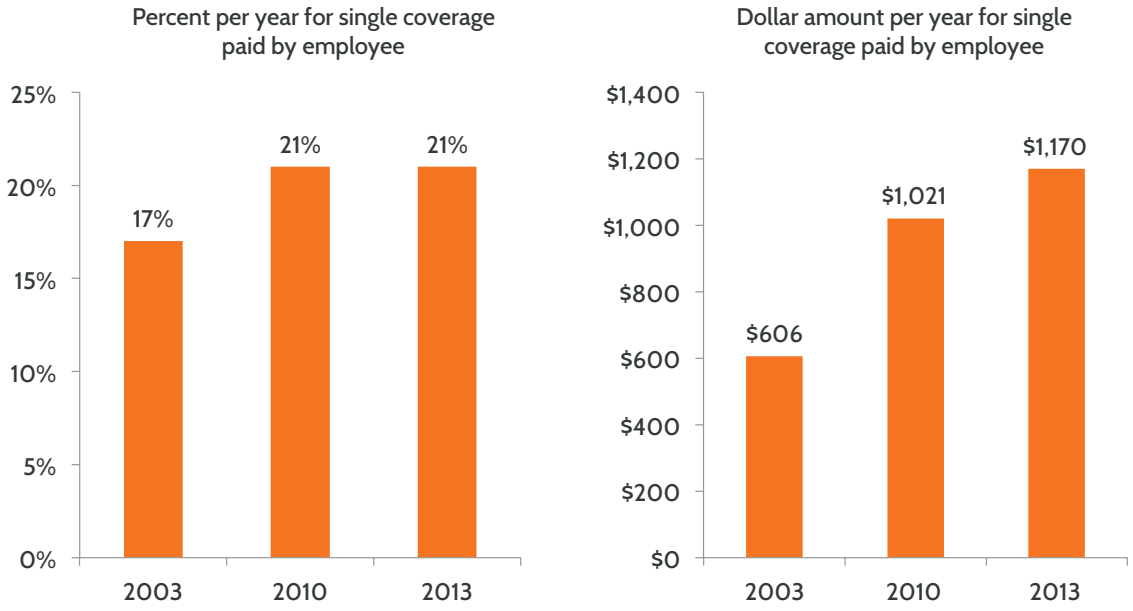
In 2013, U.S. employees contributed 21 percent of the total premium for employee-only coverage. This is unchanged from 2010, but an increase from 17 percent in 2003 (Exhibit 5). However, because premiums have grown, the actual amount that workers contribute toward premiums has climbed from $606 in 2003 to $1,021 in 2010 to $1,170 in 2013, or an increase of 93 percent over the decade.

And, because income growth has been slow throughout the decade, employees are paying more for their share of premiums. In 2013 and 2010, average premium contributions for single coverage in employer plans were 4 percent of median income, compared with 2 percent in 2003 (data not shown).

Deductibles More Than Doubled from 2003 to 2013, But Rate of Growth Moderated in Recent Years

Although workers are paying more for their health insurance, their premiums are buying less financial protection, partly because more plans include deductibles and the size of those deductibles has spiked dramatically.[4] In 2013, 81 percent of workers were enrolled in a health plan with a deductible, up from 78 percent in 2010 and just over half (52%) in 2003 (Exhibit 6).

Exhibit 5. Total Employee Contribution to Single-Person Employer-Sponsored Health Insurance Premiums, 2003, 2010, and 2013



Source: Medical Expenditure Panel Survey–Insurance Component, 2003–2013.

Exhibit 6. Private Health Insurance Deductibles: State Averages by Firm Size and Household Type, 2003, 2010, and 2013

	2003	2010	2013	Average annual growth 2003–10	2010–13
Share of enrollees who have a deductible on their employer-sponsored plan	52%	78%	81%		
Average, all firms					
Single-person plan	$518	$1,025	$1,273	10.2%	7.5%
Family plan	$1,079	$1,975	$2,491	9.0%	8.0%
Average, small firms					
Single-person plan	$703	$1,447	$1,695	10.9%	5.4%
Family plan	$1,575	$2,857	$3,761	8.9%	9.6%
Average, large firms					
Single-person plan	$452	$917	$1,169	10.6%	8.4%
Family plan	$969	$1,827	$2,307	9.5%	8.1%

Note: Small firms = firms with fewer than 50 employees; large firms = firms with 50 or more employees.
Source: Medical Expenditure Panel Survey–Insurance Component, 2003–2013.

Over the same time period, average deductibles for a single person in employer health plans more than doubled, climbing from $518 in 2003 to $1,025 in 2010 and $1,273 by 2013. The average annual rate of growth in deductibles exceeded 10 percent from 2003 to 2010, but has slowed to 7.5 percent since 2010. However, as with employee contributions to premiums, incomes have lagged growth in deductibles such that deductibles are consuming an ever-growing share of worker income. In 2013, average deductibles for a single-person plan were 5 percent of median income, up from 4 percent in 2010 and 2 percent in 2003 (data not shown). This means that by 2013, the combination of

employee premium contributions and deductibles for single coverage amounted to 9 percent of median income, up from 5 percent in 2003.

In 2013, workers in small firms (i.e., those with fewer than 50 employees) faced higher deductibles on average than their peers in larger firms (i.e., those with 50 or more employees): $1,695 vs. $1,169. This difference has narrowed over time as larger employers have increased deductibles more rapidly than have small firms.

DISCUSSION

This analysis confirms recent employer survey data from the Kaiser Family Foundation: a slowdown in the growth of premiums and deductibles in the past few years, notably since the passage of the Affordable Care Act in 2010.[5] This is consistent with prior estimates by Jon Gabel that the early provisions in the law that applied to employer plans, such as the young adult coverage requirement, would have only minor effects on premiums.[6] In addition, recent research suggests that the law's medical loss ratio requirement may have dampened premium growth over the period.[7] The 2017 implementation of the tax on higher-cost employer plans, the so-called "Cadillac tax," is expected to slow premium growth.[8]

The recent moderation in employer premiums is consistent with trends in premiums for plans offered through the Affordable Care Act's marketplaces in 2014 and 2015. In 2014, the first year that plans were available through the marketplaces, premiums on average were significantly below levels projected by the Congressional Budget Office. For 2015, changes in premiums from the prior year were modest for benchmark silver plans, and declined in many states.[9] A number of factors have contributed to this: the law's temporary reinsurance and risk corridor programs that protect insurers from above-average claims cost, insurer competition and an increase in the number of plans offered through the marketplaces in 2015, and robust enrollment with reasonably well-balanced risk pools.[10]

It is not yet clear whether moderate premium growth will continue. The slowdown in employer premium growth reflects a combination of reduced use of services by employees and their families and somewhat slower increases in prices for hospital and other services (Exhibit 7). However, this may change as the economy recovers and returns to more robust

Exhibit 7. Private Insurance 2008–2012: Change in Average Use and Prices

Percent change in use and average price paid per service, by category			
	2009/2010	2010/2011	2011/2012
Hospital (inpatient)			
Use[a]	–2.4%	–1.5%	–2.9%
Average price paid	5.2%	5.6%	5.4%
Outpatient			
Use[a]	–0.7%	1.2%	0.9%
Average price paid	5.9%	4.9%	5.6%
Professional procedures			
Use[a]	–1.4%	0.9%	1.9%
Average price paid	3.0%	2.9%	1.1%
Prescriptions (filled days)[b]			
Use[a]	0.5%	0.1%	0.6%
Average price paid	2.1%	1.6%	3.2%

[a] Per 1,000 insured people younger than age 65 and covered by employer-sponsored insurance.
[b] Includes brand-name drugs and generics. Prescriptions uncategorized as brand-name or generic not included in the data because of low dollar amounts and low utilization.
Source: 2012 Health Care Cost and Utilization Report, Health Care Cost Institute, Sept. 2013.

growth. The Centers for Medicare and Medicaid Services recently projected that the costs of private insurance will return to more rapid growth after five years of historically slow increases.[11]

The Affordable Care Act includes provisions aimed at improving the way health care is delivered and lowering the costs of doing so. These provisions, which apply only to Medicare, include testing alternative ways of paying for health services, as well as new ways of organizing health care providers to enable more coordinated care for patients. The law also helps Medicare to partner with private payers and states to spread these innovations across the country, but it is unclear how widely they will be adopted.

It is also uncertain whether families across the income spectrum will share in savings that may accrue from slower growth in health care costs and premiums. Research has shown that the slower growth in wages during the past decade has been part of a trade-off to preserve health benefits.[12] But while growth in premiums and deductibles has slowed over 2010–2013, median family income, when adjusted for inflation, remains below 2010 levels. Indeed, U.S. families are still trying to recapture lost income from the financial crisis and recession of 2008: real median income is 8 percent lower than it was in 2007. It is unlikely that most families at the middle and lower end of the income distribution are able to detect or feel the premium slowdown in their pocketbooks since they are paying more in premiums and deductibles as a share of their income than ever before.

The challenge to policymakers, researchers, and stakeholders will be to continue to pursue efforts to contain health care cost growth, while ensuring that savings are shared with patients and their families.

METHODOLOGY

The issue brief analyzes national trends in private-sector health insurance premiums, employee premium shares, and deductibles for the under-65 population from 2003 to 2013, based on the Medical Expenditure Panel Survey (MEPS) of private employers in all states. The data on premiums and deductibles come from the annual federal surveys of employers, with representative state samples. We also compare total premiums with median household incomes for the under-65 population. Income data come from the U.S. Census Bureau's Current Population Survey of households. Calculation of premiums as a share of median incomes uses the average total annual cost of private group health insurance premiums for employer-sponsored coverage, including both the employer and employee shares. This analysis updates previous Commonwealth Fund analyses of state health insurance premium and deductible trends.[13] A future issue brief will focus on the state-specific findings.

NOTES

[1] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *How Many Individuals Might Have Marketplace Coverage After the 2015 Open Enrollment Period?* (Washington, D.C.: ASPE, Nov. 10, 2014); and Congressional Budget Office, *The Budget and Economic Outlook: 2014–2024* (Washington, D.C.: CBO, April 2014).

[2] J. R. Gabel, R. D. McDevitt, and R. Lore, "Understanding the Rise in Health Insurance Premiums," *The Commonwealth Fund Blog,* Sept. 30, 2011.

[3] M. Hartman, A. B. Martin, D. Lassman, et al., "National Health Spending in 2013: Growth Slows But Remains in Step with the Overall Economy," *Health Affairs* Web First, Dec. 3, 2014, http://content.healthaffairs.org/content/early/2014/11/25/hlthaff.2014.1107.full?sid=bcc17611-2396-4fb2-ba2e-9c6e417a52ce; M. J. McCue and M. Hall, *The Federal Medical Loss Ratio Rule: Implications for Consumers in Year 2* (New York: The Commonwealth Fund, May 2014).

[4] T. S. Bernard, "High Deductible Health Plans Weigh Down More Employees," *New York Times,* Sept. 1, 2014.

[5] G. Claxton, M. Rae, N. Panchal et al., "Health Benefits In 2012: Moderate Premium Increases for Employer-Sponsored Plans; Young Adults Gained Coverage Under ACA," *Health Affairs Web First,* published online Sept. 2012.

[6] Gabel, McDevitt, and Lore, "Understanding the Rise," 2011.

[7] Hartman et al., *National Health Spending in 2013*, Dec. 3, 2014; McCue and Hall, *Federal Medical Loss Ratio Rule,* 2014.

[8] A. M. Sisko, S. P. Keehan, G. A. Cuckler et al., "National Health Expenditure Projections, 2013–23: Faster Growth Expected with Expanding Coverage and Improving Economy," *Health Affairs,* Oct. 2014 33(10):1841–50.

[9] U.S. Department of Health and Human Services, *Health Plan Choice and Premiums in the 2015 Marketplace,* ASPE Research Brief, Dec. 4, 2014; L. Skopec and R. Kronick, *Market Competition Works: Silver Premiums in the 2014 Individual Market Are Substantially Lower than Expected,* U.S. Department of Health and Human Services, ASPE Issue Brief, updated Aug. 2013; C. Cox, L. Levitt, G. Claxton et al., *Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces* (Menlo Park, Calif.: Kaiser Family Foundation, Nov. 2014); and J. Lerche, A. Bly, and J. Kingsdale, *Premium Changes in FFM States: Why Consumers Should Carefully Review Their Options for 2015* (Clearwater, Fla.: Wakely Consulting Group, Nov. 2014).

[10] Lerche, Bly, and Kingsdale, *Premium Changes in FFM States,* 2014; S. R. Collins, *Young Adult Participation In the Health Insurance Marketplaces: Just How Important Is It?* (New York: The Commonwealth Fund, Feb. 2014); S. R. Collins, P. W. Rasmussen, and M. M. Doty, *Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period* (New York: The Commonwealth Fund, July 2014).

[11] Sisko, Keehan, Cuckler et al., "National Health Expenditure Projections," 2014.

[12] D. Blumenthal and D. Squires, "Do Health Care Costs Fuel Economic Inequality in the United States?" *The Commonwealth Fund Blog*, Sept. 9, 2014; K. Baicker and A. Chandra, *The Labor Market Effects of Rising Health Insurance Premiums,* National Bureau of Economic Research Working Paper No. 11160 (Cambridge, Mass.: NBER, Feb. 2005); D. Goldman, N. Sood, and A. Leibowitz, *Wage and Benefit Changes in Response to Rising Health Insurance Costs,* National Bureau of Economic Research Working Paper No. 11063 (Cambridge, Mass.: NBER, Jan. 2005); N. Sood, A. Ghosh, and J. J. Escarce, "Employer-Sponsored Insurance, Health Care Cost Growth, and the Economic Performance of U.S. Industries," *Health Services Research,* Oct. 2009 44(5 Pt. 1):1449–64.

[13] C. Schoen, J. A. Lippa, S. R. Collins, and D. C. Radley, *State Trends in Premiums and Deductibles, 2003–2011: Eroding Protection and Rising Costs Underscore the Need for Action* (New York: The Commonwealth Fund, Dec. 2012); C. Schoen, A.-K. Fryer, S. R. Collins, and D. C. Radley, *State Trends in Premiums and Deductibles, 2003–2010: The Need for Action to Address Rising Costs* (New York: The Commonwealth Fund, Nov. 2011); C. Schoen, K. Stremikis, S. K. H. How, and S. R. Collins, *State Trends in Premiums and Deductibles, 2003–2009: How Building on the Affordable Care Act Will Help Stem the Tide of Rising Costs and Eroding Benefits* (New York: The Commonwealth Fund, Dec. 2010); and C. Schoen, J. L. Nicholson, and S. D. Rustgi, *Paying the Price: How Health Insurance Premiums Are Eating Up Middle-Class Incomes—State Health Insurance Premium Trends and the Potential of National Reform* (New York: The Commonwealth Fund, Aug. 2009).

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ACA Implementation—Monitoring and Tracking

Public Education, Outreach and Application Assistance

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Stan Dorn
The Urban Institute

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URBAN INSTITUTE
HEALTH POLICY CENTER

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. This report is one of a series of papers focusing on particular implementation issues in case study states. 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. For more information about the Robert Wood Johnson Foundation's work on coverage, visit **www.rwjf.org/coverage**.

EXECUTIVE SUMMARY

This analysis of public education and application assistance during the 2014 open enrollment period is based primarily on

- results from the Health Reform Monitoring Survey (HRMS), a quarterly national survey of the nonelderly population; and
- interviews in 24 states with diverse informants—policy-makers, consumer advocacy groups, navigators, application assisters, insurance brokers and agents—conducted by researchers from the Urban Institute and other organizations during January through May 2014.

In addition to describing general trends involving public education and application assistance, this analysis describes promising practices used by particular states as well as suggestions offered by stakeholders and researchers. Such practices and suggestions focus primarily on state-based and partnership marketplaces, but many could also apply to federally facilitated marketplaces.

Public education and outreach

Most of the public, including 66 percent of adults in the income range qualifying for subsidized coverage in health insurance marketplaces, reported hearing "some" or "a lot" about such marketplaces, according to HRMS results from June 2014. Given mass media's difficulty delivering complex messages, the ACA's many complications, and uninsured consumers' unfamiliarity with basic health insurance concepts, many state-level informants supported limiting public education to simple messages that drove consumers to seek more specific information.

However, according to HRMS data, 61 percent of surveyed adults who remained uninsured in June 2014 had heard "little" or "nothing" about subsidies to help pay for marketplace coverage. According to many informants, subsidy recipients in most states were typically unaware of tax reconciliation and thus did not know that they may lose anticipated tax refunds in 2015 or even incur tax liabilities if they turn out to have received excess subsidies because they underestimated their 2014 income. Informants throughout the country reported that educating consumers about the ACA's rules, including available subsidies, was made much more difficult by a longstanding and constant barrage of anti-ACA misinformation.

Certain states found certain messages particularly effective in generating enrollment:

- According to Minnesota informants, the most powerful message for the uninsured was, "If you don't sign up by March 31, you can't get coverage until next January."

- In both Minnesota and Colorado, advertisements in which real people—not actors—told how they had been helped by the ACA persuaded many to explore their options and then enroll.
- Many states reported that the legal requirement to obtain coverage was motivating for numerous consumers, who wanted to see themselves as law-abiding citizens.
- Kentucky's motto—"Kentucky Proud"—illustrates a branding strategy that distinguished the state's marketplace from national reform, lessening the effects of anti-ACA misinformation.

Other promising state strategies involved information dissemination methods. For example,

- Washington let navigators modify state-developed materials to fit local conditions.
- Kentucky and Minnesota used "grass-tops" education strategies focusing on clergy and other community leaders, who were equipped to educate their grassroots constituents.
- Many states used trusted community groups to reach immigrant networks.
- California law requires the provision of information about coverage options to people undergoing life transitions that often cause insurance loss, such as divorce or layoff.
- Maryland's exchange is calling all subsidy beneficiaries to educate them about changes to benchmark premiums in 2015 and encourage them to consider all coverage options.

Other education and outreach suggestions for marketplaces include the following:

- Prioritize public education about subsidies for marketplace coverage.
- Reduce tax reconciliation risks by
  - directing education at both subsidy beneficiaries and tax preparers, explaining reconciliation risks and describing possible steps to ameliorate them;
  - in the future, giving subsidy beneficiaries the option to have the marketplace automatically adjust subsidy amounts midyear to prevent later reconciliation problems; and
  - increasing the role played by played by tax preparers in helping consumers (1) apply for subsidies and (2) adjust them during the year if household circumstances change.

Application assistance

Informants in numerous states agreed that one-on-one application assistance was often essential to helping the uninsured enroll. Such assistance could address the ACA's complexity, many uninsured consumers' lack of knowledge about the basics of health insurance, and the procedural glitches sometimes experienced on marketplace Web sites.

HRMS data are consistent with the importance of application assistance. In June 2014, among previously uninsured adults, 54 percent of those enrolling through the marketplace used application assistance, compared with 32 percent of those who did not enroll.[1]

Despite evidence of the importance of application assistance, many states experienced problems:

- Many states underestimated the average time required to complete applications and so underfunded application assistance, despite federal grants available to cover all marketplace administrative costs through the end of 2014. This was a particularly serious problem with immigrant communities, which present uniquely complex eligibility and enrollment issues.
- In most states, informants reported major problems with the quality of assister training.
- In some states, officials concerned about consumer privacy barred assisters and brokers from accessing consumer records unless consumers were physically present. This limited the help that assisters and brokers could provide, including through proactive problem solving on behalf of clients. This prevented some eligible uninsured from receiving coverage, according to informants.

Several states used effective approaches to structuring application assistance:

- Minnesota secured consumer groups' buy-in by engaging them in shaping application assistance programs before the start of open enrollment, holding weekly statewide conference calls with application assisters during open enrollment, and selecting from among consumer groups a special liaison to application assisters.
- Several states contracted with undercapitalized community-based groups in underserved communities, using up-front payments that allowed the hiring of dedicated staff.

- Connecticut employed a regional structure through which one community-based group, dubbed a "Navigator," managed a small number of others, called "assisters." Navigators regularly convened assisters, used Web tools to coordinate work, identified poor performers, and helped them improve.
- In Minnesota, highly expert community groups were funded to train less knowledgeable groups and then provide technical assistance.
- The District of Columbia brought together tax preparers and application assisters at a single site, letting consumers get tax refunds and enroll in health coverage at the same time.
- D.C. also created smart phone apps for marketplace enrollment.
- Several states created portals letting certified assisters and brokers access client eligibility records directly, without going through marketplace Web sites. This increased their capacity for proactively intervening to solve enrollment problems. If such portals could also be used to streamline initial applications, finite assister resources would help more consumers.

Particular application assistance practices that proved helpful included

- providing "what to bring to your appointment" materials that let consumers enroll in one session;
- training assisters by using specific scenarios to illustrate general principles;
- using nontraditional settings for enrollment, such as libraries, bus stops, bars and laundromats;
- convening three to six consumers at computers at a single site and having assisters circulate among them, providing help as consumers worked on their applications; and
- ensuring that application assisters go out into the community rather than stay in their offices.

Many informants emphasized the importance of continuing or increasing the total level of application assistance consumers receive. Such assistance could help the remaining uninsured enroll, teach the newly insured how to use coverage, and prevent disenrollment by helping subsidy beneficiaries make renewal decisions that avoid unexpected premium increases in 2015.

Brokers and agents

Brokers and agents—collectively termed "producers" by many in the insurance industry—generated significant marketplace enrollment in some but not all states. Marketplace officials in nearly every state acknowledged producers' importance by the end of 2014 open enrollment. Most producers nevertheless felt generally unappreciated, according to informants from most states.

Compensation was often a problem. Producers are typically paid by the insurers with which their clients enroll. Helping people with Medicaid enrollment thus generates no income. Also, whether a client enrolls with a carrier inside or outside the marketplace, the producer's compensation is the same. Much more work is typically required for marketplace enrollment, however, because it may include an application for insurance affordability programs. Producers thus usually make more money enrolling individuals outside rather than inside the marketplace.

Several states have achieved particular success with producers:

- In Kentucky, where more than 40 percent of qualified health plan (QHP) enrollees used producers, one notable promising practice targets employers that do not sponsor health insurance for their workers. Producers worked with such employers to help their employees enroll in individual coverage through the marketplace. This achieved win-win results: employers earned good will from their workers, producers gained significant income, and many uninsured received coverage. To illustrate this approach's tremendous potential if replicated widely, 46 percent of all QHP-eligible uninsured adults in the U.S. work for companies that do not offer health insurance, as do 23 percent of all uninsured Medicaid-eligible adults.
- Both Kentucky and Connecticut achieved significant producer engagement. Kentucky did this by partnering with producers to design marketplace systems. Connecticut retained a broker to act as liaison. The liaison recruited producers to sell marketplace coverage and acted as a go-between to help the marketplace address producers' emerging concerns.
- In Connecticut, consumer groups uniformly reported positive experiences with producers. The marketplace encouraged assisters and producers to build strong local partnerships, including referral relationships that took advantage of complementary areas of expertise.

Many informants recommended having Medicaid programs reimburse producers for successfully enrolling clients in Medicaid, a practice long used by many child health programs. However, it is not clear that Medicaid would pay enough to change producer behavior. Some recommended

increasing funding when producers enroll consumers in marketplace plans rather than insurance outside the marketplace, given the higher cost to producers of the former enrollment.

Marketplace call centers

Call centers played a central role as the first contact point for consumers seeking information about marketplace coverage. States greatly underestimated consumer demand for call center services and so allotted insufficient resources. Callers thus experienced long delays early during 2014 open enrollment. Inadequate training also led to many consumers receiving incorrect information. Most states then ramped up funding, greatly cutting delays. Answer quality likewise improved during open enrollment, though it remained inconsistent in some states, according to informants.

A number of states used various practices to strengthen call center operations:

- While most states developed special lines for application assisters and producers, some states structured these lines to guarantee short waits and strong expertise.
- In Minnesota, call center staff developed specialized areas of knowledge. Calls requiring such expertise were routed to the relevant staff.
- Most states kept call centers open on weekends, on holidays and in the evening.
- Colorado's call center (1) made outbound calls to finish incomplete applications and (2) retained brokers on staff to help callers with plan choice.
- To solve information technology (IT) issues in D.C, video conferencing linked call centers to marketplace IT staff.

As a final suggestion, federal officials could provide states with models of effective call center operation, including information about best practices.

INTRODUCTION

This paper focuses on efforts to educate eligible consumers about individual coverage offered through health insurance marketplaces, Medicaid and the Children's Health Insurance Program (CHIP) under the Patient Protection and Affordable Care Act (ACA) and to help them enroll. It relies mainly on two sources of information:

- *Health Reform Monitoring Survey (HRMS) results from 2013 and the first two quarters of 2014*. HRMS is a quarterly national survey of the nonelderly population conducted to analyze the ACA's effects.[2]
- *State-level interviews* with a broad range of stakeholders, including policy-makers, consumer advocacy groups, navigators, application assisters, insurance brokers and agents, and some health plans and providers. Informants were recruited from 24 states, including 22 that used state-based marketplaces (SBMs) or marketplaces administered jointly by the federal and state governments, as well as two states with federally facilitated marketplaces (FFMs). Using semistructured protocols, such interviews were conducted primarily between January and May 2014 by researchers from the Urban Institute and, in some cases, Georgetown University's Health Policy Institute or the Institute for Health Policy Solutions. To distinguish the stakeholders interviewed through this process from survey respondents interviewed for the HRMS, such stakeholders are termed "informants" throughout this report.

This paper covers two general topics: (1) public education outreach; and (2) application assistance provided by a broad range of sources, including navigators, in-person assisters, marketplace call centers, and insurance agents and brokers. For each topic, the paper discusses overall trends observed in multiple states, promising practices implemented by particular states, and suggestions from stakeholders or researchers. This report seeks to help state-level policy-makers and stakeholders refine their approaches to the 2015 open enrollment period while laying the groundwork for long-term efforts to increase participation by eligible consumers. The promising practices and suggestions described here arose in the context of state-based and partnership marketplaces, but some may be helpful for FFMs as well.

PUBLIC EDUCATION AND OUTREACH

Overall trends

Almost without exception, informants reported that most of the general public learned that marketplaces were a place to get health coverage and that health coverage was important. Beyond those key facts, initial public education efforts rarely communicated much. That minimalist approach made sense to many informants. In their view, the ACA is complex, mass media cannot effectively deliver fine-grained information, and the target audience includes many people with little knowledge of such basic health insurance concepts as deductibles, premiums and copayments. Accordingly, many informants felt that a reasonable goal of initial mass media campaigns was simply to encourage the uninsured to go to the right place to obtain detailed information about their coverage options.

Our informants' conclusions are consistent with several HRMS findings. Illustrating the underlying lack of knowledge about key health insurance concepts, one study examined adults in June and July of 2013, just three months before the start of open enrollment. Those who were somewhat or very confident in their understanding of five basic health insurance financial terms, such as "premiums," "copayments," and "coinsurance," included just 35.9 percent of uninsured whites, 14.8 percent of uninsured Hispanics, and 25.7 percent of uninsured adults who were neither white nor Hispanic.[3]

One year later, in June 2014, HRMS data showed that most of the affected public had learned about marketplaces, even while missing other key information about the ACA (figure 1):

- Two-thirds (67 percent) of all nonelderly adults heard "some" or "a lot" about health insurance exchanges. They included 66 percent of adults in the income range for marketplace subsidies (138 to 400 percent of FPL), 57 percent of Hispanics, 66 percent of formerly uninsured adults receiving insurance by June 2014, and 58 percent of formerly uninsured adults who remained without coverage.[4]
- Unfortunately, less than half (48 percent) of all nonelderly adults had heard some or a lot about subsidies available to help pay premiums and out-of-pocket costs in marketplaces. The proportion of uninsured adults learning about subsidies included 48 percent of those with incomes between 138 and 400 percent of FPL, 41 percent of Hispanics, 51 percent of formerly uninsured adults receiving insurance by June 2014, and—most troubling—just 38 percent of formerly uninsured adults who remained uninsured in June 2014.

Even though most of the target audience learned about marketplaces, public education and outreach efforts faced challenges. One of these challenges is illustrated by figure 1: namely, the failure of most remaining uninsured adults to learn about available subsidies that can make marketplace coverage more affordable. Among those uninsured, 61 percent reported hearing "little" or "nothing" about subsidies. In addition, a longstanding and ongoing barrage of anti-ACA misinformation led to confusion that was hard to overcome, according to informants in multiple states. Moreover, consumers were often confused about the difference between federal and state Web sites. In many states, SBM messages were not tailored to meet the needs of low-income consumers and those who qualified for Medicaid. This was problematic, since the marketplace was typically the main portal through which consumers could enroll into expanded Medicaid. Some SBMs undermined their own credibility through ad campaigns of unrelenting cheerfulness that contrasted with newspaper headlines decrying dysfunctional rollouts.

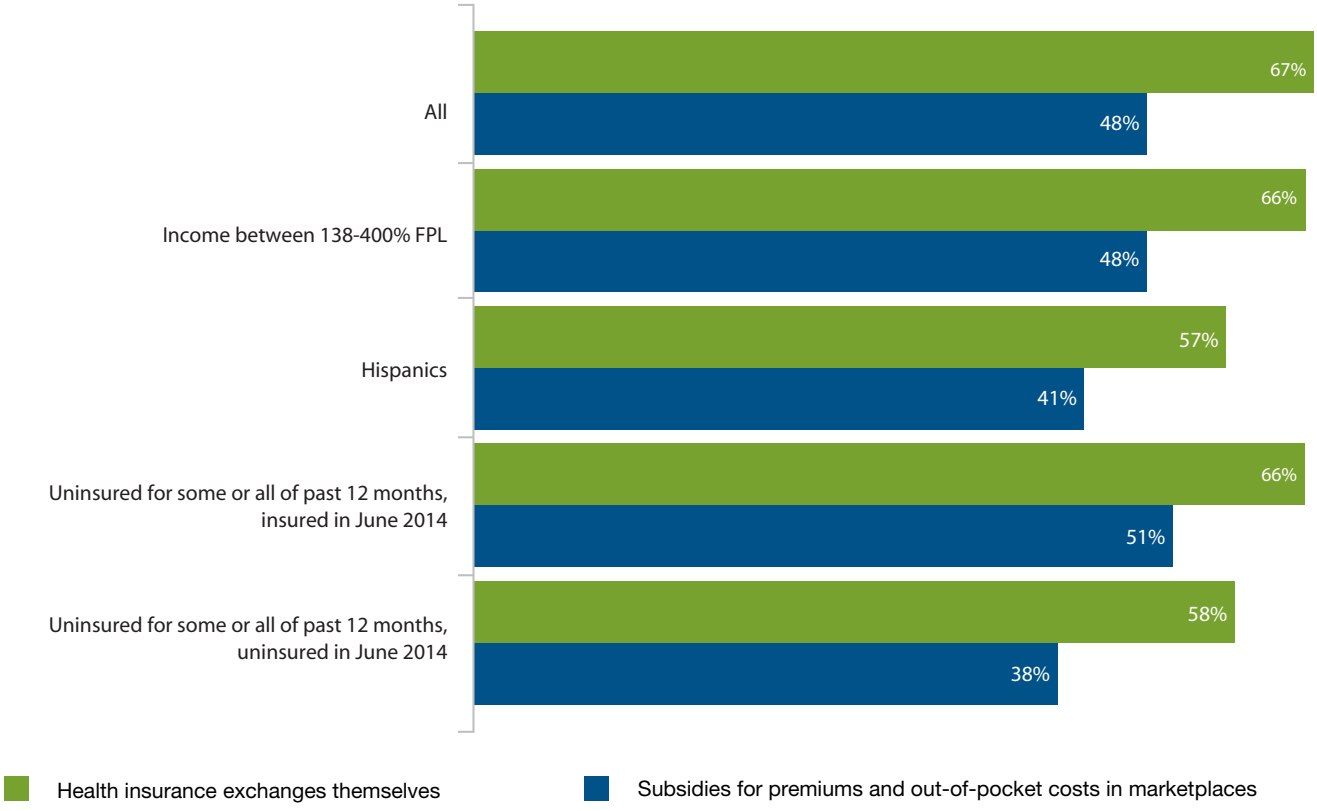
One particular issue on which most consumers received little information was tax reconciliation for beneficiaries of advance payment of premium tax credits (APTCs). In most states, informants reported that, unless APTC beneficiaries were helped by brokers or unusually sophisticated application assisters, they rarely learned that when they file their 2014 federal income tax returns, they may lose anticipated tax refunds or even incur tax liabilities if they turn out to have received excess APTCs because they underestimated their future 2014 income.

Promising practices

In several states, particular messages galvanized sign-ups, often late during open enrollment:

- Minnesota informants reported that, during February and March, the most powerfully motivating message for most uninsured was, "If you don't sign up by March 31, you can't get coverage until next January."
- In both Minnesota and Colorado, advertisements in which real people—not actors—told how they had been helped by the ACA persuaded many to explore their options and then enroll.
- Many states reported that the legal requirement to obtain coverage was motivating for numerous consumers, who wanted to see themselves as law-abiding citizens.
- Kentucky's motto—"Kentucky Proud"—illustrates a branding strategy that distinguished the state's

Figure 1. **Percentage of adults under age 65 who had heard some or a lot about certain topics related to health insurance exchanges (June 2014)**



Source: HRMS June 2014.

marketplace from national reform, lessening the effects of anti-ACA misinformation. In August 2014, Kentucky residents disapproved of the Affordable Care Act by a ratio of 51 percent to 34 percent, while approving of the state marketplace, KyNect, by a 34 percent to 27 percent margin.[5]

Other promising state strategies involved information dissemination methods, rather than messages:

- *Washington State allowed regional tailoring to fit local conditions*, which informants found quite effective. A bus tour with highly publicized local events was well received. Notably, the state gave local navigators materials that they could modify to fit local circumstances and perspectives, which varied considerably in different parts of the state.
- *Kentucky and Minnesota used "grass-tops" education strategies.* These efforts focused on clergy and other community leaders, who in turn educated their grassroots constituents.
- *Many states used trusted community groups to reach immigrant and Native American communities*, which can be hard to reach effectively through other methods.
- *California law requires situational targeting during life transitions*. For example, people going through divorce, job loss or other life changes that often cause coverage losses must be given information about available health insurance options.
- *Maryland is proactively communicating with subsidy beneficiaries to educate them about changes to benchmark premiums and to encourage them to consider coverage options when the new open enrollment period begins.* In that state, as in many others, many consumers who enrolled in the two cheapest silver plans in 2014 will find them to be the third and fourth least expensive silver plans in 2015. If they had not received information from the state and had simply stayed with their 2014 plans, many such consumers

may have been surprised by increased premium charges in January 2015. Some could have dropped coverage, particularly if they did not have serious health problems. This would have increased the number of uninsured and worsened risk pools.[6]

Suggestions

Some informants suggested innovative methods of communicating with QHP enrollees about renewals, including text messages from marketplaces and authorizing brokers and QHPs, which have a financial stake in continued enrollment, to contact enrollees and encourage renewal. Other informants noted the importance of communicating simply, without jargon, and educating consumers about the value of health insurance and basic health insurance concepts. Further approaches are possible on two core issues: educating uninsured consumers about subsidies and addressing tax reconciliation risks for APTC recipients.

Given the widespread lack of knowledge about subsidies among the remaining uninsured, public education efforts should provide information about subsidies—for example, as part of "real people" stories like those used in Minnesota and Colorado, described above.

To address tax reconciliation issues, several strategies are possible:

- Marketplaces can educate APTC beneficiaries about tax reconciliation and the importance of reporting changed circumstances.
- Other public education efforts can focus on tax preparers. Many tax preparers are worried about the burden of ACA-related tax filings this coming tax season, including time required for tax reconciliation. Making correct initial APTC claims and then adjusting such claims during the calendar year to fit changing circumstances reduces the need for year-end reconciliation. If an APTC beneficiary stays with the same preparer from one year to the next, measures to prevent reconciliation problems can save the tax preparer time and money during tax season.
- APTC beneficiaries and tax preparers can be encouraged to work together, both at the end of 2014 and the start of 2015,[7] to consider tax planning strategies that could lessen or prevent potential tax reconciliation problems.
- Going forward, marketplaces could give APTC beneficiaries the option to reduce reconciliation risks. For example, beneficiaries could be given the choice to authorize the marketplace to quickly lower the consumer's APTC whenever data matches or consumer information suggest that such reductions are needed to prevent adverse reconciliation effects. The marketplace would provide notice of such reductions, which the consumer could revoke. But unless they are revoked, the reductions would go into effect, avoiding delays that could otherwise worsen reconciliation problems.[8]
- More generally, increasing tax preparers' role in claiming and adjusting APTCs would likely have a positive impact on reconciliation. Such preparers can help overcome consumer fears about tax reconciliation, thus encouraging eligible, uninsured consumers to use APTCs to purchase coverage. Moreover, tax preparer involvement could increase the accuracy of APTC claims, lessening the total level of adverse reconciliation outcomes.

APPLICATION ASSISTANCE

Application assisters—including navigators and in-person assisters (IPAs), brokers and agents, and marketplace call centers—played a crucial role in helping consumers successfully enroll, as explored below.

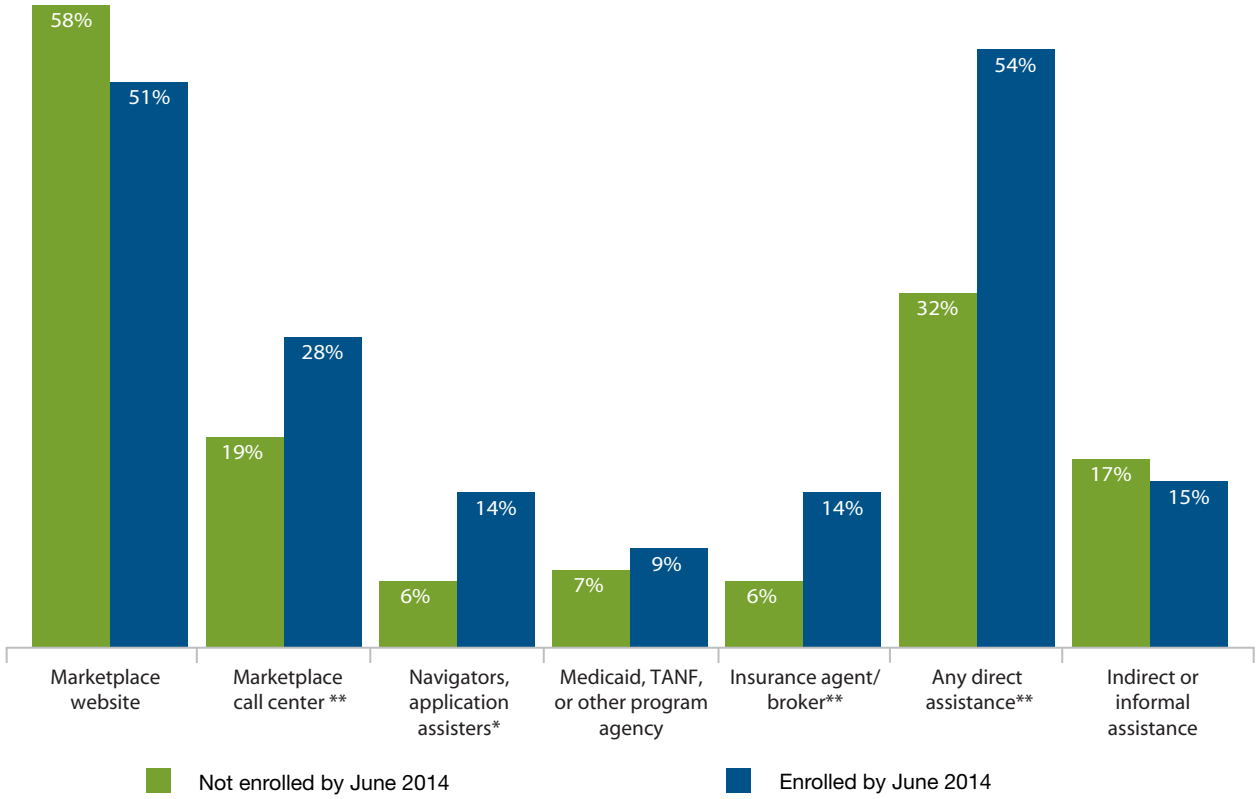
Navigators, IPAs and general application assistance

Overall trends

One-on-one application assistance made an important difference helping consumers enroll. Such assistance helped overcome the ACA's complexity and many consumers' lack of knowledge about the basics of health insurance as well as the procedural glitches often created by marketplace Web sites. Many consumers with health problems had the grim determination to persist and enroll, even without help. But for the healthy uninsured, application assistance was often essential to participation, according to many informants. Assistance thus played a role increasing coverage while lowering average risk levels within individual markets.

HRMS data are consistent with our informants' reports about the importance of individual assistance. In June 2014, among adults who had been uninsured for some or all of the previous 12 months, those who enrolled into coverage offered through a marketplace were much more likely to receive some form of individual assistance than those who did not enroll. The following differences were statistically significant (figure 2):

Figure 2. **Sources of information and assistance used by previously uninsured adults who visited a marketplace, by enrollment through the marketplace (June 2014)**



Source: HRMS June 2014. Notes: Consumers included in this figure were uninsured during some or all of the 12 months before the survey and attempted to enroll in coverage through the marketplace. In distinguishing between the percentage of those who enrolled and those who did not enroll in coverage available through the marketplace, "/**" indicates statistically significant differences at the .05 and .01 levels, respectively, using two-tailed tests. Other differences shown in this figure were not statistically significant. Results are limited to adults under age 65. The category listed here as "navigators, application assisters" also includes certified application counselors and community health workers. "Any direct assistance" includes call centers; navigators and assisters; Medicaid, TANF, or other program agencies; and agents and brokers.*

- Among adults who enrolled through a marketplace, 28 percent used a call center. Only 19 percent of those who did not enroll used a call center.
- Use of community-based application assisters and private insurance agents and brokers also had a strong association with successful enrollment through the marketplace. Among previously uninsured adults who enrolled into marketplace coverage, 14 percent received help from assisters and 14 percent were helped by brokers. For previously uninsured adults who did not enroll, just 6 percent were aided by assisters and 6 percent by brokers.
- Altogether, 54 percent of the formerly uninsured who enrolled through a marketplace used some form of direct assistance. Among those who did not enroll, only 32 percent obtained such assistance.

In contrast, adults who did not enroll in marketplace coverage were more likely to obtain information from Web sites or to receive indirect or informal assistance than were those who became insured, although those differences were not statistically significant.[9]

Certain groups were particularly helped by in-person assistance. Our informants found this to be the case for many Latinos, for people with complex health conditions or eligibility situations, people uncomfortable with computers, and people without easy internet access.

Many states did not fully meet consumers' need for assistance, resulting in waiting lists for help, particularly during high-demand periods. Most states underestimated the time applications would require and thus provided insufficient resources for application assisters, despite the availability of federal grants to cover administrative costs

through the end of 2014 in SBMs and many partnership exchanges.[10] Some states did not pay assisters in advance, instead reserving payment until after successful enrollment; this prevented many undercapitalized community groups from serving their uninsured constituents. Informants in some states reported that the assistance network had particularly large gaps in rural areas.

Immigrant communities faced unique issues requiring high per capita application assistance resources that few states provided. With many immigrants, assisters must address anxieties about whether health coverage applications will be used against them or family members in immigration enforcement. Many immigrants could not have their identity verified via the Federal Data Services Hub, forcing assisters to use more time-consuming methods. Documenting immigration status can require much more effort than verifying citizenship. Moreover, assisters must often take the time needed to explain the ACA's complex rules involving immigration.[11]

Several problems affected *both* for-profit brokers and nonprofit application assisters:

- Informants in nearly every state described training for both groups as substantially deficient.
- In some states, concerns about consumer privacy led officials to bar assisters and brokers from accessing consumer records unless consumers were physically present. Consumers having trouble enrolling online could not get help by calling their assisters. And when enrollment obstacles arose after applications were filed, consumers often did not understand what was happening. Assisters and brokers frequently did not learn about such obstacles, could not diagnose them, and could not proactively intervene to solve them. As a result, some eligible consumers needlessly remained uninsured, according to informants.

Promising practices

Several states used effective structural approaches to provide assistance, including the following examples:

- Minnesota pursued a multifaceted strategy of engaging consumer groups that resulted in application assisters being deeply committed to enrollment efforts. That commitment helped Minnesota cut uninsurance by 40.6 percent during the 2014 open enrollment period, despite a deeply flawed rollout.[12]
    - The strategy began with engaging consumer groups to shape application assistance programs long before open enrollment began.
    - During open enrollment, weekly conference calls between assisters and the exchange let assisters flag emerging problems as officials noted new developments and announced future changes.
    - The marketplace appointed a special liaison to application assisters, selected from that community, who spotted issues and brokered solutions.
- In many states, contracting with established and trusted community-based groups, including up-front payments that allowed the hiring of dedicated staff, proved effective in furnishing immigrants and other underserved populations with education and application assistance.
- Connecticut employed a regional structure, through which one navigator managed a small number of assisters. Multiple community organizations within a relatively homogenous region employed both navigators and assisters. Navigators convened assisters regularly, used Web tools to coordinate work, identified poor performers, and helped them improve.[13]
- In Minnesota, highly expert community groups, some with legal services backgrounds, were funded to train less expert assisters. Afterwards, when consumers came to the latter groups with hard questions, the trainers were available to provide backup technical assistance.

Particular application practices also proved helpful:

- In several states, assisters or marketplaces developed "what to bring to your appointment" materials that let enrollment occur in one session rather than two.
- Informants in several states reported that scenario-based training of assisters was effective. Such training went beyond stating abstract rules and principles to include specific fact patterns that illustrated the application of those principles.
- Successful nontraditional settings for outreach and enrollment included libraries in Minnesota and bus stops, bars and laundromats in the District of Columbia (D.C.).
- D.C.'s other innovative strategies included a smart phone app for enrollment and combining tax preparers and application assisters at a single site, so consumers could get tax refunds and enroll in health coverage at the same time.
- A number of assisters found it useful to convene three to six consumers at a single site's computers, circulating among them to troubleshoot as consumers completed applications.
- Many successful assisters reported that achieving high enrollment numbers requires going out into the community, investing significant time in advance to

ensure successful events. In their view, assisters who wait in their offices for clients to call will enroll many fewer people.

Suggestions

Most informants strongly emphasized the importance, during the 2015 open enrollment period and beyond, of continuing or increasing the overall level of application assistance that consumers receive. Assisters are needed both to enroll the remaining uninsured and to help new QHP members learn how to use their coverage effectively. Application assistance could also help address an emerging challenge involving renewal. In counties where the QHP benchmark plan changes or the benchmark premium rises, subsidized consumers who keep the same plan or do not change their APTC amount may find themselves surprised to pay more for coverage starting in January 2015. Some could become uninsured as a result. During the 2015 open enrollment period, application assisters could help APTC beneficiaries change QHPs or APTC amounts to prevent unexpected and potentially unaffordable increases in family premium payments.

In states that limited assisters' and brokers' ability to access client records, informants recommended modifying those limits. Given consent, assisters and brokers could access client records, co-log in to help clients on the phone, receive notice that lets them help solve problems (like nonpayment of premiums or missing verification), track the status of their clients' applications, and diagnose and overcome enrollment obstacles proactively.

Several states even created special portals through which certified assisters and licensed brokers could directly access their clients' eligibility records after applications began.[14] This let assisters and brokers obtain information about their clients without going through consumer-facing marketplace Web sites, which can be glitchy and contain consumer-friendly features that often slow access by experts. Such special portals for certified assisters and llicensed brokers could potentially be used to help them submit new applications as well, letting application resources reach more consumers by streamlining the enrollment process when assisters are involved.

Brokers and agents

Overall trends

Insurance brokers and agents (often called "producers" within the insurance industry)[15] played different roles in different states. In states like California, Connecticut and Kentucky they enrolled many consumers in QHPs. In other states, their contribution to QHP enrollment was modest. In most states, marketplace staff came to acknowledge the value of producers by the end of open enrollment, even where that understanding was not evident at the start. Despite that acknowledgment, broker informants almost universally reported that they did not feel particularly valued by marketplaces, including through communications to the public.

Compensation was typically a problem:

- Private insurers pay producers by commission, as a percentage of premiums. However, if a broker spends time enrolling a client in Medicaid, the broker goes unpaid.
- Whether a client enrolls with a carrier inside or outside the marketplace, the producer's gross compensation is the same. Much more work can be required for marketplace enrollment, however, because it typically includes an application for insurance affordability programs. As a result, brokers can make more money on a consumer who enrolls in a private plan outside the marketplace.
- Brokers in numerous states reported that marketplace glitches made it hard to attribute particular clients to particular brokers, thus preventing payment.

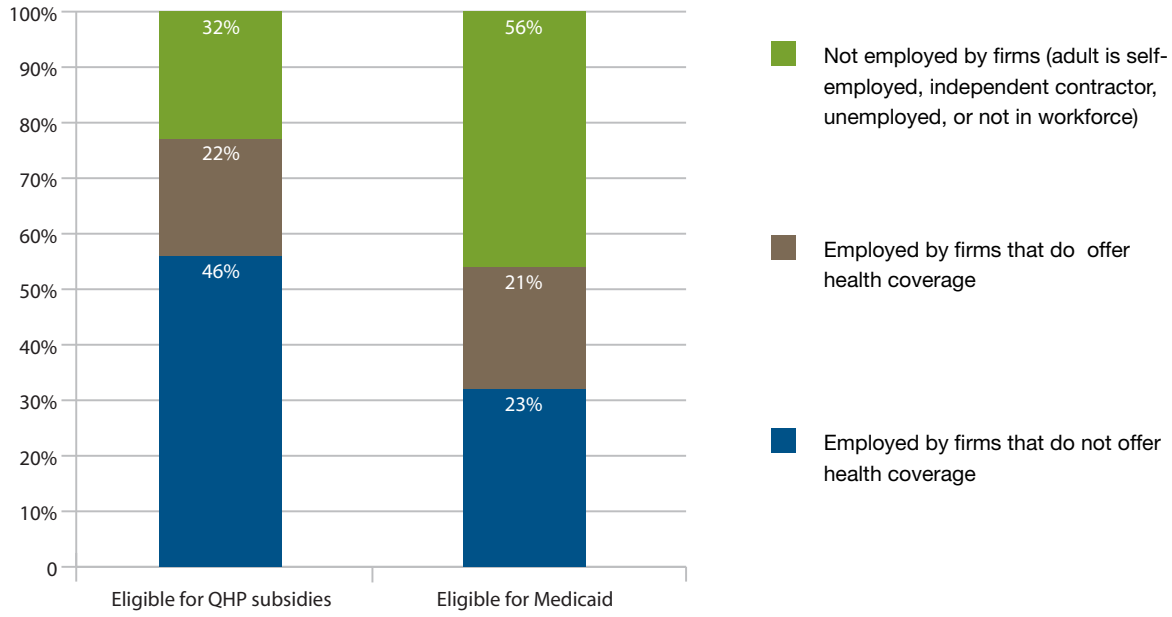
Promising practices

Kentucky, where more than 40 percent of QHP enrollees used brokers and agents, took several important steps to facilitate their effective involvement:

- Some brokers worked with firms not offering employer-sponsored insurance (ESI) and helped their workers enroll in individual coverage, including through the marketplace. According to broker informants, this arrangement led to win-win results: employers were pleased at the impact on worker morale, brokers earned significant income, and many uninsured not offered ESI received coverage. If replicated more broadly, this practice offers great potential for reaching many uninsured who qualify for insurance affordability programs. Among all uninsured adults who qualify for QHP subsidies nationally, 46 percent work for firms that do not offer ESI; such firms also employ 23 percent of Medicaid-eligible uninsured adults (figure 3).
- Kentucky officials partnered with brokers in designing marketplace mechanisms. This promoted buy-in and resulted in systems that brokers found effective.

Connecticut likewise achieved significant success with brokers:

Figure 3. **Uninsured adults who qualify for insurance affordability programs, by employers that do and do not offer health coverage**



Source: Urban Institute Health Insurance Policy Simulation Model 2014. Note: Figure displays, among adults uninsured before ACA implementation, the percentage who would qualify for insurance affordability programs in effect during 2014, taking into account state decisions on Medicaid implementation either implemented or federally approved by September 2014.

- The marketplace hired a liaison to the broker community, who was himself a broker. The liaison in turn recruited other brokers, who played a major role in QHP enrollment.
- Consumer groups in Connecticut uniformly reported positive experiences with brokers, despite their considerable initial skepticism. With marketplace encouragement, application assisters and brokers developed strong local partnerships, building referral relationships that took advantage of complementary areas of expertise.

Suggestions

Many informants recommended having Medicaid programs reimburse brokers for successfully enrolling their clients in Medicaid programs—a practice commonly used by child health programs for more than a decade. However, some experts suggested that the amounts Medicaid programs provided in the past (such as one-time payments of $50 to $75 per enrollee) would not be enough to motivate most brokers. Some suggested that brokers and agents should receive higher payments for enrolling clients in QHPs than insurance outside the marketplace, given the additional work required to complete marketplace applications.

Marketplace call centers

Overall trends

Call centers played a central role as the initial contact point for consumers seeking information about marketplace coverage and enrollment, including those having difficulty submitting their own applications. In almost every state, consumers encountered serious problems with call centers early during the 2014 open enrollment period. Most states

greatly underestimated consumer demand for call center services and so allotted insufficient resources. As a result, callers experienced long delays. Inadequate training also led to consumers often receiving inconsistent or incorrect information, according to informants from almost every state.

In nearly all states, informants reported significant improvement after the initial months of open enrollment, as added resources greatly cut wait times. In some states, however, consumers still encountered significant delays during periods of peak demand. Answer quality likewise improved, though it remained inconsistent in a number of states, according to informants.

In some states, callers who did not speak English had difficulty finding staff who knew the right answers to their questions and were linguistically and culturally competent.

In many states, initial respondents had limited authority to take action. As a result, they promised to call back, but often failed to do so.

In some states, having multiple call centers rather than a single place to call obstructed enrollment. One center might handle Medicaid, while another helped with marketplace questions. Some states had separate federal and state call centers. Either way, consumers calling the wrong center were told to call the other number. Rather than being seamlessly transferred, such consumers would need to make a second call, perhaps experiencing two waits before speaking to someone at the right call center.

Promising practices

Most states developed special lines available to application assisters and brokers, which leveraged marketplace resources efficiently. In states that structured these lines to guarantee short waits and strong expertise, many consumers received help as call centers efficiently provided necessary information to their assisters and brokers.

Other effective strategies included the following:

- In Minnesota, call center staff developed specialized areas of expertise. Calls requiring such expertise were routed to the relevant staff.
- Most states kept call centers open on weekends, on holidays and in the evening, particularly during periods of peak demand.
- Colorado's call center made outbound calls that finished the enrollment process for consumers whose applications remained incomplete.
- Colorado also kept brokers on staff at the call center to answer questions about plan choice.
- D.C. used video conferencing to link call centers to marketplace information technology staff, so call centers could address the consumer's technological issues during calls.

Suggestions

Informants suggested that states with multiple call centers could provide for "warm hand-offs." Consumers who called the wrong center would not be required to redial. Instead, they would be transferred to the other center, after the first call center provided the second with a brief summary of the call, thus expediting subsequent call handling.

A second suggestion is far broader—that is, federal officials could provide states with call center information, including best practices and model approaches. Using existing literature as a starting point,[16] such information could include elements like the following:

- *Model request-for-proposal documents for vendor contracting.* These documents would be accompanied by analyses of strategies for dealing with state competitive procurement laws so that high-performing vendors can retain contracts in preference to new bidders who offer lower prices based on an inadequate understanding of performance needs.
- *Rubrics for analyzing trade-offs* associated with (1) operating call centers in-house, rather than through outsourcing and (2) having multiple states share call-center operations.
- *Guidance on staffing structures*, including policies for routing complex problems to the most knowledgeable staff and ensuring linguistic/cultural competence.
- *Protocols* for training, performance measurement, performance reporting, quality assurance, contact management and ticket tracking, and knowledge management.
- *Recommendations about careful design of metrics to avoid untoward incentives*. For example, some informants reported that call centers were rewarded for hanging up on callers, because that could count as resolving a call promptly.

- *Plans for addressing variable demand*, avoiding the need to recruit and retrain inexperienced staff before each peak periods. Options include
  - retaining core staff during slow periods, during which they provide consumer assistance (e.g., helping consumers use coverage appropriately, helping with renewals, helping consumers enroll during special enrollment periods) and
  - developing an ongoing cadre of largely seasonal skilled workers, perhaps using the tax preparation industry as a model.

CONCLUSION

During the ACA's first open enrollment period, many states achieved notable progress educating uninsured consumers and providing them with help enrolling in coverage. These factors contributed to a nationwide reduction in the number of uninsured. However, important work remains unfinished. Further public education and intensive application assistance will be required for the number of uninsured to continue declining during the 2015 open enrollment period and beyond. In structuring such efforts, states and the federal marketplace can learn from and build on the efforts that have taken place thus far.

ENDNOTES

1. These consumers reported having been uninsured during some or all of the 12 months before the survey. Direct application assistance included assistance provided by call centers; navigators, application assisters, certified application counselors or community health workers; Medicaid or other program agencies such as Temporary Assistance for Needy Families or the Supplemental Nutrition Assistance Program; and insurance agents, brokers and insurance companies.
2. Funding for the core HRMS is provided by the Robert Wood Johnson Foundation, the Ford Foundation and the Urban Institute. For further information, see http://hrms.urban.org/.
3. Long SK and Goin D. *Large Racial and Ethnic Differences in Health Insurance Literacy Signal Need for Targeted Education and Outreach*. Washington, D.C.: Urban Institute, 2014, http://hrms.urban.org/briefs/literacy-by-race.html. Estimates presented here are regression-adjusted. The covariates included in the regression analysis are age, self-reported health status, gender, marital status, education, family income, homeownership and urban or rural status.
4. By "formerly uninsured adults," the text refers to adults who reported lacking insurance for some or all of the previous 12 months.
5. Public Policy Polling. *McConnell Leading in Re-Election Bid*, August 12, 2014, http://www.publicpolicypolling.com/main/2014/08/mcconnell-leading-in-re-election-bid.html.
6. The state's communication effort was prompted both by the desire to help consumers make informed decisions about 2015 coverage and by the marketplace's need to obtain information about subsidy eligibility directly from consumers. The latter resulted from serious problems with the state's information technology (IT) contractors. The marketplace IT system used in 2014 could not communicate with the system planned for use in 2015.
7. Most tax planning strategies to reduce adjusted gross income (AGI), thereby lessening potential tax reconciliation liabilities, require action during the year in which APTCs are received. However, contributions to Individual Retirement Accounts (IRAs) that are made during the following year but before the April 15 due date for federal income tax returns can be taken as deductions to AGI. This applies even in the case of an IRA that is first established at the time such contributions are made. Internal Revenue Service. *Publication 590 (2013), Individual Retirement Arrangements (IRAs)*, http://www.irs.gov/publications/p590/index.html.
8. See, for example, 45 CFR §§155.330(c)(1), (e)(2)(i)(B), (e)(2)(ii)(A) and (C), (f)(1)(i), (f)(2) and (3); see also 45 CFR § 155.315 (f)(2)(ii), cross-referenced in §155.330.
9. Previous analysis of HRMS data from June 2014 found, among those who were uninsured during some or all of the previous 12 months, a similar relationship between receipt of direct enrollment assistance and having coverage of any sort as of June 2014. See table 1 in Zuckerman S, Karpman M, Blavin F and Shartzer A. *Navigating the Marketplace: How Uninsured Adults Have Been Looking for Coverage*, Washington, D.C.: Urban Institute, 2014, http://hrms.urban.org/briefs/navigating-the-marketplace.html.
10. Such grants were available to partnership marketplaces where states assumed enrollment responsibilities.
11. For example, young people whose deportation had been suspended are forbidden from enrolling in marketplaces and are not penalized if they are uninsured; immigrants with pending, unresolved asylum applications can enroll in marketplaces and be penalized if they are uninsured; and undocumented parents of U.S. citizen children are not penalized if they are uninsured themselves, but are penalized if their children are uninsured.
12. Sonier J, Lukanen E and Blewett L. *Early Impacts of the Affordable Care Act on Health Insurance Coverage in Minnesota*. Minneapolis: State Health Access Data Assistance Center, 2014, http://shadac.org/MinnesotaCoverageReport.
13. This structure did not work well when navigators were asked to manage large numbers of assisters that served heterogeneous communities.
14. Pollitz K, Tolbert J and Ma R. *Survey of Health Insurance Marketplace Assister Programs: A First Look at Consumer Assistance under the Affordable Care Act*, Washington, D.C.: Kaiser Family Foundation, 2014.
15. Technically, an agent sells for a particular insurance company at which he or she is appointed. A broker sells for multiple insurers at which he or she is appointed. The term "producer" covers both groups.
16. Many useful documents come from efforts to inform the effective and efficient operation of telephone hotlines to help smokers stop using tobacco (so-called quitlines). See, for example, Reynolds P. "Call Center Metrics: Best Practices in Performance Measurement and Management to Maximize Quitline Efficiency and Quality." *NAQC Issue Paper*, Phoenix: North American Quitline Consortium, 2010, http://c.ymcdn.com/sites/www.naquitline.org/resource/resmgr/issue_papers/callcentermetricspaperbestpr.pdf and Reynolds P. "Call Center Metrics: Fundamentals of Call Center Staffing and Technologies," *NAQC Issue Paper*, Phoenix: North American Quitline Consortium, 2010, http://c.ymcdn.com/sites/www.naquitline.org/resource/resmgr/issue_papers/callcentermetricspaperstaffi.pdf. See also Holman D, Batt R and Holtgrewe U. *The Global Call Center Report: International Perspectives on Management and Employment*. Ithaca, NY: Cornell University, Global Call Center Research Network, 2007, http://www.ilr.cornell.edu/globalcallcenter/upload/gcc-intl-rept-us-version.pdf.

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THE KAISER COMMISSION ON
Medicaid and the Uninsured

REPORT

The Uninsured: A Primer

December 2014

KEY FACTS ABOUT HEALTH INSURANCE AND THE UNINSURED IN AMERICA

Prepared by:

Melissa Majerol, Vann Newkirk, and Rachel Garfield
Kaiser Family Foundation

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Introduction

Millions of people in the United States go without health insurance each year. Because nearly all of the elderly are insured by Medicare, most uninsured Americans are nonelderly (below age 65). A majority of the nonelderly receive their health insurance as a job benefit, but not everyone has access to or can afford this type of coverage. Together, Medicaid and the Children's Health Insurance Program (CHIP) fill in gaps in the availability of coverage for millions of low-income people, in particular, children. However, Medicaid eligibility for adults remains limited in some states, and few people can afford to purchase coverage on their own without financial assistance.

The gaps in our health insurance system affect people of all ages, races and ethnicities, and income levels; however, those with the lowest incomes face the greatest risk of being uninsured. Being uninsured affects people's access to needed medical care and their financial security. The access barriers facing uninsured people mean they are less likely to receive preventive care, are more likely to be hospitalized for conditions that could have been prevented, and are more likely to die in the hospital than those with insurance. The financial impact also can be severe. Uninsured families struggle financially to meet basic needs, and medical bills can quickly lead to medical debt.

A major goal of the Affordable Care Act (ACA), which was passed in 2010, was to expand coverage to millions of Americans who were previously uninsured. The ACA has filled existing gaps in coverage by providing for an expansion of Medicaid for adults with incomes at or below 138% of poverty in states that chose to expand, building on employer-based coverage, and providing premium tax credits to make private insurance more affordable for many with incomes between 100-400% of poverty.[1] Most of the major coverage provisions of the ACA went into effect in 2014, and millions of people have enrolled in coverage under the law.

The Uninsured: A Primer is structured in two parts. The first presents basic information about health coverage and the uninsured population leading up to and after the implementation of the Affordable Care Act, who the uninsured are and why they do not have health coverage. The second presents information on the impact lack of insurance can have on health outcomes and personal finances, and provides an understanding of the difference health insurance makes in people's lives.

What Was Happening to Insurance Coverage Leading up to the ACA?

The coverage provisions in the ACA built on a piecemeal insurance system that left many without affordable coverage. Historically, most people in the United States obtained health insurance coverage as a fringe benefit through a job. However, many people were left out of the employer-based system, and the availability of employer-based coverage has eroded over time. Some people purchased coverage on their own, but this type of coverage could be costly or difficult to obtain. Medicaid and the Children's Health Insurance Program (CHIP) have expanded over time to cover more low-income individuals (primarily children) and have been an important source of coverage during economic downturns. However, the gaps in our private and public health insurance systems still left over 41 million nonelderly people in the country—15% of those under age 65—without health coverage in 2013.[2]

EMPLOYER- SPONSORED HEALTH INSURANCE COVERAGE

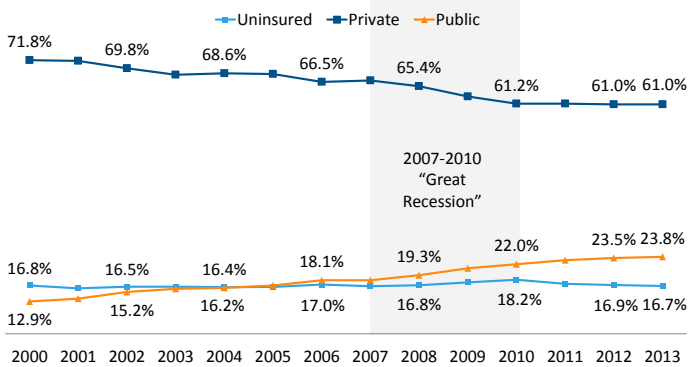
Historically, the majority of employers offered group health insurance policies to their employees and to their employees' families. In 2013, 57% of firms offered coverage to their employees, and most firms offering coverage also covered spouses and dependents.[3] When offered coverage, roughly 80% of employees participated in their employer's health plan.[4] Among individuals with employer-sponsored coverage, half were covered by their own employer and half were covered as an employee's dependent.[5]

Not all workers had access to employer-sponsored insurance. In 2013, two-thirds of uninsured adult workers were not offered health insurance by their employer.[6] Some worked in firms that did not offer coverage: small firms were less likely to offer coverage than large firms, and firms with more low-wage workers were less likely to offer coverage than firms with fewer low-wage workers.[7] Some people worked in firms that covered some employees but were not themselves eligible for coverage, often because they had not worked for their employer for a sufficient amount of time or because they had not worked enough hours.

Cost was a barrier to expanding employer-sponsored coverage. Cost was the most common reason employers cited for not offering health coverage.[8] In addition, when offered coverage, many low- and moderate-income workers found their share of the cost unaffordable, especially for non-working dependents.[9] In 2013, annual employer-sponsored premiums averaged $5,884 for individual coverage and $16,351 for family coverage, with workers contributing $380 per month for family coverage and $83 for individual coverage.[10] Total family premiums, as well as the employee's share of those premiums rose by over 70% in the ten years leading up to 2013.

Figure 1

Coverage Changes Among the Nonelderly, 2000-2013



SOURCE: KCMU Analysis of 2001-2014 National Health Interview Surveys

The availability of employer-sponsored coverage has eroded over time, and declines in employer coverage accelerated during the economic downturn. The share of the nonelderly population with employer-sponsored coverage has

declined steadily since 2000 even during years when the economy was strong and growth in health insurance premiums was slowing.[11] However, during the Great Recession, there was a substantial decline in employer coverage (Figure 1). Because health coverage is linked to employment, when people lose their jobs they frequently lose coverage. As unemployment spiked between 2007 and 2010, the uninsured rate for adults increased, resulting in 5.8 million more nonelderly adults without coverage.[12] As the economy began to recover starting in 2011, employer-sponsored coverage stabilized, and the uninsured rate did as well. However, rates of employer coverage in 2013 were still below pre-recession levels.

Non- Group Health Insurance Coverage

Very few people were covered by non-group health insurance policies prior to the ACA. Private policies directly purchased in the non-group or individual market (i.e., outside of employer-sponsored benefits) covered only 5% of people under age 65 in 2013.[13]

In the past, non-group insurance premiums could be more expensive for the enrollee than group plans purchased by employers. Though, on average, non-group insurance premiums were lower than those for employer-sponsored coverage, enrollees paid 100% of the cost because they could not share that premium expense with an employer. Nationwide, the average monthly premium per person in the non-group market in 2013 was $236, with substantial variation by state.[14] In addition, deductibles and other cost sharing in non-group plans were often higher than in employer-sponsored coverage.

Obtaining coverage in the individual market could be difficult, particularly for those who were older or had had health problems. Historically, premiums in the non-group market could vary by age or health status, and people with health problems or at risk for health problems could be charged high rates, offered only limited coverage, or denied coverage altogether. In 2013, 41% of adults who previously tried to purchase non-group insurance said that the policy offered to them was too expensive to purchase, and nearly 6% said that no insurance company would sell them a policy at any price.[15] Those who were in fair or poor health were twice as likely to be denied.

Public Health Insurance Coverage

In the past, Medicaid and CHIP provided coverage to some, but not all, nonelderly low-income individuals and people with disabilities. In 2013, Medicaid and CHIP covered just under a fifth (19%) of the nonelderly population by primarily covering four main categories of low-income individuals: children, their parents, pregnant women, and individuals with disabilities.

Medicaid and CHIP were and continue to be particularly important sources of coverage for children. Even before the ACA, federal law required state Medicaid programs to cover school age children up to 100% of the poverty level (133% for preschool children), and states had expanded coverage for children in families with slightly higher incomes through the Children's Health Insurance Program (CHIP). As a result, Medicaid and CHIP remain the largest source of health insurance for children in the U.S., covering 78% of poor children and over half (56%) of near-poor children in 2013. Still, as of 2011, over half (53%) of uninsured children were eligible for Medicaid or CHIP but not enrolled.[16] Some families may not have been aware of the availability of the programs or their eligibility. For others, burdensome enrollment and renewal requirements may have posed major obstacles to participation, despite major improvements made over the past decade.

In contrast to coverage for children, the role of Medicaid for nonelderly adults was more limited prior to the ACA. In the past, state Medicaid programs were only required to cover parents below states' 1996 welfare eligibility levels (often below 50% of the federal poverty level). Most states had much lower income eligibility for parents than for children. As of January 2013, a total of 33 states limited parent eligibility for Medicaid to less than the federal poverty level, including 16 states that limited eligibility to parents earning less than 50% of the federal poverty level.[17] In addition, although Medicaid covered some parents and low-income individuals with disabilities, most adults without dependent children—regardless of how poor—have traditionally been ineligible for Medicaid. As of January 2013, just nine states (including the District of Columbia) provided Medicaid or Medicaid-comparable coverage to non-disabled adults without dependent children.[18] As a result of limited eligibility, over a third (35%) of poor parents and 38% of poor adults without children were uninsured in 2013.[19]

Increases in Medicaid and CHIP enrollment helped to offset declines in private coverage during the recent economic downturn and slow recovery, particularly for children. During the recent economic recession and slow recovery (2007-2012), the share of children who were uninsured actually declined slightly despite a decrease in the share of children with employer-sponsored coverage. As parents lost employment and related health coverage, incomes dropped and more children became eligible for Medicaid or CHIP. The uninsured rate among children continued to decline during the recovery that began in 2010. In comparison, because Medicaid eligibility for adults was more limited than for children, public coverage did not offset the recession-related decline in employer-sponsored coverage and uninsured rates increased considerably among non-elderly adults.

The Uninsured

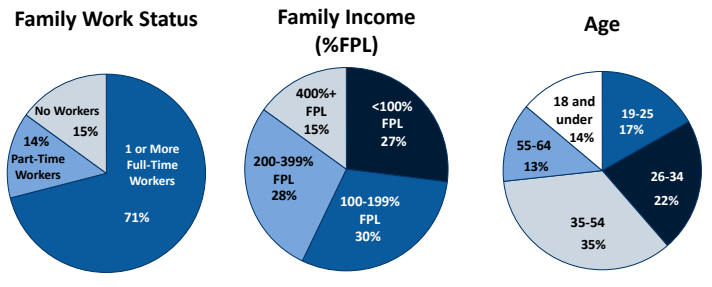
The historical gaps in the insurance system left many without an affordable source of coverage. In 2013, 41.3 million nonelderly people in the U.S. lacked health insurance.[20] The main reason that people gave for being uninsured is that they could not afford coverage.[21]

Adults were more likely to be uninsured than children. In 2013, adults made up 71% of the nonelderly population but 86% of people without health coverage (Figure 2). This pattern reflects historical exclusions or restrictions on public coverage for adults.

The vast majority of uninsured people were in low- or moderate-income families (Figure 2). Individuals below poverty are at the highest risk of being uninsured, and this group comprised 27% of the uninsured population in 2013 (the poverty level for a family of three in 2013 was $19,530[22]). In total, 85% of uninsured people were in low- or moderate-income families, meaning they were below 400% of poverty.

Figure 2

Characteristics of the Nonelderly Uninsured, 2013



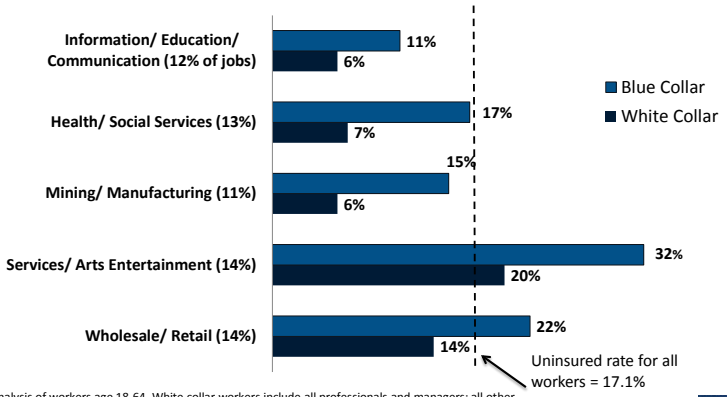
Total = 41.3 Million Uninsured

The federal poverty level was $19,530 for a family of three in 2013. Data may not total 100% due to rounding.
SOURCE: Kaiser Family Foundation analysis of the 2014 ASEC Supplement to the CPS.

Most of the uninsured were in working families but did not have access to or could not afford employer-sponsored coverage. In 2013, more than three-quarters of the uninsured population was in working families, with 71% in families with one or more full-time workers and 14% in families with part-time workers (Figure 2). Health coverage varied both by industry and by type of occupation. For example, in agriculture, uninsured rates for workers were 37% compared to just 4% in public administration.[23] But even in industries where uninsured rates are lower, the gap in health coverage between blue and white-collar workers is often two-fold or greater (Figure 3). Almost 80% of uninsured workers are in blue-collar jobs.

Figure 3

Uninsured Rates Among Selected Industry Groups, White vs. Blue Collar Jobs, 2013



Analysis of workers age 18-64. White collar workers include all professionals and managers; all other workers classified as blue collar.
SOURCE: Kaiser Family Foundation analysis of the 2014 ASEC Supplement to the CPS

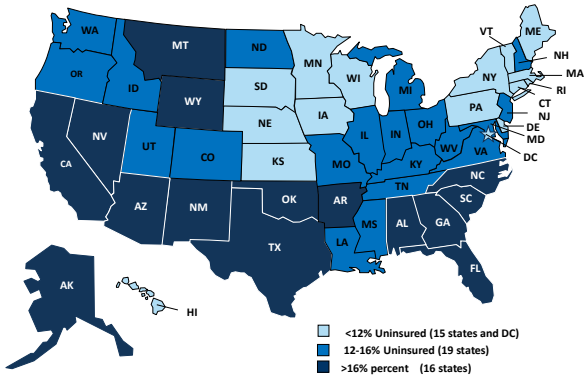
Minorities were much more likely to be uninsured than whites. A quarter (26%) of Hispanics and 17% of Black Americans were uninsured in 2013 compared to 12% of non-Hispanic Whites. Medicaid and CHIP are important sources of coverage for racial and ethnic minorities, covering around one-third of Hispanic and Black Americans.

The majority of uninsured people (80%) were native or naturalized U.S. citizens. Although non-citizens (legal and undocumented) are about three times more likely to be uninsured than citizens, they accounted for only roughly 20% of the uninsured population in 2013.[24] Non-citizens have poor access to employer coverage because they are disproportionately likely to have low wage jobs or work in industries that are less likely to offer insurance.[25,26] Further, in most cases, lawfully present immigrants who have been in the U.S. less than five years are ineligible for Medicaid or CHIP, though some states cover lawfully-residing immigrant children or pregnant women who have been in the United States for less than five years.[27]

Insurance coverage varied by state depending on the income distribution in the state, the nature of employment in the state, and the reach of state Medicaid programs. Insurance market regulations and the availability of jobs with employer-sponsored coverage also influence the insurance rate in each state.[28] Massachusetts has near universal coverage, with an uninsured rate of 4% due in part to health reform legislation enacted in 2006. In 2013, sixteen states had uninsured rates over 16% (Figure 4). Among these are states such as Nevada, Florida, and Texas with uninsured rates that are 20% or higher.

Figure 4

Uninsured Rates Among the Nonelderly by State, 2013



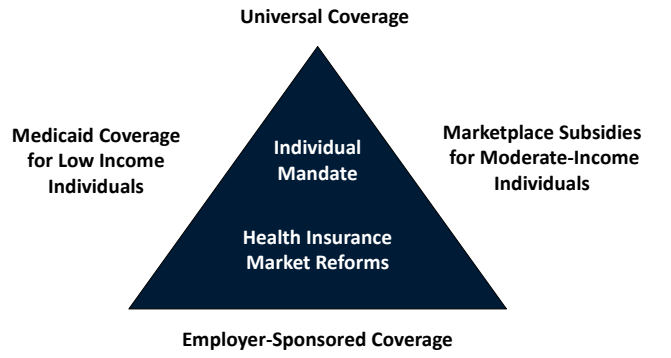
SOURCE: Kaiser Family Foundation analysis of the 2014 ASEC Supplement to the CPS

How Did Health Coverage Change Under The ACA?

A primary goal of the Affordable Care Act of 2010 (ACA) was reducing the number of uninsured people and increasing the affordability and availability of health insurance coverage. The ACA fills in existing gaps in coverage by expanding the Medicaid program, building on employer-based coverage, and providing premium subsidies to make private insurance more affordable (Figure 5). It also introduced new requirements for almost all individuals to obtain insurance coverage or pay a penalty and for insurance companies to be prohibited from denying coverage for any reason. Some of the ACA provisions went into effect as early as 2010 and others will not go into effect until 2018, but the major coverage expansions were implemented January 1, 2014.

Figure 5

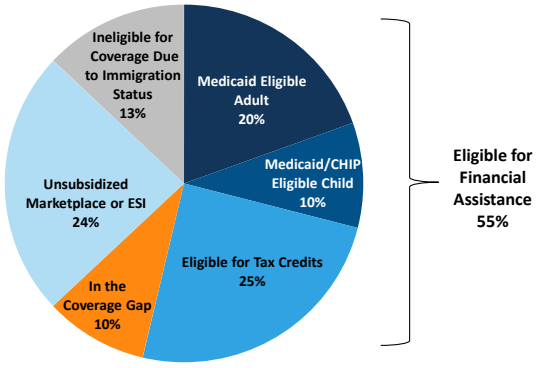
Key Elements of Health Reform



Nationally, over half (55%) of uninsured nonelderly people are eligible for financial assistance to gain coverage through either Medicaid or the Marketplaces (Figure 6). One-quarter (25%) of uninsured individuals are eligible for premium tax credits to help them purchase coverage in the Marketplace, and approximately three in ten uninsured individuals (30%) are eligible for either Medicaid or CHIP.[29] However, not all uninsured individuals are eligible for assistance under the ACA. Some (24%) have incomes above the limit for tax credits or have access to coverage through a job. Others (13%) are ineligible because they are undocumented immigrants. And one in ten fall into a "coverage gap" because they are living below poverty but their state has not expanded Medicaid. Even with the ACA, many will remain uninsured. Nationally, an estimated 29 million people are expected to remain uninsured in 2018.[30]

Figure 6

Eligibility for Coverage as of 2014 Among Currently Uninsured Nonelderly Individuals



Total = 41.3 Million Nonelderly Uninsured

Notes: Those Ineligible for financial assistance includes people with ESI, individuals eligible to purchase unsubsidized Marketplace coverage, and individuals ineligible for coverage due to immigration status. People who have an affordable offer of coverage through their employer or other source of public coverage (such as Medicare or CHAMPUS) are ineligible for tax credits. Unauthorized immigrants are ineligible for either Medicaid/CHIP or Marketplace coverage.
SOURCE: Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels and 2014 Current Population Survey.

Early estimates indicate that the uninsured rate has dropped under the ACA. Data from the first quarter (January through March) of 2014 indicates that the uninsured rate dropped for nonelderly individuals in the first quarter of 2014 by a full percentage point relative to the first quarter of the previous year.[31] Several private polls and surveys also indicate that the uninsured rate has been decreasing since the period prior to ACA open enrollment. While these surveys have different methodologies and often have high error margins that make point estimates unreliable, they are all in agreement that the uninsured rate has dropped in 2014.

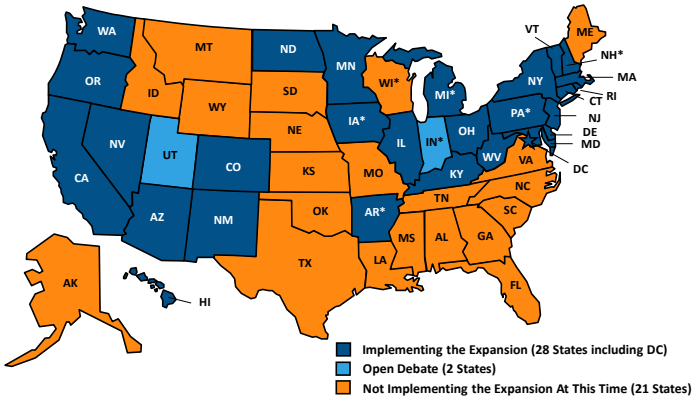
Medicaid Expansion

The ACA extended Medicaid eligibility to many individuals at or below 138% of poverty as of January 2014. The Medicaid expansion eliminates the historical exclusion of adults outside of traditional eligibility groups, such as those without dependent children. Overall, the median eligibility limit for parents in the 28 states (including DC) implementing the Medicaid expansion rose from 106% FPL to 138% FPL for parents and from 0% to 138% FPL for childless adults between January 2013 and July 2014. Overall, eligibility levels increased for parents in 20 states and for childless adults in 26 states (including Pennsylvania, which implemented the Medicaid expansion in August 2014 to begin January 2015).[32] Among the 41.3 million nonelderly uninsured people in 2013, 19% are Medicaid-eligible adults and 9% are children who are eligible for either Medicaid or CHIP.[33]

However, not all states are expanding their Medicaid programs. The 2012 Supreme Court decision effectively made the Medicaid expansion optional for states, and as of November 2014, 23 states have indicated they are not expanding Medicaid (Figure 7).[34] In these states, eligibility for adults is generally still very limited. There is no deadline on state decisions about whether to expand Medicaid, and some states are still debating whether and how to expand their programs.[35]

Figure 7

Current Status of State Medicaid Expansion Decisions



NOTES: State Medicaid expansion decisions are as of August 28, 2014. *AR, IA, MI, and PA have approved Section 1115 waivers for Medicaid expansion. In PA, coverage will go into effect January 1, 2015. NH has implemented the Medicaid expansion and plans to seek a waiver at a later date to operate a premium assistance model. IN has a pending waiver to implement the Medicaid expansion. WI amended its Medicaid state plan and existing Section 1115 waiver to cover adults up to 100% FPL in Medicaid, but did not adopt the Medicaid expansion.
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, as of August 28, 2014: http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

In states that do not expand Medicaid, millions fall into a "coverage gap" of earning too much to qualify for traditional Medicaid coverage but not enough to qualify for other ACA coverage provisions. The median Medicaid eligibility levels for parents in states not implementing the ACA Medicaid expansion is just 50% of poverty, or about $9,400 a year for a family of three, and only one of those states (Wisconsin[36]) covers adults without dependent children. State decisions not to expand their programs will leave nearly four million people without an affordable coverage option.[37]

Even in states that do expand Medicaid, undocumented immigrants and many recent lawfully present immigrants will remain ineligible. Because many uninsured non-citizens are in low-income working families, many are in the income range to qualify for the ACA Medicaid expansion. However, under federal rules, undocumented immigrants may not enroll in Medicaid. Many lawfully present non-citizens who would otherwise be eligible for Medicaid remain subject to a five-year waiting period before they may enroll, and some groups of lawfully present immigrants remain ineligible regardless of their length of time in the country.

Medicaid enrollment has grown under the ACA. Enrollment data show that as of July 2014, Medicaid enrollment has grown by 8 million since the period before open enrollment (which started in October 2013). This growth is an increase of 14% in monthly Medicaid enrollment. Enrollment increases were higher (20%) among states that chose to expand Medicaid eligibility under the ACA. These data suggest that Medicaid

enrollment growth is related to ACA expansions. However, some who are eligible remain unenrolled due to limited awareness about the Medicaid program and their eligibility or other enrollment challenges.

The ACA includes several provisions to streamline Medicaid enrollment. The ACA has addressed past barriers to enrollment by requiring states to implement new streamlined Medicaid application and enrollment processes by 2014. These processes allow individuals to apply online, by phone, by mail, or in-person, use new simplified income standards, and rely on electronic data matches to the greatest extent possible to verify eligibility criteria. To implement these processes, states built new eligibility and enrollment systems and are replacing or making major upgrades to their Medicaid systems, with the federal government providing significant funding for these efforts.[38] Even with these new streamlined enrollment processes in place, effective outreach and enrollment efforts are fundamentally important for translating the new coverage opportunities into increased coverage.

Health Insurance Marketplaces and Non- Group Coverage

The ACA establishes Health Insurance Marketplaces, also known as Marketplaces, where individuals and small employers can purchase insurance as of January 1, 2014. These new Marketplaces are designed to ensure a more level competitive environment for insurers and to provide consumers with information on cost and quality to enable them to choose among plans.

Health Insurance Marketplaces are established in each state, but only some states will run their own Marketplace. Sixteen states and DC have received approval to run their own health insurance Marketplaces, and 27 states have opted to have their Marketplace run by the federal government. The remaining 7 states use a hybrid approach and partner with the federal government to run certain aspects of their Marketplace.[39]

Marketplaces provide insurance options to millions of uninsured individuals. Over 10 million uninsured individuals are estimated to be eligible for tax credits through the Marketplace.[40] Around 7 million additional individuals who were enrolled in other (primarily non-group) coverage prior to the ACA are estimated to be eligible for tax credits through the ACA Marketplace.[41] The Department of Health and Human Services indicated that approximately 8 million people had selected a plan on the Marketplace as of the end of the open enrollment period (which extended through mid-April in most states).[42] A survey of people with private non-group plans after open enrollment found that nearly six in ten (57%) of those with Marketplace coverage were uninsured prior to purchasing their current plan.[43]

Premium tax credits help reduce the cost of non-group coverage premiums purchased in the Marketplace. To help ensure that coverage purchased in these new Marketplaces is affordable, the federal government provides tax credits for individuals and families with incomes between 100% of the federal poverty level (FPL) ($11,670 for an individual or $19,790 for a family of three in 2014) and 400% FPL ($46,680 for an individual or $79,160 for a family of three in 2014).[44] These tax credits limit the cost of the premium to a share of income and are offered on a sliding scale basis. As of the end of the first open enrollment period in April 2014, the vast majority of Marketplace enrollees (85%) qualified for premium subsidies.[45] In addition to the premium tax credits, the federal government also makes available cost-sharing subsidies to reduce what people with incomes between 100% and 250% of poverty will have to pay out-of-pocket to access health services. The cost-sharing subsidies are also available on a sliding scale based on income. The pending

Supreme Court decision in King vs. Burwell could result in the denial of such subsidies to over 13 million Americans residing in states with federally-facilitated marketplaces.[46]

Lawfully present immigrants may receive tax credits for Marketplace coverage; however, undocumented immigrants are prohibited from purchasing such coverage. Lawfully present immigrants are eligible for tax credits on coverage purchased through a Marketplace without a waiting period.[47] In addition, lawfully present immigrants who would be eligible for Medicaid but are in a five-year waiting period are also eligible for tax credits for Marketplace coverage. Undocumented immigrants are not eligible for premium tax credits and are prohibited from purchasing insurance in the Marketplace at full cost.

Some people continue to purchase non-group coverage outside the Marketplace. Among the entire non-group market in Spring 2014, about half of individuals (48%) report having coverage obtained from a state or federal Marketplace, 16% have ACA-compliant coverage purchased outside of the Marketplace, and three in ten (31%) have non-ACA-compliant plans (those that have been in effect since before January 1, 2014).[48] People purchasing coverage outside the Marketplace are not eligible for ACA premium tax credits.

Employer Sponsored Insurance under the ACA

The ACA includes provisions to promote coverage in small firms. Recognizing the challenges that small employers, especially those with low-wage workers, face in providing coverage to their employees, the ACA offers tax credits to small employers with no more than 25 full-time equivalent employees and average annual wages of less than $50,000. To access the tax credit, eligible employers must purchase insurance through the Small Business Health Options Program (or SHOP Marketplace).[49] Employers may take the tax credits for a maximum of two years.[50]

The ACA also extends dependent coverage. As of 2010, young adults may remain on their parents' private plans (including non-group plans or plans through an employer) until age 26. This provision has expanded coverage among young adults, even during a time when private coverage for other age groups was eroding.[51]

Starting next year, large employers will face penalties for not providing affordable coverage to full-time employees. Beginning in 2015**,** employers with 50 or more employees will be assessed a fee up to $2,000 per full-time employee (in excess of 30 employees) if they do not offer affordable coverage and if they have at least one employee who receives a premium tax credit through a Marketplace. To avoid penalties, employers must offer insurance that pays for at least 60% of covered health care expenses, and the employee share of the premium must not exceed 9.5% of family income.[52] This requirement does not apply to employers with fewer than 50 workers. While the employer requirements may help many uninsured individuals with a worker in their family, the majority of uninsured workers work in small firms that are not required to provide insurance coverage.

Some employer-sponsored plans will have new requirements for benefits and cost sharing. As of January 2014, all non-grandfathered plans offered by small employers must include, at a minimum, all of the benefits and consumer protections outlined in the Essential Health Benefits (EHBs) package. These benefits include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services,

laboratory services, preventive and wellness care, chronic disease management, and pediatric dental and vision care.[53] The cost-sharing under an individual plan in 2014 is not to exceed $5,000; the limit for a family is twice the dollar amount set for an individual in any given year. These requirements do not apply to large employers or to firms that self-insure; however, these employers generally offer more comprehensive coverage that already meets these standards.

Some employers will continue to offer grandfathered health plans, which are not required to include the Essential Health Benefits package. Grandfathered plans are those that were established prior to March 23, 2010 and that have not undergone significant changes in cost-sharing, premium contributions or covered benefits. Unlike other plans under the ACA, grandfathered plans are not required to cover Essential Health Benefits or preventive services without cost-sharing; provide for an internal and external appeals process for contesting coverage decisions; or allow direct access to an OB/GYN without referral.[54] Businesses wishing to keep their grandfathered plans may even change insurance carriers if benefits and cost to employees remain largely the same; however, because benefits and costs tend to change from year to year, most plans have already lost grandfather status or will lose it over time.[55]

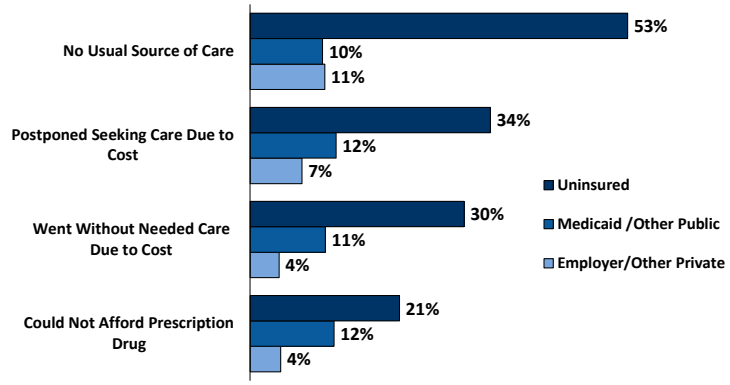
How Does Lack of Insurance Affect Access to Health Care?

Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. Uninsured adults are far more likely than those with insurance to postpone or forgo health care altogether. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected.

Uninsured people are far more likely than those with insurance to report problems getting needed medical care. Thirty percent of adults without coverage say that they went without care in the past year because of its cost compared to 4% of adults with private coverage. Part of the reason for poor access among the uninsured is that most (53%) do not have a regular place to go when they are sick or need medical advice (Figure 8).

Figure 8

Barriers to Health Care Among Nonelderly Adults by Insurance Status, 2013



In past 12 months.
Respondents who said usual source of care was the emergency room were included among those not having a usual source of care.
All differences between uninsured and insurance groups are statistically significant (p<0.05).
SOURCE: Kaiser Family Foundation analysis of 2014 NHIS.

Uninsured people are less likely than those with coverage to receive timely preventive care. Silent health problems, such as hypertension and diabetes, often go undetected without routine check-ups. In 2013, only 1 in 3 uninsured adults (33%) reported a preventive visit with a physician in the last year, compared to 74% of adults with employer coverage and 67% of adults with Medicaid.[56] Uninsured patients are also less likely to receive necessary follow-up screenings after abnormal cancer tests.[57] Consequently, uninsured patients have an increased risk of being diagnosed in later stages of diseases, including cancer, and have higher mortality rates than those with insurance.[58,59,60]

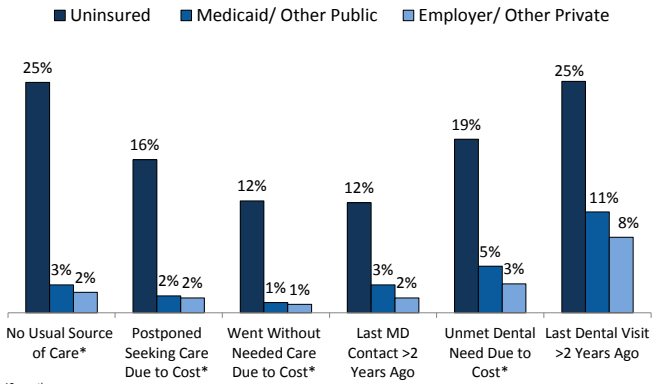
Because of the cost of care, many uninsured people do not obtain the treatments their health care providers recommend for them. In 2010, nearly a quarter of uninsured adults said they did not take a prescribed drug in the past year because they could not afford it.[61] Also, while insured and uninsured people who are injured or newly diagnosed with a chronic condition receive similar plans for follow-up care, people without health coverage are less likely than those with coverage to obtain all the recommended services.[62]

Because people without health coverage are less likely than those with insurance to have regular outpatient care, they are more likely to be hospitalized for avoidable health problems and experience declines in their overall health. When they are hospitalized, uninsured people receive fewer diagnostic and therapeutic services and also have higher mortality rates than those with insurance.[63,64,65,66]

Uninsured children also face problems getting needed care. Uninsured children are significantly more likely to lack a usual source of care, to delay care, or to have unmet medical needs than children with insurance (Figure 9).[67] Further, uninsured children with common childhood illnesses and injuries do not receive the same level of care as others. As a result, they are at higher risk for preventable hospitalizations and for missed diagnoses of serious health conditions.[68] Among children with special needs, those without health insurance have less access to care, including specialist care, than those with insurance.[69]

Figure 9

Children's Access to Care by Health Insurance Status, 2013



* In past 12 months

Questions about dental care were analyzed for children age 2-17. All other questions were analyzed for all children under age 18. MD contact includes other health professionals. Respondents who said usual source of care was the emergency room were included among those not having a usual source of care. All differences between the uninsured and the two insurance groups are statistically significant (p<0.05).

SOURCE: Kaiser Family Foundation analysis of 2014 NHIS data.

Lack of health coverage, even for short periods of time, results in decreased access to care. Research has shown that adults who experienced gaps in their health insurance coverage in the previous year were less likely to have a regular source of care or to be up to date with blood pressure or cholesterol checks than those with continuous coverage.[70] Further, research indicates that children who are uninsured for part of the year have more access problems than those with full-year public or private coverage.[71] One study found that, on a number of different measures, those lacking coverage for 12 continuous months had poorer access to care compared with either those lacking coverage for 6-11 months or 1-5 months, suggesting that even short periods of coverage results in greater access to care than no coverage at all.[72]

Research demonstrates that gaining health insurance improves access to health care considerably and diminishes the adverse effects of having been uninsured. A seminal study of the impact of a Medicaid expansion in Oregon found that uninsured adults who gained Medicaid coverage were more likely to receive care from a hospital or doctor than their counterparts who did not gain coverage.[73] Gaining Medicaid increased the likelihood of having an outpatient visit by approximately 35% and the likelihood prescription drug utilization by 15%. Findings two years out from the expansion showed significant improvements in access, utilization, and self-reported health, and virtual elimination of catastrophic out-of-pocket medical spending among the adults who gained coverage.[74] A separate study of Medicaid expansions for adults in three other states (New York, Maine, and Arizona) found that coverage gains were associated with reduced mortality, as well as improvements in access to care and self-reported health status.[75]

Public hospitals, community clinics, and local providers that serve disadvantaged communities provide a crucial health care safety net for uninsured people; however, the safety net does not close the access gap for the uninsured. Safety net providers, such as public hospitals, community health centers, rural health centers, and local health departments, provide care to many people without health coverage. In addition, nearly all other hospitals and some private, office-based physicians provide some charity care. However, the safety net has limited capacity and geographic reach. In addition, available services may not be comprehensive, and not all uninsured people have access to safety net providers.[76][77]

Increased demand and limited capacity means safety net providers are unable to meet all of the health needs of the uninsured population. The ability of health centers to serve uninsured people has been threatened in recent years due to increased demand and eroding financing[78], and many clinics report that they are at full capacity and cannot accept new patients.[79] Further, increasing financial pressures and changing physician practice patterns have contributed to a decline in charity care provided by physicians.[80]

The ACA made a large investment in community health centers (CHCs), which provide a primary care safety-net for millions of uninsured people. However, not all underserved communities have CHCs, and, especially in states not expanding Medicaid, health centers may not have sufficient resources to serve the uninsured population. To help meet the increasing demand for health care as coverage expands, the ACA established a five-year $11 billion dedicated trust fund to provide support for additional CHCs and expanded capacity in existing ones. In addition, the ACA Medicaid expansion was expected to generate increased patient revenues for CHCs in all states as low-income uninsured individuals, including both current and new CHC patients, gained coverage under the program.[81] The trust fund, which augments annual federal appropriations for CHCs, has fueled substantial growth in health centers and their patient capacity and enabled CHCs to provide more comprehensive primary care services.[82] However, in states not currently implementing the Medicaid expansion, millions of uninsured adults who could qualify for Medicaid remain uninsured, and by extension, the CHCs serving them are not receiving the associated increase in Medicaid revenues, reducing their potential resources for operations and expansion. Going forward, health centers' capacity to bridge the large gaps in access to primary care for the uninsured is likely to be affected by both state Medicaid expansion decisions and the expiration of the health center trust fund after September 30, 2015.

What Are The Financial Implications of Uninsurance?

For many uninsured people, the costs of health insurance and medical care are weighed against equally essential needs. When people without health coverage do receive health care, they may be charged for the full cost of that care, which can strain family finances and lead to medical debt. Uninsured people are more likely to report problems with high medical bills than those with insurance. Uninsured adults and those on Medicaid are three times more likely than those with higher incomes to report having difficulty paying basic monthly expenses such as rent, food, and utilities.[83]

Most uninsured people do not receive health services for free or at reduced charge. Hospitals frequently charge uninsured patients two to four times what health insurers and public programs actually pay for hospital services.[84] In 2013, only 38% of uninsured adults who received health care services report receiving free or reduced cost care.[85]

Uninsured people often must pay "up front" before services will be rendered. When people without health coverage are unable to pay the full medical bill in cash at the time of service, they can sometimes negotiate a payment schedule with a provider, pay with credit cards (typically with high interest rates), or can be turned away.[86] Among uninsured adults who received health care, nearly a third (31%) were asked to pay for the full cost of medical care before they could see a doctor.[87]

People without health coverage spend half of what those with coverage spend on health care, but they pay for a much larger portion of their care out-of-pocket. Compared to nonelderly people who had insurance for a full year and average per capita medical expenditures of $4,876 in 2013, nonelderly people who were without insurance for a full year used health care services valued at about half that amount, or just $2,443 per capita per year. Nonelderly people who were uninsured for part of the year had annual medical expenditures about 30% lower than people who were insured for the full year, spending an average of $3,439 annually per capita. Part-year uninsured individuals spent more per capita than full-year uninsured individuals largely due to higher spending in the months that they had coverage. Despite lower overall spending, people without insurance pay nearly as much out-of-pocket as insured people for their care.[88] In aggregate, the uninsured pay for almost a third (30%) of their care out-of-pocket, totaling $25.8 billion in 2013. This total included the health care costs for those uninsured all year and the costs incurred during the months the part-year uninsured have no health coverage.[89]

The remaining costs of their care, the uncompensated costs for the uninsured, amounted to about $84.9 billion in 2013. Providers do not bear the full cost of their uncompensated care. Rather, funding is available through a wide variety of sources to help providers defray the costs associated with uncompensated care. Analysis indicates that in 2013, $53.3 billion was paid to help providers offset uncompensated care costs. Most of these funds (62%) came from the federal government through a variety of programs including Medicaid and Medicare, the Veterans Health Administration, the Indian Health Service, the Community Health Centers block grant, and the Ryan White CARE Act. States and localities provided $19.8 billion, and the private sector provided $0.7 billion. While substantial, these dollars amount to a small slice of total health care spending in the U.S.[90]

The burden of uncompensated care varies across providers. Hospitals, community providers (such as clinics and health centers), and office-based physicians all provide care to the uninsured. Given the high cost

of hospital-based care, the majority (60%) of uncompensated care is provided by hospitals. Community-based providers that receive public funds provide a little over a quarter (26%) of uncompensated care and the remainder of uncompensated care, 14%, is provided by office-based physicians.[91]

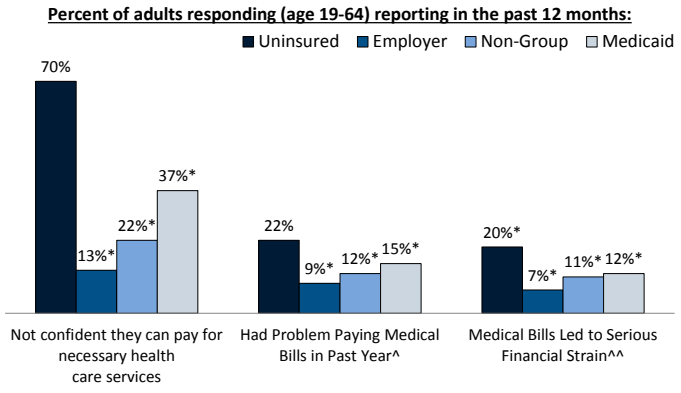
Safety net hospitals that serve a large number of uninsured individuals will receive a reduction in federal disproportionate share (DSH) Medicaid payments beginning in FY2016.[92] DSH payments are federal Medicaid payments intended to cover the extra cost incurred by hospitals serving a large number of low-income and uninsured patients. Unlike other Medicaid payments, federal DSH funds are capped at a state's annual allotted amount, determined by statutory formula, and states have two years to claim their allotments. DSH allotments currently vary considerably across states and total about $11.6 billion a year.[93] Anticipating fewer uninsured and lower levels of uncompensated care, the ACA reduces federal Medicaid DSH. Cuts were originally scheduled to begin in 2014, but other legislation delayed reductions which are now scheduled to begin in 2016 with a reduction of $1.2 billion. DSH cuts phase up to $5.6 billion in 2019, drop to $4 billion in 2020 and then increase by inflation until 2023. The legislation requires the Secretary of HHS to develop a methodology to allocate the reductions that must take into account factors outlined in the law.[94] For those states which have elected not to expand Medicaid eligibility, uninsured residents are left with few low-cost coverage options, and the hospitals that serve these individuals will receive less federal DSH funding.

Being uninsured leaves individuals at an increased risk of amassing unaffordable medical bills. Uninsured people are more likely (22%) than those with employer sponsored insurance (9%) or those with Medicaid (15%) to report having trouble paying medical bills in the past year (Figure 10). Medical bills may also force uninsured adults into serious financial strain. In 2013, 20% of uninsured adults reported that medical bills either caused them to use up all or most of their savings; caused them to have difficulties paying for medical necessities; caused them to borrow money; or caused them to be contacted by a collection agency. In contrast, only 7% among those with employer coverage and 12% among those with Medicaid experienced this type of financial strain due to medical bills.[95]

Most uninsured people have few, if any, savings and assets they can easily use to pay health care costs. Half of uninsured families living below 200% of poverty have no savings at all,[96] and the average uninsured household has no net assets.[97] Uninsured people also have far fewer financial assets than those with insurance coverage. A recent survey found that almost three-quarters (70%) of the uninsured are not confident that they can pay for the health care services they think they need, compared to 13% of those with employer sponsored coverage and 37% with Medicaid (Figure 10).

Figure 10

Financial Consequences of Medical Bills by Insurance Coverage, 2013



SOURCE: 2013 Kaiser Family Foundation Survey of Low-Income Americans and the ACA
NOTES: ^ Excludes people who reported a problem with medical bills that were not their own. ^^ Defined as reporting that medical bills caused them to use up all or most savings; have difficulty paying for necessities; borrow money; or be contacted by a collection agency. * Estimate statistically significantly different from uninsured estimate at the 95% confidence level.

Unprotected from medical costs and with few assets, uninsured people are at risk of having difficulty paying off debt. Like any bill, when medical bills are not paid or paid off too slowly, they are

turned over to a collection agency, and a person's ability to get further credit is significantly limited. In 2013, over half (57%) of uninsured adults reported having difficulty paying off debt due to medical expenses, compared to 30% of those with employer sponsored insurance.[98] Medical debts contribute to almost half of the bankruptcies in the United States, and uninsured people are more at risk of falling into medical bankruptcy than people with insurance.[99]

Conclusion

In the wake of the ACA's major coverage expansions, millions of Americans now have affordable health insurance for the very first time, allowing them to access the health care they need while protecting them against catastrophic medical costs. Historically, the options for the uninsured population were limited in the individual market, which was often expensive and under which many were denied coverage. Medicaid and CHIP have provided coverage to many families, but pre-2014 eligibility levels were low for parents and few states provided coverage to adults without dependent children. The ACA fills in many of these gaps by expanding Medicaid to low-income adults and providing subsidized coverage to people with incomes below 400% of poverty in the Marketplaces. Nonetheless, even with the ACA, the nation's system of health insurance continues to have many gaps that currently leave millions of people without coverage, including low-wage workers who do not qualify for Medicaid or Marketplace subsidies, because they do not meet the income threshold or because they reside in a state that has not expanded Medicaid. Further, undocumented immigrants are excluded from Medicaid and the Marketplace regardless of their income. In addition, many uninsured people live in health professional shortage areas and may continue to do so even if they gain insurance under the ACA, underscoring the need to continue to develop and support safety-net providers and community health clinics.[100] Even so, the ACA has the potential to provide coverage to those who need it, ensuring that fewer individuals and families will face the health and financial consequences of not having health insurance.

[1] The ACA expands Medicaid eligibility, beginning in 2014, to people under age 65 who have incomes at or below 138% of the federal poverty level. The Supreme Court ruling on the ACA maintains the Medicaid expansion but limits the Secretary's authority to enforce it. If a state does not implement the expansion, the Secretary cannot withhold existing federal program funds. For more information: Musumeci M. 2012. "Implementing the ACA's Medicaid-Related Health Reform Provisions After the Supreme Court's Decision." Kaiser Family Foundation Available at: http://www.kff.org/health-reform/issue-brief/implementing-the-acas-medicaid-related-health-reform/

[2] Kaiser Family Foundation analysis of the 2014 ASEC Supplement to the CPS.

[3] Kaiser Family Foundation and Health Research & Educational Trust. 2013. *2013 Kaiser/HRET Employer Health Benefits Survey*. Available at: http://www.kff.org/private-insurance/report/2013-employer-health-benefits/

[4] Kaiser Family Foundation and Health Research and Educational Trust, 2013.

[5] Kaiser Family Foundation analysis of the 2014 ASEC Supplement to the CPS.

[6] Garfield R, Licata R and Young K, 2014. "The Uninsured at the Starting Line: Findings from the 2013 Kaiser Survey of Low-Income Americans and the ACA," Kaiser Family Foundation. Available at: http://kff.org/uninsured/report/the-uninsured-at-the-starting-line-findings-from-the-2013-kaiser-survey-of-low-income-americans-and-the-aca/

[7] Kaiser Family Foundation and Health Research and Educational Trust, 2013.

[8] Kaiser Family Foundation and Health Research and Educational Trust, 2013.

[9] Levitt L, Claxton G and Damico A. 2011. "Measuring the Affordability of Employer Health Coverage." Kaiser Family Foundation. Available at: http://www.kff.org/health-costs/perspective/measuring-the-affordability-of-employer-health-coverage/

[10] Kaiser Family Foundation and Health Research and Educational Trust, 2013.

[11] "Reversing the Trend? Understanding the Recent Increase in Health Insurance Coverage among the Nonelderly Population," Kaiser Family Foundation, 2013. Available at: http://kff.org/uninsured/issue-brief/reversing-the-trend-understanding-the-recent-increase-in-health-insurance-coverage-among-the-nonelderly-population/

[12] Holahan J and McGrath M 2014. "As the Economy Improves, the Number of Uninsured Is Falling But Not Because of a Rebound in Employer Sponsored Insurance," Kaiser Family Foundation. Available at: http://kff.org/uninsured/issue-brief/as-the-economy-improves-the-number-of-uninsured-is-falling-but-not-because-of-a-rebound-in-employer-sponsored-insurance/

[13] Kaiser Family Foundation analysis of the 2014 ASEC Supplement to the CPS

[14] Cox C, Levitt L, Damico A, and Claxton G. 2011. "Mapping Premium Variation in the Individual Market." Kaiser Family Foundation. Available at: http://www.kff.org/health-reform/issue-brief/mapping-premium-variation-in-the-individual-market/

[15] Kaiser Family Foundation analysis of 2013 Kaiser Survey of Low-Income Americans and the ACA, 2014.

[16] Kenney G, et al. 2013. Medicaid/CHIP Participation Rates among Children: an Update, Available at: http://www.urban.org/uploadedpdf/412901-%20Medicaid-CHIP-Participation-Rates-Among-Children-An-Update.pdf

[17] Heberlein M, et al. 2013.

[18] Heberlein M, et al. 2013. "Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013." Kaiser Commission on Medicaid and the Uninsured. Available at: http://www.kff.org/medicaid/report/getting-into-gear-for-2014-findings-from-a-50-state-survey-of-eligibility-enrollment-renewal-and-cost-sharing-policies-in-medicaid-and-chip-2012-2013/

[19] Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2011 MSIS. 2010 MSIS data was used for Florida, Kansas, Maine, Maryland, Montana, New Jersey, New Mexico, Oklahoma, Texas, and Utah, because 2011 data was unavailable or unreliable.

[20] Kaiser Family Foundation analysis of the 2014 ASEC Supplement to the CPS.

[21] Kaiser Family Foundation analysis of 2013 National Health Interview Survey data.

[22] "2013 Poverty Guidelines," Office of the Assistant Secretary for Planning and Evaluation. Retrieved October 16. Available at: http://aspe.hhs.gov/poverty/13poverty.cfm

[23] Kaiser Family Foundation analysis of the 2014 ASEC Supplement to the CPS

[24] Kaiser Family Foundation analysis of the 2014 ASEC Supplement to the CPS

[25] Kaiser Family Foundation and Health Research and Educational Trust, 2013.

[26] "Key Facts on Health Coverage for Low-Income Immigrants Today and Under the Affordable Care Act," Kaiser Family Foundation. 2013. Available at: http://www.kff.org/disparities-policy/fact-sheet/key-facts-on-health-coverage-for-low/

[27] Medicaid.gov. Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women as of March 24, 2014. Retrieved November 2014. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Outreach-and-Enrollment/Lawfully-Residing.html

[28] Marks C, Schwartz T, and Donaldson L, 2009. "State Variation and Health Reform: A Chartbook". Kaiser Family Foundation. Available at: http://www.kff.org/health-reform/report/state-variation-and-health-reform-a-chartbook/

[29] Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels and 2012-2013 Current Population Survey.

[30] "Insurance Coverage Provisions of the Affordable Care Act—CBO's April 2014 Baseline," Congressional Budget Office, 2014. Available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2014-04-ACAtables2.pdf.

[31] National Center for Health Statistics. 2014.

[32] "Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013," 2013. Kaiser Family Foundation. Available at: http://kff.org/medicaid/report/getting-into-gear-for-2014-findings-from-a-50-state-survey-of-eligibility-enrollment-renewal-and-cost-sharing-policies-in-medicaid-and-chip-2012-2013/

[33] Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels and 2014 CPS

[34] "State Decisions on Health Insurance Marketplaces and the Medicaid Expansion," Kaiser Family Foundation. Retrieved October 10, 2014 from http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/#note-1

[35] Ibid.

[36] "Where Are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults as of April 1, 2014," Kaiser Family Foundation. 2014. Available at: http://kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/

[37] Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels and 2014 CPS

[38] Smith V, et al. 2013. "Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014." Kaiser Commission on Medicaid and the Uninsured. Available at: http://www.kff.org/medicaid/report/medicaid-in-a-historic-time-of-transformation-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2013-and-2014/

[39] "State Decisions For Creating Health Insurance Exchanges, as of May 28, 2013," Kaiser Family Foundation. Available at http://www.kff.org/health-reform/state-indicator/health-insurance-exchanges/

[40] Kaiser Family Foundation Analysis based on 2014 Medicaid eligibility levels.

[41] "State-by-State Estimates of the Number of People Eligible for Premium Tax Credits Under the Affordable Care Act." 2013. Kaiser Family Foundation. Available at: http://kff.org/report-section/state-by-state-estimates-of-the-number-of-people-eligible-for-premium-tax-credits-under-the-affordable-care-act-methods/

[42] Cox C, Claxton G and Levitt, 2014. "Individual Market Enrollment Ticks Up in Early 2014," Kaiser Family Foundation. Available at: http://kff.org/health-reform/issue-brief/individual-market-enrollment-ticks-up-in-early-2014/

[43] L. Hamel et al., 2014. "Survey of Non-Group Health Insurance Enrollees." Kaiser Family Foundation. Available at: http://kff.org/report-section/about-the-groups/

[44] U.S. Department of Health and Human Services, Office of The Assistant Secretary for Planning and Evaluation, 2014 Poverty Guidelines. Available at: http://aspe.hhs.gov/poverty/14poverty.cfm

[45] "Marketplace Enrollees by Financial Assistance Status," Timeframe: October 2013-April 19, 2014. Kaiser Family Foundation. Available at: http://kff.org/other/state-indicator/marketplace-enrollees-by-financial-assistance-status/

[46] Kaiser Family Foundation extrapolation of Congressional Budget Office 2016 projections of the number of people who will receive subsidies nationwide. Available at: http://kff.org/interactive/king-v-burwell/

[47] "Key Facts on Health Coverage for Low-Income Immigrants Today and Under the Affordable Care Act," Kaiser Family Foundation, 2013. Available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8279-02.pdf

[48] Hamel L et al. 2014. "Survey of Non-Group Health Insurance Enrollees," Kaiser Family Foundation. Available at: http://kff.org/report-section/about-the-groups/

[49] From 2010 through 2013, employers could receive a tax credit of up to 35% of the employer's contribution to the premium, calculated on a sliding scale basis tied to average wages and number of employees. For small businesses with tax-exempt status meeting the requirements above, the tax credit is 25% of the employer contribution. In order to qualify, a business must have offered and contribute to at least 50% of employee-only coverage for each employee.

[50] "Explaining Health Reform: How will the Affordable Care Act affect Small Businesses and their Employees?" Kaiser Family Foundation, 2012. Available at: http://kff.org/health-reform/fact-sheet/explaining-health-reform-how-will-the-affordable-care-act-affect-small-businesses-and-their-employees/#endnote_link_note9

[51] Holahan, J and McGrath M, 2014. "As the Economy Improves, the Number of Uninsured Is Falling But Not Because of a Rebound in Employer Sponsored Insurance," Kaiser Family Foundation. Available at: http://kff.org/uninsured/issue-brief/as-the-economy-improves-the-number-of-uninsured-is-falling-but-not-because-of-a-rebound-in-employer-sponsored-insurance/

[52] Ibid.

[53] "Quick Take: Essential Health Benefits: What Have States Decuded for Their Benchmark?," Kaiser Family Foundation, 2012. Available at: http://kff.org/health-reform/fact-sheet/quick-take-essential-health-benefits-what-have-states-decided-for-their-benchmark/

[54] "Explaining Health Reform: How will the Affordable Care Act Affect Small Businesses and their Employees?" Kaiser Family Foundation, 2012. Available at: http://kff.org/health-reform/fact-sheet/explaining-health-reform-how-will-the-affordable-care-act-affect-small-businesses-and-their-employees

[55] "Health Reform FAQs," Kaiser Family Foundation. Retrieved October 16, 2014. Available at: http://kff.org/health-reform/faq/health-reform-frequently-asked-questions/#question-what-is-a-grandfathered-plan-how-do-i-know-if-i-have-one

[56] Kaiser Family Foundation analysis of the 2013 Kaiser Survey of Low-Income Americans and the ACA, 2014.

[57] Tejada S et al., 2013. "Patient Barriers to Follow-Up Care for Breast and Cervical Cancer Abnormalities." *Journal of Women's Health* 22(6):507-517.

[58] Wilper et al., 2009, "Health Insurance and Mortality in US Adults." *American Journal of Public Health*, 99(12) 2289-2295.

[59] Simard EP, et al. 2012. "Widening Socioeconomic Disparities in Cervical Cancer Mortality Among Women in 26 States, 1993-2007." *Cancer*.

[60] Institute of Medicine. 2009. "America's Uninsured Crisis: Consequences for Health and Health Care." Washington, DC: National Academies Press. p. 60-63.

[61] Cohen R, et al. 2013. "Strategies Used by Adults to Reduce their Prescription Drug Costs." National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/data/databriefs/db119.pdf

[62] Hadley J, 2007. "Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition." *JAMA* 297(10):1073-84.

[63] Abdullah F, et al. 2010. "Analysis of 23 Million US Hospitalizations: Uninsured Children Have Higher All-Cause In-Hospital Mortality." *Journal of Public Health.* 32(2):236-44.

[64] Wilper, et al., 2009, "Health Insurance and Mortality in US Adults." American Journal of Public Health, 99(12) 2289-2295.

[65] Greene WR, et al. 2010. "Insurance Status is a Potential Predictor of Outcomes in Both Blunt and Penetrating Trauma." *American Journal of Surgery*. 199(4):554-7.

[66] Lyon SM. 2011. "The Effect of Insurance Status on Mortality and Procedural Use in Critically Ill Patients." *American Journal of Critical Care Medicine.* 184(7): 809-15.

[67] Kaiser Family Foundation analysis of 2014 NHIS data.

[68] Institute of Medicine. 2002. Health Insurance is a Family Matter. Washington, DC.

[69] Institute of Medicine, 2009.

[70] Collins S, et al. 2012. "Gaps in Health Insurance: Why So Many Americans Experience Breaks in Coverage and How the Affordable Care Act Will Help." The Commonwealth Fund. Available at: http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/Apr/1594_collins_gaps_in_hlt_ins_tracking_brief_v2.pdf

[71] Cassedy A, Fairbrother G, and Newacheck PW. 2008. "The Impact of Insurance Instability on Children's Access, Utilization, and Satisfaction with Health Care. *Ambulatory Pediatrics.* 8(5):321-8.

[72] Abdus S, 2014, "Part-Year Coverage and Access to Care For Nonelderly Adults," Med Care. 52(8):709-14.

[73] Finkelstein A, et al. 2011, "The Oregon Health Insurance Experiment: Evidence From the First Year", National Bureau of Economic Research. Available at http://www.nber.org/papers/w17190.

[74] Baicker K, et al. 2013. "The Oregon Experiment — Effects of Medicaid on Clinical Outcomes." *N Engl J Med.* 368:1713-1722. Available at: http://www.nejm.org/doi/full/10.1056/NEJMsa1212321

[75] Sommers BD, Baicker K, and Epstein AM. 2012. "Mortality and Access to Care Among Adults After State Medicaid Expansions." *N Engl J Med.* 367:1025-1034.

[76] Hall M. 2011. "Rethinking Safety-Net Access for the Uninsured." *N Engl J Med.* 364:7-9.

[77] Holahan J and Spillman B, 2002. "Health Care Access for Uninsured Adults: A Strong Safety Net is Not the Same as Insurance." The Urban Institute. Available at: http://www.urbaninstitute.org/UploadedPDF/310414_anf_b42.pdf

[78] Shin P, Rosenbaum S, and Paradise J. 2012. "Community Health Centers: The Challenge of Growing to Meet the Needs for Primary Care in Medically Underserved Communities." Kaiser Commission on Medicaid and the Uninsured. (#8098-02; March).

[79] Summer L. 2011. "The Impact of the Affordable Care Act on the Safety Net." AcademyHealth. Available at: http://www.academyhealth.org/files/FileDownloads/AHPolicybrief_Safetynet.pdf

[80] Cunningham P and Hadley J. 2008. "Effects of Changes in Incomes and Practice Circumstances on Physicians' Decisions to Treat Charity and Medicaid Patients." *The Milbank Quarterly* 86(1): 91-123.

[81]Shin P, Sharac J, Rosenbaum S, Paradise J 2014. "Community Health Centers: A 2012 Profile and Spotlight on Implications of State Medicaid Expansion Decisions," Kaiser Family Foundation. Available at: http://kff.org/report-section/community-health-centers-a-2012-profile-and-spotlight-on-implications-of-state-medicaid-expansion-decisions-issue-brief/

[82] Wakefield M, 2014. "Affordable Care Act Funds to Expand Services at the Nation's Community Health Centers," Health and Human Services Blog. Available at: http://www.hhs.gov/healthcare/facts/blog/2014/06/expand-services-at-community-health-centers.html

[83] Kaiser Family Foundation analysis of the 2013 Kaiser Survey of Low-Income Americans and the ACA, 2014.

[84] Anderson G. 2007. "From 'Soak The Rich' To 'Soak The Poor': Recent Trends In Hospital Pricing." *Health Affairs* 26(4): 780-789.

[85] Kaiser Family Foundation analysis of the 2013 Kaiser Survey of Low-Income Americans and the ACA, 2014.

[86] Asplin B, et al. 2005. “Insurance Status and Access to Urgent Ambulatory Care Follow-up Appointments.” *JAMA* 294(10):1248-54.

[87] Kaiser Family Foundation analysis of the 2013 Kaiser Survey of Low-Income Americans and the ACA, 2014.

[88] Coughlin T A., Holahan J, Caswell K and McGrath M, 2014. “Uncompensated Care for the Uninsured in 2013: A Detailed Examination”, Kaiser Family Foundation. Available at: http://kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/

[89] Coughlin et al, 2014.

[90] Coughlin et al, 2014.

[91] Coughlin et al, 2014.

[92] CMS, Federal Policy Guidelines, 2013. Available at: http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-27-13.pdf

[93] “Federal Medicaid Disproportionate Share Hospital (DSH) Allotments,” Kaiser Family Foundation. Available at: http://www.kff.org/medicaid/state-indicator/federal-dsh-allotments/

[94] 42 U.S.C. § 1396r-4(f)(7)(A)(ii)(VI), (VII) Available at: http://www.law.cornell.edu/uscode/text/42/1396r-

[95] Kaiser Family Foundation analysis of the 2013 Kaiser Survey of Low-Income Americans and the ACA, 2014

[96] Glied S and Kronick R, 2011. “The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills.” Office of Assistance Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Available at: http://aspe.hhs.gov/health/reports/2011/ValueofInsurance/rb.pdf

[97] Jacobs P and Claxton G. 2008. "Comparing the Assets of Uninsured Households to Cost Sharing Under High Deductible Health Plans," *Health Affairs* 27(3):w214

[98] Kaiser Family Foundation analysis of the 2013 Kaiser Survey of Low-Income Americans and the ACA, 2014.

[99] Himmelstein D, et al. 2009. “Medical bankruptcy in the United States, 2007: results of a national study.” *Am J Med*. 122(8): 741-6. Available at: http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf

[100] Hoffman C, Damico A, and Garfield R. 2011. “Research Brief: Insurance Coverage and Access to Care in Primary Shortage Areas.” *Kaiser Commission on Medicaid and the Uninsured*, February 2011.

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Congressional Addressees

Private Health Insurance: Concentration of Enrollees among Individual, Small Group, and Large Group Insurers from 2010 through 2013

Millions of Americans obtain health coverage through private health plans, which include private health insurance sold in the individual and group insurance markets.[1] Group health plans provided by both large and small employers are the leading source of health coverage in the United States. Specifically, in 2013, 58 percent of Americans under age 65 had health coverage through employer-sponsored group health plans.[2] These employers may offer fully insured plans (by purchasing coverage from an insurance company) or self-funded plans (by setting aside funds to pay for employee health care). Most small employers purchase insured plans, while most large employers self-fund. Americans without access to group health insurance coverage, such as those with employers that do not offer health insurance coverage, may choose to purchase it directly from an insurer through the individual market. About 8 percent of Americans under age 65 had coverage through the individual market in 2013.

Historically, there have been indications of high levels of concentration in the individual, small group, and large group markets—that is, markets in which a small number of insurers enroll a significant portion of the total number of beneficiaries. In a survey of the small group market, we previously found that the largest insurers increased their share of enrollment between 2002 and 2008, indicating that the small group market likely became more concentrated over time.[3] For 2008, we found that the median share of enrollment for the largest insurer in the small group market across the states surveyed was about 47 percent, with a range of about 21 percent in Arizona to about 96 percent in Alabama.[4] More recent research has also identified high levels of market concentration. For example, an analysis based on 2010 data found the median share of enrollment held by the largest insurer in each state was 54 percent and 51 percent, respectively, for the individual and small group market segments.[5]

[1]Private health insurance includes individual and group coverage—including small and large group health plans. Insurance offered by small employers is known as small group insurance and insurance offered by large employers is known as large group insurance.

[2]U.S. Census Bureau, *Table HI01, Health Insurance Coverage Status and Type of Coverage by Selected Characteristics: 2013*, Current Population Survey, 2014 Annual Social and Economic Supplement, accessed October 6, 2014, http://www.census.gov/hhes/www/cpstables/032014/health/hi01_1.xls.

[3]GAO, *Private Health Insurance: 2008 Survey Results on Number and Market Share of Carriers in the Small Group Health Insurance Market,* GAO-09-363R (Washington, D.C.: Feb. 27, 2009). Also see GAO, *Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market in 2004*, GAO-06-155R (Washington, D.C.: Oct. 13, 2005); and GAO, *Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market*, GAO-02-536R (Washington, D.C.: Mar. 25, 2002).

[4]These figures are based on data from the 39 states that provided us with market share information. See GAO-09-363R.

[5]Kaiser Initiative on Health Reform and Private Health Insurance*, Focus on Health Reform: How Competitive are State Insurance Markets?* (Menlo Park, Calif: Kaiser Family Foundation, October 2011).

Several complex factors can affect concentration in these health insurance markets and the ability of new insurers to enter these markets.[6] High concentration levels in health insurance markets have often been the result of consolidation—mergers and acquisitions—among existing insurers. In addition, concentration can persist because some factors may make it difficult for new insurers to enter the market. For example, new insurers that do not yet have large numbers of enrollees may have greater challenges negotiating discounts with providers. A highly concentrated market may indicate a less competitive market and could affect consumers' choice of health plans and their premiums.

The Patient Protection and Affordable Care Act (PPACA), enacted in 2010, contained a number of provisions that could affect market concentration and competition among health insurers.[7] Specifically, the law required the establishment of health insurance exchanges—marketplaces where eligible individuals and small employers can compare and select among qualified insurance plans offered by participating private insurers—in each state by 2014.[8] PPACA does not require insurers to offer plans through the individual and small group exchanges but instead, generally relies on market incentives to encourage their participation.[9] In addition, PPACA required the establishment of the Consumer Operated and Oriented Plan (CO-OP) program, which provides loans to encourage new consumer-governed, nonprofit insurers to offer health plans in the individual and small group exchanges.[10] Other PPACA provisions may affect how health insurance companies compete. For example, PPACA established new rating rules that limit how much insurance companies can vary premiums charged for plans, as well as guaranteed issue requirements that prohibit insurers from denying coverage based on health status.

PPACA also requires GAO to conduct an ongoing study on competition and market concentration in the health insurance market.[11] For this study, we examined these markets prior to the implementation of key PPACA provisions that went into effect in 2014 and that could affect competition and market concentration among health insurers. Specifically, GAO examined (1) how enrollment in the individual, small group, and large group health insurance market segments in each state was distributed among insurers in 2013; and (2) how the concentration

[6]In 2009, we conducted a structured literature review that examined the concentration of private health insurance markets. See GAO, *Private Health Insurance: Research on Competition in the Insurance Industry*, GAO-09-864R (Washington, D.C.: July 31, 2009).

[7]See Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (hereafter, "PPACA"), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010) ("HCERA"). In this report, all references to PPACA include any amendments made by HCERA.

[8]Prior to PPACA, federal law defined a small employer, in connection with a group health plan, as having a maximum of 50 employees. Under PPACA, states have the option of defining a small employer as having 50 or fewer employees, but starting in 2016, they must define small employers as having from 1 to 100 employees. PPACA, § 1304(b), 124 Stat. at 172 (codified at 42 U.S.C. § 18024(b)).

[9]For example, it is only through the exchanges that eligible individuals may qualify for premium tax credits and cost-sharing reductions to lower the cost of their health plans, and certain small employers may qualify for tax credits to lower the cost of the coverage they purchase on behalf of their employees. We examined insurer participation in health insurance exchanges in a recent report. See GAO, *Patient Protection and Affordable Care Act: Largest Issuers of Health Coverage Participated in Most Exchanges, and Number of Plans Available Varied*, GAO-14-657 (Washington, D.C: Aug. 29, 2014).

[10]PPACA, § 1322, Stat. at 187 (codified at 42 U.S.C. § 18042).

[11]PPACA, § 1322(i), 124 Stat. at 192. Specifically, PPACA directs GAO to conduct an ongoing study on competition and market concentration in the health insurance market in the United States after the implementation of PPACA health insurance reforms and to report to Congress biennially beginning in 2014.

of insurers in the individual, small group, and large group health insurance market segments in each state changed from 2010 through 2013.

To describe both how enrollment in the individual, small group, and large group health insurance market segments in each state was distributed among insurers in 2013, and how the concentration of insurers in these market segments in each state changed from 2010 through 2013, we analyzed 2010 data reported by insurance companies to the National Association of Insurance Commissioners (NAIC), as well as 2011 through 2013 data that PPACA requires insurers to report annually to the Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS), beginning in 2011.[12] Specifically, we identified the private health insurers that sold fully insured policies in each state's individual, small group, and large group markets.[13] For both the NAIC and CMS data, insurers submitted data separately for each market segment and state in which they conducted business; these data were not submitted separately by health plan, product, or policy. We analyzed each insurer's enrollment share in each of the 51 states by calculating the total number of covered life-years.[14] If there were multiple insurers in a state that shared a parent company, we aggregated the individual insurer data in order to determine the state-wide experience of the parent company; otherwise, we analyzed the data by the individual insurers. For the individual, small group, and large group market segments in a state, we calculated the three-firm concentration ratio—the combined shares of covered life-years for the three largest insurers in each market segment. While states may have multiple local markets with differing concentrations of enrollees among health insurers, the data we used to measure this concentration by type of market segment are only available at the state level. Therefore, to make comparisons between state and local level estimates of concentration, we also analyzed a recent study by the American Medical Association (AMA). Although the AMA study does not report concentration by type of market segment, it does report concentration for Metropolitan Statistical Areas (MSA) within each

[12]NAIC is the organization of insurance commissioners from the 50 states, the District of Columbia, and the five U.S. territories that regulate the conduct of insurance companies in their respective state or territory. All insurers, with some exceptions, report financial statements to NAIC each year that include data for all health insurance markets offered by an insurer, including Medical Loss Ratio (MLR) data, or the percent of premiums the insurers spent on their enrollees' medical claims and quality initiatives. The largest exception to the NAIC reporting requirements is insurers that are regulated by the California Department of Managed Health Care, which report directly to that department and not to NAIC. Insurers began reporting MLR data to CMS in 2011, as required by PPACA. Both the NAIC and CMS data collected from insurers also include enrollment data that can be used to calculate the share of covered life-years for fully insured health plans. Insurers reported their 2010 data to NAIC by April 2011 based on their experience for the prior calendar year and insurers reported their 2011, 2012, and 2013 data to CMS by June 2012, June 2013, and June 2014, respectively, based on their experience for the prior calendar year. At the time of our analysis, 2013 data was the most recent year available.

For purposes of this report, the term "state" includes the District of Columbia.

[13]For the purposes of this report, insurer refers to the parent company of the insurance entity that is licensed by the state to engage in the insurance business. In cases where there is no parent company, the insurer refers to the insurance entity that is licensed by the state.

[14]One way to measure beneficiary enrollment is by measuring covered life-years, which represent the average number of lives insured, including dependents, on a pre-specified day over the 12 months in the reporting year.

state.[15] We assessed the reliability of the NAIC, CMS, and AMA data by reviewing documentation and discussing the data with knowledgeable officials. For the NAIC and CMS data, we analyzed the enrollment data as they were reported by insurers, and we did not independently verify the accuracy or completeness of the information. Also for the NAIC and CMS data, we performed data reliability checks, such as examining the data for missing values and obvious errors to test the internal consistency and reliability of the data. For analyses over time, we excluded data from California because the NAIC data did not include all insurers in that state. We did not assess the availability of insurers' health plans, products, or policy offerings, as these data were not submitted by insurers to NAIC and CMS. We assessed the reliability of the AMA data as it was reported in the study, and we did not independently verify the reliability of the original dataset used by AMA in its analysis. After taking these steps, we determined the data from each of these three sources were sufficiently reliable for our purposes.

We conducted this performance audit from May 2014 to December 2014 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.

Results In Brief

We found that, while several insurers participated in each state's individual, small group, and large group health insurance markets in 2013, enrollment was concentrated among the three largest insurers in most states. Specifically, in each of the three market segments, the three largest insurers had at least 80 percent of the total enrollment in at least 37 states.

Further, these three market segments remained concentrated in most states from 2010 through 2013. Specifically, for each of these market segments, there were at least 30 states for which the three largest insurers had at least 80 percent of the total enrollment in each of the 4 years.

We provided HHS with a draft of this report for review; it indicated that it had no comments.

Enrollment in the Individual, Small Group, and Large Group Health Insurance Market Segments Was Concentrated among a Small Number of Insurers in Most States in 2013

While several insurers participated in each state's individual, small group, and large group health insurance markets in 2013, enrollment was concentrated among the three largest insurers in most states. On average in each state, there were several insurers participating, with about twice as many insurers participating in the individual market (24) as the small group (12) and large group (11) markets.[16] (See enclosure 2 for state-by-state trends.) However, in each of

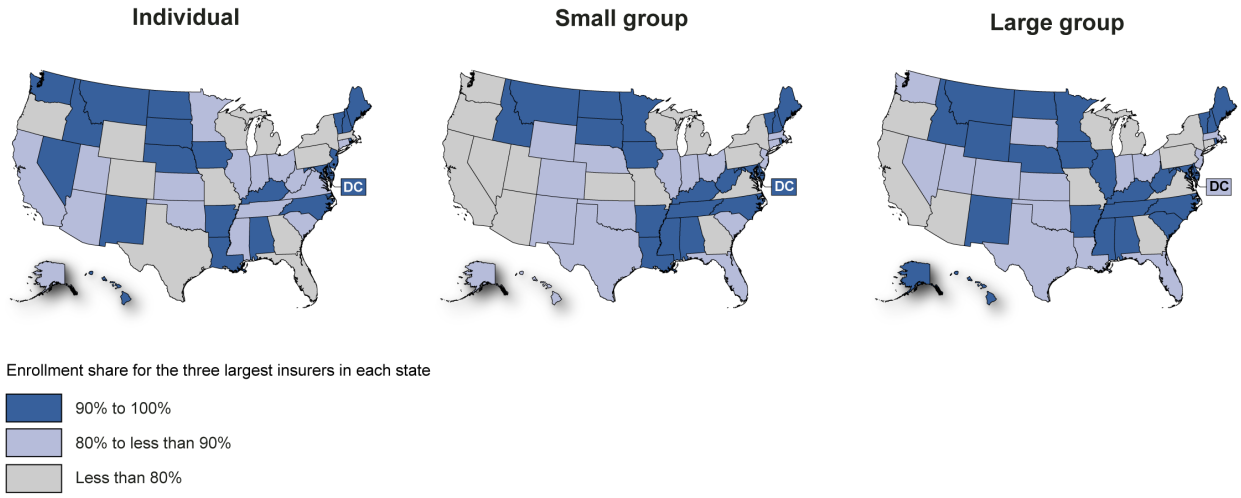
[15]AMA reported data collected by HealthLeaders-InterStudy through its Managed Market Surveyor from January 1, 2011, for self-funded and fully insured plans and, according to the study's authors, includes plans from the individual, small group, and large group markets. However, the data reported by AMA do not differentiate by these market segments. AMA reported market concentration by state and by MSA, which includes a county or counties associated with a city or urbanized area that has a population of at least 50,000. In some cases, AMA reported the data at other geographic levels such as metropolitan divisions, which are smaller geographic units located within MSAs. As is done in the AMA study, we refer to these as "MSAs" for the purposes of this report. American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets* (2013).

[16]While, on average, more insurers participated in the individual market segment, enrollment was higher in the small and large group markets. Specifically, in 2013, there were about 11.0 million total covered life-years in the individual market, 17.3 million total covered life-years in the small group market, and 48.3 million total covered life-years in the large group market. (See enclosure 1 for state-by-state trends.)

the three market segments, the three largest insurers had at least 80 percent of the total enrollment in at least 37 states.[17] (See the interactive map in fig. 1.) Further, in more than half of these states, a single insurer had more than half of the total enrollees and in 5 of these states there was at least one market segment in which the largest insurer had at least 90 percent of all the enrollees. For example, in Alabama's small group market, the largest insurer—Blue Cross and Blue Shield of Alabama—had 97 percent of the total enrollment in the state.

The interactive map can be accessed here: http://www.gao.gov/products/GAO-15-101R.

Figure 1: Enrollment Share for the Three Largest Insurers, Name and Enrollment Share for the Largest Insurer, and Total Number of Insurers by State and Market Segment, 2013



Sources: GAO analysis of 2013 Medical Loss Ratio data from the Centers for Medicare & Medicaid Services. (data); Map Resources (map). | GAO-15-101R

Notes: We measured enrollment share using covered life-years, which represent the average number of lives insured, including dependents, on a pre-specified day over the 12 months in the reporting year.

In the remaining states, more insurers participated and the market segments were less concentrated, with enrollment spread out among more insurers. Specifically, in 12 states' individual markets, 14 states' small group markets, and 11 states' large group markets, the 3 largest insurers held less than 80 percent of the total enrollment. On average in each state, there were 30 insurers in the individual market, 16 in the small group market, and 17 in the large group market. In nearly all of these states' market segments, the largest insurer had less than half of the total enrollment. For example, in Wisconsin's large group market, the 3 largest insurers had 39 percent of the total enrollees in the state, and the largest of these insurers had 15 percent of the total enrollees.

While this report examines the concentration of enrollment at the state level, concentration can vary within a state. According to 2011 data reported by AMA, which did not differentiate by market segment, the largest insurer in most states was also the largest insurer in at least three-quarters of the MSAs in that state. In the other states, the largest insurer varied across the MSAs. Specifically, insurers sometimes offer health plans that are only available in certain geographic areas, rather than statewide. For example, in Pennsylvania, the largest insurer in

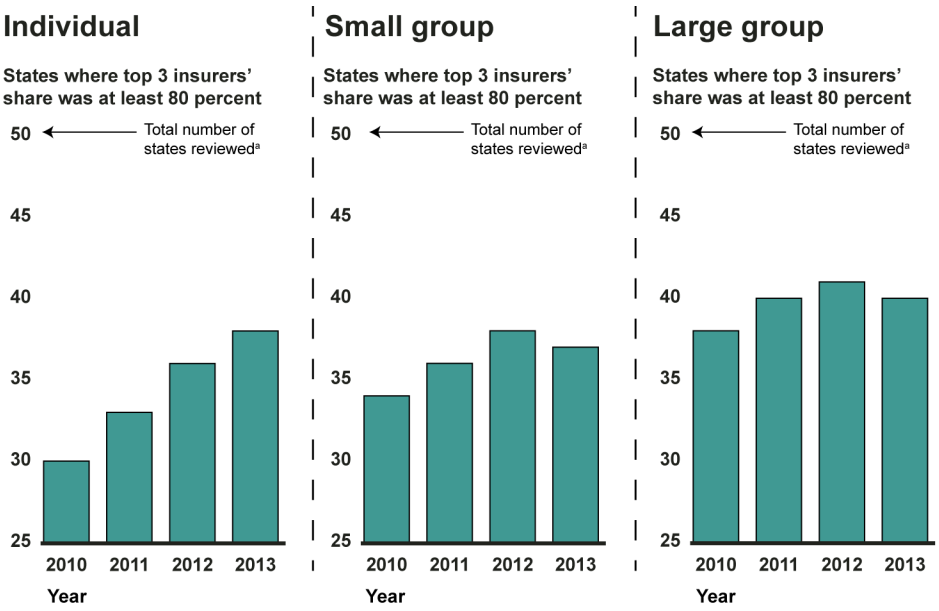
[17]Specifically, the three largest insurers in a particular state had at least 80 percent of the total enrollment in the individual market in 39 states, in the small group market in 37 states, and in the large group market in 40 states.

one MSA did not operate in all MSAs in the state and, therefore, was not the largest insurer in the state.

The Individual, Small Group, and Large Group Health Insurance Market Segments in Most States Remained Concentrated from 2010 through 2013

In most states, the individual, small group, and large group markets remained concentrated from 2010 through 2013. Specifically, for each of these market segments, there were at least 30 states for which the three largest insurers had at least 80 percent of the total enrollment in each of the 4 years.[18] For example, the largest three insurers had at least 80 percent of total enrollment in 30 states, 34 states, and 38 states respectively in the individual, small group, and large group markets in 2010. In each market segment, the number of such states increased by 2013.[19] The individual market increased to 38 states by 2013. While the small group and large group markets also increased overall by 2013, to 37 states and 40 states, respectively, each had a small decrease between 2012 and 2013. (See fig. 2 for state counts and see enclosure 3 for state-by-state data.)

Figure 2: The Number of States Where the Enrollment Share for the Top Three Insurers Was at Least 80 Percent, by Market Segment 2010-2013



Source: GAO analysis of 2010 Supplemental Health Care Exhibit data from the National Association of Insurance Commissioners and 2011 through 2013 Medical Loss Ratio data from the Centers for Medicare & Medicaid Services. | GAO-15-101R

Note: We measured the enrollment share of the three largest insurers using covered life-years, which represent the average number of lives insured, including dependents, on a pre-specified day over the 12 months in the reporting year.

[a]We excluded data from California from all years because the National Association of Insurance Commissioners' 2010 data for this state did not include all insurers.

[18]For all analyses of trends from 2010 through 2013, we excluded data from California for all years because the NAIC 2010 data for this state did not include all insurers. Therefore, these counts are out of 50, rather than 51, states.

[19]In each of the three market segments, for most of the states in which the largest three insurers had an enrollment share of at least 80 percent in 2010, this was also the case in 2013—specifically, 29 of the 30 states in the individual market, 32 of the 34 states in the small group market, and 36 of the 38 states in the large group market.

We also examined the companies that comprised the largest insurers in each state and found that, in addition to having at least half of the enrollment in most states from 2010 through 2013, these same companies generally remained the top insurers during the time period.[20] Specifically, of the 50 states we analyzed, the largest insurer remained the same in 43 states in the individual market, 41 states in the small group market, and 43 states in the large group market. For example, in Iowa's small group market, the largest insurer—Wellmark Group—had at least 61 percent of the total enrollees from 2010 through 2013. In addition, in most of the states where the largest insurer did not remain the same, the largest insurer generally had less than half of the total enrollees. For example, in Washington's individual market, the largest insurer in 2010 and 2011—Regence Group—had 45 percent and 37 percent of the total enrollees in the state, respectively. Premera Blue Cross Group replaced Regence Group as the largest insurer in 2012 and 2013 and had 40 percent and 39 percent of the total enrollees in the state, respectively, in each year. (See enclosure 4 for state-by-state trends.)

We also found that a Blue Cross and Blue Shield insurer was the largest insurer in most states in each of the market segments from 2010 through 2013.[21] Specifically, a Blue Cross and Blue Shield insurer was consistently the largest insurer in 44 states in the individual market, 38 states in the small group market, and 40 states in the large group market across the time period.

Agency Comments

We provided HHS with a draft of this report for review; it indicated that it had no comments.

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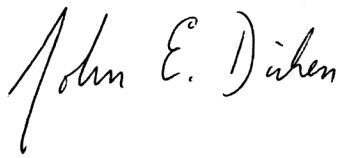
We are sending copies of this report to the Secretary of Health and Human Services and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov. If you or your staffs have any questions about this information, please contact me at (202) 512-7114 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 were William D. Hadley, Assistant Director; Laura Sutton Elsberg; Sandra George; Giselle Hicks; Sarah-Lynn McGrath; Laurie Pachter; and Vikki Porter.



John E. Dicken
Director, Health Care

Enclosures – 4

[20]Specifically, in the individual market, there were 31 states where the largest insurer had at least half of the enrollment in 2010 and also in 2013. In the small group market, there were 27 states in 2010 and 29 states in 2013. In the large group market, there were 33 states in 2010 and 32 states in 2013.

[21]We identified insurers that were independent licensees of the Blue Cross and Blue Shield Association in a particular state. An insurer may or may not be the Blue Cross and Blue Shield licensee in all counties within a particular state. In 2002, 2005, and 2009, we reported that a Blue Cross and Blue Shield insurer was the largest insurer in most states in the small group market. See GAO-09-363R, GAO-06-155R, and GAO-02-536R.

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Total Covered Life-Years by State in the Individual, Small Group, and Large Group Markets, 2013

State	Individual	Small group	Large group
Alabama	174,370	292,186	491,750
Alaska	14,917	32,855	49,487
Arizona	270,470	208,312	547,992
Arkansas	114,367	133,682	202,449
California	1,571,566	2,182,529	11,170,956
Colorado	275,631	243,530	688,456
Connecticut	119,528	226,684	402,343
Delaware	20,951	47,530	89,853
District of Columbia	19,755	86,054	803,704
Florida	854,167	782,577	1,848,192
Georgia	353,593	482,737	830,215
Hawaii	28,353	148,481	654,842
Idaho	95,574	86,882	231,540
Illinois	461,044	629,598	2,110,423
Indiana	174,155	326,423	365,273
Iowa	180,758	159,174	351,064
Kansas	124,520	192,966	398,922
Kentucky	131,663	175,900	376,001
Louisiana	173,641	276,836	357,172
Maine	32,855	76,652	189,564
Maryland	188,624	320,665	945,595
Massachusetts	88,546	556,772	1,263,142
Michigan	339,410	591,713	1,950,458
Minnesota	254,372	315,473	720,744
Mississippi	83,244	112,774	197,304
Missouri	257,861	303,705	708,075
Montana	48,023	54,937	83,833
Nebraska	124,966	95,023	209,633
Nevada	94,882	104,027	402,033
New Hampshire	36,192	82,925	147,505
New Jersey	177,955	646,930	1,034,253
New Mexico	58,879	56,726	169,347
New York	248,495	1,376,783	6,084,031
North Carolina	473,565	309,032	589,287
North Dakota	45,937	70,287	155,103
Ohio	330,315	884,544	959,784
Oklahoma	122,598	185,376	488,160
Oregon	167,095	222,870	685,508

State	Individual	Small group	Large group
Pennsylvania	463,591	884,908	2,149,143
Rhode Island	18,300	78,838	179,025
South Carolina	129,263	126,408	332,032
South Dakota	65,951	50,790	107,063
Tennessee	243,526	329,491	496,229
Texas	746,168	1,293,831	1,821,661
Utah	140,289	239,979	444,548
Vermont	20,291	57,661	73,718
Virginia	319,580	431,183	1,423,171
Washington	269,757	268,282	1,190,643
West Virginia	28,061	68,571	133,181
Wisconsin	161,048	390,883	985,288
Wyoming	21,852	24,087	32,641
Total covered life-years	**10,960,513**	**17,327,059**	**48,322,334**

Source: GAO analysis of 2013 Medical Loss Ratio data from the Centers for Medicare & Medicaid Services. | GAO-15-101R.

Notes: Covered life-years represent the average number of lives insured, including dependents, on a pre-specified day over the 12 months in the reporting year. State covered life-years may not add to total due to rounding.

Number of Insurers by State in the Individual, Small Group, and Large Group Markets, 2013

State	Individual	Small group	Large group
Alabama	23	8	7
Alaska	14	6	5
Arizona	24	12	12
Arkansas	24	11	9
California	30	22	24
Colorado	25	9	10
Connecticut	19	7	5
Delaware	16	8	6
District of Columbia	18	6	6
Florida	31	14	12
Georgia	31	20	16
Hawaii	12	6	7
Idaho	19	11	9
Illinois	34	21	18
Indiana	28	24	19
Iowa	25	15	14
Kansas	28	13	13
Kentucky	23	9	8
Louisiana	26	11	10
Maine	18	5	5
Maryland	23	8	6
Massachusetts	28	13	11
Michigan	33	24	24
Minnesota	26	9	11
Mississippi	22	8	8
Missouri	31	17	15
Montana	21	8	7
Nebraska	26	12	9
Nevada	21	14	13
New Hampshire	15	6	6
New Jersey	20	6	8
New Mexico	22	7	7
New York	28	14	15
North Carolina	25	13	11
North Dakota	19	6	8
Ohio	34	25	18
Oklahoma	25	15	12
Oregon	25	8	11

State	Individual	Small group	Large group
Pennsylvania	36	19	18
Rhode Island	13	3	4
South Carolina	22	12	10
South Dakota	25	11	12
Tennessee	26	14	9
Texas	36	23	22
Utah	19	12	14
Vermont	12	3	4
Virginia	29	17	16
Washington	25	13	12
West Virginia	24	12	11
Wisconsin	35	24	27
Wyoming	21	7	7
Average number of insurers	**24**	**12**	**11**

Source: GAO analysis of 2013 Medical Loss Ratio data from the Centers for Medicare & Medicaid Services. | GAO-15-101R.

Share of Enrollment for the Largest Three Insurers by State in the Individual, Small Group, and Large Group Markets from 2010 through 2013

Below are three tables that show the share of enrollment for the largest three insurers in each state in the individual, small group, and large group markets from 2010 through 2013.

Table 1: Share of Enrollment for the Largest Three Insurers by State in the Individual Market, 2010 through 2013

	Share of enrollment for the largest three insurers (%)			
State	**2010**	**2011**	**2012**	**2013**
Alabama	94	97	98	98
Alaska	77	76	79	82
Arizona	75	77	80	80
Arkansas	89	91	94	94
California[a]	–	78	87	84
Colorado	54	53	57	59
Connecticut	85	84	84	85
Delaware	88	85	83	92
District of Columbia	89	88	90	92
Florida	74	73	74	73
Georgia	74	68	70	70
Hawaii	100	99	99	99
Idaho	86	93	94	93
Illinois	77	79	82	83
Indiana	84	82	84	85
Iowa	92	92	92	95
Kansas	74	76	78	81
Kentucky	97	96	98	97
Louisiana	87	85	90	91
Maine	98	92	98	98
Maryland	90	89	89	92
Massachusetts	87	88	79	77
Michigan	78	77	77	77
Minnesota	86	85	87	87
Mississippi	78	83	88	89
Missouri	66	69	72	72
Montana	84	85	90	90
Nebraska	87	88	90	91
Nevada	84	83	86	91
New Hampshire	93	93	96	97
New Jersey	98	90	95	95
New Mexico	91	90	91	92
New York	71	56	57	60
North Carolina	90	90	92	93

	Share of enrollment for the largest three insurers (%)			
State	**2010**	**2011**	**2012**	**2013**
North Dakota	94	90	90	93
Ohio	71	80	84	84
Oklahoma	81	79	86	88
Oregon	66	65	63	62
Pennsylvania	74	72	69	74
Rhode Island	100	100	100	99
South Carolina	78	80	82	82
South Dakota	86	89	89	90
Tennessee	75	80	83	81
Texas	72	74	77	79
Utah	82	86	88	88
Vermont	100	99	99	100
Virginia	86	86	89	89
Washington	92	96	96	95
West Virginia	78	78	85	87
Wisconsin	56	59	60	65
Wyoming	74	71	72	71
Average	**83**	**83**	**85**	**86**

Source: GAO analysis of 2010 Supplemental Health Care Exhibit data from the National Association of Insurance Commissioners and 2011 through 2013 Medical Loss Ratio data from the Centers for Medicare & Medicaid Services. | GAO-15-101R.

Notes: We measured enrollment using covered life-years, which represent the average number of lives insured, including dependents, on a pre-specified day over the 12 months in the reporting year.

[a]We excluded 2010 data for California because the National Association of Insurance Commissioners' data for this state did not include all insurers in this year.

Table 2: Share of Enrollment for the Largest Three Insurers by State in the Small Group Market, 2010 through 2013

	Share of enrollment for the largest three insurers (%)			
State	**2010**	**2011**	**2012**	**2013**
Alabama	99	100	100	100
Alaska	88	87	89	88
Arizona	72	66	67	69
Arkansas	92	95	97	98
California[a]	–	63	76	75
Colorado	75	81	82	81
Connecticut	80	83	85	84
Delaware	97	95	97	97
District of Columbia	96	94	96	96
Florida	87	80	82	84
Georgia	73	69	65	66
Hawaii	94	83	87	85
Idaho	95	96	96	94
Illinois	80	81	84	86
Indiana	73	76	77	80
Iowa	90	90	94	91
Kansas	81	81	84	79
Kentucky	98	93	94	95
Louisiana	93	95	96	97
Maine	98	98	98	99
Maryland	96	91	91	95
Massachusetts	83	81	83	82
Michigan	74	81	80	79
Minnesota	88	84	90	91
Mississippi	93	97	98	98
Missouri	71	78	79	78
Montana	87	90	88	91
Nebraska	80	89	91	88
Nevada	76	73	73	76
New Hampshire	97	99	99	99
New Jersey	94	92	90	87
New Mexico	82	87	89	88
New York	68	67	70	74
North Carolina	95	95	95	93
North Dakota	100	99	98	98
Ohio	70	78	80	81
Oklahoma	74	76	81	88
Oregon	60	60	60	56

	Share of enrollment for the largest three insurers (%)			
State	**2010**	**2011**	**2012**	**2013**
Pennsylvania	73	57	55	55
Rhode Island	99	99	100	100
South Carolina	90	90	89	89
South Dakota	91	90	91	90
Tennessee	95	95	96	95
Texas	77	80	85	87
Utah	82	78	78	77
Vermont	100	100	100	100
Virginia	75	76	79	76
Washington	77	78	77	75
West Virginia	89	92	95	94
Wisconsin	59	51	51	54
Wyoming	86	88	87	87
Average	**85**	**84**	**86**	**85**

Source: GAO analysis of 2010 Supplemental Health Care Exhibit data from the National Association of Insurance Commissioners and 2011 through 2013 Medical Loss Ratio data from the Centers for Medicare & Medicaid Services. | GAO-15-101R.

Notes: We measured enrollment using covered life-years, which represent the average number of lives insured, including dependents, on a pre-specified day over the 12 months in the reporting year.

[a]We excluded 2010 data for California because the National Association of Insurance Commissioners' data for this state did not include all insurers in this year.

Table 3: Share of Enrollment for the Largest Three Insurers by State in the Large Group Market, 2010 through 2013

	Share of enrollment for the largest three insurers (%)			
State	**2010**	**2011**	**2012**	**2013**
Alabama	99	100	100	100
Alaska	99	99	100	99
Arizona	73	80	79	79
Arkansas	98	99	99	99
California[a]	–	69	70	74
Colorado	83	84	86	86
Connecticut	77	73	72	71
Delaware	97	94	93	93
District of Columbia	83	75	77	80
Florida	77	76	81	83
Georgia	80	83	81	77
Hawaii	97	93	94	93
Idaho	96	97	97	97
Illinois	86	86	86	90
Indiana	78	82	86	89
Iowa	93	94	95	93
Kansas	93	92	90	81
Kentucky	94	88	89	92
Louisiana	87	88	83	87
Maine	95	94	95	94
Maryland	89	94	92	91
Massachusetts	85	85	84	85
Michigan	90	80	80	78
Minnesota	93	83	95	95
Mississippi	96	97	98	99
Missouri	78	75	79	78
Montana	97	99	99	99
Nebraska	94	99	99	95
Nevada	88	87	88	87
New Hampshire	93	94	94	95
New Jersey	83	86	86	85
New Mexico	94	93	94	94
New York	69	62	68	66
North Carolina	93	93	92	93
North Dakota	100	99	99	100
Ohio	76	79	80	80
Oklahoma	84	80	82	82
Oregon	74	77	77	78

	Share of enrollment for the largest three insurers (%)			
State	**2010**	**2011**	**2012**	**2013**
Pennsylvania	73	69	71	67
Rhode Island	98	98	97	97
South Carolina	97	98	97	98
South Dakota	89	88	89	89
Tennessee	89	93	94	94
Texas	77	82	83	83
Utah	92	90	88	87
Vermont	99	100	100	100
Virginia	71	75	77	75
Washington	90	89	88	88
West Virginia	97	96	98	95
Wisconsin	41	41	38	39
Wyoming	95	96	95	96
Average	**87**	**87**	**87**	**87**

Source: GAO analysis of 2010 Supplemental Health Care Exhibit data from the National Association of Insurance Commissioners and 2011 through 2013 Medical Loss Ratio data from the Centers for Medicare & Medicaid Services. | GAO-15-101R.

Notes: We measured enrollment using covered life-years, which represent the average number of lives insured, including dependents, on a pre-specified day over the 12 months in the reporting year.

[a]We excluded 2010 data for California because the National Association of Insurance Commissioners' data for this state did not include all insurers in this year.

Share of Enrollment for the Largest Insurer by State in the Individual, Small Group, and Large Group Markets from 2010 through 2013

The three tables below show the share of enrollment for the largest insurer by state in the individual, small group, and large group markets from 2010 through 2013, as well as which of these insurers was a Blue Cross and Blue Shield insurer.

Table 4: Share of Enrollment for the Largest Insurer by State in the Individual Market, 2010 through 2013

		Share of enrollment for the largest insurer (%)			
State	**Largest insurer**	**2010**	**2011**	**2012**	**2013**
Alabama	BCBS OF AL GRP†	86	90	91	90
Alaska	PREMERA BLUE CROSS GROUP†	58	58	60	61
Arizona	BLUE CROSS AND BLUE SHIELD OF ARIZONA, INC.†	49	49	50	49
Arkansas	ARKANSAS BCBS GRP†	76	79	80	79
California[a]	WELLPOINT INC GRP†	–	37	47	46
Colorado	WELLPOINT INC GRP†	30	32	34	35
Connecticut	WELLPOINT INC GRP†	52	48	44	39
Delaware	HIGHMARK GRP†	50	51	49	53
District of Columbia	CAREFIRST INC GRP†	73	69	70	71
Florida	BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC. †	49	47	49	47
Georgia	WELLPOINT INC GRP†	47	48	46	42
Hawaii	HAWAII MEDICAL SERVICE ASSOCIATION†	52	52	52	50
Idaho	REGENCE GRP†	38	*	*	*
	BLUE CROSS OF IDAHO HEALTH SERVICE, INC. †	*	44	45	50
Illinois	HCSC GRP†	65	66	67	67
Indiana	WELLPOINT INC GRP†	64	62	62	59
Iowa	WELLMARK GROUP†	83	83	64	84
Kansas	BCBS OF KS GRP†	45	47	42	39
Kentucky	WELLPOINT INC GRP†	83	79	81	79
Louisiana	LOUISIANA HLTH SERV GRP†	73	72	74	73
Maine	WELLPOINT INC GRP†	49	45	49	55
Maryland	CAREFIRST INC GRP†	71	70	67	64
Massachusetts	BCBS OF MA GRP†	57	63	39	34
Michigan	BCBS OF MI GRP†	59	56	54	54
Minnesota	BCBS OF MN GRP†	66	63	59	57
Mississippi	MISSISSIPPI INS GRP†	54	57	60	62
Missouri	WELLPOINT INC GRP†	31	32	33	34
Montana	HCSC GRP†	*	*	*	57
	BLUE CROSS BLUE SHIELD OF MONTANA†	51	56	62	*

State	Largest insurer	Share of enrollment for the largest insurer (%)			
		2010	2011	2012	2013
Nebraska	BLUE CROSS AND BLUE SHIELD OF NEBRASKA†	63	65	69	70
Nevada	UNITEDHEALTH GRP	39	42	45	46
New Hampshire	WELLPOINT INC GRP†	67	76	81	83
New Jersey	BCBS OF NJ GRP†	73	63	75	78
New Mexico	HCSC GRP†	59	53	49	49
New York	WELLPOINT INC GRP†	33	25	25	24
North Carolina	BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA†	80	83	85	86
North Dakota	NORIDIAN MUTUAL INSURANCE COMPANY†	77	75	75	78
Ohio	WELLPOINT INC GRP†	*	36	36	*
	MEDICAL MUTUAL OF OHIO	36	*	*	35
Oklahoma	HCSC GRP†	59	58	63	64
Oregon	REGENCE GRP†	38	35	33	31
Pennsylvania	HIGHMARK GRP†	32	33	35	35
Rhode Island	UNITEDHEALTH GRP	52	*	*	*
	BLUE CROSS & BLUE SHIELD OF RHODE ISLAND†	*	95	94	92
South Carolina	BCBS OF SC GRP†	53	55	57	58
South Dakota	WELLMARK GROUP†	73	74	74	73
Tennessee	BCBS OF TN INC†	36	*	39	42
	TRH HEALTH INSURANCE COMPANY	*	37	*	*
Texas	HCSC GRP†	55	57	59	60
Utah	IHC INC GRP	44	43	41	41
Vermont	BCBS OF VT GRP†	75	77	90	92
Virginia	WELLPOINT INC GRP†	74	74	75	74
Washington	PREMERA BLUE CROSS GROUP†	*	*	40	39
	REGENCE GRP†	45	37	*	*
West Virginia	HIGHMARK GRP†	41	44	54	54
Wisconsin	WISCONSIN PHYSICIANS SERV INS GRP	*	23	24	26
	WELLPOINT INC GRP†	21	*	*	*
Wyoming	BLUE CROSS BLUE SHIELD OF WYOMING†	42	38	38	40

Legend: * This symbol indicates that this insurer was not the largest in that particular year. †This symbol indicates an insurer that we identified as being an independent licensee of the Blue Cross and Blue Shield Association in the designated state. An insurer may or may not be the Blue Cross and Blue Shield licensee in all counties within the state.

Source: GAO analysis of 2010 Supplemental Health Care Exhibit data from the National Association of Insurance Commissioners and 2011 through 2013 Medical Loss Ratio data from the Centers for Medicare & Medicaid Services. | GAO-15-101R.

Notes: We measured enrollment using covered life-years, which represent the average number of lives insured, including dependents, on a pre-specified day over the 12 months in the reporting year. We reprinted insurer names as they were reported in the data from the Centers for Medicare & Medicaid Services and the National Association of Insurance Commissioners.

[a]We excluded 2010 data for California because the National Association of Insurance Commissioners' data for this state did not include all insurers in this year.

Table 5: Share of Enrollment for the Largest Insurer by State in the Small Group Market, 2010 through 2013

		Share of enrollment for the largest insurer (%)			
State	**Largest insurer**	**2010**	**2011**	**2012**	**2013**
Alabama	BCBS OF AL GRP†	96	97	97	97
Alaska	PREMERA BLUE CROSS GROUP†	71	72	69	65
Arizona	AETNA GRP	26	*	*	*
	BLUE CROSS AND BLUE SHIELD OF ARIZONA, INC. †	*	26	26	24
Arkansas	ARKANSAS BCBS GRP†	51	56	61	65
California[a]	KAISER FOUNDATION GRP	–	30	31	31
Colorado	UNITEDHEALTH GRP	32	31	32	30
Connecticut	WELLPOINT INC GRP†	*	31	37	40
	UNITEDHEALTH GRP	31	*	*	*
Delaware	HIGHMARK GRP†	57	61	65	64
District of Columbia	CAREFIRST INC GRP†	63	76	81	81
Florida	UNITEDHEALTH GRP	39	36	36	36
Georgia	WELLPOINT INC GRP†	31	41	36	34
Hawaii	HAWAII MEDICAL SERVICE ASSOCIATION†	67	50	45	48
Idaho	REGENCE GRP†	45	*	*	*
	BLUE CROSS OF IDAHO HEALTH SERVICE, INC. †	*	48	50	49
Illinois	HCSC GRP†	51	57	59	59
Indiana	WELLPOINT INC GRP†	52	56	55	54
Iowa	WELLMARK GROUP†	61	61	62	63
Kansas	BCBS OF KS GRP†	61	58	59	61
Kentucky	WELLPOINT INC GRP†	63	72	70	67
Louisiana	LOUISIANA HLTH SERV GRP†	80	81	81	81
Maine	WELLPOINT INC GRP†	46	50	48	40
Maryland	CAREFIRST INC GRP†	70	72	73	69
Massachusetts	BCBS OF MA GRP†	46	40	40	41
Michigan	BCBS OF MI GRP†	62	52	55	57
Minnesota	BCBS OF MN GRP†	50	37	36	37
Mississippi	MISSISSIPPI INS GRP†	80	73	87	84
Missouri	WELLPOINT INC GRP†	42	48	46	48
Montana	HCSC GRP†	*	*	*	68
	BLUE CROSS BLUE SHIELD OF MONTANA†	71	72	69	*
Nebraska	BLUE CROSS AND BLUE SHIELD OF NEBRASKA†	42	42	56	61
Nevada	UNITEDHEALTH GRP	47	35	35	36
New Hampshire	WELLPOINT INC GRP†	60	67	75	73
New Jersey	BCBS OF NJ GRP†	47	59	59	59

State	Largest insurer	Share of enrollment for the largest insurer (%)			
		2010	2011	2012	2013
New Mexico	PRESBYTERIAN HLTHCARE SERV GRP	*	*	31	33
	HCSC GRP†	34	31	*	*
New York	UNITEDHEALTH GRP	41	36	44	48
North Carolina	BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA†	63	63	62	62
North Dakota	NORIDIAN MUTUAL INSURANCE COMPANY†	88	85	86	86
Ohio	WELLPOINT INC GRP†	34	41	40	40
Oklahoma	HCSC GRP†	46	48	55	60
Oregon	REGENCE GRP†	24	21	*	*
	PACIFICSOURCE HLTH PLAN GRP	*	*	22	23
Pennsylvania	AETNA GRP	37	*	*	*
	HIGHMARK GRP†	*	24	22	*
	INDEPENDENCE BLUE CROSS GRP†	*	*	*	21
Rhode Island	BLUE CROSS & BLUE SHIELD OF RHODE ISLAND†	70	74	75	76
South Carolina	BCBS OF SC GRP†	67	70	67	69
South Dakota	WELLMARK GROUP†	66	62	60	59
Tennessee	BCBS OF TN INC†	70	70	70	69
Texas	HCSC GRP†	39	46	51	53
Utah	IHC INC GRP	40	42	41	40
Vermont	CIGNA HLTH GRP	38	*	*	*
	BCBS OF VT GRP†	*	43	74	74
Virginia	WELLPOINT INC GRP†	47	50	48	46
Washington	PREMERA BLUE CROSS GROUP†	*	33	36	37
	REGENCE GRP†	50	*	*	*
West Virginia	HIGHMARK GRP†	50	57	66	73
Wisconsin	UNITEDHEALTH GRP	35	30	30	33
Wyoming	BLUE CROSS BLUE SHIELD OF WYOMING†	55	61	58	60

Legend: * This symbol indicates that this insurer was not the largest in that particular year. †This symbol indicates an insurer that we identified as being an independent licensee of the Blue Cross and Blue Shield Association in the designated state. An insurer may or may not be the Blue Cross and Blue Shield licensee in all counties within the state.

Source: GAO analysis of 2010 Supplemental Health Care Exhibit data from the National Association of Insurance Commissioners and 2011 through 2013 Medical Loss Ratio data from the Centers for Medicare & Medicaid Services. | GAO-15-101R.

Notes: We measured enrollment using covered life-years, which represent the average number of lives insured, including dependents, on a pre-specified day over the 12 months in the reporting year. We reprinted insurer names as they were reported in the data from the Centers for Medicare & Medicaid Services and the National Association of Insurance Commissioners.

[a]We excluded 2010 data for California because the National Association of Insurance Commissioners' data for this state did not include all insurers in this year.

Table 6: Share of Enrollment for the Largest Insurer by State in the Large Group Market, 2010 through 2013

		Share of enrollment for the largest insurer (%)			
State	**Largest insurer**	**2010**	**2011**	**2012**	**2013**
Alabama	BCBS OF AL GRP†	93	92	92	92
Alaska	PREMERA BLUE CROSS GROUP†	79	79	84	85
Arizona	UNITEDHEALTH GRP	*	39	*	*
	BLUE CROSS AND BLUE SHIELD OF ARIZONA, INC. †	40	*	31	33
Arkansas	ARKANSAS BCBS GRP†	80	78	77	78
California[a]	KAISER FOUNDATION GRP	–	42	41	41
Colorado	KAISER FOUNDATION GRP	47	47	48	47
Connecticut	WELLPOINT INC GRP†	48	38	35	34
Delaware	HIGHMARK GRP†	63	71	69	66
District of Columbia	AETNA INC	*	29	31	34
	KAISER FOUNDATION GRP	30	*	*	*
Florida	BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC. †	42	42	49	54
Georgia	WELLPOINT INC GRP†	56	52	50	44
Hawaii	HAWAII MEDICAL SERVICE ASSOCIATION†	60	62	70	69
Idaho	BLUE CROSS OF IDAHO HEALTH SERVICE, INC. †	71	68	67	67
Illinois	HCSC GRP†	74	68	69	72
Indiana	WELLPOINT INC GRP†	59	55	60	62
Iowa	WELLMARK GROUP†	76	74	77	76
Kansas	BCBS OF KS GRP†	56	47	45	46
Kentucky	WELLPOINT INC GRP†	65	62	63	67
Louisiana	LOUISIANA HLTH SERV GRP†	61	65	64	64
Maine	WELLPOINT INC GRP†	74	74	73	73
Maryland	CAREFIRST INC GRP†	51	62	70	70
Massachusetts	BCBS OF MA GRP†	53	54	54	56
Michigan	BCBS OF MI GRP†	62	52	51	52
Minnesota	HEALTHPARTNERS GRP	45	39	48	45
Mississippi	MISSISSIPPI INS GRP†	84	81	84	83
Missouri	WELLPOINT INC GRP†	39	33	36	36
Montana	HCSC GRP†	*	*	*	80
	BLUE CROSS BLUE SHIELD OF MONTANA†	66	66	81	*
Nebraska	BLUE CROSS AND BLUE SHIELD OF NEBRASKA†	77	86	80	82
Nevada	UNITEDHEALTH GRP	66	66	68	66
New Hampshire	WELLPOINT INC GRP†	52	55	60	57
New Jersey	BCBS OF NJ GRP†	52	54	54	56

State	Largest insurer	Share of enrollment for the largest insurer (%) 2010	2011	2012	2013
New Mexico	HCSC GRP†	47	40	39	40
New York	UNITEDHEALTH GRP	29	26	26	*
	HIP INS GRP	*	*	*	23
North Carolina	BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA†	78	73	73	76
North Dakota	NORIDIAN MUTUAL INSURANCE COMPANY†	97	97	96	97
Ohio	WELLPOINT INC GRP†	45	42	41	41
Oklahoma	HCSC GRP†	53	52	52	54
Oregon	KAISER FOUNDATION GRP	39	41	41	41
Pennsylvania	HIGHMARK GRP†	*	32	36	36
	INDEPENDENCE BLUE CROSS GRP†	31	*	*	*
Rhode Island	BLUE CROSS & BLUE SHIELD OF RHODE ISLAND†	83	74	77	78
South Carolina	BCBS OF SC GRP†	92	93	90	91
South Dakota	WELLMARK GROUP†	56	56	59	60
Tennessee	BCBS OF TN INC†	63	72	75	78
Texas	HCSC GRP†	46	46	46	48
Utah	IHC INC GRP	48	49	48	45
Vermont	BCBS OF VT GRP†	62	73	78	79
Virginia	WELLPOINT INC GRP†	45	52	46	44
Washington	PREMERA BLUE CROSS GROUP†	33	*	*	*
	GROUP HLTH COOP GRP	*	33	33	31
West Virginia	HIGHMARK GRP†	74	81	82	84
Wisconsin	UNITEDHEALTH GRP	16	16	*	*
	DEAN HEALTH GRP	*	*	16	15
Wyoming	BLUE CROSS BLUE SHIELD OF WYOMING†	66	73	75	76

Legend: * This symbol indicates that this insurer was not the largest in that particular year. †This symbol indicates an insurer that we identified as being an independent licensee of the Blue Cross and Blue Shield Association in the designated state. An insurer may or may not be the Blue Cross and Blue Shield licensee in all counties within the state.

Source: GAO analysis of 2010 Supplemental Health Care Exhibit data from the National Association of Insurance Commissioners and 2011 through 2013 Medical Loss Ratio data from the Centers for Medicare & Medicaid Services. | GAO-15-101R.

Notes: We measured enrollment using covered life-years, which represent the average number of lives insured, including dependents, on a pre-specified day over the 12 months in the reporting year. We reprinted insurer names as they were reported in the data from the Centers for Medicare & Medicaid Services and the National Association of Insurance Commissioners.

[a]We excluded 2010 data for California because the National Association of Insurance Commissioners' data for this state did not include all insurers in this year.

(291197)

Taking Stock: Health Insurance Coverage under the ACA as of September 2014

Sharon K. Long, Michael Karpman, Adele Shartzer, Douglas Wissoker, Genevieve M. Kenney, Stephen Zuckerman, Nathaniel Anderson, and Katherine Hempstead

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At a Glance

- The number of uninsured nonelderly adults fell by an estimated 10.6 million between September 2013 and September 2014 as the uninsurance rate fell from 17.7 percent to 12.4 percent—a drop of 30.1 percent.
- Most of the gain in coverage was among the low- and middle-income adults targeted by the ACA's Medicaid and Marketplace provisions.
- The uninsurance rate dropped 36.3 percent in states that implemented the ACA's Medicaid expansion, compared with 23.9 percent in nonexpansion states; 54.7 percent of uninsured nonelderly adults lived in nonexpansion states in September 2014.

The Urban Institute's Health Reform Monitoring Survey (HRMS) has been tracking insurance coverage since the first quarter of 2013. Data from the HRMS have provided an early look at changes in the nation's uninsurance rate following the implementation of the Affordable Care Act's (ACA) key coverage expansion provisions, including the launch of new health insurance Marketplaces and the state option to expand Medicaid to nearly all adults with family income at or below 138 percent of the federal poverty level (FPL).[1] The HRMS provides early feedback on ACA implementation to complement the more robust assessments that will be possible when the federal surveys, which are on a slower schedule, begin to release data (Long, Kenney, Zuckerman, Goin, et al. 2014).[2]

Between September 2013, just before the first Marketplace open enrollment period, and early March 2014, just before the end of the open enrollment period, an estimated 5.4 million nonelderly adults (ages 18 to 64) gained coverage as the uninsurance rate fell by 2.7 percentage points (Long, Kenney, Zuckerman, Wissoker, Goin, et al. 2014). By June 2014, following a surge in Marketplace enrollment in March and April (Assistant Secretary for Planning and Evaluation 2014) and accelerated growth in Medicaid enrollment through the spring and summer,[3] the estimated decline in the uninsurance rate was 4.0 percentage points—equivalent to approximately 8.0 million nonelderly adults—since September 2013 (Long, Kenney, Zuckerman, Wissoker, Shartzer, et al. 2014). Data from other rapid-cycle surveys tracking changes in coverage show similar patterns (Carman and Eibner 2014; Collins, Rasmussen, and Doty 2014; Sommers et al. 2014), and the US Centers for Disease Control and Prevention estimates that 3.8 million nonelderly adults gained coverage between 2013 and January-March 2014 (Cohen and Martinez 2014).[4]

This brief examines continued changes in the uninsurance rate for nonelderly adults through September 2014, when the most recent round of the HRMS was completed. Though the Marketplace open enrollment period ended in April 2014, those who have since experienced a qualifying life event, such as marriage, divorce, birth or adoption of a child, or loss of coverage, have been eligible to apply for coverage through the Marketplace during a special enrollment period.[5] Also, coverage may change because enrollment in Medicaid is available to eligible adults any time during the year, and the nation's ongoing economic recovery may cause gains in private coverage. Moreover, states' continued processing of their Medicaid application backlogs may have led to

increased Medicaid enrollment (including coverage retroactive to the application date).[6] Simultaneously, other factors may dampen coverage gains, such as a decline in coverage because some Marketplace plan enrollees failed to pay their premiums.

What We Did

Our analysis compares the estimated uninsurance rate for nonelderly adults from September 2013 through September 2014. We focus on estimated changes in the uninsurance rate because estimates of the level of uninsurance often vary across survey programs because of differences in the surveys unrelated to the ACA (State Health Access Data Assistance Center 2013). Although the HRMS includes information for all four quarters of 2013, we focus on changes between quarter 3 2013 (the survey for which was fielded in September 2013, just before the first Marketplace open enrollment period) and quarter 3 2014 (the survey for which was fielded in September 2014).[7]

Although each round of the HRMS is weighted to be nationally representative, it is important in examining changes over time that we base our estimates on comparable samples over time. For example, if the share of those with insurance grows simply because more respondents were older or from higher income groups than in an earlier round of the survey, it would be incorrect to associate such a change with the ACA Marketplaces and Medicaid expansions. This is particularly challenging for comparing estimates from survey samples over time because the composition of the sample surveyed can change from round to round in ways that are not fully captured in the weights and that may distort the estimates of change.

To control for the potential influence of changes in the characteristics of the HRMS sample, we estimate weighted regression models that control for demographic and socioeconomic characteristics, internet access, and geography.[8] We consider changes in insurance coverage for (1) all nonelderly adults;[9] (2) adults targeted by the Medicaid expansion and the Marketplaces; (3) adults in states that had and had not adopted the ACA's optional Medicaid expansion by September 1, 2014; and (4) adults in important demographic and socioeconomic subgroups such as age, gender, race and ethnicity, and family income. Controlling for differences in the respondents' characteristics through time allows us to remove variation in insurance coverage caused by changes in the types of people responding to the survey rather than by changes in the health insurance landscape. In presenting the regression-adjusted estimates, we use the predicted rate of uninsurance in each quarter for the same nationally representative population. For this analysis, we base the nationally representative sample on survey respondents from the most recent 12-month period of the HRMS (i.e., quarter 4 of 2013 and quarters 1–3 of 2014). Although we control for sample characteristics over time, we are not attempting to disentangle the effects of the ACA from other factors that also changed between September 2013 and September 2014, such as gains in insurance coverage caused by the economy continuing to recover from the recession.

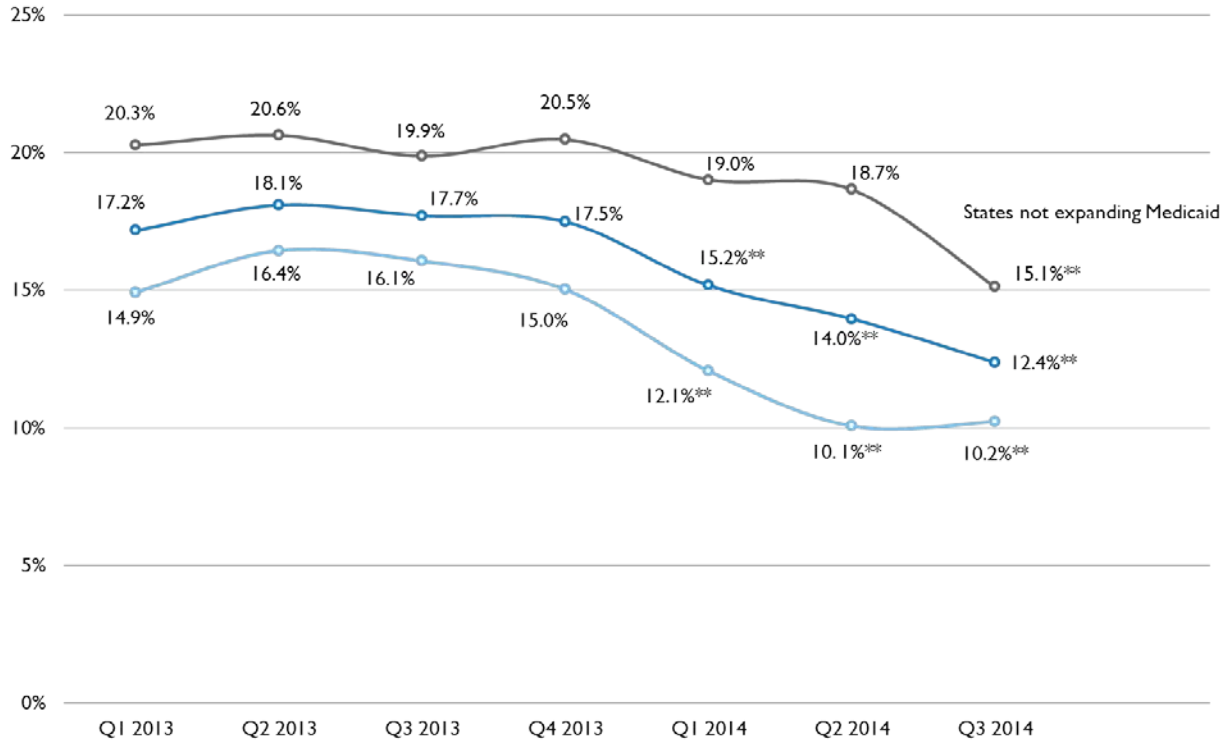
In discussing our findings, we focus on statistically significant changes in insurance coverage over time (defined as differences that are significantly different from zero at the 5 percent level or lower) and highlight changes relative to September 2013. We provide a 95 percent confidence interval (CI) for key estimates. The basic patterns shown for the regression-adjusted measures are similar to those based solely on simple weighted (unadjusted) estimates. To extrapolate our estimates of changes in uninsurance rates to the number of adults who have gained coverage over the same period, we use projections for the size of the 2014 population from the US Census Bureau.[10]

What We Found

The number of uninsured nonelderly adults fell by an estimated 10.6 million between September 2013 and September 2014: a drop of 30.1 percent in the uninsurance rate. In September 2014, the uninsurance rate for nonelderly adults was estimated to be 12.4 percent (95% CI [11.6, 13.2]) for the nation, a drop of 5.3 percentage points (95% CI [4.3, 6.4]) since September 2013 (figure 1).[11] Applying the estimated 5.3 percentage-point decrease in the uninsured rate to the estimated national population of nonelderly adults implies that the number of uninsured adults declined by 10.6 million between September 2013 and September 2014 (95% CI [8.5 million, 12.6 million]).

Adults in states that implemented the ACA's Medicaid expansion sustained the large coverage gains from the previous quarter, and insurance coverage also rose sharply for adults in nonexpansion states. The uninsurance rate for adults in expansion states dropped 5.8 percentage points (95% CI [4.5, 7.2]) since September 2013; the rate dropped 4.8 percentage points (95% CI [3.2, 6.3]) in the nonexpansion states. This is a decline in the uninsurance rate of 36.3 percent in expansion states and 23.9 percent in nonexpansion states. Most of the estimated decline in the uninsurance rate in the nonexpansion states occurred between June and September 2014 (figure 1). Consequently, the gap in the uninsurance rate between expansion and nonexpansion states, which had widened between September 2013 and June 2014, narrowed somewhat between June 2014 and September 2014. Nonetheless, in September 2014, the uninsurance rate in expansion states was 4.9 percentage points lower than in nonexpansion states; that difference was 3.8 percentage points in September 2013. In September 2014, 54.7 percent of uninsured adults resided in nonexpansion states.

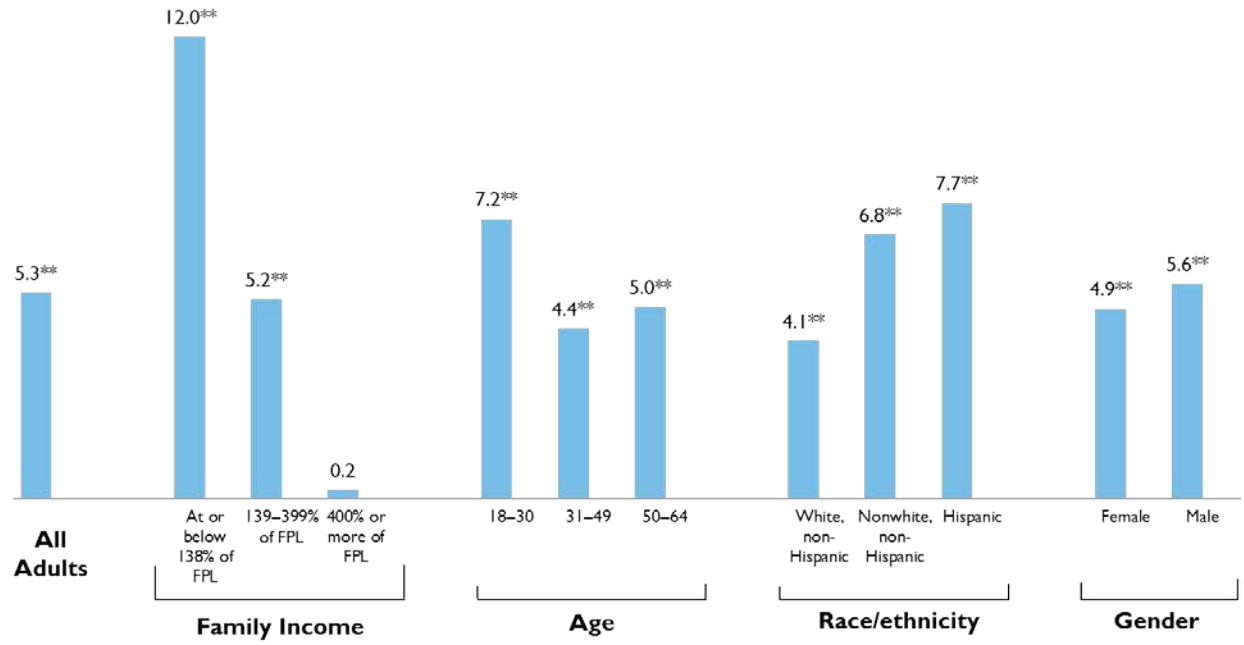
Figure 1. Trends in Uninsurance for Adults Ages 18 to 64 from Quarter 1 2013 to Quarter 3 2014



Source: Health Reform Monitoring Survey, quarter 1 2013 through quarter 3 2014.
Notes: Estimates are regression adjusted.
*/** Estimate differs significantly from quarter 3 2013 at the .05/.01 levels, using two-tailed tests.

Low- and middle-income adults targeted by the ACA's key coverage provisions reported large gains in insurance coverage. Insurance coverage increased by 12.0 percentage points (95% CI [9.2, 14.7]) between September 2013 and September 2014 for low-income adults (those with family income at or below 138 percent of FPL, the target population for the ACA's Medicaid expansion) and by 5.2 percentage points (95% CI [3.4, 6.9]) for middle-income adults (those with family income from 139 to 399 percent of FPL, the target population for the new health insurance subsidies available through the Marketplaces) (figure 2).

Figure 2. Percentage-Point Increase in Insurance Coverage for Adults Ages 18 to 64 between Quarter 3 2013 and Quarter 3 2014

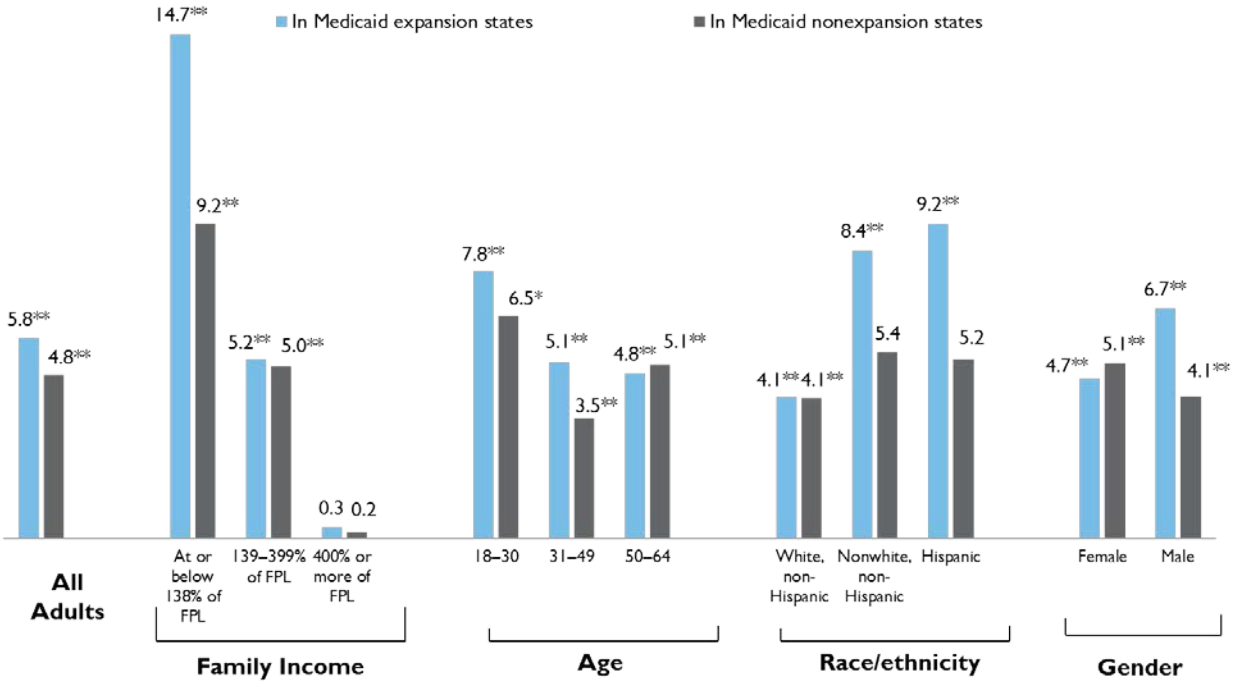


Source: Health Reform Monitoring Survey, quarter 1 2013 through quarter 3 2014.
Notes: Estimates are regression adjusted. FPL is federal poverty level.
*/** Estimate differs significantly from zero at the .05/.01 levels, using two-tailed tests.

Low-income adults targeted by the Medicaid expansion had large gains in insurance coverage in expansion states (figure 3). Insurance coverage increased by 14.7 percentage points (95% CI [9.7, 19.7]), or 40.2 percent, between September 2013 and September 2014 for low-income adults in expansion states. Dissimilar to earlier HRMS findings, insurance coverage increased 9.2 percentage points (95% CI [6.9, 11.4]) for low-income adults in nonexpansion states, with the majority of the increase occurring between June and September 2014. This increase in coverage was likely caused by a gain in Medicaid coverage: there was no evidence of an increase in employer-sponsored coverage over the period (data not shown), and most of the low-income adults would not be eligible for subsidized Marketplace coverage.

Middle-income adults who could potentially qualify for Marketplace subsidies experienced similar gains in coverage in expansion and nonexpansion states from September 2013 to September 2014: an increase of 5.2 percentage points (95% CI [3.3, 7.2]) and 5.0 percentage points (95% CI [2.1, 7.9]), respectively.

Figure 3. Percentage-Point Increase in Insurance Coverage for Adults Ages 18 to 64 between Quarter 3 2013 and Quarter 3 2014, by State Medicaid Expansion Status



Source: Health Reform Monitoring Survey, quarter 1 2013 through quarter 3 2014.
Notes: Estimates are regression adjusted. FPL is federal poverty level.
*/** Estimate differs significantly from zero at the .05/.01 levels, using two-tailed tests.

Assessing the Estimate of Coverage Gains in the Nonexpansion States

We conducted several analyses to assess the significant gains in coverage for low-income adults in nonexpansion states between June 2014 and September 2014, which drove the overall decline in uninsurance estimated for adults in those states between September 2013 and September 2014. These analyses included (but were not limited to) (1) a comparison across quarters of the characteristics of the HRMS sample, survey respondents, and survey nonrespondents to see if the results could be attributed to changes in sampling or response patterns; (2) the use of alternative regression-adjustment models that included additional demographic and socioeconomic characteristics, interactions between quarters and characteristics, and measures of sampling for the survey and survey response in previous rounds of the HRMS[12] to see whether there was evidence of panel conditioning; (3) a comparison between changes in the uninsurance rate among those who completed the survey in the previous quarter (June 2014) and the change for the portion of each sample that did not complete the survey in both quarters, to test whether changes reported by individuals followed over time were consistent with those estimated for the remaining sample; and (4) an analysis of coverage changes in individual states to see whether there were changes in coverage in particular states that were driving the results. Our results were robust to all of the sensitivity tests that were conducted. We found no evidence that the results were driven by changing sample or respondent characteristics, by outlier states, or by sample members' participation in earlier rounds of the survey.

We also benchmarked our estimates with external data sources where possible, including administrative data and data from other surveys. The overall coverage gains for low-income adults in nonexpansion states between September 2013 and September 2014 are consistent with administrative data on the change in Medicaid and CHIP enrollment in nonexpansion states between July through September 2013 and September 2014 (Centers for Medicare and Medicaid Services 2014a, 2014b).[13] However, most of those enrollment gains occurred before June 2014 in the administrative data. One possible explanation for the HRMS data showing a gain between June 2014 and September 2014 is that individuals with Medicaid applications in processing backlogs may not have realized they were covered by Medicaid as they waited for official notice of Medicaid coverage. Administrative data would capture coverage gains caused by retrospective eligibility that would not be reported by the individual.

The comparison to data from other sources included a comparison to findings from the Gallup-Healthways Well-Being Index, which has a much larger sample size than the HRMS. Though the patterns of change across quarters are different (Gallup data shows no decline in uninsurance beyond quarter 2 2014), both the HRMS and Gallup show a 5.3 percentage-point decline in uninsurance among nonelderly adults between quarter 3 2013 and quarter 3 2014 (data not shown).[14] HRMS and Gallup also estimate similar reductions in uninsurance in expansion states (6.4 percentage points in Gallup compared with 5.8 percentage points in the HRMS) and nonexpansion states (4.3 percentage points in Gallup compared with 4.8 percentage points in the HRMS). Furthermore, the two data sources are generally consistent when coverage changes are compared across broad income and age groups.

Finally, HRMS and Gallup estimates of the change in the overall uninsurance rate for nonelderly adults in both expansion and nonexpansion states are similar to estimated changes between 2013 and 2014 reported by Enroll America and Civis Analytics, which rely on a different methodology than both the HRMS and Gallup.[15] They estimate that the uninsured rate fell by approximately 5.1 percentage points for the national population of nonelderly adults, including declines of 5.7 percentage points in Medicaid expansion states and 4.4 percentage points in nonexpansion states.

The gains in coverage benefited adults across all age, sex, and race and ethnicity groups, with stronger gains among groups that historically have had higher uninsurance rates. As shown in figure 2, there were large gains in coverage for adults ages 18 to 30 (a 7.2 percentage–point increase; 95% CI [4.2, 10.3]), nonwhite, non-Hispanic adults (a 6.8 percentage–point increase; 95% CI [3.6, 10.1]) and Hispanic adults (a 7.7 percentage–point increase; 95% CI [4.3, 11.0]), groups that have historically had higher than average uninsurance rates. Coverage rates increased for both men and women (5.6 percentage points, 95% CI [3.5, 7.7], and 4.9 percentage points, 95% CI [3.2, 6.7], respectively). Historically, men have had a higher rate of uninsurance than women.

All of the population subgroups examined in the expansion states experienced gains in coverage except high-income adults (those with family incomes at or above 400 percent of FPL). Young adults, men, and minority adults reported strong gains in insurance coverage. In nonexpansion states, young adults and women reported the strongest gains. Though the magnitude of coverage gains for minority adults was greater than the gains for white, non-Hispanic adults, only the estimated increase in coverage for white, non-Hispanic adults was statistically significant, likely because of smaller sample sizes for minority groups in the HRMS.

What It Means

The uninsurance rate for nonelderly adults has fallen sharply since the first Marketplace open enrollment period began in October 2013, with larger gains in states that expanded Medicaid and among adults targeted by the Medicaid expansion and the new Marketplace subsidies. Our estimates show that approximately 10.6 million nonelderly adults (with a 95 percent confidence interval of 8.5 million to 12.6 million) gained coverage between September 2013 and September 2014: a 30.1 percent decrease in the national uninsurance rate for this population. As noted previously (Long, Kenney, Zuckerman, Wissoker, Shartzer, et al. 2014), these estimates do not reflect the effects of ACA provisions implemented before 2013 (such as the ability to keep dependents on a parent's health plan until age 26 and early state Medicaid expansions), nor do they account for changes in health insurance coverage that would have occurred independently of the ACA, such as those associated with an improving economy.

Beyond changes at the national level, we see a continued drop in uninsurance in the expansion states, at roughly 6 percentage points in September 2014 (a drop of 36 percent since September 2013), and, for the first time, a significant drop in uninsurance in the nonexpansion states: about 5 percentage points in September 2014 (a drop of 24 percent since September 2013). Most of the coverage gains in both the expansion and nonexpansion states are among low-income adults targeted by the Medicaid expansion. In the expansion states, nearly all low-income adults are now eligible for Medicaid; in the nonexpansion states, low-income adults include those who are eligible for Medicaid under the state's existing, and lower, income eligibility standards and those between 100 and 138 percent of FPL who are newly eligible for coverage (and subsidies) through the Marketplace.

Though the timing of the gains in nonexpansion states differs across survey and administrative sources, the overall change in coverage between September 2013 and September 2014 is consistent with existing survey and administrative data. However, we recognize that the magnitude of the quarter-to-quarter changes in HRMS do not line up as well with those sources. Consequently, we will continue to assess the timing of the coverage changes reported throughout the past year. For example, though we would have expected some increased enrollment among those previously eligible for Medicaid because of the expanded outreach and education efforts coinciding with the Marketplace open enrollment period (Sonier, Boudreaux, and Blewett 2013), administrative data from the end of May to the end of September suggest that at best, such gains were small in the nonexpansion states (Centers for Medicare and Medicaid Services 2014a, 2014b). However, the administrative data would include retrospective enrollment decisions, which may not reflect the respondent's assessment of his or her insurance coverage at the time of the survey. Individuals who had yet to be informed of their Medicaid eligibility might well have reported that they were uninsured. We have added survey questions to the quarter 4 2014 HRMS to better understand coverage changes among the low-income adults going forward, and we will benchmark the quarterly HRMS estimates for 2014 against quarterly data from the National Health Interview Survey as those data become available.

References

American Association for Public Opinion Research. 2010. *AAPOR Report on Online Panels*. Deerfield, IL: American Association for Public Opinion Research.

Assistant Secretary for Planning and Evaluation. 2014. *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period.* Washington, DC: United States Department of Health and Human Services.

Carman, Katherine Grace, and Christine Eibner. 2014. *Changes in Health Insurance Enrollment since 2013*. Santa Monica, CA: RAND Corporation.

Centers for Medicare and Medicaid Services. 2014a. *Medicaid and CHIP: May 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report.* Baltimore: US Department of Health and Human Services.

Centers for Medicare and Medicaid Services. 2014b. *Medicaid and CHIP: September 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report*. Baltimore: US Department of Health and Human Services.

Cohen, Robin A., and Michael E. Martinez. 2014. *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–March 2014*. Hyattsville, MD: National Center for Health Statistics.

Collins, Sara R., Petra W. Rasmussen, and Michelle M. Doty. 2014. *Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period.* New York: The Commonwealth Fund.

Long, Sharon K., Genevieve M. Kenney, Stephen Zuckerman, Dana E. Goin, Douglas Wissoker, Frederic Blavin, Linda J. Blumberg, Lisa Clemans-Cope, John Holahan, and Katherine Hempstead. 2014. "The Health Reform Monitoring Survey: Addressing Data Gaps to Provide Timely Insights into the Affordable Care Act." *Health Affairs* 33 (1): 161–67.

Long, Sharon K., Genevieve M. Kenney, Stephen Zuckerman, Douglas Wissoker, Dana E. Goin, Michael Karpman, and Nathaniel Anderson. 2014. "QuickTake: Number of Uninsured Adults Falls by 5.4 Million since 2013." Washington, DC: Urban Institute.

Long, Sharon K., Genevieve M. Kenney, Stephen Zuckerman, Douglas Wissoker, Adele Shartzer, Michael Karpman, Nathaniel Anderson, and Katherine Hempstead. 2014. "Taking Stock at Mid-Year: Health Insurance Coverage under the ACA as of June 2014." Washington, DC: Urban Institute.

Sommers, Benjamin D., Thomas Musco, Kenneth Finegold, Munira Z. Gunja, Amy Burke, and Audrey M. McDowell. 2014. "Health Reform and Changes in Health Insurance Coverage in 2014." *New England Journal of Medicine* 371: 867–74.

Sonier, Julie, Michel H. Boudreaux, and Lynn A. Blewett. 2013. "Medicaid 'Welcome-Mat' Effect of Affordable Care Act Implementation Could Be Substantial." *Health Affairs* 32 (7): 1319–25.

State Health Access Data Assistance Center. 2013. *Comparing Federal Government Surveys that Count the Uninsured.* Minneapolis, MN: Robert Wood Johnson Foundation.

About the Series

This brief is part of a series drawing on the Health Reform Monitoring Survey (HRMS), a quarterly survey of the nonelderly population that is exploring the value of cutting-edge Internet-based survey methods to monitor the Affordable Care Act (ACA) before data from federal government surveys are available. The briefs provide information on health insurance coverage, access to and use of

health care, health care affordability, and self-reported health status, as well as timely data on important implementation issues under the ACA. Funding for the core HRMS is provided by the Robert Wood Johnson Foundation, the Ford Foundation, and the Urban Institute.

For more information on the HRMS and for other briefs in this series, visit www.urban.org/hrms.

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Notes

[1] The list of states that have expanded Medicaid is increasing over time as more states decide to implement the ACA expansion. States that expanded Medicaid by September 1, 2014, are AZ, AR, CA, CO, CT, DE, DC, HI, IL, IA, KY, MD, MA, MI, MN, NH, NV, NJ, NM, NY, ND, OH, OR, RI, VT, WA, and WV. Several of those states, including CA, CT, DC, and MN, expanded Medicaid under the ACA before 2013.

[2] Benchmarking of the HRMS data against federal survey data is provided in Long, Kenney, Zuckerman, Goin, et al. 2014.

[3] "Medicaid and CHIP Application, Eligibility Determination, and Enrollment Data," Centers for Medicare and Medicaid Services, accessed November 21, 2014.

[4] Because data collection through the National Health Interview Survey was ongoing between January 2014 and March 2014, this figure does not fully reflect the change in health insurance coverage that occurred by March.

[5] "Getting Help Outside Open Enrollment: Applying for a Special Enrollment Period," Centers for Medicare and Medicaid Services, accessed November 21, 2014.

[6] Phil Galewitz, "More Than 1.7 Million Consumers Still Wait for Medicaid Decisions," *Kaiser Health News*, June 9, 2014.

[7] Although Marketplace coverage for people enrolling between October 2013 and December 2013 did not start until January 2014, some who signed up in the fall may have reported having coverage during the December 2013 HRMS survey. Further, some of those seeking coverage through the Marketplace between October 2013 and December 2013 were enrolled in Medicaid.

[8] Specifically, we control for the variables used in the poststratification weighting of the KnowledgePanel (the internet-based survey panel that underlies the HRMS) and the poststratification weighting of the HRMS. These variables are sex, age, race and ethnicity, language, education, marital status, whether any children are present in the household, household income, family income as a percentage of FPL, homeownership status, internet access, urban or rural status, and census region. In this analysis, we also control for citizenship status and participation in the previous quarter's survey (i.e., whether the respondent completed survey in the previous quarter, was sampled in the previous quarter but did not complete the survey, or was not sampled in the previous quarter).

[9] In this brief, we are not looking at the effects of the ACA on coverage for children, but we recognize that their coverage and well-being may be affected by their parent's enrollment in coverage or by other ACA provisions.

[10] We use 2014 national population predictions available from the US Census Bureau. These files give population projections by race, ethnicity, and sex of all ages from 2012 to 2060 based on estimated birth rates, death rates, and net migration rates. Using the "Table 1, Middle Series" file (which has a 2014 projected population of 318,892,103), we summed the 2014 population projections for all 18-to-64-year-olds to arrive at 198,461,688 nonelderly adults in 2014. See

US Census Bureau, "2012 National Population Projections: Downloadable Files," US Department of Commerce, last revised May 15, 2013.

[11]The uninsurance estimates reported here differ from some early estimates reported elsewhere. This reflects two factors: (1) we revised the editing process for insurance coverage in quarter 3 2013 to make better use of information from an open-ended follow-up question that was added in quarter 2 2013 to learn the type of insurance coverage of those who said they were covered but did not pick a type of coverage from the list provided, and (2) the regression-adjusted estimates are always based on the most recent four quarters of data (this brief, for example, uses quarter 4 2013 and quarters 1–3 2014).

[12] Because the HRMS is drawn from an Internet panel, there is the possibility of panel conditioning (American Association for Public Opinion Research 2010). To assess the possibility of such bias, we estimate models that included (1) the number of past quarters in which respondents completed the survey, (2) the number of past quarters in which the respondent was included in the HRMS sample but did not respond to the survey, (3) the number of quarters included in the HRMS sample, and (4) simple dummy variables for whether respondents completed the survey or did not respond to the survey in any past quarter.

[13] Between July 2013 through September 2013 and September 2014, Medicaid and CHIP enrollment increased by about 1.3 million people (both children and adults of all ages) in nonexpansion states, including Pennsylvania, where the Medicaid expansion will not take effect until 2015 (Centers for Medicare and Medicaid Services 2014c). Though the HRMS only distinguishes between adults with incomes at or below 100 percent of FPL and those with incomes 100–138 percent of FPL beginning in the September 2014 round, combining lower-income adults' estimated September 2013 to September 2014 coverage gain in nonexpansion states with the estimated September 2014 population of poor adults (those with under 100 percent of FPL) in nonexpansion states shows an increase in coverage of about 1.6 million poor adults, if we assume that they experienced the same change as all low-income adults in nonexpansion states. Therefore, our estimates may overstate the gains in coverage among poor adults in nonexpansion states. Simultaneously, we may be understating the gains in expansion states. Administrative data show Medicaid/CHIP enrollment growth of about 7.8 million from July 2013 through September 2013 to September 2014; our estimates imply a total coverage gain of about 6.4 million for nonelderly adults of all income groups.

[14] Quarterly estimates of uninsurance among nonelderly adults at the time of the Gallup survey were provided by the US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. These estimates are based on survey data collected throughout the quarter (e.g., July through September 2014 for quarter 3 2014, compared with HRMS estimates for quarter 3 2014 that rely on surveys completed only in September). We thank staff at the Office of the Assistant Secretary for Planning and Evaluation for providing these tabulations. More information on the Gallup-Healthways Well-Being Index is available at http://www.well-beingindex.com.

[15] Kevin Quealy and Margot Sanger-Katz, "Obamacare: Who Was Helped Most?" *New York Times*, October 29, 2014.

ASPE

RESEARCH BRIEF

HEALTH PLAN CHOICE AND PREMIUMS IN THE 2015 HEALTH INSURANCE MARKETPLACE

December 4, 2014

Since open enrollment began on November 15, 2014, millions of Americans can once again shop for high-quality, affordable health care coverage in the Health Insurance Marketplace established by the Affordable Care Act.[1] Our research indicates that the Affordable Care Act is working to enhance competition, expand choice and promote affordability among Marketplace health insurance plans in 2015.[2]

This year, the Marketplace is welcoming new consumers as well as encouraging those who enrolled last year to come back, update their information and select the plan that best meets their needs. All plans in the Marketplace cover essential health benefits and recommended preventive care, and do not exclude people based on preexisting conditions. Consumers can see detailed information about each health insurance plan offered in their area before they apply. Factors they may consider in choosing a health insurance plan include premiums, deductibles, out-of-pocket costs, provider network, formulary, customer service and more.[3] Consumers may be eligible for financial assistance to help pay for the cost of premiums. In fact, 85 percent of consumers who selected a Marketplace plan in 2014 received financial assistance.[4]

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[1] The Health Insurance Marketplace includes the Marketplaces established in each of the states (and the District of Columbia) and run by the state or the federal government. This report addresses the individual market Marketplaces that use the HealthCare.gov eligibility and enrollment system in both 2014 and 2015.

[2] It is important to note that this brief uses only information on individuals who selected a Marketplace individual market health plan, and the analysis excludes stand-alone dental plans.

[3] This brief does not analyze consumers' final expenses, after considering other health plan features, such as deductibles and copayments. Consumers may examine all elements of health insurance plans in order to estimate expected total out-of-pocket costs. Moreover, while premium tax credits can be applied to a plan in any metal tier with the exception of catastrophic plans, cost-sharing reductions are available only for silver plans.

[4] This represents the percentage of individuals who selected a Marketplace plan and qualified for an advance premium tax credit (APTC), with or without a cost-sharing reduction. See: U.S. Department of Health and Human Services, "Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period," *ASPE Issue Brief*, ASPE, May 1, 2014, available at: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf

This brief presents analysis of Qualified Health Plan (QHP) data in the Marketplace for 35 states, providing a look at the plan choice and premium landscape that new and returning consumers will see for 2015.[5] It also examines plan affordability in 2015 after taking into account premium tax credits. The findings presented here include states for which sufficient plan data were available for both 2014 and 2015.

Key Findings

- The Affordable Care Act is increasing competition and choice among affordable Marketplace health insurance plans in 2015.
- There are over 25 percent more issuers participating in the Marketplace in 2015. About 91 percent of consumers will be able to choose from 3 or more issuers—up from 74 percent in 2014. Consumers can choose from an average of 40 health plans for 2015 coverage—up from 30 in 2014—based on analysis at the county level.
- Premiums for the benchmark (second-lowest cost) silver plan will increase modestly, by 2 percent on average this year before tax credits, while premiums for the lowest-cost silver plan will increase on average by 5 percent. The plans offering the lowest prices have sometimes changed from 2014 to 2015, so consumers should shop around to find the plan that best meets their needs and budget.
- More than 7 in 10 current Marketplace enrollees can find a lower premium plan in the same metal level before tax credits by returning to shop. To illustrate the significance of shopping we consider the following example: if all consumers switched from their current plan to the lowest-cost premium plan in the same metal level, the total savings in premiums would be over $2 billion. These savings represent the sum of savings to consumers and taxpayers.
- For customers returning to the Marketplace, the vast majority of enrollees have low cost plans available to them. If they look across all metal levels, fully 79 percent of current Marketplace enrollees can get coverage for $100 or less, after any applicable tax credits, in 2015.
- Sixty-five percent of current Marketplace enrollees can get coverage for $100 or less for 2015, after tax credits, if they shop for a more affordable plan within their current metal level, compared to 50 percent of current Marketplace enrollees who can get coverage for $100 or less, after any applicable tax credits, if they stay in the same plan in 2015.

[5] The 35 states for which sufficient data in the individual market were available in both 2014 and 2015 for this analysis are listed in the methodology section at the end of this brief. References to the Marketplace in this report refer to the individual market Marketplaces that use the HealthCare.gov eligibility and enrollment system in both 2014 and 2015. The small group Marketplace, also known as SHOP, is not included in this brief.

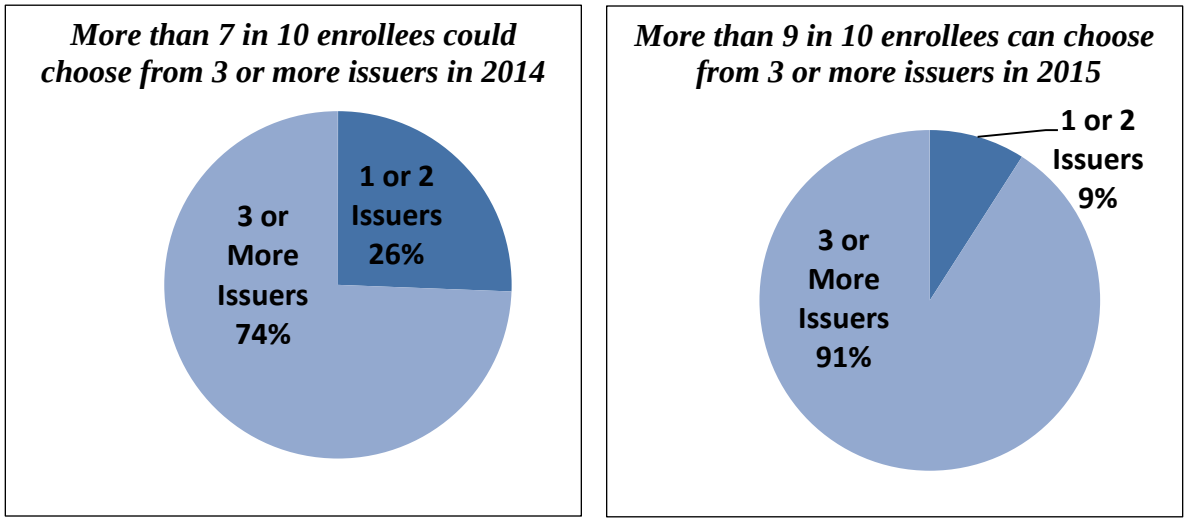
Consumer Choice among Health Insurance Issuers in 2014 and 2015

The Affordable Care Act is working to create a dynamic, competitive Marketplace, with more choice and affordable premiums in 2015. This offers new opportunities for consumers to comparison shop to select the plan that best meets their needs and budget. More choice also means more competition between plans that in turn results in downward pressure on premiums. Consumers who bought a 2014 plan and decide to shop actively for a comparable 2015 plan will often be able to find lower premiums.

There are 25 percent more issuers participating in the Marketplace in 2015, compared with 2014.[6] During the 2014 open enrollment period, 74 percent of the people who enrolled in a qualified health plan lived in counties with three or more issuers offering plans in the Marketplace; for 2015 this percentage has increased to 91 percent.

Figure 1 shows the distribution of the 2014 Marketplace enrollees by the number of issuers in their county.

FIGURE 1
Enrollee Choice of Marketplace Issuers in 35 States in 2014 and 2015



Source: Information on plans and issuers is from the plan landscape files as of November 2014 for 35 states.
Note: See "Methods and Limitations" section for more details regarding data and methods used. "Enrollees" refers to those people who selected a qualified health plan in the Marketplace in 2014 and is based on active plan selections in the CMS Multidimensional Insurance Data Analytics System (MIDAS) as of May 12, 2014. The number of issuers available to those who selected a Marketplace plan in 2014 is based on the number of issuers offering qualified health plans in 2015 in the county of residence of those persons.

Consumers can also choose from among more plans for 2015 coverage. On average, there are 40 plans available per county, including catastrophic plans. This is an increase from an average of

[6] The increase in total number of issuers in the 35 states is calculated based on identifying an issuer by its unique five-digit Health Insurance Oversight System (HIOS) ID. In some cases, issuers with different HIOS IDs belong to the same parent company. An issuing entity's HIOS issuer ID is specific to the state in which it operates, such that a company offering QHPs through the Marketplace in two states would be counted twice—once for each state.

30 total plans per county last year. Note that previous ASPE issue briefs on plan choice and availability presented analyses at the rating area level. Because plans available in some part of a rating area are not always available in all parts of a rating area, conducting the analysis at the county level better captures the set of options consumers will see when they shop and thus more closely matches consumers' shopping experience.

The average number of plans per county in the bronze, silver, gold, and platinum metal tiers—which signify different levels of plan actuarial value or how much of every claim dollar the plan covers—has also increased from 2014 (see Table 1).

TABLE 1
Summary of Marketplace Health Plans and Issuers for 35 States, 2014 and 2015

	2014 Average	2015 Average
Issuers per State	5	7
Issuers per County	3	4
Total Qualified Health Plans *(excluding catastrophic)*	28	37
Total Health Plans	30	40
Catastrophic Plans	3	2
Bronze Plans	9	12
Silver Plans	10	15
Gold Plans	8	9
Platinum Plans	1	2

Source: Information on plans and issuers is from the plan landscape files as of November 2014 for 35 states.
Note: All averages in this table are unweighted. Averages are calculated at the county level for all counties in the 35 states unless otherwise specified. The number of issuers per state is the total number of issuers offering QHPs anywhere in a state. Child-only and morbid obesity plans were excluded from these counts. Numbers may not sum due to rounding.

Marketplace Health Plan Premiums in 2014 and 2015

The Marketplace enables consumers to comparison shop for a plan that meets their needs and budget. Many will receive financial assistance to help with the cost of their monthly premiums. In 2014, 64 percent of individuals who selected a plan in the Marketplace selected the lowest cost (43 percent) or second-lowest cost plan (21 percent) in their metal tier—indicating that many Marketplace consumers shop on price.[7]

Consumers who return to the Marketplace will see that premiums for the *benchmark* plan (the second-lowest cost silver plan in each market) increased modestly, by 2 percent on average this year before tax credits. For example, the average premium for the benchmark silver plan for a

[7] Percentages are based on analysis of 2014 Marketplace plan selections in 36 states. See: Amy Burke, Arpit Misra, and Steven Sheingold, "Premium Affordability, Competition and Choice in the Health Insurance Marketplace, 2014," *ASPE Research Brief*, June 2014, available at: http://aspe.hhs.gov/health/reports/2014/Premiums/2014MktPlacePremBrf.pdf

27-year-old increased from $218 in 2014 to $222 in 2015 before tax credits.[8] The benchmark silver plan premiums are significant because the premium tax credits that are available to help make Marketplace coverage more affordable are calculated based on the premium for those plans.[9] The lowest-cost silver plan in each market saw modest growth of 5 percent on average before tax credits.

The new Marketplace is competitive and dynamic. As described in the last section, the 2015 Marketplace includes many new issuers and plans, and issuers are competing to offer more affordable options to consumers. This means that the plan that was the benchmark or lowest-cost plan in 2014 is often not the benchmark or lowest-cost plan in 2015, so it will be important for returning consumers to shop around in 2015 to ensure that they select the plan that best meets their circumstances.

More than 7 in 10 current Marketplace enrollees can find a lower premium plan in the same metal level by returning to shop. For instance, the average lowest-cost premium for a silver plan available to current silver-level enrollees is $336 for 2015. The average consumer who bought a silver plan last year and decides to shop for a better deal this year can save $41 a month before tax credits—which works out to $492 a year. If all silver plan holders switch to the lowest-cost silver plan for 2015, the total savings for the year would be $1.6 billion. Across all metal levels, the total savings in premiums would be over $2 billion (see Table 2 for all metal levels). These savings represent the sum of savings to consumers and taxpayers.

Eighty-five percent of consumers who selected a plan for 2014 coverage received premium tax credits to help with the cost of monthly premiums. Consumers who receive premium tax credits are protected against excessive rate increases because the Affordable Care Act sets a cap on the amount they pay for the benchmark, second-lowest silver plan. Additionally, during the open enrollment period, all new and returning Marketplace consumers can easily compare plans' pricing and benefits to shop for a plan with a lower premium.

[8] Plan and premium information are from the Center for Consumer Information and Insurance Oversight as of November 2014 for 35 states. Amounts represent monthly premiums and do not take into account potential premium tax credits. For averages, each county's second-lowest cost silver premium is weighted by the number of Marketplace plan selections in each county. See Table 7 at the end of this brief for average premiums by state.

[9] The Affordable Care Act specifies that an individual or family with a particular household income who is eligible for the premium tax credit will be required to pay no more than a fixed percentage of their income for the second-lowest cost silver plan available in the Marketplace in their local area. See the "Methods and Limitations" section at the end of this brief for more details on benchmark plans and premium tax credits.

TABLE 2
Potential Savings from Shopping Based on Premium if Current Marketplace Enrollees Switch to 2015 Lowest-Cost Premium Plan within Metal Level for 35 States

Premiums Before Tax Credits, Current Marketplace Enrollees	Bronze	Silver	Gold	Platinum
Average Lowest-Cost 2015 Monthly Premium Within Metal Level	$265	$336	$382	$439
Average 2015 Monthly Premium Savings if Consumers Switch to Lowest-Cost Plan within Metal Level	$36	$41	$54	$55
% of Enrollees Who Could Save on Premium Costs by Switching to the Lowest-Cost Plan in Metal Level	78%	78%	77%	71%
ANNUAL Average Potential Savings in Premium Costs per Enrollee	$432	$492	$658	$660
MONTHLY Total Amount of Potential Savings in Premium Costs across All Enrollees	$28 M	$131 M	$23 M	$11 M
ANNUAL Total Amount of Potential Savings in Premiums Costs Across All Enrollees	$336 M	$1.6 B	$271 M	$127 M

Source: Plan information is from the plan landscape files as of November 2014 for 35 states. Enrollment information is based on active plan selections in the CMS Multidimensional Insurance Data Analytics System (MIDAS) as of May 12, 2014.
Note: Amounts presented here do not take into account potential tax credits. The lowest-cost premium refers to the plan with the lowest premium within the county within each metal tier and is based on all the plans available in 2015. The lowest cost plan does not take into account other cost-sharing features, but refers only to the cost of the premium charged for that plan. In some cases, plans were tied for lowest premium. This analysis includes only enrollees linked to complete plan and premium data for both 2014 and 2015, and excludes tobacco users. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. We assume that *all* enrollee characteristics are unchanged and calculate premiums based on the same age, family composition, and household income as percentage of the FPL as in 2014. See the "Methods and Limitations" section at the end of this brief for more details.

Health Insurance Plan Affordability after Tax Credits in the Marketplace in 2015

With over 25 percent more issuers in the Marketplace this coming year, the increased choice and competition means there are affordable premiums for new consumers and for those who selected a plan last year and are returning to shop.

In order to make health insurance affordable, the Affordable Care Act established premium tax credits to help consumers with the cost of coverage based on their incomes. During the initial open enrollment period, 85 percent of consumers who selected a Marketplace plan received financial assistance.[10] And nearly 7 out of 10 who selected a plan with tax credits found coverage for less than $100 after tax credits.[11]

The tax credits are based on the premium of the so-called benchmark plan in their area (the second-lowest-cost silver plan). The health plan category or "metal level" determines how consumers and plans share the costs of care. For example, with a silver level plan the health plan pays about 70 percent of the total costs of care for essential health benefits, on average, and the consumer pays 30 percent of these costs. This takes into account the plan's deductibles, copayments, coinsurance, and out-of-pocket maximums. The second-lowest cost silver plan premiums are significant because premium tax credits that are available to help make Marketplace coverage more affordable are calculated based on the premium for those plans. The actual payment made by consumers for their insurance depends on the plan they choose and the level of tax credit they qualify for.

Competition and tax credits are related. Increased numbers of plans in a market means more competition. More competition tends to put downward pressure on premiums. As competition intensifies, the benchmark plan (second-lowest cost silver plan) may change. This means that the benchmark premium (and thus the tax credit) may grow more slowly than a consumer's current plan's premium. For this reason, consumers that want to make their tax credit's purchasing power go as far as possible should shop. Another implication is that premium competition serves to benefit taxpayers by holding down tax credit costs.

The percentages in Tables 3, 4, and 5 include current Marketplace enrollees who selected a plan, with or without tax credits. Table 3 shows the percent of current Marketplace enrollees in the 35 states who could get coverage for as little as $100 or less per month, taking into account any applicable tax credits in 2015, *regardless of the metal level they selected in 2014*. For example, 79 percent of all customers returning to the Marketplace can get coverage for $100 or less after tax credits, regardless of their 2014 plan metal level choice. Sixty-six percent can get coverage for $50 or less, and an additional 12 percent could get coverage for as little as $50 to $100.

[10] Represents the percentage of individuals who selected a 2014 Marketplace plan and qualified for an advance premium tax credit (APTC), with or without a cost-sharing reduction, from: HHS, ASPE, May 1, 2014, "Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period."
[11] Amy Burke, Arpit Misra, and Steven Sheingold, "Premium Affordability, Competition and Choice in the Health Insurance Marketplace, 2014," *ASPE Research Brief*, June 2014.

TABLE 3
It Pays to Shop: Percent of Current Marketplace Enrollees Who Could Obtain Coverage for $100 or Less after Any Applicable Tax Credits in 2015, 35 States
Regardless of Metal Level in 2014

Monthly Premium After Tax Credits	Any Plan Type	Bronze	Silver	Gold	Platinum
$100 or less	79%	79%	64%	36%	9%
$50 or Less	66%	66%	42%	8%	1%
$50 to $100	12%	12%	22%	27%	8%

Source: Plan information is from the plan landscape files as of November 2014 for 35 states. Enrollment information is based on active plan selections by in the CMS Multidimensional Insurance Data Analytics System (MIDAS) as of May 12, 2014.
Note: Columns may not sum due to rounding. This analysis holds *all* enrollee characteristics unchanged and calculates 2015 premiums and tax credits based on the same age, family composition, and household income as percentage of the FPL as in 2014. This analysis includes only enrollees whose could be linked to complete plan and premium data for both 2014 and 2015, and excludes tobacco users. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. See the "Methods and Limitations" section at the end of this brief for more details.

Table 4 shows the percentage of current Marketplace enrollees who could get covered for $100 or less, taking into account any applicable tax credits, *if they keep their current plan* and do not switch to a lower-premium plan for 2015. For example, 58 percent of Marketplace enrollees who selected a silver-level plan in 2014 will have 2015 coverage for $100 or less if they do not change plans.

TABLE 4
It Pays to Shop: Percent of Current Marketplace Enrollees Who Would Be Covered for $100 or Less after Any Applicable Tax Credits in 2015, 35 States
If They Did Not Switch Plans

Monthly Premium After Tax Credits	All Plan Types	Bronze	Silver	Gold	Platinum
$100 or less	50%	47%	58%	8%	4%
$50 or Less	26%	26%	31%	1%	0%
$50 to $100	23%	20%	27%	7%	3%

Source: Plan information is from the plan landscape files as of November 2014 for 35 states. Enrollment information is based on active plan selections in the CMS Multidimensional Insurance Data Analytics System (MIDAS) as of May 12, 2014.
Note: Columns may not sum due to rounding. This analysis holds *all* enrollee characteristics unchanged and calculates 2015 premiums and tax credits based on the same age, family composition, and household income as percentage of the FPL as in 2014. This analysis includes only enrollees linked to complete plan and premium data for both 2014 and 2015, and excludes tobacco users. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. See the "Methods and Limitations" section at the end of this brief for more details.

However, there may be more affordable plans in 2015 available to current enrollees. Table 5, below, shows the percentage of current Marketplace enrollees in the 35 states that could get coverage for $100 or less, taking into account any applicable tax credits, *while staying in their current metal level*. For example, 65 percent of all people who selected a plan in 2014 could get coverage for $100 or less if they selected a lower-premium plan in their same metal level. Of those who selected a silver plan in 2014, 77 percent could get silver plan coverage for $100 or less in 2015 if they choose a lower-cost plan.

TABLE 5
It Pays to Shop: Percent of Current Marketplace Enrollees Who Could Obtain Coverage for $100 or Less after Tax Credits in 2015, 35 States
within Their Current Metal Level

Monthly Premium After Tax Credits	All Plan Types	Bronze	Silver	Gold	Platinum
$100 or less	65%	58%	77%	14%	7%
$50 or Less	45%	39%	54%	2%	1%
$50 to $100	20%	19%	23%	12%	7%

Source: Plan information is from the plan landscape files as of November 2014 for 35 states. Enrollment information is based on active plan selections by in the CMS Multidimensional Insurance Data Analytics System (MIDAS) as of May 12, 2014.
Note: Columns may not sum due to rounding. This analysis holds *all* enrollee characteristics unchanged and calculates 2015 premiums and tax credits based on the same age, family composition, and household income as percentage of the FPL as in 2014. This analysis includes only enrollees linked to complete plan and premium data for both 2014 and 2015, and excludes tobacco users. Catastrophic plans, which are not available to all consumers, were not considered in these calculations. See the "Methods and Limitations" section at the end of this brief for more details.

Conclusion

New and returning customers to the Health Insurance Marketplace will see improved choice and affordable premiums in 2015, a clear sign that the Marketplace is succeeding in creating a competitive and dynamic environment. Consumers should take advantage of this by shopping around to find the plan that best meets their needs and their budget. They can do so by going to HealthCare.gov, which provides information for consumers looking to compare plans on premiums and other plan features.

Methodology and Limitations

Data

The plan and premium data reported here are from the Marketplace QHP landscape individual market medical files, which are publicly available at HealthCare.gov.[12] Data were not available for all states. This analysis considers the 35 states which were included in both the 2014 and 2015 Marketplace landscape files: Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

For most State-based Marketplaces (SBMs), comprehensive plan and premium data were not available for both 2014 and 2015. The State-based Marketplaces not included in the analysis in this brief are California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Oregon, Nevada, New York, Rhode Island, Vermont, and Washington. Some State-based Marketplaces submit plan data to the Center for Consumer Information and Insurance Oversight (CCIIO) for display using Federal web architecture. New Mexico's SBM utilized the FFM platform to support its eligibility and enrollment functions in 2014, will continue to do so in 2015, and is included in this analysis in this brief. Oregon and Nevada did not rely on the FFM platform in 2014 but will in 2015; Idaho relied on the FFM platform in 2014, but will not in 2015.

The analysis in this brief does not include stand-alone dental plans, child-only plans, morbid obesity plans, or small-group Marketplace plans. In our estimates of the lowest available Marketplace premiums, we also did not consider catastrophic plans and their enrollees. Catastrophic coverage is not available to all consumers.

Most of the increase in number of plans available to consumers for 2015 is due to newly available plans on the Marketplaces. However, a small proportion of the increase in plan offerings is due to returning issuers breaking 2014 plans into two or more plans for 2015 because of changes in the Marketplace rules governing premium rates.

Enrollment information is based on active QHP selections in the CMS Multidimensional Insurance Data Analytics System (MIDAS) as of May 12, 2014. In this brief, we use the term "enrollees" to refer to individuals with active Marketplace individual market health plan selections; it does not refer to "effectuated enrollees"—individuals who selected and paid the premium. Additionally, we exclude tobacco users and morbid obesity plan enrollees from our calculations of average premiums because their premium rates may be higher than standard, non-tobacco rates. Our calculations of the savings from switching plans (Table 2) and premium tax credits (Table 3, 4, and 5) are based on only enrollees whom we were able to link to complete premium and plan data for both 2014 and 2015.

[12] The Marketplace plan landscape files can be downloaded at: https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/

Premiums

In this issue brief, we examine the plans and premiums available at the county level. Because some plans may not serve all counties within a rating area, county-level analysis provides a better approximation of plan availability. Note that analysis in previous ASPE briefs on Marketplace premiums was typically at the rating area level; therefore, numbers in this brief should not be compared against those in previous briefs using rating-area analysis.

Our analysis of premiums in Tables 2-5 considers only current enrollees whose 2014 Marketplace plan is available in 2015, based on each plan's unique ID code. Consumers can be auto-enrolled into a similar coverage even if their exact plan is not available for next year.

Premium Tax Credits

The Affordable Care Act specifies that an individual or family who is eligible for premium tax credits will be required to pay no more than a fixed percentage of their income for the second-lowest cost silver plan available in the Marketplace in their local area. This applicable percentage varies only by household income as a percentage of the Federal Poverty Level (FPL) and does not depend on household members' ages, the number of people within the household covered through the Marketplace, or Marketplace premiums. (For examples of 2015 incomes and benchmark premiums for those who are eligible for tax credits, see Table 6.) The applicable percentage is converted into a maximum dollar amount the household is required to pay annually for the benchmark plan, and the tax credit is applied to make up the difference between the maximum dollar amount and the actual premium, if any.[13] The exact dollar amount of the tax credit depends on the premium of the second-lowest cost silver plan available to the household and the cost of covering the family members who are seeking Marketplace coverage.

For example, a 27-year-old woman with an income of $25,000 in 2014 would be at 218 percent of the FPL.[14] For tax credits in coverage year 2014, the amount she pays for the second-lowest cost silver plan is capped at $145 per month. If her premium for the second-lowest cost silver plan available is $336 per month before tax credits, then the amount of the premium tax credit will be $191 per month—the difference between specified contribution to the benchmark plan and the actual cost of the benchmark plan. Her use of the tax credit is not restricted to the second-lowest cost silver plan. She can apply the $191 per month tax credit toward any plan of her choosing in any metal level. By applying her tax credit to the lowest-cost bronze plan, which may be priced at $199 per month, she could obtain Marketplace coverage for just $8 per month after tax credits. If she picks the lowest-cost silver plan, at $226 per month, she pays just $35 per month after tax credits.

[13] If the premium of the second-lowest cost silver plan falls below the maximum amount the household pays for benchmark coverage, then the household does not receive a tax credit and pays the full premium for the benchmark plan.

[14] For coverage in 2014, the 2013 Federal Poverty Guidelines are used to calculate FPL. For coverage in 2015, the 2014 Federal Poverty Guidelines are used to calculate FPL.

Suppose that for 2015, this woman's income is again equivalent to 218 percent of the FPL. The maximum she will pay for the second-lowest cost silver plan in her area in 2015 is capped at $148 for 2015 (see Table 6 for 2015 applicable percentages). She can choose to buy the second-lowest silver plan if she wishes, and it will cost her up to $148 after tax credits—*regardless of how much the second-lowest silver plan's actual premium may have increased*. Her tax credit for 2015 will be the difference between $148 and what the second-lowest cost silver plan premium would be for her in 2015. Again, she can take her tax credit and apply it to whatever plan in any metal tier that best fits her needs.

TABLE 6
Examples of Maximum Monthly Health Insurance Premiums for the Second-Lowest Cost Silver Plan for Marketplace Coverage for a Single Adult in 2015[15]

Single Adult Income[16]	Percent of the Federal Poverty Level	Maximum Percent of Income Paid toward Second-Lowest Cost Silver Plan	Maximum Monthly Premium Payment for Second-Lowest Cost Silver Plan
$11,670	100%[17]	2.01%	$20
$17,505	150%	4.02%	$59
$23,340	200%	6.34%	$123
$29,175	250%	8.10%	$197
$35,010	300%	9.56%	$279
$40,845	350%	9.56%	$325
$46,797	401%	Not Applicable	No Limit

Source: Applicable percentages for 2015 coverage are available at: www.irs.gov/pub/irs-drop/rp-14-37.pdf. The 2014 Federal Poverty Guidelines, used for premium tax credits for 2015 coverage, are at: http://aspe.hhs.gov/poverty/14poverty.cfm.

Many families may also be eligible for premium tax credits. For example, suppose a family with an income of $60,000 was shopping for Marketplace coverage for 2015 for all four family members. The family's income is equivalent to 252 percent of the FPL; therefore, the family's premium is capped at 8.15% of income or no more than $407 per month for the benchmark second-lowest cost silver plan in its local area. If the premium for the second-lowest cost silver plan for the family is $805 per month, the family will receive a tax credit of $398, making the premium after tax credits $407 ($805 – $407 = $398). The family can apply its $398 tax credit toward the purchase of coverage in any metal level. Note that the maximum percent of income paid toward the second-lowest silver plan is adjusted annually by a measure of the difference between premium growth and income growth.

[15] For more information on premium tax credits, see the Internal Revenue Service final rule on "Health Insurance Premium Tax Credit," (*Federal Register*, May 23, 2012, vol., 77, no. 100, p. 30392; available at: http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf).
[16] Income examples are based on the 2014 federal poverty guidelines for the continental United States. Alaska and Hawaii have higher federal poverty guidelines, which are not shown in this table.
[17] In states expanding Medicaid, individuals and families at 100 percent of the FPL who are eligible for Medicaid coverage are not eligible for premium tax credits.

APPENDIX: TABLES BY STATE AND CITY

TABLE 7
Average Monthly Premiums for Second-Lowest Cost Silver Plans for a 27-Year-Old (Before Tax Credits), 2014 and 2015 in Selected States

State	Average Second-Lowest Cost Silver Premium for a 27-Year-Old		
	2014	2015	% Change
AK	$349	$449	28%
AL	$210	$216	3%
AR	$241	$234	-3%
AZ	$164	$158	-4%
DE	$237	$247	4%
FL	$217	$231	6%
GA	$235	$220	-6%
IA	$206	$215	4%
IL	$185	$191	3%
IN	$270	$265	-2%
KS	$196	$187	-5%
LA	$252	$257	2%
ME	$266	$262	-2%
MI	$206	$207	0%
MO	$234	$232	-1%
MS	$311	$249	-20%
MT	$208	$196	-5%
NC	$244	$262	8%
ND	$233	$248	7%
NE	$205	$216	5%
NH	$237	$205	-14%
NJ	$264	$259	-2%
NM	$184	$165	-10%
OH	$216	$220	2%
OK	$175	$184	5%
PA	$200	$196	-2%
SC	$222	$222	0%
SD	$234	$216	-8%
TN	$161	$170	6%
TX	$203	$210	3%
UT	$206	$211	2%
VA	$222	$230	3%
WI	$246	$251	2%
WV	$231	$248	7%
WY	$343	$359	5%

Source: Plan information is from the plan landscape files as of November 2014 for 35 states.
Note: The numbers in this table represent premiums before the application of tax credits. Premiums are weighted averages across each county in each state, weighted by the number of Marketplace health plan selections in each county, as of May 12, 2014.

TABLE 8
Number of Marketplace Issuers by State, 2014 and 2015 in Selected States

State	Number of Issuers in State		Net Change in Number of Issuers in State	Number of New Issuers to the State	Number of Issuers Exiting the State
	2014	2015			
AK	2	2	0	0	0
AL	2	3	1	1	0
AR	3	4	1	1	0
AZ	10	13	3	3	0
DE	3	3	0	2	2
FL	11	14	3	4	1
GA	5	9	4	4	0
IA	4	4	0	0	0
IL	8	10	2	3	1
IN	4	9	5	6	1
KS	4	5	1	1	0
LA	5	6	1	1	0
ME	2	3	1	1	0
MI	12	16	4	4	0
MO	4	7	3	3	0
MS	2	3	1	1	0
MT	3	4	1	1	0
NC	2	3	1	1	0
ND	3	3	0	0	0
NE	4	4	0	1	1
NH	1	5	4	4	0
NJ	4	6	2	2	0
NM	4	5	1	1	0
OH	12	16	4	5	1
OK	6	4	-2	1	3
PA	14	15	1	4	3
SC	4	5	1	1	0
SD	3	3	0	0	0
TN	4	5	1	1	0
TX	12	15	3	3	0
UT	6	6	0	0	0
VA	8	9	1	1	0
WI	13	15	2	2	0
WV	1	1	0	0	0
WY	2	2	0	0	0

Source: Plan information is from the plan landscape files as of November 2014 for 35 states.
Note: An issuer is counted as “new” in 2015 if it did not offer an individual market health plan in a given state’s Marketplace in 2014 based on its HIOS ID number, and “exiting” if it was active in a given state in 2014 but not in 2015.

TABLE 9
Average Number of Marketplace Plans per County, 2014 and 2015 in Selected States

State	Average Number of Qualified Health Plans		Net Change in Average Number of Marketplace Plans, 2014-2015
	2014	2015	
AK	34	28	-6
AL	6	17	11
AR	22	34	12
AZ	81	71	-10
DE	19	24	5
FL	66	42	-24
GA	22	41	19
IA	27	23	-4
IL	38	46	8
IN	23	43	20
KS	32	27	-5
LA	33	44	11
ME	17	25	8
MI	29	64	35
MO	17	20	3
MS	13	27	14
MT	26	40	14
NC	18	26	8
ND	23	26	3
NE	23	25	2
NH	10	38	28
NJ	26	45	19
NM	36	43	7
OH	30	54	24
OK	29	29	0
PA	41	50	9
SC	25	59	34
SD	32	38	6
TN	48	71	23
TX	25	31	6
UT	55	69	14
VA	30	23	-7
WI	49	67	18
WV	12	14	2
WY	16	40	24

Source: Plan information is from the plan landscape files as of November 2014 for 35 states.
Note: Number of plans in 2014 and 2015 represent the average number of Marketplace QHPs per county within each state. Averages are unweighted and exclude catastrophic plans. Rows may not sum due to rounding.

TABLE 10
Average Monthly Marketplace Premiums, Issuers, and QHPs Available by County, 2014 and 2015 in Selected States

State	2015						2014			
	Total Number of Issuers in State	Average Number of QHPs per County	27-Year-Old with an Income of $25,000		Family of Four with an Income of $60,000		27-Year-Old with an Income of $25,000		Family of Four with an Income of $60,000	
			Average		Average		Average		Average	
			Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit***	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit
AK*	2	28	$449	$105	$1,624	$319	$349	$107	$1,265	$323
AL	3	17	$216	$143	$783	$407	$210	$145	$761	$410
AR	4	34	$234	$143	$847	$407	$241	$145	$874	$410
AZ***	13	71	$158	$143	$573	$407	$164	$144	$595	$410
DE	3	24	$247	$143	$893	$407	$237	$145	$859	$410
FL	14	42	$231	$143	$835	$407	$217	$145	$787	$410
GA	9	41	$220	$143	$797	$407	$235	$145	$850	$410
IA**	4	23	$215	$143	$777	$407	$206	$145	$747	$410
IL	10	46	$191	$143	$692	$407	$185	$145	$669	$410
IN	9	43	$265	$143	$959	$407	$270	$145	$978	$410
KS	5	27	$187	$143	$677	$407	$196	$145	$710	$410
LA	6	44	$257	$143	$932	$407	$252	$145	$913	$410
ME	3	25	$262	$143	$950	$407	$266	$145	$962	$410
MI	16	64	$207	$143	$751	$407	$206	$145	$745	$410
MO**	7	20	$232	$143	$839	$407	$234	$145	$847	$410
MS	3	27	$249	$143	$901	$407	$311	$145	$1,127	$410
MT**	4	40	$196	$143	$710	$407	$208	$145	$752	$410
NC	3	26	$262	$143	$950	$407	$244	$145	$883	$410
ND	3	26	$248	$143	$898	$407	$233	$145	$842	$410
NE	4	25	$216	$143	$782	$407	$205	$145	$742	$410
NH	5	38	$205	$143	$741	$407	$237	$145	$859	$410
NJ**	6	45	$259	$143	$937	$407	$264	$145	$957	$410

State	2015						2014			
	Total Number of Issuers in State	Average Number of QHPs per County	27-Year-Old with an Income of $25,000		Family of Four with an Income of $60,000		27-Year-Old with an Income of $25,000		Family of Four with an Income of $60,000	
			Average		Average		Average		Average	
			Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit***	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit
NM	5	43	$165	$143	$597	$407	$184	$145	$665	$410
OH	16	54	$220	$143	$796	$407	$216	$145	$783	$410
OK	4	29	$184	$143	$668	$407	$175	$145	$632	$410
PA***	15	50	$196	$143	$709	$407	$200	$144	$725	$410
SC	5	59	$222	$143	$805	$407	$222	$145	$804	$410
SD	3	38	$216	$143	$783	$407	$234	$145	$848	$410
TN	5	71	$170	$143	$614	$407	$161	$145	$582	$410
TX	15	31	$210	$143	$760	$407	$203	$145	$736	$410
UT	6	69	$211	$143	$681	$407	$206	$145	$619	$410
VA	9	23	$230	$143	$833	$407	$222	$145	$805	$410
WI**	15	67	$251	$143	$909	$407	$246	$145	$891	$410
WV**	1	14	$248	$143	$900	$407	$231	$145	$835	$410
WY	2	40	$359	$143	$1,299	$407	$343	$145	$1,243	$410
35 State Average	7	37	$222	$143	$803	$407	$218	$145	$789	$410

Source: Plan information is from the plan landscape files as of November 2014 for 35 states.

Note: The average number of QHPs per county is unweighted across counties within a state and excludes catastrophic plans. Premiums are weighted averages across all counties in each state, weighted by the county's number of Marketplace health plan selections as of May 12, 2014. In this example, the family of four is one 40-year-old adult, one 38-year-old adult, and two children under the age of 21. For households eligible for premium tax credits, after-tax-credit benchmark premiums are capped at a given percentage of household income. As shown in the table, after-tax benchmark premiums will differ slightly between 2014 and 2015 for identical family compositions and income amounts because of changes in the applicable percentages and the Federal Poverty Guidelines. The 2014 guidelines are used to calculate benchmark premiums for coverage in 2015, and 2013 guidelines are used for coverage in 2014. Because poverty guideline thresholds generally increase each year, a given dollar amount of income may equate to a smaller percentage of the Federal Poverty Level (FPL) this year than it did in the year previous. For example, a four-person family with an income of $60,000 is at 252 percent of the FPL by 2014 guidelines and at 255 percent of the FPL by 2013 guidelines. As a result, the percentage of income the family would pay for the benchmark plan is smaller for 2015 than for 2014.

* Alaska's federal poverty guidelines are higher than those for the continental United States; consequently, the after tax credit premium is lower for a given amount of income.

** In all 35 states, our calculations of premiums after tax credits assume that all members of the family of four making $60,000 would be eligible for premium tax credits. However, in states with higher Medicaid/CHIP thresholds the children would be eligible for Medicaid/CHIP and not eligible for premium tax credits.

*** If the benchmark plan premium is below the applicable percentage of income after tax credit, the tax credit-eligible enrollee pays the actual premium. In Pennsylvania and Arizona in 2014, average premiums for second-lowest silver after tax credit for a 27-year-old making $25,000 were below the amount corresponding to the applicable percentage.

TABLE 11
Second-Lowest Cost Silver Plan Monthly Premiums for a 27-Year-Old (Before Tax Credits), 2014 and 2015 in Selected Cities

State	City	County	Second-Lowest Cost Silver Monthly Premium for a 27-year-old		
			2014	2015	% Change
AK	Anchorage	Anchorage	$355	$449	26%
AK	Juneau	Juneau	$334	$449	34%
AL	Birmingham	Jefferson	$211	$217	3%
AR	Little Rock	Pulaski	$251	$245	-2%
AZ	Phoenix	Maricopa	$161	$145	-10%
AZ	Tucson	Pima	$138	$147	7%
DE	Wilmington	New Castle	$237	$247	4%
FL	Ft. Lauderdale	Broward	$199	$198	-1%
FL	Jacksonville	Duval	$210	$223	6%
FL	Miami	Miami-Dade	$221	$225	2%
FL	Orlando	Orange	$225	$244	8%
FL	Tampa	Hillsborough	$199	$240	21%
FL	West Palm Beach	Palm Beach	$220	$236	7%
GA	Atlanta	Fulton	$205	$209	2%
IA	Cedar Rapids	Linn	$209	$202	-3%
IL	Chicago	Cook	$174	$177	2%
IN	Indianapolis	Marion	$290	$270	-7%
KS	Kansas City	Wyandotte	$213	$188	-12%
KS	Wichita	Sedgwick	$184	$179	-3%
LA	New Orleans	Orleans Parish	$255	$243	-5%
ME	Portland	Cumberland	$242	$231	-5%
MI	Detroit	Wayne	$184	$188	2%
MO	St. Louis	Saint Louis	$216	$226	5%
MS	Jackson	Jackson	$332	$253	-24%
MT	Bozeman	Gallatin	$206	$195	-5%
NC	Charlotte	Mecklenburg	$251	$269	7%
NC	Greensboro	Guilford	$228	$259	14%
NC	Raleigh-Durham	Wake	$222	$251	13%
ND	Fargo	Cass	$222	$223	0%
NE	Omaha	Douglas	$222	$216	-3%
NH	Manchester	Hillsborough	$237	$202	-15%
NJ	Newark	Essex	$264	$259	-2%
NM	Albuquerque	Bernalillo	$159	$142	-11%
OH	Cincinnati	Hamilton	$196	$194	-1%
OH	Cleveland	Cuyahoga	$204	$202	-1%
OH	Columbus	Franklin	$207	$219	6%

State	City	County	Second-Lowest Cost Silver Monthly Premium for a 27-year-old		
			2014	2015	% Change
OH	Dayton	Montgomery	$212	$219	3%
OK	Oklahoma City	Oklahoma	$165	$179	8%
OK	Tulsa	Tulsa	$183	$183	0%
PA	Philadelphia	Philadelphia	$246	$219	-11%
PA	Pittsburgh	Allegheny	$139	$141	1%
SC	Columbia	Richland	$220	$226	3%
SD	Sioux Falls	Lincoln	$217	$210	-3%
SD	Sioux Falls	Minnehaha	$217	$210	-3%
TN	Memphis	Shelby	$159	$158	-1%
TN	Nashville	Davidson	$154	$166	8%
TX	Austin	Travis	$205	$197	-4%
TX	Dallas	Dallas	$223	$230	3%
TX	Houston	Harris	$201	$205	2%
TX	McAllen	Hidalgo	$155	$165	6%
TX	San Antonio	Bexar	$196	$191	-3%
TX	San Antonio	Comal	$202	$195	-3%
TX	San Antonio	Medina	$202	$217	7%
UT	Salt Lake	Salt Lake	$197	$202	3%
VA	Richmond	Henrico	$208	$213	2%
WI	Milwaukee	Milwaukee	$258	$273	6%
WV	Huntington	Cabell	$220	$237	8%
WV	Huntington	Wayne	$220	$237	8%
WY	Cheyenne	Laramie	$324	$334	3%

Note: The premiums in this table represent premiums before the application of tax credits. The number of QHPs in the county excludes catastrophic plans. Plan and premium information is from the Center for Consumer Information and Insurance Oversight as of November 2014 for 35 states.

TABLE 12
Number of Marketplace Plans in County, 2014 and 2015 in Selected Cities

State	City	County	Number of Plans		Net Change in Number of Marketplace Plans 2014-2015
			2014	2015	
AK	Anchorage	Anchorage	34	28	-6
AK	Juneau	Juneau	34	28	-6
AL	Birmingham	Jefferson	10	21	11
AR	Little Rock	Pulaski	38	34	-4
AZ	Phoenix	Maricopa	111	127	16
AZ	Tucson	Pima	110	103	-7
DE	Wilmington	New Castle	19	24	5
FL	Ft. Lauderdale	Broward	132	94	-38
FL	Jacksonville	Duval	86	44	-42
FL	Miami	Miami-Dade	137	90	-47
FL	Orlando	Orange	98	53	-45
FL	Tampa	Hillsborough	102	53	-49
FL	West Palm Beach	Palm Beach	132	94	-38
GA	Atlanta	Fulton	58	89	31
IA	Cedar Rapids	Linn	30	29	-1
IL	Chicago	Cook	65	143	78
IN	Indianapolis	Marion	18	68	50
KS	Kansas City	Wyandotte	16	24	8
KS	Wichita	Sedgwick	36	32	-4
LA	New Orleans	Orleans	44	55	11
ME	Portland	Cumberland	17	25	8
MI	Detroit	Wayne	52	126	74
MO	St. Louis	Saint Louis	22	41	19
MS	Jackson	Jackson	18	24	6
MT	Bozeman	Gallatin	26	40	14
NC	Charlotte	Mecklenburg	28	44	16
NC	Greensboro	Guilford	17	26	9
NC	Raleigh-Durham	Wake	28	39	11
ND	Fargo	Cass	24	30	6
NE	Omaha	Douglas	43	44	1
NH	Manchester	Hillsborough	10	39	29
NJ	Newark	Essex	26	47	21
NM	Albuquerque	Bernalillo	42	51	9
OH	Cincinnati	Hamilton	63	102	39
OH	Cleveland	Cuyahoga	42	102	60
OH	Columbus	Franklin	26	57	31
OH	Dayton	Montgomery	36	92	56
OK	Oklahoma City	Oklahoma	61	50	-11
OK	Tulsa	Tulsa	55	50	-5
PA	Philadelphia	Philadelphia	24	40	16
PA	Pittsburgh	Allegheny	35	58	23
SC	Columbia	Richland	28	62	34

State	City	County	Number of Plans		Net Change in Number of Marketplace Plans 2014-2015
			2014	2015	
SD	Sioux Falls	Lincoln	32	39	7
SD	Sioux Falls	Minnehaha	32	39	7
TN	Memphis	Shelby	72	106	34
TN	Nashville	Davidson	72	106	34
TX	Austin	Travis	76	111	35
TX	Dallas	Dallas	36	64	28
TX	Houston	Harris	39	71	32
TX	McAllen	Hidalgo	24	79	55
TX	San Antonio	Bexar	58	95	37
TX	San Antonio	Comal	53	80	27
TX	San Antonio	Medina	23	33	10
UT	Salt Lake	Salt Lake	85	98	13
VA	Richmond	Henrico	43	23	-20
WI	Milwaukee	Milwaukee	84	109	25
WV	Huntington	Cabell	12	14	2
WV	Huntington	Wayne	12	14	2
WY	Cheyenne	Laramie	16	40	24

Note: The number of QHPs in the county excludes catastrophic plans. Plan information is from the Center for Consumer Information and Insurance Oversight as of November 2014 for 35 states.

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National Health Spending In 2013: Growth Slows, Remains In Step With The Overall Economy

ABSTRACT In 2013 US health care spending increased 3.6 percent to $2.9 trillion, or $9,255 per person. The share of gross domestic product devoted to health care spending has remained at 17.4 percent since 2009. Health care spending decelerated 0.5 percentage point in 2013, compared to 2012, as a result of slower growth in private health insurance and Medicare spending. Slower growth in spending for hospital care, investments in medical structures and equipment, and spending for physician and clinical care also contributed to the low overall increase.

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Total spending for health care in the United States increased 3.6 percent to $2.9 trillion in 2013, or $9,255 per person (Exhibit 1). The increase in 2013 was slower than that of 4.1 percent in 2012 and continued a pattern of low growth—between 3.6 percent and 4.1 percent for five consecutive years.[1] The low rate of health care spending growth coincides with modest overall economic growth since the end of the recent severe recession, which averaged 3.9 percent since 2010. As a result, the health spending share of the gross domestic product (GDP) remained stable at 17.4 percent in 2013.

In 2013 slower growth in both private health insurance and Medicare contributed to the 0.5-percentage-point slowdown in health care spending growth. Private health insurance premium growth slowed from 4.0 percent in 2012 to 2.8 percent in 2013 (Exhibit 1). Growth in private health insurance benefits slowed from 4.4 percent in 2012 to 2.8 percent in 2013, largely driven by slower growth in hospital services and physician and clinical services.

Medicare spending growth decelerated from 4.0 percent in 2012 to 3.4 percent in 2013, primarily as a result of slower growth in enrollment, the impacts of the Affordable Care Act (ACA), and the federal budget sequestration of 2013. The ACA affected Medicare spending through lower fee-for-service payment updates and adjustments in Medicare Advantage benchmark payment rates, both of which contributed to reduced Medicare spending growth. Additionally, the slower growth in overall health care spending in 2013 was influenced by a deceleration in investment in medical structures and equipment as the medical sector held back on spending, in part because of uncertain economic conditions and cost control efforts by providers (Exhibit 2).[2,3]

Although average health spending growth has exceeded overall economic output over the history of the National Health Expenditure Accounts, the similarity in the growth rates between the two experienced in 2012 and 2013 is not unique, based on an analysis of recent historical trends (Exhibit 3). Growth in health spending and GDP have tended to converge several years after the end of economic recessions; as a result, the health spending share of GDP stabilizes at those times.

During 1994–2000 and 2004–07 health spending and GDP grew at similar average annual rates. This resulted in an increase in the health spending share of GDP of less than one-tenth of a percentage point and a half-percentage point, respectively, over these periods.[4] Similarly, during 2012–13 the health sector's share of GDP did not increase.

This contrasts with 1990–93, 2001–03, and 2008–11—three periods that contained reces-

EXHIBIT 1

National Health Expenditures (NHE), Aggregate And Per Capita Amounts, Share Of Gross Domestic Product (GDP), And Annual Growth, By Source Of Funds, Calendar Years 2007–13

Source of funds	2007[a]	2008	2009	2010	2011	2012	2013
EXPENDITURE AMOUNT							
NHE, billions	$2,303.9	$2,414.1	$2,505.8	$2,604.1	$2,705.3	$2,817.3	$2,919.1
Health consumption expenditures	2,158.8	2,258.9	2,359.5	2,454.5	2,548.0	2,653.6	2,754.5
Out of pocket	293.7	300.9	300.9	306.2	317.3	328.8	339.4
Health insurance	1,611.8	1,702.3	1,797.9	1,875.7	1,952.4	2,029.1	2,102.9
Private health insurance	777.7	808.0	833.1	862.2	899.4	935.7	961.7
Medicare	432.8	467.1	499.7	519.9	544.7	566.6	585.7
Medicaid	326.1	344.7	374.9	397.6	407.5	423.7	449.4
Federal	185.7	203.4	247.7	266.7	247.8	243.7	258.8
State and local	140.4	141.3	127.2	131.0	159.7	180.0	190.6
Other health insurance programs[b]	75.2	82.5	90.2	95.9	100.9	103.1	106.1
Other third-party payers and programs and public health activity	253.3	255.7	260.7	272.5	278.3	295.7	312.2
Investment	145.1	155.3	146.3	149.7	157.3	163.7	164.6
Population (millions)	301.1	303.9	306.5	309.0	311.0	313.2	315.4
GDP, billions of dollars	$14,477.6	$14,718.6	$14,418.7	$14,964.4	$15,517.9	$16,163.2	$16,768.1
NHE per capita	7,652	7,944	8,175	8,428	8,698	8,996	9,255
GDP per capita	48,084	48,432	47,040	48,429	49,894	51,610	53,160
Prices (2009 = 100.0)							
Chain-weighted NHE deflator	95.8	97.7	100.0	102.7	105.2	106.9	108.3
GDP price index	97.3	99.2	100.0	101.2	103.3	105.2	106.7
Real spending							
NHE, billions of chained dollars	$ 2,404	$ 2,471	$ 2,506	$ 2,535	$ 2,571	$ 2,635	$ 2,695
GDP, billions of chained dollars	14,874	14,830	14,419	14,784	15,021	15,369	15,710
NHE as percent of GDP	15.9	16.4	17.4	17.4	17.4	17.4	17.4
ANNUAL GROWTH							
NHE	6.3%	4.8%	3.8%	3.9%	3.9%	4.1%	3.6%
Health consumption expenditures	6.1	4.6	4.5	4.0	3.8	4.1	3.8
Out of pocket	5.9	2.4	0.0	1.8	3.6	3.6	3.2
Health insurance	6.0	5.6	5.6	4.3	4.1	3.9	3.6
Private health insurance	5.1	3.9	3.1	3.5	4.3	4.0	2.8
Medicare	7.2	7.9	7.0	4.0	4.8	4.0	3.4
Medicaid	6.3	5.7	8.8	6.1	2.5	4.0	6.1
Federal	6.7	9.5	21.8	7.7	–7.1	–1.7	6.2
State and local	5.7	0.7	–9.9	2.9	21.9	12.8	5.9
Other health insurance programs[b]	7.4	9.8	9.2	6.4	5.1	2.2	2.9
Other third-party payers and programs and public health activity	6.7	0.9	2.0	4.5	2.1	6.3	5.6
Investment	10.3	7.0	–5.8	2.3	5.1	4.0	0.5
Population	0.9	0.9	0.9	0.8	0.7	0.7	0.7
GDP, billions of dollars	4.5	1.7	–2.0	3.8	3.7	4.2	3.7
NHE per capita	5.3	3.8	2.9	3.1	3.2	3.4	2.9
GDP per capita	3.5	0.7	–2.9	3.0	3.0	3.4	3.0
Prices (2009 = 100.0)							
Chain-weighted NHE deflator	3.3	2.0	2.3	2.7	2.4	1.6	1.3
GDP price index	2.7	1.9	0.8	1.2	2.1	1.8	1.5
Real spending							
NHE, billions of chained dollars	2.9	2.8	1.4	1.2	1.4	2.5	2.3
GDP, billions of chained dollars	1.8	–0.3	–2.8	2.5	1.6	2.3	2.2

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and US Department of Commerce, Bureau of Economic Analysis and Bureau of the Census. **NOTES** Definitions, sources, and methods for NHE categories can be found in the National Health Accounts methodology paper (see Note 20 in text). Numbers may not add to totals because of rounding. Percentage changes are calculated from unrounded data. [a]Annual growth, 2006–07. [b]Includes health-related spending for Children's Health Insurance Program (CHIP) Titles XIX and XXI; Department of Defense; and Department of Veterans Affairs.

sions and the years immediately following—when health care spending increased at a much faster average annual rate than GDP. Accordingly, the share of the economy devoted to health care increased substantially during those three periods—by 2.0 percentage points, 2.1 percentage points, and 1.5 percentage points, respectively.

EXHIBIT 2

National Health Expenditures (NHE) Amounts And Annual Growth, By Spending Category, Calendar Years 2007–13

Spending category	2007[a]	2008	2009	2010	2011	2012	2013
EXPENDITURE AMOUNT							
NHE, billions	$2,303.9	$2,414.1	$2,505.8	$2,604.1	$2,705.3	$2,817.3	$2,919.1
Health consumption expenditures	2,158.8	2,258.9	2,359.5	2,454.5	2,548.0	2,653.6	2,754.5
Personal health care	1,921.0	2,017.3	2,117.9	2,196.2	2,281.8	2,379.3	2,468.6
Hospital care	692.5	728.9	776.8	814.9	849.9	898.5	936.9
Professional services	618.6	652.8	672.4	694.2	721.5	752.0	777.9
Physician and clinical services	461.8	486.5	503.2	519.0	540.8	565.3	586.7
Other professional services	59.5	64.0	66.8	69.8	73.1	76.8	80.2
Dental services	97.3	102.4	102.5	105.4	107.6	110.0	111.0
Other health, residential, and personal care	107.7	113.5	122.5	128.5	132.5	140.1	148.2
Home health care	57.8	62.3	67.2	71.2	73.8	77.1	79.8
Nursing care facilities and continuing care retirement communities	126.4	132.6	138.5	143.0	149.2	152.2	155.8
Retail outlet sales of medical products	318.1	327.1	340.3	344.4	354.8	359.4	370.0
Prescription drugs	236.0	242.7	255.0	256.2	263.0	264.4	271.1
Durable medical equipment	34.3	34.9	35.0	37.0	39.1	41.3	43.0
Other nondurable medical products	47.8	49.5	50.3	51.2	52.8	53.7	55.9
Government administration	29.3	29.4	29.8	30.5	32.8	34.2	37.0
Net cost of health insurance	142.6	140.7	137.8	152.3	160.0	165.3	173.6
Government public health activities	65.9	71.5	74.0	75.5	73.5	74.8	75.4
Investment	145.1	155.3	146.3	149.7	157.3	163.7	164.6
Noncommercial research	42.5	44.0	45.2	48.7	49.3	48.0	46.7
Structures and equipment	102.7	111.2	101.1	101.0	108.0	115.7	117.9
ANNUAL GROWTH							
NHE	6.3%	4.8%	3.8%	3.9%	3.9%	4.1%	3.6%
Health consumption expenditures	6.1	4.6	4.5	4.0	3.8	4.1	3.8
Personal health care	6.2	5.0	5.0	3.7	3.9	4.3	3.8
Hospital care	6.2	5.3	6.6	4.9	4.3	5.7	4.3
Professional services	5.7	5.5	3.0	3.2	3.9	4.2	3.4
Physician and clinical services	5.2	5.3	3.4	3.1	4.2	4.5	3.8
Other professional services	8.2	7.6	4.4	4.6	4.7	5.0	4.5
Dental services	6.4	5.2	0.1	2.8	2.1	2.2	0.9
Other health, residential, and personal care	5.9	5.5	7.9	4.9	3.1	5.8	5.8
Home health care	9.9	7.8	8.0	5.8	3.7	4.5	3.4
Nursing care facilities and continuing care retirement communities	7.7	4.9	4.5	3.2	4.3	2.0	2.4
Retail outlet sales of medical products	5.9	2.8	4.0	1.2	3.0	1.3	2.9
Prescription drugs	5.2	2.8	5.0	0.5	2.6	0.5	2.5
Durable medical equipment	6.2	1.6	0.4	5.6	5.6	5.6	4.2
Other nondurable medical products	9.2	3.6	1.7	1.8	3.0	1.8	4.0
Government administration	1.8	0.5	1.2	2.4	7.3	4.3	8.2
Net cost of health insurance	4.3	–1.4	–2.0	10.5	5.0	3.4	5.0
Government public health activities	8.3	8.5	3.5	1.9	–2.7	1.8	0.8
Investment	10.3	7.0	–5.8	2.3	5.1	4.0	0.5
Noncommercial research	2.4	3.7	2.5	7.9	1.2	–2.7	–2.6
Structures and equipment	14.0	8.3	–9.1	–0.2	7.0	7.1	1.9

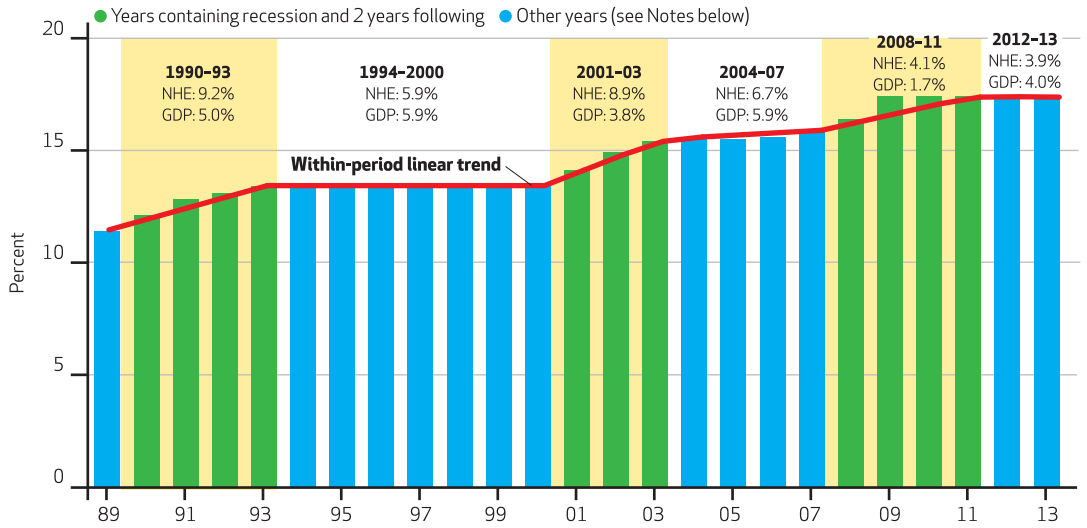
SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Definitions, sources, and methods for NHE categories can be found in the National Health Accounts methodology paper (see Note 20 in text). Numbers may not add to totals because of rounding. Percentage changes are calculated from unrounded data. [a]Annual growth, 2006–07.

Factors Accounting For Growth

National health spending growth can be disaggregated into economywide price inflation, medical-specific price inflation, and three nonprice factors: changes in population, shifts in the age and sex mix of the population, and a residual that primarily reflects the use and intensity of services.[5] On a per capita basis, national health spending growth slowed from 3.4 percent in 2012 to 2.9 percent in 2013 (Exhibits 1 and 4). Medical prices and residual use and intensity were almost equally responsible for the deceler-

EXHIBIT 3

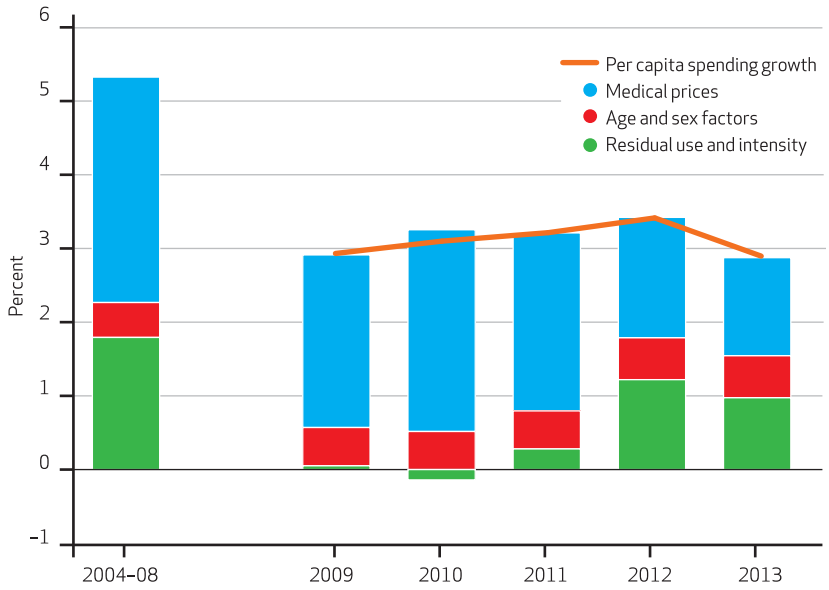
National Health Expenditures (NHE) As A Share Of Gross Domestic Product (GDP), 1989–2013



SOURCES Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; National Bureau of Economic Research; and US Department of Commerce, Bureau of Economic Analysis. **NOTES** Health spending was grouped into the following two categories for selected periods between 1990 and 2013: "recession and aftermath," or years during which three or more months were in recession, and two additional years after the official end of the recession; and "between recessions," or year 3 after the official end of each recession and all subsequent years until the next recession began. We selected these groupings based on a historical analysis suggesting that recessions tend to have a lagged impact on the health sector that is strongest 2–3 years after the end of the recession. Growth rates were calculated using nominal dollars. Growth for each period reflects the average annual change between the year before the period and the last year of the period. For example, the growth for the period 1990–93 is calculated as the average annual growth from 1989 to 1993.

EXHIBIT 4

Factors Accounting For Growth In Per Capita National Health Expenditures, Selected Calendar Years 2004–13



SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Medical price growth, which includes economywide and excess medical-specific price growth (or changes in medical-specific prices in excess of economywide inflation), is calculated using the chain-weighted national health expenditures (NHE) deflator for NHE. "Residual use and intensity" is calculated by removing the effects of population, age and sex factors, and price growth from the nominal expenditure level.

ation (Exhibit 4).

Medical price growth increased just 1.3 percent in 2013, following growth of 1.6 percent in 2012. The slower growth in 2013 reflected slower growth in prices for physician and clinical services, hospital care, and nursing care facilities and continuing care retirement communities and declines in the prices for home health care and the net cost of insurance. The 1.3 percent medical price growth in 2013 was slightly less than the 1.5 percent growth in economywide prices (as measured by the GDP price index), which suggests that excess medical-specific price inflation declined compared to economywide inflation in that year.

Growth in the use and intensity of services also decelerated slightly, from 1.2 percent in 2012 to 1.0 percent in 2013. The slowdown was in part due to lower growth in the use and intensity of hospital services.

A broader view shows that the relatively stable and historically low growth in aggregate health spending during 2009–13 masks the variation that occurred between medical prices and residual use and intensity. During 2009–11 per capita health spending grew 3.1 percent each year, on average, with use and intensity of services accounting for just 0.1 percentage point of the average annual growth during this period. By com-

Growth in health spending and GDP have tended to converge several years after the end of economic recessions.

parison, use and intensity grew, on average, 1.8 percent during 2004–08, when per capita health spending growth was 5.3 percent. This reduction in the contribution of use and intensity between these two periods was largely due to a significant loss of private health insurance coverage, a decline in total investment in medical structures and equipment as well as changes in types of investments, and reduced demand for health care services as a result of financial uncertainty caused by the recession.[6]

In 2012 and 2013 per capita health spending continued to grow slowly (averaging 3.1 percent). However, growth in use and intensity increased on average 1.1 percent per year, which was higher than the rates of growth in use and intensity in 2009–11. Medical price growth, however, was much lower in 2012 and 2013: It averaged 1.5 percent per year, compared to average increases of 2.5 percent per year in 2009–11. This slowdown was due in part to the ACA-mandated productivity adjustments to Medicare fee-for-service payments, the budget sequestration, and the impacts of the ACA-mandated medical loss ratio and rate reviews on the net cost of private health insurance.[7]

The ACA And The Sequester

Two notable pieces of legislation affected growth trends in 2013, particularly for Medicare. The ACA, which was enacted in 2010, was designed to be implemented over multiple years, with implementation of the major coverage provisions beginning in 2014. A few key provisions exerted downward pressure on health spending growth in 2013, including the productivity adjustments to Medicare fee-for-service payments, reduced Medicare Advantage base payment rates, increased Medicaid prescription drug rebates, and the medical loss ratio requirement for private insurers. At the same time, other provisions—such as early Medicaid expansion initiatives, a temporary increase in Medicaid primary care provider payments, reducing the size of the Medicare Part D doughnut hole, and the implementation of drug industry fees—exerted upward pressure on health spending growth.

Budget sequestration was implemented March 1, 2013, as mandated by the Budget Control Act of 2011. Notable impacts of budget sequestration on the health sector included an across-the-board 2 percent reduction in spending on Medicare benefits in 2013 and reduced funding for federal research, federal public health activities, and other selected federal programs. Some programs—such as Medicaid, the Children's Health Insurance Program (CHIP), and health care programs sponsored by the Department of Veterans Affairs—were exempt from sequestration.

Medicare

Medicare accounted for 20 percent of national health spending in 2013, when expenditures reached $585.7 billion (Exhibit 1). Total Medicare spending growth slowed in 2013, increasing 3.4 percent compared to 4.0 percent in 2012. This slowdown was primarily attributable to slower Medicare enrollment growth and the impacts of the ACA and sequestration. Per enrollee spending growth was similar in 2012 and 2013.

Fee-for-service expenditures, which accounted for 72 percent of total Medicare spending, increased 1.7 percent in 2013—a growth rate similar to the 1.8 percent growth in those expenditures in 2012. Medicare Advantage spending, which accounted for the remainder of Medicare spending, decelerated in 2013, increasing 7.8 percent after growing 10.6 percent in 2012.

In 2013 total Medicare enrollment (both fee-for-service and Medicare Advantage) increased by 1.6 million beneficiaries, or by 3.2 percent, to 51.3 million enrollees. This was a slowdown from the enrollment growth of 4.1 percent in 2012, when a higher-than-average increase occurred as the oldest members of the baby-boom generation became eligible to join Medicare. Enrollment growth slowed for both the fee-for-service and Medicare Advantage programs in 2013. However, the number of enrollees increased at a much faster rate for Medicare Advantage (a growth rate of 9.4 percent) than for fee-for-service (a growth rate of only 1.0 percent).

Per enrollee growth in total Medicare spending was relatively flat: It increased just 0.2 percent in 2013 after a growth rate of less than 0.1 percent in 2012, as relatively younger and healthier baby boomers continued to join the program. The low growth in total Medicare spending per beneficiary is in part attributable

to Medicare Advantage spending per enrollee, which declined 1.4 percent after growing only 0.5 percent in 2012. The slower growth in total Medicare Advantage expenditures and decline in per enrollee spending in 2013 was due primarily to an ACA-mandated payment-mechanism change that reduced benchmark payment rates to be more in line with fee-for-service costs.[8]

Fee-for-service per enrollee growth also remained low (an increase of 0.7 percent in 2013, after a decline of 0.3 percent in 2012), as a result of slower increases in outpatient hospital utilization, a decline in the volume and intensity of physician services, the budget sequestration, and the continued impacts of the ACA-mandated payment update reductions.[9]

Private Health Insurance

In 2013, 189.3 million people in the United States (or 60 percent of the population) were covered by private health insurance. Aggregate private health insurance premiums grew at a slower rate in 2013 than in 2012, increasing just 2.8 percent to $961.7 billion (33 percent of total health care spending) compared to an increase of 4.0 percent in 2012 (Exhibit 1). Slower premium growth in 2013 reflected numerous factors, including low overall enrollment growth; a continuing shift to enrollment in consumer-directed high deductible plans and other benefit design changes; historically low underlying benefit cost trends; and the impact of several provisions of the ACA, such as the medical loss ratio requirement and rate review.

Private health insurance enrollment increased 0.7 percent in 2013—the third straight year of positive growth—albeit low, following a significant enrollment decline of 11.2 million individuals in 2008–10, which was due mainly to the recession. From 2011 to 2013, the slight rebound in enrollment (an additional 3 million covered individuals during the period) resulted in total private health insurance enrollment levels that were well below the pre-recession peak of 197.5 million in 2007. At the same time, enrollment in consumer-directed high-deductible plans—which cost 9–12 percent less than the average preferred provider organization plan—increased, further dampening the growth in private health insurance premiums.[10] In 2013 these plans insured 20 percent of covered workers, compared to 17 percent in 2011.[10]

Changes in plan design and several provisions of the ACA also contributed to slower growth in private health insurance premiums in 2013. A recent study indicated that changes to plan design resulted in a 1.9-percentage-point reduction in premiums, compared to what they would have been without the changes.[11] In addition, the medical loss ratio requirement and rate review mandated by the ACA put downward pressure on premium growth.

Private health insurance benefit expenditures increased 2.8 percent in 2013, compared to 4.4 percent in 2012, and reached $846.0 billion. The slow growth in 2013 was driven primarily by low spending growth for hospital services and physician and clinical services and a decline in retail prescription drugs. Combined, these expenditures accounted for 87 percent of total private health insurance medical benefits.

Some of this slower growth in private health insurance benefit spending may be due to the increased enrollment in high-deductible health plans. Consumers enrolled in high-deductible plans tend to use services at a lower rate than those enrolled in plans with lower or no cost sharing.[12] A recent report found that 38 percent of workers with employer-sponsored single coverage were enrolled in a plan with an annual deductible of $1,000 or more in 2013, up from 34 percent in 2012.[10]

Medicaid

Total Medicaid spending by the federal government and state and local governments reached $449.4 billion in 2013 (Exhibit 1) and accounted for 15 percent of total national health expenditures. Medicaid spending increased 6.1 percent in 2013, following growth of 2.5 and 4.0 percent in 2011 and 2012, respectively. Those were the two slowest annual rates of growth in the history of Medicaid except for 2006, when the implementation of Medicare Part D changed the way in which Medicaid paid for some beneficiaries' prescription drugs.

In 2013 Medicaid enrollment grew 2.7 percent. This was the first acceleration since the most recent recession, during which Medicaid enrollment growth peaked at 7.6 percent in 2009 and slowed each year thereafter (6.9 percent in 2010, 4.5 percent in 2011, and 1.8 percent in 2012). Some of the increase in 2013 was due to new beneficiaries who enrolled as a result of early Medicaid expansion in some states.[13]

Medicaid spending per enrollee increased 3.3 percent in 2013 after growing 2.1 percent in 2012. This acceleration was driven by growth in some provider reimbursement rates and by some states' expanding benefits.[14]

Hospital care and other health, residential, and personal care services together accounted for just over half of all Medicaid spending in 2013. Medicaid spending for hospital care (36 percent of total Medicaid spending) grew 4.5 percent in both 2012 and 2013. Spending

for other health, residential, and personal care services (including Medicaid home and community-based waivers, rehabilitation services, and nonemergency medical transportation services) grew 9.3 percent, accelerating from its 8.6 percent growth in 2012.

Both physician and clinical services (11 percent share) and government administration and the net cost of private health insurance (together, 9 percent share) also contributed to the overall acceleration in Medicaid spending in 2013. Physician and clinical services spending growth accelerated from 2.7 percent in 2012 to 10.1 percent in 2013, as a result of the temporary increase in payments to primary care physicians mandated by the ACA.[15] Government administration and the net cost of insurance together grew 11.3 percent in 2013, compared to 4.8 percent in 2012. This was partially a result of large increases in managed care programs and states' preparations for expanding Medicaid.

Medicaid spending growth for the federal government and state and local governments returned to more typical patterns in 2013: Federal spending increased 6.2 percent, and state and local spending increased 5.9 percent. This more characteristic pattern of similar growth rates followed two years of substantial increases in state and local Medicaid spending (12.8 percent in 2012 and 21.9 percent in 2011) and declines in federal Medicaid spending (–1.7 percent in 2012 and –7.1 percent in 2011). These growth patterns reflected the end of additional federal funding that had been mandated by the American Recovery and Reinvestment Act of 2009, which increased the Federal Medical Assistance Percentage from October 2008 through June 2011.

Out-Of-Pocket Spending

Out-of-pocket spending by consumers, which includes direct consumer payments such as copayments and deductibles and spending on noncovered services, was $339.4 billion, or 12 percent of national health expenditures, in 2013 (Exhibit 1). Out-of-pocket spending gradually declined from a 15 percent share of health spending in 1998. It grew 3.2 percent in 2013—slightly slower than its growth of 3.6 percent in both 2011 and 2012—or almost two and a half times as fast as the average annual growth rate of 1.4 percent during 2008–10, the period during and just after the most recent recession.

Faster growth in 2011–13 compared with 2008–10 reflects a modestly improved economy; higher cost sharing for group health insurance plans; and increased enrollment in consumer-directed health plans that have higher deductibles, higher copayments, or both.

Hospital Care

Expenditures for hospital care reached $936.9 billion in 2013, an increase of 4.3 percent (Exhibit 2). This was slower than the 5.7 percent rate of growth in 2012. Overall, hospital spending was influenced by decelerations in growth for both price and nonprice factors (such as residual use and intensity). Hospital prices (as measured by the Producer Price Index) increased at a slower rate of 2.2 percent in 2013, compared to 2.5 percent in 2012.[16] The use of hospital inpatient services also contributed to the slower growth in 2013, as the number of inpatient days declined by 1.6 percent[17] and discharges decreased by 1.4 percent.[18]

Private health insurance spending growth for hospital services decelerated sharply from 7.5 percent in 2012 to 4.0 percent in 2013, and Medicare spending growth for hospital services slowed from 3.8 percent in 2012 to 2.6 percent in 2013. These two payers accounted for almost two-thirds of total hospital spending in 2013.

Slower growth in private health insurance spending for hospital care is attributable in part to increased cost-sharing requirements and a shift in enrollment toward higher deductible plans. For example, among covered workers with separate cost sharing for a hospital admission, the average patient cost-sharing charge per day increased 19.5 percent in 2013, while the average cost sharing for an outpatient surgery episode increased by 10 percent.[10,19]

The low rate of increase for Medicare hospital spending in 2013 reflected the impacts of the ACA's productivity adjustments, reductions in inpatient hospital readmissions, overall lower use of both inpatient and outpatient services, and the impacts of sequestration. Medicare spending growth for fee-for-service inpatient hospital care remained low, increasing only 0.6 percent in both 2012 and 2013. Fee-for-service outpatient hospital spending growth slowed from 8.4 percent in 2012 to 4.4 percent in 2013.

Physician And Clinical Services

Spending for physician and clinical services[20] grew 3.8 percent in 2013 to $586.7 billion (Exhibit 2)—a slowdown from 2012, when spending grew 4.5 percent. Slower price growth (from 1.2 percent in 2012 to less than 0.1 percent in 2013) contributed to the deceleration.[21] Price growth of less than 0.1 percent in 2013 was the slowest rate since 2002. This was due in part to reductions in payments to Medicare providers resulting from the sequester and a zero-percent payment update for 2013.[9]

Spending for physician services, which accounted for 80 percent of physician and clinical

services expenditures, grew 3.7 percent in 2013, down slightly from growth of 4.1 percent in 2012. Clinical services spending increased 4.1 percent in 2013, compared to 6.1 percent in 2012. Although the 4.1 percent increase was the lowest rate since 2001, spending for clinical services grew at a higher rate than expenditures for physician services for the ninth consecutive year. The 2-percentage-point decline in clinical services spending growth was due, in part, to slower growth in spending for freestanding ambulatory surgical and emergency centers.

Private health insurance and Medicare accounted for the largest proportion of all physician and clinical services payments (just over two-thirds in 2013). Spending by both of these payers increased at lower rates in 2013 than in 2012, while growth in Medicaid and out-of-pocket spending (the two next-largest payers) accelerated.

The slowdown in Medicare spending was driven by the trend for physician fee-for-service spending, which decelerated from growth of 2.6 percent in 2012 to less than 0.1 percent in 2013. The physician fee schedule declined 0.6 percent in 2013, in part as a result of the American Tax Relief Act of 2012, which provided a 0 percent payment update for physicians in 2013.[9] In contrast, Medicaid spending growth for physician and clinical services increased from 2.7 percent in 2012 to 10.1 percent in 2013, primarily as a result of temporary increases in payments to primary care physicians.[15]

Retail Prescription Drugs

In 2013 total spending growth for retail prescription drugs accelerated, increasing 2.5 percent to $271.1 billion (Exhibit 2). This increase compares to low growth of just 0.5 percent in 2012, which was largely due to the one-time impact of the "patent cliff"—when blockbuster drugs worth $35 billion in annual sales lost their patent protection in 2012 and became available in generic form.[22] The result was lower overall prices paid for these drugs.[23] Factors influencing the faster growth in prescription drug spending in 2013 included price increases for brand-name and specialty drugs,[24] increased spending on new medicines, and increased utilization.

In recent years, specialty drug prices grew at double-digit rates, while generic prices continued to fall.[25] According to a major pharmacy benefit manager, increased prices for brand-name drugs, especially for specialty drugs, was the most significant factor explaining growth in 2013.[26]

Higher prices for specialty drugs were due in part to expensive new medicines—in particular, those used to treat multiple sclerosis and cancer—as well as more rapid price increases for existing specialty drugs.[26,27] Although specialty drugs accounted for less than 1 percent of prescriptions dispensed, they represented almost 28 percent of total pharmacy-related prescription drug spending in 2013.[26] Additionally, more new drugs were launched in 2013 than in any of the previous ten years, which led to increased spending.[27]

The key question is whether health spending growth will accelerate once economic conditions improve significantly.

Utilization, measured as the number of prescriptions dispensed, increased 1.6 percent in 2013, accelerating slightly from growth of 1.2 percent in 2012.[27] These growth rates represent a rebound from the ten-year low of 0.7 percent in 2011 and reflect, in part, increased demand. Additionally, increased utilization was influenced by the greater availability of lower-cost generic drugs, which occurred primarily because of the large number of high-cost medications that recently lost patent protection and became available in generic form.

Typically, generic drugs cost 80–85 percent less than brand-name versions of the same medication.[28] In 2011 the share of dispensed prescriptions that was generic (excluding branded generics) was 73 percent. In 2012 it was 77 percent, and in 2013 it reached 80 percent.[27] Furthermore, private health insurance plans' continued movement to three- or four-tier coinsurance or copayment structures, which charge less for generics and more for higher-cost drugs, has contributed to the low prescription drug spending growth.[10]

Medicare spending on prescription drugs (that is, expenditures for drugs covered mainly under the Part D benefit with some additional coverage under the Part B benefit) increased 10.7 percent in 2013 and reached $74.6 billion. This was a faster rate of growth than in 2012, when spending grew 6.6 percent.

Medicare accounts for 28 percent of total retail prescription drug spending—a share that in-

EXHIBIT 5

National Health Expenditures (NHE) Amounts, Annual Growth, And Percent Distribution, By Type Of Sponsor, Calendar Years 2007–13

Type of sponsor	2007[a]	2008	2009	2010	2011	2012	2013
EXPENDITURE AMOUNT							
NHE, billions	$2,303.9	$2,414.1	$2,505.8	$2,604.1	$2,705.3	$2,817.3	$2,919.1
Businesses, household, and other private revenues	1,372.5	1,416.8	1,415.2	1,446.6	1,508.4	1,592.7	1,652.8
Private businesses	522.6	530.5	530.3	533.7	560.4	587.3	610.9
Household	678.0	713.0	717.3	738.3	764.5	801.5	823.8
Other private revenues	171.9	173.3	167.6	174.6	183.5	203.9	218.1
Governments	931.4	997.3	1,090.6	1,157.5	1,196.9	1,224.6	1,266.3
Federal government	530.7	583.6	682.8	733.1	733.1	731.5	757.5
State and local governments	400.8	413.7	407.9	424.5	463.7	493.1	508.8
ANNUAL GROWTH							
NHE	6.3%	4.8%	3.8%	3.9%	3.9%	4.1%	3.6%
Businesses, household, and other private revenues	6.0	3.2	–0.1	2.2	4.3	5.6	3.8
Private businesses	4.4	1.5	0.0	0.6	5.0	4.8	4.0
Household	5.8	5.2	0.6	2.9	3.6	4.8	2.8
Other private revenues	12.5	0.8	–3.3	4.2	5.1	11.1	7.0
Governments	6.7	7.1	9.4	6.1	3.4	2.3	3.4
Federal government	6.4	10.0	17.0	7.4	0.0	–0.2	3.5
State and local governments	7.1	3.2	–1.4	4.1	9.3	6.3	3.2
PERCENT DISTRIBUTION							
NHE	100%	100%	100%	100%	100%	100%	100%
Businesses, household, and other private revenues	60	59	56	56	56	57	57
Private businesses	23	22	21	20	21	21	21
Household	29	30	29	28	28	28	28
Other private revenues	7	7	7	7	7	7	7
Governments	40	41	44	44	44	43	43
Federal government	23	24	27	28	27	26	26
State and local governments	17	17	16	16	17	18	17

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Definitions, sources, and methods for NHE categories can be found in the National Health Accounts methodology paper (see Note 20 in text). Numbers may not add to totals because of rounding. Percentage changes are calculated from unrounded data. [a]Annual growth, 2006–07.

creased from just 2 percent in 2005 (one year before the introduction of Part D). Spending on Part D drugs accelerated to a 10.5 percent growth rate in 2013 (from 5.3 percent in 2012). This was driven in part by continued strong growth in Part D enrollment and by increased subsidies for the expanding number of Part D enrollees who reached the catastrophic phase of the benefit.[29]

Medicaid spending on prescription drugs also accelerated in 2013, increasing 4.7 percent compared to 1.1 percent in 2012. Total Medicaid prescription drug expenditures reached $21.2 billion in 2013 and accounted for 8 percent of total retail prescription drug spending.

Sponsors Of Health Care

As the main sponsors of health care, households; private businesses; and the federal government and state and local governments are responsible for financing the nation's health care bill. In 2013 households accounted for the largest share of spending (28 percent), followed by the federal government, private businesses, and state and local governments (Exhibit 5).

Household health spending, which includes out-of-pocket payments, contributions to private health insurance premiums, and contributions to Medicare through payroll taxes and payment of premiums, grew 2.8 percent in 2013—a slower rate of growth than the 4.8 percent rate in 2012. This slowdown was due in part to the low rate of increase in employee contributions to private health insurance premiums, which grew just 2.2 percent in 2013. Despite the slower growth in 2013, the household share of health spending has remained steady at 28 percent since 2010.

Health care spending financed by private businesses—a category that includes the employer share of contributions to private health insurance premiums, workers' compensation, temporary disability insurance premiums, contribu-

tions to the Medicare Hospital Insurance Trust Fund, and health care provided directly at the worksite—increased 4.0 percent in 2013, contributing to an average annual rate of 4.6 percent during 2011–13. This rate of increase is much higher than the average increase of 0.7 percent during 2008–10 caused by recession-related job losses and declines in private health insurance enrollment during and just after the recession. The private business share of overall health spending has remained fairly steady since 2009, at about 21 percent.

Federal government spending for health care increased 3.5 percent in 2013. This was influenced in part by an increase in Medicaid payments to primary care physicians mandated by the ACA and paid entirely by the federal government. State and local government spending increased 3.2 percent in 2013. This increase followed strong growth of 6.3 percent in 2012 and 9.3 percent in 2011 that was due largely to the expiration in June 2011 of the Medicaid enhanced matching rates for states funded through the American Recovery and Reinvestment Act.

The federal government's share of health spending has diminished in recent years, from 28 percent in 2010 to 27 percent in 2011 and 26 percent in both 2012 and 2013. This reduction was caused primarily by the expiration of Medicaid enhanced matching rates. In the same period, state and local governments' share of total health care spending increased from 16 percent in 2010 to 17 percent in 2011; it remained relatively stable through 2013. Together, overall government spending for health care increased 3.4 percent in 2013 and accounted for 43 percent of overall health care spending.

Conclusion

During the past five years, health care spending grew at historically low rates, between 3.6 percent and 4.1 percent each year. During 2010–13, this slow growth mirrored that of the overall economy, which increased 3.7–4.2 percent per year. The result was a stable health spending share of GDP, at 17.4 percent. The recent similarity between national health care spending and GDP growth is consistent with historically observed patterns as the economy moves further from the end of the recession.

The key question is whether health spending growth will accelerate once economic conditions improve significantly; historical evidence suggests that it will. However, in the near term, the health sector will undergo major changes that will have a substantial impact on the consumers, providers, insurers, and sponsors of health care.

More notable provisions of the ACA, such as those related to the health insurance Marketplaces and the Medicaid expansion, will affect the future health care spending trend through the expansion of health insurance to people who were previously uninsured and the availability of plans with more comprehensive benefits for those who previously had coverage.[30] At the same time, there have been and will continue to be forces that keep medical price growth low, particularly for Medicare. In addition, shifts to private coverage with higher deductibles could continue to have an effect. The balance of these and many other factors over the next few years will determine how the historically low health spending growth from 2009 to 2013 is viewed: as the temporary aftermath of the great recession or the beginning of a new era. ■

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NOTES

1 Health spending estimates for years before 2013 differ from those published January 6, 2014, and reflect new and revised source data that were unavailable for previous vintages of the National Health Expenditure (NHE) Accounts. Most notably, the 2012 NHE growth rate was revised from 3.7 percent to 4.1 percent, mainly because of upward revisions to hospital care and investment in structures and equipment categories.

2 Baker K. After a year of moving sideways, nonresidential building activity poised to resume recovery in 2014 [Internet]. Washington (DC): American Institute of Architects; 2014 Jan 24 [cited 2014 Oct 21]. Available from: http://www.aia.org/practicing/AIAB101318

3 Carpenter D, Hoppszallern S. Market reset. Health Facilities Management [serial on the Internet]. 2013 Feb 01 [cited 2014 Oct 21]. Available from: http://www.hfmmagazine.com/display/HFM-news-article.dhtml?dcrPath=/templatedata/HF_Common/NewsArticle/data/HFM/Magazine/2013/Feb/0213HFM_FEA_CoverStory

4 For further description of the selection of the periods for analysis, see the Exhibit 3 notes.

5 Residual use and intensity is calculated by removing the effects of population, age-sex factors, and price growth from the nominal expenditure level.

6 Hartman M, Martin AB, Benson J, Catlin A, National Health Expenditure Accounts Team. National health spending in 2011: overall growth remains low, but some payers and services show signs of acceleration.

Health Aff (Millwood). 2013;32(01): 87–99.
7 The medical loss ratio requires individual and group health insurance plans to spend a minimum portion of premium revenues on clinical services and quality improvement. The ACA's provision on rate review has set minimum standards for the review of any proposed premium rate increases above 10 percent in the individual and small-group market.
8 The ACA also required that beginning in 2012, plans' quality ratings be factored into Medicare Advantage payments. Quality ratings may either increase payments to qualified plans through bonus payments, or decrease payments to qualified plans by affecting the amount of rebates paid to plans.
9 Boards of Trustees. 2014 annual report of the boards of trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2014 Jul 28 [cited 2014 Aug 13]. Available from: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2014.pdf
10 Kaiser Family Foundation, Health Research and Educational Trust. Employer health benefits: 2013 annual survey [Internet]. Menlo Park (CA): KFF; 2013 [cited 2014 Oct 22]. Available from: https://kaiserfamilyfoundation.files.wordpress.com/2012/09/8465-employer-health-benefits-2013.pdf
11 Towers Watson. The new health care imperative: driving performance, connecting to value. 19th annual Towers Watson/National Business Group on Health employer survey on purchasing value in health care [Internet]. New York (NY): Towers Watson; 2014 [cited 2014 Oct 22]. Available from: http://www.towerswatson.com/DownloadMedia.aspx?media={B5CC3143-9B78-4B92-96A4-3F569300406F}
12 Newhouse JP. Consumer-directed health plans and the RAND Health Insurance Experiment. Health Aff (Millwood). 2004;23(6):107–13.
13 Based on an unpublished analysis by the CMS Office of the Actuary of enrollment data from CMS.gov. Medicaid Statistical Information System (MSIS) state summary database [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; [last modified 2014 Jul 22; cited 2014 Oct 22]. Available from: http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/MSIS-Mart-Home.html
14 Smith VK, Gifford K, Ellis E, Rudowitz R, Snyder L. Medicaid in a historic time of transformation: results from a 50-state Medicaid budget survey for state fiscal years 2013 and 2014 [Internet]. Washington (DC): Kaiser Commission on Medicaid and the Uninsured; 2013 Oct [cited 2014 Oct 22]. Available from: http://kaiserfamilyfoundation.files.wordpress.com/2013/10/8498-medicaid-in-a-historic-time-of-transformation.pdf
15 Centers for Medicare and Medicaid Services. 2013 actuarial report on the financial outlook for Medicaid [Internet]. Baltimore (MD): CMS; 2013 [cited 2014 Jul 7]. Available from: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2013.pdf
16 Bureau of Labor Statistics. Producer Price Index industry data, series report: series ID PCU622- - -622- - - [Internet]. Washington (DC): BLS; [cited 2014 Aug 08]. Available for download from: http://data.bls.gov/cgi-bin/srgate
17 Census Bureau. Business and industry: time series/trend charts: hospitals: U.S. total—not seasonally adjusted total inpatient days [Internet]. Washington (DC): Census Bureau; 2014 Sep 11 [cited 2014 Oct 30]. Available from: http://www.census.gov/econ/currentdata/dbsearch?program=QSS&startYear=2003&endYear=2014&categories=622A&dataType=INPAT&geoLevel=US&notAdjusted=1&submit=GET+DATA
18 Census Bureau. Business and industry: time series/trend charts: hospitals: U.S. total—not seasonally adjusted total discharges [Internet]. Washington (DC): Census Bureau; 2014 Sep 11 [cited 2014 Oct 30]. Available from: http://www.census.gov/econ/currentdata/dbsearch?program=QSS&startYear=2003&endYear=2014&categories=622A&dataType=DISC&geoLevel=US&notAdjusted=1&submit=GET+DATA
19 Kaiser Family Foundation, Health Research and Educational Trust. Employer health benefits: 2012 annual survey [Internet]. Menlo Park (CA): KFF; 2012 [cited 2014 Sep 10]. Available from: http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8345.pdf
20 The definition of *physician and clinical services* in the National Health Expenditure Accounts includes expenditures for offices of physicians (North American Industry Classification System [NAICS] code 6211) and outpatient care centers (NAICS 6214), and some spending for independently billing laboratories (NAICS 6215). For more information, see Centers for Medicare and Medicaid Services. National Health Expenditures Accounts methodology paper, 2013: definitions, sources, and methods [Internet]. Baltimore (MD): CMS; [cited 2014 Dec 3]. Available from: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/dsm-13.pdf
21 Authors' analysis of Producer Price Index data for North American Industry Classification Codes 6211 and 6215 as of October 2013. See Bureau of Labor Statistics. Producer Price Indexes [Internet]. Washington (DC): BLS; [cited 2014 Aug 22]. Available from: http://www.bls.gov/ppi/
22 CVS Caremark. Insights 2014: 7 sure things [Internet]. Woonsocket (RI): CVS Caremark; 2014 [cited 2014 Oct 23]. Available from: http://info.cvscaremark.com/insights2014/INSIGHTS%20Trend%202014-v2.pdf
23 IMS Institute for Healthcare Informatics. Declining medicine use and costs: for better or worse? Parsippany (NJ): The Institute; 2013 May.
24 Specialty drugs are used to treat complex conditions and are typically more expensive than traditional brand-name drugs.
25 Authors' analysis, based on unpublished data from the Bureau of Labor Statistics Consumer Price Index.
26 Express Scripts. 2013 drug trend report [Internet]. St. Louis (MO): Express Scripts; 2014 April 8 [cited 2014 Oct 23]. Available from: http://www.drugtrendreport.com/docs/downloads/Commercial.pdf
27 IMS Institute for Healthcare Informatics. Medicine use and shifting costs of healthcare. Parsippany (NJ): The Institute; 2014 Apr.
28 Food and Drug Administration. Facts about generic drugs [Internet]. Silver Spring (MD): FDA; [last updated 2012 Sep 19; cited 2014 Oct 23]. Available from: http://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/understandinggenericdrugs/ucm167991.htm#_ftn3
29 Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2014 Mar. Chapter 14: Status report on Part D [cited 2014 Sep 19]. Available from: http://www.medpac.gov/documents/reports/mar14_entirereport.pdf?sfvrsn=0
30 Sisko AM, Keehan SP, Cuckler GA, Madison AJ, Smith SD, Wolfe CJ, et al. National health expenditure projections, 2013–23: faster growth expected with expanded coverage and improving economy. Health Aff (Millwood). 2014;33(10):1841–50.