Reports and Research

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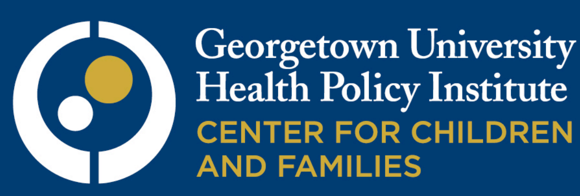

The Center on Health Insurance Reforms
Georgetown University Health Policy Institute

A COMPILATION OF ASSISTER QUESTIONS

As part of our Robert Wood Johnson Foundation-funded project providing technical assistance to navigators and assisters in five states, we have received a broad range of questions. This compilation includes a subset of those questions that may be of broader interest. As questions continue to come in, we'll send out semi-regular compilations.

The Navigator Resource Guide referred to throughout can be found at: http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/11/navigator-resource-guide-on-private-health-insurance-coverage---.html

Questions in this compilation

- Student Health Insurance and Premium Tax Credits
- Stuck in a Non-ACA Plan
- 90 Day Grace Period for Payment of Premiums
- Accessing Providers in Border Counties/States
- Medicaid Residency Rules
- Counting Social Security Benefits
- Same-sex couples and eligibility for premium tax credits

Student Health Insurance and Premium Tax Credits

Question: A man is covered by student insurance but it would cost $600 to add his wife. Would she be free to go to the marketplace and apply for a subsidy, or does student insurance work like employer insurance?

Answer: In terms of eligibility for the marketplace/Advanced Premium Tax Credits, student insurance works under a different set of rules than employer-based coverage. While student insurance is minimum essential coverage, you can be eligible for it and still be eligible for a Qualified Health Plan (QHP) with financial assistance. We have some FAQs on this in our Navigator Resource Guide, (see p. 85-88). Of course, if she wants to apply for a QHP outside of open enrollment she would need to meet the requirements for getting a Special Enrollment Period.

Stuck in a Non-ACA Plan

Question: We have a client who is pregnant and her policy doesn't cover pregnancy-related services. How is that possible if the Essential Health Benefits include maternity coverage? The representative who enrolled her in the plan in 2012 said there was nothing she can do to update her plan until open enrollment at the end of the year. She was told that there is no guarantee that pregnancy-related services would be covered since it could be considered a preexisting condition. Regardless, it would not be helpful because it wouldn't go into effect until Jan 1st, which is after her expected due date.

Answer: Sounds like she has an individual policy but it renewed in 2013 (i.e., Dec. 1, 2013 or earlier), which means it does not have to cover the essential benefits, including maternity care. If, however, the policy renewed on or after Jan. 1, 2014, then the insurer is required to cover maternity. Traditional individual health insurance policies are on a 12-month contract and renew on your anniversary date of purchase. If her plan renews in 2014 (even if outside open enrollment) she will have a 30-day window to find a new plan either on or off the Marketplace, and that plan must cover maternity as part of the Essential Health Benefits. She does NOT have to worry about pre-existing condition exclusions if she is buying a health insurance policy on or after Jan. 1, 2014, whether on or off the Marketplace. Those are prohibited.

90 Day Grace Period for Payment of Premiums

Question: Our feedback loop has been hearing about insured people not being listed as insured when their provider attempts to confirm coverage. When a person misses a payment and is in the 90-day grace period, is he considered covered? Or is the grace period simply an opportunity to catch up the premium without having to wait until the next Open Enrollment to enroll. So when the doctor calls to verify coverage, is it correct for the insurance company to say uncovered because one premium has been missed?

Answer: The 90-day grace period for non-payment of premium only applies (a) if the policyholder is receiving advanced premium tax credits and (b) if he/she has paid at least one month's premium. If both of those are true, the insurer cannot terminate coverage until the end of the 90-day grace period. However, the insurer only needs to pay

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claims for the first 30 days of the 90-day period. After that, the insurer can hold off paying any claims. If the enrollee doesn't pay premiums in full by the end of the 90 day grace period, s/he could be liable for payment of the health services in the 2nd and 3rd months if they don't catch up with their premium payments.

The insurer is supposed to let providers know if a policyholder's claims are being held until payment of premium. In such a case, a provider may choose not to provide care until the premiums are paid up. But the person is still technically enrolled in the plan until the end of the 90-day period.

Accessing Providers in Border Counties/States

Question: Is there any exception for individuals living in border counties (or cities) to see doctors in a neighboring state? We have an individual with lung cancer who sees a doctor in a county across the state line. He is eligible for a special enrollment period, but his oncologist isn't included in the network of the marketplace plan available to him. This situation applies to many other individuals who see providers out-of-state and out-of-network, since we are close to the borders of two states.

Answer: Your client and others in his situation may have a few options to consider. First, depending on the plan rules, he may be able to obtain care from the same providers but with higher cost sharing. If it's an HMO without any out-of-network coverage, that won't be an option. But the Summary of Benefits and Coverage (SBC) will tell him if the plan will pay for any out-of-network care and what his costs would be. Note, however, that the plan is not required to count his out-of-pocket costs for out-of-network care toward the annual limit on out-of-pocket costs; the SBC will provide details on that, too.

He can also appeal to the insurer to see if he can obtain care from out-of-network providers at in-network rates. That is one of the benefit denials or "adverse determinations" that can be appealed. You can find more about that process in the Navigator Resource Guide, FAQ # 262. He'll need his doctor's help to make this case. He should also report this to your state's Department of Insurance. Appendix C of the Navigator Guide includes a list of state Departments of Insurance websites. They may be able to help with the appeal and/or work something out with the plan. Regardless, they should know that the plan's network is not meeting needs of some enrollees in that area.

Finally, some states have "continuity of care" laws that require insurers to allow consumers to continue to see their providers under certain circumstances. However, there are typically limits to be aware of: such protections may apply only to certain individuals, for example, people with terminal illness or in the middle of an acute episode of care; it may be limited in duration, for example, 60 days of continued coverage; and it may apply only when a provider ceases to be in-network (rather than discovering, as above, that the provider was not in-network prior to the consumer's enrollment in the plan).

Medicaid Residency Rules

Question: A family just moved from another state, where they qualified for Medicaid. Their Medicaid coverage in that state is not accepted here, in their new state of residence. As a result of the move, the parents are currently unemployed. Would this family not qualify for MAGI Medicaid because of the new state's residency rules?

Answer: Residency is established even without a permanent address if the family intends to reside in a new state. For kids, the state of residency is where the parent resides.

The federal definition of state residence is as follows (under 42 CFR §435.403):
(h) Individuals age 21 and over. Except as provided in paragraph (f) of this section, with respect to individuals age 21 and over —
(1) For an individual not residing in an institution as defined in paragraph (b) of this section, the State of residence is the State where the individual is living and—
(i) Intends to reside, including without a fixed address; or
(ii) Has entered the State with a job commitment or seeking employment (whether or not currently employed).

If they don't intend to live in the new state, the state where they previously lived has an obligation to provide coverage to absent residents as follows, from the same federal rule above (42 CFR §435.403):
(a) Requirement. The agency must provide Medicaid to eligible residents of the State, including residents who are absent from the State. The conditions under which payment for services is provided to out-of-State residents are set forth in §431.52 of this chapter.

§431.52 Payments for services furnished out of State.
(a) Statutory basis. Section 1902(a)(16) of the Act authorizes the Secretary to prescribe State plan requirements for furnishing Medicaid to State residents who are absent from the State.
(b) Payment for services. A State plan must provide that the State will pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a beneficiary who is a resident of the State, and any of the following conditions is met:
(1) Medical services are needed because of a medical emergency;
(2) Medical services are needed and the beneficiary's health would be endangered if he were required to travel to his State of residence;
(3) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State;
(4) It is general practice for beneficiaries in a particular locality to use medical resources in another State.

(c) Cooperation among States. The plan must provide that the State will establish procedures to facilitate the furnishing of medical services to individuals who are present in the State and are eligible for Medicaid under another State's plan.

Counting Social Security Benefits

Question: Does the Marketplace and Medicaid count Survivor's Social Security Benefits for a 15 year old when estimating income?

Answer: If the 15 year old earns income that meets the tax filing threshold ($6,100 in 2014) or has other unearned income over $1,000, then his/her income reported on taxes plus the non-taxable Social Security survivor benefits would count toward income. However, if the teen does not have sufficient income to be required to file taxes, the Social Security survivor benefits DO NOT count. For adults, it's different. Social Security income, including social security disability income (Social Security Disability Insurance, or SSDI, but not Supplemental Security Income, or SSI) is added to other taxable income for eligibility purposes.

Question: Is only the taxable amount of Social Security Retirement Income counted as income when looking at a person's 1040 tax form? The Social Security Income is $34,000.00, but the taxable amount is only $2,435.00, which brings down their adjusted gross income on the 1040 to $24,000.00. The client is retired, works part time and also gets a pension.

Answer: No, the non-taxable portion of Social Security Income is added back to line 37 of the 1040 (which includes the taxable portion of the Social Security retirement income) for his/her eligibility. In other words, all of the Social Security retirement income counts.

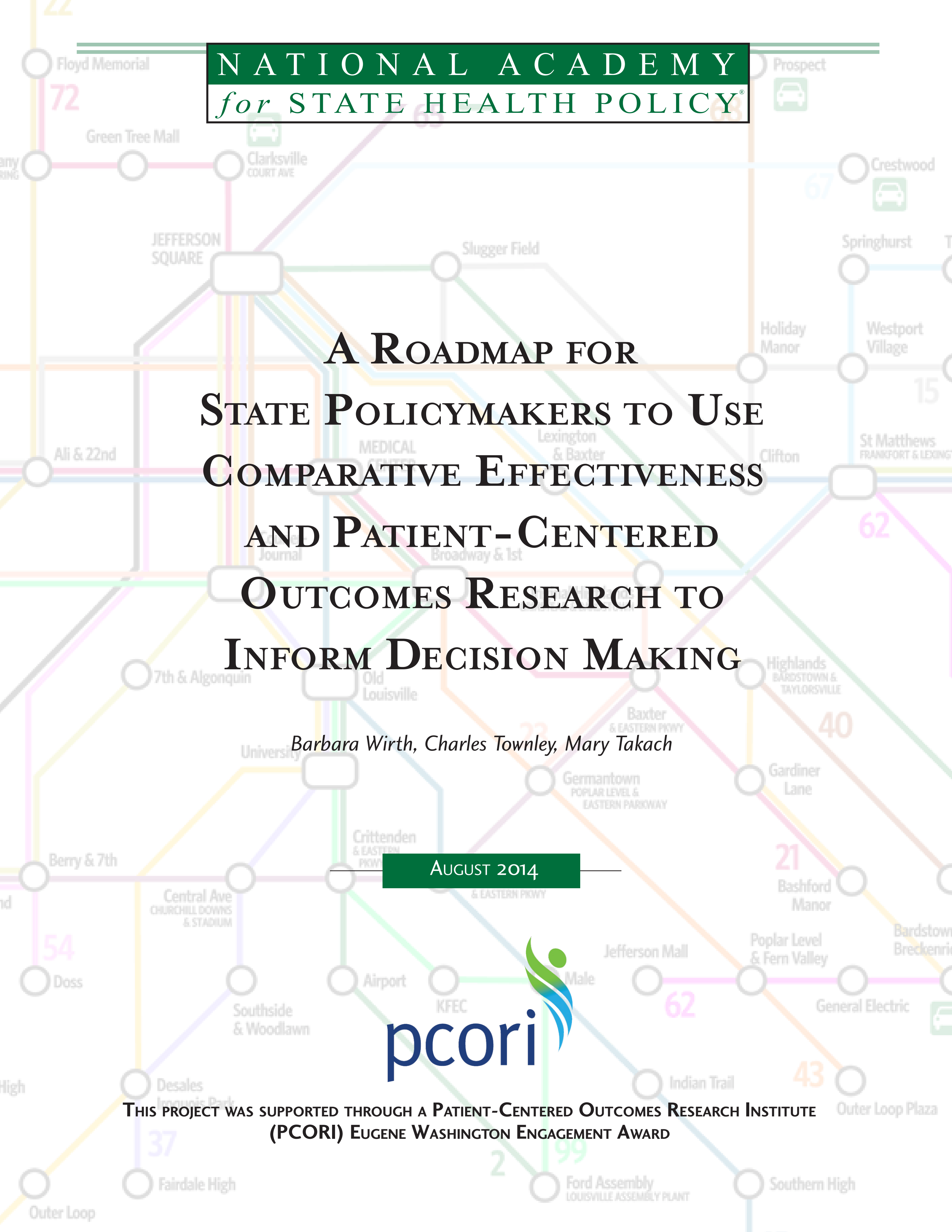
Same-Sex Couples and Eligibility for Premium Tax Credits

Question: A consumer recently asked if Marketplace plans have to treat same-sex marriages as able to enroll jointly no matter what state they live in. Related to this, if the employer of one spouse does NOT offer benefits to same-sex spouses, is the person able to get insurance on the marketplace as a family? Is there a difference if they are married vs. domestic partners?

Answer: Yes, same-sex married couples are able to enroll in the same marketplace plan. Under CMS Guidance, which can be found at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/frequently-asked-questions-on-coverage-of-same-sex-spouses.pdf, Marketplace plans must treat same-sex married couples as they would opposite-sex married couples. The federal rule does not require plans to cover domestic partners. Same-sex married couples may also apply for advanced premium tax credits (APTCs) as a household, regardless of what state they live in. CMS Guidance last fall, which can be found at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/marketplace-guidance-on-irs-2013-17.pdf, says for purposes of applying for APTCs, as long as the couple files jointly, they are eligible to apply for APTCs. It doesn't matter if their state recognizes same-sex marriage (because premium tax credits fall under the federal tax code).

However, states are permitted, but not required, to recognize same-sex couples who are legally married in other jurisdictions as spouses for purposes of Medicaid and CHIP. Since state recognition of same-sex marriages may affect Medicaid and CHIP eligibility determinations, and applicants must first be screened for Medicaid and CHIP eligibility before being considered for APTCs, then the state treatment of same-sex marriages may affect eligibility for APTCs. And, as always, APTC eligibility requires that a household have income above 100% FPL in non-Medicaid states and 138% FPL in Medicaid expansion states, with the exception of lawfully present immigrants who are eligible for APTCs under 100% FPL.

On the question of whether a spouse without benefits from the employer of a same-sex spouse can get APTCs if they don't have an offer of employer coverage, the answer is yes. Employers are free to define who is eligible for coverage as a spouse and many employers recognize same-sex partners for spousal benefits. The test for whether a same sex spouse is entitled to APTCs is the same as it would be for any other married couple: if the spouse is not eligible for benefits under the employer coverage, s/he is eligible to apply for APTCs. If the spouse is eligible for benefits under the employer coverage, then the affordability test would apply, looking at the cost of self-only coverage in the lowest cost plan.



NATIONAL ACADEMY *for* STATE HEALTH POLICY®

A Roadmap for State Policymakers to Use Comparative Effectiveness and Patient-Centered Outcomes Research to Inform Decision Making

Barbara Wirth, Charles Townley, Mary Takach

August 2014

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Introduction

Making informed decisions aimed at improving health care access and quality in a rapidly changing health care environment is hard. Recent interest by the federal government and others in funding comparative effectiveness research (CER) and patient-centered outcomes research (PCOR) will provide new resources to help inform decision making by policymakers and all involved in the health care system.[1] The purpose of this Roadmap is to guide policymakers in the use of CER and PCOR as well as other research to support the decision-making process.

With support from the Patient-Centered Outcomes Research Institute (PCORI), the National Academy for State Health Policy (NASHP) has created this guide to support the use of various types of research in state policymaking. Authorized by the Patient Protection and Affordable Care Act, PCORI is funding research on the comparative effectiveness of different interventions but does not fund research examining cost-effectiveness.[2] Therefore, for the purposes of this Roadmap, we will not reference studies that solely examine cost-effectiveness.

Information for the Roadmap was obtained from several sources, including a national survey of 494 state health policymakers and a series of interviews with a variety of state policymakers including Medicaid, public health, worker's compensation directors, state employee health benefits directors and others.[3] All parts of this project were guided by an advisory group composed predominately of state policymakers (see Appendix A). Policymakers' input on the benefits and challenges they face in using research, particularly CER and PCOR, and the steps they described in using evidence throughout the decision-making process were the foundation of this guide.

Findings from the national survey and calls with policymakers indicate many involved in crafting public policy are not familiar with CER and PCOR and could use additional information on the use of this evidence within the decision-making process. This Roadmap was created to help policymakers with varying levels of experience understand CER and PCOR and learn strategies to more effectively use this research to inform their work throughout their decision-making process from the earliest stages of first identifying an issue requiring a review of the research to the later evaluation of an implemented program.

How to Use The Roadmap

As with other maps, we begin this document with a legend designed to help orient those who are new to using this research before they begin using CER and PCOR in their work on policy and program development. Readers who are more familiar with CER and PCOR can move ahead directly to the Roadmap and the steps provided. While the steps follow a general progression, they are not intended to be strictly linear. Within each step, we have organized strategies that range from short-term to long-term, understanding that states have varying degrees of resources and time available and, for those early in this process, may need different strategies from states with long-standing programs utilizing CER and PCOR.

Steps 1 through 3 of the Roadmap provide information to identify when CER and PCOR can inform policymaking and strategies to find and evaluate the available research. **Steps 4 and 5** review approaches for using the evidence-based findings in designing the program or policy and communicating the findings after a decision has been made. **Step 6** addresses the need to evaluate the program or policy and monitor new CER and PCOR as it becomes available. The section following is entitled Stories from the Road and provides several case studies of states' use of CER in the decision-making process.

Throughout the Roadmap, the beginning of each section presents a list of key questions to consider as the material is reviewed. Text boxes are included to highlight both ‘at-a-glance’ resources and to present commentary from state policymakers that informed the project. In addition to the final case studies, readers are provided with examples of the application of the steps including three brief hypothetical scenarios referenced throughout the sections.

The appendices provide additional resource material for state policymakers. This material includes other sources of research, guides and tools (including glossaries and research appraisal tools), a list of suggested reading on CER, PCOR and evidence-based decision making, and an overview of conducting a systematic review that policymakers may find useful as a handout.

Unless otherwise noted, the views expressed in this guide are those of the authors.

Legend for the Roadmap

Comparative Effectiveness and Patient-Centered Outcomes Research and How They Differ from Other Types of Research

Policymakers are increasingly expected to base their policy and program decisions on evidence showing the effectiveness of the selected intervention. In order to do so, policymakers are tasked with identifying, reviewing, and translating available research findings to fit specific program and policy needs. Many policymakers are familiar with the term 'evidence-based practice', an approach defined by the Agency for Healthcare Research and Quality (AHRQ) as "applying the best available research results when making decisions about health care."[4] Two other specific forms of research - comparative effectiveness research (CER) and patient-centered outcomes research (PCOR) - are often underutilized sources of evidence that can help inform policymaking.

Comparative Effectiveness Research

Definition: Comparative Effectiveness Research (CER) refers to research designed to compare the effectiveness of different interventions, examining the risks and benefits of several treatment interventions, supporting consistent and rational decision making, and improving the delivery of care.[5]

Methodological approaches used in CER include studies designed to compare clinical, safety, or cost differences between two interventions, as well as studies reported as systematic reviews examining and comparing a number of different single-intervention studies. For example, a single study may directly compare the outcomes of two or more interventions designed to help obese individuals manage their weight (e.g., wellness programs, different medications); similarly, researchers may compare individual studies by conducting a systematic review of the existing literature on each intervention. The direct comparison of two or more interventions distinguishes CER from studies utilizing control groups or placebo as the comparison population. CER goes beyond simply validating one particular treatment and can be used to identify which of the myriad available treatments can best meet the needs of a population, particularly when given limited resources.

Examples of federal sources of CER include the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health (NIH), the Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC). AHRQ, a leader in driving CER, has also developed Evidence-based Practice Centers (EPCs), housed in universities and non-academic research institutions.[6] The American Recovery and Reinvestment Act of 2009 provided funding for the CDC to launch four new Prevention Research Centers, which conduct comparative effectiveness projects examining the benefits and harms associated with various public health interventions in community settings.[7] State agencies and academic centers—either individually or through multi-state collaboratives—also fund and conduct such research (discussed further in *Legend for the Roadmap*). Additionally, private research organizations (e.g., RTI International, the Cochrane Collaborative, etc.) also conduct comparative effectiveness research.

Patient-Centered Outcomes Research

Definition: Patient-Centered Outcomes Research (PCOR) refers to research that assesses the benefits and harms of different interventions while also including an individual's preferences and needs, focusing on those outcomes of most value to the patient.[8]

PCOR is a relatively new field within CER, spurred in part by the creation of the Patient-Centered Outcomes Research Institute (PCORI) in Section 6301 of the Affordable Care Act.[9] By identifying and selecting interventions that include the needs and preferences of patients, policymakers are more likely to address potential barriers to implementation and therefore design programs and policies in which patients will actively participate and achieve the desired health outcomes.[10]

Current availability and use of PCOR, as strictly defined by PCORI, is still limited given the recent definition of this form of research. However, the field will likely flourish over the next few years; between 2012 and 2014, PCORI awarded nearly $550 million to fund 313 patient-centered studies, and additional awards are made on a regular cycle.[11] Projects funded by PCORI include research specifically aimed to improve healthcare systems, including five priority areas: assessment of options; improving healthcare systems; addressing disparities; communication and dissemination research; and improving PCOR methods and infrastructure. Examples of specific awards include: Using Technology to Deliver Multi-Disciplinary Care to Individuals with Parkinson Disease in Their Homes; A Toolbox Approach to Obesity Treatment in Primary Care; Optimizing Behavioral Health Homes by Focusing on Outcomes that Matter Most for Adults with Serious Mental Illness; and, Evaluating the Impact of Patient-Centered Oncology Care.[12]

How State Health Policymakers View Comparative Effectiveness and Patient-Centered Outcomes Research

As part of the project that informed this document, NASHP conducted an online survey to better understand how state officials view and use research—CER and PCOR in particular—to inform their work. The survey was sent via email to 494 health policymakers in all 50 states, the District of Columbia, and select US territories. Recipients represented a wide variety of state offices and agencies, including governors' health policy advisors, legislators, public health officials, Medicaid/Children's Health Insurance Program (CHIP) directors, state employee/retiree health benefits administrators, workers' compensation directors, and state insurance commissioners. Following the survey, NASHP conducted a series of semi-structured interviews with individuals and groups of state policymakers.

Survey Results

In total, 130 state officials representing 48 states and the District of Columbia completed the first set of questions (26 percent response rate), and 101 of those 130 (78 percent) completed the entire survey. The majority of respondents (55 percent) represented Medicaid, CHIP, or public health. Overall, state officials responding to the survey tended to report at least moderate familiarity with the concept of research evidence (92 percent), although they were relatively less familiar with the specific concepts of CER (73 percent) and PCOR (69 percent). Respondents were generally positive about the use of research to informing policymaking:

- 93 percent agreed with a statement that state health policymakers should use research to inform their work;
- 89 percent agreed with a statement that research should be used to determine health benefits coverage; and
- 89 percent agreed with a statement that research should be used to address the needs of patients with complex health issues.

The majority of respondents also agreed that research with a focus on outcomes identified by patients was considered important in their work on state health programs and policy (82 percent), making health

benefits coverage decisions (71 percent), and addressing needs of patients with complex health issues (71 percent).

Most respondents also agreed to statements that they would like to use research more often in their work (87 percent), to determine benefits coverage (74 percent), or address the needs of patients with complex health issues (76 percent). The most commonly reported barriers to using CER in their work included difficulty in finding CER (54 percent), difficulty translating CER to inform programs and policies (49 percent), and significant concerns that CER would be used to restrict patients' freedom of choice (31 percent).

Semi-Structured Interviews with Policymakers

Following the survey, NASHP conducted a series of semi-structured interviews with individuals and groups of state policymakers. Participants were selected from those who indicated an interest in follow-up calls when completing the survey and others who were identified through NASHP's database. Over the course of seven calls, 24 state policymakers were interviewed, and several provided additional information through follow-up emails and individual calls. The common themes identified through these calls, with guidance from our advisory group, were used to develop the action steps and considerations included in the Roadmap that follows. Key differences across agencies were also identified, such as the unique considerations that arise from being both a policymaker and a health care purchaser (e.g., Medicaid).

How State Policymakers Use Comparative Effectiveness and Patient-Centered Outcomes Research

The state health policymakers that responded to our survey reported a much lower use of CER and PCOR compared to use of evidence in general. While 63 percent of respondents replied "almost always" or "often" when asked whether they use research to inform their work, only 35 percent of respondents replied using CER and 31 percent of respondents replied that they used PCOR with regularity. For policymakers that use CER and PCOR to inform their work (e.g., to set preferred drug lists or determine coverage for a new treatment), the research may be collected, analyzed, and implemented in a number of different ways, such as using advisory groups or committees, specific programs, or in collaboration with other agencies or states. Additional information on various programs states may use to incorporate this research into their work is available through a companion document entitled *Programs Supporting the Use of Comparative Effectiveness Research and Patient-Centered Outcomes Research by State Policymakers* developed as part of the same NASHP project.[13]

Advisory Groups and Committees

State agencies often form advisory groups and committees to help policymakers identify and review evidence-based solutions to pressing issues. Depending on the agency for which they serve, membership may range from a panel of clinicians to a multi-stakeholder group including legal advisors, epidemiologists, consumers and other experts. Members' familiarity and understanding of CER and PCOR can vary widely. While many of these groups are standing committees that meet regularly, policymakers may also field an ad hoc workgroup to examine specific issues. For example:

- A legislative ruling in 2007 resulted in the **California** Division of Worker's Compensation forming a committee to inform decision making. The California Worker's Compensation Medical Evidence Evaluation Committee is a closed, multi-disciplinary committee composed of members of the medical community. It is responsible for ranking the evidence and advising the Medical Director on

how to adopt and update medical treatment guidelines. Clinicians are required to use the adopted guidelines, and must present a higher level of evidence when requesting to use another approach. Contractors perform the studies to inform policy decisions on guidelines.[14]

State Health Technology Assessment Programs

Several states have created formal health technology assessment (HTA) programs to support program and policy decisions within their states. The key components of HTA programs include multi-disciplinary stakeholder involvement, transparency, the review of evidence of selected topics, and the promotion of the use of HTA in decision making.[15] For example:

- The **Oregon** Health Evidence Review Commission (HERC) is responsible for conducting CER of health technologies or treatments and developing or identifying evidence-based guidelines to be used by the state's clinicians, consumers and purchasers of health care.[16] HERC maintains a list of health services showing the comparative benefits of each service. The Commission is made up of volunteer members of the health care community, including physicians, nurses, pharmacists and consumer representatives, and emphasizes a transparent process to include input from the public and those impacted by the decisions. Using HERC findings, the Oregon State Employee Benefits Board has built additional charges into their benefit design for those services that do not have good HERC research to support their effectiveness.

Cross-Agency Collaboratives

States have also created formal research and evaluation bodies to provide recommendations to multiple agencies separate from those qualifying as HTA programs. For example:

- The **Washington** State Health Care Authority maintains a State Prescription Drug Program, in which the Washington State Pharmacy and Therapeutic Committee reviews and evaluates the comparative safety, efficacy and effectiveness of drugs within a therapeutic class. The Committee then makes recommendations to the state to develop the Washington State Preferred Drug List, which is used by the Public Employees Benefits Board, Medicaid, and the Worker's Compensation Administration.[17,18]

Multi-State Collaboratives

Many states participate in national and/or regional multi-state research collaborations. Depending on the organization, comparative effectiveness studies may be made available for public review or may be restricted to those states participating in the collaborative. For example:

- *National:* The Center for Evidence-based Policy at the Oregon Health & Science University (OHSU) administers two multi-state research collaboratives: the Drug Effectiveness Review Program (DERP) and the Medicaid Evidence-based Decisions Project (MED).[19] Nine states currently participate in DERP, which provides comprehensive systematic reviews of drug safety and effectiveness,[20] and 13 states participate in MED, which provides Medicaid agencies with tools and resources to help make evidence-based decisions and share best practices.[21] Two examples of state use include **Colorado's** Pharmacy and Therapeutic Committee using DERP findings in their review to make recommendations on the efficacy and safety of different insulin groups and **Texas** Medicaid's use of MED resources in their work on health homes, payment reform, telemedicine and chronic conditions.

- *Regional:* The New England Comparative Effectiveness Public Advisory Council (CEPAC), managed by the Institute for Clinical and Economic Review (ICER), is an independent group of physicians and other experts tasked with assisting policymakers and other stakeholders apply comparative effectiveness information to "improve the quality and value of healthcare in the region."[22] Reports have included comparative effectiveness on treatments for attention deficit disorder, breast cancer screening, depression, and on the use of community health workers.

The Roadmap

An Overview

Identifying When Comparative Effectiveness and/or Patient-Centered Outcomes Research can Inform Policymaking

- What are the desired outcomes for the intervention under consideration?
- Would comparative effectiveness or patient-centered research help in understanding the best course of action to reach the desired outcomes?
- Do stakeholders, experts, and colleagues recognize the utility of CER and PCOR in their work?

Finding Research and Other Relevant Resources

- What types of research and resources are needed to help make an informed decision?
- Where can the relevant research and resources be found?
- Who can help find relevant research and resources?
- Has another agency or state already conducted or reviewed research for a similar policy or program decision?
- What can be done when research or other resources are not currently available?

Evaluating the Evidence

- How were the patients or participants selected?
- Was the approach used to analyze the results valid?
- Was the study “patient-centered” and did it include the patient perspectives and priorities?
- What studies besides specific comparative effectiveness research studies might be useful to compare the impact of different interventions?
- How can studies with conflicting findings be evaluated?
- Has enough evidence been found to make an informed decision?
- Who can help evaluate the research findings?

Using The Evidence To Design A Program Or Policy

- What local, regional, or state data should be used to inform your decision?
- Is implementation of a specific intervention feasible?
- Are there time or resource constraints that will impact feasibility?
- Is there enough buy-in from leadership and stakeholders that this intervention can be successfully implemented?

Communicating And Disseminating The Decision

- How will different stakeholders react to this decision?
- What information is most important to provide the various stakeholder groups?
- How should the information be presented and delivered to reach different groups?
- Who are the most appropriate representatives to communicate the decision?

Monitoring And Evaluating New Research As It Becomes Available

- What information is needed to evaluate the effectiveness of the selected intervention?
- How can new research be used to impact an existing program or policy?
- How can policymakers build flexibility into programs and policy decisions to ease the use of new research evidence to make modifications?

Consider the following scenarios:

- Public health officials want to address the leading preventable causes of death in their state and are presented with statistics showing a rapid increase of opioid-related deaths.
- A member of the Senate Standing Committee on Health must determine whether to support a colleague's bill that increases nurse practitioners' scope of practice.
- A Medicaid official must determine which treatments for childhood autism should be covered under a state plan.

In each of these scenarios, state policymakers are presented with making a policy decision for which there may be multiple interventions available. This Roadmap will provide policymakers with guidance from the initial consideration on whether to review comparative effectiveness or patient-centered outcomes research to the evaluation of new research once a program or policy is put in place. Over the next six sections, the Roadmap will provide strategies for how states can increase the frequency and efficiency of using these types of research in policymaking and, when possible, will present these considerations as short-, medium-, and long-term strategies depending on the time and resources involved.

A key component of each of the steps includes, whenever possible, broad stakeholder engagement and a transparent decision-making process. Making decisions behind closed doors may create animosity or skepticism among some stakeholders—particularly on controversial or "hot-button" issues—which later can potentially create challenges prior to or during implementation of a new program or policy. In these cases, a transparent process and the dissemination of the research and materials being used to make the decision is of particular importance.

1 2 3 4 5 6

Step 1: Identifying When Comparative Effectiveness and/or Patient-Centered Outcomes Research Can Inform Policymaking

Key Questions

Questions to consider during this step may include:

- **What are the desired outcomes for the intervention under consideration?**
- **Would comparative effectiveness or patient-centered research help in understanding the best course of action to reach the desired outcomes?**
- **Do stakeholders, experts, and colleagues recognize the utility of CER and PCOR in their work?**

The use of comparative effectiveness research (CER) and patient-centered outcomes research (PCOR) to inform decision making may help counter pressures from advocates, lobbyists, other stakeholders, and colleagues by ensuring policies are patient-centered and grounded in evidence rather than as a result of anecdotes, emotion, or agenda. Though policymakers are often faced with short deadlines and significant pressure to support a specific intervention, recognizing when CER and PCOR may be useful in the decision-making process may also prevent selecting an intervention unlikely to achieve the desired outcomes.

Short-Term Strategies

Examine whether the issue being addressed lends itself to CER. Comparing the effectiveness of several different interventions may add considerable strength to your decision-making process. When there is little or no opportunity to use CER—for instance when a decision has been mandated—a review of CER may still provide valuable information on the anticipated effectiveness of the intervention. Reviewing CER may also offer ideas of how to amend or modify an intervention along the way so that it reflects the best available research.

Examine whether the issue being addressed lends itself to PCOR. PCOR may provide a valuable perspective in shaping policy decisions that are dependent on achieving outcomes important to patients. If PCOR is not relevant to the intervention under consideration, recognize the potential value of patients' input into the process and consider other opportunities to include the patients and their families in the decision-making process.

Identify the key outcomes the intervention intends to impact. After determining that CER/PCOR is relevant to your decision-making process, the next step is to focus on desired outcomes. For example, when a legislator examines whether to expand nurse scope-of-practice laws, the legislator may focus

on the impact of this change on access to primary care, emergency department utilization, or chronic illness management. Selecting the desired outcomes will make it easier to find the research (**Step 2**). For instance, drawing from our previous example, the legislator may want to compare the outcomes of patients seen by physicians only, patients seen by nurse practitioners supervised by a physician, and patients seen independently by nurse practitioners.

Ask for help to assist in determining whether CER or PCOR would be useful. State policymakers have ample opportunity to bring other policymakers, stakeholders and experts together to provide guidance about whether CER/PCOR would be useful to the decision-making process and to help make the entire process more objective.

Medium-Term Strategies

Anticipate opportunities for the inclusion of CER and PCOR in decision making. The engagement of different individuals knowledgeable about CER and PCOR will vary widely by agency and state and may require effort to identify and involve in the process.

- Review existing advisory group or stakeholder group memberships and add someone knowledgeable about CER and PCOR to the group. If this is not possible (for instance, if the membership is closed), consider strategies to increase stakeholders' as well as the general public awareness of CER and PCOR.
- Invite experts, local thought leaders, and patients and advocates to open meetings to further promote an understanding of CER and PCOR and how this research may be impacting the decisions being made.
- Post research findings related to the intervention(s) being considered on state or agency websites for public review.
- Ask an expert from PCORI, AHRQ, or other organizations to speak at a webinar or conference call to brief state policymakers on the use of CER or PCOR.
- Convene focus groups to include consumer representation and the review of CER and PCOR. Engaging patients and consumers in the process may also help offset the lack of formal patient-centered outcomes research and provide the needed patient perspective on the implementations being considered.
- Circulate pertinent journal articles to help educate colleagues. The Agency for Healthcare Research and Quality, for example, sponsored the January/February 2005 issue of *Health Affairs*, which focused on "putting evidence into practice."[23]

Long-Term Strategies

Create state entities to raise awareness and promote the use of CER and PCOR across state agencies. Many issues, for example autism treatment and the impact of opioid addiction, would benefit from a multi-agency collaboration and approach to review CER and PCOR when decisions for different populations or programs are being considered.

- Form workgroups of cross-agency leaders and experts to share differing perspectives on the interventions being considered and examine the potential for use of CER and PCOR.

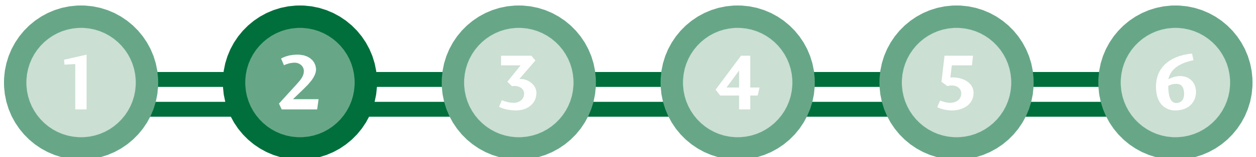
- Form long-term commissions such as health technology assessment (HTA) programs through private or legislative support to examine the potential for use of CER and PCOR. See page 7 for a description of the Oregon Health Evidence Review Commission (HERC).

Establish formal relationships with other states that are leaders in using CER and PCOR to inform their work. States may not be able to establish a state-specific entity to serve as a support in identifying if CER or PCOR would be useful for an intervention under consideration and therefore cross-state collaborations might be useful.

- Reach out and engage with colleagues from states that are further along in their use of CER and PCOR, especially states similar to your own.
- Enlist help from associations or organizations representing state officials, including the National Association of Medicaid Directors, a bipartisan, nonprofit organization, providing information and expertise across the states on issues pertinent to Medicaid.
- Join or form a multi-state collaborative (described on page 7). These collaboratives can engage different states through conference calls, webinars, etc. to develop a vision of how the decision-making process may be better informed. The Drug Evaluation Research Program (DERP) is one example of a paid membership program and is described on page 7.

Promote a vision within and across state agencies on the value of CER and PCOR in the design of health programs and policies. Barriers to recognizing when to use CER and PCOR in decision making may require a long-term effort to raise awareness and promote a culture of using evidence-based findings. For this report, a third of survey respondents noted that a significant barrier for their use of CER included a specific concern that CER may be used to restrict access to different interventions.[24] In addition, PCOR, patient engagement, or patient-centered outcomes may be concepts unfamiliar to policymakers.

- Develop an agency mission statement or strategic priorities that emphasize the use of best available evidence including CER and PCOR in policy decisions.
- Develop interagency agreements that promote the consideration of CER and PCOR in policy decisions.



Step 2: Finding Research and Other Relevant Resources

Key Questions

Questions to ask during this step:

- **What types of research and resources are needed to help make an informed decision?**
- **Where can the relevant research and resources be found?**
- **Who can help find relevant research and resources?**
- **Has another agency or state already conducted or reviewed research for a similar policy or program decision?**
- **What can be done when research or other resources are not currently available?**

As discussed in the Legend section, state health policymakers face significant barriers in finding research to inform policymaking, particularly comparative effectiveness research (CER) and patient-centered outcomes research (PCOR). Despite these reported difficulties, a myriad of sources and strategies are available that can be adapted to meet short- and long-term needs.

Short-Term Strategies

Become familiar with sources of available research. For the purpose of this section, research refers to published information or studies that examine the impact of a given intervention. Research may be available as findings on individual interventions, findings on research designed to compare two or more interventions, or as reviews or compilations of the individual research reports. Currently, research materials are available from a number of sources, including journals, national organizations and federal and state resources (see textbox At-A-Glance: Key Sources of Research).

Focus the search for research on outcomes the intervention intends to address. A targeted approach to finding the research begins with knowing the questions the research should address and outcomes the intervention intends to achieve. A legislator may need to focus on short-term outcomes for an opioid treatment program, for example, to show a rapid return on investment and obtain support from other state legislators.

Use available staff to find and review research. Designate staff in your agency or department skilled in research analysis to find research; cultivate their skills through staff development opportunities.

Use other entities within your state as a source of available research. Other entities in your state may have researched the same issue and be a resource to you. For example, the California Division of Workers' Compensation research[25] and the Minnesota Health Services Advisory Council (HSAC)[26] are both charged

At a Glance

Key Sources of Research

Peer-Reviewed Journals include both health policy and medical journals. Examples include *Health Affairs* and the *American Journal of Managed Care*. Leading medical journals include the *New England Journal of Medicine* and the *Journal of the American Medical Association*. Policymakers may utilize online databases such as MEDLINE® and PubMed® to find relevant journal articles. *Subscription fees may apply.*

Grey Literature includes materials such as issue briefs, policy reports, white papers, and industry reports that are not published in peer-reviewed journals. Sources of grey literature may include both non-profit research organizations (National Academy for State Health Policy, Institute for Healthcare Improvement, AcademyHealth, etc.) and non-profit health foundations, (such as The Commonwealth Fund, Robert Wood Johnson Foundation, etc.). These materials are more likely to be found by using general web searches on specific topics, although the New York Academy of Medicine maintains a bimonthly Grey Literature Report. *Most resources available at no cost.*

Federal resources include materials available from various agencies, for example:

- **Agency for Healthcare Research and Quality (AHRQ):** Evidence-based Practice Centers Program; National Guideline Clearinghouse
- **Centers for Disease Control and Prevention (CDC):** Prevention Research Centers
- **Centers for Medicare & Medicaid (CMS):** Research, Statistics, Data & Systems
- **Food and Drug Administration (FDA):** Scientific Publications
- **Health Resources and Services Administration (HRSA):** Maternal and Child Health Research & Data; Rural Health Research Centers
- **National Institutes of Health (NIH):** Clinical Trials Registry; National Information Center on Health Services Research and Health Care Technology; National Library of Medicine
- **Substance Abuse and Mental Health Services Administration (SAMHSA):** Center for Integrated Health Solutions Research; National Registry of Evidence-based Programs and Practices

Quasi-public entities include organizations such as the National Quality Forum or the Patient Centered Outcomes Research Institute (PCORI). PCORI is an independent agency authorized by the Affordable Care Act and specifically charged with funding research that "provide[s] information about the best available evidence to help patients and their health care providers make more informed decisions." As a relatively new entity, the research funded may not yet be available; however, information on each study funded by PCORI is available on its website.

International clearinghouses include the International Network of Agencies for Health Technology Assessment (*briefs available at no charge)* and the Health Systems Evidence Database *(free registration required)* and McMaster Health Forum *(no cost)* at McMaster University in Hamilton, Ontario, Canada.

Private programs are available to provide access to research either free to the general public or for a fee**.** Institute for Clinical and Economic Review (ICER), for example, is an independent non-profit research firm that conducts CER, organizes groups to review and discuss research, and supports the dissemination and implementation of evidence-based best practices. Additional organizations such as the Cochrane Collaborative and Hayes, Inc. are a resource for obtaining information through systematic reviews and evaluations of medical technologies.

National membership and professional organizations are a resource for state policymakers interested in reviews of available research. The National Governors Association, for example, houses a Center for Best Practices and the National Association for Insurance Commissioners oversees the Center for Insurance Policy and Research. Similarly, national professional and trade organizations—as well as their state chapters—may play a similar role in providing resources specific to their constituency.

State Resources. States may find that other states may be a rich source of relevant research. Other state programs, such as Health Information Technology Assessment programs (see page 7), may publically report research of relevance to multiple agencies and states. More informal approaches include networking at meetings and contacting the state agencies directly. More formal sharing may occur through membership organizations such as the National Association of Medicaid Directors, a bipartisan, nonprofit organization representing Medicaid directors.

with being a source for finding research to support policymakers in their states.

Use "off-the-shelf" guidelines that can either be adapted en masse or modified to fit local needs. For example, the American College of Physicians has guidelines based on best practices with recommendations for management of different conditions.[27] Many states' workers compensation offices have subscribed to the Evidence-Based Medical Treatment and Return to Work Guidelines (also known as Official Disability Guidelines or ODG) developed by the Work Loss Data Institute and either adopted the guidelines entirely or used them to supplement their own standards.[28] The use of standard guidelines may avoid the potentially costly process of determining a new set of guidelines for a particular issue.[29]

Notable Quote

"Developing our own guidelines…quickly proved to be unmanageable, which is why so many states end up adopting other guidelines. It is hundreds of thousands of dollars to look at original literature and do a comprehensive review."

- Worker's Compensation Official

Develop contacts both inside and outside of academia to assist with finding research. Local academic settings—particularly schools of medicine and schools with public health or policy-related centers—may provide faculty and researchers knowledgeable of the current research findings in a specific field, as well as have resources to help find and interpret the research. Outside of academia, local thought leaders or other agencies with extensive experience with the issue can be an additional resource and may aid in locating available research.

Medium-Term Strategies

Establish ongoing partnerships with local colleges or universities, particularly in agencies with limited resources. Academic institutions can serve as an ongoing resource to either find needed research or provide the support needed to translate evidence-based findings into a format usable by policymakers.

- Contact heads of academic departments with graduate programs to develop partnerships with faculty and access to graduate students. You benefit from having a pool of researchers to tap into and the students benefit from getting experience working with policymakers.
- Request academic centers provide training for agency staff on evidence-based practices, CER and PCOR.

Notable Quote

"[It would be useful for] high-level decision makers to come together on a semi-regular basis to talk about things they might be doing that impact health and then for that information to filter down to the relevant channels."

- State Office of Health Policy Official

Find an AHRQ Evidence-based Practice Center near you. These centers are housed in multiple universities and are available as a resource to the health care community, including policymakers. For example, reports created for North Carolina by the RTI, International-University of North Carolina Evidence-based Practice Center[30] examined the impact of a Medicaid funding cut for a maternity care coordination project run through a local public health department. See page 15 to locate these centers.

Coordinate with other agencies to pool resources to find research. Connecting with other state agencies makes sense when several are working on similar issues. Finding research to support decisions for the coverage of autism therapies, for example, was cited as a need by multiple agencies impacted by the issue including legislators, public health, state employee health plans and Medicaid.[31] Though agencies may have different goals or priorities, colleagues in another agency may have valuable information to share having already used research to inform their decisions.

Long-Term Strategies

Contract for services from independent research organizations when you cannot find needed CER and PCOR. Private contractors and independent research organizations may also be of value to states when needed research cannot be found. Alabama's Bureau of Children's Health Insurance utilized tools from Truven, a for-profit organization that conducts CER, to consider coverage for the HPV vaccine, resulting in a recommendation to the State Health Officer to cover the vaccine.[32]

Identify academic partners to conduct novel research and evaluations. When research is not available, states can also build partnerships with existing research entities or develop entirely new entities. For these relationships to be successful, both policymakers and researchers must learn to work in the other's space, which typically includes recognizing and addressing significant differences in "professional incentives and timetables."[33]

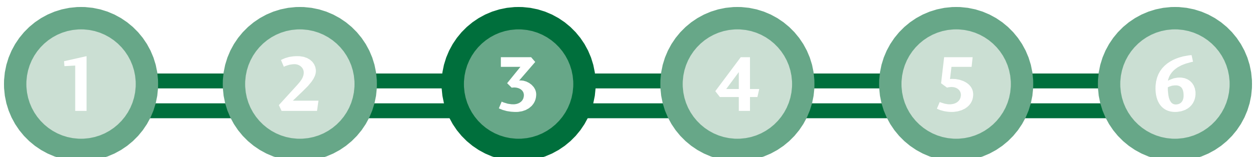
- Pass legislation to establish research centers to conduct CER and PCOR. The Evidence-based Practice Institute (EBPI) at the University of Washington was established by the legislature in 2007. EBPI acts as a resource to help the state identify, evaluate and partner with the community to use evidence-based practices and offers trainings and consultations on their use.[34]
- Establish agreements with local universities. Partnerships between state agencies and academic centers can either be informal or codified through contract or statute. University of Alabama at Birmingham conducts specific health services research at the request of the Alabama Department of Public Health. Examples of special studies include whether successive years of insurance coverage decrease asthma-related emergency use or hospitalizations, as well as how access to more preventive dental visits may impact subsequent dental visits and costs.[35]
- Form public and quasi-public state entities charged with using research to inform health policy at the state level. Examples of such entities include the Kentucky Office of Health Policy within the Kentucky Cabinet for Health and Family Services[36] and the independent Massachusetts Health Policy Commission.[37]

Other long-term strategies to consider to help find research:

- **Create health technology assessment (HTA) programs to identify CER and PCOR and support other decision-making steps.** See description in Legend section on page 7.
- **Establish formal multi-stakeholder collaboratives within a state.** The Washington state legislature, for example, established the public/private Robert Bree Collaborative composed of 24 members that includes purchasers, employers, plans, and clinician organizations. The intent of the Collaborative is to annually study topics "for which there are substantial variation in practice patterns or high utilization trends…without producing better care outcomes for patients [or] are indicators of poor quality and potential waste in the healthcare system."[38] Though the Collaborative has no authority to implement the recommendations, findings are made available to

the public and various state agencies, employers, clinicians, and health plans.[39] A report on obstetrics care and early C-section, for example, led to state purchased health plans adopting the recommended strategies and contributed to changes in the state payment policies for deliveries.[40]

- **Obtain support and funding for membership in existing multi-state collaboratives to help find research and support other decision-making steps.** See description of multi-state collaboratives on page 7.
- **Create or join an independent regional group to help find research and support other decision-making steps.** See page 8 describing the New England Comparative Effectiveness Public Advisory Council.



Step 3. Evaluating the Evidence

Key Questions

Questions to ask during this step may include:

- **How were the patients or participants selected?**
- **Was the approach used to analyze the results valid?**
- **Was the study "patient-centered" and did it include the patient perspectives and priorities?**
- **What studies besides specific comparative effectiveness research studies might be useful to compare the impact of different interventions?**
- **How can studies with conflicting findings be evaluated?**
- **Has enough evidence been found to make an informed decision?**
- **Who can help evaluate the research findings?**

The various design methodologies used by researchers can be overwhelming to state officials trying to evaluate different studies and determine if they are useful in the decision-making process. Strategies to successfully evaluate evidence are provided below and, depending on a state's resources, may range from accessing research already vetted by a reliable source to establishing formal educational programs for policymakers to better use CER in their decision-making process.

Short-Term Strategies

Determine whether evidence on different interventions has already been evaluated by a reputable source. In addition to research expertise, evaluating research takes time and resources—all valuable and limited commodities for state policymakers. States may not have the resources or staff to fully evaluate available research to compare different interventions or include patient needs and priorities.

- Consult with reputable sources such as academic institutions, and programs such as MED and DERP (see Legend).

Notable Quote

"For a lot of these policies, the evidence is not particularly strong either way. You do evidence-informed decision making and it gives you some clues. You need to be able to interpret what the evidence is or is not. There are a lot of studies that claim to be evidence but when you look at them there are all sorts of issues. Need to make sure not to take something and run…Need to look under the hood."

- Medicaid Official

- Use external research organizations including, for example, organizations such as Hayes, Inc. to provide a review for a fee[41] or use the Cochrane Collaboration's Cochrane Database of Systematic Reviews, which includes more than 8,000 reviews and protocols on various health care issues available at a range of costs (**see Step 2**).[42]

Use multiple sources to obtain information for use in the decision-making process. The existence of a research study or an article on the web or in a publication alone does not guarantee the findings presented are valid or will be useful to include in the decision-making process. While single sources or research collaboratives may ease the burden of reviewing the evidence, you risk potential pushback from some stakeholders. Utilizing multiple sources of research during the decision-making process may alleviate these concerns.

Encourage policymakers to develop a basic understanding of research methodologies including CER and PCOR. Policymakers need to recognize different research methodologies examining the same intervention can result in different outcomes depending on specific aspects of the methodology. For example, a study with patients *randomly* assigned to receive different treatments may result in different findings than a study where patients are allowed to *choose* the treatment they prefer, potentially resulting in a concept known as selection bias. In addition, preference should be given to studies with larger sample sizes and longer study periods. The success of an opioid treatment, for example, for a six-month period may report a success rate that differs significantly from the same program evaluated one year after treatment.

- Use tools similar to the Agency for Healthcare and Research Quality Glossary on research terminology (see text box At-a-Glance: Examples of Key Terms) and the George Health Policy Center's "Blue Book" created for legislators reviewing research and replicated by a number of other state programs.[43]

Evaluate the source of the research to examine any risk for real or potential bias. A research report on an intervention provided on the web or through a special interest group does not necessarily mean the findings have been reviewed by peers in the field or is reproducible and reliable. Even peer-reviewed journals or organizations may suffer from some bias.[44] In particular, clinical practice guidelines face scrutiny for potential conflicts of interest; a 2013 review found that on average, 30 percent of type-2 diabetes guideline authors had a disclosed financial interest in manufacturers of the recommended drugs.[45] Though no association was shown between the drugs recommended and specific authors, the researchers raised the concern about the credibility of the guidelines based on the potential for conflicts of interest.

- Select data from an independent third-party source when available. It is more likely to be viewed as trustworthy by stakeholders when compared to research or reports where the researcher, publisher, or reviewer may appear to have a personal or financial interest in demonstrating a certain result.

Compare the study population to the population impacted by the intervention under consideration. Lack of external validity—the application of research findings to a broader population—may make the research findings irrelevant for the program or policy being considered. An understanding of important features of the population likely to impact the success of an intervention— for example, geography, demographics, and culture—will also provide important information as to whether research findings being considered are realistic to pursue.

Medium-Term Strategies

Utilize tools from academic and research organizations to develop formal processes for ranking the strength of evidence found. Once research evidence has been gathered, strategies can be used to rank the different findings for specific criteria such as safety, effectiveness and impact on a specific outcome.[46]

- Become familiar with examples of tools including hierarchies developed by the Centre for Evidence-Based Medicine at the University of Oxford.[47] Thomas Jefferson University illustrated a similar hierarchy as a pyramid (see text box At-a-Glance: The Heirachy of Evidence).[48]
- Find tools at the Centre for Evidence-Based Medicine. They have developed a number of tools to help individuals find, evaluate, and make decisions using evidence, including critical appraisal sheets. These tools can be adopted or adapted to assess and compare individual studies and systematic reviews.[49]

At a Glance

The Hierarchy of Evidence

1. Meta-analysis* *(Best)*
2. Systematic Reviews*
3. Randomized Control Trials
4. Cohort Studies
5. Case Control Studies
6. Case Reports

*Both meta-analyses and systematic reviews use statistical techniques to combine the findings of separate studies; however, not all systematic reviews include such analysis.

Adapted from The Evidence Pyramid, Thomas Jefferson University (November 2008); available at: http://jeffline.tju.edu/Ask/Help/Handouts/evidence_pyramid.pdf

For more information on the difference between a meta-analysis and a systematic review, please visit: http://www.cochrane-net.org/openlearning/html/mod3-2.htm

- Check out references to tools and resources state health policymakers may wish to use included in Appendix B at the end of this document.

Conduct a systematic review of the findings from multiple single-intervention studies. In the absence of formal CER, policymakers should evaluate and compare the evidence on different interventions including their effectiveness and emphasis on patient-centered outcomes.

- Use "Five Steps to Conduct a Systematic Review" (see At-a-Glance text box and Appendix D). This reference cites an example facing public health officials making a decision on public water fluoridation.[50] A careful systematic review provides the policymaker with both a thorough understanding of research available to inform their decisions and provides information to potentially address concerns regarding the selection of one intervention over another.

At a Glance

Five Steps to Conduct a Systematic Review

1. Frame Questions that Must be Answered
2. Identify Relevant Materials
3. Assess the Quality of the Research
4. Summarize the Evidence Found
5. Interpret the Findings

Adapted from Khan et al, Five Steps to Conducting a Systematic Review.

Long-Term Strategies

Establish opportunities to educate policymakers and others on the use of research for decision making. Learning needs vary and groups will need to be evaluated for their familiarity with research methods and designs, as well as the barriers they face in translating findings to use for their particular program or policy decisions. For example, training a lay advisory group on how to compare different medical treatment options would require a different approach than ensuring a medical advisory committee consisting primarily of physicians uses available comparative effectiveness research.

- Refer to handbooks or glossaries created by states that translate key terms used in health care policy and research into lay language (see suggested glossaries in Appendix B).

Collaborate with local partners to develop the training curriculum for policymakers. Training stakeholders to use research will better prepare them to help review the evidence, understand the differences between different interventions, and be more informed participants throughout the decision-making process.

- Refer to the Georgia Health Policy Center's Legislative Health Policy Certificate Program, an example of a training program specifically targeted to state legislators. A unique tool includes a computer simulation model embedding the research evidence that allows legislators to see the impact of different decisions on key outcomes. (See Stories from the Road).[51]
- Adopt or adapt the Centers for Disease Control and Prevention online guide to using evidence-based approaches in public health training programs.[52]

At a Glance

Examples of Key Terms

Unless otherwise noted, the definitions have been adapted from the Agency for Healthcare Research and Quality Glossary, found at: http://effectivehealthcare.ahrq.gov/index.cfm/options/glossary/

Bias: Any factor that distorts the findings of a study; bias may influence observations, results, or conclusions, and may make the study less accurate or believable.

Blinding (sometimes referred to as Masking)**:** A way to ensure that the participants, clinicians, or researchers do not know which participants have been assigned to one of a study's intervention or control groups.

Clinical Practice Guidelines *(from www.pcori.org/about-us/glossary)***:** Systematically developed statements or recommendations to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.

Cohort Study: A research study in which people with a common condition or treatment plan are followed over time and compared with a group of people who do not have the same condition or treatment plan.

Comparative Effectiveness: A type of research that compares the results of one approach for managing a disease to the results of other approaches, usually comparing two or more types of treatment for the same disease.

Evidence-Based Practice: Applying the best available research results when making decisions about health care.

External Validity: The extent to which research applies to broader populations. A study has external validity if the results can be generalized to the larger population.

Internal Validity: The extent to which the results of a study are not biased.

Meta-Analysis: A way of combining the findings from multiple research studies.

Patient-Centered Outcomes Research (from www.pcori.org/about-us/glossary): Research that helps patients and their caregivers make better-informed healthcare decisions by incorporating their voices into the process of assessing the effectiveness of healthcare options.

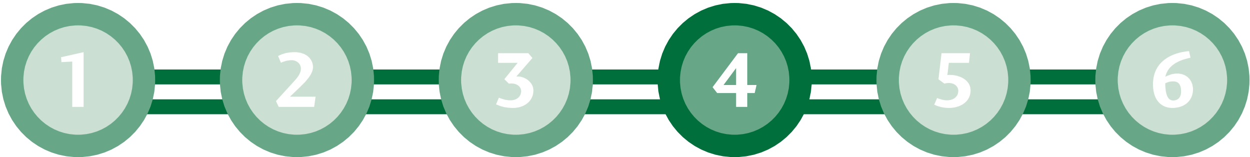
Publication Bias: The tendency to publish findings that have a positive result, while not publishing findings when results are negative or inconclusive.

Randomized Controlled Trial: A controlled study where participants are randomly assigned to two or more groups.

Selection Bias: A type of bias where the way in which participants are assigned to intervention and control groups create differences in the groups in ways that may affect the study's outcome.

Statistical Significance: A mathematical technique to measure the likelihood of whether a study's results occurred due to chance instead of the intervention.

Systematic Review: A critical assessment and evaluation summarizing the current research available on a specific topic.



Step 4: Using the Evidence to Design a Program or Policy

Key Questions

Questions to ask during this step may include:

- **What local, regional, or state data should be used to inform your decision?**
- **Is implementation of a specific intervention feasible?**
- **Are there time or resource constraints that will impact feasibility?**
- **Is there enough buy-in from leadership and stakeholders that this intervention can be successfully implemented?**

After collecting and evaluating research comparing the different interventions under consideration, the next step is to determine how the findings can be used to develop and implement a program or policy. Geography, culture, and available resources influence a selected intervention's feasibility and success, and—as discussed in the previous section—what worked for one population may not necessarily translate to success elsewhere. Similarly, the feasibility of implementing a particular program may even vary across different agencies or regions within a single state. Several strategies are presented to aid in translating the research into policy.

Short-term Strategies

Secure and maintain involvement from multiple stakeholders throughout the process. Sharing the evidence and keeping the process transparent when possible will help inform the design of the program or policy, promote the use of evidence, and identify potential challenges early on regarding the feasibility of implementing a potential approach. Policymakers should keep in mind that different stakeholder groups may need different information—or the information presented in different ways—for the resources used to be understood and useful (discussed in **Step 5**).

- Engage and educate advisory groups during the design period.
- Provide opportunities for public comment, such as public hearings, comment periods, or focus groups.
- When appropriate, include various state professional groups, For example, when considering expanding the nurse practitioner's role, including clinicians in the discussion will provide a valuable perspective on the practical considerations for how the clinicians and potentially local or state communities may be impacted.

Use data to assess whether the intervention is a 'good fit' and would be feasible to implement within a given state or agency. A careful review using relevant data will both identify interventions less

likely to be successful and provide opportunities to adapt and modify certain interventions to better fit a state or agency's needs.

- Request and leverage local and state data (e.g., claims/encounter data or public health registry data) and use experts to compare local demographics or available resources with those described in evidence-based reports. Using data will help translate whether the research being reviewed is applicable to the targeted population.

Examine local, regional and state data for any similarities that can inform applicability across state lines. As discussed in **Step 2**, other states can be a valuable source for information about how to address a pressing health issue. However, citing evidence from the success of another state's program or policy to support an intervention may raise concerns from some stakeholders that the outcomes are meaningless due to real or perceived differences.

- Explore potential similarities between two populations before determining that an intervention taking place in a "dissimilar" state would not translate to your state.

Focus on agency-specific needs and goals when comparing evidence on interventions. Different state agencies may have similar goals, but the interventions to reach the goals often differ and may require the use of different research. For example, a state employee health plan smoking cessation program implemented within a workforce environment will likely differ significantly from a program available to the Medicaid population within a local community health care site. Given the differences in the two populations, different agencies may also select interventions targeting different places within the system. For example, state employee benefits agencies may be more likely to attempt solving issues by changing the behavior of the beneficiaries and not involve the health care system (e.g., workplace wellness programs) while Medicaid may attempt to make a program change at the clinician-level through payment reform or enhanced clinician requirements.

Notable Quote

"I'd like (state employees) to stay outside the health care system as much as possible. That is the goal. I want them to hardly ever have to enter the system."

- State Employee Health Benefits Official

Medium-term Strategies

When possible, educate stakeholders on the value of using comparative effectiveness research and patient-centered outcomes research in the decision-making process. Providing data or strong research evidence may not be sufficient to influence the selection of one intervention over another. Cost and limited resources may be key priorities during the selection process and may need to override the findings from a review of the evidence. Different stakeholders may also have differing priorities or agendas for resisting the inclusion of findings from CER. Depending on the issue and the environment, an agency or state may need to increase support for the education of policymakers and other stakeholders on the potential value of CER and PCOR.

Assess your local infrastructure and analyze the readiness for program implementation. Local, regional, or state resources to support the intervention need to be evaluated and, when not available, put in place. Implementing an opioid treatment program within a rural community, for example, may require the training of local community clinics or an assessment of transportation support for the population engaged in the program.

Obtain leadership buy-in for a new policy or program. Recommendations from expert advisory groups, for example, may be of limited value if leaders with decision-making capacity are not convinced of the value of a selected intervention.

- Ensure key leadership understands the intervention selected and key features of the research supporting the design or selection of the program or policy once a decision is made. Even commissioners and directors may need to secure the support of the governor or the legislature before implementation can begin.
- Have back-up options lined up when the first choice is likely to face significant resistance.

Long-term Strategies

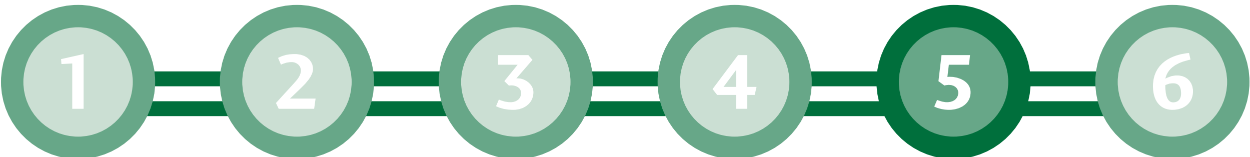
Secure support for using an intervention shown to be more effective. Policymakers may not always be able to select an intervention solely based on its effectiveness - even with strong CER available. A state's budget, for example, may influence willingness to support or continue supporting a program or policy that is not expected to produce a rapid improvement in outcomes and yield a strong return-on-investment.

> **Notable Quote**
>
> **"I look at the infrastructure we already have to see what our readiness is. So it is not just the data, but do we have the stakeholders and their buy-in? Do we have the resources to effectively implement this? Is it what people are ready to do?"**
>
> *- Public Health Official*

- Explore multi-stakeholder processes to focus on key, high impact topics. For instance, the Massachusetts Prevention and Wellness Trust Fund provides an example of a state entity focusing on four conditions found likely to have an immediate impact or produce short-term returns on investment within four years: pediatric asthma, hypertension, tobacco use, and falls among older adults.[53] Applicants were allowed to propose interventions for other conditions, but were required to address at least two of the priority conditions in their proposal to show a short-term impact.
- Educate policymakers on the potential value of investing in interventions likely to show results over a longer period of time and result in a more efficient use of resources.

Pursue private and federal funding sources to support the use of CER and PCOR in the decision-making process. Given that many states and agencies may have limited funding, agencies can use public and private sources to both create supports within their state to use CER and PCOR and to pilot and evaluate programs using this research.

- Explore private foundations or organizations such as the Patient-Centered Outcomes Research Institute, Robert Wood Johnson Foundation or private insurers.
- Explore federal grants opportunities including, for example, the Centers for Medicare and Medicaid Innovation State Innovation Models grants which provide significant opportunities to integrate evidence-based practices and offset the cost to the state or agency.



Step 5: Communicating and Disseminating the Decision

Key Questions

Questions to ask during this step may include:

- **How will different stakeholders react to this decision?**
- **What information is most important to provide the various stakeholder groups?**
- **How should the information be presented and delivered to reach different groups?**
- **Who are the most appropriate representatives to communicate the decision?**

Recognizing that stakeholder groups are often motivated by different priorities is essential to successfully securing buy-in both prior to and during implementation of the program or policy decision. When the Oregon Public Employees' Benefits Board adopted value-based insurance design for coverage for state workers, for example, communication of the change was found to be incredibly important, both in "crafting the message" and "managing the reaction."[54] Several strategies policymakers may use to communicate and disseminate the decision are presented below.

Notable Quote

"Regardless of how good the idea, concept, or program is, if it's not properly communicated and implemented it lacks ultimate effectiveness."

- State Employee Health Plan Official

Strategies

Communicate policy decisions using content that is both real and relevant to those impacted by the decision. Ultimately, a successful communications strategy will address the concerns of the different target audiences and may require different information depending on the stakeholder group.

- Keep experts and those impacted by the decision engaged throughout to provide valuable insight into what information is of most importance to stakeholders.
- Tailor the message to fit the audience. For example, physicians and academics would likely prefer the information comparing the interventions reviewed be presented in clinical and research terms, while the public or media would likely need to receive information in lay terms. Similarly, legislators often short on time

Notable Quote

"When you are in a position of implementation, you have to be very practical about how you use literature, how you communicate to folks that you need to get on board."

- Medicaid/CHIP Official

may prefer high-level information or a review of the resources needed and potential return on investment, while physicians would value a greater level of clinical information.

- Leverage the communication process and advance the use of CER and PCOR when informing consumers and others of the value of using this research evidence to make more informed decisions. To accomplish this, states may be able to leverage the materials developed through Choosing Wisely®, a program led by the American Board of Internal Medicine Foundation in which family medicine and specialty organizations developed lists of questions that physicians and patients should ask regarding many common tests and treatments.[55]

Use different formats and venues to deliver the information on the selected intervention to different audiences. Different audiences are likely to want—and need—different approaches to learn about selected programs or policies and why they were chosen**.** Informing the public on the benefits of participating in a selected tobacco cessation program, for example, will require a different approach than those used to engage insurers and clinicians to promote the program through their organizations and offices.

- Tailor the format: press releases, short 'elevator' speeches, talking points, fact sheets, and data reports are all useful depending on the time and place.
- Vary information by length, level of detail, terminology used and issues. For example, some audiences may be better reached by information that emphasizes considerations of a condition's burden or impact on health while others focus on quality outcomes or safety.
- Identify novel approaches to disseminate information to ensure the target audience can find the information; policymakers may find value in using social media or other venues when providing information to consumers.

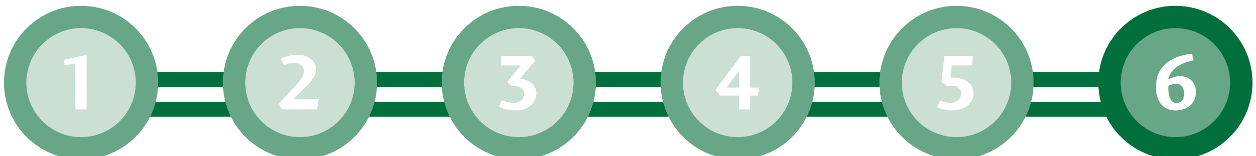
Notable Quote

"You need the strong analysis, but also understand the limitations of it and [the importance of] how to communicate with folks who don't come from [a research] background."

- Medicaid Official

Determine the best level(s) of leadership to communicate the decision. An important consideration in disseminating a program or policy decision is identifying the appropriate individual(s) and the appropriate venue to communicate the decision to the public and others impacted. In many cases, it makes sense for the spokesperson to be the person within the agency that made the decision, such as the public health commissioner. Alternatively, if the decision is part of a larger state agenda, it may be appropriate for the messaging to come from a higher office, potentially the health secretary or even the governor's office.

Recruit stakeholders external to state government to communicate support for decisions when appropriate. Trusted community leaders or other non-governmental parties may be in a position to meet with and address specific questions and concerns raised by their constituencies—especially if they were engaged in the decision-making process. These spokespersons may be of particular importance for those decisions likely to create resistance from particular groups of stakeholders. A patient may experience receiving information from a well-informed patient or clinician differently, for example, than from a state official when a treatment option is no longer available due to a review of the evidence.



Step 6: Monitoring and Evaluating New Research as It Becomes Available

Key Questions

Questions to ask during this step may include:

- **What information is needed to evaluate the effectiveness of the selected intervention?**
- **How can new research be used to impact an existing program or policy?**
- **How can policymakers build flexibility into programs and policy decisions to ease the use of new research evidence to make modifications?**

The rapid growth in medical and healthcare research—particularly comparative effectiveness research (CER)—has created an ever-changing body of evidence for policymakers to inform their decision making. Evaluations of programs and policies will provide important information on their effectiveness and provide opportunities to incorporate findings from new CER and Patient-Centered Outcomes Research (PCOR) and modify if needed.

Strategies

Create an evaluation process for the selected program or policy. To determine the impact of a program or policy and recognize when modifications may be needed, an evaluation component should be included in the design of the program. The evaluation component may be brief with specific measures collected through basic methods or may be more comprehensive requiring an investment of skilled personnel and resources. Though a selected intervention may initially appear to be a 'good fit,' evaluating key outcomes will provide specific information on the effectiveness of the intervention and suggest when modifications are necessary.

Review new research findings including CER and PCOR as they become available. Numerous policies and programs are put in place with limited research to support their effectiveness. As discussed in earlier sections, establishing formal processes to review CER and PCOR in the decision-making process will create or strengthen a culture to continue to evaluate established programs and policies. Additional CER and PCOR studies could impact, for example, current payment methodologies aimed to enhance the delivery of comprehensive and coordinated care or a

Notable Quote

"Since evidence changes, we want to give flexibility to best practices and new evidence."

- State Legislator

revision of established guidelines for the coverage for bariatric surgery for morbid obesity. As mentioned in previous steps, this includes:

- Designate staff in your agency or department to perform ongoing monitoring of new relevant CER and PCOR.
- Establish relationships with reputable sources such as academic institutions or research collaboratives such as MED and DERP to learn of new research as it becomes available. (Discussed in Legend)
- Use external research organizations such as the Cochrane Collaboration, described in **Step 2**. The Cochrane Collaboration maintains a Cochrane Database of Systematic Reviews and conducts evidence-based systematic reviews of different interventions and added 516 new reviews and 685 new protocols to their Cochrane Library over a 14-month period (2013-2014); another 603 reviews were updated in that time period, and 141 of those 603 included changed conclusions.[56]
- Explore federal sources, including the Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, and other federal agencies posting research findings (See **Step 2**).
- Review research findings reported by the Patient-Centered Outcomes Research Institute (See **Step 2**).
- Join a multi-state collaboratives and/or look to associations or organizations representing state officials for assistance with review (described in **Step 3**)

Build a process that allows for some flexibility to modify a program or policy, particularly when minimal evidence was available to support the decision. The lack of evidence may discourage policymakers from relying on research to inform decision making, particularly when facing pressure from stakeholders or colleagues to implement specific interventions. Evidence can change rapidly—sometimes faster than it takes to fully implement a new policy or program after a decision. Acknowledging that new—and potentially conflicting—research is likely to be released in the near future, policymakers can anticipate and prepare for these changes and avoid unnecessary delays in implementing promising practices (e.g., needing to pass new legislation or re-authorizing an advisory group).

- Use legislation or administrative rules to ease implementation of revised policies or programs**.** Minnesota, for example, used the confidence-with-evidence development (CED) approach when designing their program policy on autism treatment coverage, given limited research to support a specific intervention (see Stories from the Road). CED includes a process to make conditional payments for providing the intervention while also collecting data to show their impact on specific outcomes.[57]
- Include either mandatory review periods or use permissive 'may' language instead of mandatory 'shall' language when codifying specific program elements in statute or regulation. For example, the regulations governing the operation of the California Division of Worker's Compensation grants the division's administrative director, in consultation with the medical director, the authority to revise, update, and supplement the medical treatment utilization schedule (MTUS) as necessary; furthermore, the division's Medical Evidence Evaluation Committee is required to meet at least four times annually, presenting ample opportunities to adapt the MTUS as new CER or PCOR becomes available.[58]

Stories from the Road

This section provides several examples of how policymakers have used evidence to inform their decision making, particularly using comparative effectiveness research (CER) when available.

Minnesota: Using Comparative Effectiveness Research to Inform Autism Legislation

Multiple states are struggling to determine appropriate benefits for the treatment of autism spectrum disorders (ASD). In 2013, the Minnesota Legislature passed legislation for coverage of an "early intensive intervention" benefit for treating children diagnosed with ASD and enrolled in Minnesota's public health care programs. This case study offers a snapshot of Minnesota's use of research, including comparative effectiveness research (CER), to impact this policy change and pass legislation built on evidence. The Minnesota case study also provides an excellent example of how the Roadmap can be used to inform the decision-making process. (In 2013, Minnesota passed separate ASD legislation pertaining to children covered by commercial health plans and insurers. This summary pertains only to the benefit provided in public health care programs, not commercial policies).

Throughout the process, ample opportunities were provided for public comment. In 2012, the Department of Human Services (DHS) assembled an ASD Advisory Council that includes parents, clinicians, county workers, service providers, educators, and state employees. The Council was convened to provide input on the successful implementation of early intervention services for children with ASD. DHS also convened a clinical/professional focus group, a parent focus group, and an advocate focus group to obtain patient and consumer perspectives in the decision-making process. To date, the ASD Advisory Council continues to meet to further develop the benefit and communicate updates and the minutes from related meetings and public comments are made available on a state website.[59]

Step 1: Identifying When Comparative Effectiveness and/or Patient-Centered Outcomes Research Can Inform Policymaking: The existence of numerous treatments for autism spectrum disorders (ASD) but a paucity of strong scientific evidence demonstrating effectiveness made ASD treatment a ripe issue for the application of CER. In 2012, the Minnesota Legislature directed the Health Services Advisory Council (HSAC), which provides external, evidence-based, clinical advice to the Minnesota DHS, to review the evidence concerning treatments for ASD to inform coverage recommendations.[60]

Step 2: Research and other Relevant Resources: The HSAC was the primary entity responsible for reviewing research and other relevant resources to inform a coverage recommendation. HSAC included a review of CER studies published by AHRQ as well as further research from the Medicaid Evidence-based Project Initiative collaborative (MED).[61,62]

Step 3: Evaluating the Evidence: Based on their review of different treatments, the committee concluded that, although there was less evidence than was desired, Early Intensive Behavioral and Developmental Interventions (EIBDI) had the best strength of evidence.[63]

Step 4: Using the Evidence to Design a Policy: The HSAC developed a final report delivered to the Minnesota DHS Commissioner that included recommendations for the selected early intensive intervention benefit. Minnesota Legislature had also specifically allowed HSAC to make recommendations that included 'coverage-with-evidence development' (CED). CED includes a process to make conditional payments for providing the intervention while collecting data to show the impact on specific outcomes. [64] A lack of strong evidence to support coverage for one particular treatment for children with ASD also resulted in

DHS adopting an approach that gives patients and clinicians some flexibility in choosing the specifics of a treatment plan.

Step 5: Communicating and Disseminating the Decision Made: DHS let the existing ASD Advisory Council take the lead in disseminating and communicating information on the selected early intervention benefit. The ASD Advisory Council continues to hold open meetings, allowing the public to sit in and learn about updates to the benefit.

Step 6: Monitoring and Evaluating New Research as It Becomes Available: Acknowledging a dearth of research providing conclusive and consistent results on autism treatments, including EIBDI, Minnesota plans to collect outcomes data, monitor new research as it becomes available and adjust policies as necessary.[65] The legislation specifically contains a provision for the "revision of treatment options" and allows the commissioner to "revise covered treatment options as needed based on outcome data and other evidence."[66]

Georgia: Educating Legislators on the Use of CER

The George Health Policy Center (GHPC) was formed in 1995 in partnership with business leaders, donors, clinicians and others to provide objective evidence-based research to policymakers and help inform their decisions on health policy and programs in their state.[67] Recognizing their state legislature only was in session 40 days each year, GHPC aimed to provide legislators with the research and support needed to make fully informed decisions within the limited time available.

Several levels of learning needs among legislators were identified and resulted in the recognition of four different broad categories of learners:

- Group 1: Novice legislators
- Group 2: Legislators interested in the "hot" and controversial topics but who required concise summaries of material due to time constraints.
- Group 3: Legislators, often on health-related committees, with an understanding of nuances and an interest in better understanding how pieces fit together.
- Group 4: Legislators in leadership positions seeking understanding at high-level to recognize the implications of the policy and resource decisions in the broader context.

Recognizing the range of needs among legislators, GHPC has developed several specific tools on health policy interventions. Included in these materials, for example, is the *Little Blue Book, A Health Glossary*, a resource created by GHPC and adapted by other states as well (see Appendix B).[68] Two structured programs are key to educating legislators: the Legislative Health Policy Certificate Program and the Advanced Health Policy Institute. The Legislative Health Policy Certificate Program is designed for those in Group 3 and helps legislators develop an approach to policy issues through systems thinking: examine the big picture, and consider multiple factors and possible high-leverage interventions. The Advanced Health Policy Institute is a three-day course for legislators to develop a higher-level understanding of issues and approaches to examining solutions; per diem is covered by the state.

GHPC Childhood Obesity Model for State Legislators

As part of the Legislative Health Policy Certificate Program for Georgia policymakers, GHPC developed a childhood obesity model to provide Georgia legislators with a systemic perspective on childhood obesity using research findings and help them understand policy impacts.[69] This model was designed

by a collaborative team comprised of state legislators, legislative staff, and experts in nutrition, exercise physiology, epidemiology pediatric medicine, economics, and system dynamics. The team designed a computer-based tool that allowed policymakers and stakeholders the opportunity to rapidly explore health impacts of specific policy changes prior to enacting them. The model relied on epidemiological data, a review of the research literature on childhood obesity, and structure from a similar tool previously developed by the Centers for Disease Control and Prevention. The six policy areas that were modeled were:

1) Ensuring safe routes to school
2) Improving school food options
3) Improving school physical education
4) Improving nutrition/physical activity education in preschool programs
5) Improving nutrition/physical activity education in after school programs
6) Reimbursing Medical Nutrition Therapy for obese children insured by Medicaid

The simulation occurred in a real-time, hands-on learning lab environment with legislators and their staff. Following the simulation, participating legislators commented that the model informed their deliberations during the legislative session and contributed to the passage of HB 229, requiring fitness testing and stricter enforcement of physical education requirements in Georgia's school system.

The model and the collaborative model-building process facilitated more rigorous discussions among legislators, their staff, and nutrition and physical activity experts. The computer simulation model provided an opportunity to learn about the consequences of actions before policies are set in motion. Further, the model creates a transparent framework for organizing published evidence and expert assumptions in a way that makes research accessible to, and easily understood by, legislators.

Massachusetts: Implementing Evidence-Based Community Interventions through the Prevention and Wellness Trust Fund

Massachusetts established the Prevention and Wellness Trust Fund in Chapter 224 of the Acts of 2012, which is administered by the Massachusetts Department of Public Health (DPH).[70] Designed to reduce the prevalence and costs of chronic diseases, the Trust Fund provides funding for a competitive grant program for community-based partnerships to implement targeted evidence-based public health interventions. Grants were awarded in January 2014.

Advocates were instrumental in ensuring the Prevention and Wellness Trust Fund was included in the omnibus health care legislation. Once passed, the Massachusetts DPH held four listening sessions across the state to engage stakeholders and communities in informing program development. Additionally, the legislation established an Advisory Board charged with assisting DPH in administering and allocating the Fund. The Advisory Board, appointed by the governor, included broad expert and stakeholder representation, including a public health economist, a health equity expert, local health officials, and payer/clinician representatives. The Massachusetts case study also provides an excellent example of how the steps in the Roadmap can be used to inform the decision-making process.

Step 1: Identifying When Comparative Effectiveness and/or Patient-Centered Outcomes Research Can Inform Policymaking: For the most part, the evidence that informed the development of the program included single-intervention studies; meta-analyses were used when available. Patient-centered outcomes research was not specifically prioritized.

Step 2: Finding Research and other Relevant Resources: DPH staff conducted a literature review and consulted with external experts to identify additional research. The Cochrane Database of Systematic Reviews was one tool used to identify relevant meta-analyses.

Step 3: Evaluating the Evidence: Content experts, including those on the Advisory Board and other members of academia, were asked to rank the evidence found using an existing "A, B, C" grading system. DPH also worked with a non-profit organization (Social Finance US) to conduct analyses.

Step 4: Using the Evidence to Design the Program: Chapter 224 of the Acts of 2012 requires the Commission on Prevention and Wellness to complete an evaluation of the program, including a recommendation on whether to continue the program beyond 2016, by June 30, 2015. Given the short timeframe, the Advisory Board and DPH developed four priority conditions that had a significant evidence-base of producing results in a short timeframe: pediatric asthma, hypertension, tobacco use, and falls among older adults. Applicants were also able to propose interventions for diabetes, substance abuse, oral health, and mental health/depression, but at least two of the priority conditions had to be included as well.

Step 5: Communicating and Disseminating the Decision: After DPH released the grant application, advocates provided a great deal of feedback on the program, particularly the list of priority conditions, the number of available grants, and the focus on return-on-investment. DPH developed a communication strategy that used the evidence to address stakeholders concerns, including that return on investment can translate into reduced utilization and better public health.

Step 6: Monitoring and Evaluating New Research as It Becomes Available: The grants provided under the Prevention and Wellness Trust Fund included three phases: capacity building, implementation, and sustainability. DPH continued monitoring and evaluating evidence during the capacity building phase to support grantees implement best practices. In April 2014, DPH provided grantees with an updated set of potential evidence-based interventions tiered by the strength of evidence.

Closing Remarks

The use of evidence comparing the effectiveness of different interventions when developing state programs and policies is increasingly a priority for state and federal policymakers. Interventions being considered may range from treatment for mental or physical conditions, the best use of the health care workforce, or methods to pay physicians for care delivery. Multiple approaches may need to be considered, each with varying amounts of research on their effectiveness and safety. Including patients in research and engaging them in their health care decision making is also an increasing priority within the health care system. When faced with options, policymakers will benefit from reviewing comparative effectiveness research (CER) and patient-centered outcomes research (PCOR) to select the program or policy more likely to be effective for a given investment of resources. This guide provides information and strategies for policymakers to support their use of CER and PCOR from the initial stage of recognizing issues that would benefit from a review of available CER and PCOR to using CER and PCOR to evaluate and maintain a policy or program already in place.

APPENDICES

APPENDIX A: Roadmap Advisory Group Members

Gregory Allen, Director of the Division of Program Development and Management, Office of Health Insurance Programs, New York State Department of Health

Alison Beam, Policy Director, Pennsylvania Insurance Department

Jane Beyer, Assistant Secretary for Behavioral Health and Service Integration, Aging and Disability Services Administration, Washington Department of Social and Health Services

Ted Cheatham, Director, West Virginia Public Employees Insurance Agency

Russell Frank, Former CHIP Director, Department of Vermont Health Access

Leah Hole-Marshall, Medical Administrator, Office of the Medical Director, Washington State Department of Labor and Industries

Laurie Jinkins, State Representative, 27th District, Washington State House of Representatives

Joan Kapowich, Former Administrator, Oregon Public Employees' Benefit Board and Oregon Educators Benefit Board

Laura Kelly, State Senator, 18th District, Kansas State Legislature

Judy Lee, State Senator, 13th District, North Dakota State Legislature

Doris Lotz, Medicaid Medical Director, New Hampshire Department of Health and Human Services

Sheena Olson, Assistant Director, Medicaid Programs and Provider Management, Division of Medical Services, Arkansas Department of Human Services

Gail Propsom, Director, Bureau of Long-Term Support, Wisconsin Department of Health Services

Linda Sheppard, Special Counsel and Director of Healthcare Policy and Analysis, Kansas Insurance Department

Jeanene Smith, Chief Medical Officer, Oregon Health Authority

Nan Streeter, Director, Maternal and Child Health Bureau, Utah Department of Health

Robert Zavoski, Medical Director, Connecticut Department of Social Services

Judy Zerzan, Chief Medical Officer/Clinical Services Office Director, Colorado Department of Health Care Policy and Financing

APPENDIX B: Additional Sources of Research and Tools

Sources of Research

Agency for Healthcare Research and Quality, Evidence-based Practice Center Reports: http://www.ahrq.gov/research/findings/evidence-based-reports/a-z/index.html

Agency for Healthcare Research and Quality, National Guideline Clearinghouse: http://www.guideline.gov/

Agency for Healthcare Research and Quality, "Systematic Review Data Repository," http://srdr.ahrq.gov/

Center for Integrated Health Solutions, Research: http://www.integration.samhsa.gov/research

Centers for Disease Control and Prevention, Prevention Research Centers Research Projects: http://nccd.cdc.gov/PRCResearchProjects/Search/SearchCriteria.aspx

The Cochrane Library: http://www.thecochranelibrary.com/

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Patient-Centered Outcomes Research Institute, Funding Awards: http://pfaawards.pcori.org/

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APPENDIX C: Suggested Reading

Policymakers who want to learn more about using research in policymaking may wish to consider the following articles and resources, many of which were included or referenced in the Roadmap.

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APPENDIX D: Handout

STEPS FOR A SYSTEMATIC REVIEW (Khan et al.)[71]

Step 1: Framing questions for a review

The problems to be addressed by the review should be specified in the form of clear, unambiguous and structured questions before beginning the review work. Once the review questions have been set, modifications to the protocol should be allowed only if alternative ways of defining the populations, interventions, outcomes or study designs become apparent

Step 2: Identifying relevant work

The search for studies should be extensive. Multiple resources (both computerized and printed) should be searched without language restrictions. The study selection criteria should flow directly from the review questions and be specified *a priori*. Reasons for inclusion and exclusion should be recorded

Step 3: Assessing the quality of studies

Study quality assessment is relevant to every step of a review. Question formulation (Step 1) and study selection criteria (Step 2) should describe the minimum acceptable level of design. Selected studies should be subjected to a more refined quality assessment by use of general critical appraisal guides and design-based quality checklists (Step 3). These detailed quality assessments will be used for exploring heterogeneity and informing decisions regarding suitability of meta-analysis (Step 4). In addition they help in assessing the strength of inferences and making recommendations for future research (Step 5)

Step 4: Summarizing the evidence

Data synthesis consists of tabulation of study characteristics, quality and effects as well as use of statistical methods for exploring differences between studies and combining their effects (meta-analysis). Exploration of heterogeneity and its sources should be planned in advance (Step 3). If an overall meta-analysis cannot be done, subgroup meta-analysis may be feasible

Step 5: Interpreting the findings

The issues highlighted in each of the four steps above should be met. The risk of publication bias and related biases should be explored. Exploration for heterogeneity should help determine whether the overall summary can be trusted, and, if not, the effects observed in high-quality studies should be used for generating inferences. Any recommendations should be graded by reference to the strengths and weaknesses of the evidence

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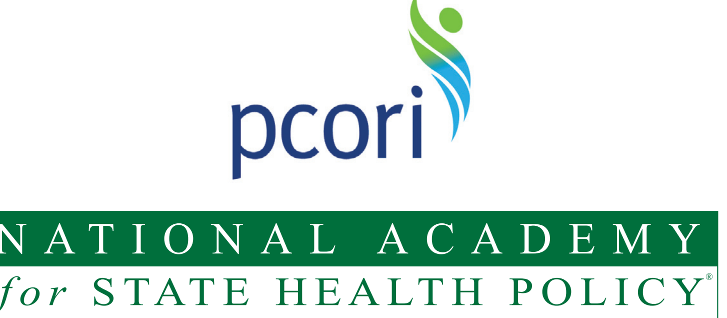

State Health Reform Assistance Network
Charting the Road to Coverage

ISSUE BRIEF
August 2014

Boosting Enrollment: Lessons Learned from 2013-2014

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Executive summary

As part of Wakely Consulting Group's (Wakely) participation in the Robert Wood Johnson Foundation's State Health Reform Assistance Network, the authors interviewed staff at five successful state-based marketplaces (SBMs), as well as field personnel under contract to the same SBMs, to learn what could be used from the first open enrollment to improve sign-ups for 2015. While broad educational efforts, such as informing citizens about the Affordable Care Act (ACA) and helping patients navigate the health care delivery system, are certainly worthy objectives, this paper focuses on the challenge of getting low- to moderate-income people to purchase qualified health plans (QHPs). While marketplaces also play a role in Medicaid/Children's Health Insurance Program (CHIP) enrollment, QHP enrollment is uniquely their responsibility, and selling a selection of health plans differs significantly from enrolling beneficiaries in free coverage. This paper focuses on QHP enrollment because improving the ability of SBMs to reach and enroll more people in commercial insurance, especially the uninsured, is so challenging. To the extent that SBMs believe that they should, and can afford to, pursue broader goals than QHP enrollment, they should recognize that the recommendations in this paper relate to only a subset of their outreach and communications mission.

Of course, fixing the basic functionality of SBMs so that consumers, brokers, navigators and insurers can rely on the marketplace to perform its core functions well, and to provide credible and timely information, is the single most important "fix" for improving sales. This is well recognized by all, and there is little that this study has to offer by way of suggestions for doing so. Rather, the authors focus on the marketing and sales efforts that can optimize enrollment, assuming that an SBM's core functions work.

We organize these recommendations based on observations drawn from Colorado, Connecticut, Kentucky, Rhode Island and Washington, plus an occasional reference to other states. We have reviewed the observations and recommendations with staff of the five SBMs in an effort to improve accuracy and ensure validity. Nevertheless, these are qualitative assessments, based primarily on interviews filtered through the authors' experience in operating and consulting with SBMs and private health plans. The recommendations are set forth in this Executive Summary with a brief summary of related observations. The observations are detailed in the associated issue brief.

ABOUT STATE NETWORK
State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit *www.statenetwork.org.*

ABOUT WAKELY CONSULTING GROUP
Wakely Consulting Group is an actuarial and healthcare consulting firm specializing in government healthcare programs including state and federal reform, Medicaid and Medicare Advantage. For more information, visit *www.wakely.com.*

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SUMMARY OF OBSERVATIONS

Observation: All five states consider an early start to building public awareness and generating leads to be important to enrollment success. These states feel that they did begin early, but some felt that it was not early enough. Navigators, brokers and issuers generally commented that training on websites and back-office systems was neither adequate nor timely, and the SBMs generally agreed. The states are all concerned about renewals for 2015, and understand that renewal planning should begin as soon as possible and that training for both new enrollment and renewals should be better than it was in 2013.

Recommendations:

1. Evaluate penetration of target markets (neighborhoods, towns, counties, linguistic groups, demographic groups, etc.) as soon as possible, and focus advertising and sales on specific population segments. Coordinate advertising with the ground game of enrollment events, and coordinate both advertising and enrollment events with the brokers, navigators and other enrollment assisters that have special ties to those target markets. End-to-end coordination is key to direct sales.

2. Continue to generate leads for brokers, navigators and other enrollment assisters, but develop less expensive ways than those typically used in 2013 to build awareness. Having built a baseline of awareness, SBMs must continue some use of mass media to maintain awareness, but should carefully target much of the advertising dollars to high-priority segments (e.g., postcards and billboards in certain zip codes, foreign language media, digital advertising).

3. Renewing existing enrollees is a high priority for 2015. SBMs need to develop both subsidy redetermination and QHP re-enrollment processes for renewing enrollees, including decision support and default options. They also need to develop corresponding communications plans with issuers, brokers and navigators. Since these enrollees are also clients and members of brokers, navigators and issuers, they should be included in a joint plan for the renewal process, if only to clarify their respective roles. Doing so as soon as feasible will help in executing a systematic, timely and consumer-friendly renewal process.

Observation: Wrapping a touring RV or bus to generate local buzz increases awareness and visibility, provides recognition to coalition partners and can be used by enrollment assisters to qualify prospects, i.e., to develop lists of potential purchasers. In large cities and densely populated states, walk-in stores and pop-up enrollment centers proved effective, if well located. Enrollment centers physically reinforce the presence of the SBM in target communities, and provide a setting where consumers who feel stymied can get the personal attention they need; and they can be staffed in a cost-effective manner by a combination of brokers, navigators and marketplace employees.

Recommendations:

4. Test and evaluate different ways to establish a cost-effective physical presence in high-priority communities. The experience with stores and vans and buses on tour seems to have been positive, but can be expensive. As the focus shifts from awareness and education to maximizing enrollment with a limited spend, SBMs should track the cost per acquisition (CPA) for different set ups in cities and smaller towns, such as permanent storefronts, roving vans, or pop-up centers, staffed by employees, brokers, assisters or some combination of all three.

Observation: Individual sales are very expensive compared to large group sales, so SBMs will need to focus their resources on the most effective outreach tactics to identify qualified leads and call them to act. For example, to the extent that navigators require grant support from SBMs newly challenged by limited funding, particular scrutiny should be given to their effectiveness as enrollers. Even at the point where a motivated consumer makes contact, there are still many opportunities to lose the sale. For example, Connecticut averaged four 11-minute calls to the contact center before prospects eventually enrolled through this channel. Barriers to enrollment—such as a challenging web experience, long waits to reach a customer service representative, multiple transfers, dropped calls, the inability to resolve problems in one call, different answers from different customer service representatives or glitches in billing—can decrease the ratio of sales closed and exacerbate the general confusion about health insurance. Even with generous federal funding, some SBMs did better than others in generating qualified leads, eliminating barriers to enrollment and integrating the entire marketing and sales effort.

With less time and money for the next open enrollment season, SBMs must increase the efficiency and return on investment of their marketing spend. With far more experience and data, they can develop a more cost-effective sales focus.

Recommendations:

5. Building on the theme of a cost-effective sales focus, integrate all marketing and sales activities. Sales and marketing activities can be most readily integrated by a single, unified management structure under a senior manager responsible for advertising, other promotional activities, internal sales staff and management of external sales channels.

6. Hire commercial insurance expertise and adopt standard industry tools and measures to evaluate and refine the marketing and sales process.

7. Carefully manage the cost of attracting and enrolling members, or the CPA. This requires SBMs to track the cost and results of marketing campaigns and different sales channels in order to compare the costs for enrolling customers in QHPs using standard metrics and techniques for direct marketing and sales.

Observation: The management and training of navigators and brokers is challenging. Because SBMs were all racing to develop their systems for October 1, 2013, there simply wasn't time for adequate, hands-on training. Moreover, the two sets of actors are very different in orientation and expectations. For example, most navigators do not depend upon the volume of sign-ups to determine their personal compensation. They are instead driven by mission to help clients with eligibility determination for public programs and may be most familiar with their state's Medicaid and CHIP programs. Most brokers are "producers," focused on commercial enrollment and coordination with the health insurance issuer, but are unfamiliar with Medicaid and CHIP. Typically, navigators know the Medicaid/CHIP programs far better than brokers, and typically brokers know commercial insurance far better than navigators. Moreover, many navigators view their role as supportive, with or without enrollment, whereas brokers define their productivity in terms of enrollments (and renewals) per month. These and other differences, as well as brokers' fears that marketplaces intend to replace them with navigators, sometimes led to mutual suspicion and distrust between brokers and navigators. While far from entirely dissipated, over time some brokers and navigators found ways to overcome distrust and work together productively, recognizing their complementary strengths and knowledge.

Recommendations:

8. Recognize and accommodate the different roles of navigators and brokers. Do this by: (a) introducing and helping brokers and navigators work together or make referrals to each other; and (b) developing data collection tools that allow both to share credit for cooperating on enrolling a client.

9. Focus navigator and broker training programs less on the basics of the ACA, and more on the specifics of the insurance application and the operational support available for problematic cases or application glitches. While timing of systems development for 2014 delayed hands-on training, in-person, hands-on training on the SBMs' systems in advance of November 15, 2014 will be critical.

10. First and foremost, SBMs must fix their systems, and a systematic assessment would be very helpful. Evaluate the obstacles to enrollment and ensure execution of those components critical to an easy and simple enrollment experience.

Observation: Navigator programs were most successful when tailored to a specific region or community. Particularly for linguistic and ethnic communities with high rates of uninsured, use of navigators with roots in the community was very helpful. Similarly, certain brokers in some areas proved very effective, whereas many certified brokers did not produce much enrollment, at least in the initial open enrollment period. To maximize productivity across the state, it will be important to identify and work with effective navigators and productive, motivated agents in each region. The concept of lead entities for navigators by region seems equally applicable to lead brokers by region.

One of the most credible and widely cited sources of information about SBMs was local news stories. They can be relatively inexpensive to generate. Similarly, issuers will be advertising in advance of the next open enrollment season, and should have a strong interest in joint marketing activities.

Recommendations:

11. Focus marketplace's limited human and financial resources on the navigators most effective at enrolling individuals and families, particularly in QHPs. On the one hand, this may necessitate culling navigators focused more on mission-based outreach and less on QHP enrollment; on the other hand, continuing support for some of them will be especially important for enrolling hard-to-reach target segments and for maintaining politically important alliances.

12. To maximize the use of brokers as a free resource (excluding a few "non-brokered" markets), consider developing local marketing and sales plans built around lead agents for each community. Identify those producers across the state that are committed to, and capable of, retaining and enrolling many new clients—initiate a campaign early to recruit them, and focus sales resources and planning on supporting their efforts. Joint planning should aim to drive qualified prospects to them and support their efforts to develop highly productive enrollment processes.

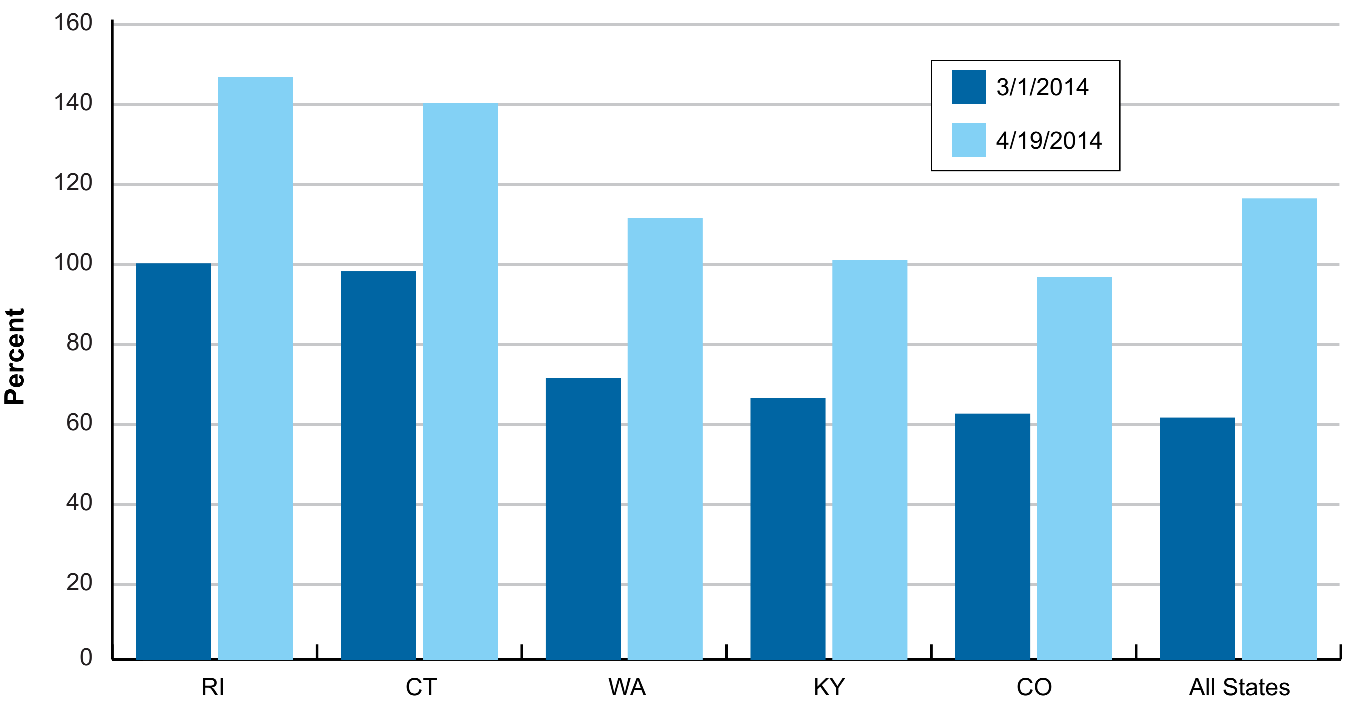
13. To maximize the use of other free or low-cost resources, focus on generating as much earned media and marketing support from issuers as possible.

Introduction

In all, Wakely conducted approximately 100 interviews between February and June of 2014 in Colorado, Connecticut, Kentucky, Rhode Island and Washington. These interviews are the basis for most of the observations in this report, and are not individually cited. These states were selected for their early success—as of March 1, 2014, all five states had exceeded the national average of enrollments as a percentage of projections—and the generous willingness of SBM staff to facilitate our research. Primarily, we interviewed the SBM personnel directly involved in outreach and enrollment, plus navigators and in-person assisters (collectively, "navigators"), health insurance agents and brokers (brokers), and marketing and sales personnel for QHPs. We did not interview certified application counselors (CACs) because they are generally not under contract to SBMs, but several SBMs noted that they were also very effective in enrolling consumers in QHPs as well as into Medicaid.

The enrollment success of these five states can be measured by comparing actual to projected growth using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM).

Based on enrollments started before April 1, 2014, and completed by April 19, 2014, four states exceeded their QHP enrollment targets for 2014, and the fifth, Colorado, achieved 96.4 percent of the projection:



Not shown above, but worthy of note, are these states' robust increases in Medicaid and CHIP beneficiaries. While Medicaid/CHIP enrollment increases averaged 8 percent from third quarter 2013 to March 2014 in all Medicaid expansion states that reported to the Centers for Medicare & Medicaid Services (CMS), Colorado reported a 29 percent increase, Kentucky 34 percent, Rhode Island 28 percent and Washington 23 percent (Connecticut did not report).[2] Most of the QHP enrollment reported by SBMs has been in the individual market, which is the focus of this report.

For simplicity, we use the term "navigator" to refer to any type of in-person assistance excluding agents and brokers. In reality, each of the five states organized their in-person assistance networks differently and the resulting terminology has specific meaning for each state. In Connecticut, navigators are community-based organizations responsible for spearheading outreach efforts in six designated regions. They can put consumers in touch with an "in-person assister," who can help them understand all of their options. Kentucky recognizes "kynector" entities for designated regions, and affiliated individual "kynectors" to provide face-to-face assistance. Washington organized their in-person assistance program by selecting 10 lead organizations to manage partner entities and in-person assisters affiliated with each entity (some lead organizations also provide direct in-person assister support). Colorado chose a network of community-based organizations to provide in-person assistance to consumers, with "health coverage guides" providing the face-to-face services. Rhode Island selected one administrator to manage their statewide network, comprised of both community health centers and community-based organizations that utilize individual navigators to provide assistance. Additionally, Rhode Island promotes in-person assistance at its Contact Centers, and does not use the navigator moniker for this staff. While terminology, organization and funding strategies differ from state to state, we include both navigators and in-person assisters under our references to "navigators" to distinguish these non-commissioned assisters operating under contract with marketplaces from commissioned brokers.

Recommendations & observations

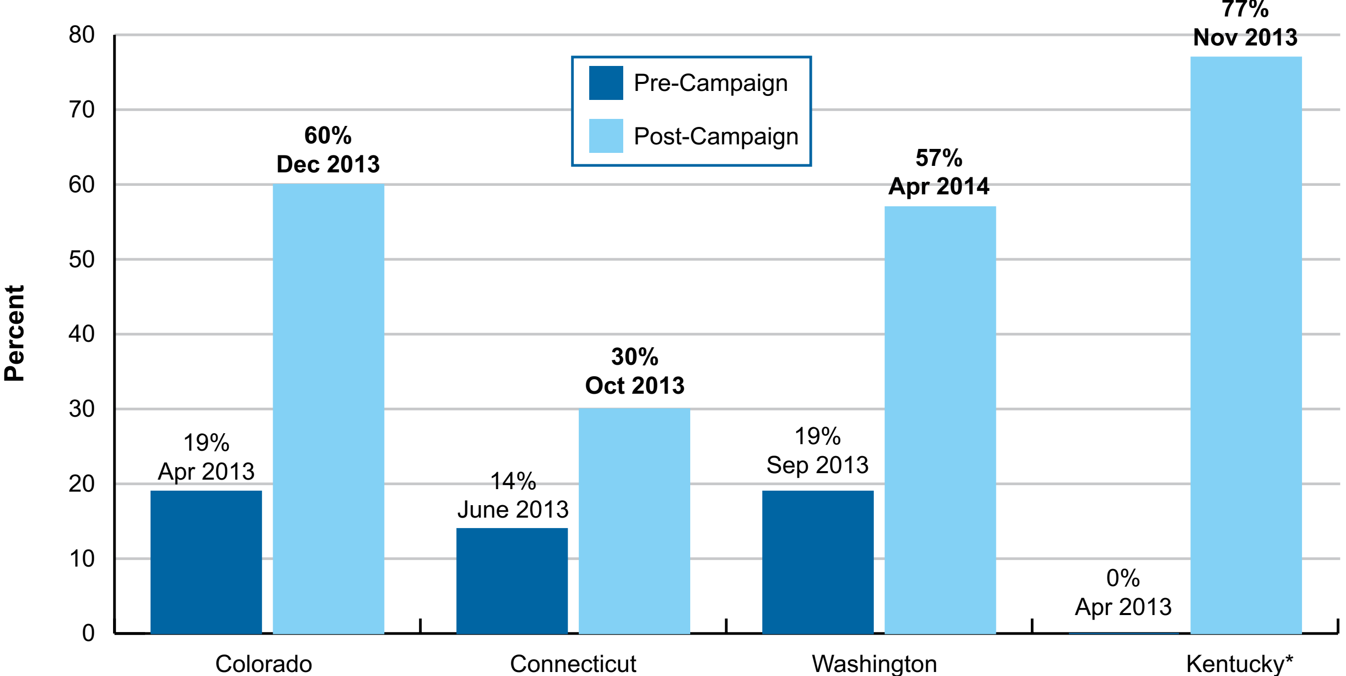
1. **Integrate and execute as early as possible the next marketing and sales campaign.** *Evaluate penetration of target markets (neighborhoods, towns, counties, linguistic groups, demographic groups, etc.) as soon as possible, and focus advertising and sales on specific segments. Coordinate advertising with the ground game of enrollment events, and coordinate both advertising and enrollment events with the brokers, navigators and other enrollment assisters that have special ties to those target markets. End-to-end coordination is key to direct sales.*

The SBMs interviewed for this project cite early outreach and advertising as the most important instrument for educating consumers on the changing health insurance marketplace and the new options available to consumers through state health benefit marketplaces. While the states differed in their approaches to building awareness, many of them utilized creative strategies that moved beyond standard government outreach practices by adopting flexible campaigns that targeted populations with low rates of being insured. Campaigns typically succeeded at raising awareness of the marketplace, reform, subsidies, etc., with a multi-pronged campaign that relied heavily on paid and earned mass media, and then by adding other forms of outreach—local ads, enrollment events, mall intercepts, digital advertising, billboards, direct mail, etc.—as well as a focus on enrollment. Connecticut, for example, raised public awareness (unaided) from 14 percent in June 2013 to 30 percent by October.[3] Washington took a broad approach with a universal message—"Here's a new way to get insurance and you should check it out." Unaided awareness of Washington's marketplace increased from 19 percent in September 2013 to 49 percent in November 2013 to 57 percent in April 2014.[4]

Beyond mass messaging, each state contracted with a vendor to conduct research to better understand its own population profile and segments, what they wanted from the SBM and if/how the SBM could best position itself to serve them. Washington used these data to get navigators to take messages to specific target segments. Connecticut purchased Thompson-Reuter's data on insurance rates by town to target most of its enrollment events and its two storefronts in communities with the highest numbers of uninsured.

Most SBMs targeted young adults (especially males), low-income households and Hispanics. For example, Colorado ran a young adult campaign with ads featuring young people during broadcasts of Colorado Rockies baseball games. In addition, they created specific messaging and videos for young adults, placed paid media on Hulu, aired radio spots on Pandora, Facebook, and cable and network stations that are popular among this demographic and conducted mobile phone texting advertising for young adults. Colorado also sponsored a rap concert at Red Rocks, giving out branded hand warmers, beanie hats and brochures. In addition, Colorado fielded "Street Teams" at approximately 230 locations, focusing on places where young adults congregate—including pubs and shopping areas—and as a result, spoke with more than 64,000 people.

Public Awareness of State-Based Marketplaces and Advertising Campaigns: *Pre- and Post-Outreach*[5]



**Kentucky's percentage reflects aided public awareness (comparative data was unavailable pre-campaign). This means that the interviewer mentioned the name of the SBM (kynect), described what it does and then asked if the respondents had heard of it. All other data is reflective of unaided awareness where the interviewer simply asked the respondents if they were aware that they could get health insurance through the new state-run insurance marketplaces.*

Washington partnered with the concert promoter Live Nation to tie education efforts with select Live Nation concerts across the state. Kentucky focused on establishing a physical presence at events frequented by young people, including regional sporting events, the Kentucky Bourbon Festival, Newport Oktoberfest, the Bourbon and Blues Festival and several half marathons in various locations around the state. Connecticut also hit the beaches over the summer, knowing that young adults would congregate there.

While these activities built awareness among young people, it is hard to know whether they generated a great deal of enrollment (in pre-/post-campaign metrics, young adults' awareness generally increased after the campaign, but still lagged behind awareness among those older than 30). Connecticut tried to go one step further with its outreach to young people. It partnered with Clear Channel to sponsor raffles with concert tickets as prizes for listeners who actively engaged with the marketplace (e.g., by visiting its website or tweeting about the ACA or the SBM). Washington also used free tickets to the concert series it sponsored with Live Nation as a draw to call prospects to act—many online pieces promoting the concert series linked to *Washington Healthplanfinder's* Facebook page, which hosted a promotional contest for free tickets to the Sasquatch! Music Festival Launch Party and V.I.P. tickets to both weekends of the Sasquatch! Festival.

Rhode Island took a somewhat different approach by targeting segments on their propensity to purchase health insurance, rather than relying on demographics or geographic profiles. The state reasoned that traditional market segmentation strategies are less helpful when it comes to defining what motivates core buying groups. Under this approach, Rhode Island developed a model built on the basis of who wanted the coverage most and who the marketplace needed the most, and then projected the costs of reaching these audiences efficiently. To best gauge the level of need for insurance, Rhode Island began by dividing its population into two groups, the insured and the uninsured, but took care to focus on those uninsured individuals who would be eligible to purchase subsidized coverage. In the final analysis, Rhode Island determined that small businesses were their first priority because they represented the largest pool of potential enrollees. Employers who currently offer coverage are seen as the more likely sale, but non-offering businesses are also part of the Small Business Health Options Program (SHOP) target

audience. Rhode Island is intent on converting as many non-offering businesses as possible because sales will build SHOP membership and many uninsured are likely to gain coverage in the process.

Rhode Island's second priority group is individuals and families in the 36 to 65 age group, who are likely to have dependents and find the choice and customer service features of Rhode Island's marketplace most appealing. In targeting this age cohort, Rhode Island acknowledged that enrollees under the age of 36 are certainly attractive from a risk perspective, but are also a small and more challenging market segment to convert.

All SBMs agreed that it is important to start efforts well before open enrollment season begins. Washington enjoyed a big head start, beginning in 2010, the same year that the ACA was signed into law, with their efforts to get the word out about a new way for the uninsured to find coverage. Connecticut began a series of "Healthy Chat" meetings around the state and other promotional efforts in November 2012. Colorado and Kentucky formally launched their marketing and outreach campaigns in May 2013, including television and radio ads, digital and print ads, as well as in-person outreach events across the state. In July of 2013, Rhode Island kicked off their "39 in 3" campaign to hold an outreach and education event in all 39 of the state's cities and towns within a three month period. In early 2012, Kentucky partnered with two stakeholders (Kentucky Voices for Health and the Kentucky Health Cooperative) to develop an issuer neutral health insurance literacy seminar, titled "Health Insurance: How it Works," to successfully raise advance awareness. ***Starting early allowed these marketplaces to blanket the community with information about the ACA and the benefits of a state-based marketplace, raising awareness and collecting "qualified leads" well before open enrollment.*** Many stakeholders felt that the early start allowed states to get ahead of some misinformation, and therefore focus outreach efforts in the summer and fall of 2013 on driving enrollment.

The earlier a state began its campaign, the better it was able to coordinate with partners on the ground to help increase awareness and provide trusted intermediaries for hard-to-reach groups. All five states found that working with entities that interact with residents on a day-to-day basis was especially effective in getting the word out. These partners included the small market media, drugstores, grocery stores, food pantries, post offices, public transit, libraries, community health centers and tax preparation firms, just to name a few. Some more unique partnerships seen in Kentucky were navigators holding enrollment sessions in beauty salons or experts being invited to answer questions at local restaurants and bars.

Key to converting this outreach and promotion from mere awareness building into a step towards actual enrollment was using these educational opportunities to identify and capture contact information for prospective customers. Well before open enrollment began, Colorado generated approximately 12,000 leads, and Connecticut generated a total of 20,000 leads (8,000 from various enrollment events plus another 12,000 from its websites). Connecticut deployed a calculator on its website early in 2013, with various hypothetical household scenarios to engage visitors and illustrate how much they could save by enrolling and how much it might cost to go without coverage. Those who engaged with the calculator turned out to have a high probability of later enrolling.

Of course, these qualified leads needed to be kept warm by continuous outreach until they enrolled. Connecticut used what its ad agency, Pappas MacDonnell, refers to as a constant drip of emails, robo-calls, outbound live calls and mailings to refresh and try to convert leads to sales (see graphic on next page).[6] It tracked the efficacy of different outreach media and messages using vanity telephone numbers to track response rates, i.e., a different telephone number for each tactic, so that response rates could be measured for specific tactics. Direct mail turned out to be especially effective, so Connecticut used more and more of it.

Local entities, especially in smaller towns, can reach into a community without having to expend staff resources or additional advertising dollars. Anecdotally, many enrollees identified the people in their community as the best sources for information: family, friends, neighbors, clergy, physicians, pharmacists, hospitals and local government leaders. Word of mouth referrals were cited by many interviewees as the most influential and potent form of advertising. Kentucky recognized this early and made it a policy to never decline a request for a speaker or more information, no matter how small the event or the audience. Staff reported speaking to parishioners during or after services as a particularly effective way to establish contacts within a community. One navigator in Colorado mentioned a community listserv (unknown to outsiders) as the best and least expensive way to reach the residents of her town; another discovered through trial and error that inexpensive advertising at the local movie theater was incredibly effective. More than a few Washington brokers relied on simple poster boards in their local communities or chats on local radio programs to get the word out. If these local entities are there to follow up on such outreach efforts with active assistance in enrolling, then the integration needed to ensure that marketing leads to closing sales is also much easier to achieve.

Connecticut experience: Enrollments were made possible by multiple touches, from awareness and education through engagement.

2. **Move from a shotgun approach for building awareness to more targeted marketing.** *Continue to generate leads for brokers and other enrollment assisters, but develop less expensive ways than those typically used in 2013 to build awareness. Having built a baseline of awareness, SBMs must continue some mass media to maintain it, but should target advertising dollars to high-priority segments (e.g., postcards and billboards in certain zip codes, foreign language media, digital advertising).*

With a higher percentage of the population now aware of the ACA and with fiscal sustainability of increasing concern, SBMs should build on the less costly outreach tools that provided the most measurable success during the first open enrollment season, such as direct mail and enrollment centers. One of Kentucky's most successful initiatives was sponsoring the Cabinet for Health and Family Services area at the Kentucky State Fair. SBM staff manned a booth during all 12 days of the fair and gave away an estimated 50,000 *kynect* tote bags with informational brochures. Before handing out the branded bags, marketplace staff would answer questions and provide background information. The brochures were inexpensive to produce and many applicants referred to them when speaking with the call center during first few weeks of open enrollment. For the next open enrollment period, these events should focus on disseminating low-cost informational material, enrolling on-site or referring qualified leads to brokers, navigators and CACs in their communities.

In Washington, Kentucky and Rhode Island, partnerships with local libraries were regarded as particularly successful, low-cost venues for outreach and enrollment events. Public libraries are trusted institutions that often provide outreach and programming for a multitude of interests and people of all ages, ranging from tax assistance, to job labs, to language services for non-English speaking citizens. In Washington, many libraries also provided an extra supply of laptops with internet access for enrollment events, and some libraries promoted the availability of coverage on their own websites (for one example, see the Fort Vancouver Regional Library page designed to help people navigate state-specific ACA-related information: http://mylibrary2.fvrl.org/AffordableCare.html). Kentucky held two "Sign-up Saturday" events where they had navigators in libraries in

Kentucky residents receive kynect tote bags at the Kentucky State Fair.

almost all 120 counties across the state. The two events, held in December and March, garnered good earned media and successfully enrolled high volumes of individuals and families.

Providing a place for motivated shoppers to get their questions answered, their problems addressed, and to shop and enroll, and orienting outreach around these enrollment centers, clearly connects the entire process flow. Connecticut realized a 50 percent close ratio at its two stores from heavy daily traffic, most of which was unscheduled walk-ins. Rhode Island ascribes approximately 17 percent of its 70,000 enrollees (QHP and Medicaid/CHIP) to walk-ins. Colorado sent over 700,000 emails to account holders during open enrollment informing them of deadlines, enrollment events and walk-in sites in their communities. Colorado achieved a 42.7 percent open rate on emails, far higher than industry standards on email campaigns.

Social media and digital integration will continue to be an important channel for SBMs to reinforce their brand and call prospective clients to action. Many consumers will go to a search engine first to find health insurance information or their state's marketplace website. Searchable and shareable online content should be in place prior to open enrollment, and this content should be more and more self-generated, i.e., testimonials from enrollees and news/announcements created to be shared through social media channels. With the success of in-person outreach, this may also include more interactive community events or publicized online events. Video testimonials from enrollees, online Q&A sessions and TV ads seemed to be the most popular materials on social media. In addition to television ads, Connecticut, Colorado, Washington and Kentucky released informational videos on YouTube for targeted populations including the self-employed, small business owners, families and the unemployed. While the unique views of some of videos remain low, states should continue to grow these low- or no-cost information channels.

SBMs may also find that coordination with CACs located at hospitals and health centers is a productive, low-cost enrollment channel.[7] Connecticut found that CACs actually accounted for more enrollees than navigators, and cost the SBM nothing (for obvious reasons, health services providers are strongly motivated to help with outreach and enrollment activities). States should focus on those delivery sites with large proportions of the uninsured and find ways to partner with them. The social workers or discharge planners on staff at these facilities may be an excellent untapped resource for the marketplace to work with to understand what enrollment barriers continue to exist for the uninsured. Providers themselves also need education. A properly informed physician's office staff can offer not only great care to consumers, but also peace of mind about the marketplace itself. In one state, local boards of health were encouraged to conduct meetings between representatives from the SBM, health clinics and several medical and community organizations to coordinate efforts to implement the health law locally. As a result, area hospitals reached out to uninsured patients who frequented emergency rooms for routine conditions or who arrived very sick because they had forgone care. If there weren't CACs on staff, patients were provided information on the SBM and contacts for navigators to help them enroll.

3. **Develop a simple, effective renewal process in conjunction with brokers, navigators and issuers.** *SBMs need to develop both subsidy redetermination and QHP re-enrollment processes, including decision support and default options. They also need to develop corresponding communications plans. Since these enrollees are also clients and members for brokers, navigators and issuers, they all should be included in joint planning for the renewal process, if only to clarify their respective roles. Doing so as soon as feasible will help in executing a systematic, timely and consumer-friendly renewal process.*

After the abundance of operational challenges that SBMs confronted in the first open enrollment, none should be surprised by the need to adequately prepare for 2015 renewals. SBMs should develop, communicate, test and finalize their processes for renewals as early as possible and begin to train partners on these new processes.

To support a smooth renewal process, an SBM should develop routine processes for standard, easy renewals, including a balance between easing auto-redetermination and encouraging active consumer shopping within the regulatory framework provided by CMS.[8] This will be challenging enough, including both operational readiness and making decisions on important policy issues, such as automatic re-enrollment. In addition, adequate planning includes identifying and preparing for special problem cases, such as those families that may need in-person assistance because their members are covered by different programs, enrollees in QHPs with double-digit premium increases or reductions in service areas. Using filing data from health insurance carriers, the SBM should project the impact of changes in the second lowest-cost silver plan (in each rating region) and which enrollees will be most adversely affected by such swings. Identifying these groups as far ahead as possible will allow time to develop ways to cushion the impact, and to provide support through brokers, navigators and call center staff trained on handling these more difficult situations.

SBMs should be thinking now about whether and how they want to impact choice dynamics for QHP renewals. Some states will have new entrants to the market that require changes to comparison tools and education materials, and new plans need extra exposure and explaining. For example, Connecticut's co-op did not feel that it was given an adequate opportunity to explain itself to navigators, and Connecticut expects to offer more issuers in 2015 and 2016. Explaining these new options to consumers, and deciding on how to balance the benefits of auto-re-enrollment (increased enrollment) against its anti-competitive impact is something SBMs should decide soon. Specifically, the SBM should consider a default option of a passive renewal scenario versus requiring active redetermination and enrollment, and should seek buy-in to its preferred approach.

The SBM should also reach out to people who started accounts during the initial open enrollment period, but failed to complete the process. The easiest group to reach out to would be those individuals who selected a plan, but did not pay their first month's premium. Estimates show that they represent 10 percent to 20 percent of enrollees, but Kentucky estimates 32 percent and Colorado recently estimated 35 percent did not pay. Even at 10 percent to 20 percent of enrollees, this is a large target market. While some of these people may be unable to enroll again until November 2014, it may be useful to begin communicating with them once 2015 marketplace rates are public, especially if some rates decline.

The other group to contact consists of those individuals who never completed their applications. During the first open enrollment period, resolving application problems was often difficult. Consumers didn't know where to go for help and sometimes were unable to get issues resolved even when they went to the right place. As a result, many consumers abandoned their applications. Of course, improving the process for resolving their application problems would also help. SBMs that have email addresses for these individuals should survey or meet with them to assess what roadblocks prevented these consumers from completing enrollment.

SBMs are generally aware that the risk is high for confusing enrollees in this first renewal anniversary, both because of the absence of prior experience with renewals and because they represent an important source of enrollment for 2015. The partnering entities—brokers, issuers and navigators—will have maintained a stronger communications link with many enrollees than the SBM has, simply because enrollees are likely to turn to these parties for answers to coverage, claims and billing questions throughout the year, especially if the issuers collect premiums directly. These parties share an interest in renewing eligible individuals, simplifying messaging and redetermining subsidy levels as accurately as possible. Therefore, SBMs should seek to leverage and coordinate their partners' activities, including early consultation, planning and training.

As the issuers and brokers are accustomed to renewal procedures, and some of the navigators have experience with annual redetermination issues, SBMs can learn a lot from their partners about how to plan for this fall. Actively engaging them in an open dialogue about any issues from the first open enrollment period, coupled with their questions and concerns about the next enrollment season, is a good way to build trust.

4. **Develop a cost-effective physical presence in communities.** *Test and evaluate different ways to configure walk-in sites located in densely populated, high-need areas of the state. The experience with stores and vans and buses on tour seems to have been positive enough to justify this tactic. As the focus shifts from awareness and education to maximizing enrollment with a limited spend, SBMs should track the cost per acquisition for different set ups in cities and smaller towns such as: permanent stores, roving vans, or pop-up centers, staffed by the SBM's employees, brokers, assisters or some combination of all three.*

Wrapping a touring RV or bus to generate local buzz increases awareness and provides coalition partners with opportunities for outreach and recognition. Better yet, for population centers, walk-in stores or pop-up centers proved very effective for enrollment, particularly if well located. Enrollment centers physically reinforce the presence of the SBM in target communities, and provide a setting where consumers who feel stymied can get the personal attention they need; and the centers can be staffed by a combination of brokers, navigators and paid marketplace staff.

Both Colorado and Washington used a vehicle wrapped with their branded graphics to stop in cities and towns on designated days during the open enrollment season. Typically, local media was used to promote these enrollment events or at least turned out to cover them. In Washington, each of the 10 navigator-lead organizations was given its own date for an appearance by the SBM's bus. While the number of on-site enrollments varied at each stop, virtually all of the entities reported significant earned media from their events, and the partnering agencies received a promotional boost for their efforts in staffing and endorsing the event. The five-week tour secured more than 60 stories across various outlets, and a media monitoring service estimated that the coverage generated the equivalent of $1.4 million in paid advertising.[9]

The exterior and interior of Washington's enrollment bus.

Colorado partnered with a large grocery chain, King Soopers, often parking the RV in its parking lots, and setting up its information and enrollment tables inside the stores near the check-out counters. The RV was driven by staff, and the enrollment tables were staffed by a combination of local navigators and employees. (Brokers said they attended a few stops, but found them to be relatively less efficient compared to other venues for enrollment. A general complaint from agents in several states was that many SBM-organized events were not optimally organized for efficiently processing as many enrollments as possible.) Colorado's RV Tour in December 2013 included an earned media campaign that generated over 20 media stories, including print, radio and television. The December RV campaign was so successful that Colorado chose to keep leasing the RV through the end of open enrollment, driving over 3,300 miles across the state to dozens of events.

Connect for Health Colorado RV in Grand Junction during the enrollment tour.

Both SBMs consider these vehicles to have been successful. While enrollment directly at these events was modest, they generated media attention and attracted considerable local foot traffic.

Based on the recent Enroll America survey[10] suggesting that local news was the top source of information about the new insurance options, high-visibility events that attract local news coverage may be cost-justified for outreach. For the next open enrollment season, ***as the focus shifts from building awareness to renewal and enrollment, it will be important to evaluate the cost-effectiveness of continuing this effort; in particular, can inexpensive, local advertising be used to drive a large number of qualified leads to these events, and can the events be used efficiently to enroll large numbers?***

Interestingly, Connecticut used their advertising spend somewhat differently than Colorado during the earlier months of the open enrollment season. Connecticut spent advertising dollars driving people to their enrollment centers and their website. For example, it not only advertised on Clear Channel radio to reach young adults, but raffled off free concert tickets to listeners

who visited the SBM's website or attended an enrollment event. On its website, Connecticut used a calculator to engage visitors in figuring out how little it would cost to buy coverage versus how much it might cost to forego insurance. Of course, the website itself was an almost no-cost vehicle for engaging consumers, and at the enrollment centers—far more so than at enrollment events—enrollments could be processed very efficiently. In March, Colorado switched a portion of its radio, digital and TV advertising to promote five newly developed walk-in sites. Colorado also conducted countdown campaigns on digital and outdoor media (10 days left to enroll) to drive the message about the deadline.

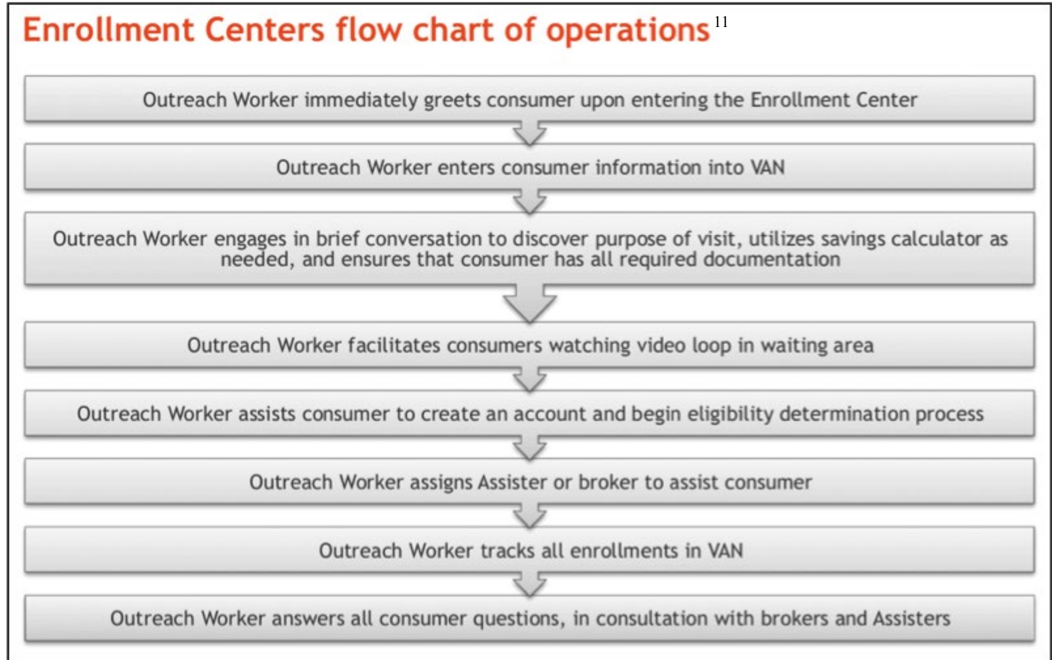
Enrollment Centers

- One-stop shops for consumers to utilize technology, receive in-person help, and access services of brokers and Assisters
- Locations
  - New Britain (200 Main St.)
  - New Haven (55 Church St.)
- Hours
  - Monday - Friday: 12 pm - 8 pm
  - Saturday: 10 am - 4 pm
  - Sunday: 12 pm - 4 pm

On the other hand, stores represent a major investment: Connecticut planned to develop a half-dozen, but opened only two in New Haven and New Britain. Modeled loosely on Apple stores, both drew a lot of foot traffic from their own cities and surrounding towns. They were productive, but that was not their only benefit: like RVs and buses, they also generated considerable earned media, and presented the public face of the marketplace. In addition, brokers, navigators and staff interacted and learned from each other at the stores. They will also be used as training sites later in 2014.

An employee who had previously managed bookstores opened and managed Connecticut's two insurance stores. One storefront is 2,100 square feet, the other is 3,000. Each site is leased for one year and took about six to seven weeks to build out and open. Over time, Connecticut worked out an effective staffing arrangement, with greeters to help triage walk-in or scheduled visitors, navigators to work on eligibility applications and Medicaid enrollments and brokers to help qualified prospects understand their options, enroll and make plans for premium payment. The SBM also learned to open stores earlier (10 a.m., rather than noon, as originally scheduled) to capture the heaviest foot traffic, and moved from scheduled appointments (with many no-shows) to heavy reliance on walk-in traffic.

The stores have about 50 percent close ratios, meaning that half the customers who walk in actually enroll; by comparison, contact centers handled 10 to 20 times as many separate calls during open enrollment as actually enrolled in total. In March, their combined enrollments averaged over 100 *per day*, and they were open seven days a week. A broker could come in for part or all of a day, process 10 or more enrollments, and conduct other business out of a private office in between enrollments. One very supportive broker said she eventually stopped attending enrollment fairs altogether in favor of staffing the stores because they were so efficient and productive. She added 1,000 new clients during this open enrollment period, and these same clients are now calling her back for homeowners, auto and life insurance.



The cost of building out both stores was $149,000, and the cost of operating both of them was $23,600 per month, including rent, staffing, signage, utilities, etc. New Haven was actually 30 percent more expensive to operate than New Britain, yet it produced far fewer enrollments. Staff ascribes the difference in performance to site selection of the store, rather than differences in the regions they serve. For example, New Britain seems to have had more success being located in a more secure neighborhood with adequate parking. While far from inexpensive to operate, the CPA for both stores was moderate—far higher than brokers and a few other channels, but considerably lower than some channels. As a result, Connecticut plans to maintain its stores for 2015, but not to expand this approach. Rather, it is considering ways to work with "lead" brokers and other, more cost-effective alternatives for establishing a branded, semi-permanent presence in communities across the state.

	NEW BRITAIN[12]						
Months in Operation	OCT	NOV	DEC	JAN	FEB	MARCH	**TOTAL**
Total Enrollments	10	320	1143	772	760	1941	**4946**

	NEW HAVEN[13]						
Months in Operation	OCT	NOV	DEC	JAN	FEB	MARCH	**TOTAL**
Total Enrollments	–	105	538	427	369	1307	**2746**

Other states learned from experience that their clientele liked to walk in and enroll in person. So, in addition to its walk-in office in Providence, in March, Rhode Island opened another walk-in center in Warwick. Interestingly, both sites are not located in a retail or otherwise consumer-friendly area, yet both were extremely successful. Walk-in enrollments in Rhode Island totaled 11,800, or about 17 percent of their 70,000 enrollments for Medicaid and QHPs. Similarly, Colorado recognized the value of walk-in centers as open enrollment built to a crescendo in March, quickly setting up five different venues. Colorado staffed the pop-up centers with a combination of employees, brokers and navigators, inviting the most productive to participate. In total, they accommodated 2,600 customers, generated over 700 enrollments on the spot and hundreds of applications for completion at a later point. Sites were staffed by brokers (75), navigators (11) and employees (22).

Providence, Rhode Island walk-in center.

5. Integrate all marketing and sales activities into a coordinated effort focused on enrollment. *Sales and marketing activities can be most readily integrated by a single, unified management structure under a senior manager responsible for advertising, other promotional activities, internal sales staff and management of external sales channels.*

SBMs organized their outreach and enrollment efforts along a number of different models:

- By stakeholder groups, with separate managers of SHOP/brokers, of navigators and of QHPs and issuers, each reporting up the line separately;
- By function, with separate managers of communications, of enrollment, of customer service and of operations, each reporting up the line separately; and/or
- By end-goal, with managers of related processes all reporting to one director of sales and marketing.

If the SBM does not already have a fully integrated sales and marketing team under one accountable manager, it may have good reasons not to. However, this model has some obvious advantages. Because sales do not occur until a prospect completes all the steps in the process, and because so many different stakeholders or partners might touch the prospective customers, having one senior manager accountable for overseeing most of the steps and most of the external relationships in this marketing and sales process should increase coordination and facilitate timely prioritization of tasks and focus on a common goal.

By contrast with some SBMs, for example, Kentucky invited brokers and navigators early on to an advisory group to get to know each other and jointly advise the marketplace on how to differentiate their roles. Connecticut put all functions related to marketing and sales (except management of the call center) under one senior manager, and used the same database of the state's uninsured trial to drive the placement of advertising and the location of enrollment events and its stores. To further integrate marketing and sales, Connecticut hired approximately 30 full-time enrollers to staff outreach events, retail intercepts (e.g., malls) and stores. These were generally young people with political campaign experience, who were brought in for the intense outreach and enrollment work that began in July 2013 and ended in April 2014.

6. Leverage commercial insurance sales expertise on-staff and adopt standard industry measures. *SBMs need to understand, measure and manage their various enrollment channels—stores versus broker, versus navigator, versus website, versus call center—and they also need to manage diverse marketing and sales tools effectively. This requires analytic depth and experience on-staff with commercial health insurance.*

The key to long-term customer sales planning and budgeting is the cost of acquiring a customer and the longevity of lives acquired through various marketing efforts and sales channels. What do storefronts cost per enrollee, versus brokers, versus navigators, versus the website, versus the call center? Because the same customer may well receive information from multiple sources and be served by more than one sales channel, there is an art as well as a science to the measurements. Both begin with building systematic data collection and reporting all marketing and sales-related activities. For SBMs which did not do this last time, building the capability to do so going forward will be critical to managing the return on their investments. For illustrative purposes, we include links to a series of reports that Connecticut uses to manage marketing and sales activities. (See Appendices: A.I – Summary Report; A.II – Enrollment Activity and Penetration Report; A.III – Enrollment and Cost Projections for First Open Enrollment Season; A.IV – Enrollment Results by Month; and A.V – Cost Per Acquisition Analysis)

Advertising and communications expertise can be contracted through agencies—although managing any vendor requires considerable expertise on the client's end—but broker management in particular requires in-house experience with this specialized sales channel. Building trust with agents is critical. Brokers in several states said that they worked with SBMs because they knew and trusted the former broker who had been hired to organize and support the broker sales channel. Connecticut hired three brokers on staff, and insisted that the outsourced call center hire brokers as well. Connecticut also contracted with another broker in the field to help recruit and train her colleagues. In fact, the majority of Connecticut's sales and marketing staff, including its Executive Director, had experience in sales and marketing of commercial insurance.

Washington hired four support staff members to work with brokers in the field, and all four are licensed brokers with health insurance experience. A fifth position is being contemplated for the next open enrollment season when the state plans to expand SHOP. (In 2014, SHOP was only available in two of the state's 39 counties due to a lack of carrier participation.) Rhode Island also leveraged the use of licensed brokers in staffing for their SHOP exchange (brokers do not play any role in the individual market in this state). The broker liaison is a licensed broker with prior experience in the sales department of the state's largest carrier, and the manager of the contact center's broker relations team is a licensed broker who previously worked at several regional carriers.

7. Carefully manage the cost of acquiring enrollees. *To evaluate acquisition costs, SBMs should track the cost and results of marketing campaigns and sales channels in order to compare the costs for enrolling customers in QHPs, using standard metrics and techniques for direct marketing and sales.*

Individual sales are very expensive compared to group sales. With federal grant support winding down, SBMs must be more conservative in budgeting for marketing and sales; Colorado and Connecticut have budgeted to spend about half as much for this function next year as they did last year, and major reductions are expected for all SBMs. The challenge of efficiency in sales now takes on far greater significance.

Marketing may have to begin by building awareness and brand, but eventually it must focus on priming the pump of the sales process, i.e., identifying qualified leads and/or calling the retail customer to access a sales channel (walk-in visit, contact a broker or navigator, call the SBM or visit the website). Even at the point where a motivated customer initiates contact, there are still many opportunities to lose the sale. Barriers to enrollment, such as a challenging web experience, long waits to reach a customer service representative (CSR), multiple transfers, dropped calls, time-outs, inability to resolve problems in one call, different answers from different CSRs, glitches in generating bills, etc., will decrease the close ratio. Efficiency requires integration and operational excellence from end-to-end.

A standard metric of efficiency in retail sales of this nature is the CPA, meaning the dollars spent to attract and enroll a subscriber. The total CPA typically includes advertising, other promotional expenses, website maintenance, shopping and enrollment through the contact center(s), sales and marketing staff, support for navigators, premium billing and collection and broker commissions. To the extent that these costs are borne by issuers rather than the marketplace, they can be excluded from the SBM's own CPA, but they still affect premiums.

The average CPA can be compared for different sales channels, as a way to measure their relative efficiency. For example, Connecticut calculates that the average CPA for its stores is a little under $180 per subscriber. This is more efficient than brokers (if their commissions are included), navigators or the call center. However, customers often use multiple channels for shopping, especially the website and the call center, in addition to using a broker or navigator. So care must be taken in comparing these costs. Some of these channels serve multiple purposes, in which case their costs cannot be attributed solely to customer acquisition. A classic example is the call center, for which it is helpful to divide calls and costs into pre- and post-enrollment contacts.

CPA can also be compared for different channels against the revenue stream over the average lifetime of an enrollee, i.e., the monthly user fees or premiums. Channels will differ in the average household size that they deliver and the tenure of the enrollees they bring in. For example, brokers in Connecticut's individual market brought in slightly larger households, on average, than other channels. Several of the states captured data from every channel on each encounter, including race/ethnicity, length of interaction, referral source and problems with enrollment. Using these kinds of tools to evaluate and adjust marketing and sales strategies is standard procedure in direct-to-consumer sales. They can be used, for example, to test one advertising strategy against another, or to adjust the mix of direct communications and enroller capacity in a locale. They do require collecting key measures as a matter of routine reporting by channel. Not every SBM was able to collect these data systematically, and without such data, undertaking efforts to approve efficiency will be somewhat like flying blind.

8. **Recognize and accommodate the different roles of navigators and brokers.** *Do this by: (a) introducing and helping brokers and navigators work together or make referrals to each other; and (b) developing data collection tools that allow both to share credit for cooperating on enrolling a client.*

Navigator and broker management is challenging, and the two groups differ in mission, experience, prior training and expectations. Importantly, navigators do not generally depend upon the volume of enrollments to determine compensation, and are oriented by mission and licensure status (or lack thereof) to fulfill a different role than most health insurance agents. Many navigators expect to help clients with income-related eligibility determination, are familiar with Medicaid and CHIP and help in accessing a variety of social and economic supports. By contrast, brokers are paid by carriers as producers (of enrollment), and focus on coordination with the health insurance issuer and ongoing service issues with commercial insurance, but are generally unfamiliar with Medicaid, CHIP and other support programs. Many navigators may view their role as supportive, with or without enrollment, whereas brokers define their productivity in terms of enrollment and renewal.

These and other differences led to some mutual suspicion and distrust between brokers, navigators and the marketplaces. For one, brokers expressed fear that marketplaces intended to replace them with navigators, or to sell directly to prospective customers without any intermediary for enrollment. For example, one broker complained of massive advertising by the marketplace, and that such ads never mention brokers; another broker in a different state complained that the marketplace's website almost seemed to hide the names of brokers. This broker did admit that as open enrollment proceeded, the marketplace made more frequent and more prominent mention of brokers for consumers who wanted their help. Other brokers stated that the marketplaces should promote the broker's role in assisting consumers and explain that using a broker does not cost the enrollee anything. (Brokers pointed out that many prospective enrollees simply do not understand that commissions are included in premium costs and shared by all enrollees, regardless of whether an enrollee uses a broker or not.)

Some navigators mentioned that they had never worked with brokers in their areas, and only happened to meet at enrollment events sponsored by the marketplace. Many more expressed a concern that the navigator's duty to remain issuer-neutral precluded them from working with brokers who are perceived as biased in favor of whatever issuer pays the highest commission. In fact, health plans (not brokers) establish the broker compensation programs, which tend to be competitive, if not exactly the same, but (a) there are differences in compensation from plan to plan, and (b) there are some plans that do not use brokers or that have a very different broker footprint and program than competing plans. (Similarly, CACs work for providers affiliated with some health plans and not others.) Some SBMs, including Colorado and Oregon, require all issuers that use brokers to pay fees and commissions in effect to any willing broker, but depending on the market such requirements can backfire on SBMs. Bias in the sales channel by any type of assisters can be a problem for marketplaces and consumers, but whether and how SBMs should intervene to promote even-handed consumer assistance remains a topic for debate.

Still other navigators complained that when they make referrals to brokers, the broker gets full credit for the enrollment and the marketplace is unaware that the navigator helped educate and determine eligibility for these enrollees. Because the broker is paid by the health plan and the navigators are supported by grants, it should be possible to work out these sorts of obstacles to referrals.

Where collaboration and collegial relationships were encouraged, experience and exposure seemed to reduce these barriers, to the point where brokers who were active and wanted to participate felt that their services were valued by the marketplace; ***some brokers and navigators expressed appreciation of their complementary roles and desire to work together***. The differences in roles between many brokers and navigators, their access to specific linguistic, ethnic and other communities, and their contacts among and appeal to insured versus uninsured residents, can tend to obstruct cooperation. Alternately, these complementary strengths can be harnessed to promote enrollment in QHPs and Medicaid/CHIP if the marketplace can identify the most productive and cooperative brokers and navigators in each area, work with them to develop complementary roles, training and other supports and actively facilitate cooperation. For example, providing an electronic application form that allows both a navigator and a broker to share credit for an enrollment would recognize and encourage such cooperation. Triaging through the call center and website requests for assistance between brokers for QHP selection and navigators for Medicaid enrollment and special complex household eligibility cases can help as well.

9. **Refocus broker and assister training for 2015 on hands-on enrollment issues.** *Focus navigator and broker training programs less on the basics of the ACA, and more on the specifics of the insurance application and the operational support available for problematic cases. While the rush to ready operations for October 1, 2013, may have prevented timely, hands-on training last year, in-person training in advance of November 15, 2014, on the systems to be used for enrolling—and renewing—clients will be critical.*

Both navigator and broker training were challenging for the first open enrollment period. In one state, outreach to the brokers began early and training was conducted by two experts, one of them an active broker who specialized in helping applicants who were denied coverage for pre-existing conditions. The SBM also hired several brokers well in advance of the fall to manage broker relationships by answering their questions on the fly, inviting them to enrollment events, overseeing their training, etc. By contrast, this same state only identified and began training navigators in October of 2013.

Ironically, the brokers in this state expressed more concern than the navigators about the inadequacy of training because it was more theoretical than hands-on. They particularly hungered for training on the system that they would actually use to enroll consumers. In another state, brokers articulated this same issue, but added that it was because the IT system was evolving in real-time throughout the enrollment season that their hands-on training was not very useful. Of course, this SBM (like all others) was in the difficult position of trying to understand its own role, while simultaneously understanding the roles of its outreach and enrollment partners, building and testing its systems and training all its partners on the system. As a result, training was considered wanting, especially by brokers. They did, however, understand the difficulty the SBM faced, but hoped for substantial improvement in training for 2015.

In addition, both brokers and navigators in several states specifically referenced the lack of adequate training to help self-employed individuals calculate their modified adjusted gross income (MAGI) correctly. Others cited difficulty in providing direction on how to report the number of people in a given household and suggested more pop-up information boxes to provide enrollees tips on this calculation. Many brokers and navigators noted that the application itself suggested that both enrollees and assisters were more knowledgeable about the basics of tax filings than they were prepared for. And importantly, both brokers and navigators reported that some of the most perplexing application-related issues could not be answered by anyone they contacted at the SBM (some issues remain open to this day).

For SBMs that have experienced one enrollment season, and are modifying existing systems, there is an opportunity this fall to revamp training and recoup support from brokers and navigators. A remedial course in all the basics of the ACA and marketplaces can be provided online, but personal support (or real-time, online training) in using the eligibility determination and enrollment systems would likely be very welcome and would provide an early venue for feedback from the field. Other skills in need of sharpening might include teaching elementary health insurance literacy, use of the SBM's decision-support tools and the likely financial impact on beneficiaries total spend of various cost-sharing features.

10. **Identify the obstacles to enrollment and ensure their correction.** *First and foremost, SBMs must fix their systems, and a systematic assessment would be very helpful. Evaluate the obstacles to enrollment and ensure delivery of those components critical to an easy and simple enrollment experience. Flexible, scalable call center staffing will be critical.*

The user experience with the website and call center is a critical element of the enrollment experience, and improving it is crucial to reputation management. Kentucky's operational readiness paid off when midway through its first full day of operation, nearly 60,000 individuals seeking information about affordable health care had visited its website. By day 10 of open enrollment, nearly 10,000 Kentuckians had enrolled, and the pace of enrollment actually picked up for the rest of the month, averaging just over 1,000 Kentuckians a day.

By contrast, long wait times on the telephone were typical in other states during the first weeks and months of open enrollment. After hours and weekend access were necessary just to sustain even low levels of customer service. And now, stakeholders are wary as they begin to hear about the next generation of systems capabilities before the most basic problems with the existing systems are fully repaired. This time, the fixes should be rolled out and tested serially, so that programmers can identify which fixes have failed or have created new problems.

During the last open enrollment period, SBMs increased staff to compensate for IT deficiencies and cumbersome processes. For example, Colorado eventually hired eight trainers to go into the field to work with brokers and their employers who could not get through the SHOP enrollment process. Colorado estimates that it could take 20 hours to enroll a small group of five employees in SHOP. Clearly, systems need to be improved to remove these kinds of impediments to enrollment.

Kentucky highlighted the benefits of partnering with willing navigators and brokers in evaluating changes needed to customer service or the enrollment process. Kentucky relied on these entities to test the online application prior to going live, to provide daily feedback on consumers' experiences, and to record needed system changes. Kentucky credits these front-line resources as a key source of information about what worked well and not so well for consumers using the website or contact center.

Some SBMs are now considering adding a responsibility to their contracts with navigators to drive program improvement. In several states, assisters complained that the "one front door" policy for prospective enrollees did not seem to apply to brokers and navigators trying to get both QHP and Medicaid answers; SBM and Medicaid staffs were unable or unwilling to assist callers with questions they viewed as "belonging" to the other side. Assisters felt caught in the middle and struggled to find an efficient way to get answers to their questions.

SBMs must staff to and plan for surges in application/enrollment volume via multiple channels during open enrollment. After experiencing challenges during the initial weeks of open enrollment, Kentucky worked with its IT vendor to plan in advance for surges in application volume. This meant that no matter what was working (or not), and even during technical releases, the system had to be prepared to handle a planned number of applications. Surge planning focused the vendor on what was critical—getting applications through the system—and set expectations for server bandwidth. It also focused the SBM on funneling applicants to the website during these surge periods, both through organized triage at the contact center and by alerting navigators and brokers on when to expect these high-performance intervals.

Flexible, scalable staffing at the call center should allow SBMs to use data from the first open enrollment (call volume, wait time, call length, call type, walk-in numbers, verifications and turn around on paper applications) to plan for surges in consumer support at the next open enrollment. Customer service resources will need to adjust for renewal communications, open enrollment deadlines, tax season questions, IT/website releases, mailings, advertising, etc. Similarly, resources should also be adjusted to support navigators and brokers. Perhaps most importantly, SBMs will need to be very mindful of the shortened open enrollment season for 2015, particularly in light of the holiday season, the competing priority of the Medicare and group open enrollment seasons likely impacting many brokers in November and December, and the large number of early 2013 renewals that will be terming late in 2014.

11. **Prioritize limited resources for the support of navigators.** *Focus limited human and financial resources on the most effective navigators for enrollment. On the one hand, this will necessitate culling navigators; on the other hand, continuing support for the more effective ones may be especially important for enrolling hard-to-reach target segments and for maintaining politically important alliances.*

Navigators can vary considerably in their productivity. For example, one navigator in Southwest Colorado seemed content to schedule four clients per day, and to refer those who were Medicaid eligible to a Medicaid/CHIP enrollment specialist. By contrast, another agency hired and trained 14 part-time navigators (7.5 full-time equivalents) for five locations north of Denver (Laramie County), and booked up very quickly. This agency developed an online scheduling system to process clients more efficiently: in addition to scheduling a time to come in, clients pre-populated the intake tool with information on household size, income, language spoken, current coverage status, etc.

Although no doubt working very hard, some navigators take pride in their focus on developing relationships and helping clients with a broad array of issues, distinct from the more transactional focus of the SBM's staff. "We take our time and build personal relations," said one navigator in Connecticut. By contrast, she further stated that " … the outreach staff allows no more than one hour per consumer."

The most successful navigators are already integrated into the communities they serve. When it comes to enrolling hard-to-reach populations and the uninsured, a localized approach can be very effective. For example, Kentucky organized and managed its program in accordance with the state's eight Medicaid managed care organization (MCO) regions. With many established organizations already serving Medicaid recipients, this structure was intended to align with the current outreach process, and to address specific needs of residents. Kentucky identified the demographics of each region and highlighted those population segments with the highest need. Responders were required to identify one hard-to-reach population that they had a history of working with, and what program customizations and accommodations they would undertake to make information and services especially relevant and accessible to this population.

In addition to assisting with individual applications and enrollments, navigators in Kentucky are required to work primarily in the community, facilitating outreach and enrollment at consumer locations and assisting Kentucky with local community events. Navigators must report their total driving time monthly, the number of locations/events attended and the ratio of total drive time to total number of hours spent on enrollment activities. In addition to reporting on the number of events attended (including venue, date/time and materials distributed), they must also provide a photograph of the booth or poster from the specific events to prove the accuracy of the report.

Kentucky also established a payment schedule and metrics tailored to each region. Fixed payments are made monthly to the navigator entities based on the entity's size and the region's demographics, with additional incentive payments made at the SBM's discretion. The number of applications each navigator entity is expected to process monthly is based on its size and the expected enrollment for that region. Outside the open enrollment season, navigators are still expected to facilitate outreach events and assist with any application or enrollment changes the consumer needs.

By contrast, utilizing a lead organization model, whereby the SBM contracts with regional organizations which then select and subcontract with multiple navigators in their region, seems to have had mixed results. Washington used this model with good success when enrollment was used as the measure. The state selected 10 regional lead organizations from across the state through a competitive request for proposal (RFP) process to manage the program. Lead organizations picked community partners to provide outreach and managed navigators' efforts. The RFP process forced organizations to think through participation requirements very early and carefully. Washington meets with all lead organizations monthly and maintains close coordination to handle issues. Compensation is based on both day-to-day activities and meeting performance targets. By April 2014, each of the 10 lead organizations had exceeded its enrollment target established for December 2014, and in the aggregate, navigator assisted enrollments were more than three times the target.

Similarly, Connecticut broke its small geography down into six substate regions, with a single lead organization for each region, including one Hispanic entity with both its own region and statewide responsibilities for Spanish speakers. However, Connecticut selected and trained its navigators, bypassing the six lead organizations, and navigators underperformed in meeting the SBM's QHP enrollment targets in the state (albeit this group achieved much success in other important measures, such as reducing health disparities and providing enrollees with other forms of social assistance).

We observed considerable variance in approach to managing navigators and in their individual performance. However, no single preferred approach to managing the program emerged from our observations.

12. **Consider building local marketing and sales plans around lead brokers for each community.** *To maximize the use of brokers as a free resource (excluding a few "non-brokered" markets), consider developing local marketing and sales plans built around lead agents for each community. Identify those producers across the state that are committed to, and capable of, retaining and enrolling many new clients, initiate a campaign early to recruit them, and focus sales resources and planning on supporting their efforts. Joint planning should aim to drive qualified prospects to them and support their efforts to develop highly productive enrollment processes.*

In most states, brokers are compensated for enrollments in the individual market through a sales commission that is "baked" into premium rates, both inside and outside the marketplace (Rhode Island is a notable exception, where carriers do not pay nongroup commissions). So long as issuers continue to pay commissions in and outside the marketplace, SBMs do not incur a separate cost for brokers, with an exception for the administrative cost of managing and servicing this sales channel. In this sense, brokers are a "free" resource—although clearly commission levels affect premiums.

In all four states where brokers are already active in the individual market, they produced far more QHP enrollment than did

navigators. In Washington, brokers assisted over 42,000 QHP enrollees and almost 29,000 Medicaid enrollees.[14] ***By comparison, navigators assisted less than 30,000 QHP enrollees, but approximately 244,000 Medicaid enrollees.***[15] Brokers were cited by Connecticut as a major factor in exceeding its enrollment target; they accounted for 31 percent of the QHP enrollment. In Kentucky, brokers accounted for 44 percent of total QHP enrollment, about three times as much as navigators produced. In Colorado, brokers accounted for approximately one-third of QHP enrollment.

While many brokers in the individual market are qualified, only some appear to be interested and willing to work with SBMs. Among those who are, only a few in each state aggressively pursued this opportunity for 2014 enrollment by adding staff, developing new record-keeping systems, learning the details of the ACA and actively recruiting new clients. The broker in Connecticut who helped train her colleagues estimates that only 20 or so brokers—out of 750 who started the training and 250 who produced any enrollment volume—fit this mold. Working closely with a handful of such brokers in each region of the state could be a very cost-effective way for SBMs to field a professional sales force that will not simply convert previously insured clients who qualify for subsidies, but will reach out to the uninsured.

A number of brokers interviewed expressed an interest in developing such partnerships with their SBMs, and some have already placed big bets on health reform. In Connecticut, for example, an individual who was interested enough in health reform to become licensed as a broker built his brokerage entirely around the SBM. An agency southeast of Denver expanded from 6 to 10 employees in preparation for open enrollment, conducted seminars throughout 2013 in libraries and other venues, opened its own enrollment center, sent out 90,000 postcards, spent another $50,000 to $60,000 on local ads and enrolled 1,000 clients. Of these, about 250 to 300 were conversions of existing clients, but the majority were new, often previously uninsured clients.

In Kentucky, a few of the larger brokerages began creating and disseminating information on the ACA as early as 2012. As the SBM formalized its policies on brokers and agents, these groups were able to publicize their services in lockstep with marketplace developments. Clearly, these were groups who saw the ACA as a business opportunity and, while many other brokers were still skeptical, took advantage of any opportunity to participate. Many successful smaller brokers in the state turned to the web to create an online presence for themselves as a primary channel serving SBM customers. Early difficulties with the website drove volume to these brokers who were offering “expertise” and “convenience” for shoppers.

In Washington state, the top selling brokers used a variety of ways to grow their book of business, leveraging the availability of premium subsidies to attract prospective buyers. Some brokers reported using “guerilla” marketing techniques, such as posting signs advertising low-cost coverage (“Obamacare is very affordable—call or visit me to see how you can sign up”). Others tapped into social media outlets or went on talk radio to tell people in their community about “Obamacare.” (A majority of brokers reported that “Obamacare” resonated with prospective enrollees, while the “Affordable Care Act” or “ACA” meant virtually nothing.) ***Word of mouth—particularly in hard-to-reach communities—was extremely effective in bringing in large groups of people who were personally encouraged by a highly satisfied friend or family member to sign up.*** In particular, many of the word of mouth brokers stated that they expect such referrals to increase for the next open enrollment season.

When asked, the more productive brokers expressed interest in looking for ways to partner actively with their SBMs. One agent suggested that he could organize and host group enrollment sessions for up to 20 clients an hour, four sessions per day during open enrollment, if Colorado’s SBM would help him reach out to prospects. He even offered to invite competing agents to participate in group enrollments at his site, similar to how Connecticut’s stores in New Haven and New Britain function.

Working with just a few such highly motivated brokers in each region of the state, an SBM could develop joint sales plans, organize cost-efficient ways to process high volumes of enrollees and create a cadre of “champions” among small business people who can recruit other brokers, as well as enroll many individual households. Developing a lead sales agent strategy and plans around such brokers seems a plausible strategy for effectively decentralizing outreach and sales, with high performance at minimal ongoing cost to the SBM. Working closely with such brokers on jointly funded outreach and servicing could generate even better results for 2015.

Some SBMs have already started to support top producers. Connecticut was successful in using their two stores to generate leads for brokers. Brokers could sign up for specified blocks of time to serve qualified prospects in the two sites. In Colorado, several brokers observed a progressive warming in their relationships with the SBM. Over time, they were invited to help staff enrollment events, it became easier to find them on the SBM’s website and the call center representatives would more readily refer customers to brokers for assistance. Eventually, the SBM identified the top 20 percent who wrote 10 plus sales, and referred clients looking for a broker to them.

Some brokers who were successful in enrolling large numbers of people over the last six months are now thinking about how they can further reconfigure their office staffing to take advantage of the next enrollment season. These are the brokers who have figured out the most efficient ways to bring people through the process and they want to expand their ability to service more enrollees and keep existing clients enrolled.

To clarify, the authors do not recommend that an SBM stop working with brokers who want to enroll smaller numbers of people, nor that SBMs base future arrangements only on past performance. Some brokers simply took a wait and see approach during this first open enrollment season, and others were interested, but were put off either by problems with the enrollment process or the bad press generated by HealthCare.gov. If an SBM uses a lead agency model, this role should be open to brokers who can make the requisite commitments. It will be important for the SBM to be both transparent and open to all brokers willing to work to achieve lead agency stature.

For brokers who *are* enthusiastic, there should be many ways to encourage participation and productivity: a broker-dedicated team at the contact center; a broker portal for self-service; appointment to an advisory council on policy development and broker performance standards; modest credits against commissions (perhaps administered by the SBM's ad agency) to help defray upfront advertising and collateral costs in advance of enrollment; inclusion on a referral list of experienced brokers; access to qualified leads at enrollment centers; links from the SBM's website; and promotion of ancillary broker services. As noted elsewhere, SBMs might also help brokers and navigators collaborate. Of course, the biggest single opportunity is to improve the brokers' own customer experience with the SBM.

A few cautions about working with brokers are also worth noting. First, some agencies may have reported high numbers the first year, but only enrolled existing clients in the SBM if they were subsidy-eligible. Unsubsidized clients were not enrolled through the SBM because: (a) there are more health plans (or provider networks) available outside the SBM, (b) there are administrative hassles to enrolling through the SBM, and (c) there was no advantage to doing so. If brokers only enroll their existing, subsidy-eligible clients, can they deliver many more enrollments next fall?

Second, brokers acknowledged that many navigators are far more familiar than they are with Medicaid, and on average navigators helped many more Medicaid than QHP enrollees. Many brokers ignored Medicaid, but some want to help clients with Medicaid, especially if they can be at least modestly compensated for this work. Others would just as soon refer those clients to navigators. Indeed, a few brokers and navigators found ways to cooperate effectively, despite little encouragement, or even active discouragement from the SBM.

Finding ways to introduce navigators and brokers and help them partner effectively should improve the enrollment effort for both programs. In Connecticut, the two stores did serve to connect a few brokers and navigators. Colorado eventually sponsored some pilot events where brokers and navigators were brought together to help support each other. (One SBM not directly interviewed for this paper actually conducted "mixers" to help introduce brokers and navigators to one another.) In Washington, two of the lead organizations had greater interactions with the broker community: in one, the head contact is a licensed broker, and in the second, a member of the lead organization board is a licensed broker.

Third, brokers operate businesses, and time is money for them, with critical implications for those on commission. The majority of brokers interviewed reported an unacceptably low level of support from the SBM, often citing average hold times exceeding an hour or more as the top complaint. A second common concern among brokers was a general lack of sufficiently trained, experienced and dedicated staff for support services. Brokers who produce a high volume of enrollment for carriers are accustomed to receiving top service and carriers usually staff broker support teams with their most experienced personnel. Carriers are known to incent brokers in two ways: one is through the sales commission program, and the second is through a package of services intended to reward the best producers. Brokers expect SBMs to meet industry norms of servicing this sales channel.

While brokers were generally understanding of challenges over the first several months of operations, they are unlikely to demonstrate similar patience next fall. For many brokers, it was the collective impact of poor service, long wait times, late or missing commissions and the lack of financial consideration for Medicaid enrollments that turned them off. Adequate service levels are likely to be regarded as nonnegotiable. In addition, brokers would appreciate even nominal compensation for Medicaid enrollments (Covered California provided brokers with a one-time stipend of $58 for Medicaid applications).[16] With the next open enrollment season just around the corner, states should consider this issue in the near term.

13. **To maximize the use of other free or low-cost resources, focus on generating as much earned media and marketing support from issuers as possible.** *Earned media, a powerful enrollment tool, will be tougher to get in the second open enrollment period, but is achievable with planning and creativity. Issuers now have a stake in the game and may be more willing to co-market to renew and build their market share.*

SBMs generally did a masterful job at generating earned media. Consumer surveys often ranked local news media among the top sources of their information on the ACA and marketplaces. Unavoidably, some of the news coverage was negative, both because of the troubled launch of the federally-facilitated marketplace and particular problems in some states. Overall, the local coverage was generally positive or turned positive as problems were resolved and enrollment climbed in the five states examined. And "free media" is both cheaper and more impactful than most paid advertising.

Because the SBMs are no longer new, this level of free coverage will be challenging, if not impossible, to sustain in 2014. On the other hand, the ACA promises to be a focus of the 2014 elections, and in "blue" and "purple" states with SBMs, earned media can be quite positive. Moreover, the SBM's experience and history will present new opportunities for earned media, particularly to celebrate success. For this purpose, a coalition of supporters to raise the flag can be invaluable.

SBMs can promote earned media by releasing data and policy briefs on enrollment trends, new issuers and new QHPs, celebrating key milestones, releasing various kinds of lists and working with partners in the community on promotions related to external events and the editorial calendar. Tax season, graduation, back-to-school time and Labor Day all represent earned media opportunities. Partnering with state and local officials is another way to generate local news coverage. The SBMs we studied were very successful last year in capitalizing on and creating these opportunities.

Given the hesitancy of some carriers to participate, the uncertainty confronting most participating issuers and the focus of SBMs on their own federally-funded outreach and marketing campaigns, it is not surprising that co-marketing with issuers was not the highest priority in 2013. However, in theory, issuers and marketplaces share an interest in maximizing enrollment. Building on some of the tentative steps taken in 2013, SBMs should reach out to issuers in order to leverage multiple marketing campaigns all gearing up for the fall of 2014.

For example, health fairs in the community where navigators, CACs and other assisters can get to know the issuers better, where consumers can talk to plan representatives and compare options and where the press can literally see the insurance marketplace, provide a good opportunity for joint promotion. Indeed, a commitment by issuers to participate in such events should be incorporated into their contractual obligations (if need be). Joint sponsorship with issuers of other community events and concerts represents another opportunity to leverage carriers' marketing funds, and to convey the message that the SBM is a "store" for their products.

Summary

Based on observations and interviews with brokers, navigators, insurers and SBM staff in five states, we recommend that SBMs consider these 13 strategies for improving the productivity of their outreach and enrollment efforts. Some will fit one SBM better than another, and some may not fit at all with an SBM's other priorities or a particular insurance market. These 13 strategies represent learnings based on what is working and what those in the field suggest might work better.

1. Integrate and execute the next marketing and sales campaign as early as possible.
2. Move from a media shotgun approach to more targeted marketing to build awareness.
3. Develop a simple, effective renewal process in conjunction with brokers, navigators and issuers.
4. Develop a cost-effective physical presence in target communities.
5. Integrate all marketing and sales activities into a coordinated effort focused on enrollment.
6. Leverage commercial insurance expertise on staff and adopt standard industry tools and measures.
7. Carefully manage the CPA.
8. Coordinate complementary roles for navigators, brokers and CACs.
9. Refocus broker and assister training for 2015 on hands-on enrollment issues.
10. Identify the SBM's operational obstacles to enrollment and ensure their correction.
11. Prioritize limited resources for the support of navigators on the most effective, productive ones.
12. Consider building local marketing and sales plans around lead brokers for each community.
13. Generate earned media and solicit marketing support from issuers.

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By Matlin Gilman, E. Kathleen Adams, Jason M. Hockenberry, Ira B. Wilson, Arnold S. Milstein, and Edmund R. Becker

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California Safety-Net Hospitals Likely To Be Penalized By ACA Value, Readmission, And Meaningful-Use Programs

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ABSTRACT The Affordable Care Act includes provisions to increase the value obtained from health care spending. A growing concern among health policy experts is that new Medicare policies designed to improve the quality and efficiency of hospital care, such as value-based purchasing (VBP), the Hospital Readmissions Reduction Program (HRRP), and electronic health record (EHR) meaningful-use criteria, will disproportionately affect safety-net hospitals, which are already facing reduced disproportionate-share hospital (DSH) payments under both Medicare and Medicaid. We examined hospitals in California to determine whether safety-net institutions were more likely than others to incur penalties under these programs. To assess quality, we also examined whether mortality outcomes were different at these hospitals. Our study found that compared to non-safety-net hospitals, safety-net institutions had lower thirty-day risk-adjusted mortality rates in the period 2009–11 for acute myocardial infarction, heart failure, and pneumonia and marginally lower adjusted Medicare costs. Nonetheless, safety-net hospitals were more likely than others to be penalized under the VBP program and the HRRP and more likely not to meet EHR meaningful-use criteria. The combined effects of Medicare value-based payment policies on the financial viability of safety-net hospitals need to be considered along with DSH payment cuts as national policy makers further incorporate performance measures into the overall payment system.

Key provisions of the Affordable Care Act (ACA) redistribute prospective payments under Medicare to reward higher hospital performance and, ultimately, penalize lower-performing hospitals. These provisions include value-based purchasing (VBP), the Hospital Readmissions Reduction Program (HRRP), and criteria for the meaningful use of electronic health records (EHRs).

Given the prospect of financial penalties under these programs, there is growing concern among health policy experts that vulnerable safety-net hospitals could be adversely affected, because they are likely to perform worse on the quality measures that are used to determine payment adjustments. Simultaneously, other provisions of the ACA will reduce the additional payments—known as disproportionate-share hospital (DSH) payments—that these safety-net hospitals receive from Medicare and Medicaid for treating disproportionately high proportions of patients covered by these insurance programs.

New payment reform policies are an effort to improve the quality of and reduce spending on

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hospital care. Creating such policies requires deciding how to define and measure quality and which aspects of cost to target. Consequently, the approaches used in the ACA, as in any major legislation that encompasses multiple policy programs, are complex and research based. Nevertheless, they have the potential to produce undesirable consequences.

Current debate on hospital performance centers on the relative importance of performance scores that measure processes and the patient experience of care versus scores that measure health outcomes. In its first year (fiscal year 2013) the VBP program used both scores measuring process of care and those measuring patient experience. In fiscal year 2014 the program also used mortality scores.

Process scores are assumed to be within hospitals' control and can be evaluated relatively easily.[1] Yet their use may not result in improved outcomes, which patients value most.[2,3] In contrast, using health outcomes as a metric is problematic because illness severity and social challenges that affect health—an especially important issue at safety-net hospitals—might not be fully captured in the financial models that are designed to reallocate a proportion of payments between hospitals to reward quality.[3]

Measures of patient experience could bridge the gap between process and outcomes in this respect. This gap has led to appeals for patient-centered measures of quality and is reflected in the creation of the Patient-Centered Outcomes Research Institute.[3] However, safety-net hospitals could still be disproportionately penalized if measures of patient experience reflected nonclinical dimensions of quality, even if outcomes and costs are similar at safety-net and other hospitals.

Despite the coverage expansions in the ACA, almost thirty million people are projected to remain uninsured because they will be exempt from the coverage mandate, refuse to enroll for benefits, or be excluded because of their legal status or their residence in states that are not currently expanding Medicaid.[4] Safety-net hospitals are likely to remain the provider of choice for uninsured people, and possibly those who are newly covered under the Medicaid expansion, because of the hospitals' historical missions, cultural competencies, and experience in serving lower-income populations. In Massachusetts the demand for safety-net hospital services continues to rise even after health reform. Most safety-net patients reported using these hospitals because they were convenient, were affordable, and offered preferred services.[5]

Medicare's hospital inpatient VBP program, the HRRP, and the EHR meaningful-use criteria are now in place.[6–9] Since safety-net hospitals tend to have lower scores on processes and the patient experience of care, they are likely to be disproportionally hurt under the VBP program, which relies on those measures.[10–14] Safety-net hospitals' worse performance on VBP measures such as scores of patient experience, rates of readmission,[12,13] and rates of meaningful use of EHRs[15,16] could reflect their lack of resources to invest in these areas.[10,11,17–20] Therefore, these programs, coupled with planned cuts to DSH payments, may exacerbate the financial pressures that these hospitals already face by virtue of serving higher proportions of poorer patients.[11,21,22]

In this article we examine whether safety-net hospitals are disproportionately penalized under these programs and whether this trend might be warranted because these hospitals have worse outcomes or higher costs. We compared safety-net hospitals' performance to that of non-safety-net hospitals in terms of health outcomes, costs, and exposure to penalties under recently enacted Medicare payment policies.

We focused on hospitals in California as a bellwether of these effects nationwide. California's Medicaid DSH program makes payments to only a small percentage of hospitals,[23] and state efforts to track and improve hospital quality are extensive. Thus, if safety-net hospitals in California are more likely than others in the state to be penalized under these various Medicare value-based incentive programs, this may suggest even worse consequences for safety-net hospitals in other states, where Medicaid DSH payments are not targeting the hospitals that are most in need.

We note that Medicaid DSH payments have been larger than Medicare DSH payments in recent years. However, a key difference is that Medicare makes DSH payments directly to hospitals, while Medicaid DSH allotments are made to the states, which then make payments to hospitals.

Policies' Consequences For Hospital Payment

The VBP program, the HRRP, and the EHR meaningful-use program have important consequences for hospital payment.

VALUE-BASED PURCHASING PROGRAM The VBP program shifts financial incentives away from a supply-driven paradigm to patient-centered health care based on value to the patient. Specifically, incentive payments are based on thirteen scores related to processes of care (for example, the percentage of heart attacks in which the physician responds quickly) or patients' experiences (such as the percentage of patients who report good communication with their doctor).

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Starting in October 2012 Medicare payments to hospitals were reduced by 1 percent to create a pool that would be used to fund these payments. Each hospital's VBP score was calculated relative to the overall mean. A score of 0.9945 meant that the hospital received 99.45 percent of its usual payment per discharge; values above 1.00 led to percentage increases. In 2012, 1,557 hospitals qualified for higher Medicare payment rates under the VBP program, and 1,427 hospitals received reduced Medicare payment rates.

HOSPITAL READMISSIONS REDUCTION PROGRAM The HRRP, also launched in October 2012, levies financial penalties against hospitals with readmission rates that are deemed to be excessive. For each hospital, the Centers for Medicare and Medicaid Services (CMS) calculates the expected readmission rates for all acute myocardial infarction (AMI), congestive heart failure, and pneumonia hospitalizations, adjusting for patients' characteristics and coexisting conditions. The rates are compared with actual readmission rates in a given period to derive an adjustment factor. Penalties are assessed when the observed rate exceeds the expected rate.

CMS set the penalty cap at 1 percent of its reimbursement for Medicare patients in fiscal year 2012. The penalty cap increased to a maximum of 3 percent for fiscal year 2014. In 2012 approximately two-thirds of hospitals were assessed a penalty under the HRRP.

MEANINGFUL USE Finally, "meaningful use" is the federal standard of eligibility for physicians and hospitals to receive incentive payments from CMS for adopting and using an EHR. The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, set aside nearly $30 billion for direct incentives for providers to start using EHRs. Stage 1 of this program was meant to incentivize providers to move key clinical data into electronic formats. Stage 2, initiated in 2014, raised the bar by tying EHR adoption more closely to improvements in patient care.

Study Data And Methods

We used five primary data sources to assemble the measures needed for our analysis: the Medicare Impact File for 2013; a CMS list of hospitals that received payment from Medicare in March 2013; Hospital Compare data for 2011; the California Office of Statewide Health Planning and Development; and data on hospital referral regions from the Dartmouth Institute. We describe these data sources below.

SAMPLE Our hospital sample was drawn from the general acute care hospitals in California that

New payment reform policies are an effort to improve the quality of and reduce spending on hospital care.

were paid prospectively under Medicare. California is one of the few states where financial data were available to allow us to calculate hospitals' Medicaid DSH payments (net of provider taxes that are paid to the state) and examine their effect on hospitals' operating margins. Each state uses its own methods to tax and distribute Medicaid DSH funds; in contrast, Medicare DSH payments are based on a common formula.

We excluded critical-access hospitals, which are paid by CMS using different formulas. We also excluded Kaiser Permanente hospitals, which do not report financial data to California and are not classified as general acute care hospitals in the annual financial data of the California Office of Statewide Health Planning and Development.

Of the remaining 263 general acute care hospitals in California, we excluded 17 (mostly small) hospitals with no Medicare provider charge data for 2011 or with fewer than a hundred discharges. We also excluded four hospitals whose mortality rates were not recorded in the Hospital Compare data for 2011.

Our final sample of 242 hospitals provided inpatient care to 98 percent of all discharges from general acute care prospective payment hospitals in California—or 85 percent of the discharges when all Kaiser Permanente hospitals were included. The 242 hospitals also constituted 91 percent of the prospective payment hospitals in California with mortality rates in the Hospital Compare data for 2011. The hospitals that had mortality rates but were not included in our sample tended to be Kaiser hospitals or institutions with fewer than a hundred Medicare discharges among the top hundred diagnosis-related groups nationally.

SAFETY-NET HOSPITALS There is no standard definition of a *safety-net hospital*. The use of three common measures—Medicaid caseloads, uncompensated care burden, and facility characteristics—to define safety-net hospitals is known to

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The EHR incentive program could be redesigned to avoid further dividing hospitals into haves and have-nots.

result in different quality rankings by safety-net status.[24]

We used a variant of the Medicaid caseload measure: the Medicare DSH patient percentage. This percentage is the sum of the proportion of a hospital's hospital days used by elderly patients receiving Supplemental Security Income and its proportion of nonelderly Medicaid patient days. Specifically, we defined *safety-net hospitals* as those hospitals whose Medicare DSH patient percentages were in the highest quartile among the 242 hospitals in our sample.

A major advantage of using the DSH patient percentage as opposed to just Medicaid caseloads is that it identifies poor patients regardless of their age.[10] Using only the Medicaid caseloads fails to identify elderly patients who are poor and whose hospital charges are covered by Medicare.[10] Our approach allowed us to place our results in the context of both VBP and Medi-Cal (California Medicaid) DSH payment policy.

The advantages of using the DSH patient percentage instead of uncompensated care as a share of total expenses to identify safety-net hospitals are twofold. First, since there are wider differences across hospitals in the DSH patient percentage than in the ratio of uncompensated care to expenses, the DSH patient percentage is better able to identify hospitals that serve a large share of poor patients. Second, since hospitals serve more Medicaid patients than uninsured patients, the revenue involved in providing care for Medicaid patients is a much larger share of the hospitals' revenue than that involved in providing uncompensated care. We calculated the number of low-income Medicaid or Medicare patients that a hospital cares for, relative to the other hospitals in its hospital referral region. If a hospital's DSH patient percentage was higher than expected given the average percentage in its region, this measure was greater than 1.0.

All safety-net hospitals had a value of greater than 1.0 on this measure. This indicates that in addition to having larger low-income patient caseloads than other hospitals did, safety-net hospitals also served a disproportionate share of low-income patients relative to the other hospitals in their referral region.

VALUE-BASED PURCHASING Using the Medicare Impact File for 2013, we obtained hospital-specific data on the combined (process-of-care and patient experience scores) payment adjustments for the VBP program for fiscal year 2013. Using VBP performance data from CMS, we also compared the average safety-net hospital's VBP process-of-care and patient experience scores for 2013 with those of the average non-safety-net institution.

READMISSIONS PENALTY The HRRP adjustments were obtained from the 2013 Medicare Impact file. As explained above, hospitals were penalized if their observed readmission rates were higher than the expected rates.

EHR INCENTIVES AND PENALTIES To measure the proportion of safety-net and non-safety-net hospitals in California receiving meaningful-use incentive payments, we used data from the CMS list of hospitals that received such payments from Medicare in March 2013. There are currently no penalties for Medicaid providers who fail to demonstrate the meaningful use of an EHR. However, beginning in 2016 all eligible Medicare providers will be required to demonstrate that they meet the stage 3 meaningful-use criteria or face penalties.

HEALTH OUTCOMES Our primary measure for health outcomes was mortality rates. We used Hospital Compare data for 2011 to measure average thirty-day risk-adjusted mortality rates for three major conditions—AMI, heart failure, and pneumonia—averaged across 2009–11. These rates are presented as percentages of discharges in the respective diagnosis categories.

EFFICIENCY To derive measures of the costs of providing services, we followed an approach used by the Medicare Payment Advisory Commission, which adjusts costs for factors beyond the hospital's control that reflect the hospital's financial structure instead of its efficiency.[25] This method standardizes Medicare costs by adjusting for Medicare severity diagnosis-related groups' (MS-DRGs') case-mix, wage index, prevalence of outlier payments and transfer cases, and the empirically estimated effects of teaching activity on costs per discharge.[25]

STATISTICAL ANALYSIS We used chi-square tests to determine if there were significant differences in the proportions of safety-net and non-safety-net hospitals that were rewarded or penalized under the VBP program, the HRRP, and the EHR incentive program. We also used the

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Hospital Compare file to derive actual thirty-day risk-adjusted hospital readmission rates for AMI, heart failure, and pneumonia averaged across 2009–11, and we used *t*-tests to assess statistical differences between safety-net and non-safety-net hospitals. Finally, we tested for differences in mean adjusted cost per Medicare discharge.

LIMITATIONS Our study has several limitations. We defined *safety-net hospitals* as the hospitals in the highest quartile of the Medicare DSH patient percentage, but other definitions exist.

In addition, our study examined the proportion of safety-net hospitals at risk of financial penalties under the VBP program, the HRRP, and the EHR incentive program. However, we did not compare the magnitude of the penalties. In other words, it may be that more safety-net hospitals incurred penalties, but their penalties were smaller than those of the non-safety-net hospitals that incurred penalties.

Our analysis did not account for the dynamic effect of CMS's imminent performance-based payment adjustments, which means that there could be variations across time in which hospitals were classified as safety net under our definition and in which hospitals got penalties. Ashish Jha and coauthors' analysis of dynamic effects suggests that safety-net hospitals respond more effectively to such adjustments than other hospitals do.[11]

Study Results

HOSPITAL CHARACTERISTICS Of the 242 hospitals in our analyses, 60 were in the highest (fourth) quartile of the Medicare DSH patient percentage and therefore were defined as safety-net hospitals (Exhibit 1). The safety-net hospitals had a lower average operating margin than the non-safety-net hospitals—those in the other three quartiles.

Safety-net hospitals were also much more likely than other hospitals to benefit from Medi-Cal DSH payments. When we excluded Medicaid DSH net payments (that is, accounting for taxes

EXHIBIT 1

Characteristics Of 242 California Hospitals, By Medicare Disproportionate-Share Hospital (DSH) Patient Percentage Quartiles, 2011

Characteristic	Quartile 1 (*n*=61)	2 (*n*=60)	3 (*n*=61)	4 (*n*=60)
Operating margin				
With Medicaid DSH	5.7%	7.4%	4.7%	0.1%
Without Medicaid DSH	5.7	7.4	4.3	−7.8
Bed size				
Small (fewer than 100 beds)[a]	30	30	25	22
Medium (100–299 beds)[b]	56	52	51	52
Large (300 or more beds)[c]	15	18	25	27
Ownership				
City or county[d]	0	0	2	20
District[e]	10	10	16	0
For-profit[f]	20	22	18	47
Nonprofit[g]	70	68	64	33
Teaching				
Yes[h]	2	7	10	18
Setting				
Urban[i]	95	93	97	100
Caseload				
Share of Medicare patient days	50	46	43	30
Share of Medicaid patient days	15	22	31	46
DSH patient percentage relative to the average in the HRR DSH index[j] (interquartile range)	0.5 (0.3, 0.6)	0.8 (0.6, 1.0)	1.2 (0.9, 1.4)	1.6 (1.3, 1.8)

SOURCE Authors' analysis of annual financial data for 2011 from the California Office of Statewide Health Planning and Development, data from the Medicare Impact Files for 2011 and 2013, and data on hospital referral regions (HRRs) from the Dartmouth Institute. **NOTES** The Medicare DSH patient percentage is the sum of the proportion of a hospital's hospital days used by elderly patients receiving Supplemental Security Income and its proportion of nonelderly Medicaid patient days. We defined *safety-net hospitals* as those in quartile 4, the highest quartile. Additional analytic details for the exhibit are included in the online Appendix (to access the Appendix, click on the Appendix link in the box to the right of the article online). [a]*n* = 64 (26 percent of the hospitals). [b]*n* = 127 (52 percent). [c]*n* = 51 (21 percent). [d]*n* = 13 (5 percent). [e]*n* = 22 (9 percent). [f]*n* = 64 (26 percent). [g]*n* = 143 (59 percent). [h]*n* = 22 (9 percent). [i]*n* = 233 (96 percent). [j]Actual over expected.

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paid to the state), safety-net hospitals' average operating margin fell from 0.1 percent to –7.8 percent. In contrast, the average operating margin for other hospitals was virtually unchanged.

In addition, safety-net hospitals were more likely than other hospitals to be large and to be either for profit or owned by a city or county. They were also more likely than other hospitals to be teaching hospitals, have lower Medicare caseloads and higher Medicaid caseloads, and have a higher DSH patient percentage relative to the other hospitals in their referral areas.

PENALTIES AND INCENTIVES When we examined the proportion of hospitals that would likely be subject to VBP and HRRP penalties and miss out on EHR meaningful-use incentive payments, we found that safety-net hospitals were at greater risk of experiencing reduced payments than other hospitals (Exhibit 2). We found that 70.0 percent of safety-net hospitals had a VBP final adjustment factor for 2013 that was less than 1.0, compared to 58.2 percent of other hospitals. However, this difference was not significant.

Consistent with this finding, when we compared the average total VBP performance scores for safety-net and non-safety-net hospitals, we found that safety-net hospitals were marginally more likely to have a lower process score, which accounted for 70 percent of a hospital's VBP factor for 2013. Safety-net hospitals were also more likely to have a significantly lower patient experience score, which accounted for the remaining 30 percent of the VBP factor for 2013.

When we examined final payment adjustment factors for the hospital readmissions reduction program in 2013, we found that 88.3 percent of safety-net hospitals had an HRRP factor of less than 1.0, compared to 68.1 percent of other hospitals (Exhibit 2). Thus, safety-net hospitals were significantly more likely than other hospitals to experience reductions in payments under the HRRP. Similarly, we found that safety-net hospitals were significantly more likely to have higher thirty-day risk-adjusted readmission rates for acute myocardial infarction, heart failure, and pneumonia in 2009–11.

We also found that safety-net hospitals were significantly less likely than non-safety-net hospitals to have received payment from Medicare for having met EHR meaningful-use criteria.

MORTALITY RATES Exhibit 3 shows the average mortality rates for acute myocardial infarction, heart failure, and pneumonia in 2009–11. For acute myocardial infarction, the average mortality rate among safety-net hospitals was 14.5 percent, compared to 15.0 percent among other hospitals ($p = 0.0950$). For heart failure, the average mortality rate among safety-net hospitals was 9.5 percent, compared to 11.2 percent among other hospitals ($p < 0.0001$). For pneumonia, the average mortality rate was 10.9 percent among safety-net hospitals, compared to 11.8 percent among other hospitals ($p = 0.0036$). These differences in condition-specific mortality were significant.

EFFICIENCY The estimated average adjusted Medicare cost per discharge among safety-net hospitals in our sample was $7,688, compared to $7,973 among other hospitals. However, this difference was not significant ($p = 0.1413$).

EXHIBIT 2

Impacts Of Value-Based Purchasing (VBP), Hospital Readmissions Reduction Program (HRRP), And Electronic Health Record (EHR) Incentive Programs On Safety-Net And Non-Safety-Net Hospitals, 2013

Impact	Safety-net hospitals (*n*=60)	Other hospitals (*n*=182)	*p* value
Hospitals penalized under VBP	70.0%	58.2%	0.1051
VBP total performance score	45.0	52.2	0.0035
VBP process score	53.8	60.0	0.0615
VBP patient experience score	24.4	34.2	<0.0001
Hospitals penalized under the HRRP	88.3	68.1	0.0022
30-day readmission rate for acute myocardial infarction	19.9	19.2	0.0051
30-day readmission rate for heart failure	25.7	24.1	<0.0001
30-day readmission rate for pneumonia	18.9	18.2	0.0100
Hospitals receiving Medicare payment for demonstrating EHR meaningful use	38.3	55.0	0.0256

SOURCE Authors' analysis of data from the Medicare Impact File for 2013, Hospital Compare for 2011, and VBP performance scores for 2013 from Hospital Compare and the Centers for Medicare and Medicaid Services website. **NOTES** Readmission rates are risk-adjusted. Additional analytic details for the exhibit are included in the online Appendix (to access the Appendix, click on the Appendix link in the box to the right of the article online).

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EXHIBIT 3

Thirty-Day Risk-Adjusted Mortality Rates For Acute Myocardial Infarction, Heart Failure, And Pneumonia, 2009–11

	Safety-net hospitals (*n*=60)	Other hospitals (*n*=182)	*p* value
Mortality rate for:			
Acute myocardial infarction	14.5%	15.0%	0.0950
Heart failure	9.5	11.2	<0.0001
Pneumonia	10.9	11.8	0.0036
Mortality rate index (actual over expected)	0.91	1.02	<0.0001
Hospitals with lower-than-expected mortality	66.7	41.2	0.0006

SOURCE Authors' analysis of data from Hospital Compare for 2011 and the Medicare Impact File for 2013. **NOTE** Additional analytic details for the exhibit are included in the online Appendix (to access the Appendix, click on the Appendix link in the box to the right of the article online).

Discussion

Our study of hospitals in California has three key findings. First, safety-net hospitals were more likely than other hospitals to be penalized under the value-based purchasing program, the Hospital Readmissions Reduction Program, and the electronic health record meaningful-use program. Second, thirty-day risk-adjusted mortality outcomes in safety-net hospitals were better than those in other hospitals for patients with acute myocardial infarction, heart failure, or pneumonia. Third, the adjusted cost per Medicare discharge was virtually identical at safety-net and non-safety-net hospitals. Taken together, these results indicate that safety-net hospitals provided better health outcomes than other hospitals at a similar cost level yet were more likely to be penalized under programs that are intended to improve and reward high performance.

Thirty-day risk-adjusted readmission rates for the three conditions listed above were higher in safety-net hospitals than in other hospitals (Exhibit 2). Hence, safety-net hospitals were more likely penalized under the HRRP.

A readmission could represent a high-quality outcome (because a patient survived long enough to be readmitted), a low-quality outcome (because a patient needed to be readmitted), or other factors (such as lack of access to primary care) that are potentially beyond a hospital's control.[26] Higher readmission rates could even lead to less costly overall care. This would occur if the per admission cost were lower in hospitals with higher readmission rates.

Reducing readmission rates is costly. Nearly the entire patient population needs to be treated with additional care to prevent readmission because predicting readmission is notoriously difficult, and this cost might be higher than the additional cost of simply allowing the additional readmissions to occur.[26,27] In addition, the HRRP algorithm used to adjust for differences in hospitals' patient populations explicitly excludes adjustments for patients' socioeconomic status. This further increases the probability that safety-net hospitals will incur these penalties.[24]

Policy Adjustments To Protect Safety-Net Hospitals

In 2014 the VBP adjustment will be weighted by 30 percent of the patient experience score, 25 percent of the mortality (survival) score, and 45 percent of the process-of-care score for each hospital participating in Medicare's prospective payment system. A heavier weighting on the mortality outcome could help address the seeming policy disconnect that penalizes hospitals with lower mortality for having higher readmission rates.

Our finding of very low operating margins among safety-net hospitals in California highlights the potential of small adjustments in Medicare payments to adversely affect these hospitals and low-income patients. One issue is that patient experience scores across the entire suite of measures in the Consumer Assessment of Healthcare Providers and Systems survey are not adjusted for low patient income. Such an adjustment could ultimately reduce perceived access to care.[28,29] However, CMS may wish to resolicit stakeholders' input as consequences for hospitals with such thin margins shift from reputational (that is, patients with generous private insurance often avoid hospitals known as safety-net institutions) to financial.

In addition, the EHR incentive program could be redesigned to avoid further dividing hospitals into haves and have-nots. Unless safety-net hospitals catch up to other hospitals in their meaningful use of EHRs before the penalties go into effect in 2015, safety-net institutions will be more likely than other hospitals to be penalized.

Recent evidence suggests that safety-net hospitals are responding dynamically to EHR adoption incentives by taking advantage of HITECH's "adopt, implement, and upgrade" option to access the capital needed to purchase or upgrade systems. This option allows hospitals with Medicaid patient volumes below 10 percent to receive financial incentives in advance of meeting the criteria.[30] This gives hospitals the capital they need to purchase an EHR system.

However, this capital might not be adequate. Productivity losses are common in hospitals during the period of EHR adoption, and upkeep and upgrades needed to meet future meaningful-use criteria can be expensive. The Office of the National Coordinator for Health Information Technology in the Department of Health and Human

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Medicare payments have already begun to affect revenues.

Services could consider the adequacy of its ongoing support to encourage EHR adoption by low-margin hospitals before penalties are applied, especially in states where the uninsured population remains high.

Concerns over the effect of these payment policies are compounded by the potential impact on safety-net hospitals of imminent reductions in DSH funding under the ACA.[31] The ACA incentivizes states to target DSH payments to hospitals that are most in need of Medicaid DSH funding, which may lead some states to redirect payments away from non-safety-net hospitals. However, it is not clear that under the targeting scenario, safety-net hospitals would maintain the same level of DSH payment.

In addition, these targeting incentives are related to Medicaid expansion. At a minimum, these forces will play out differently in the twenty-seven states (including the District of Columbia) that are now planning to expand Medicaid in 2014, compared to states that are still debating an expansion or have decided not to expand.[32]

Conclusion

Safety-net hospitals in California provide better health outcomes than other hospitals at a reasonable cost. This would suggest good performance on the part of safety-net hospitals. However, the value-based purchasing program, the Hospital Readmissions Reduction Program, and the electronic health record meaningful-use program are more likely to penalize these hospitals than non-safety-net institutions. These policies could be reexamined to better align incentives and prevent unintended consequences from placing further financial pressure on safety-net hospitals.

Medicare payments have already begun to affect revenues. Medicare and Medicaid DSH payment reductions are also on the horizon for these hospitals, which will only compound the financial issue. ■

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Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children

ABSTRACT Both Medicaid and the Children's Health Insurance Program (CHIP), which are run by the states and funded by federal and state dollars, offer health insurance coverage for low-income children. Thirty-three states charged premiums for children at some income ranges in CHIP or Medicaid in 2013. Using data from the 1999–2010 Medical Expenditure Panel Surveys, we show that the relationship between premiums and coverage varies considerably by income level and by parental access to employer-sponsored insurance. Among children with family incomes above 150 percent of the federal poverty level, a $10 increase in monthly premiums is associated with a 1.6-percentage-point reduction in Medicaid or CHIP coverage. In this income range, the increase in uninsurance may be higher among those children whose parents lack an offer of employer-sponsored insurance than among those whose parents have such an offer. Among children with family incomes of 101–150 percent of poverty, a $10 increase in monthly premiums is associated with a 6.7-percentage-point reduction in Medicaid or CHIP coverage and a 3.3-percentage-point increase in uninsurance. In this income range, the increase in uninsurance is even larger among children whose parents lack offers of employer coverage.

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Publicly funded health insurance coverage for children in the United States is rapidly approaching yet another crossroads.[1] While the coverage provisions of the Affordable Care Act (ACA) focus primarily on adults, and particularly those with incomes below 400 percent of the federal poverty level, they also affect children. Some children can gain coverage through the ACA's publicly subsidized private Marketplace (exchange) plans and through individual and future employer mandates. Also, the ACA may indirectly affect enrollment in public coverage as a result of "welcome mat" or "woodwork" effects; that is, the new programs may spur enrollment among the currently eligible. The ACA requires states to maintain their March 23, 2010, eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) through 2019. However, no federal CHIP funding is allotted after 2015, which raises important questions about whether CHIP maintenance of effort will be accomplished via renewed federal funding for CHIP or through a mix of Medicaid and Marketplace coverage, and how this decision will affect children's coverage.[2]

As the country navigates its path forward on children's coverage, an important issue is the appropriate level for premiums in public and publicly subsidized children's coverage. At present, premiums for children's coverage vary considerably by family income, state of residence, public program, and number of children in the family. CHIP itself is not uniform. Some states

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run CHIP as an independent program separate from Medicaid. Some use their CHIP funds to run an expanded Medicaid program, and some run combined CHIP and Medicaid programs. Some states do not charge premiums for children's public coverage, while others levy premiums in an effort to reduce program costs.[3,4] Premiums are generally prohibited in Medicaid for children with family incomes at or below 150 percent of poverty. In contrast, separate state CHIP programs face no such prohibition, although both Medicaid and CHIP limit the sum of premiums and cost sharing to 5 percent of family income, and some states do not charge any premium or charge low premiums in their separate state CHIP programs.[3,5]

Unlike premium costs in public insurance programs, the premiums families face when children and families are enrolled in coverage through ACA Marketplaces are reduced by premium tax credits that vary on a sliding scale. For families with access to both the Marketplace and public programs, for example, one or more parents covered through a Marketplace policy and children covered by CHIP, concerns have been raised that there is no cap on combined Marketplace and public program premiums across family members.[6] The ACA is also expected to affect coverage incentives through the individual mandate, by increasing many parents' incentives to obtain insurance for their children.[7]

Given the complex pattern of existing premiums and incentives for children's coverage and the likelihood of changes over the next few years, the goal of this article is to provide new evidence on the relationship between premiums and children's health insurance coverage.

Background

A number of state-specific analyses of administrative data have examined the effects of premium increases on enrollment and disenrollment.[8–13] Fewer studies have used nationally representative data to examine this question. In this study we broadly follow the methodologies of two previous studies. The first one is a study by Genevieve Kenney, Jack Hadley, and Frederic Blavin, which used data from the 1999–2003 Current Population Surveys.[14] The second one is a study by Jack Hadley and colleagues, which used data from the Community Tracking Study, 1996–2003.[15,16] Our analysis provides updated estimates, using data from the period of the greatest within-state and within–income band change in CHIP premiums. We also extended prior work by incorporating Medical Expenditure Panel Survey (MEPS) information on whether children have parents with offers of employer-sponsored insurance, which enabled us to test whether parental offers affect the relationship between children's insurance coverage and premiums for public coverage.

Study Data And Methods

Our analysis used data from the 1999–2010 MEPS. MEPS contains individual- and household-level data on health spending and use, health insurance coverage, self-reported health status, and a wide range of demographic and socioeconomic characteristics for a nationally representative sample of households in the civilian noninstitutionalized population.[17]

We focused on children ages 0–18 who were simulated to be eligible for Medicaid or CHIP as of the first MEPS interview in each calendar year. Following prior literature, we excluded children with family incomes at or below 100 percent of poverty (whose coverage would rarely if ever entail premiums). We also excluded a small number of children who were not living with any adult parent (natural, adoptive, or step) or who faced premiums that included both children's and parents' coverage. The final sample consisted of 30,991 observations.

Using this subsample, we estimated a multinomial logistic model with three outcomes: any public coverage during the round, any private (and no public) coverage during the round, and no insurance coverage during the round. The main explanatory variable was a simulated measure of public premiums. The model also controlled for the cost of obtaining private coverage, a rich array of child and family characteristics, and state and year fixed effects. Because Kenney, Hadley, and Blavin found evidence that premium effects vary with income, we interacted all variables in the model (apart from the state effects) with an indicator for family income being at or below 150 percent of poverty.[14,18]

SIMULATING ELIGIBILITY AND PUBLIC PREMIUMS Our eligibility simulation refined the approach used in previous studies.[19,20] We used MEPS data on child age, family earned and unearned income, family assets, family structure, child and parent immigration status, state of residence, and more, combined with state by year by program eligibility rules regarding income thresholds, income disregards, asset tests, assistance unit composition, deprivation tests, immigration status, and more.

Rules regarding premiums for children's Medicaid and CHIP coverage for each state and each year were used to simulate the premiums, if any, that a family would face to cover an eligible child for a full year.[21] Premiums varied across states and over time. Moreover, within a given state

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Higher public premiums are associated with lower public coverage and with increases in private coverage and uninsurance.

and year, premiums generally varied by children's age, family income, and family size. All premiums were adjusted to 2010 dollars using the Consumer Price Index for All Urban Consumers (CPI-U).

PRIVATE PREMIUMS AND OTHER VARIABLES Following Kenney, Hadley, and Blavin, we controlled for the cost of private coverage for children, using average premium estimates, by state, year, and firm size, from the MEPS Insurance Component (MEPS-IC) survey of establishments.[14] Moreover, the MEPS household data enabled us to improve on Kenney and colleagues' method by factoring in MEPS measures of whether a child's parents (or caretakers) were offered employer-sponsored insurance. For children with such offers, we used MEPS-IC averages for employee contributions; for children without such offers, we used MEPS-IC averages for full premiums—in both cases taking the difference between average premiums for family and single coverage to proxy the cost of dependent coverage. This permitted us, in contrast to prior research, to test whether having a parental offer of employer coverage affects the relationship between public premiums and children's coverage.

Our multivariate analysis also controlled for child age, sex, race or ethnicity, physical and mental health status, citizenship, having two parents, family income level (and income squared) measured in 2010 dollars, residence in a Metropolitan Statistical Area, highest parental educational attainment, parental employment, and parental health status.

STATISTICS All estimates used sampling weights to generate nationally representative, average annual estimates. All standard errors and statistical tests accounted for the complex design of MEPS and intrafamily correlation. All differences discussed in the Study Results section are statistically significant at the 5 percent level (using two-tailed tests) unless stated otherwise.

LIMITATIONS Our study's main limitations are as follows. First, eligibility and premiums for Medicaid and CHIP were simulated rather than directly measured and are, therefore, subject to error. Second, state decisions regarding Medicaid and CHIP may be caused by unobserved factors that may be controlled for only partially by our inclusion of state fixed effects.

Third, some states impose medical service copays at the same time they impose premiums.[3] State fixed effects may not account for this change in benefits, and our estimates may somewhat overstate the effects of premium increases on public enrollment. Fourth, simulated premiums may be correlated with omitted family characteristics that affect enrollment, which could bias our estimates. We controlled for parental offers of employer coverage (via our private premium measure), family income, and its square to minimize any remaining correlation between the error term and premiums. Nevertheless, care must be taken when inferring a causal interpretation of our results.

Fifth, we studied a period before the ACA was implemented, and families' responses under the ACA may be affected by the mandate; shared-responsibility payments; and premium tax credits, which cap premiums regardless of the number of family members covered.

Study Results

PUBLIC PREMIUMS Exhibit 1 presents estimates from the two most recent years of our sample (2009–10) regarding percentages of eligible children whose coverage would require premiums if they were enrolled and mean annualized premiums among those facing premiums. Both estimates increase with poverty level. Among those with family incomes of 101–150 percent of poverty, only 22 percent faced premiums, with the average amount being $65. Among children with family incomes of 151–200 percent of poverty, both the percentage facing premiums and the conditional mean of premiums more than double, to 59 percent and $132, respectively. At income levels of 201–250 percent of poverty, 87 percent of children faced premiums, with the average premium being $336. Among the relatively few eligible children with family incomes above 250 percent of poverty, 96 percent faced premiums, with the average premium being $562.

INSURANCE STATUS Exhibit 2 presents the coverage distribution by poverty level and parental offer of coverage in 2009–10. Among children who were eligible for Medicaid or CHIP and had

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EXHIBIT 1

Percent Of Children Eligible For Medicaid And The Children's Health Insurance Program (CHIP) Facing A Premium And Mean Annualized Premiums, By Federal Poverty Level, 2009–10

Sample of eligible children	Population (millions)	Facing a premium		Mean annualized premiums among those with premiums	
		Percent	SE	2010 $	SE
All eligible children	19.7	51	2	247	11
Eligible children by federal poverty level					
101–150%	8.3	22	2	65	4
151–200%	6.6	59	3	132	8
201–250%	3.1	87	3	336	15
Above 250%	1.8	96	2	562	31

SOURCE Authors' average annual estimates from the Medical Expenditure Panel Survey (MEPS), 2009–10. NOTES $N = 6,154$. Eligibility is simulated based on MEPS data and state program rules. Standard errors (SEs) have been adjusted for the complex design of MEPS.

family incomes above 100 percent of poverty, 12.7 percent were uninsured, 37.0 percent had public coverage, and 50.3 percent had private coverage. The proportion with public coverage was much higher among those with incomes of 101–150 percent of poverty (50.6 percent) versus those with higher incomes (27.1 percent).

The first column of results in Exhibit 2 presents estimates for the distribution of children by poverty status and parental offers of employer coverage. We estimate that almost three-fourths of the 19.7 million eligible children in families with incomes above the federal poverty level had at least one parent who had an offer of employer coverage (5.4 million had incomes below 150 percent of poverty, and 9.1 million had incomes above 150 percent of poverty). Parental offer rates for children in the lower and higher poverty groups were 65 percent and 80 percent, respectively.

The remaining columns of Exhibit 2 clearly demonstrate the strong association between parental offers and children's coverage. Having a parent with an offer of employer coverage greatly reduces families' marginal cost of providing their children with private insurance. Moreover, switching from employer-sponsored to public coverage often entails waiting periods (spells of uninsurance), though several states have recently dropped waiting periods in CHIP.[6] Both factors likely contribute to our finding that public coverage rates are substantially lower in both poverty groups when children have parents with offers: 41.4 percent versus 68.1 percent in the group with incomes of 101–150 percent of poverty and 20.9 percent versus 50.9 percent in the group with incomes above 150 percent of poverty.

Lacking a parental offer of employer coverage is also a strong predictor of uninsurance. Among children with family incomes of 101–150 percent of poverty, uninsurance rates were 11.2 percent

EXHIBIT 2

Distribution Of Coverage Among Children Eligible For Medicaid And The Children's Health Insurance Program (CHIP) With Family Incomes Above 100 Percent Of Poverty, By Federal Poverty Level And Parental Employer-Sponsored Insurance (ESI) Offer, 2009–10

Sample of eligible children	Population (millions)	Coverage					
		Public		Private		Uninsured	
		Percent	SE	Percent	SE	Percent	SE
All eligible children over federal poverty level	19.7	37.0	1.3	50.3	1.5	12.7	0.8
Eligible children at 101–150% of poverty	8.3	50.6	2.1	35.5	2.2	13.8	1.1
Parent had ESI offer	5.4	41.4	2.4	47.4	2.6	11.2	1.3
Parent did not have ESI offer	2.9	68.1	2.8	13.1	2.4	18.8	2.0
Eligible children above 150% of poverty	11.4	27.1	1.5	61.0	1.7	11.8	1.1
Parent had ESI offer	9.1	20.9	1.5	71.1	1.7	8.0	0.9
Parent did not have ESI offer	2.4	50.9	3.8	22.4	3.4	26.7	3.8

SOURCE Authors' average annual estimates from the Medical Expenditure Panel Survey (MEPS), 2009–10. NOTES $N = 6,154$. Eligibility is simulated based on MEPS data and state program rules. Standard errors (SEs) have been adjusted for the complex design of MEPS.

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for children with parental offers versus 18.8 percent for those without. Among children with family incomes over 150 percent of poverty, the difference in uninsurance rates is even larger: 8.0 percent versus 26.7 percent.

These results mirror estimates already in the literature based on the 2003–04 MEPS.[22] We present updated estimates here because they highlight the important roles played by income and parental offers, thereby setting the stage for our multivariate analysis of public premiums and coverage.

SIMULATED EFFECTS OF INCREASING PUBLIC PREMIUMS Exhibit 3 presents our main multivariate results. We used our estimated model to simulate the effect of increasing (annualized) public premiums by $120 for every child in our sample (an increase of $10 per child per month), taking means of the associated effects by poverty and parental offers. Online Appendix Section A presents multinomial logistic coefficient estimates.[23] Appendix Section B presents our full set of simulated effects, including standard errors and statistical tests computed using the method of balanced repeated replication.[23]

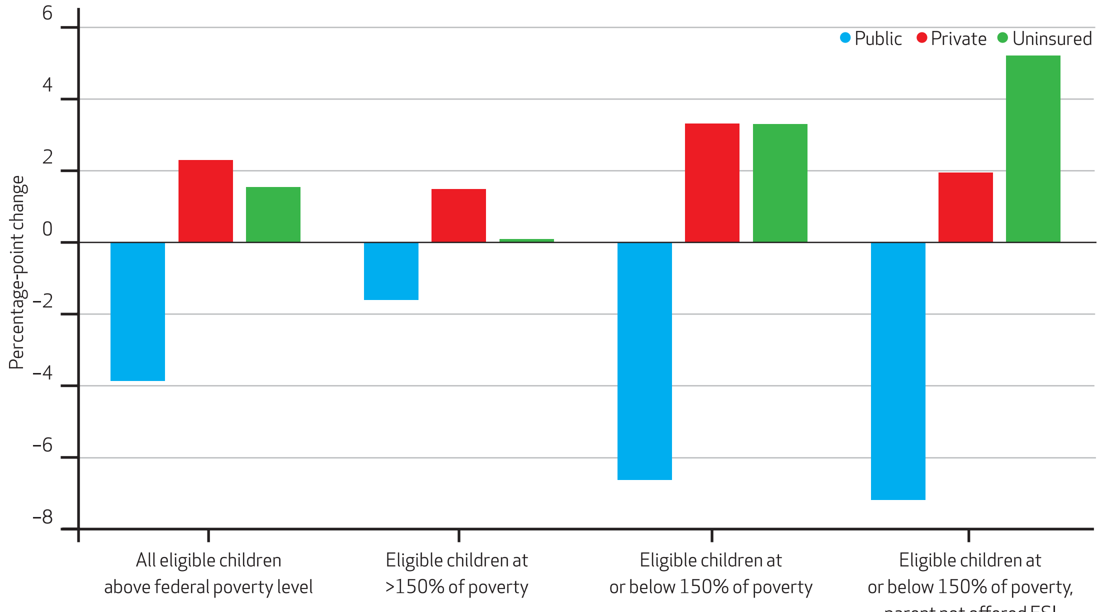
Among eligible children with family incomes above the federal poverty level, a $120 premium increase is, on average, associated with a 3.9-percentage-point reduction in public coverage, with private coverage and uninsurance rising by 2.3 percentage points and 1.6 percentage points, respectively. The effects of increasing premiums, however, vary considerably by family income and parental coverage offers. Among children with family incomes above 150 percent of poverty, a $120 premium increase is associated with a public coverage reduction of only 1.6 percentage points—most of which is offset by a 1.5-percentage-point increase in private coverage (the uninsurance increase is only 0.1 percentage point and not statistically significant).

In contrast, the same $120 premium increase is associated with a 6.7-percentage-point reduction in public coverage among children in families with incomes of 101–150 percent of poverty—four times the effect for the higher-income group. Moreover, the 6.7-percentage-point reduction in public coverage is associated with a 3.3-percentage-point increase in uninsurance.

Exhibit 3 also presents results for the subset of children with family incomes of 101–150 percent of poverty who lacked parental offers of employer-sponsored insurance. Note that unlike the differences by income level presented above, which

EXHIBIT 3

Comparisons Of Simulated Changes In Coverage Distributions If Annualized Public Premiums Were Increased By $120 For All Children Eligible For Medicaid And The Children's Health Insurance Program (CHIP) With Family Incomes Above 100 Percent Of The Federal Poverty Level



SOURCE Authors' average annual estimates from the Medical Expenditure Panel Survey (MEPS), 1999–2010. **NOTES** $N = 30,991$. The simulations were based on a multinomial logistic regression of insurance coverage outcomes. The coefficient estimates from the regression model and the standard errors associated with the simulated changes are presented in the online Appendix (see Note 23 in text). The percentage-point changes shown in the graph may not add up to zero because of rounding.

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are identified by the inclusion of interaction effects, differences in responses to public premiums across parental offers of employer coverage are identified from the nonlinearity of the multinomial logistic regression model. Those with and without such offers vary in their child and family characteristics and other variables and, therefore, respond differently to the increase in public premiums. One variable that clearly differs is private premiums, with means of $7,197 and $2,519 for those without and with parental coverage offers, respectively (data not shown).

Among children with family incomes of 101–150 percent of poverty who lacked parental offers of employer coverage, the $120 premium increase is associated with a 7.2-percentage-point decrease in public coverage and a 5.3-percentage-point increase in uninsurance—which is significantly larger than the 2.2-percentage-point increase in uninsurance among children in families with incomes of 101–150 percent of poverty with parental offers (see the online Appendix).[23] Among children in families with incomes above 150 percent of poverty, the increase in uninsurance is also higher among those without parental coverage offers compared to those with such offers—a difference of 0.7 percentage point (statistically significant only at the 10 percent level, shown in the online Appendix).[23]

We also experimented with including interaction effects to identify further differences in public premium responses between children with and without parental coverage offers. However, the interaction effects were jointly insignificant and yielded simulation results with large standard errors.

Discussion

In this article we have examined the effects of public premiums on insurance coverage of children who were eligible for Medicaid or CHIP and whose family incomes were above 100 percent of the federal poverty level in 1999–2010. Higher public premiums are associated with lower public coverage and with increases in private coverage and uninsurance. The magnitudes of these premium effects vary considerably by poverty level and by parental coverage offers. Among eligible children in families with incomes above 150 percent of poverty, premiums are associated with relatively small changes in coverage, and we found limited evidence that the increase in uninsurance associated with higher public premiums is higher among children lacking parental offers of employer coverage compared to children with such offers. Among lower-income children, premium increases are associated with larger reductions in enrollment in public coverage, and a larger share of the decline in enrollment takes the form of increased uninsurance. The association between premiums and uninsurance is particularly strong among lower-income children who lack access to employer-sponsored insurance through parental offers.

The association between premiums and uninsurance is particularly strong among lower-income children who lack access to employer-sponsored insurance through parental offers.

Medicaid generally prohibits premiums for children with family incomes at or below 150 percent of poverty. Thus, the ACA, by shifting children in separate state CHIP programs to Medicaid if they have family incomes under 139 percent of poverty, reduced the number of low-income children whose public coverage entails a premium.[24] Yet children in families with incomes of 139–150 percent of poverty continue to face premiums in eight states.[3] In its March 2014 report to Congress, the Medicaid and CHIP Payment and Access Commission recommended that Congress prohibit CHIP premiums for children in families with incomes at or below 150 percent of poverty.[6] Several factors were cited in making this recommendation: the goal of aligning CHIP with Medicaid, the minor budgetary impact of collecting premiums on children in this income range, a desire to align CHIP with ACA affordability standards so that total family premiums (across CHIP and the Marketplace) are capped for families at this level of poverty, and the goal of removing barriers to coverage at this level of poverty (even if those barriers affect relatively few children in families with incomes under 150 percent of poverty).[6]

Whereas the Medicaid and CHIP Payment and Access Commission is recommending reductions in CHIP premiums for children, the Centers

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Our results may offer insights into issues surrounding the possible exhaustion of CHIP federal funding.

for Medicare and Medicaid Services has recently granted Iowa and Michigan Medicaid waivers that would allow those states to charge premiums for adults with incomes of 100–138 percent of poverty.[25,26] Although our results pertain most directly to policy choices regarding premiums for children's coverage within CHIP, the premium sensitivity we observed for children highlights the importance of research to inform policy decisions on premiums for public coverage of adults.

Our results may also offer insights into issues surrounding the possible exhaustion of CHIP federal funding. If federal CHIP funding is not renewed, children formerly eligible for separate state CHIP programs would be eligible for subsidized Marketplace coverage so long as they are not eligible for "affordable" employer-sponsored coverage through their parents. The marginal cost to families of covering these children is likely to be zero, because Marketplace premiums net of tax credits are capped on a sliding-scale share of income between 2.0 percent and 9.5 percent (for the silver plan with the second-lowest premium in the area). Once the cap is met, there is no additional cost to the family of enrolling children. Given the premium sensitivity we observed, the result might be increased coverage (if families would otherwise have been facing a premium through CHIP), although differences between CHIP and Marketplace plans in cost sharing and provider networks may also be important for children and their families.

As can be seen in Exhibit 2, however, the large majority of CHIP-eligible children do have access to employer-sponsored insurance through parental offers (most of which are likely to qualify as affordable). In most cases, such offers would prevent children from accessing Marketplace subsidies (a problem known as the "family glitch"). For families of these children, losing access to CHIP might entail additional and potentially burdensome employer coverage premium payments if the children are to remain insured.

Conclusion

The primary finding of this article is that children's coverage may be sensitive to the premiums charged for public coverage—especially among children with low family incomes and among children lacking access to employer-sponsored coverage through their parents. Our study may also provide useful information for policy makers as the country debates the possible renewal of federal CHIP funding for fiscal years after 2015. What will be the roles of CHIP, Marketplace coverage, and employer-sponsored coverage for children currently eligible for CHIP, and how much will that coverage cost? Our evidence on the association between premiums and coverage—and how this association varies with income and parental employer coverage offers—may help inform the debate ahead as the nation once again approaches a crossroads for children's coverage. ■

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Early 2014 Stakeholder Experiences With Small-Business Marketplaces in Eight States

August 2014

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The Urban Institute

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 (ACA) of 2010. 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 in selected states to help states, researchers, and policy-makers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in these case study states. Cross-cutting reports and state-specific reports on case study states 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**.

Though the enrollment of individuals into the nongroup health insurance Marketplaces exceeded expectations for the 2014 open enrollment period, participation of employers in the small group Marketplaces, or the Small Business Health Options Program (SHOP), has started very slowly. Enrollment figures, for the few states that have released them, measure in the low thousands—sometimes only in the hundreds. Though the SHOP Marketplaces have emerged sluggishly, the reasons for this are largely consistent across the states, and many of them lend themselves to reversal or improvement. Significant challenges remain, but it would be inappropriate to judge the long term prospects of SHOP merely on its first-year experiences.

This analysis of early implementation experiences with the SHOP is based on case study interviews in eight states: Colorado, Illinois, Maryland, Minnesota, New Mexico, New York, Oregon, and Rhode Island. Interviews were conducted with a broad array of stakeholders in each state, including producers (brokers and agents), small business representatives, insurance carriers, consumer advocates, and application assisters (navigators and in-person assistors). The general consistency of information provided across these states suggests a significant degree of generalizability with other state-based Marketplaces and partnership Marketplaces taking responsibility for both consumer assistance and plan management activities.

THE EARLY SHOP EXPERIENCE AND CHALLENGES FACED

There was a widespread perception across the study states that SHOP had yet to be made a priority either at the state or national level. Rhode Island and New Mexico were exceptions in that there was some explicit state marketing focused on the SHOP (sources described the Rhode Island effort as "robust" and the New Mexico effort as "comprehensive"); our sources were not aware of SHOP-targeted marketing by the state agencies in the other six states studied. The one-year delay in the introduction of the federal online SHOP Marketplace, which received significant press attention, fueled the sense that SHOP was of secondary importance.

Sources reported that there is a tremendous lack of awareness of the SHOP at the most basic level within the small-employer community, and that many of those who are aware of it do not understand its function or role in the market. Consequently, a significant marketing and sales effort is required to engage employers, but such an effort has yet to significantly materialize. A clear, concise description of the SHOP and the added value it brings to the existing small group market seems not to have been elucidated or communicated. But developing an accurate, convincing description of the added value of SHOP has been challenging because of limitations of the reach of the small business tax credit, early renewals, extensions of non-ACA compliant plans, and other issues.

Small-business tax credit. The first obvious advantage of SHOP coverage, the ACA's small-employer tax credit provided exclusively through the SHOP, has shown itself to be largely irrelevant (with isolated exceptions). At its maximum, the small-employer credit covers 50 percent of the employer's contribution to the workers' coverage provided through the SHOP, but the maximum is only provided to employers of 10 or fewer full-time equivalents and with an average wage of $25,000 per year or less. At larger sizes and higher average wage levels, the credit phases down, disappearing for employers of 25 or more full-time equivalents and with an average wage of $50,000 or more per year. The phase-out is cumulative, so it can go to zero even before either the size or wage maximum is hit. Even for those eligible for sizable credits, the credit is only provided for two years.

Because of the narrow targeting of the credit and the phase-out schedule, few employers are eligible for sizable credits; this is particularly true in high cost-of-living areas where wages are higher. A source in Illinois, for example, noted that almost no small employers that offer or want to offer insurance qualify for the tax credits, adding that those employers that do qualify have employees who are better-off getting subsidized nongroup Marketplace coverage. Others noted that the complexity of computing the potential credit meant that employers felt that they had to use an accountant to explore their eligibility, the cost of which sometimes exceeded the value of the credit.

Off-SHOP plan options. The coverage options available to small employers outside of the SHOP for 2014 also decreased small employers' incentives to investigate and use the SHOP. The most important of these in many states was probably the widespread early renewals of existing policies. Even before the Obama administration relaxed the ACA's rules around the continuation of nongrandfathered non-ACA compliant small group and nongroup insurance plans, some insurers were already encouraging their 2013 customers to renew their existing plans early, before the end of 2013. By doing so, insurers could retain a larger share of their existing market in plans that did not comply with the ACA's rules introducing modified community rating, essential health benefit standards, and consumer cost-sharing standards. This was also a strategy that likely helped these carriers to retain a larger segment of their small employers with low risk profiles.

In addition to renewals of already held plans, sources indicated that similar or identical plans to those offered on the SHOP were frequently available in the off-SHOP small group market at the same (or nearly the same) price as those provided inside. Sources in New Mexico reported that off-SHOP small group coverage options had more attractive benefit designs, and more-flexible PPO plans were available outside the SHOP, compared to mostly HMOs inside the SHOP. As explained further below, familiarity with, simplicity of, and encouragement by brokers to enroll in the off-SHOP alternatives also reduced demand for purchasing through the SHOP. Plus, as some broker sources indicated, no small employer wanted to be out front on changing their sources of coverage. Though they may participate more significantly in the future, continuity for their workers (i.e., keeping what they had) was a higher priority, where financially feasible.

Other factors affecting SHOP enrollment in 2014. First-year software problems also discouraged SHOP use in 2014; in some cases, the IT problems were sufficiently serious that they all but prohibited enrollment. Multiple sources noted that small employers were much faster to abandon an online enrollment process when they ran into problems than individual purchasers seemed to be. In Maryland and Oregon, major IT problems created tremendous barriers for SHOP enrollment, no online enrollment was available, and SHOP plans could only be obtained via brokers and without employee choice.

In some substate areas, no plans provided coverage for providers outside of the plan's designated network. Multiple informants saw these types of circumstances as particularly unattractive to small-employer groups, particularly those who had provided broader coverage in the past. Some sources in Minnesota feared that the slow start for the SHOP there would discourage some of the carriers currently participating from doing so in the future.

FUTURE COMPETITIVE CHALLENGES FACING SHOPS

In several states, sources reported potential competition for the SHOP coming from private insurance exchanges. Though these private exchanges focus on large-employer business in some locations, others are already selling small-group coverage. They provide some degree of employee choice of plan as well as administrative relief for small employers, similar to some of the public SHOPs' advantages. These private exchanges take on different forms, with some organized by a single carrier and offering a choice of plans offered only by that carrier; others are run by benefit-consulting firms or broker organizations, with these able to offer multiple plans from different carriers. Coverage via the private exchanges does not qualify for small employer tax credits, however, and private exchanges are not thought to have currently achieved substantial market share. In some states, such as Colorado and New Mexico, informants were unaware of any new private exchanges, but in other states, such as Minnesota, New York, and Rhode Island, the advent of private exchanges is seen as a threat to the viability of the SHOP.

The ACA allows for two central exemptions from its small-group market reforms for employers with 50 or fewer employees (this threshold will increase to 100 or fewer employees in 2016): coverage via self-insurance or through an arrangement such as a bona fide association of employers under the Employee Retirement Income Security Act (ERISA).[1] The issues associated with these employer coverage options have been discussed in depth elsewhere.[2] To the extent that states do not regulate whether small employers can purchase private reinsurance policies (the product that makes it financially feasible for small employers to self-insure) or the structure of those policies sold in the state (e.g., minimum attachment points), small employers with low expected health care costs may purchase these policies in an effort to avoid sharing in the costs associated with their less-healthy counterparts in the regulated small-business insurance pool.

Similarly, states that are not closely scrutinizing the status of associations claiming to be large groups under ERISA may find substantial shares of their healthier small employers opting out of the small-group insurance pool regulated under the rules of the ACA. In the extreme case, these alternatives could undermine the stability of the ACA's small-group market reforms, with the ACA-compliant plans attracting predominantly employers with higher health care–cost workforces, or those employers with more-expensive cost profiles during particular periods of time.

In response to such potential risk-pooling problems, New York prohibited the sale of reinsurance to small employers even before the ACA, and Colorado and Rhode Island recently increased the minimum attachment point of reinsurance sold in the state. Oregon had similarly prohibited the sale of such policies to small employers, but rescinded that prohibition recently. The others have yet to take any steps in this direction. Most sources felt it was too early to tell whether reinsurance, a product traditionally unattractive to most small-employer purchasers, would become sufficiently widespread to compromise the ACA-compliant small group market. However, many noted that there is a growing interest among small employers in self-insurance options and a broader marketing of reinsurance products directed at small employers than in the past. In Oregon, many of the small-employer associations that offered association health plan coverage before the ACA are now claiming status as bona fide employer groups under ERISA.[3] Under federal law, an association health plan sponsored by an association that meets this status would be regulated under the standards applicable to the large-group market. In the other study states, associations claiming to be a large-employer group under ERISA were not reportedly widespread currently, though they remain a point of potential vulnerability without explicit regulatory action to set standards to limit the number of applicants meeting the criteria.

Finally, some sources voiced concern that SHOP price competition could actually decrease if the low rates of small-employer enrollment leads carriers to stop participating, but it was too soon to identify whether or not this would be an issue in 2015, and if so, in what specific geographic areas.

EMPLOYEE CHOICE

Historically, small employers have seldom been able to provide a choice of health insurance plans to their workers. In 2012, for example, only 15.4 percent of employers in firms of fewer than 10 workers that offered health insurance to their workers provided a choice of two or more plans to their workers.[4] In contrast, 79.0 percent of employers in firms of 1000 or more workers that offered health insurance provided a choice of two or more plans. Early research cited employee choice models in the SHOPs as a major draw for employers considering whether or not to offer coverage through the new Marketplaces. Though the employee choice model may eventually encourage larger numbers of small employers to explore SHOP Marketplaces, the lack of a widespread small-employer marketing effort and time-consuming application processes have left many employers unaware of employee choice and have added to the first year's low enrollment numbers.

Some large, well-established carriers articulated early concerns that employee choice would allow high-cost workers to cluster in particular plans while healthier workers chose other options (i.e., adverse selection). At times, such concerns may have contributed to particular carriers deciding not to participate in SHOP Marketplaces in 2014, but generally, carrier participation was quite high (among our study states, the number of carriers participating in the first year were: six in Colorado, three in Illinois, 13 in Maryland,[5] three in Minnesota, three in New Mexico, nine in New York, eight in Oregon, and three in Rhode Island).

Business groups and associations in the study states have mixed opinions on the value of employee choice. In Colorado, a state that implemented employee choice in the first year, some employers expressed their preference for a limited choice model because they believe it will be more cost-efficient given the significant time it took to assist employees in selecting a plan (Colorado offers SHOP-participating employers three options, including employer choice of one plan (no employee choice), employee choice of any plan within a single actuarial-value tier (bronze, silver, gold, or platinum), or employee choice of a single plan in any actuarial-value tier. Other small business groups, in Colorado and elsewhere, were adamant that the concept of employee choice will be a draw to the SHOP, but only if the IT systems are flawless and facilitate quick shopping, which is not yet the case in most states.

In New York, small-business representatives expressed concern that a lack of understanding of employee choice will lead to "accounting nightmares" during tax reconciliation. For businesses, as part of the employee-choice model, the employer has the option to instruct employees to select any plan at a designated actuarial-value tier or any plan offered by one carrier at different actuarial-value tiers. Employees will likely choose different plans; consequently, the amount of benefit falling under the auspices of the employer-based tax exclusion will need to be accounted for and adjusted for each employee. From the employees' side, if an employee purchases the cheapest plan available to them, thus using a smaller percentage of their wages toward healthcare, they may end up with more taxable income than expected when reviewing their taxes.

The federal government announced that it would delay the implementation of employee choice in the states in which the federal government is responsible for operating the SHOP.[6] Though this was believed to be a major setback for the SHOP, delaying employee choice likely helped the federal government focus on the nongroup marketplace, repair its IT problems, and maximize enrollment in the individually purchased market. Small employers who did purchase coverage through the SHOP in any of the 34 federally facilitated Marketplaces chose one plan from the locally available insurance plans that chose to participate and which met the qualified health plan standards. Each participating employer provided the selected plan as a single option to their employees—an approach known as traditional employer choice.

The federal government recently announced that they will allow some states to further delay implementation of employee choice until 2016.[7] Eighteen states have chosen to take up this option to delay, while 14 will implement employee choice through the federally facilitated Marketplace SHOP in 2015.[8]

AGENT AND BROKER PARTICIPATION

In the small business community, brokers and agents have long been employers' trusted partners, educating and connecting small-employer groups to health coverage and other forms of insurance and services. Brokers and agents feel, however, that marketing campaigns for the new Marketplaces failed to recognize and advertise the support brokers can offer, focusing instead on navigators and in-person assistors under contract to the Marketplaces. In addition to feeling left out of the advertising campaigns, brokers frequently reported problems with the state-run broker training sessions, often finding the substance of the trainings inadequate. They also expressed frustration that the level of compensation was inadequate given the time demands of selling coverage through the SHOP; they consistently reported the time to sell coverage through the SHOP was much greater than the time to sell outside products. Consequently, even brokers certified to sell coverage in 2014 generally stated that they performed few to no sales through it, and many were unclear whether that would change in 2015. As one informant noted, "one of the main reasons that SHOP enrollment is low is because small businesses trust their brokers, and brokers have been steering people away from the SHOP."

In order to sell coverage through the SHOP in a state-based Marketplace, brokers must go through a state-specific training and certification process. Many brokers noted that the training program and materials provided were often ineffective and sometimes inaccurate. In New York, brokers noted that the training and certification materials were factually inaccurate—misstating the state's insurance market rules that differ from the federal minimums. Because this incorrect information was also reflected in questions on the certification test, instructors had to teach false information in order for the group to pass the test, hopefully correcting the group afterward. In Colorado, the broker training session was held before the website was functional, leaving many feeling like the training was impractical because they were unable to learn how to interact with the Marketplace system. In Minnesota, two of the "true or false" questions on the broker certification exam were, according to one source, "MNsure can be relied on as a reliable source of information," and "Using MNsure's on-line tools can be fast, easy and convenient." Puff questions such as these fed the perception that the process was "embarrassingly uninformative." In Maryland, some sources complained that the navigators and assistors were inadequately trained on the SHOP and thus were unable to assist employers, the presumption being that the small employers would rely upon agents and brokers.

One chief complaint from brokers across all states was that the compensation structure for SHOP sales was the same as for selling directly through a carrier, despite the substantially greater time necessary to enroll a small business group through the SHOP's IT system. Whereas applying for off-Marketplace products is simply filling out one or two short forms, working with the Marketplace can take brokers up to a few days, especially if they have to educate employees about employee choice options. Brokers frequently felt that the training did not prepare them sufficiently for using the SHOP interface, sometimes adding to the time necessary to enroll a client because the broker had to work through the website with little to no understanding of the system. Consequently, brokers quickly lost interest in selling SHOP-based coverage. In states that allowed early renewal of policies, small-business groups reported that their brokers often urged them to renew their plan early rather than explore SHOP coverage.

In addition to complaints about the rate of compensation, brokers have expressed frustration with broker attribution systems, which have left some uncompensated for completed work. The attribution problem breaks down at one of two places: either the enrollment system does not properly inform the insurance company which broker helped sell the policy, or the enrollment system only allows for one name to be applied per consumer, leading to call centers dropping brokers from the system and vice versa. The call center in Colorado staffs brokers and health coverage guides; if a small business employer used the call center brokers even for a simple question, in order to receive compensation for the help, the call center broker could "drop" another broker's assignment to the same small group, regardless of whether or not the call center broker actually conducted the sale.

EFFECT ON THE SMALL BUSINESS ENVIRONMENT

Because of the SHOP's slow start, it has had little impact on the small business environment so far. Although data on employer offers and worker coverage through their employers is unavailable for 2014, sources did note some changes that could grow in the coming years.

In some states, sources noted that, particularly for the very smallest employers with low-wage workers, the presence of a reformed and subsidized nongroup insurance market encouraged some small groups to drop coverage all together, sending their employees to the new Marketplaces for insurance. Employees seemed to appreciate this, especially because of the availability of subsidized coverage for their dependents. One source expressed concern about employers that drop coverage and add a health coverage stipend to their employees' wages; this may adversely affect the employees because the employees may earn more taxable income despite part of that income being used for healthcare services. In addition, according to some sources, the reformed nongroup market may be facilitating hiring for small employers who have traditionally not offered coverage and have thus been at a competitive disadvantage in the labor market.

CONCLUSION

There is no doubt that the ACA SHOP Marketplaces have a long way to go to become successful. However, their current status is due in significant degree to the focus of resources and attention in the first year on the nongroup Marketplaces. This approach can be altered as the nongroup Marketplaces continue to increase in enrollment and stability. To move the SHOP business to stronger ground, however, considerable thought and effort must be put into the most effective framework for marketing and sales of the small-group products that they offer. A clear and concise understanding of the extra value brought to the market by the SHOP is particularly important, and is an effort that can be taken jointly by the state-based Marketplaces and the federally facilitated ones. Administrative simplification and employee choice hold substantial promise in this regard, but developing avenues for adding additional product lines (e.g., COBRA management, disability insurance) may be especially vital to developing a strong competitive stance in the face of the growing presence of private insurance exchanges. In addition, smoothly operating websites, shorter application processing times, and increased business functionality for brokers are fundamentally needed improvements in order to make the SHOP product more attractive for small employers and, perhaps even more importantly, the individuals upon whom they have traditionally relied to sell them insurance coverage and other business services.

ENDNOTES

1. An association health plan is deemed to be bona fide, and therefore treated as large group insurance under the Affordable Care Act (even if small employers are the ones purchasing the product for their employees), if it meets the federal standards set by ERISA for an employer. The Department of Labor has issued very little guidance on the requirements to meet those standards, and, as such, state departments of insurance are taking different approaches in deciding which applicants are and are not to be classified as bona fide association health plans under ERISA.
2. See Lucia K, Monahan C and Corlette S. *Cross-Cutting Issues: Factors Affecting Self-Funding by Small Employers: Views From the Market*. Washington: Urban Institute, 2013, http://www.urban.org/UploadedPDF/412799-Factors-Affecting-Self-FundingbySmall-Employers.pdf; Buettgens M and Blumberg LJ. *Small Firm Self-Insurance Under the Affordable Care Act*. New York: The Commonwealth Fund, 2012, http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2012/nov/1647_buettgens_small_firm_self_insurance_under_aca_ib.pdf; and Lucia K, Corlette S and Ahn S. *Association Health Plans: A Changing Market in Oregon?* Washington: Urban Institute (Forthcoming 2014).
3. Lucia K, Corlette S and Ahn S, *Association Health Plans*.
4. Agency for Healthcare Research and Quality. “Percent of Private-Sector Establishments That Offer Health Insurance That Offer Two or More Health Insurance Plans by Firm Size and Selected Characteristics: United States, 2012.” From *2012 Medical Expenditure Panel Survey–Insurance Component*, http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2012/tia2d.pdf (accessed July 30, 2014).
5. Although identified as 13 separate carriers, some of the 13 in Maryland have some relationship to one another. The full set includes: Aetna Health Insurance Inc., Aetna Life Insurance, CareFirst Blue Choice, CareFirst of Maryland, GHMSI (a CareFirst Company), Coventry Health and Life Insurance Co., Coventry Health Care of Delaware, Evergreen Health Cooperative, Kaiser Foundation Health Plan, MAMSI Life and Health Co., Optimum Choice, United Healthcare Insurance Co., United Healthcare of the Mid-Atlantic.
6. Pear R. “Small Firms’ Offer of Plan Choices Under Health Law Delayed,” *New York Times*, April 1, 2013, http://www.nytimes.com/2013/04/02/us/politics/option-for-small-business-health-plan-delayed.html (accessed July 30, 2014).
7. Centers for Medicare and Medicaid Services. “Small Business Health Options Program (SHOP),” http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/2015-Transition-to-Employee-Choice-.html (accessed July 30 2014).
8. Of the 34 states with federally facilitated Marketplaces, 14 will implement employee choice this year: Arkansas, Florida, Georgia, Indiana, Iowa, Missouri, Nebraska, North Dakota, Ohio, Tennessee, Texas, Virginia, Wisconsin, and Wyoming. Eighteen states will not implement employee choice until 2016: Alabama, Alaska, Arizona, Delaware, Illinois, Kansas, Louisiana, Maine, Michigan, Montana, New Hampshire, New Jersey, North Carolina, Oklahoma, Pennsylvania, South Carolina, South Dakota, and West Virginia.

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By David Dranove, Craig Garthwaite, and Christopher Ody

Health Spending Slowdown Is Mostly Due To Economic Factors, Not Structural Change In The Health Care Sector

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ABSTRACT The source of the recent slowdown in health spending growth remains unclear. We used new and unique data on privately insured people to estimate the effect of the economic slowdown that began in December 2007 on the rate of growth in health spending. By exploiting regional variations in the severity of the slowdown, we determined that the economic slowdown explained approximately 70 percent of the slowdown in health spending growth for the people in our sample. This suggests that the recent decline is not primarily the result of structural changes in the health sector or of components of the Affordable Care Act, and that—absent other changes in the health care system—an economic recovery will result in increased health spending.

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Health spending increased from 4.4 percent of the US gross domestic product (GDP) in 1950 to 17.7 percent in 2011. During this time health expenditures grew approximately 2.4 percentage points per year faster than GDP. Given historical trends, health spending has been projected to consume approximately 20 percent of GDP by 2021.[1] However, these projections are in doubt given the recent slowdown in the growth of health spending. From 2000 to 2007 annual health expenditures grew at a rate of 6.6 percent, but this growth rate slowed to an average of only 3.3 percent per year from 2008 to 2011.[2]

The ultimate source of this slowdown remains an open question. Potential explanations include a decline in medical innovations, recent patent expirations for popular and expensive pharmaceuticals, various features of the Affordable Care Act (ACA), and the economic slowdown that began in December 2007. This article joins a number of previous studies that have attempted to measure how much of the decline in the growth of health spending can be explained by that economic slowdown.[3–5] Understanding the slowdown's relative role will provide an upper bound on the effect of other factors.

Previous studies attempted to answer this question by modeling how GDP affected national health spending before the most recent economic slowdown and using the results to estimate how the recent slowdown affected current health spending.[5,6] Taking this approach, the Kaiser Family Foundation concluded that declines in health spending that were attributable to the most recent downturn in GDP growth accounted for 75 percent of the overall health spending slowdown.[5] In contrast, David Cutler and Nikhil Sahni estimated that only 37 percent of the change in health spending from 2008 to 2010 resulted from the downturn in GDP growth.[3] The different estimates of the relative role of the macroeconomy are primarily the result of different definitions of the timing and severity of the most recent recession.

We took a different analytic approach by exploiting variation in the regional severity of the economic slowdown: We compared trends in spending in metropolitan areas that experienced sharp economic declines and trends in spending in areas that saw little if any decline. Thus, we were able to estimate the effect of the slowdown on spending based on what actually occurred

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during the slowdown, instead of using projections from past macroeconomic shocks. To accomplish this, we used new data from the Health Care Cost Institute (HCCI), an independent, nonprofit entity that has obtained insurance claims data from Aetna, Humana, and UnitedHealthcare.

In addition to adopting a new empirical strategy, we departed from previous work by measuring macroeconomic conditions using the employment-to-population ratio—the percentage of the working-age population that was actually working—instead of GDP. We did this in part because our empirical strategy exploited local economic variation, and GDP is not reliably measured at the local level. Of equal importance, there are good theoretical reasons, discussed below, to use employment instead of GDP to predict health spending.

Our analytical approach has both advantages and disadvantages when compared with previous work. Previous studies generally assume that the statistical relationship between GDP and health spending that prevailed during prior economic slowdowns continues in the current economy. This assumption may be problematic, however, because the most recent slowdown has been characterized by an economically meaningful difference between the recovery in employment and GDP growth that is unlike what occurred in historical business cycles.

Our approach avoids making any assumptions about the continuation of past relationships. In addition, we can separately control for contemporaneous national trends in health care spending that are unrelated to the slowdown.[7]

However, this benefit comes with two primary costs. First, employment is a potentially preferably measure of the local economic climate during the most recent slowdown, but our results are not directly comparable to other studies that rely on national GDP. Second, because we used HCCI data, our findings may not be generalizable to the entire US population.

Our findings may be summarized as follows: In our sample of insured patients (described below), annual growth in health spending in the period 2009–11 was 2.6 percent below growth in the period 2007–09. We estimate that each percentage-point decrease in the employment-to-population ratio is associated with a statistically significant 0.84 percent decline in mean health spending per patient during 2007–11. Based on the overall decline in employment, we calculate that if the economic slowdown had not occurred, annual growth in aggregate health expenditures from 2009 to 2011 among our sample would have been approximately 1.8 percentage points higher. This implies that the economic slowdown explained approximately 70 percent of the reduction in health care spending for our sample.

The Relationship Between The Macroeconomy And Health Spending

According to long-standing tradition, GDP is used to define a recession. But GDP may not be an ideal predictor of health spending in the years since the latest economic slowdown. The benefits of GDP growth in the recovery following the 2007–09 recession appear to have been concentrated among the wealthy.[8] However, overall trends in health spending might be more likely to reflect the decisions of the entire population than just those of the wealthy.

For many people, the negative effects of the slowdown have lasted long after the official end of the recession in June 2009. Indeed, two years after GDP growth signaled the official "end," the unemployment rate remained approximately 65 percent above the pre-recession level. Similarly, throughout 2011 the University of Michigan's Index of Consumer Sentiment, a summary measure of consumers' expectations about the economy, remained at roughly the same average level as during the official period of the recession. This rate was well below the average level in the year before the recession began.[9] The difference between GDP growth and other outcomes such as employment and median income following a slowdown is a relatively new phenomenon that has often been described as a "jobless recovery."[10] For these reasons, it is important to consider alternative macroeconomic measures to GDP that could be predictive of health spending.

When we considered other measures, we observed that changes in the macroeconomy might affect health spending through several channels: Such changes affect current income and expected lifetime wealth (also called "permanent income"), both of which might affect health spending in turn. In the following discussion we use the term *wealth* broadly, to refer to both current and permanent income.

There are many channels through which wealth could affect health spending. First, wealth might directly affect demand for health services, if both health and insurance status are held constant, because nearly all people make some direct payments for medical care. If consumers have less wealth, they may purchase fewer health services.[11]

Second, wealth might indirectly affect spending through the choice of insurance. A person who suffers a decline in wealth might prefer to

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Future economic growth will cause health spending to be higher than it would have been if the economy remained stagnant.

purchase a less generous policy for a lower premium or to go without coverage altogether.

Third, wealth might directly affect health status. Several studies suggest that lower wealth may cause poorer health.[12,13] It is hypothesized, for example, that people who lose their jobs may experience stress, which in turn leads to poorer health.[14] These health declines could translate to higher health spending.[15–17]

Finally, wealth might affect the rate of the adoption of and change in available technologies. In the short run, providers may be reluctant to adopt costly new technologies if patients are reluctant to pay for them. Thus, local supply may respond to local demand.[18,19] And in the long run, medical research and development spending might fall in the wake of a decline in demand. The latter effect, which we would not expect to appear in our short time horizon, should be felt in roughly equal proportions in all markets (except to the extent that the adoption of new technology varies by market, as discussed above).

Given the breadth and depth of the most recent economic slowdown, the channels described above likely affected the health spending of even people who retained employer-provided insurance. Some of these people—or perhaps more likely their family members—may have lost their jobs. Others may perceive a much greater risk of losing their jobs and thus meaningfully alter their expectations of permanent income. Beyond the direct effect on earnings, the slowdown caused large decreases in the value of people's homes—often a major component of their wealth.

In light of these points, we used the employment-to-population ratio as our measure of the economic impact of the slowdown. Not only does this ratio capture the direct effect of the slowdown on earnings, but it is also correlated with changes in housing wealth. Thus, local employment is a good proxy for the broader effect of the slowdown. And, as a practical matter, employment can be reliably measured at the level of the Core Based Statistical Area (CBSA), which allowed us to implement our empirical strategy.

Study Data And Methods

DATA SOURCES Our data on health spending in the period 2007–11 came from the HCCI. In addition to aggregate health spending, the data contained monthly enrollment and disenrollment figures, rudimentary plan characteristics, and geographic market identifiers. The *geographic market* is defined as either the CBSA or the state for people who reside outside of a CBSA.

We restricted our analysis to people ages 26–64[20] with employer-sponsored nongroup health insurance of one of the following types: exclusive provider organization, health maintenance organization, point-of-service plan, or preferred provider organization.[21] We assigned people to a fixed CBSA as of their entry month into the sample, and we excluded people who resided outside of a CBSA, who had gaps in coverage, or who had inconsistencies in the data (such as different birth years). This gave us a sample of nearly forty-seven million enrollees during the study period.

Using the HCCI claims data, we measured mean total health care expenditures in each CBSA and quarter.[22] We also determined in each CBSA and quarter the number of enrollees, the average age of the insured person, and the share of enrollees who were insured through their spouses.

The annual rate of growth in national health expenditures declined from 2002 to 2011 (Exhibit 1). In 2008 there was a sudden drop in the annual growth rate, which remained depressed through 2011. Our sample of HCCI claims data covers only the period 2007–11. As expected, spending growth for our sample of insured people was generally higher than overall health spending growth. However, the pattern of the changes in health spending after 2008 for our sample was broadly similar to that of the national estimates.[23] Given the substantial slowdown in spending by the insured people in our sample, it is clear that insurance losses among people who lost employment cannot be the only explanation for the overall slowdown in health spending.

To measure the severity of the recession for each CBSA, we used employment data from the Local Area Unemployment Statistics of the Bureau of Labor Statistics. We then used census estimates to calculate the employment-to-population ratio for each CBSA.[24] The red line in

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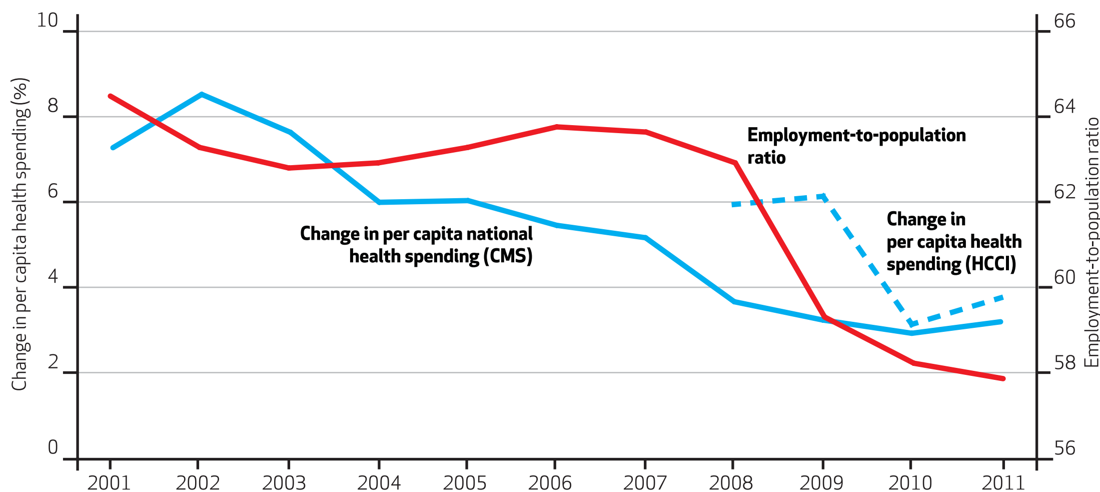
EXHIBIT 1

Per Capita Health Spending Growth And Employment-To-Population Ratio, 2001–11



SOURCE Authors' analysis of 2007–11 data from the the Health Care Cost Institute (HCCI), 2000–11 national health expenditure data from the Centers for Medicare and Medicaid Services, 2001–11 June employment data from the Local Area Unemployment Statistics of the Bureau of Labor Statistics, and 2001–11 annual working-age population data from the Census Bureau. **NOTES** Per capita HCCI health spending growth is for our sample population. The red solid line (employment-to-population ratio) relates to the right-hand *y* axis. The blue solid and dotted lines (change in health spending) relate to the left-hand *y* axis.

Exhibit 1 shows changes in the national employment-to-population ratio from 2001 to 2011.

This ratio was relatively flat until 2008, when it experienced a large drop. The decline was concurrent with the dating of the 2007–09 recession by the National Bureau of Economic Research.[25] However, employment remained depressed through 2012—well after the recession officially ended, in June 2009. This may explain why growth in health spending remained muted well beyond 2009.

ANALYSIS We gauged the local intensity of the most recent economic slowdown by calculating the total absolute change in the employment-to-population ratio from January 2008 to January 2010 in each CBSA. This represents the change from the approximate peak to the approximate trough in the employment-to-population ratio.

To make our results easier to interpret, we multiplied this measure by –1, so areas that were hit hardest by the slowdown had higher (more positive) values on the measure. For the 366 CBSAs in our sample, this variable ranged from 0.6 to 8.6. The mean was 4.4, and the interquartile range was 3.1–5.9.[26] This demonstrates that there was substantial regional variation in the impact of the economic slowdown on employment.[27]

LIMITATIONS As discussed above, one limitation of our approach was that we studied only privately insured people. However, this group is both important and interesting. In 2011, 64 percent of all Americans had private insurance, and approximately half of all health expenditures of insured people were paid by private insurers. Therefore, understanding the health spending of the privately insured is critical to understanding total health expenditures.

It is possible that our estimates were driven by a change in the composition of the insured population during the slowdown.[28] Unfortunately, the data did not permit us to fully explore this possibility. However, we could document that the local severity of the slowdown was unrelated to the average age of enrollees, the total number of enrollees in an area, or the share of enrollees who were insured through their spouses. Nor did including these variables as controls affect the magnitude of our estimates. This suggests that changes in the composition of the insurance pool did not drive our results.

Study Results

We begin with a simple observation from our data set: Insured people residing in areas that were hardest hit by the economic slowdown experienced the smallest increases in health spending. For example, from 2008 to 2009, Las Vegas, Nevada, and Birmingham, Alabama—two particularly hard-hit CBSAs—experienced declines in their employment-to-population ratios of 5.6 percentage points and 5.9 percentage points, respectively. From 2007 to 2011, the changes in health spending in these areas were only

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5.4 percent and 7.2 percent, respectively. In contrast, in the same periods Trenton, New Jersey, and Dallas, Texas, saw employment-to-population ratio declines of 1.6 percentage points and 3.0 percentage points and health spending increases of 29 percent and 28 percent, respectively.

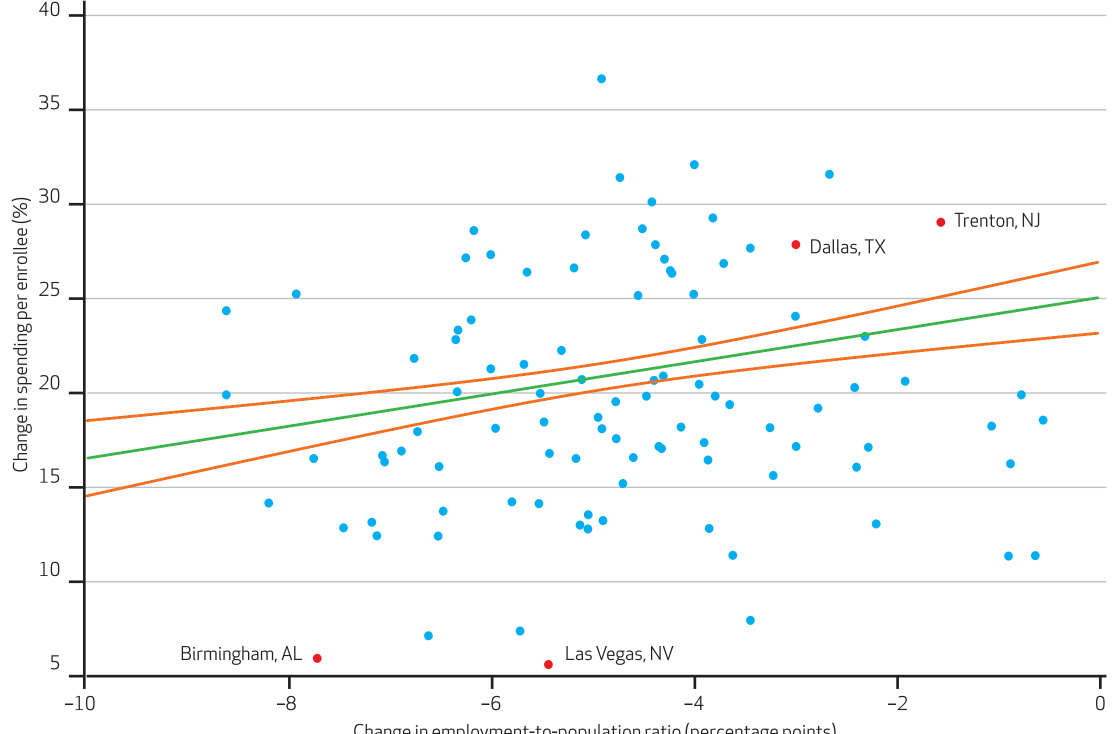
Exhibit 2 compares changes in health spending and changes in the employment-to-population ratio for the hundred largest CBSAs in our sample. The green line in the exhibit represents a weighted regression of the change in health spending on the change in the employment-to-population ratio. This shows that each percentage-point decrease in the ratio from January 2008 to January 2010 is associated with a 0.84-percentage-point decline (95% confidence interval: 0.477, 1.2) in the change in mean health spending per enrollee from 2007 to 2011. To place the magnitude of this estimated change in context, a CBSA with an employment decline in the 75th percentile would have had 2.1 percentage points lower health spending growth from 2007 to 2011 than a CBSA with an employment decline in the 25th percentile.

We cannot fully rely on the results depicted in Exhibit 2, because the differential trend in spending growth in geographic areas that were harder hit by the economic slowdown may have been a continuation of a previous trend that was unrelated to the recession. To rule out this possibility, we performed an additional regression analysis that included a variable for each quarter year in our sample that was interacted with our measure of the slowdown—that is, the "peak to trough" decline in the employment-to-population ratio for the CBSA. The coefficient on each interaction term told us how the economic slowdown affected the level of health spending in that quarter relative to the first quarter of 2007.[29]

Given the large number of coefficients produced by our regression analysis, we summarize our estimates graphically in Exhibit 3. If the relationship depicted in Exhibit 2 was caused by the slowdown as opposed to some unrelated previous trend, the coefficients in Exhibit 3 should

EXHIBIT 2

Effect Of Changes In The Employment-To-Population Ratio, January 2008–January 2010, On Changes In Per Capita Health Spending, 2007–11



SOURCE Authors' analysis of 2007–11 data from the Health Care Cost Institute (HCCI), January 2008 and January 2010 employment data from the Local Area Unemployment Statistics of the Bureau of Labor Statistics, and 2007–11 annual working-age population data from the Census Bureau. **NOTES** The scatter plot depicts the hundred largest Core Based Statistical Areas (CBSAs) in the sample. The population-weighted regression line (the green line) and the lines indicating the 95 percent confidence interval (the orange lines) are for our entire sample of 366 CBSAs.

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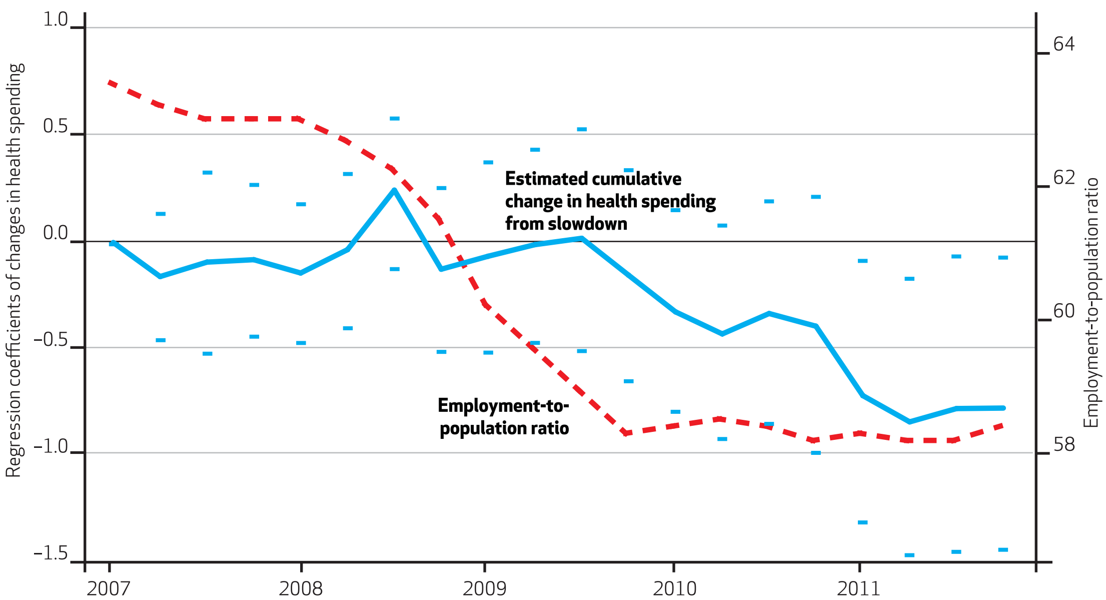
EXHIBIT 3

Regression Estimates Of The Effect Of The Economic Slowdown On The Change In Health Spending, By Quarter, 2007–11



SOURCE Authors' analysis of 2007–11 data from the Health Care Cost Institute (HCCI), 2007–11 employment data from the Local Area Unemployment Statistics of the Bureau of Labor Statistics, and 2007–11 annual working-age population data from the Census Bureau. **NOTES** Trough-to-peak change is from January 2008 to January 2010. The cumulative effect is based on a percentage-point drop in the employment-to-population ratio. The solid blue line indicates the coefficients, and the blue tick marks indicate the 95 percent confidence intervals; these relate to the left-hand *y* axis. The national employment-to-population ratio is in red; this relates to the right-hand *y* axis.

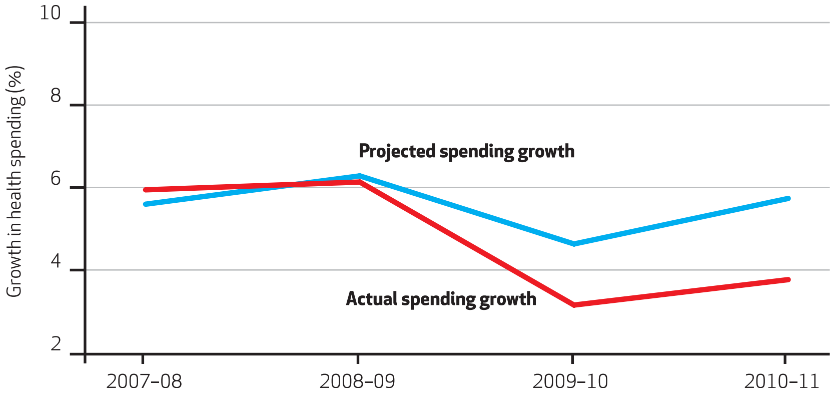
be near zero before the economic slowdown. That is, health spending changes should not have foreshadowed the impending economic crisis. Once the slowdown hit, the coefficients should be negative, and their absolute magnitude should increase over time as the effects of the slowdown mount. This expected pattern of coefficients is exactly what we observed, and thus we can rule out unrelated prior trends as the drivers of our main results.[30,31]

Our goal was to assess the extent to which the recent economic slowdown has contributed to the slowdown in health spending. Thus, we performed a simple counterfactual exercise whose results are summarized in Exhibit 4. From 2009 to 2011 the actual growth rate in per capita health spending was 2.6 percentage points slower than the actual growth rate in per capita health spending from 2007 to 2009. We predicted that the average decline in spending would have been only 0.8 percentage points if the economy had not faltered in 2008. Therefore, we conclude that approximately 70 percent of the decline in spending growth in our sample can be attributed to the recent slowdown.

In addition, the employed people in our sample may have been somewhat sheltered from the economic impact of the slowdown. Thus, our estimates may understate the impact of the change in macroeconomic conditions on the health spending of the entire population.

EXHIBIT 4

Actual Change In Per Capita Health Spending And Projected Change From One Year To The Next, Holding The Employment-To-Population Ratio Constant, 2007–11



SOURCE Authors' analysis of 2007–11 data from the Health Care Cost Institute (HCCI), January 2008 and January 2010 employment data from the Local Area Unemployment Statistics of the Bureau of Labor Statistics, and 2007–11 annual working-age population data from the Census Bureau. **NOTES** Actual spending growth is the actual annual change in per capita health spending in our sample from one year to the next, in the year pairs shown. Projected spending growth is the predicted annual change in per capita health spending in our sample, if the employment-to-population ratio had not changed.

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Conclusion

Our estimates show that most of the recent slowdown in health spending growth, at least among the working population, can be attributed to the economic slowdown and not to other factors such as early responses to the ACA. However, it is important to note that our findings do not automatically imply that spending will increase at a faster pace as the economy recovers, because the ACA (or other new factors) may offset future growth. That being said, our results indicate that future economic growth will cause health spending to be higher than it would have been if the economy remained stagnant. ■

The authors thank the Health Care Cost Institute (HCCI) for providing the data, Carolina Herrera at the HCCI for patiently answering questions about the data, Jeffrey Parnaby and other staff members at Optum Insight for assistance with the data, Bob Doyle for setting up the necessary data security protocols, and Tomasz Wisniewski and the Kellogg Data Center for hosting the data for this project. All remaining errors are those of the authors.

NOTES

1 CMS.gov. National health expenditure projections 2011–2012 [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; [cited 2014 Jun 3]. Available from: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf

2 Authors' calculations based on the projections in Note 1.

3 Cutler DM, Sahni NR. If slow rate of health care spending growth persists, projections may be off by $770 billion. Health Aff (Millwood). 2013;32(5):841–50.

4 Ryu AJ, Gibson TB, McKellar MR, Chernew ME. The slowdown in health care spending in 2009–11 reflected factors other than the weak economy and thus may persist. Health Aff (Millwood). 2013;32(5):835–40.

5 Kaiser Family Foundation. Assessing the effects of the economy on the recent slowdown in health spending. Menlo Park (CA): KFF; 2013 Apr 22 [cited 2014 Jun 3]. Available from: http://kff.org/health-costs/issue-brief/assessing-the-effects-of-the-economy-on-the-recent-slowdown-in-health-spending-2/

6 The Kaiser Family Foundation (Note 5) forecasts health spending as a function of lagged GDP growth and inflation using pre-recession data and uses its estimates of GDP growth and inflation during the recession to predict health spending. David Cutler and Nikhil Sahni (Note 3) base their predictions of health spending during the recession on a Centers for Medicare and Medicaid Services (CMS) model that also uses pre-recession data.

7 National trends will not bias our estimates unless regional departures from trends in health spending are correlated with the magnitude of the slowdown yet are not results of the slowdown. (In statistics parlance, "time-varying unobservable covariates" would be correlated with the magnitude of the slowdown.) One standard approach in the public economics literature for assessing this possibility is to look for substantial differences in trends prior to the recession across areas and to see whether or not trends prior to the recession are correlated with changes in the employment-to-population ratio. For example, in our setting we would be concerned if our pattern of coefficients on the quarterly variables were not flat and near zero before the recession. However, we found no such pattern.

8 For example, Emmanuel Saez estimates that from 2009 to 2012, average real incomes per family for the top 1 percent of families grew by 31.4 percent, while average real incomes per family for the bottom 99 of families grew by 0.4 percent. Saez E. Striking it richer: the evolution of top incomes in the United States (updated with 2012 preliminary estimates) [Internet]. 2013 Sep 3 [cited 2014 Jun 3]. Unpublished paper. Available from: http://eml.berkeley.edu/~saez/saez-UStopincomes-2012.pdf

9 The Index of Consumer Sentiment is available at University of Michigan. Surveys of consumers [Internet]. Ann Arbor (MI): Regents of the University of Michigan; c2014 [cited 2014 Jun 3]. Available from: http://www.sca.isr.umich.edu/tables.php

10 Berger D. Countercyclical restructuring and jobless recoveries. Paper presented at: Society for Economic Dynamics annual meeting; 2012 Jun 24; Limmasol, Cyprus.

11 Acemoglu D, Finkelstein A, Notowidigdo MJ. Income and health spending: evidence from oil price shocks. Rev Econ Stat. 2013;95(4):1079–95.

12 Evans WN, Garthwaite CL. Giving mom a break: the effect of higher EITC payments on maternal health. Am Econ J Econ Policy. 2014;6(2):258–90.

13 Lindahl M. Estimating the effect of income on health and mortality using lottery prizes as an exogenous source of variation in income. J Hum Resour. 2005;40(1):144–68.

14 Sullivan D, von Wachter T. Job displacement and mortality: an analysis using administrative data. Q J Econ. 2009;124(3):1265–306.

15 Ruhm CJ. Are recessions good for your health? Q J Econ. 2000;115(2):617–50.

16 Stevens AH, Miller DL, Page ME, Filipski M. The best of times, the worst of times: understanding procyclical mortality [Internet]. Cambridge (MA): National Bureau of Economic Research; 2011 Dec [cited 2014 Jun 3]. (NBER Working Paper No. 17657). Available from: http://www.nber.org/papers/w17657.pdf

17 Two studies (Notes 15 and 16) that examined the aggregate relationship between the macroeconomy and health have found that mortality falls during recessions. This might suggest lower spending during a recession results from health status. However, Ann Stevens and coauthors (Note 16) found that these mortality changes during a recession occurred primarily among the elderly. This suggests that any confounding direct effects of the economy on health are less of a concern for our sample of nonelderly people.

18 Dranove D, Garthwaite C, Ody C. How do hospitals respond to negative financial shocks? The impact of the 2008 stock market crash. Cambridge (MA): National Bureau of Economic Research; 2013 Feb. (NBER Working Paper No. 18853).

19 Some hospitals may have experienced sharp declines in endowments during our study period, which might have led to reductions in investments (see Note 18). However, this effect should not be tied to local economic conditions.

20 We imposed this restriction because the ACA requires insurers to allow dependents ages 19–25 to be covered through their parents' insurance, which resulted in large enrollment changes in this age group during our study period.

21 We excluded people with a number

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of plan types that rarely appear in the data, such as short-term health insurance plans or indemnity plans (most indemnity plans appear to be supplemental Medicare insurance).

22 One limitation of the HCCI data is the lack of prescription drug expenditures for enrollees whose employers use a third-party firm to administer their prescription drug benefits. In the data these enrollees are coded as not having drug coverage.

23 Alexander Ryu and colleagues (Note 4) documented a very similar pattern in spending growth changes in the large employer market during the same time period. The striking similarity in trends should alleviate some concerns when our results are extrapolated to the private health insurance market in general.

24 We used the employment-to-population ratio because it is not affected by decisions to enter the labor force and instead provides a local measure of changes in economic activity resulting from the slowdown. However, our results were broadly consistent with results using the local unemployment rate instead of the employment-to-population ratio.

25 National Bureau of Economic Research. Business cycle dating committee [Internet]. Cambridge (MA): NBER; 2010 Sep 20 [cited 2014 Jun 3]. Available from: http://www.nber.org/cycles/sept2010.html

26 We winsorized the changes in the employment-to-population ratio at the 5th and 95th percentiles largely to facilitate the graphical presentation of our results. Our conclusions did not change qualitatively when we did not winsorize the variable.

27 Our measure of the absolute change explained the majority of the variation during this time period. In particular, if we estimated our model using a twelve-month smoothed moving average of the employment-to-population ratio as the dependent variable, then our measure of the absolute change during this time period explained over two-thirds of the variation not otherwise explained by the model.

28 It is also possible that the changes in benefit design could lead to changes in health spending. We did not control for insurance plan type in our main regression. To the degree that the slowdown itself might have caused consumers to change to less generous insurance coverage and that this benefit design decreased health spending, this should be considered an effect of the slowdown and should not be controlled for in the regression. That said, when we did control for plan type, we obtained qualitatively similar results.

29 We used the same peak-to-trough change in the employment-to-population ratio for each time period to avoid having to determine the lag between macroeconomic changes and health spending changes. When we used a moving average of period-by-period measures of employment, we obtained similar results. Our regression also included a full set of dummies for quarter years and CBSAs.

30 Mian A, Sufi A. The consequences of mortgage credit expansion: evidence from the U.S. mortgage default crisis. Q J Econ. 2009;124(4):1449–96.

31 This should not be surprising. Atif Mian and Amir Sufi (Note 30) have shown that changes in unemployment from 2007 to 2009 were strongly related to the amount of household debt relative to household income in the local economy before the recession—a variable that is unlikely to be correlated with the growth in health spending.

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AUGUST 2014

How Did Rural Residents Fare on the Health Insurance Marketplaces?

In-Brief

One of the ongoing questions about the Affordable Care Act (ACA) is its impact on rural areas, many of which had lacked a competitive individual market for health insurance. Would the ACA foster competition among plans in these areas? Or would they be dominated by one or two insurers and face higher premiums and fewer plan choices than their urban counterparts? This Data Brief examines 2014 premiums, issuers, and plans offered to residents of urban and rural counties. In 2014, while it appears that residents of rural counties, as a whole, did not face higher premiums than residents of urban counties, substantial differences emerge within a number of states and between states of varying degrees of rurality. In particular, states with largely rural populations face fewer choices and higher premiums. These are the states to watch in the coming months as new issuers enter the marketplaces and 2015 premiums are filed.

One of the cornerstones of the ACA health reforms was the establishment of private market, government-regulated "marketplaces" in which individuals could shop for health insurance coverage. In theory, the marketplaces would foster competition among insurers for millions of newly covered people, thereby leading to lower premiums and expanded choices for consumers.

However, the pre-ACA landscape was one of highly concentrated individual markets dominated by one or two large insurers. In 2012, a single insurer dominated more than half the market in 29 states. Relying on the power of the competitive marketplace was especially concerning for rural populations, who disproportionately faced higher premiums and less competition prior to the ACA compared with urban populations.

Reasons for higher costs in rural areas may include lack of economies of scale and lack of competition among providers. And the relationship between insurance plan competition and premiums is complicated by the level of provider consolidation; that is, the bargaining power of insurers is constrained in markets with just a few dominant hospitals and health systems.

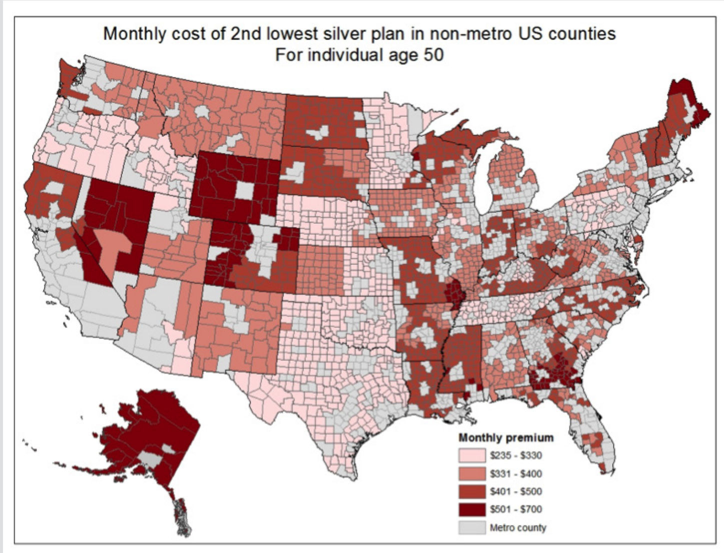
Our goal is to examine and compare 2014 premiums, issuers, and plans offered on health insurance exchanges to residents of urban and rural areas.

APPROACH

To accomplish this goal we use premium and plan data from the HIX Compare dataset of all silver plans offered in the new health insurance marketplaces, as well as information on geographic rating areas from the HIX 2.0 dataset. We take a unique approach to this question by summarizing the marketplace offerings from the perspective of residents eligible to participate in the health insurance marketplace. We do this by using county-level weighted means where the weights are based on the number of residents in a county eligible for health insurance exchanges. Eligibility is based on adding estimates of the number of uninsured in a county ineligible for Medicaid (thus eligible for the health insurance marketplace) and the number of participants in the individual insurance market to create a county-level estimate of individuals eligible to buy health insurance in the marketplace. We identify urban counties as those counties that meet the Office of Management and Budget criteria for metropolitan counties. These are counties that are part of or adjacent to an urbanized area of 50,000 or more population. The rural counties in this study are defined by all nonmetropolitan counties. As shown in Table 1, rural counties outnumber urban counties (1,976 vs. 1,167), but urban counties have more people (265 million vs. 46 million).

Variation in the characteristics of health insurance marketplace plans facing urban and rural residents could be driven by differences in the plans facing residents of states that are more or less urban, or they can be driven by differences between the urban and rural areas within states. Only because premiums under the ACA are permitted to vary based on geographic rating area are within-state variations in premiums and plans possible. States have some flexibility in defining their geographic rating areas. According to the Centers for Medicare and Medicaid Services:

> [E]ach state will have a set number of



geographic rating areas that all issuers in the state must uniformly use as part of their rate setting. The default geographic rating areas for each state will be the Urban Statistical Areas (MSAs) plus the remainder of the State that is not included in a MSA. States may seek approval from Health and Human Services (HHS) for a number of geographic rating areas that is greater than the number of MSAs in the state plus one (MSAs+1), provided the rating areas are based on counties, three-digit zip codes, or MSAs/non-MSAs.

Six states (DE, HI, NH, NJ, RI, and VT) and D.C. have one statewide rating area; 7 states chose the default of the MSAs+1 (AL, ND, NM, OK, TX, VA, and WY) ; and the remaining 37 states had more rating areas than MSA+1 that were, with few exceptions, defined based on groups of contiguous counties. We note states with a single rating area with an asterisk when examining within-state differences between urban and rural areas, as no within-state variation is possible for these states.

WHAT WE FOUND

As a first step, we mapped the rural counties and their 2014 marketplace premiums for a 50-year-old nonsmoker choosing the silver plan with the second lowest premium. As shown in the map above, there is far more variation between states than within states.

Table 1 compares the number of issuers, plans, plan types, and premiums for a 50-year-old individual in urban vs. rural counties. Urban counties have 32% more issuers than rural counties (mean, 5.0 vs. 3.8) and 20% more plans (mean, 17.0 vs. 14.2) and plan types (mean, 2.5 vs. 2.1). Monthly premiums are slightly higher in rural areas than urban areas ($387 vs. $369), and the "spread" between the minimum and maximum silver plan is slightly smaller in non-urban areas. Thus, rural residents do not have as many choices as urban residents in terms of premiums, issuers, plans, and plan types. They also have less availability of HMOs, EPOs, and PPOs, and greater availability of POS plans. Most notable is the fact that Exclusive Provider Networks (EPOs) are available to half the number of rural residents as urban residents. These differences in plan types may reflect the notion that it is easier to develop and more strictly enforce a restrictive provider network in urban areas than in the more sparsely populated rural areas where there are fewer convenient choices of providers.

Table 1. Silver Plan Characteristics by Urban Classification of County

	Urban	Rural
Counties	1167	1967
Population (Million)	265.0	46.3
Exchange Eligible Population (Million)	39.5	6.6
Number of Issuers	5.0	3.8
Number of Plans	17.0	14.2
Number of Plan Types	2.5	2.1
Premium (Second-Lowest Silver) 50-Year-Old Ind	$369	$387
Max-Min Spread, 50-Year-Old Silver Plan Premiums	$160	$147
Plan Type Availability		
PPO	84%	83%
HMO	84%	61%
EPO	39%	18%
POS	25%	35%

Table 2. Premium Differences Between Urban and Rural Counties Within States

State	Rural (% of State Eligible Pop.)	Urban Premium ($)	Rural Premium ($)	Premium Difference ($)
Nevada	9%	$353	$554	$-201
Colorado	14%	$352	$532	$-181
Georgia	18%	$385	$478	$-93
New Mexico	34%	$297	$370	$-73
Kentucky	44%	$322	$380	$-58
Minnesota	23%	$236	$292	$-55
Missouri	27%	$388	$442	$-54
Illinois	10%	$313	$366	$-53
Maine	44%	$433	$484	$-51
Arizona	6%	$282	$329	$-47
Michigan	18%	$337	$383	$-46
Florida	3%	$371	$417	$-46
Wyoming	71%	$551	$596	$-44
Ohio	21%	$355	$390	$-36
California	2%	$419	$454	$-35
Utah	11%	$311	$337	$-27
Tennessee	23%	$270	$291	$-21
North Carolina	23%	$411	$429	$-19
Iowa	42%	$342	$359	$-17
Louisiana	17%	$422	$439	$-17
Oregon	17%	$292	$308	$-16
Oklahoma	36%	$294	$308	$-15
West Virginia	40%	$389	$401	$-12
Kansas	34%	$312	$324	$-12
North Dakota	51%	$391	$401	$-10
South Dakota	54%	$398	$407	$-10
South Carolina	16%	$380	$384	$-4
Washington	11%	$399	$401	$-3
Idaho	36%	$328	$330	$-2
Indiana	23%	$451	$452	$-1
Montana	66%	$354	$355	$-1
Maryland	3%	$310	$311	$-1
Arkansas	40%	$410	$410	$0
Hawaii*	21%	$256	$256	$0
New Hampshire*	39%	$404	$404	$0
Vermont*	67%	$413	$413	$0
Delaware**	0%	$404	NA	NA
District of Columbia**	0%	$355	NA	NA
New Jersey**	0%	$444	NA	NA
Rhode Island**	0%	$411	NA	NA
Wisconsin	27%	$408	$405	$2
Virginia	14%	$377	$373	$3
New York	6%	$357	$349	$8
Alaska	37%	$600	$589	$12
Alabama	25%	$359	$347	$12
Massachusetts	2%	$333	$317	$15
Texas	11%	$342	$323	$20
Nebraska	36%	$363	$326	$37
Connecticut	5%	$511	$461	$50
Pennsylvania	12%	$325	$274	$51
Mississippi	55%	$542	$470	$72

**Single Rating Area, **Only Urban Counties*

Table 3. Silver Plan Characteristics by Fraction of State's Exchange Eligible Population in Rural Counties

	% of State's Exchange-Eligible Pop. in Rural Counties			
	<5%	5-25%	25-50%	50+%
Counties	201	1705	943	294
Population (Million)	84.1	181	39.5	6.7
Exchange Eligible Population (Million)	13.1	26.6	5.4	1.1
Number of Issuers	4.8	5.2	3.3	2.4
Number of Plans	11.8	13.8	13.9	8.2
Number of Plan Types	2.7	2.3	2.0	2.0
Premium (Second-Lowest Silver) 50-Year-Old Ind	$402	$353	$369	$452
Min-Max Spread, 50-Year-Old Silver Plan Premiums	$140	$172	$144	$115
Plan Type Availability				
PPO	88%	80%	93%	91%
HMO	92%	81%	51%	80%
EPO	77%	21%	10%	7%
POS	18%	27%	47%	20%

Overall, national averages of urban and rural residents may mask within-state and between-state differences. We observe within-state differences in urban/rural premiums by state in Table 2. In nine states, average monthly premiums for the second-lowest silver plan are at least $50 higher in rural areas than in urban areas; in seven other states, that difference ranges between $25 and $50. Just four states have rural premiums that are at least $25 lower than urban premiums. These within-state differences in premiums are not apparent from the $18 difference in national averages for urban and rural areas as shown in Table 1 ($369 vs. $387).

Finally, we explore between-state differences in plan characteristics based on the rurality of the state. Column 1 of Table 2 lists the percentage of each state's marketplace-eligible population in rural counties. In our final analysis, we grouped states by their percentage of rural population (less than 5%; 5%-25%; 25%-50%, and 50% or higher). Table 3 compares the number of issuers, plans, plan types, and premiums for our 50-year-old in these different groups of states. Here we see a stark two-fold difference between the most urban and most rural states in number of issuers (mean, 4.8 vs. 2.4). The number of plans (mean, 11.8 vs. 8.2) and plan types are also 35 precent greater in urban areas. From this perspective we also now see that monthly premiums are meaningfully lower in states that are the most urban when compared to the least urban ($402 vs. $452).

WHAT DOES IT MEAN?

These data reflect the state-based nature of health insurance markets, oversight, and regulations. In 2014, while it appears that residents of rural counties, as a whole, did not face higher premiums than residents of urban counties, substantial differences emerge within a number of states and between states of varying degrees of rurality. In particular, states that have largely rural populations face more challenges in terms of increasing the choices available on their exchanges and in terms of premiums. These are the states to watch in the coming months as new issuers enter the marketplaces and 2015 premiums are filed.

About the Authors

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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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Marketplace Competition & Insurance Premiums in the First Year of the Affordable Care Act

August 2014

John Holahan and Linda Blumberg
The Urban Institute

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 (ACA) of 2010. 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 in selected states to help states, researchers, and policy-makers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in these case study states. Cross-cutting reports and state-specific reports on case study states 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**.

It is well documented that premiums in the individual Health Insurance Marketplaces (Marketplaces) in large numbers of geographic areas have been surprisingly low, particularly for the second lowest cost silver plans to which federal subsidies are attached.[1] But at the same time, there is considerable variation within most rating regions between the lowest cost and highest-cost plans within a state. Using a local benefit package as an essential health benefits benchmark limits differences in benefits across plans. The actuarial value tiers limit the variation in deductible and co-payments, setting natural limits on how much cost sharing overall can vary at a particular plan level. So what drives significant differences in premiums?

Carriers appear to set rates based on assumptions about the population being covered – what is their expected utilization, how much risk does the carrier face? Carriers also make assumptions about how well the Affordable Care Act's (ACA) risk adjustment, risk corridors and reinsurance (3Rs) will work to mitigate risk, and such assumptions will vary among carriers. If a carrier believes the 3Rs will be effective, its rates will be lower than those of a competitor that has less confidence in the 3Rs. Similarly, if a carrier projects it will attract a healthier group of enrollees than its competitors, then its rates will be lower. Another factor, of course, is the leverage that carriers have over providers, which will vary by both carrier and market. Related to this are area labor costs. Finally, premiums will vary with the decisions that carriers make in whether to be aggressive in pursuing market share versus being conservative to avoid losses and their perceptions of likely pricing behavior on the part of competitors.

In this paper, we consider the variation in premiums within markets and the effects of competition, or lack thereof, on premiums. We look at both markets that are highly competitive and those in which competition is more limited. The carriers that chose to be aggressive acknowledge the importance of being one of the two second lowest cost silver plans to attract large numbers of enrollees; this is because federal subsidies limit premiums for individuals based on their incomes. For example, those with incomes between 133–150 percent of federal poverty level (FPL) pay between 3–4 percent of their incomes for coverage in the second lowest cost silver plan, regardless of the actual premium set by the carrier;[2] the federal government pays the balance. Those choosing a more expensive plan than the second lowest cost silver plan must pay 100 percent of the difference in premiums in addition to the percent of income cap. Those choosing a lower cost plan contribute less to the premium. Carriers cannot know whether they will be one of the second lowest cost plans when they submit their rates for review, but they face incentives to try to be. They can also make different assumptions about factors influencing individuals' plan choices—whether individuals will primarily focus on price or whether networks, brand recognition and other factors are important. While it was not clear when 2014 rates were set, based on interviews and state it seems clear that large numbers of individuals have chosen plans primarily based on price.

In this paper, we present data on silver-tier premiums in several markets within each of 10 states. Four states (Alabama, Arkansas, Rhode Island, and West Virginia) had fairly limited competition. The other six (Colorado, Maryland, Massachusetts, New York, Oregon, and Virginia) were very competitive, especially in urban, more populated markets. The data in the Tables below were obtained from information collected by the Breakaway Policy Strategies for the Robert Wood Johnson Foundation.[3] Table 1 summarizes the differences across states in the lowest silver tier premiums in a major metropolitan area. We show two regions in New York and Virginia because New York City and northern Virginia are not typical of the rest of their states. In Table 1, we show premiums for a 45-year-old (using the Health and Human Services standard default age curve),[4] roughly the midpoint of the 18-64 population; in the later Tables, we show premiums for 27-and 50-year-olds. In general, premiums in less competitive markets are higher than in more competitive insurer markets. Other factors, such as local labor costs and presence of academic medical centers, are also important to premiums.

In Tables 2–11, the premiums shown are for the lowest cost silver plan offered by each carrier in each of three to four rating regions; in the same rating region, a single carrier may have several plans with lower premiums than other carriers. We also specify the type of plan offered by each insurer: preferred provider organizations (PPO), point of service (POS), health maintenance organizations (HMO) or exclusive provider organizations (EPO). HMOs and EPOs contract with a defined network of providers and typically do not provide reimbursement to consumers for services provided from out-of-network providers. PPOs and POSs offer consumers a broader choice of providers by providing some reimbursement for out-of-network providers, although out-of-pocket costs are higher for consumers who receive care from an out-of-network provider instead of from an in-network provider. The data we used were supplemented with several interviews with state officials, insurer representatives and insurance plan associations; the interviews were designed to learn how some carriers achieved low premiums and why others did not.

Table 1: Lowest Silver Premiums for a 45-Year-Old in Selected Areas

	State	City	Calculated Premium: 45-Year-Old	45-Year-Old Index (Denver=1.0)
Less Competitive	Alabama	Birmingham (Rating Area 3)	$288.19	1.04
	Arkansas	Little Rock (Rating Area 1)	$331.79	1.20
	Rhode Island	Entire state (Rating Area 1)[a]	$309.52	1.12
	West Virginia	Charleston (Rating Area 2)	$325.86	1.18
More Competitive	Colorado	Denver/Aurora/Lakewood (Rating Area 3)	$277.01	1.00
	Maryland	Baltimore (Rating Area 1)	$257.66	0.93
	Massachusetts	Boston/Cambridge (Rating Area 5)	$271.53	0.98
	New York	New York City (Rating Area 4)	$359.26	1.30
		Buffalo (Rating Area 2)	$275.00	0.99
	Oregon	Portland/Gresham/ Hillsboro (Rating Area 1)	$219.08	0.79
	Virginia	Northern Virginia DC Suburbs (Rating Area 10)	$293.48	1.06
		Richmond (Rating Area 7)	$259.40	0.94

[a] *There is only one carrier (three plans) with rates available for Rhode Island.*

STATES WITH LIMITED COMPETITION

The four states with limited insurer competition for which we examined rates are Alabama, Arkansas, Rhode Island, and West Virginia. Each state market has a Blue Cross Blue Shield (BCBS) plan with a large market share; this scenario has long pre-dated the ACA. Entrance of new carriers into markets heavily dominated by a single carrier is very challenging, as providers generally are willing to negotiate the best payment rate discounts with carriers that have a significant market share. No new market entrant would have such leverage.

Alabama

The Alabama market is dominated by a single carrier, BCBS, with little competition in most parts of the state; however, in 2014 BCBS's market power does not seem to have been exploited in the Marketplace. The lowest cost silver option's monthly premiums are not particularly high, ranging from $192.23 in rural areas of the state to $209.16 in Birmingham for a 27-year-old and $327.60 (rural) to $356.46 (Birmingham) for a 50–year-old (Table 2). In the Birmingham area, BCBS has competition from Humana (that has slightly lower premiums), but in the rest of the state there are no competitors in the Marketplace. Given its market dominance, BCBS has considerable power in negotiating rates with providers. However, the large number of one-hospital cities or counties throughout the state makes it difficult to negotiate in many areas. The nonprofit status of BCBS may also limit its use of its near-monopoly power. It is not clear whether BCBS in Alabama will see more competitors in the future. New entrants would face the considerable problem of developing provider networks with comparable discounts to BCBS.

Arkansas

Arkansas is also dominated by Blue Cross Blue Shield, with limited competition in most parts of the state. Its monthly premiums are relatively high by national standards, ranging from $238.48 (in the southeast portion of the state) to $240.80 (in Little Rock) for a 27-year-old and $406.42 to $410.37 for a 50-year-old in the two regions we examined (Table 3). There is some competition from a small nonprofit plan (Qual Choice), and a previously Medicaid only plan (Ambetter) in

Table 2: Monthly Premiums for the Lowest Cost Silver Plan Offered by Each Carrier in Alabamain Selected Areas

Location	Insurer	Plan Type	Premium: 27-Year-Old	Premium: 50-Year-Old
Rating Area 3: Birmingham	Humana Insurance Company	PPO	$209.16	$356.46
	BCBS of Alabama	PPO	$211.24	$360.00
Rating Area 11: Montgomery	BCBS of Alabama[a]	PPO	$198.57	$338.40
Rating Area 13: 37 Rural Counties	BCBS of Alabama	PPO	$192.23	$327.60

[a] *Blue Cross Blue Shield of Alabama has the only two plans in Montgomery (rating area 11) and the rural counties (rating area 13).*

Table 3: Monthly Premiums for the Lowest Cost Silver Plan Offered by Each Marketplace Carrier in Arkansas

Location	Insurer	Plan Type	Premium: 27-Year-Old	Premium: 50-Year-Old
Rating Area 1: Little Rock	Arkansas BCBS[a]	PPO	$240.80	$410.37
	QualChoice Health Insurance	POS	$264.17	$450.20
	Ambetter of Arkansas	PPO	$268.97	$458.38
Rating Area 5: 13 Counties in the Southeast Part of the State	Arkansas BCBS[a]	PPO	$238.48	$406.42

[a] *Arkansas Blue Cross Blue Shield has the lowest three plans in Little Rock (rating area 1) and the only three plans in the southeast rural counties (rating area 5).*

Little Rock, but premiums for these carriers are higher than for BCBS. This reflects the difficulty in negotiating provider payment rates for carriers without significant market share. One argument given for the state's Medicaid waiver plan that would give newly Medicaid eligible individuals access to private insurance plans in the Marketplace is that it would add a large number of additional enrollees and could attract more insurers into the Arkansas market.

Rhode Island

The Rhode Island insurance market is also dominated by BCBS. Neighborhood Health Plan, a prominent Medicaid plan in the state, entered the Marketplace, but its objective is to offer coverage to those with incomes below 250 percent FPL. It is not considered an active competitor to BCBS for the above 250 percent nongroup population, though that may change in 2015. BCBS and Neighborhood Health Plan have a difficult time negotiating with Rhode Island's two major hospital systems and this affects premiums. The state has a single rating region with the 2014 BCBS lowest cost monthly premium for costing $224.64 for a 27–year-old and $382.83 for a 50–year-old (Table 4). Neighborhood Health Plan premiums were higher than those of BCBS. Tufts and United also offer coverage in the state, but did not enter the individual insurance Marketplace.

The BCBS premiums are relatively high in comparison with most states, but this only partially reflects the lack of competition. State respondents cite a large number of state mandated benefits as contributing to costs. Another important factor in Rhode Island is the lack of leverage over providers. The two dominant hospital systems are hard for carriers to negotiate with: Rhode Island Hospital, a major teaching hospital, and Care New England, a large maternity care center. Each owns or has ties with other hospitals in the state, leaving few unaffiliated hospitals. Thus, the market dominance of a BCBS plan does not translate into lower premiums when the hospital systems have commensurate market power. In the past, the Rhode Island Department of Insurance has intervened and scrutinized hospital-insurer contracts for their effect on premium increases.[5]

West Virginia

West Virginia is another state with only one insurer participating in the Marketplace: Highmark, another Blue Cross Blue Shield carrier. Premiums in the state reflect the lack of competition but also the difficulty of negotiation with local providers. Highmark sells both its product and a multistate plan. Coventry, which has a small presence in the state, declined to participate in the Marketplace. Highmark's premiums are relatively high, with premiums for its traditional product ranging from $215.22 to $250.19 for a 27-year-old across the two regions we examined and $366.77 to $426.37 for a 50-year-old (Table 5). The Highmark multistate plan had rates that were the same or slightly lower (marked MSP in the Table) than its traditional product. Highmark is considered to be fairly aggressive when negotiating provider payment rates.

Whether West Virginia will attract more competitors is unclear. There is the expectation that the co-op operating in Kentucky will enter the individual West Virginia market in 2015, partnering with Aetna/Coventry for administrative services and using their provider network. There are three Medicaid managed care organizations in the state, but none are expected to enter the Marketplace. There are no narrow networks in West Virginia; Highmark contracts with nearly all providers. Providers need Highmark because of its market share, though provider specialties in short supply have some leverage in negotiating rates. Respondents indicate that it is difficult for insurers such as Aetna/Coventry and United to compete successfully in West Virginia because they cannot contract with West Virginia hospitals at rates as low as Highmark. It is difficult to establish narrow networks in a state like West Virginia where there are a large number of small hospitals spread throughout the state and little effective competition among them.

Table 4: Monthly Premiums for the Lowest Cost Silver Plan for Rhode Island

Location	Insurer	Plan Type	Premium: 27-Year-Old	Premium: 50-Year-Old
Rating Area 1: Entire State	BCBS of Rhode Island[a]	PPO	$224.64	$382.83
Rating Area 1: Entire State	Neighborhood Health Plan of Rhode Island[b]	HMO	$243.00	$414.00

[a] *Blue Cross Blue Shield of Rhode Island has the only three plans available for those above a certain income level.*

[b] *Neighborhood Health Plan of Rhode Island is only available to those below a certain income level.*

Table 5: Monthly Premiums for the Lowest Cost Silver Plan Offered by Each Marketplaces' Carrier West Virginia

Location	Insurer	Plan Type	Premium: 27-Year-Old	Premium: 50-Year-Old
Rating Area 2: Charleston	Highmark BCBS MSP	PPO	$236.50	$403.05
	Highmark BCBS West Virginia	PPO	$250.19	$426.37
Rating Area 9: Nine Rural Counties in the Middle-Eastern Part of the State	Highmark BCBS MSP	PPO	$215.22	$366.77
	Highmark BCBS West Virginia	PPO	$215.22	$366.77

Note: MSP = Multistate plan.

MORE COMPETITIVE STATES

The pressure to be the second lowest cost plan and the expectation that people will choose plans based on price have led to intense competition in a number of markets. Carriers' flexibility to design price-competitive policies is limited by the actuarial value tiers and the essential health benefits in designing strategies to limit premiums at a particular level. One strategy that carriers are using to lower premiums in these environments is to create more limited provider networks—including those doctors and hospitals with whom they can negotiate more favorable rates or who tend to have more efficient practice patterns and adhere to high-quality practice. In some cases, efforts to develop limited network plans have led to close alignment between carriers and hospitals.

In some states, Medicaid plans, which have limited networks by definition, have driven the competition in the new Marketplaces, resulting in lower premiums; in other cases, Medicaid plans are not able to be competitive, primarily because of an inability to negotiate the same rates across a state for a commercial product as they do for Medicaid business. The experience of co-ops has also been uneven. In some markets, they have been highly competitive with fairly low premiums; in other markets, they have had difficulty in setting low provider payment rates because of difficulty in establishing networks or having to rely on "rental" networks. Below, we look at the premium offerings in several of the more competitive states.

Colorado

Colorado has relatively low premiums, benefitting from considerable pre-ACA market competition across the state. Eight carriers offer coverage in the nongroup market in the Denver area, four in Grand Junction and six in a rating region that includes 18 rural counties in the southeast part of the state. The carrier offering the lowest premiums varies by market. In Denver, the lowest silver premiums are $201.04 for a 27-year-old and $342.62 for a 50-year-old (both with Kaiser Permanente). In Grand Junction, the lowest cost silver premiums cost $233.91 for a 27-year-old and $398.64 for a 50-year-old (with Rocky Mountain Health Plans) (Table 6). Premiums are significantly higher in the rural areas we examined.

In Denver, the lowest silver-plan rates are offered by Kaiser Permanente and Humana, as shown in Table 6. Rocky Mountain Health Plans has rates about 25 percent above Kaiser's, and Anthem, Cigna and Access Health Colorado were even higher. Kaiser is extremely competitive in markets in Colorado in which it participates. Rocky Mountain is the lowest cost plan in the Grand Junction area, but less competitive in other markets throughout the state. In Grand Junction, it has an integrated system, a fairly broad network, and is considered very well managed. In markets outside of the Grand Junction area, Rocky Mountain needs to establish contracts with physicians and hospitals with whom it does not have as close a relationship; this contributes to its less-competitive premiums. Anthem has large market share throughout the state in the commercial market and offers a somewhat narrow "value" network in the Marketplace. It does not have the lowest silver Marketplace premiums in any of the rating areas we studied. Colorado Choice, an HMO centered in San Luis Valley, has relatively low premiums in its home market. Colorado Health OP, the state's co-op, is fairly competitive in Denver, but less so in Grand Junction. It is the lowest cost silver plan in the rural rating region we

Table 6: Monthly Premiums for the Lowest Cost Silver Plan Offering by Each Carrier for Colorado

Location	Insurer	Plan Type	Premium: 27-Year-Old	Premium: 50-Year-Old
Rating Area 3: Denver, Aurora, Lakewood	Kaiser Permanente	HMO	$201.04	$342.62
	Humana	HMO	$205.20	$349.90
	Colorado HealthOP	EPO	$223.78	$381.36
	Denver Health	HMO	$225.37	$384.08
	Rocky Mountain Health Plans	HMO	$253.67	$432.30
	Cigna	PPO	$260.91	$444.64
	Anthem	HMO	$262.17	$446.79
	Access Health Colorado	PPO	$372.33	$634.52
Rating Area 5: Grand Junction	Rocky Mountain Health Plans[a]	HMO	$233.91	$398.64
	Anthem	HMO	$294.46	$501.81
	Colorado HealthOP	PPO	$334.44	$569.95
	Access Health Colorado	PPO	$412.33	$702.69
Rating Area 9: 18 Rural Counties in the Southeast Part of the State	Colorado HealthOP	EPO	$292.81	$499.00
	Colorado Choice Health Plans[b]	HMO	$293.72	$500.55
	Anthem	HMO	$368.04	$627.21
	Rocky Mountain Health Plans	PPO	$385.40	$656.80
	UnitedHealthcare	EPO	$405.64	$691.29
	Access Health Colorado	PPO	$419.18	$714.36

[a] *Rocky Mountain has the 16 lowest cost plans in Grand Junction (rating area 5).*
[b] *Colorado Choice Health Plan has five of the six lowest cost plans in the southeast rural counties (rating area 9), though not the lowest.*

examined, though rates in this region are well above the lowest cost options in Denver and Grand Junction. This reflects the challenges all carriers face in negotiating provider payment rates in small towns and rural areas where there are few providers, deceasing carriers' leverage.

Maryland

CareFirst, a Blue Cross Blue Shield (BCBS) carrier, is dominant in Maryland's commercial market and has the lowest premiums in all regions of the state (Table 7). CareFirst faces competition from Kaiser in the more populous areas of the state. In 2014, there were no limited- or tiered-network plans in the state. Maryland's hospital rate-setting system has limited the movement to limited or tiered networks by CareFirst and others. All payers must reimburse a given hospital at the same rate for the same service. Thus, there is no ability to negotiate rates. In principle, carriers could choose to contract with only the less expensive hospitals; and they can limit their networks of physicians. To date, carriers have not done so, though there is some expectation that this could change. We show participation and premiums in Baltimore, the Washington, DC suburbs, and a rural area. Carefirst's lowest cost silver premiums range from $174 to $187 a month for a 27-year-old and $297 to $319 for a 50-year-old, well below competitors in the three regions we examined. CareFirst has a broad network, contracting with virtually all providers throughout the state. The BCBS multistate plan uses the CareFirst network and has similar premiums. CareFirst had a huge market share in the commercial market prior to the ACA, and this has not changed so far within the Marketplace. CareFirst bid aggressively and sees its mission as providing affordable care. The insurer has developed a primary care medical home model that they believe is controlling spending.

Kaiser Permanente is a staff-model HMO and seems

Table 7: Monthly Premiums for the Lowest Cost Silver Plan for Maryland

Location	Insurer	Plan Type	Premium: 27-Year-Old	Premium: 50-Year-Old
Rating Area 1: Baltimore	CareFirst Blue Choice[a]	HMO	$187	$319
	Blue Cross Blue Shield MSP	PPO	$197	$335
	Evergreen	HMO	$207	$352
	Kaiser Permanente	HMO	$221	$377
	United All Savers	EPO	$278	$473
Rating Area 3: DC Suburbs	CareFirst Blue Choice[a]	HMO	$174	$297
	Blue Cross Blue Shield MSP	PPO	$183	$312
	Evergreen	HMO	$196	$335
	Kaiser Permanente	HMO	$221	$377
	United All Savers	EPO	$278	$473
Rating Area 2: 12 Rural Counties in the Southern Part of the State	CareFirst Blue Choice[a]	HMO	$184	$313
	Blue Cross Blue Shield MSP	PPO	$193	$329
	Evergreen	HMO	$203	$346
	Kaiser Permanente	HMO	$221	$377
	United All Savers	EPO	$278	$473

[a] *CareFirst BlueChoice/CareFirst Blue Cross Blue Shield has the five lowest plans in Baltimore (rating area 1) and the DC suburbs (rating area 3).*

poised to be increasingly competitive. Kaiser has a significant presence in the DC metropolitan area suburbs and the I-95 corridor to Baltimore, where the bulk of the Maryland population resides. Their premiums are 18 percent (DC suburbs) to 27 percent (Baltimore) above CareFirst's premiums.

The state's new co-op, Evergreen, has high 2014 premiums but has been looking to limit its network and compete more aggressively in 2015. United's All Savers affiliate's 2014 premiums were very high and the result has been little market share. United has announced that its national plan will enter the Maryland market in 2015 in addition to All Savers. Cigna has also announced they will enter the market.

Early indications are that CareFirst will have substantial increases in premiums in 2015 on the order of 25 percent.[6] Evergreen and Kaiser will lower their premiums modestly and both are expected to have plans with lower rates than CareFirst. However, rates recently filed with the state are not final pending the Maryland Insurance Administration's review. Maryland's Marketplace enrollment was very low in 2014, due to technical problems with the state's website. Enrollment is expected to increase significantly in 2015 as these problems are overcome and the anticipated risk of future enrollees will certainly play an important role in premium setting. Thus, some convergence in premiums is expected in the coming year as competition increases.

Massachusetts

Massachusetts, the health reform precedent setter, has one of the more competitive Marketplaces in the country. Its premiums are fairly low, particularly in comparison with other New England states. This reflects the development of provider based insurance plans that secured preferential treatment under the 2006 health reforms. The lowest cost offerings range from $210.31 to $221.02 for 27-year-olds and $300.19 to $315.62 for 50-year-olds (Table 8). The low premiums are noteworthy given the high health care costs in the state related to the large number of academic medical centers, particularly in the Boston market. Massachusetts has kept premiums fairly moderate through aggressive competition among several fairly narrow network plans.

Competition among plans in the Massachusetts

Marketplace is a direct result of the 2006 health reforms. The 2006 law established Commonwealth Care, a subsidized program offering managed care plans, for those with income below 300 percent of the federal poverty level and Commonwealth Choice, offering commercial plans for the unsubsidized population. When the ACA Marketplaces opened in 2014, federal subsidies consistent with the ACA schedule were introduced, extending assistance to families with incomes up to 400 percent of the FPL. Federal subsidies, however, were not as generous as the previous Massachusetts subsidies, and Massachusetts has supplemented the federal subsidies with their own funds, intending that their residents would not be worse off with the national reforms in place.

Commonwealth Care's enrollees were, by state design, served only by the managed care plans that had previously served the state's Medicaid populations. These included Boston Medical Center's HealthNet Plan, Network Health, Neighborhood Health Plan, and Fallon Community Health Plan. Ambetter, formerly Celticare, was later permitted to offer plans in Commonwealth Care. These plans continue to serve the ACA's Marketplace enrollees; Minuteman Health co-op and Health New England were added as well. These are the only plans allowed to compete for subsidized enrollees at present. These plans and three others (Harvard, BCBS, Tufts) serve the unsubsidized Marketplace enrollees. The Commonwealth Care plans tend to be the lowest cost plans in the Marketplace. Most, including Boston Medical Center and Network, which have the lowest premiums, are limited-network plans centered on safety-net hospitals and community health centers. Both offer access to the Partners HeathCare system for tertiary care. Neighborhood Health Plan, also formerly a Medicaid plan, has a broader network. It is now owned by the Partners HealthCare system and thus offers access to all Partners facilities (which tend to be higher cost than many of their competitors). Network Health and Boston Medical Center Health Net Plan generally have the lowest cost plans throughout the state, followed closely by Neighborhood Health Plan and Ambetter. Minuteman has the lowest premiums in the Worcester region.

The Tufts Health Plan purchased Network Health and thus offers a lower cost product in the Marketplace to subsidized enrollees; it also operates a somewhat broader network option under its own name within the Marketplace for unsubsidized enrollees. Harvard Pilgrim Healthcare offers a broad network plan and is one of the most expensive carriers in all markets in the state. Blue Cross Blue Shield of Massachusetts participates in the Marketplace but did not aggressively price in the first year and has little market share as a result. This is unusual for BCBS plans throughout the country, particularly because they have historically been the market leader in the state.

New York

The New York market has become noticeably more competitive under the ACA, led by several provider-sponsored Medicaid health plans, a co-op and another new entrant. Limited networks and difficult negotiations between insurers and providers have emerged. Premiums are about average for the nation, with the exception of New York City, which reflects the higher labor costs and the large number of academic medical centers. In addition, age rating is prohibited in the nongroup and small-group markets in the state, making premiums for young adults noticeably higher relative to those in other states, even absent any underlying cost and use differences. The lowest (community rated) premiums are $359.26 in New York City (Metro Plus), $275.00 in Buffalo (Health Republic), $286.00 in Syracuse (Health Republic), $294.00 (Health Republic) in Albany, and $337.37 in upstate rural counties (Fidelis Care) (Table 9). The lowest cost plan in New York City was a local Medicaid plan, Metro Plus, followed by the state's co-op (Health Republic), a new entrant (Oscar) and a statewide Medicaid plan (Fidelis). Emblem, a New York-based commercial plan, retains a broad network and had high premiums in most markets. Empire Blue Cross Blue Shield had relatively high premiums despite establishing a more limited network in an attempt to lower provider payment rates and premiums. A new hospital-based plan, North Shore LIJ, had relatively high premiums despite its link to a major hospital system.

Fidelis is one of the lowest cost plans throughout several markets in the state. Blue Cross Blue Shield premiums are somewhat competitive but are not at the low end despite developing more limited networks. Still, the better known BCBS plans have successfully earned significant market share in the Marketplaces, primarily because of their brand name. Health Republic also has low premiums throughout the state. There is concern among other carriers that Health Republic underpriced its plans. Fidelis was able to contract with providers at relatively low rates but not always as low as contracts for their Medicaid products. Commercial plans, in general, have attempted to negotiate lower rates with providers than

Table 8: Monthly Premiums for the Lowest Cost Silver Plan for Massachusetts

Location	Insurer	Plan Type	Premium: 27-Year-Old	Premium: 50-Year-Old
Rating Area 5: Boston, Cambridge	Boston Medical Center HealthNet Plan	HMO	$219.21	$312.89
	Network Health	HMO	$240.71	$343.58
	Neighborhood Health Plan	HMO	$253.54	$361.82
	Ambetter	HMO	$258.79	$369.31
	Minuteman Health	HMO	$261.69	$373.51
	Fallon Community Health Plan	HMO	$290.08	$414.03
	Tufts Health Plan	HMO	$309.50	$441.74
	Harvard Pilgrim Health Care	PPO	$339.80	$484.99
	BCBS Massachusetts	HMO	$369.37	$527.11
Rating Area 2: Worcester	Minuteman Health	HMO	$221.12	$315.62
	Neighborhood Health Plan	HMO	$222.62	$317.70
	Network Health	HMO	$245.39	$350.25
	Ambetter	HMO	$245.57	$350.44
	Boston Medical Center HealthNet Plan	HMO	$263.92	$376.69
	Health New England	HMO	$272.63	$389.05
	Fallon Community Health Plan	HMO	$275.09	$392.63
Rating Area 1: Springfield, Berkshires	Network Health	HMO	$210.31	$300.19
	Boston Medical Center HealthNet Plan	HMO	$217.00	$309.74
	Neighborhood Health Plan	HMO	$222.62	$317.70
	Ambetter	HMO	$241.94	$345.26
	Tufts Health Plan	HMO	$269.19	$384.21
	Health New England	HMO	$272.63	$389.05
	Fallon Community Health Plan	HMO	$300.74	$429.24
	BCBS Massachusetts	HMO	$322.38	$460.05
	Harvard Pilgrim Health Care	PPO	$324.64	$463.34

Table 9: Monthly Premiums for the Lowest Cost Silver Plan for New York

Location	Insurer	Plan Type	Premium: All Ages – Community Rating
Rating Area 4: New York City	Metro Plus	HMO	$359.26
	Health Republic Insurance of New York, Freelancers	EPO	$365.28
	Oscar	EPO	$384.72
	New York Fidelis	HMO	$390.15
	Emblem	HMO	$385.31
	Empire BCBS	HMO	$417.57
	Northshore LIJ	EPO	$419.62
	Healthfirst	HMO	$440.00
	Affinity	HMO	$440.44
	United		$642.43
Rating Area 2: Buffalo	Health Republic Insurance of New York, Freelancers[a]	EPO	$275.15
	New York Fidelis	HMO	$338.11
	BCBS of Western NY	POS	$371.71
	Univera	PPO	$430.05
	American Progressive - Today's Options	HMO	$432.00
	Independent Health		$444.39
Rating Area 6: Syracuse	Health Republic Insurance of New York, Freelancers	EPO	$285.65
	New York Fidelis	HMO	$341.34
	MVPHP	HMO	$397.43
	Excellus	EPO	$415.80
	American Progressive - Today's Options	HMO	$459.47
	CDPHP	HMO	$513.79
Rating Area 1: Albany	Health Republic Insurance of New York, Freelancers	EPO	$293.93
	New York Fidelis	HMO	$342.05
	MVPHP	HMO	$347.80
	Empire BCBS	HMO	$388.79
	Excellus	PPO	$442.61
	CDPHP	HMO	$458.12
	American Progressive - Today's Options	HMO	$488.34
	Blue Shield of Northeastern New York	EPO	$492.76
Rating Area 7: 13 Rural Counties Upstate	New York Fidelis	HMO	$337.37
	MVPHP	HMO	$372.61
	Excellus	EPO	$442.61
	CDPHP	HMO	$493.45
	Blue Shield of Northeastern New York	EPO	$505.47

[a] *Health Republic Insurance of New York, Freelancers, has the two lowest cost plans in Buffalo (rating area 2), where they both cost $275, in Syracuse (rating area 6), where they both cost $286, and in Albany (rating area 1), where they both cost $294.*

they had pre-2014, but it is generally believed that they are paying more than the Medicaid plans and the co-op, thus causing the observed differences in premiums.

Concerns over network adequacy have surfaced in New York. All plans were required, if they had out of network coverage off the Marketplace, to offer at least one out-of-network product at the silver and platinum levels in the Marketplace as well. This led to commercial nongroup plans dropping their out-of-network options across the board; the result is that only in-network plans are offered both inside and outside the Marketplace in all but Western New York. There has been pressure for changes, including some call to require out-of-network coverage. As a first response, the state passed legislation requiring more transparency and disclosure of networks; requiring carriers to make providers available at in network prices if a network provider is not available and requiring protection on pricing in emergency situations.[7] The conversation is not over, however, and there could be more pressure on Medicaid plans and others to broaden their provider networks.

Oregon

Oregon's Marketplace has a considerable amount of competition among local commercial plans with the emergence of limited networks and aggressive negotiation over provider payment rates.There are nine carriers in Portland, nine in Salem and seven in the rural county rating region we examined. The premiums in Oregon for the lowest cost silver plans offered by Moda Health are below those in any other state we examined, ranging from $159.00 to $175.00 (depending on the rating region) for a 27-year-old and $270.00 to $298.00 for a 50-year-old (Table 10). Moda Health has the lowest-priced plans in all regions. It established a narrow network of providers at relatively low payment rates and it has over 70 percent of all Marketplace enrollees in the state. There is some belief that Moda underpriced its plans and its premiums will come up. But premiums set by other carriers, including Health Net, Providence, Lifewise, Pacific Source and Kaiser, are also relatively low by national standards. All of these insurers developed relatively narrow networks. Kaiser has always had a limited network, relying on its salaried physicians and system owned hospitals. Pacific Source established a tiered network in which one had to pay more depending upon the providers chosen. Regence BCBS, a major carrier in Oregon, does not offer a plan in the Marketplace; rather their affiliate, Bridgespan, offers coverage there. Bridgespan has a broader network than its competitors, and, in general, its rates are among the highest in the state.

Limited and tiered networks had been developing in Oregon before the ACA. These arrangements are reflected in the plans offered in the Marketplace and reflect carriers' expectations that prices will determine the market share and that more limited and tiered networks were essential to developing low premiums. Some observers question the ability of carriers to maintain these networks and whether, in the case of the tiered approach, there will be sufficient low-cost tier providers to meet enrollee demand. There has been a great deal of provider consolidation in response to insurer competition. Hospitals have expanded capacity to provide a wide range of services, as have multispecialty groups. With provider consolidation, there will be more limited ability to negotiate provider payment rates when establishing limited networks. The state also has a number of one-hospital towns, which also constrains negotiations.

Virginia

Virginia has one of the most competitive markets we examined. Anthem has a large share of the individual and small group market, but alliances between other carriers, such as Aetna, and provider systems are becoming increasingly important. The carriers' lowest cost silver plan premiums range from $188.26 (Richmond) to $221.34 (Roanoke) for a 27-year-old and $320.83 (Richmond) to $377.21 (Roanoke) for a 50-year-old (Table 11). Which carriers have the lowest premiums varies across markets. Anthem has a substantial amount of market power throughout the state, with the exception of Northern Virginia. This has allowed them to negotiate favorable contracts with hospitals and even more so with physicians. In the Richmond market, Anthem has developed a close relationship with the Hospital Corporation of America, and it is the second lowest cost plan in that market. Coventry offers a point of service product at an even lower premium, in part because of its close working relationship with the Bon Secours hospital system.

In Virginia, insurer-hospital system relationships are evolving quickly. In the Tidewater region, the Optima Health Plan has been established by the Sentara hospital system. In markets such as this one, where Optima can offer access to Sentara hospitals, its premiums are near the lowest. The Sentara system is growing throughout the state. Optima is not only competitive in the Tidewater area but offers the lowest premiums in the Roanoke area as well. Aetna has a close working relationship with the Carillion system in Roanoke and the University of Virginia system in Charlottesville. This has not yet led to the lowest rates in these markets but reportedly has

Table 10: Monthly Premiums for the Lowest Cost Silver Plan for Oregon

Location	Insurer	Plan Type	Premium: 27-Year-Old	Premium: 50-Year-Old
Rating Area 1: Portland, Gresham, Hillsboro	Moda Health[a]	PPO	$159.00	$270.00
	Health Net Health Plan of Oregon, Inc.	EPO	$176.00	$300.45
	Providence Health Plan	EPO	$192.00	$327.08
	LifeWise Health Plan of Oregon	PPO	$203.00	$346.00
	PacificSource Health Plans	PPO	$203.00	$347.00
	Kaiser Permanente	HMO	$210.00	$357.00
	Health Republic Insurance	EPO	$210.00	$357.71
	Oregon's Health CO-OP	PPO	$223.00	$379.39
	BridgeSpan Health Company	EPO	$223.00	$380.34
Rating Area 3: Salem	Moda Health[a]	PPO	$165.00	$281.00
	Health Republic Insurance	EPO	$183.00	$311.82
	PacificSource Health Plans	PPO	$203.00	$347.00
	LifeWise Health Plan of Oregon	PPO	$208.00	$355.00
	Kaiser Permanente	HMO	$210.00	$357.00
	Providence Health Plan	EPO	$213.00	$362.94
	Oregon's Health CO-OP	PPO	$223.00	$379.39
	ATRIO Health Plans	EPO	$228.00	$388.74
	BridgeSpan Health Company	PPO	$243.00	$413.50
Rating Area 6: 15 Rural Counties in the Northeast Part of the State	Moda Health[b]	PPO	$175.00	$298.00
	Health Republic Insurance	EPO	$190.00	$323.32
	LifeWise Health Plan of Oregon	PPO	$208.00	$355.00
	Providence Health Plan	EPO	$223.00	$380.34
	PacificSource Health Plans	PPO	$240.00	$409.00
	Oregon's Health CO-OP	PPO	$272.00	$463.14
	BridgeSpan Health Company	PPO	$278.00	$473.05

[a] *Moda has the three lowest cost plans in both Portland/Gresham/Hillsboro (rating area 1) and in Salem (rating area 3).*
[b] *Moda has the two lowest cost plans in the rural counties (rating area 6).*

introduced serious competition into the market in which their influence may grow over time.

In the Washington, DC suburbs, the Inova hospital system is a key player in the hospital market, owning all but one of the major hospitals in Northern Virginia. Inova has combined with Aetna to offer an insurance product in the Marketplace: the Innovations Health Insurance Company. With its hospital market share, its premiums are the lowest in all of the Northern Virginia markets. Kaiser has developed a large ambulatory care facility in the area, but is constrained by its need to contract for inpatient care with Inova or alternatively with Washington, DC hospitals. They do not receive the favorable rates in Virginia that are provided to Inova's own insurance plan. Anthem and CareFirst are in somewhat similar positions but without the organizational model of Kaiser. Thus, premiums are somewhat higher for Anthem and CareFirst products.

Table 11: Monthly Premiums for the Lowest Cost Silver Plan for Virginia

Location	Insurer	Plan Type	Premium: 27-Year-Old	Premium: 50-Year-Old
Rating Area 9: Virginia Beach, Norfolk, Chesapeake, Newport News	Optima Health	HMO	$222.68	$379.49
	Anthem BCBS	HMO	$227.99	$388.54
	Anthem Health Plans of Virginia	HMO	$242.70	$413.60
Rating Area 7: Richmond	CoventryOne	POS	$188.26	$320.83
	Anthem BCBS	HMO	$207.51	$353.65
	Anthem Health Plans of Virginia	HMO	$220.90	$376.45
	Kaiser Permanente	HMO	$225.54	$383.55
	Aetna	PPO	$260.00	$443.00
	Optima Health	HMO	$285.47	$486.51
Rating Area 10: Washington, DC Suburbs	Innovation Health Insurance Company	PPO	$213.00	$362.00
	CareFirst Blue Choice, Inc.	HMO	$222.97	$379.99
	Kaiser Permanente	HMO	$225.54	$383.55
	Anthem BCBS	HMO	$237.11	$404.08
	CareFirst BCBS	PPO	$246.74	$420.50
	Anthem Health Plans of Virginia	HMO	$252.40	$430.14
	Optima Health	HMO	$272.77	$464.87
Rating Area 8: Roanoke	Optima Health	HMO	$221.34	$377.21
	Anthem BCBS	HMO	$234.62	$399.83
	Anthem Health Plans of Virginia	HMO	$249.75	$425.62
	Aetna	PPO	$255.00	$434.00
	CoventryOne	POS	$258.98	$441.35

CONCLUSION

The Affordable Care Act has resulted in a considerable amount of competition. In a large number of markets, this has resulted in lower premiums than expected, though there is considerable variability within each metal tier. The low premiums available in the Marketplaces have been one of the real success stories of the ACA. The managed competition structure of the ACA tying premium tax credits to the second lowest cost silver plan creates strong incentives for carriers to offer products that are low cost. Individuals have to pay the full marginal cost of premiums above the second lowest cost silver plan for either a more costly silver plan or a plan in a higher-metal tier.

The premiums we have reported in this paper depend on market conditions; some markets are less competitive. In general, these are dominated by a major insurer, typically Blue Cross Blue Shield, but even in these markets, the dominant insurer is still faced with the need to negotiate with providers. This is problematic in a state such as Rhode Island that has two dominant hospital systems that face little competition. In small towns and rural areas of some states, the limited number of providers gives the providers leverage even relative to a dominant insurer.

In the other six study states, markets are far more competitive; there are many carriers, including large national plans, local commercial carriers, Medicaid managed care plans, and co-ops. More competitive markets are often characterized by limited or tiered provider networks. Carriers offer plans with providers with whom they are able to negotiate reasonable rates or meet quality or efficiency standards. In some markets, we are seeing new alignments of insurers with providers. This is becoming particularly common in Virginia but also New York (e.g. North Shore-LIJ Health System). The low premiums that have sometimes resulted from these new arrangements mean lower than expected costs for the federal government as well as lower premiums for unsubsidized enrollees.

Limited- or tiered-network strategies are allowing carriers to keep premiums low, but they are also raising issues of network adequacy. States may respond in the future with more stringent standards which could potentially have an effect on premiums. The aggressive efforts by carriers to limit networks could also result in another round of provider consolidation which could strengthen providers' negotiating power. In general, the amount of Marketplace competition and its effect on premiums is an important outcome of the ACA, but the network adequacy issue warrants careful monitoring over time. Increased Marketplace enrollment and more stable risk pools will encourage new entrants in at least some areas, including large commercial insurers such as United that took cautious stances in the first year. Such market evolution should contribute to moderation in premium growth.

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Enrollment

Using Volunteers in Navigator and Assister Programs: Doing More with Less:

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As navigators and assisters contend with limited resources and growing demand, recruiting and training volunteers may help these entities increase capacity without increasing costs.

During the first open enrollment period, navigators and other enrollment assisters provided help to more than 10 million people seeking information and assistance with their applications for coverage in the new health insurance marketplaces.[1] In-person assistance to consumers filling out health insurance applications proved crucial to the success of the first open enrollment period, making it significantly more likely that people of color and others who face barriers to enrollment would ultimately sign up for coverage.[2]

Future open enrollment periods will be shorter than the initial open enrollment period, and assisters will need to enroll new people in coverage while also assisting consumers through the renewal process. To meet this additional demand in a shorter timeframe, navigator and assister programs should consider ways to provide more assistance to a greater number of people. One way navigators and assisters can do more with less is to use volunteers, either directly or through partnership with certified application counselor (CAC) volunteers from other organizations.

Differences Between Navigator and Certified Application Counselor Programs

Navigator and CAC programs exist in every state, regardless of whether the marketplace is operated by the state or federal government. Navigator programs are required by the Affordable Care Act. CAC programs are not required by law, but were created by the Department of Health and Human Services to augment the availability of in-person assistance offered by navigators. Navigators are funded through state or federal grants. Some CAC programs receive funding through government sources, but others are privately funded.

Both navigators and CACs can help consumers apply for and enroll in coverage, but there are important differences in the scope, duties, and overall time investment required in the two consumer assistance roles.

Although CACs and navigators must follow most of the same rules about helping consumers apply for health coverage, navigators must generally undergo significantly more training to be certified.[3] Training requirements for navigators and CACs vary depending on whether they are in a federal or state-run marketplace. States participating in the federally-facilitated marketplace (FFM) may establish additional training requirements for both navigators and CACs.[4,5]

Recruiting volunteer navigators or partnering with Certified Application Counselor (CAC) organizations can help groups provide more assistance to a greater number of people.

Options for Using Volunteers

While federal rules do not forbid the use of volunteers in navigator and CAC programs volunteers, organizations must ensure their volunteers follow all of the same rules that apply to paid staff.

Volunteers can be particularly useful at outreach and enrollment events, when navigators and assisters are working to enroll large numbers of people throughout the day. Volunteers trained as navigators or CACs can add additional capacity for enrollment assistance. Other volunteers can assist in support tasks to better streamline the event. Such tasks include educating consumers about the Affordable Care Act (ACA) and the enrollment process, identifying consumers with a simple enrollment situation, and flagging those with more complex situations that could require extra assistance.

Given the different training requirements for each type of position, organizations must determine which type of volunteer best suits their needs. The following section discusses the unique features of each type of volunteer.

OPTION 1

Train volunteers to serve as navigators

Navigator entities may recruit and train volunteers to perform the same functions as paid navigators. There is no distinction between paid and unpaid navigators with regard to the training they receive, the assistance they perform, certification requirements, or their responsibilities.

OPTION 2

Train volunteers to serve as CACs or partner with a CAC organization

Navigator and assister programs can use CAC-certified volunteers to help consumers with simpler enrollment situations and leave navigators free to focus on more complicated situations that require extra assistance.

Navigator organizations can partner with a CAC organization or be designated as a CAC. Becoming designated as a CAC allows organizations to use CACs as volunteers and train and certify those volunteer as CACs. Due to the intensity and duration of the training required for volunteer navigators, this may prove to be a more attractive option for both the organization and the volunteer. This is especially true in states that impose additional training and certification costs for navigators beyond what is required by the federal government.

Navigators and CACs can work together to assist consumers by coordinating outreach, sharing space, and publicizing events, and are encouraged to develop relationships.[6] However, navigator grantees must be certain not to pay for CAC expenses with their navigator funds, including compensating staff or volunteers for performing CAC functions.[7]

Just as if they were coordinating with a CAC entity, an organization designated as both a navigator and a CAC

should ensure that the programs are treated distinctly in terms of finances and reporting on enrollment. Navigator funds cannot be used to pay for CACs and enrollments performed by CACs would not count toward any totals for grant reporting for the navigator entity.[8]

OPTION 3

Recruit volunteers to take on support tasks

There are many tasks that do not require certification which volunteers can perform. For example, non-certified volunteers can:

- Schedule appointments
- Screen prospective clients
- Give clients information in preparation for their appointments
- Conduct outreach in communities
- Educate consumers about how health insurance works
- Act as translators for clients (although you will want to ensure that anyone acting as a translator has the skills necessary for translation services)
- Help clients with email account creation

Using volunteers to take care of activities such as those listed above means that certified staff can focus on providing in-depth enrollment assistance to clients who need it.

Advantages to Using Volunteers

Expand organizational capacity: The principal advantage to using volunteers in a navigator program is to increase capacity. During the initial open enrollment period, navigator and assister groups were often overwhelmed with demand from consumers that exceeded the supply of assistance available. Consumers needed more hands-on help and assistance than was anticipated and this demand only increased around important coverage deadlines, like the end of December 2013 (the deadline for coverage beginning January 1, 2014) and March 2014 (the end of the first open enrollment period).[9]

Use fewer resources than hiring of new staff: The other chief advantage to using volunteers is financial: Navigator organizations can use volunteers to increase capacity, by spending less than the cost of hiring full-time or even part-time staff. This is true even when factoring in resources required to train and supervise them.

Bring in diverse skills and backgrounds: Using volunteers may also allow organizations to bring in additional skills to augment the work they are undertaking. Local universities and community colleges can provide a valuable volunteer pool with ties to the local community. Retirees also have ties to the community and may have past professional experience that is valuable to enrollment assistance (such as experience with the health care system or with health

Using volunteers to take care of support tasks means that certified staff can focus on providing in-depth enrollment assistance to clients who need it.

insurance). Volunteers who are active with church groups, civic organizations, or other local groups can add value to the program without working on it full time. Such individuals bring outside knowledge and additional community connections that can broaden the reach of a navigator program.

Volunteers are mission driven: People volunteer because they believe in a cause and want to make a difference in their local community. This is a powerful sentiment that navigator programs can harness to help consumers enroll in coverage.

Considerations Regarding the Use of Volunteers

Organizational time and resources: While navigator volunteers may be unpaid, there are organizational costs associated with using them. Developing a volunteer program and managing the volunteers takes resources. Volunteers require oversight and this can be more difficult without payment as an incentive. Volunteers also need support and guidance. Volunteers trained as CACs may need to refer some cases to trained navigators, putting additional demands on navigators' time. CACs may also not be able to take on all tasks that navigators can, as they may not have as extensive training.

Without proper support and clear expectations, programs may experience attrition from volunteers. Training and application assistance can be time consuming, and so volunteers may find themselves strained and overwhelmed if they are not aware of the time commitment from the outset. From an organizational perspective, it is also costly to lose volunteers when time, training, and money have been invested.

Additional training and licensing: Some states place additional training and licensure requirements on navigators and other assisters, which may increase the cost and time required for volunteers and organizations using volunteers. At least 19 states have laws that place additional requirements on navigators, some of which involve additional training, licensure, and/or a fee to register with the state. Five states require organizations to purchase a surety bond or carry insurance. Additional legislation is pending in six states.[10]

Using Volunteers to Help Consumers in the First Open Enrollment Period: Examples from the States

Enroll Virginia tapped students to volunteer and set up computer bank rooms to increase capacity

One of the navigator entities in Virginia, Enroll Virginia, (a project of the Virginia Poverty Law Center), used volunteers throughout the first open enrollment period to increase resources and enroll consumers more efficiently. The group used volunteers in two main ways: Individual navigators managed volunteers at their regional locations throughout the state and at large enrollment events throughout the state. Many of these volunteers were certified as navigators. This decision

helped reduce the resources required to supervise the volunteers and ensure that they could assist consumers through the process without needing to make a referral.

Establishment of regional offices

Due to Virginia's diverse and dispersed population, Enroll Virginia created regional offices where each navigator was responsible for a certain portion of the state. One particular navigator built a relationship with a local university and was able to utilize student volunteers. The student volunteers received college credit in return for 10-15 hours of volunteering each week. Enroll Virginia found bilingual students to be a unique advantage of recruiting from the student population, as they were a great resource for reaching out to and serving diverse communities in the area.

Volunteers essential at enrollment events

One way that Enroll Virginia made optimal use of volunteers was at large enrollment events they hosted throughout the state. Volunteers helped to screen and sort individuals before the event and upon arrival to ensure the education and enrollment process ran smoothly. They helped inform individuals of what documents to bring, checked to see if they might fall into the Medicaid gap, and screened them for potential circumstances that might require the help of a more experienced navigator. This ensured that the needs of individuals and families were met—and that they were prepared and ready to enroll once they sat down with a navigator.

Enroll Virginia also used volunteers in "computer bank" rooms where individuals with simple enrollment situations could complete the application on their own, with a navigator resource on standby to help as needed. This allowed Enroll Virginia to focus navigator attention on people with more complex situations.

Plans for second enrollment period: Looking forward to 2014 and 2015, Enroll Virginia plans to expand its coalition and use of volunteers. It will reach out to organizations in a large swath of communities to encourage them to become CAC entities. Enroll Virginia will then partner with these CAC entities to provide them with expertise and technical assistance as needed. These CAC partnerships will allow Enroll Virginia to expand its reach across the state and into communities where there may not otherwise be enough resources to adequately cover.

Kansas Association for the Medically Underserved coordinated volunteer navigators throughout the state

One of the Kansas navigator grantees, the Kansas Association for the Medically Underserved (KAMU), placed volunteers at partner organizations throughout the state per signed agreed assignments. Partners agreed to support the volunteer navigator and provide oversight. KAMU recruited and trained a local volunteer navigator for each organization. Some of these locations included Federally Qualified Health Centers (FQHCs) and local health departments. This allowed KAMU to spread its reach across the state, even with limited resources.

> Enroll Virginia used volunteers to help their enrollment events run efficiently and smoothly.

A team of three navigators oversaw the program and coordinated the volunteer placement. KAMU also developed a volunteer navigator position description to be clear about the roles, duties, and expectations of volunteers.

Plans for second enrollment period: Moving forward into 2015, KAMU seeks to increase its use of volunteers and reach out to more partner organizations to place volunteer navigators around the state. Another initiative involves reaching out to communities to develop community advisory teams and become Covered Kansas Champions. Hosting a volunteer navigator in their community is one of the activities Covered Kansas Champions can undertake, allowing KAMU to place more volunteer navigators throughout the area and reach out to diverse populations.

Shepherd's Center in Missouri drew volunteers from pool of retired professionals

Shepherd's Center in Kansas City, Missouri, was a navigator subcontractor to one of the state's navigator grantees. As a senior service agency, the center had systems in place to recruit and work with volunteers. Shepherd's Center made sure to clarify expectations and requirements at the outset, so volunteers would know what was expected of them.

The center largely drew from a resource pool of retired professionals—including lawyers, doctors, social workers, and IT professionals. These volunteers brought experience and knowledge from their primary careers that substantially strengthened their work as navigators. Missouri had additional licensing requirements on top of federal requirements, so all volunteers had to complete a background check and be licensed as navigators.

Shepherd's Center had two locations in Kansas City that were staffed by volunteer navigators in shifts, with three staff members who served as coordinators as well as part-time navigators.

Another successful aspect of the Shepherd Center volunteer program was the community that the volunteers built among themselves. They had weekly gatherings where they shared stories and worked through issues together.

Recommendations for a Successful Volunteer Program

If your organization is considering using volunteers during the 2014 open enrollment and beyond, you should follow the steps outlined below to ensure that you are getting the most benefit from your program.

1. **Get familiar with applicable state law:** Are there additional training/licensing requirements for navigators? Additional background checks? Paying a fee? Know what might be a barrier to volunteer recruitment.

2. **Draw on resource strengths in local area (colleges, retirees, legal aid):** Identify potential partner organizations and sources of volunteers in your community. Is there a local college with a student population? Are there a large number of retired professionals in the area?

3. **Set clear expectations:** Becoming a volunteer navigator or CAC requires commitment from the volunteer to follow through on required training, background checks, and to perform applicable duties. Ensure that volunteers are aware of the time investment and proficiencies required ahead of time to avoid attrition. This could be done via a screening interview or a job description.

4. **Create a program that will support/retain volunteers:** Volunteers will need supervision, oversight, and support. Given that volunteers are unpaid and thus motivated by a desire to serve in the community, it is important to create an environment that gives the volunteers the support they need to do the job well and feel that it is worth their while to return. Volunteers require an investment of resources—money, time, and knowledge—so retaining them will save money over the long run and build a strong knowledge base on enrollment issues.

5. **Use volunteers efficiently:** Determine where your program needs extra capacity, how volunteers can help fill in those gaps, and how volunteers can help expand the reach of your organization. Assign tasks to volunteers that match their skill sets and allow paid staff to focus their time where they are most needed: helping consumers who need significant assistance with signing up or renewing their health coverage. Ensure that your program has a way to communicate effectively and efficiently with volunteers to keep them up to date about policy changes, administrative issues, scheduling, and other matters.

Conclusion

While the use of volunteers may not be right for every navigator or assister program, a number of programs have found benefits to developing and training volunteers as navigators or CACs. Before recruiting volunteers, organizations should consider which type of volunteer will enhance their existing capacity and weigh the time and costs associated with their training and supervision. Given limited resources, organizations may find that volunteers can be valuable to the important task of enrolling consumers in health coverage.

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10 Justin Giovannelli, Kevin Lucia, and Sabrina Corlette, op. cit.

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What Is the Result of States Not Expanding Medicaid?

Stan Dorn, Megan McGrath, John Holahan

Timely Analysis of Immediate Health Policy Issues

AUGUST 2014

Results In-Brief

In the 24 states that have not expanded Medicaid, 6.7 million residents are projected to remain uninsured in 2016 as a result. These states are foregoing $423.6 billion in federal Medicaid funds from 2013 to 2022, which will lessen economic activity and job growth. Hospitals in these 24 states are also slated to lose a $167.8 billion (31 percent) boost in Medicaid funding that was originally intended to offset major cuts to their Medicare and Medicaid reimbursement.

A review of state-level fiscal studies found comprehensive analyses from 16 diverse states. Each analysis concluded that expansion helps state budgets. State savings and new state revenues exceeded increased state Medicaid expenses, with the federal government paying a high share of expansion costs. Even if future lawmakers reduce federal Medicaid spending, high federal matching rates are likely to remain at the ACA's enhanced rates, given historic patterns. Facing bipartisan gubernatorial opposition, Congress lowered the federal share of Medicaid spending just once since 1980, while cutting Medicaid eligibility, services, and provider payments more than 100 times. Medicaid expansion thus offers significant state-level fiscal and economic benefits, along with increased health coverage.

	State Price Tags to Expand Medicaid	Consequences of NOT Expanding Medicaid	
	10-year total cost *to expand Medicaid* **(millions)**	*Federal Medicaid funding* **LOST (billions)**	*Hospital reimbursement* **LOST (billions)**
Alabama	$1,081	$14.4	$7.0
Alaska	$147	$1.5	$0.6
Florida	$5,364	$66.1	$22.6
Georgia	$2,541	$33.7	$12.8
Idaho	$246	$3.3	$1.5
Indiana	$1,099	$17.3	$9.2
Kansas	$525	$5.3	$2.6
Louisiana	$1,244	$15.8	$8.0
Maine	$(570)	$3.1	$0.9
Mississippi	$1,048	$14.5	$4.8
Missouri	$1,573	$17.8	$6.8
Montana	$194	$2.1	$1.1
Nebraska	$250	$3.1	$1.6
North Carolina	$3,075	$39.6	$11.3
Oklahoma	$689	$8.6	$4.1
Pennsylvania	$2,842	$37.8	$10.6
South Carolina	$1,155	$15.8	$6.2
South Dakota	$157	$2.1	$0.8
Tennessee	$1,715	$22.5	$7.7
Texas	$5,669	$65.6	$34.3
Utah	$364	$5.3	$3.1
Virginia	$1,326	$14.7	$6.2
Wisconsin	$(248)	$12.3	$3.7
Wyoming	$118	$1.4	$0.4
Total:	**$31.6** BILLION	**$423.6** BILLION	**$167.8** BILLION

For States that **EXPAND Medicaid**

$1 → $13.41

For every $1 a state invests in Medicaid expansion, $13.41 in federal funds will flow into the state. Expanding Medicaid will likely also generate state savings and revenues that exceed expansion costs.

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Notes: Some states are shown with state Medicaid savings, indicated by placing numbers in parentheses, based on the assumed continuation of pre-ACA Medicaid eligibility for adults. State costs do not include offsetting savings and revenues.

Introduction

Twenty-four states have not expanded Medicaid eligibility to adults with incomes at or below 138 percent of the federal poverty level (FPL), as permitted by the Patient Protection and Affordable Care Act (ACA).[1] Here, we describe some coverage, fiscal, and macroeconomic implications of this choice, including previous results from the Health Insurance Policy Simulation Model. We also summarize state-specific fiscal analyses and examine the high federal matching rates on which those analyses rely.

The estimates we present generally are projections. They accordingly involve inherent uncertainty. However, the effects on states not expanding Medicaid are already being seen, even at this early date:

- **Coverage.** Between September 2013 and June 2014, the proportion of nonelderly uninsured adults in non-expansion states fell from 20.0 to 18.3 percent, compared to a drop from 16.2 to 10.1 percent in states that expanded Medicaid. Put differently, the number of uninsured declined by 9 percent in nonexpanding states and 38 percent in states that expanded Medicaid.[2] The proportion of America's uninsured living in nonexpanding states rose from 49.7 percent in September 2013 to 60.6 percent in June 2014.[3]
- **Hospital finances.** First-quarter, 2014 earnings reports from several interstate hospital chains described major differences between states that expanded Medicaid—where hospital finances improved as uncompensated care fell and Medicaid revenue rose, both by significant amounts—and nonexpanding states, where hospital finances worsened, with uncompensated care and self-pay patient caseloads rising and Medicaid revenue falling.[4]

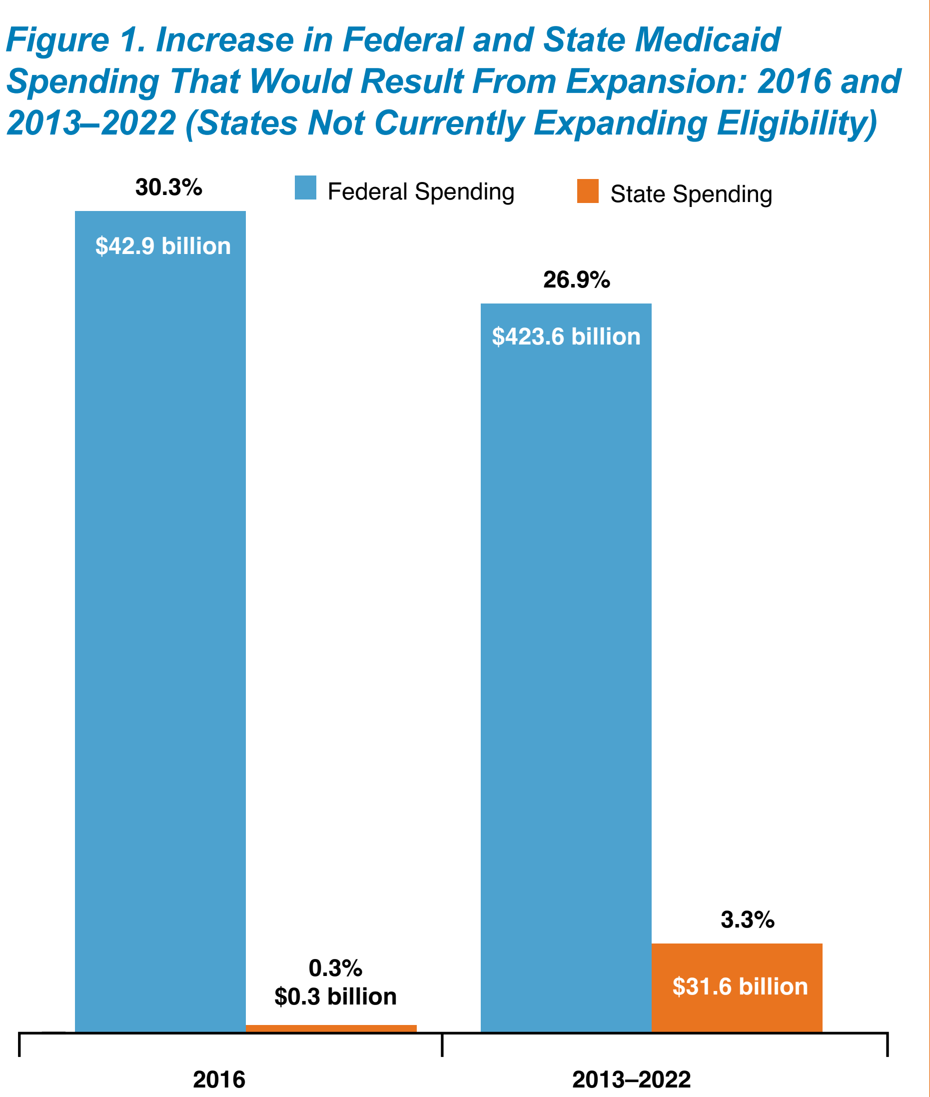
Coverage

In the 24 states that have not expanded Medicaid, 6.7 million residents are projected to be uninsured in 2016 unless their states expand eligibility (table 2).[5] They will be ineligible for tax credits in health insurance marketplaces for two reasons: most have incomes below 100 percent FPL, the minimum income threshold for general tax credit eligibility in nonexpanding states; but some have incomes slightly above that level and are disqualified because of employer-sponsored insurance the ACA classifies as affordable. Coverage that firms offer to employees and their dependents is deemed affordable if worker-only insurance costs 9.5 percent of family income or less.

State Economies

The 24 nonexpanding states have rejected federal Medicaid funds projected to equal $42.9 billion in 2016, which would have increased such states' federal Medicaid receipts by 30.3 percent. To claim those resources, states would need to spend $0.3 billion ($291 million), representing a 0.3 percent increase over state Medicaid costs without expansion. Each additional state dollar would thus yield an extra $147.42 in federal funds.[6]

From 2013 to 2022, these states would forgo an estimated $423.6 billion in federal Medicaid funding, representing a 26.9 percent increase above federal Medicaid dollars received without expansion. The required state contribution is $31.6 billion, raising projected state Medicaid spend-



Source: Health Insurance Policy Simulation Model 2012.

Note: The figure shows how total Medicaid spending would change compared with spending under the ACA, without expansion. The figure does not include state savings or revenues resulting from expansion. States included in the figure had not expanded eligibility as of July 2014. They include Indiana, Pennsylvania, and Utah, which have pending waiver proposals to expand eligibility.

ing by 3.3 percent. Each new state dollar would accordingly draw down $13.41 in additional federal funds over this 10-year time period (figure 1).

The Council of Economic Advisers (CEA) recently concluded that expanding Medicaid under the ACA boosts state economic growth and employment, primarily by bringing in significant new federal funding to buy additional health care within the state. According to CEA's estimates, Medicaid expansion would add, in non-expanding states, 78,600 jobs in 2014, 172,400 jobs in 2015, and 98,200 jobs in 2016.[7] CEA expects the economy to return to full employment by 2017, after which CEA does not anticipate continued employment gains from Medicaid expansion, "because an increase in labor demand in one sector will mostly tend to reallocate workers away from other sectors." Many state-level analysts appear to assume less than full employment and project that Medicaid expansion would continue to boost job growth well beyond 2017.[8]

Ordinarily, health coverage expansions have little effect on net economic activity, because the increased growth triggered by additional health care spending is offset by economic shrinkage caused by paying for that spending. In this case, however, federal law rather than state decisions determine the ACA's financing mechanisms. The only question within state policymakers' control is whether to counter the adverse economic effects of those mechanisms by bringing in federal Medicaid dollars to buy additional health care. Adding these federal dollars to a state's economy while leaving the ACA's funding sources unchanged can generate economic growth and employment, as found by both CEA and state-level analysts.

To place state policy choices in perspective, the 24 states not expanding Medicaid spent an estimated $44.9 billion on tax reductions and other subsidies to attract private business during the most recent single year for which data are available.[9] Nonexpansion states thus spend on these business incentives more than 14 times the $3.16 billion average annual amount that would be required to finance Medicaid expansion during 2013–2022 (table 1).

Table 1. Cost to Expand Medicaid Compared with State Incentive Payments to Attract Private Business (Millions) (States Not Currently Expanding Eligibility)

	State cost to expand Medicaid (without considering offsetting savings and revenue)		Incentive payments to attract private business
	2013–2022		Most recent year for which data are available *Usually 2012, sometimes earlier*[10]
	10-year total	*Average annual amount*	
Alabama	$1,081	$108	$277
Alaska	$147	$15	$991
Florida	$5,364	$536	$3,980
Georgia	$2,541	$254	$1,400
Idaho	$246	$25	$338
Indiana	$1,099	$110	$1,010
Kansas	$525	$52	$1,790
Louisiana	$1,244	$124	$379
Maine	$(570)	$(57)	$416
Mississippi	$1,048	$105	$97
Missouri	$1,573	$157	$101
Montana	$194	$19	$1,390
Nebraska	$250	$25	$39
North Carolina	$3,075	$307	$2,190
Oklahoma	$689	$69	$896
Pennsylvania	$2,842	$284	$28
South Carolina	$1,155	$115	$19,100
South Dakota	$157	$16	$207
Tennessee	$1,715	$171	$1,290
Texas	$5,669	$567	$1,530
Utah	$364	$36	$89
Virginia	$1,326	$133	$921
Wisconsin	$(248)	$(25)	$4,840
Wyoming	$118	$12	$1,580
Total:	**$31,605**	**$3,160**	**$44,879**

Sources: Holahan, Buettgens, et al., July 2013; New York Times, December 2012, cited in Glied and Ma 2013.

Notes: Listed states had not expanded eligibility as of July 2014. They include Indiana, Pennsylvania, and Utah, which have pending waiver proposals to expand eligibility. Some states are shown with state Medicaid savings, indicated by placing numbers in parentheses, based on the assumed continuation of pre-ACA Medicaid eligibility for adults. Incentive payments to attract private business include tax reductions, grants, loans, loan guarantees, free services, and other subsidies. Totals may not add because of rounding.

Hospitals

The combination of increased private and Medicaid coverage is expected to yield hospital revenue that offsets the ACA's $22 billion in Medicaid cuts to disproportionate share hospital payments, $34 billion in Medicare disproportionate share hospital cuts, and $260 billion in Medicare fee-for-service cuts during 2013–2022.[11] In nonexpansion states, hospitals will pay the full cost of the ACA's funding mechanisms. However, they will receive only part of the increased revenue for the newly insured that was included in the ACA's original design, before the Supreme Court made Medicaid expansion optional for states.

The 24 states that have not expanded Medicaid are projected to cost their hospitals an estimated $15.9 billion in Medicaid revenue for 2016 and $167.8 billion for 2013–2022 (table 2). These sums would have raised hospitals' Medicaid payments by 32.3 percent and 30.7 percent, respectively.

Medicaid expansion increases hospital costs by increasing utilization. In addition, expansion modestly lowers hospitals' private insurance revenue, mainly by raising the lower bound of financial eligibility for marketplace subsidies from 100 to 138 percent FPL. However, these two factors are significantly outweighed by the increased Medicaid revenue resulting from expansion.[12]

State Budgets

In many states, both private- and public-sector organizations have analyzed the fiscal impact of Medicaid expansion. Comprehensive assessments considered effects in four categories:[13]

1. **Increased state costs because of new enrollees.** Expanded eligibility increases enrollment among people who qualify within pre-ACA eligibility categories, for whom states pay their standard share of Medicaid costs. This is sometimes called the "welcome mat" or "woodwork" effect. Beginning in 2017, states that expand coverage also pay a small percentage of costs for newly eligible adults.

Table 2. Projected consequences of States Not Expanding Medicaid

	Uninsured not qualifying for coverage (thousands)	Federal Medicaid funding lost (billions)		Hospital reimbursement lost (billions)	
	2016	2016	2013–2022	2016	2013–2022
Alabama	254	$1.5	$14.4	$0.7	$7.0
Alaska	25	$0.1	$1.5	$0.1	$0.6
Florida	1,060	$6.7	$66.1	$2.1	$22.6
Georgia	572	$3.4	$33.7	$1.2	$12.8
Idaho	78	$0.3	$3.3	$0.1	$1.5
Indiana	291	$1.8	$17.3	$0.9	$9.2
Kansas	109	$0.5	$5.3	$0.2	$2.6
Louisiana	287	$1.6	$15.8	$0.8	$8.0
Maine	30	$0.3	$3.1	$0.1	$0.9
Mississippi	201	$1.5	$14.5	$0.5	$4.8
Missouri	274	$1.8	$17.8	$0.6	$6.8
Montana	50	$0.2	$2.1	$0.1	$1.1
Nebraska	57	$0.3	$3.1	$0.1	$1.6
North Carolina	414	$4.0	$39.6	$1.1	$11.3
Oklahoma	182	$0.9	$8.6	$0.4	$4.1
Pennsylvania	381	$3.8	$37.8	$1.0	$10.6
South Carolina	237	$1.6	$15.8	$0.6	$6.2
South Dakota	34	$0.2	$2.1	$0.1	$0.8
Tennessee	257	$2.3	$22.5	$0.7	$7.7
Texas	1,552	$6.6	$65.6	$3.2	$34.3
Utah	98	$0.5	$5.3	$0.3	$3.1
Virginia	268	$1.5	$14.7	$0.6	$6.2
Wisconsin	11	$1.3	$12.3	$0.4	$3.7
Wyoming	20	$0.1	$1.4	$0.0	$0.4
Total:	**6,740**	**$42.9**	**$423.6**	**$15.9**	**$167.8**

Sources: Buettgens, et al. May 2014; Holahan, Buettgens, et al., July 2013; Dorn, Buettgens, et al., March 2013.

Notes: Listed states had not expanded eligibility as of July 2014. They include Indiana, Pennsylvania, and Utah, which have pending waiver proposals to expand eligibility. Totals may not add because of rounding.

2. **State Medicaid savings.** With expansion, some pre-ACA coverage qualifies for a higher federal medical assistance percentage (FMAP). For example, in a state with standard FMAP at the national average of 57 percent, suppose a Medicaid application is submitted by an adult with income below 138 percent of FPL who is eventually found to have a disability that qualifies him for Medicaid under pre-ACA rules. Such determinations typically take months to obtain. At that point, Medicaid retroactively covers care furnished while the application was pending.[14] If the state does not expand eligibility, it gets 57 percent FMAP for services provided before the disability determination. By contrast, if the state expands eligibility, the applicant is immediately classified as a newly eligible adult, and the state receives 100 percent FMAP for care provided before the disability determination, eliminating the state share of those costs.[15]

3. **Non-Medicaid savings.** For example, states generally fund mental health treatment for poor, uninsured adults. A state expanding eligibility can place most of these adults on Medicaid and shift many (but not all) of their mental health care costs to Medicaid, with the federal government taking over significant financial responsibilities from the state.

4. **Increased revenue.** Expansion raises state and local general revenue to the extent that increased federal Medicaid funding boosts economic activity. Also, many states tax provider or insurer revenue, which can rise with expansion.[16]

To illustrate, economic consulting firms commissioned by a consortium of Pennsylvania foundations concluded that, on balance, Medicaid expansion would help that state's budget by $5.1 billion during 2013-2022. Analysts reached the following conclusions about the four, above-listed categories of state fiscal effects:[17]

- Expansion would increase state Medicaid costs by $2.8 billion during 2013-2022, including $0.3 billion in "welcome mat" or "woodwork" expenses;

- State Medicaid costs for medically needy coverage and certain services for women would decline by $390 million, due to higher FMAP paid for affected beneficiaries;

- Pennsylvania would save $4.0 billion on non-Medicaid costs, including a pre-ACA health insurance program for childless adults, state mental health and substance abuse services, inpatient care for state prisoners, and state uncompensated care payments; and

- State personal and corporate income tax, sales tax, and insurance gross receipts tax revenue would increase by $3.6 billion.

After an intensive search, we found 57 fiscal analyses from 35 states estimating the impact of Medicaid expansion. For 16 states, we found comprehensive studies, like the Pennsylvania analysis, that included effects in all four categories. Each of those 16 comprehensive analyses found that expansion would help overall state budgets.[18] Given the ACA's very high FMAP for low-income adults, state-level savings and revenue exceeded increased state costs in every case, over whatever multi-year period was studied.[19]

The costs, savings, and revenues that result from expansion are highly context-specific, so a future comprehensive analysis in a different state might reach a different result. But that would be surprising, given the unanimous findings thus far in these 16 diverse states—California, Colorado, Kansas, Kentucky, Maryland, Michigan, Missouri, Montana, New Hampshire, New Mexico, Ohio, Oregon, Pennsylvania, Texas, Virginia, and Utah—as well as conclusions from other heterogeneous states like Indiana, Mississippi, New York, South Carolina, and Wyoming that expansion would help each state's overall budget, based on partial rather than full analyses of potential fiscal gains.[20] To illustrate the latter analyses:

- Researchers from the Universities of Alabama and South Carolina found that, in 2014-2020, increased general revenue resulting from expansion would exceed the state cost of expansion by $935 million, $848 million and $9 million for Alabama, Mississippi, and South Carolina, respectively—creating state budget gains even without considering possible state savings from enhanced FMAP or reduced spending on non-Medicaid programs;[21] and

- The Wyoming Department of Health found that savings resulting from enhanced FMAP and reduced spending on non-Medicaid programs would exceed increased state costs from higher Medicaid enrollment by $126.8 million, yielding overall state fiscal gains without considering any revenues resulting from expansion.[22]

Federal Matching Payments

Some state officials worry that Congress may not sustain the high FMAP ACA provides for expansion, on which the above favorable fiscal analyses rely.[23] These officials believe the federal government must someday focus on deficit reduction and, when it does, they fear it will have little choice but to cut ACA's unusually high FMAP for low-income adults.

Such fears can seem reasonable until one delves into Medicaid's current budget situation and past budget history. The federal Medicaid budget contains many other places to cut. For 2015, the Congressional Budget Office (CBO) estimates the federal government will spend $330 billion on Medicaid,[24] of which $42 billion results from the ACA's coverage expansion.[25] Within the latter amount, enhanced FMAP accounts for less than $21 billion,[26] or 6.4 percent of all federal Medicaid spending for 2015 (21/330=6.4%). Throughout all of 2015-2024, enhanced FMAP for expansion is projected to consume less than 7.4 percent of federal Medicaid spending (table 3).[27]

Historically, Congress has cut almost any other part of Medicaid before low-

Table 3. Increased Federal Matching Funds for Newly Eligible Adults as a Percentage of Total Federal Medicaid Spending, 2015–2027

	1. Increased federal Medicaid/ CHIP costs resulting from ACA (billions of dollars)	2. Upper bound to increased federal costs resulting from enhanced FMAP (billions of dollars)	3. Total federal Medicaid spending (billions of dollars)	Maximum possible percentage of total federal Medicaid spending due to enhanced FMAP (2/3)
2015	42.0	21.0	330.0	6.4%
2016	62.0	31.0	368.0	8.4%
2017	70.0	31.5	397.0	7.9%
2018	77.0	33.9	418.0	8.1%
2019	82.0	35.3	441.0	8.0%
2020	84.0	33.6	464.0	7.2%
2021	87.0	34.8	490.0	7.1%
2022	91.0	36.4	516.0	7.1%
2023	96.0	38.4	545.0	7.0%
2024	101.0	40.4	576.0	7.0%
2025	107.1	42.8	610.6	7.0%
2026	113.5	45.4	647.2	7.0%
2027	120.3	48.1	686.0	7.0%
2015–24	792.0	336.2	4,545.0	**7.4%**
2016–25	857.1	358.1	4,825.6	**7.4%**
2017–26	908.5	372.5	5,104.8	**7.3%**
2018–27	958.8	389.1	5,393.8	**7.2%**

Source: CBO April 2014.[28]

Notes: FMAP is federal medical assistance percentage. CHIP is Children's Health Insurance Program. Enhanced FMAP costs estimated by CBO are necessarily below the amounts shown here as upper bounds, which are calculated based on the following assumptions: (1) All increased federal Medicaid/CHIP spending projected by CBO to result from the ACA is for newly eligible adults, the only group qualifying for enhanced FMAP; and (2) CBO's projection assumed that the only states implementing the Medicaid expansion: (a) receive the legal minimum 50 percent for standard FMAP, so increased FMAP for expansion consumes as much of the projection as possible, and standard FMAP consumes as little of the projection as possible; and (b) receive full increased FMAP, not the reduced increase to FMAP provided to states that expanded eligibility for poor adults before 2019. CBO estimates are through 2024. We extrapolated estimates for later years by assuming a continuation of 6 percent annual increases to Medicaid costs.

ering the federal share of Medicaid costs, largely due to bipartisan gubernatorial resistance. Since 1980, 11 federal laws have made more than 100 different cuts to reduce projected Medicaid spending by eliminating benefits, raising consumer charges, cutting eligibility, reducing provider payments, etc.[29] Only once—in 1981—did Congress lower the federal share of Medicaid spending.[30] More recent budget bills actually *raised* the federal Medicaid share, even while making other federal Medicaid cuts.[31]

CONCLUSION

The states that did not expand Medicaid left nearly 7 million uninsured residents without help. While the number of uninsured in other states fell by 38 percent since September 2013, nonexpanding states experienced a decline of just 9 percent.

If they expand Medicaid, nonexpanding states would obtain more than $400 billion in federal funding over ten years, creating 172,400 jobs during 2015, according to the Council of Economic Advisers. Their hospitals would receive $168 billion in new revenue, offsetting the ACA's cuts to Medicare and Medicaid reimbursement. Every comprehensive state-level budget analysis of which we know found that expansion helps state budgets, because it generates state savings and additional revenues that exceed increased Medicaid costs. The current structure and past history of federal Medicaid spending show that, when federal leaders turn to deficit reduction, they will almost certainly seek and find other ways to cut Medicaid without lowering the federal share of Medicaid spending below the ACA's statutory level.

In nonexpanding states, officials face the challenge of securing expansion's practical benefits for their constituents without violating lawmakers' core principles. States have thus made creative expansion proposals that incorporate privatization, personal responsibility, and commercial-style benefits. Federal agencies receiving such proposals then face the challenge of accommodating state leaders' philosophical commitments without setting precedents that could endanger what federal officials view as Medicaid's essential features. Low-income Americans' access to care now depends on these diverse leaders working together effectively.

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Notes

1 We include a state in this category if, as of July 2014, the state had not implemented Medicaid expansion. We therefore include Indiana, Pennsylvania, and Utah, notwithstanding those states' pending waiver proposals to expand eligibility.

2 Among uninsured adults with incomes at or below 138 percent FPL, states that expanded Medicaid saw uninsurance rates fall by 13.7 percentage points; non-expansion states did not experience a statistically significant decline. Sharon K. Long, Genevieve M. Kenney, Stephen Zuckerman, Douglas Wissoker, Adele Shartzer, Michael Karpman, Nathaniel Anderson, and Katherine Hempstead. *Taking Stock at Mid-Year: Health Insurance Coverage under the ACA as of June 2014.* July 29, 2015, Washington, DC: Urban Institute and Robert Wood Johnson Foundation, http://hrms.urban.org/briefs/taking-stock-at-mid-year.html. See also Sommers, BD, T Musco, K Finegold, MZ Gunja, A Burke, AM McDowell. "Health Reform and Changes in Health Insurance Coverage in 2014." *New England Journal of Medicine,* July 23, 2014, DOI: 10.1056/NEJMsr1406753. To similar effect regarding adults with incomes below poverty, see Collins, SR, PW Rasmussen, and MM. Doty. *Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period,* July 2014, New York, NY: The Commonwealth Fund, http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/jul/1760_collins_gaining_ground_tracking_survey.pdf.

3 Adele Shartzer, Genevieve M. Kenney, Sharon K. Long, Katherine Hempstead, and Douglas Wissoker. *Who Are the Remaining Uninsured as of June 2014?* July 29, 2015, Washington, DC: Urban Institute and Robert Wood Johnson Foundation, http://hrms.urban.org/briefs/who-are-the-remaining-uninsured-as-of-june-2014.html.

4 See, e.g., Tenet Healthcare Corporation, "Tenet: Q1 '14," May 5, 2014, http://www.tenethealth.com/Investors/Documents/Earnings/Q1%202014%20SLIDES_2014_Q1_D_16_trr_FINAL%205_5_2014.pdf; Community Health Systems, Inc., "First Quarter 2014 Financial and Operating Results Conference Call," May 7, 2014; Hospital Corporation of American, "First Quarter 2014 Earnings Conference Call," April 29, 2014. The latter calls are summarized at Millman, J. "Hospitals see blue-red divide early into Obamacare's coverage expansion." *Washington Post Wonkblog*, May 12, 2014, http://www.washingtonpost.com/blogs/wonkblog/wp/2014/05/12/hospitals-see-blue-red-divide-early-into-obamacares-coverage-expansion/. See also Center for Health Information and Data Analytics. *Impact of Medicaid Expansion on Hospital Volumes,* June 2014, Denver, CO: Colorado Hospital Association. The latter analysis compared data from 465 hospitals in 15 expanding and 15 nonexpanding states, concluding as follows:

- "The Medicaid proportion of patient volume at hospitals in states that expanded Medicaid increased substantially in the first quarter of 2014. At the same time, the proportion of self-pay and overall charity care declined in expansion-state hospitals…. The Medicaid proportion of total charges increased over three percentage points to 18.8 percent in 2014 from 15.3 percent in 2013, representing a 29 percent growth in the volume of Medicaid charges. When compared to the first quarter of 2013, there was a 30 percent drop in average charity care per hospital across expansion states, to $1.9 million from $2.8 million. Similarly, total self-pay charges declined 25 percent in expansion states, bringing its proportion of total charges down to 3.1 percent from 4.7 percent."
- "Medicaid, self-pay and charity care showed no change outside normal variation for hospitals in non-expansion states in 2014."

5 Buettgens M, Kenney GM, and Recht H. *Eligibility for Assistance and Projected Changes in Coverage Under the ACA: Variation Across States, May 2014 Update.* Washington, D.C.: Urban Institute and Robert Wood Johnson Foundation, 2014. http://www.urban.org/url.cfm?ID=413129.

6 Holahan J, Buettgens M and Dorn S. *The Cost of Not Expanding Medicaid.* Washington, D.C.: Urban Institute, 2013. http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8457-the-cost-of-not-expanding-medicaid4.pdf.

7 Council of Economic Advisers. *Missed Opportunities: The Consequences of State Decisions Not to Expand Medicaid*, July 2014, Washington, DC: http://www.whitehouse.gov//sites/default/files/docs/missed_opportunities_medicaid_0.pdf.

8 See, e.g., Missouri Office of Administration, Division of Budget & Planning. *Medicaid Restructuring Budget background.* February 2013, Springfield, MO, http://www.mobudget.org/files/Medicaid_Expansion_Save_MO_Money.pdf; Custer WS. *The Economic Impact of Medicaid Expansion in Georgia.* February 2013, Atlanta, GA: Institute of Health Administration, J. Mack Robinson College of Business, Georgia State University, 2013. For a comprehensive list of state macroeconomic analyses as of November 2013, see Kaiser Commission on Medicaid and the Uninsured, *The Role of Medicaid in State Economies and the ACA*, November 2013, https://kaiserfamilyfoundation.files.wordpress.com/2013/11/8522-the-role-of-medicaid-in-state-economies-looking-forward-to-the-aca.pdf.

9 New York Times, "United States of Subsidies: A Series Examining Business Incentives and Their Impact on Jobs and Local Economies," December 1, 2012, http://www.nytimes.com/interactive/2012/12/01/us/government-incentives.html?_r=0. In no state was the year in question more recent than 2012. This article is cited in Glied S and S Ma. *How States Stand to Gain or Lose Federal Funds by Opting In or Out of the Medicaid Expansion.* New York: The Commonwealth Fund, 2013. http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2013/dec/1718_glied_how_states_stand_gain_lose_medicaid_expansion_ib_v2.pdf.

10 The date for which information about incentive payments is available varies by state and program. For example, the New York Times describes California as making at least $4.17 billion per year in incentive payments. All quantified payments are estimated for FY 2012 except $38.9 million in sales and use tax exemptions for clean technology manufacturing, estimated for calendar year 2011; $36.4 million for employment training services, estimated for FY 2009; and $211 million for the alternative and renewable fuel and vehicle technology program (involving cash grants, loans, or loan guarantees), estimated for calendar year 2010. The latter three incentive programs combined represent less than 7 percent of the state's quantified incentive payments as estimated by the New York Times, with the rest coming in FY 2012. Additional unquantified incentive payments are listed for pre-2012 time periods. Story, L, T Fehr and D Watkins, "California," *New York Times*, December 1, 2012, http://www.nytimes.com/interactive/2012/12/01/us/government-incentives.html?_r=1&.

11 Dorn S, Buettgens M, Holahan J and Carroll C. *The Financial Benefit to Hospitals from State Expansion of Medicaid.* Washington, D.C.: Urban Institute, 2013. http://www.urban.org/uploadedpdf/412770-The-Financial-Benefit-to-Hospitals-from-State-Expansion-of-Medicaid.pdf.

12 Dorn, Buettgens, Holahan, Carroll; Dorn, S, B Garrett, J Holahan. *Redistribution Under the ACA is Modest in Scope.* Washington, D.C.: Urban Institute, 2014. http://www.urban.org/UploadedPDF/413023-Redistribution-Under-the-ACA-is-Modest-in-Scope.pdf.

13 Expansion will also affect administrative costs. Some will rise—for example, more applications and renewals will need to be processed. Others will fall—for example, states with pre-ACA medically needy, "spend-down" coverage will carry out fewer labor-intensive spend-down determinations, because some former "spend-downers" will qualify as newly eligible adults. We are not aware of any state-level analysis that has analyzed administrative costs in a comprehensive way, taking into account specific factors like these, which are described in Holahan, Buettgens and Dorn, *The Cost of Not Expanding Medicaid.*

14 Coverage extends retroactively to care provided up to three months before the date of application.

15 After 2016, the state will start paying some of those costs, with its share rising to 10 percent in 2020 and beyond—still substantially less than the 43 percent it must finance if it does not expand eligibility.

16 When the Medicaid program pays state taxes or fees on providers or insurers, the state share of Medicaid payments is a "wash" fiscally—that is, the state Medicaid program pays the state revenue office—but the federal share is a transfer from the federal Treasury to the state. With expanded eligibility, most new Medicaid dollars are federal.

17 Pennsylvania Economy League, Inc., and Econsult Solutions, Inc. *The Economic And Fiscal Impact Of Medicaid Expansion In Pennsylvania*. April 2013, Harrisburg, PA: PA Health Funders Collaborative, http://economyleague.org/files/PEL_MEDICAID_EXPANSION_REPORT_FINAL.pdf.

18 For Colorado, Maryland, Michigan, New Mexico, Oregon, and Virginia, see Dorn S, Holahan J, Carroll C, et al. *Medicaid Expansion Under the ACA: How States Analyze the Fiscal and Economic Trade-Offs.* Washington, D.C.: Urban Institute, 2013. http://www.urban.org/UploadedPDF/412840-Medicaid-Expansion-Under-the-ACA.pdf. In addition, comprehensive analyses were conducted analyzing state fiscal effects in California, Ohio, Kansas, Kentucky, Missouri, Montana, New Hampshire, Pennsylvania, Texas, and Utah. For links to studies of the latter states, see the supplement to this paper, available at http://www.urban.org/UploadedPDF/413192-What-is-the-Result-of-States-Not-Expanding-Medicaid-appendix.pdf.

19 Many (but not all) of these analyses find that, by the end of the estimated multi-year periods, when the federal share of costs for newly eligible adults falls to 90 percent, increased costs exceed, by a small amount, the combination of savings and revenues resulting from expansion. However, none of the estimates that we found considered state savings, which are likely to be significant, allowed by CMS's guidance permitting states to claim enhanced FMAP for health care costs provided for certain adults with disabilities at or below 138 percent FPL, including for services provided while such adults are awaiting their disability determinations. CMS. "Medicaid and the Affordable Care Act: FMAP Final Rule Frequently Asked

Questions." August 29, 2013, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/FMAP-FAQs.pdf. On the other hand, if CEA's analysis of the impact of future labor markets on Medicaid expansion's macroeconomic effects is correct, revenue gains from Medicaid expansion may fall below projected levels, in some states.

20 The studies that considered only some of the above categories of state budget gains reached mixed conclusions. While most such studies found expansion had a negative overall impact, in 10 states analysts found net state budget gains even without considering all potential categories of state fiscal benefits. In addition to Minnesota and New York, (Dorn, Holahan, Carroll, et al., *Medicaid Expansion Under the ACA*) those states were Alabama, Indiana, Louisiana (under a scenario that did not increase provider reimbursement), Mississippi, South Carolina, Tennessee, Wisconsin (in one of several analyses), and Wyoming. For links to the latter studies, as well as the more numerous state-level analyses that failed to consider all categories of potential state fiscal gains and concluded that Medicaid expansion would harm state budgets, see the on-line supplement to this paper, available at http://www.urban.org/UploadedPDF/413192-What-is-the-Result-of-States-Not-Expanding-Medicaid-appendix.pdf.

21 The estimates for Alabama and Mississippi are for the "intermediate take-up scenario," Becker DJ and MA Morrisey. *An Economic Evaluation of Medicaid Expansion In Alabama under the Affordable Care Act*. Department of Health Care Organization and Policy, School of Public Health, University of Alabama at Birmingham. 2012, http://www.soph.uab.edu/files/faculty/mmorrisey/Becker-Morrisey%20Study%20of%20Alabama%20Medicaid%20Expansion%202012.pdf; Becker DJ and MA Morrisey. *An Economic Analysis of the State and Local Impact of Medicaid Expansion in Mississippi*. Department of Health Care Organization and Policy, School of Public Health, University of Alabama at Birmingham. 2013. For the South Carolina estimates, see Von Nessen, J. *Medicaid Expansion in South Carolina*: *The Economic Impact of the Affordable Care Act*. December 2013, Columbia, SC: Moore School of Business, University of South Carolina, prepared for the South Carolina Hospital Association, http://www.scha.org/files/documents/medicaid_expansion_in_sc_report.pdf. Note that if CEA is correct and labor market slack completely disappears, Medicaid expansion may not yield the economic growth forecast by these state-level analysts, leading to less general revenue growth than anticipated.

22 Wyoming Department of Health. *The Optional Expansion of Medicaid in Wyoming: Costs, Offsets, and Considerations for Decision-Makers*. Cheyenne, WA: November 2012, http://www.health.wyo.gov/Media.aspx?mediaId=13196.

23 See, for example, New York Times Editorial Board, "A Health Care Showdown in Virginia," *New York Times*, May 10, 2014, http://www.nytimes.com/2014/05/11/opinion/sunday/a-health-care-showdown-in-virginia.html; Howell WJ and Cox K, "Medicaid Expansion: Promises on Future Costs Don't Ring True," *Richmond Times-Dispatch*, February 2, 2014, http://www.timesdispatch.com/opinion/their-opinion/columnists-blogs/guest-columnists/howell-and-cox-medicaid-expansion-promises-on-future-costs-don/article_0285f36b-9652-5a5a-9524-ae0f914d4afc.html; Associated Press, "Kansas Legislature Extends Ban on Medicaid Expansion," *Modern Healthcare*, April 5, 2014, http://www.modernhealthcare.com/article/20140405/INFO/304059935; Miller D, "Medicaid—To Expand or Not to Expand?" *Capitol Ideas: Council of State Governments E-Newsletter*, May/June 2014, http://www.csg.org/pubs/capitolideas/enews/issue108_1.aspx; Shorman J, "Shouting Protestors Shut Down Senate, Some Arrested," *Springfield News-Leader*, May 7, 2014, http://www.news-leader.com/story/news/local/ozarks/2014/05/06/shouting-protestors-shut-state-senate/8765497/.

24 CBO. *Detail of Spending and Enrollment for Medicaid for CBO's April 2014 Baseline*. April 2014. Washington, DC, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44204-2014-04-Medicaid.pdf.

25 CBO. *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act*, April 2014. April 2014. Washington, DC, http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf.

26 That estimate is based on the following assumptions:, all of which assume the maximum possible proportion of federal Medicaid funding devoted to increased FMAP: (1) All increased federal Medicaid/CHIP spending projected by CBO to result from the ACA is for newly eligible adults, the only group qualifying for elevated FMAP; and (2) that CBO projection of increased spending assumed that the only states implementing the Medicaid expansion: (a) receive the legal minimum 50 percent for standard FMAP, so increased FMAP for expansion consumes as much of the projection as possible, and standard FMAP consumes as little of the projection as possible; and (b) receive full increased FMAP, not the reduced increase to FMAP provided to states, such as New York, that expanded eligibility for poor parents and childless adults before 2019.

27 That percentage will decline in the future as CBO's 10-year "scoring window" moves forward to include additional years with 90 percent FMAP and fewer years with 100 percent FMAP. That is why, as shown by table 3, the percentage of total federal Medicaid spending consumed by enhanced FMAP drops from an upper bound of 7.4 percent in 2015–2024 to an upper bound of 7.2 percent in 2018–2027.

28 Congressional Budget Office (CBO). *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014*. April 2014. Washington, DC, http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf; CBO. *Detail of Spending and Enrollment for Medicaid for CBO's April 2014 Baseline*. April 2014. Washington, DC, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44204-2014-04-Medicaid.pdf.

29 Omnibus Reconciliation Act of 1980 (P.L. 96-499), Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248), Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509), Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508), Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66), Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193), Balanced Budget Act of 1997 (P.L. 105-33) , Deficit Reduction Act of 2005 (P.L. 109-171) .

30 Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35). At that time, Medicaid's contribution to state budgets (hence governors' motivation to resist cuts) was a third of current levels. In 1981, state general fund expenditures totaled $145.0 billion, and the federal government spent $16.9 billion on Medicaid—the equivalent of 12 percent of state general fund dollars. By 2012, those two amounts rose to $666.8 billion and $237.9 billion, respectively. Federal Medicaid dollars thus equaled 36 percent of state general fund expenditures. See Center on Medicare and Medicaid Services. "National Health Expenditures by Type of Service and Source of Funds, CY 1960–2012," http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE2012.zip; National Governors Association Office of Research and Development and National Association of State Budget Officers. *Fiscal Survey of the States: 1981-1982.* Washington D.C.: National Governors Association Office of Research and Development and National Association of State Budget Officers, 1982, http://www.nasbo.org/sites/default/files/pdf/fs1981-1982.PDF; National Governors Association Office of Research and Development and National Association of State Budget Officers. *The Fiscal Survey of States: Fall 2013.* Washington, D.C.: National Governors Association Office of Research and Development and National Association of State Budget Officers, 2013, http://www.nasbo.org/sites/default/files/NASBO%20Fall%202013%20Fiscal%20Survey%20of%20States.pdf.

31 For example, the two most recent budget reconciliation bills that made Medicaid cuts were the Balanced Budget Act of 1997 (BBA) and the Deficit Reduction Act of 2005 (DRA). The BBA eliminated the need for federal waivers before states could force Medicaid beneficiaries into closed-panel managed care plans; repealed the so-called "Boren Amendment," thereby letting states cut payments to hospitals and nursing homes; cut payments to federally qualified health centers, pediatricians, and obstetricians; cut payments to providers serving Medicare Savings Program beneficiaries; and limited states' use of disproportionate share hospital payments and provider donations and taxes. At the same time, the BBA raised FMAP for Alaska and the District of Columbia and increased the dollar ceiling on FMAP claimable by U.S. territories. Several years later, the DRA cut Medicaid payments for prescription drugs; cut Medicaid eligibility for long-term care; required states to take specified anti-fraud measures; increased private insurers' third-party liability payments to Medicaid; let states raise beneficiaries' premiums and co-payments; let states cut benefits for adults; limited states' use of managed care taxes; ended coverage of certain case management services for children; made it harder for applicants to prove U.S. citizenship; capped emergency payments to out-of-network providers for managed care enrollees; and terminated states' authority to grant new CHIP waivers to cover childless, nonpregnant adults. At the same time, the DRA raised FMAP for Alaska, Louisiana, and the District of Columbia and increased the dollar cap on FMAP for U.S. territories. Other examples of increased FMAP include enhanced FMAP to provide state Medicaid programs with fiscal relief in 2003 and 2009, neither of which was accompanied by Medicaid cuts; an elevated federal match rate for covering children through CHIP, enacted as part of the BBA in 1997, that exceeded the federal match rate available through previous Medicaid coverage expansions for children; and still higher match rates for covering newly eligible adults enacted through the ACA in 2010.

THE INDEPENDENT AND NON-PARTISAN SURVEY
OF PUBLIC OPINION ESTABLISHED IN 1947 AS
THE CALIFORNIA POLL BY **MERVIN FIELD**

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2014 TCWF-Field Health Policy Poll - Part 1
Increase in California Voter Support for Affordable Care Act
Most Say the State's Implementation of the Law Has Been Successful
Growing Proportions Satisfied with the Way California's Health Care System Is Working

By Mark DiCamillo and Mervin Field

Following its first year of full implementation in California, the Affordable Care Act (ACA) is now receiving greater support from this state's voters than at any time since its introduction in 2010. At present, 56% of registered voters say they support the law, while 35% are opposed. This twenty-one point margin in support is up from 15 points last year.

By a two-to-one margin (60% to 30%) voters think the state of California has been successful in implementing the ACA. This contrasts with their much more divided assessment of the way the federal government has implemented the law (49% successful vs. 46% not successful).

Many more voters say the state has been successful than feel it has been unsuccessful in achieving six of seven goals that California set out to achieve when it began implementing the law. This includes encouraging uninsured residents to get coverage, expanding Medi-Cal, providing consumers with more insurance choices, obtaining the federal funds needed to implement the law, providing better consumer protections, and establishing a one-stop place where consumers can go to shop for health insurance online.

The one area where more voters think the state has not been successful in its implementation of the law relates to limiting the rate increases that insurance companies charge to their customers. Statewide, 46% feel California has been unsuccessful in meeting this goal, while 37% think it has been successful. Another 17% aren't sure. Related to this is the finding that 46% of voters say they have difficulty paying the costs of their health care, including 17% who say it's very difficult. However, the proportion reporting that their health care costs are very difficult to afford declined four points from 21% who said this last year.

These generally positive evaluations of the ACA and its implementation in California appear to be impacting voters' overall views of the way the state's health care system is performing. Currently, 56% say they are satisfied with the way the state's health care system is working, while 34% are dissatisfied. This is a significant improvement from prior *TCWF-Field Health Policy Surveys*.

The poll also finds two-thirds of California voters (66%) in support of the ACA's requirement that private health insurance plans cover the full cost of birth control. In addition, most disagree (56%) with the recent U.S. Supreme Court ruling allowing certain employers, whose owners object to birth control on religious grounds, to be exempt from this requirement.

These are the findings from Part One of the *2014 TCWF-Field Health Policy Survey* conducted June 26-July 19, 2014 by *The Field Poll* among 1,535 California registered voters in seven languages and dialects, under a grant from The California Wellness Foundation. Part Two, for publication tomorrow, will examine voter visits to and views of the Covered California health insurance exchange website, the expansion of the state's Medi-Cal system under the ACA, and proposals aimed at improving the state's health care system, including the proposal to extend Medi-Cal to the state's undocumented immigrants and likely voter preferences regarding Proposition 45, the "Approval of Healthcare Insurance Rate Changes" initiative on the upcoming November election ballot.

"For those monitoring the implementation of the Affordable Care Act, it was clear that the experience in California would be critical to the national success of this important reform," said Judy Belk, president and CEO of The California Wellness Foundation. "The poll's findings related to increased satisfaction among voters with the performance of the health care system in our state indicate that the hard work of policymakers, advocates and others is paying off. More Californians are now insured and able to access health care."

Voter support for the ACA moves higher in California

This most recent assessment of California voters' overall opinion of the ACA shows 56% in support (35% strongly and 21% somewhat). This compares to 35% who are opposed (26% strongly and 9% somewhat). The current 21 percentage-point plurality in favor is up from 15 points last year and is the largest margin of support for the law in annual *TCWF-Field Health Policy Surveys* dating back to 2010.

Like other Americans, Californians' views of the ACA are highly partisan. While California Democrats support the law greater than five to one, Republicans oppose it greater than three to one. However, compared to last year, Republican opposition in the state has moderated some, from greater than four-to-one opposition last year.

Support for the law continues to be stronger in the nine-county San Francisco Bay Area and in Los Angeles County than in other regions. However, most of this year's increase in regional support is derived from somewhat greater support for the law among voters in the Central Valley and in areas of Southern California outside of Los Angeles County.

While the state's ethnic voter population continues to be overwhelmingly supportive of the law, a plurality of the state's white non-Hispanic voters now favors the law (50% to 44%).

When asked what further actions Congress should take with regard to the law, the proportion of voters who favor expanding the law has grown from 38% last year to 43% this year. Another 12% believes Congress should leave the law as is, while 36% of Californians favor repealing all or parts of the law.

The state of California's implementation of the ACA viewed much more favorably than the federal government's efforts

By a two-to-one margin (60% to 30%) voters believe the state of California has been successful in implementing the ACA. This contrasts to a much more divided assessment of the way the federal government has implemented the law. Statewide, 49% of Californians believe the federal government's implementation of the law has been successful, while 46% say it has not.

Many more voters believe that the state has been successful than feel it has been unsuccessful in achieving six of seven specific goals that California set out to achieve when it began implementing the law. This includes encouraging more previously uninsured residents to get coverage, expanding Medi-Cal to extend health insurance to more low-income residents, providing consumers with more insurance choices, obtaining the federal funds needed to implement the law, providing insurance buyers with better consumer protections, and establishing a one-stop place where consumers can go to shop for health insurance online.

However, a plurality believes the state has not been successful in limiting the rate increases that insurance companies charge to their customers. Statewide 46% of voters feel California has not been successful in meeting this goal, while 37% feel it has, and 17% aren't sure.

Growing proportions of voters say they're satisfied with the way the health care system is working in California

By a 56% to 34% margin, more voters now say they're satisfied than dissatisfied with the way the health care system is working in California. This represents a significant improvement in voter assessments of the state's health care system from prior measures. For example, in 2008 50% were satisfied and 46% dissatisfied.

Overall satisfaction with the state's health care system is related to household income. By a greater than two to one margin, voters with annual incomes of less than $40,000 now report being satisfied with the way the state's health care system is working, a much more positive assessment than was observed two years ago.

Nearly half report some difficulty paying for health care

Nearly half of voters statewide (46%) say they have difficulty paying the costs of their health care, while 52% do not. About one in six voters (17%) say it's "very difficult." However, this is less than the 21% of voters who felt it was very difficult for them to pay their health care costs in 2013. Most likely to report that health care costs are very difficult to afford are the uninsured (46%).

In addition, 47% of voters say the total amount they are paying for health care increased over the past year. Higher income Californians are more likely to say this than lower income Californians.

Californians support ACA's requirement that private health plans cover the full cost of birth control; most disagree with recent Supreme Court ruling on the matter

Two-thirds of California voters (66%) support the health care law's requirement that private health insurance plans cover the full cost of birth control, while 25% are opposed. However, opinions about this divide sharply along party lines, with 83% of Democrats supporting it, compared to 39% among Republicans.

Most Californians disagree with the recent U.S. Supreme Court ruling allowing certain employers, whose owners object to birth control on religious grounds, to be exempt from this requirement. A 56% majority of voters who were interviewed after the High Court ruled on this issue on June 30 say they disagreed with the decision, while 36% agreed. There were big differences in views of the ruling by party, with 72% of Democrats disagreeing with it, compared to 31% among Republicans.

-30-

About the Survey

The *2014 TCWF-Field Health Policy Survey* is the eighth in an annual series of health policy surveys conducted among random samples of California registered voters by *The Field Poll* through a grant from The California Wellness Foundation. This year's findings are based on a survey of 1,535 California registered voters interviewed by telephone in seven languages and dialects – English, Spanish, Cantonese, Mandarin, Korean, Vietnamese and Tagalog. Interviews were completed on either a voter's landline phone or a cell phone. In this survey 859 voters were contacted on their cell phone, while 676 were reached on a regular landline or other phone.

In order to enable the survey to more closely examine the opinions of the state's growing ethnic voter populations the survey included additional interviews with Asian American voters. A total of 1,167 of the interviews were conducted in English and 368 in non-English languages.

Interviewing was conducted June 26 – July 19, 2014 from Field Research Corporation's central location call center. Up to six attempts were made to reach and interview each randomly selected voter on different days and times of day during the interviewing period. After the completion of interviewing, the overall sample was weighted to align it to the proper statewide distribution of voters by race/ethnicity and by other demographic, geographic and political characteristics of the California registered voter population.

Sampling error estimates applicable to any probability-based survey depend upon its sample size. According to statistical theory, 95% of the time results from the overall sample are subject to a maximum sampling error of +/- 2.6 percentage points. The maximum sampling error is based on percentages in the middle of the sampling distribution (percentages around 50%). Percentages at either end of the distribution have a smaller margin of error. Sampling error will be larger for analyses based on subgroups of the overall sample.

About The California Wellness Foundation

The California Wellness Foundation is a private, independent foundation created in 1992, with a mission to improve the health of the people of California by making grants for health promotion, wellness education and disease prevention. Since its founding in 1992, the Foundation has awarded 7,338 grants totaling more than $890 million. For more information, visit the Foundation's website, www.calwellness.org, or contact Cecilia Laiché, communications officer, at (818) 702-1900.

2014 TCWF-Field Health Policy Survey

Part 1

Updating Voter Views of the Affordable Care Act and the Health Care System in California

Conducted by

The Field Poll

for

The California Wellness Foundation

for release

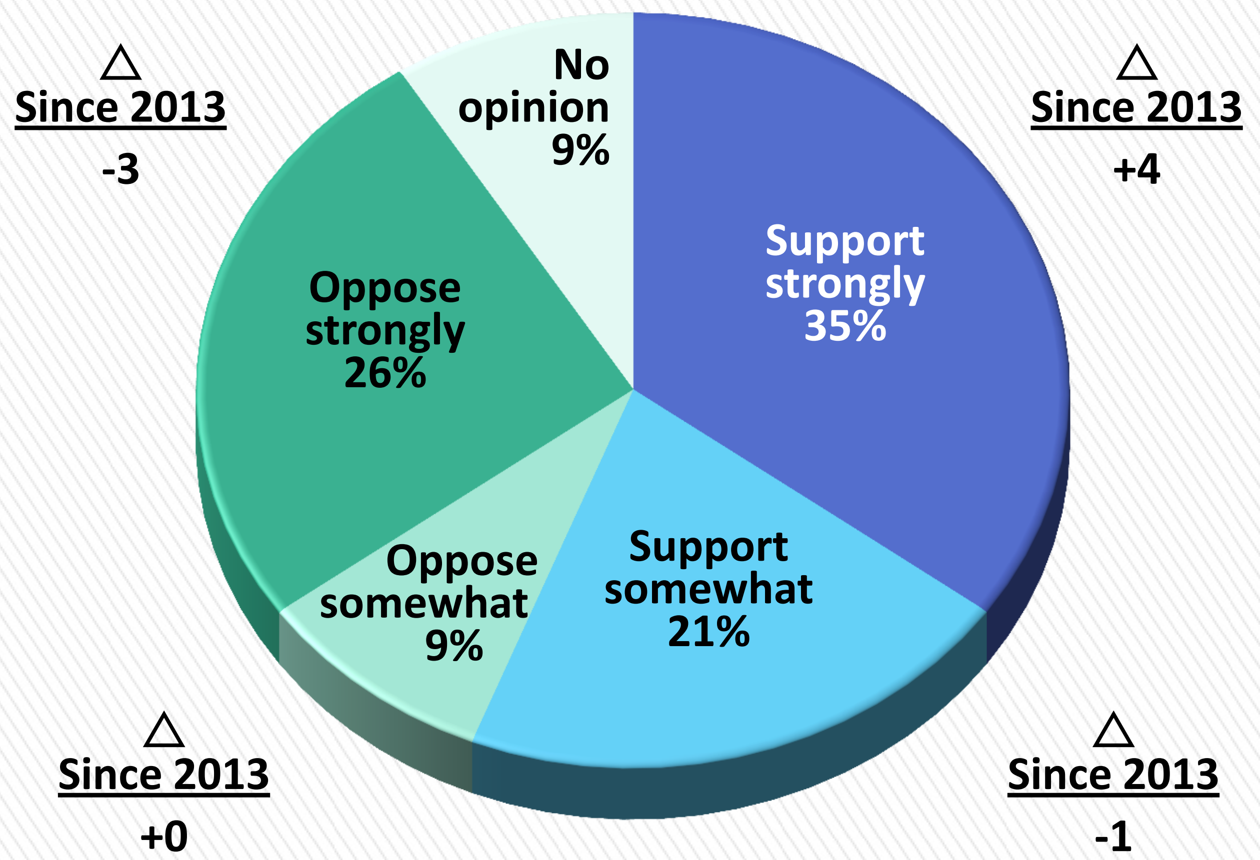
Tuesday, August 19, 2014

About the Survey

Population surveyed:	California registered voters.
Number of interviews:	1,535 interviews completed including an augmented sample of Asian American voters.
Data collection:	June 26-July 19, 2014 by cell and landline telephone using live interviewers from Field Research's central location call center.
Languages of administration:	English, Spanish, Cantonese, Mandarin, Tagalog, Korean and Vietnamese. 1,169 completed in English and 368 in non-English languages.
Sampling error:	Overall findings have a sampling error of +/- 2.6 percentage points at the 95% confidence level.

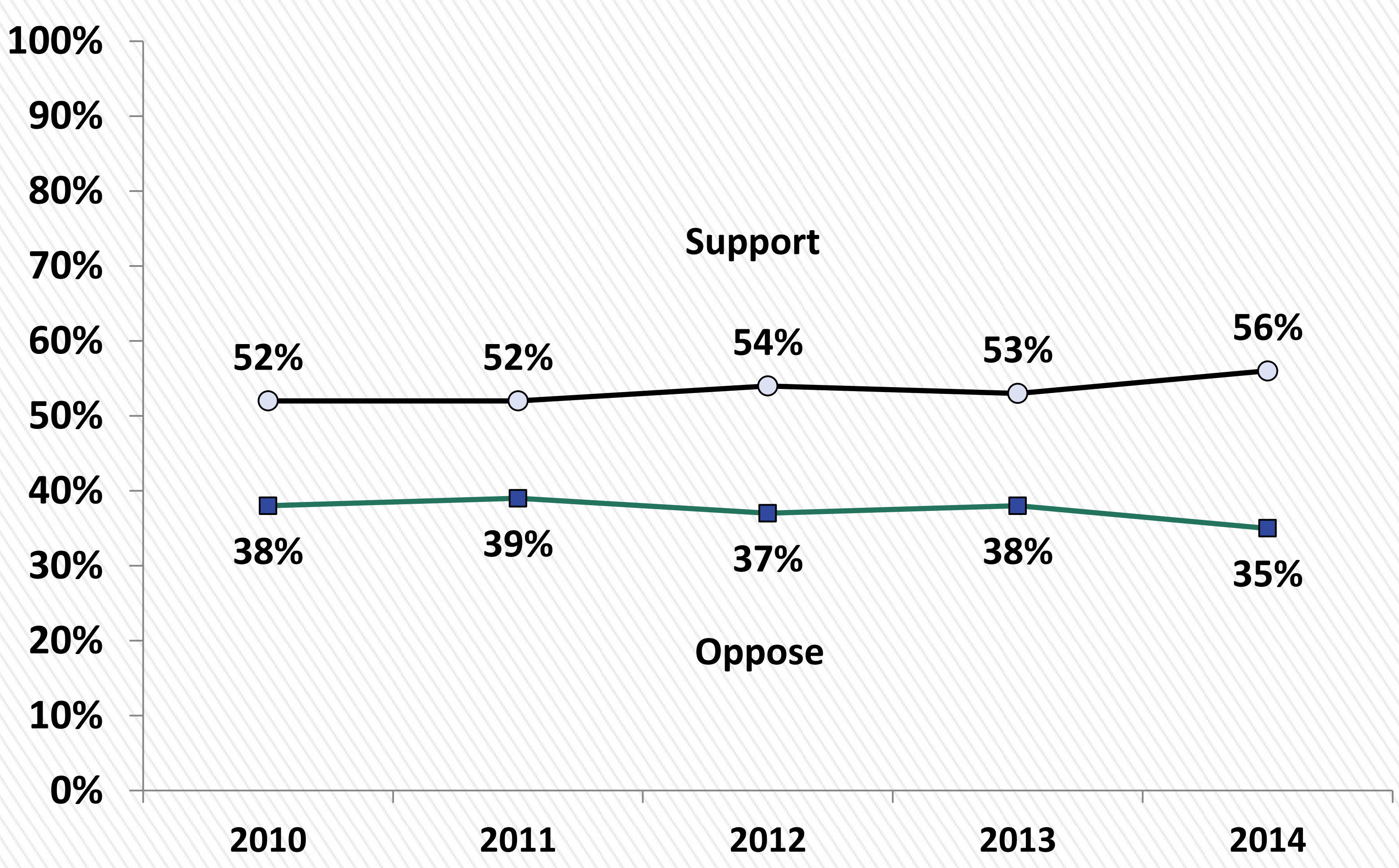
Graph 1

Current public opinion of California voters toward the Affordable Care Act *(July 2014)*



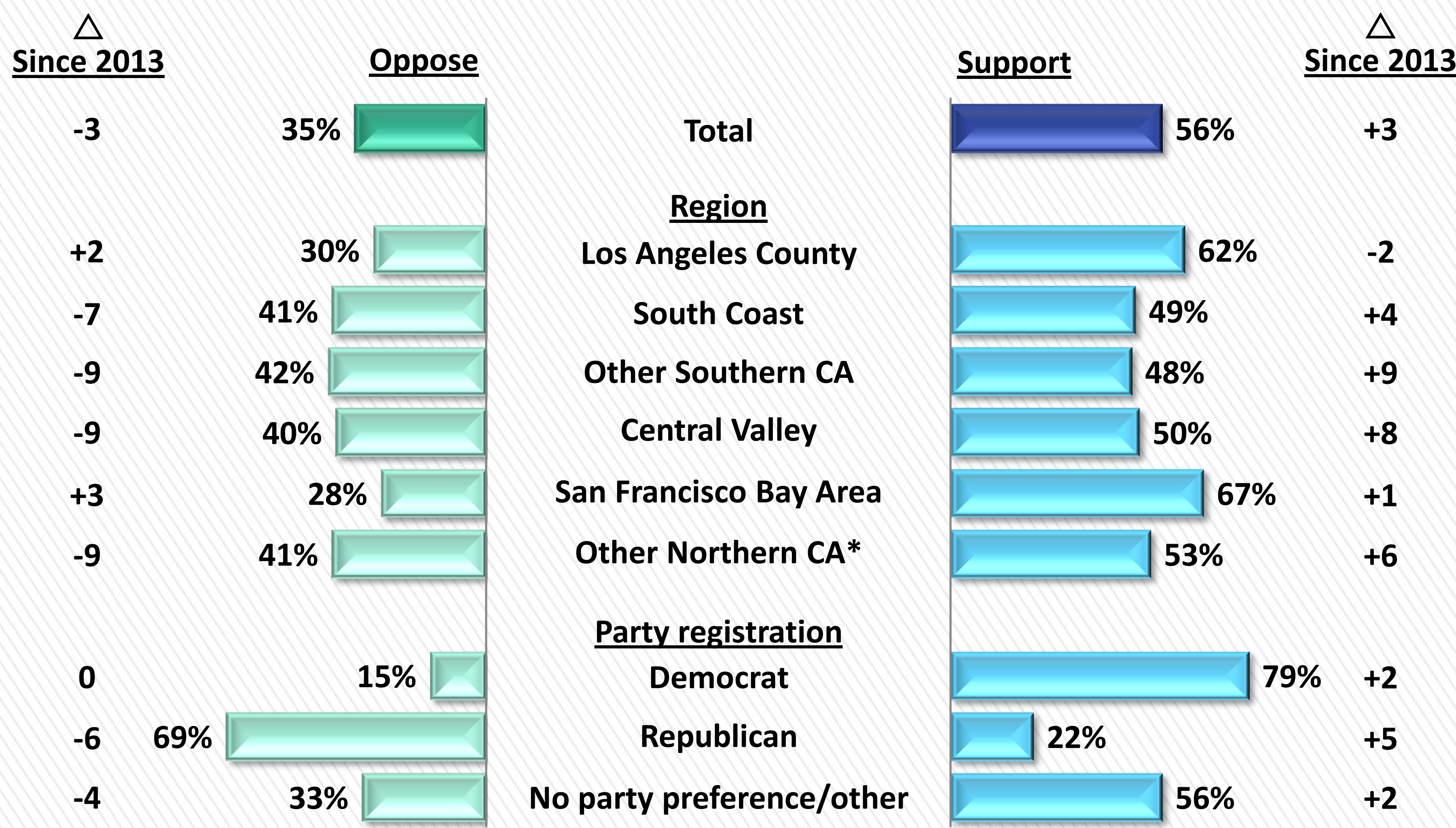
Graph 2

Trend of California voter opinions of the Affordable Care Act



Graph 3a

Current voter opinions of the Affordable Care Act by region and party registration

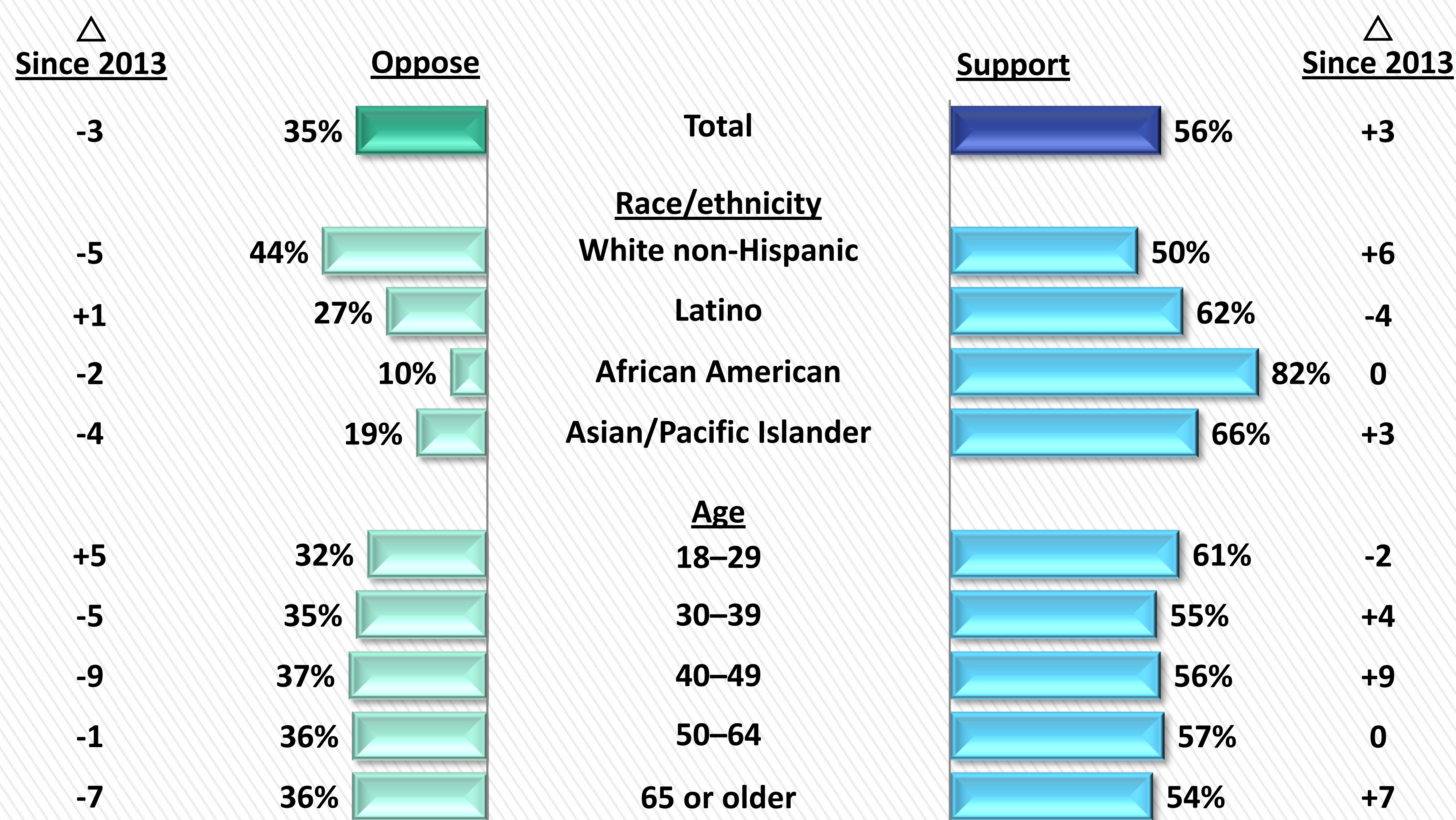


Note: Differences between 100% and the sum of each subgroup's percentages equal proportion with no opinion.

** Small sample base.*

Graph 3b

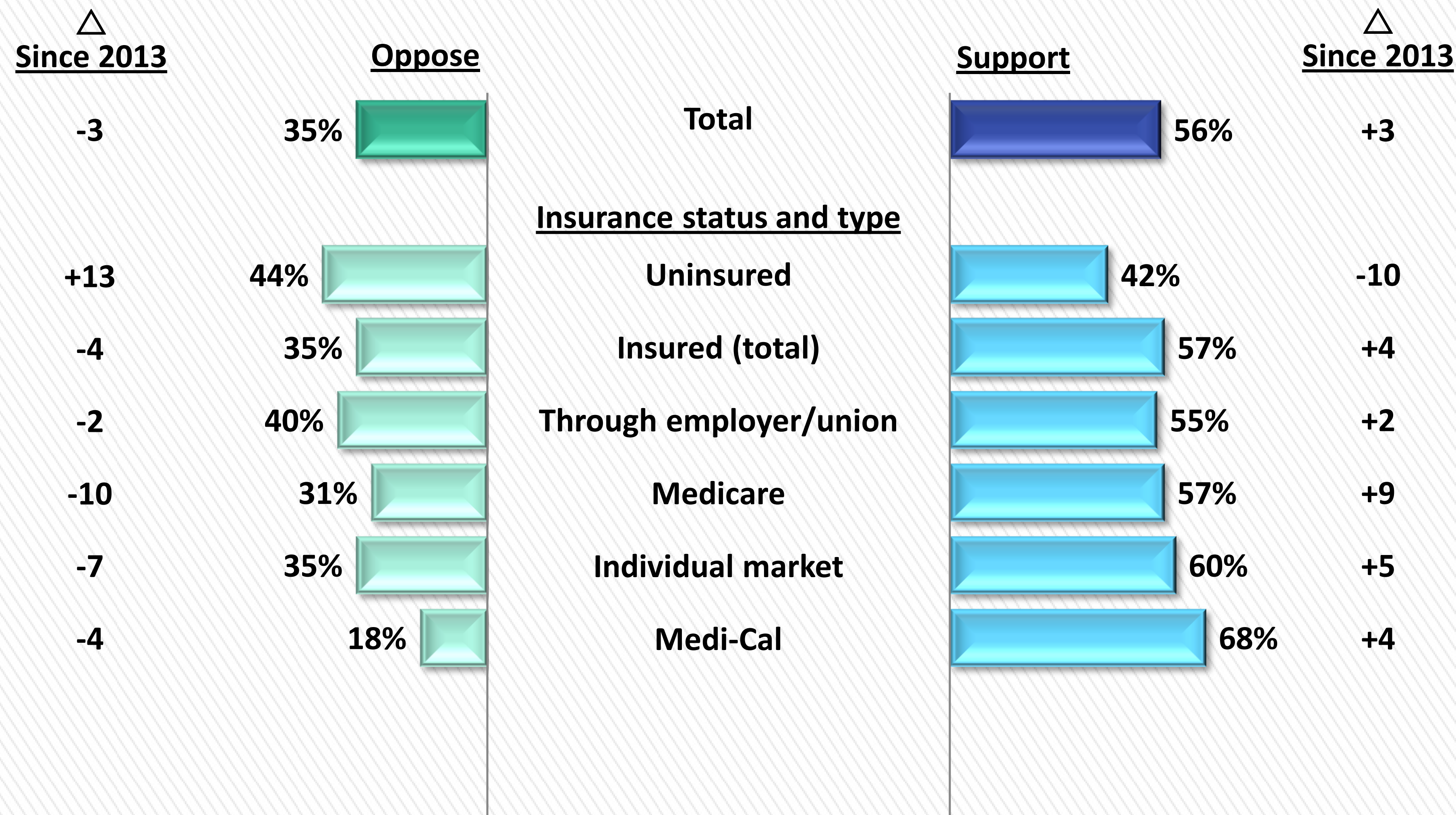
Current voter opinions of the Affordable Care Act by race/ethnicity and age



Note: Differences between 100% and the sum of each subgroup's percentages equal proportion with no opinion.

Graph 3c

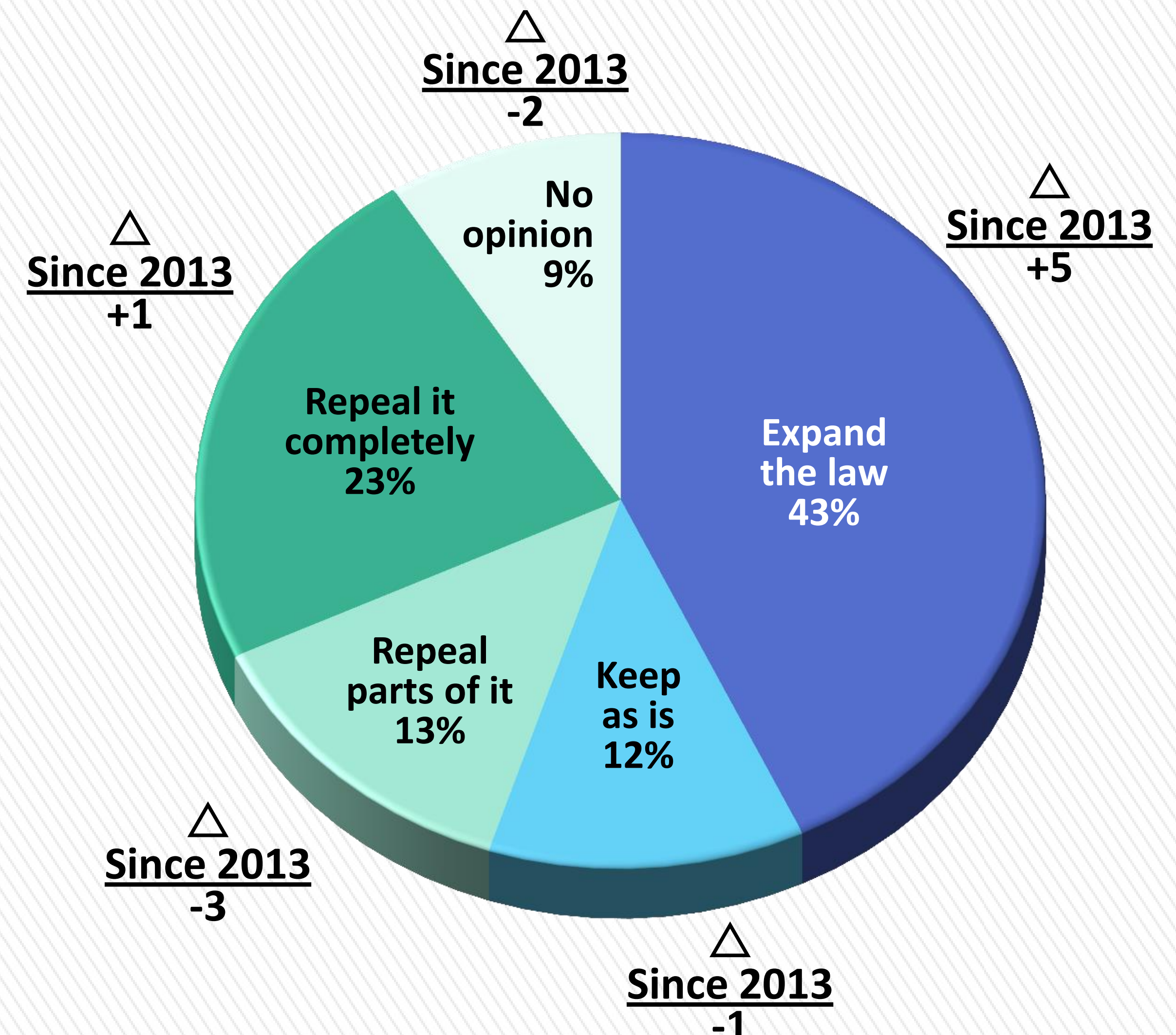
Current voter opinions of the Affordable Care Act by insurance status and type



Note: Differences between 100% and the sum of each subgroup's percentages equal proportion with no opinion.

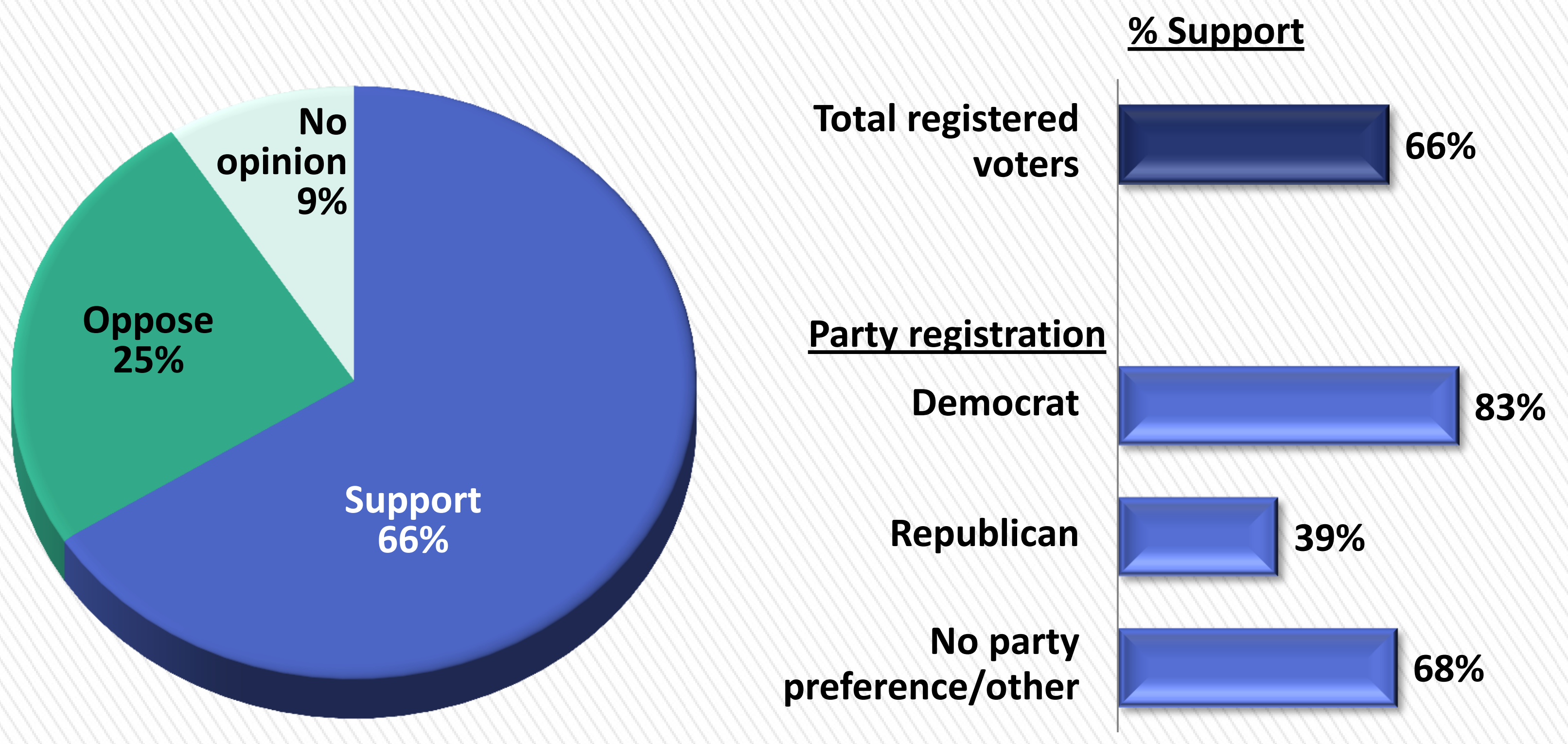
Graph 4

What further actions should Congress take with regard to the Affordable Care Act



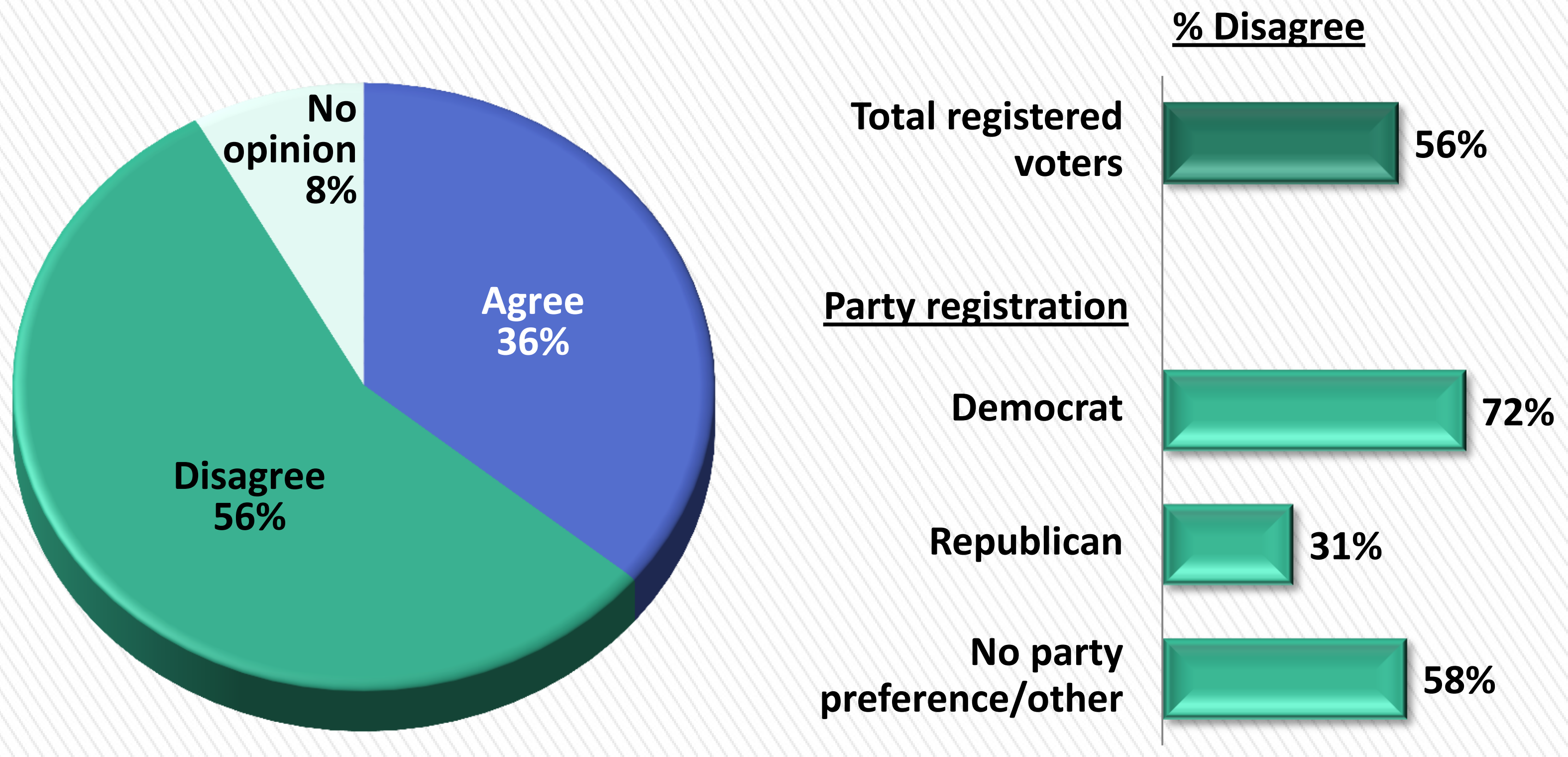
Graph 5

California voter views about ACA's requirement that private health insurance plans cover the full cost of birth control



Graph 6

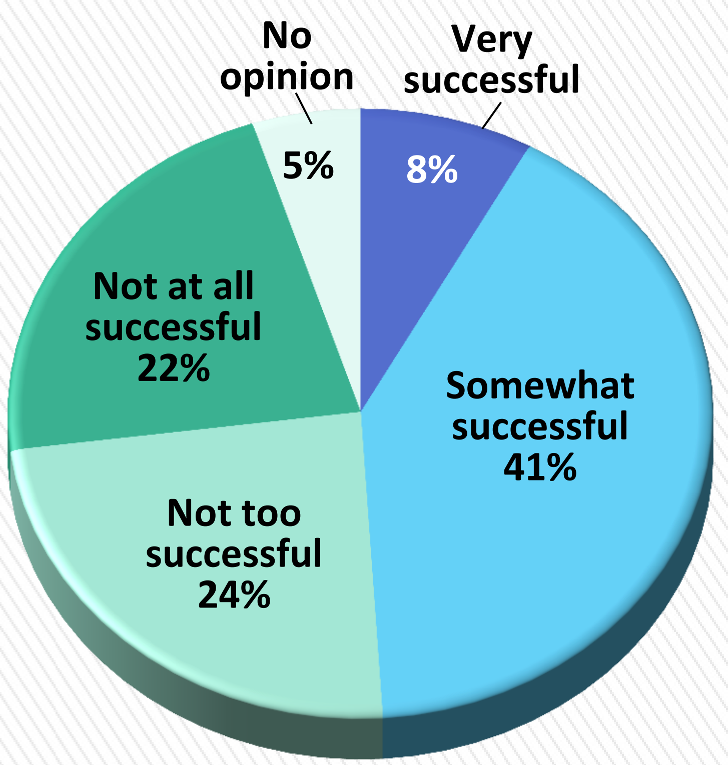
California voters' views about the U.S. Supreme Court ruling allowing certain employers (whose owners object to birth control on religious grounds) to be exempt from the ACA's requirement to cover costs of prescription birth control in their company's health plans



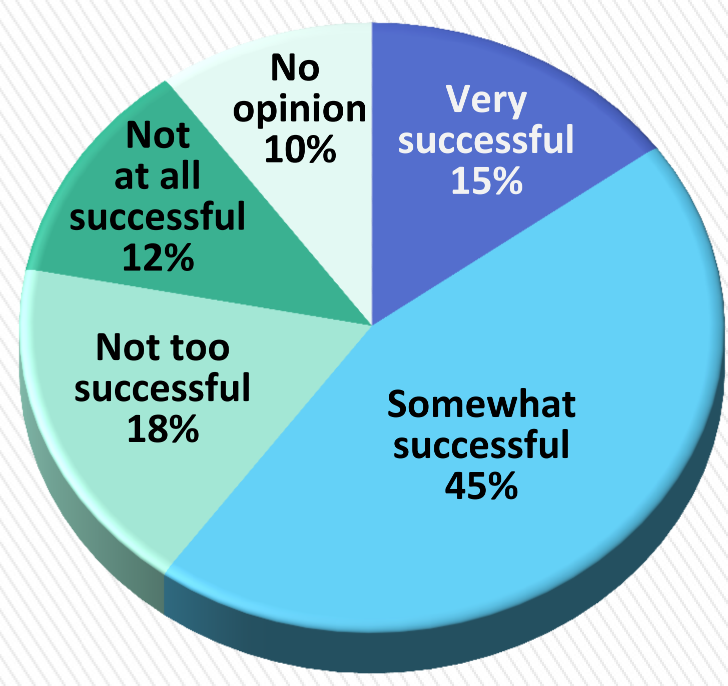
Note: Question added to the poll immediately after the U.S. Supreme Court issued its ruling on this case and was asked of 1,302 registered voters statewide.

Graph 7

Opinions of how successful the federal government and the state of California have been in implementing the Affordable Care Act



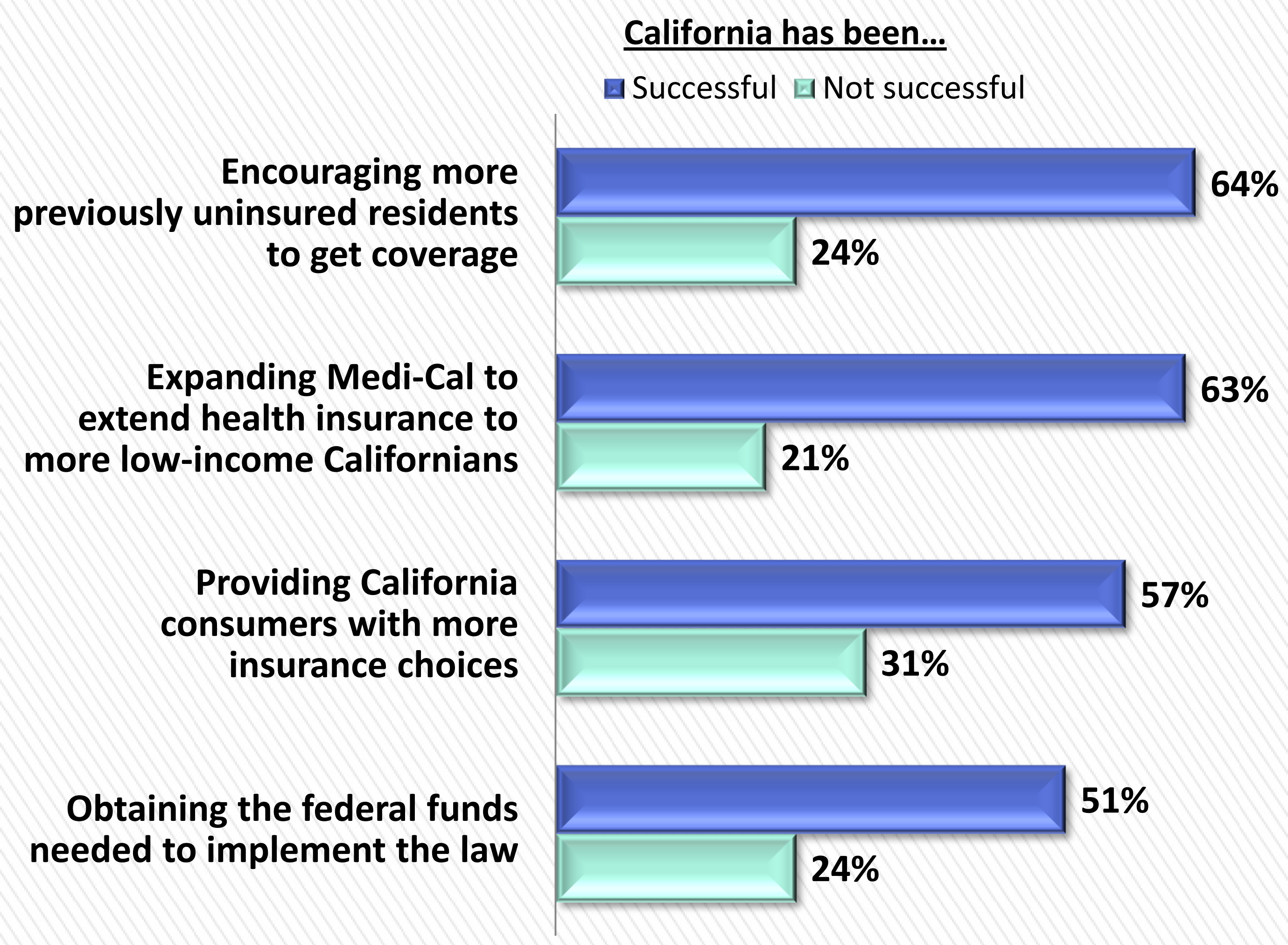
Federal Government



State of California

Graph 8a

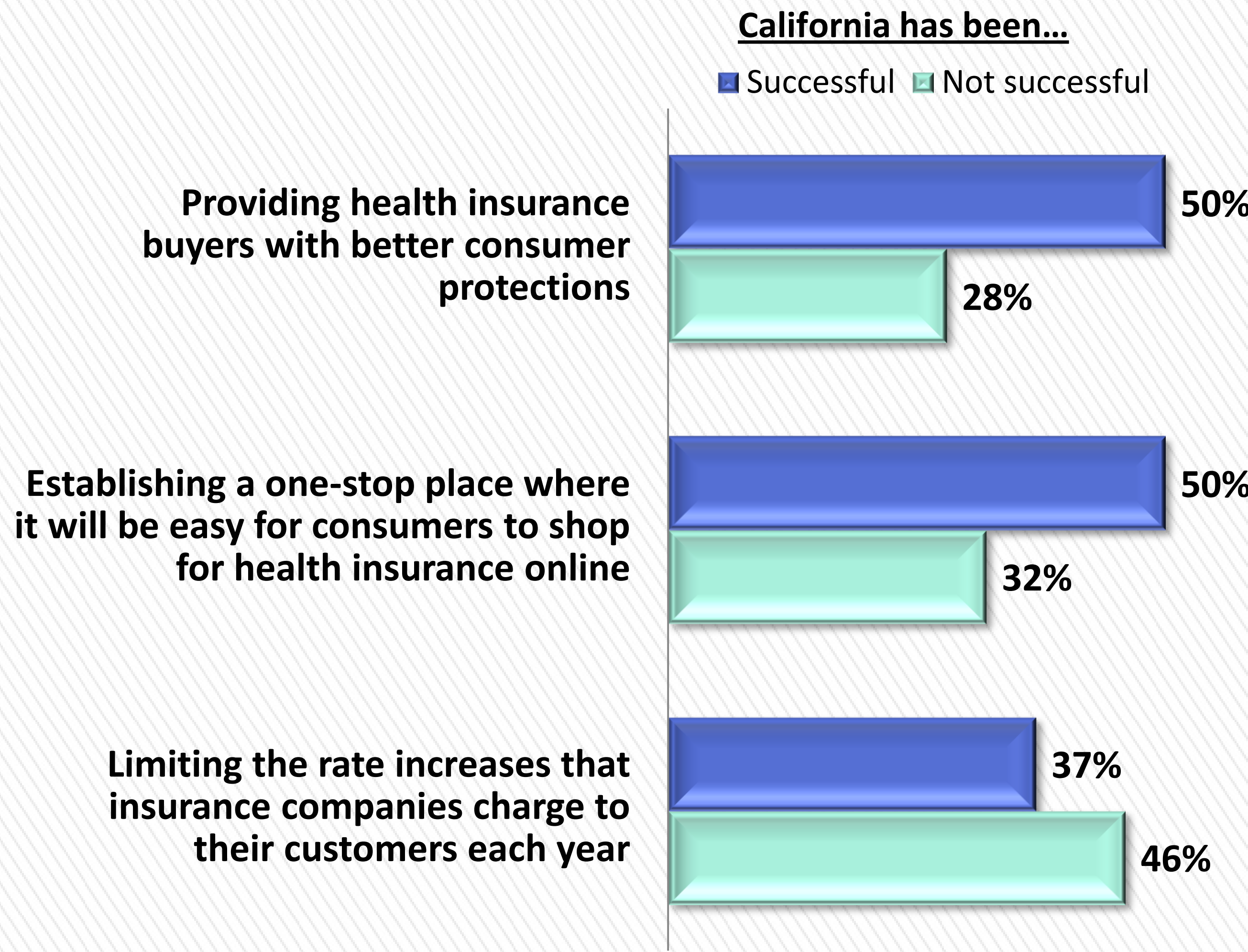
Voter opinions about how successful California has been in achieving specific goals of the ACA (1 of 2)



Note: Differences between 100% and the sum of each subgroup's percentages equal proportion with no opinion.

Graph 8b

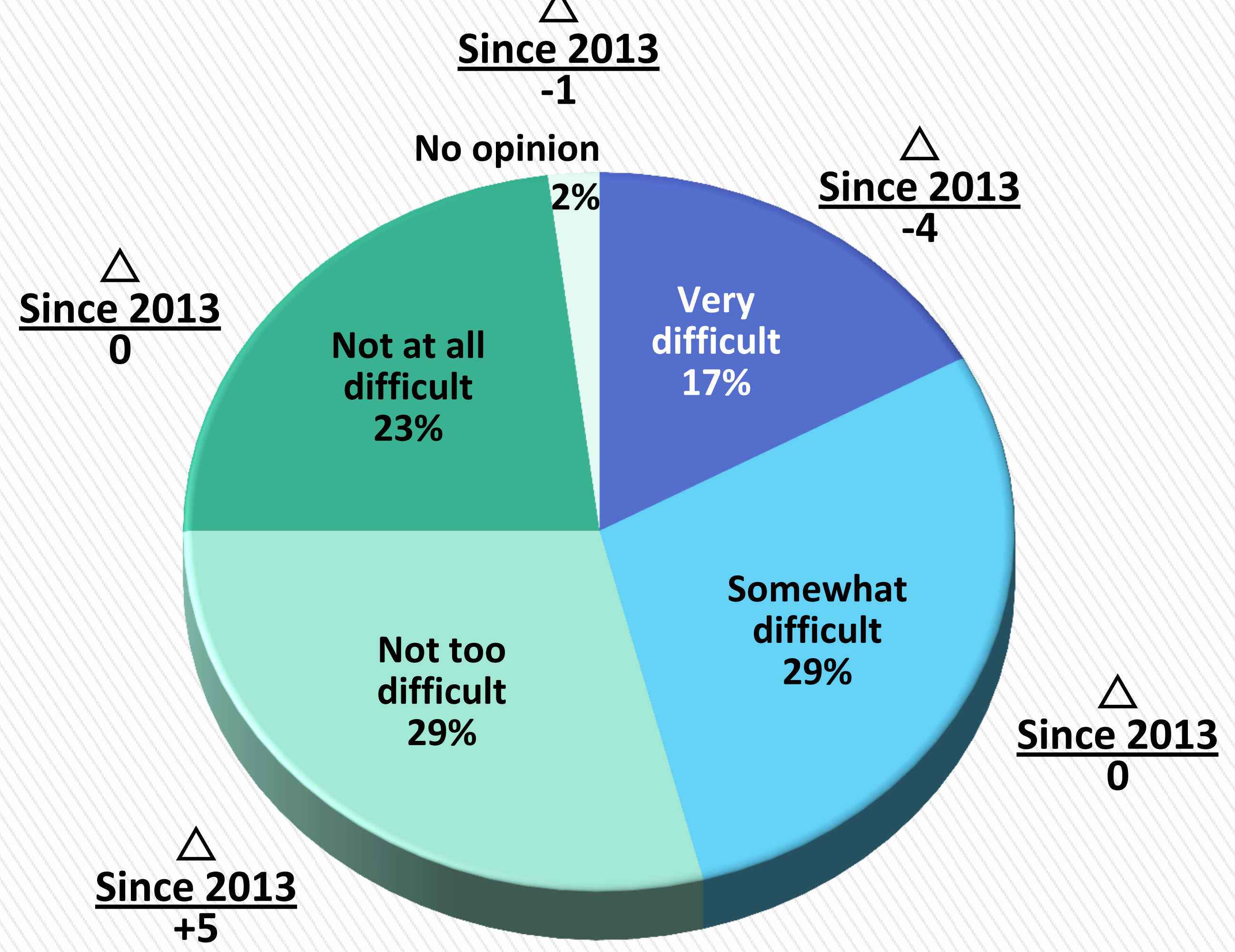
Voter opinions about how successful California has been in achieving specific goals of the ACA (2 of 2)



Note: Differences between 100% and the sum of each subgroup's percentages equal proportion with no opinion.

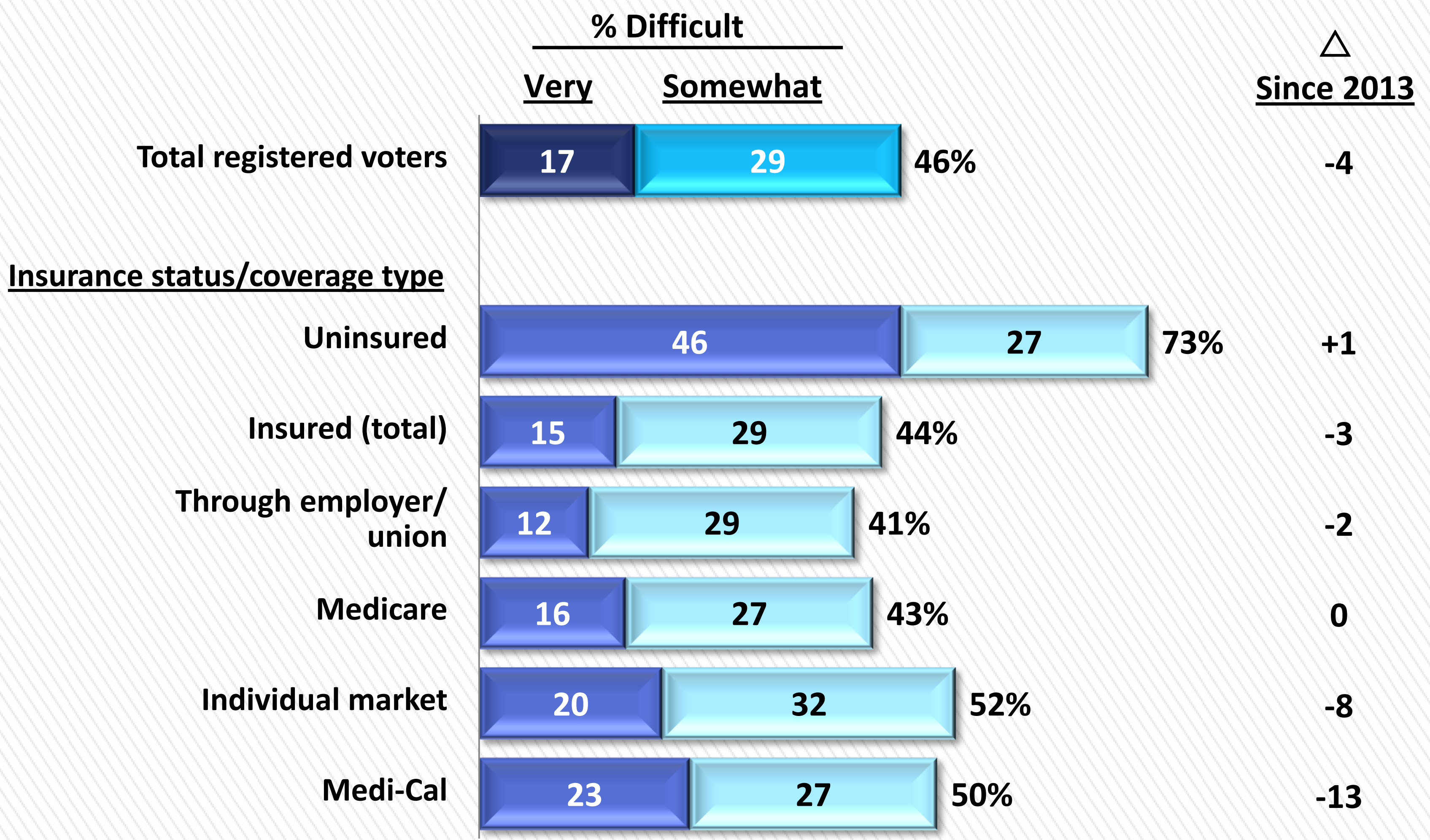
Graph 9

Voters' reported difficulty in paying for health care



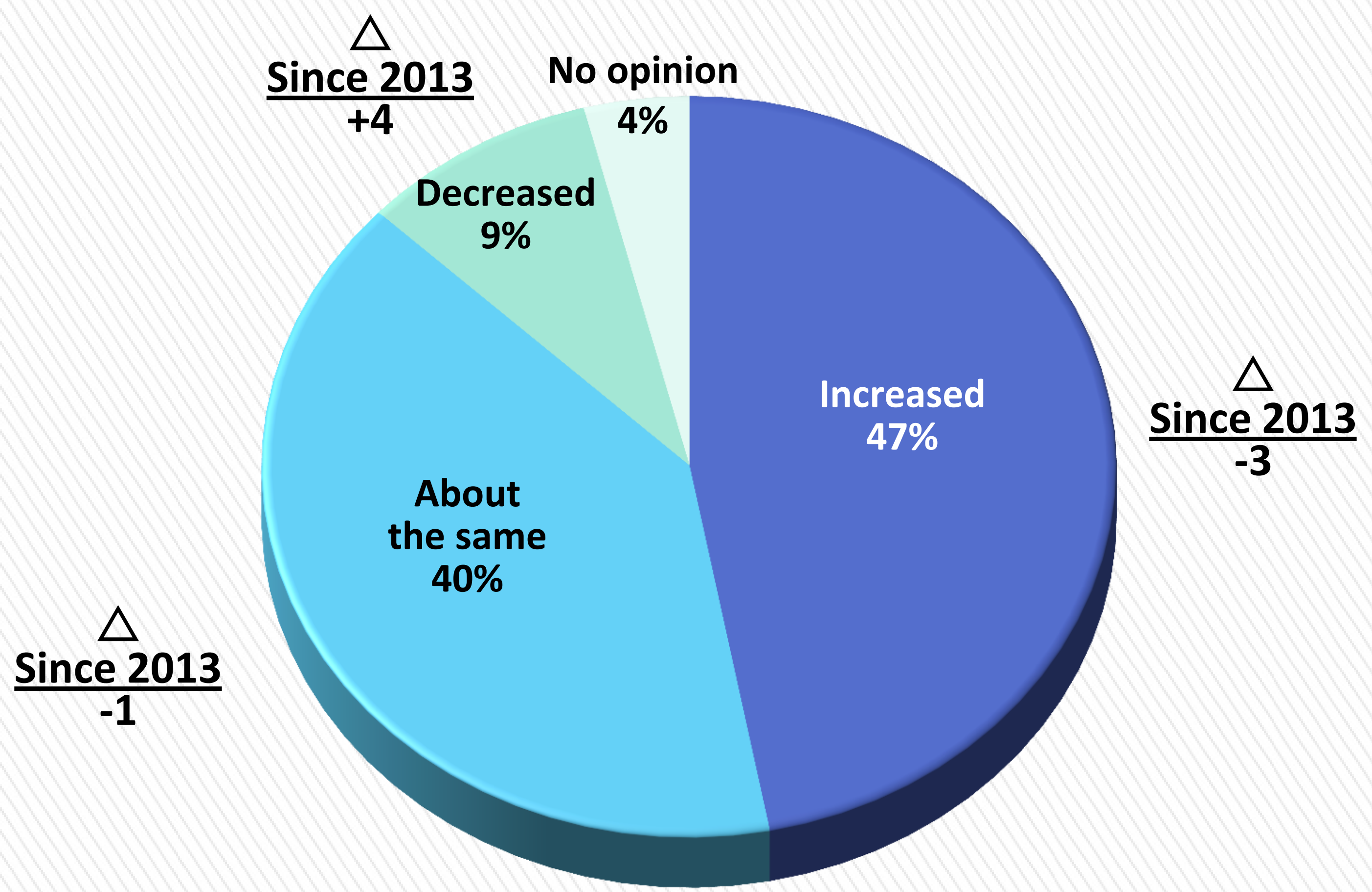
Graph 10

Difficulty in paying for health care by insurance status and type



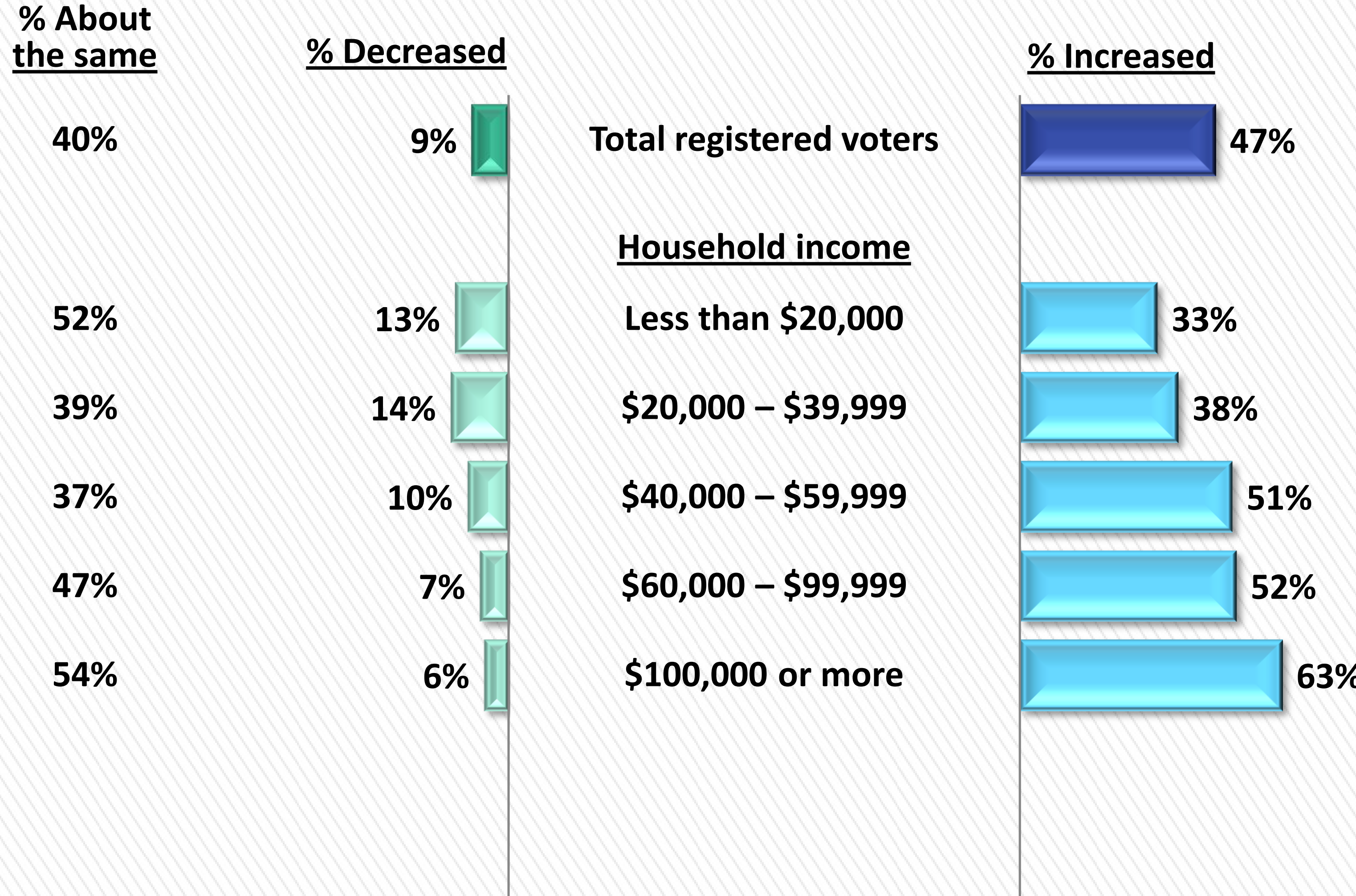
Graph 11

Perceived changes in amount paid for health care over the past year



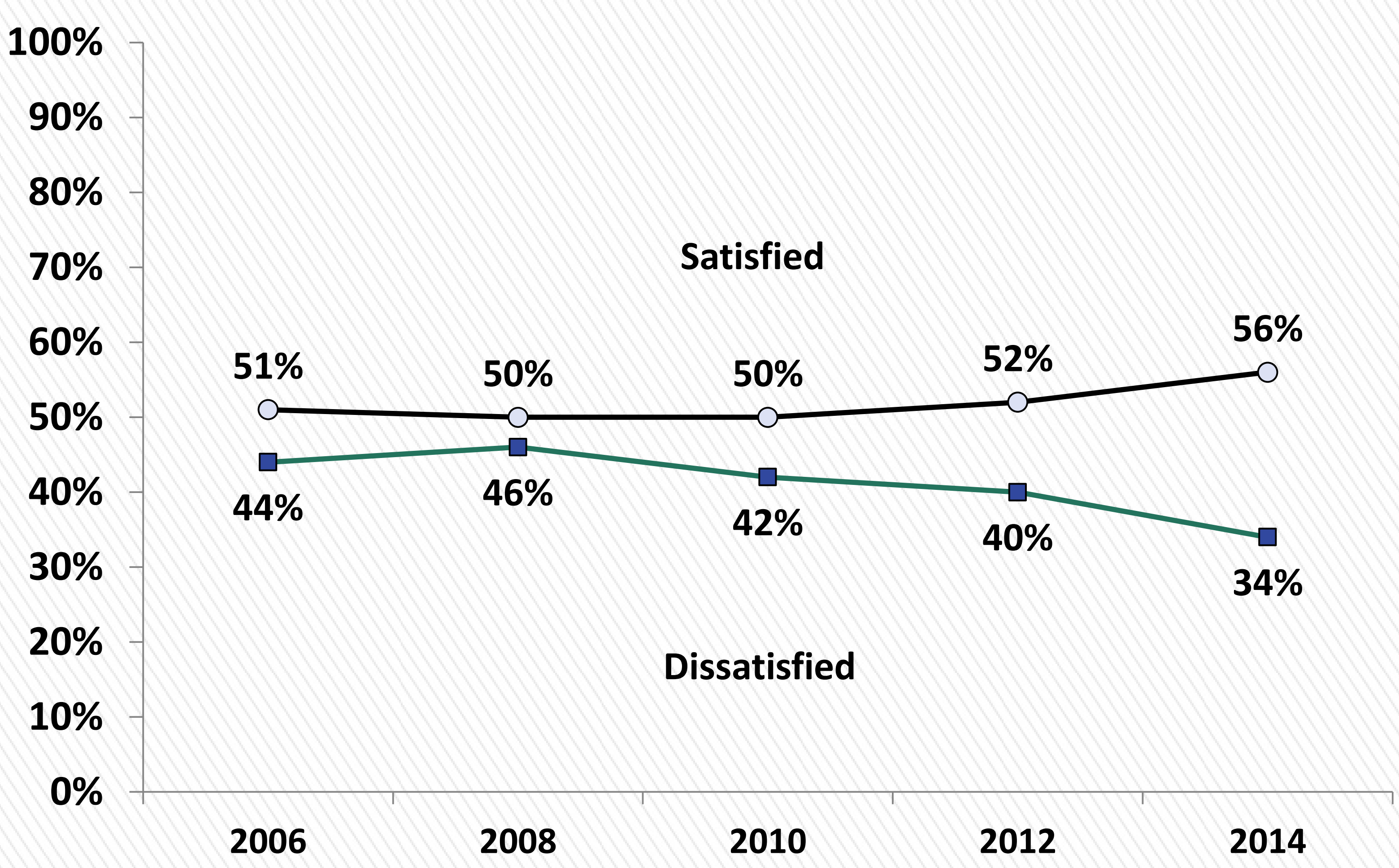
Graph 12

Perceived changes in amount paid for health care over the past year by household income



Graph 13

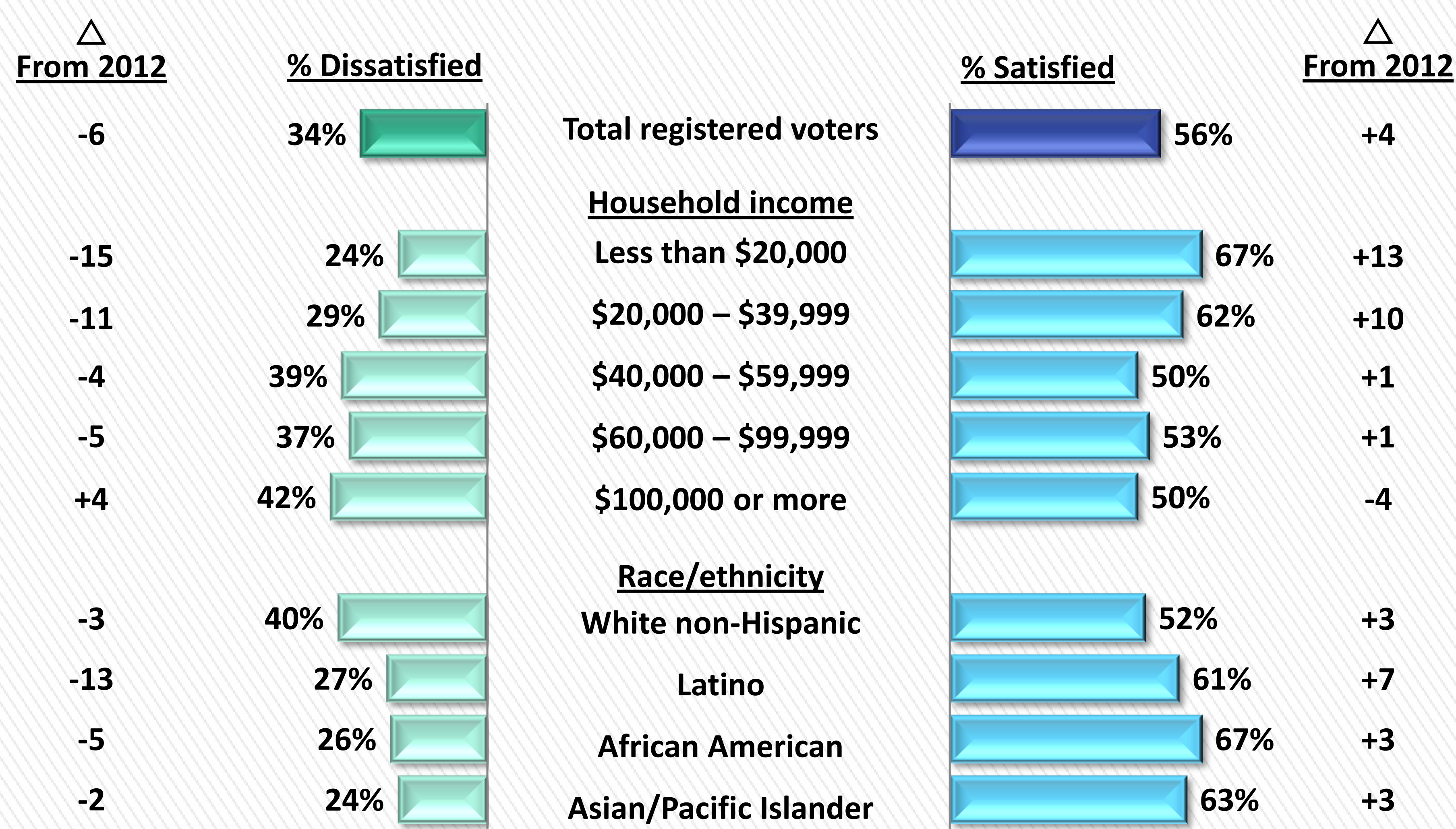
Trend of voter satisfaction with the way the health care system is working in California *(2006 – 2014)*



Note: Differences between 100% and the sum of each year's percentages equal proportion with no opinion.

Graph 14

Satisfaction with the way the health care system in California is working by household income and race/ethnicity



Note: Differences between 100% and the sum of each subgroup's percentages equal proportion with no opinion.

Field Research Corporation
San Francisco, California 94108

600-046
081914

Topline Findings
2014 TCWF-Field Health Policy Poll – Part 1
Updating Voter Views of the Affordable Care Act and the Health Care System in California

1. How satisfied are you with the way the health care system is working in California? Are you very satisfied, somewhat satisfied, somewhat dissatisfied or very dissatisfied?

VERY SATISFIED	22%
SOMEWHAT SATISFIED	34
SOMEWHAT DISSATISFIED	16
VERY DISSATISFIED	18
NO OPINION	10

As you know, about four years ago the Congress passed and President Obama signed into law the Affordable Care Act, to reform the nation's health care system and it is now being enacted.

2. Generally speaking, do you support or oppose the health care reform law? (**IF SUPPORT OR OPPOSE, ASK:**) Do you feel that way strongly or somewhat?

SUPPORT STRONGLY	35%
SUPPORT SOMEWHAT	21
OPPOSE SOMEWHAT	9
OPPOSE STRONGLY	26
NO OPINION	9

3. What would you like to see Congress do when it comes to the health care law – leave it as is, expand it so the law does more, repeal parts of it so the law does less, or repeal it completely?

KEEP AS IT	12
EXPAND IT	43
REPEAL PARTS TO DO LESS	13
REPEAL IT COMPLETELY	23
NO OPINION	9

4. In general, do you support or oppose the health care law's requirement that private health insurance plans cover the full cost of birth control?

SUPPORT	66%
OPPOSE	25
NO OPINION	9

5. (**ASKED FOLLOWING JUNE 30 SUPREME COURT RULING**)
The U.S. Supreme Court recently ruled that certain employers whose owners object to birth control on religious grounds should not be required to cover the cost of prescription birth control in their companies' health plans, even if this means their female employees will have to pay the cost of birth control themselves. Do you agree or disagree with the Supreme Court's ruling in this case?

AGREE	36%
DISAGREE	56
NO OPINION	8

6. Regardless of whether you support or oppose the health care law, how successful do you think the federal government has been in implementing the law – very successful, somewhat successful, not too successful or not at all successful?

VERY SUCCESSFUL	8%
SOMEWHAT SUCCESSFUL	41
NOT TOO SUCCESSFUL	24
NOT AT ALL SUCCESSFUL	22
NO OPINION	5

7. How successful do you think the state of California has been in implementing the law – very successful, somewhat successful, not too successful or not at all successful?

VERY SUCCESSFUL	15%
SOMEWHAT SUCCESSFUL	45
NOT TOO SUCCESSFUL	18
NOT AT ALL SUCCESSFUL	12
NO OPINION	10

8. I am going to read some of the goals that California initially set out to achieve when it began implementing the health care law. For each, please tell me how successful you think the state has been in achieving each goal. (**ITEMS IN RANDOM ORDER**) How successful do you think California has been in achieving this goal – very successful, somewhat successful, not too successful, or not at all successful?

	VERY SUCCESSFUL	SOMEWHAT SUCCESSFUL	NOT TOO SUCCESSFUL	NOT AT ALL SUCCESSFUL	NO OPIN
( ) a. encouraging more previously uninsured residents to get health insurance coverage	19%	45	17	7	12
( ) b. providing health insurance buyers with better consumer protections	8%	42	18	10	22
( ) c. obtaining the federal funding needed to implement the law	12%	39	15	9	25
( ) d. providing California consumers with more health insurance choices	15%	42	18	13	12
( ) e. limiting the rate increases that health insurance companies charge to their customers each year	6%	31	26	20	17

Think for a moment about the total amount of money you now pay out-of-pocket for health care. This includes any costs you pay for insurance coverage, for paying any portion of your health care bills that you pay out of pocket when you use health care services, such as deductibles and co-pays, as well as the amount you pay for any health care services you receive that are not paid for by insurance.

9. Overall, how difficult would you say it is to pay for the costs of your health care – very difficult, somewhat difficult, not too difficult or not at all difficult?

VERY DIFFICULT	17%
SOMEWHAT DIFFICULT	29
NOT TOO DIFFICULT	29
NOT AT ALL DIFFICULT	23
NO OPINION	2

10. In the past year, has the total amount you pay for you and your family's health care increased, decreased, or remained the same?

INCREASED	47%
DECREASED	9
REMAINED THE SAME	40
NO OPINION	4

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

August 11, 2014

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate

The Honorable Tom Harkin
Chairman
Committee on Health, Education, Labor and Pensions
United States Senate

The Honorable Sheldon Whitehouse
United States Senate

Health Prevention: Cost-effective Services in Recent Peer-Reviewed Health Care Literature

Cost-effective health preventive services, such as immunizations and screenings, may assist providers in helping patients avoid the onset or worsening of various health conditions. Services are determined to be cost-effective when they improve the benefit (e.g., health outcomes) in a less costly way than a given alternative. Some preventive services may also result in cost savings, where the cost of implementing the service is less than the expected future costs to treat a disease or condition. However, some preventive services may not be appropriate for the entire patient population.

We previously reported on available information about the cost-effectiveness of and cost savings from preventive health services in December 2012.[1] We found that multiple factors affect these estimates, including the population targeted for a health benefit (e.g., children and high-risk populations) and assumptions about effectiveness of the service (e.g., how many years of protection a vaccine provides). In a January 2012 report, we examined preventive care use in Medicare, including how these services were aligned with U.S. Preventive Services Task Force (Task Force) and Advisory Committee on Immunization Practices (ACIP) recommendations, and the use of these services by Medicare beneficiaries.[2] The Task Force develops its recommendations by reviewing research on clinical services and issuing each service a grade. Task Force grades of “A” or “B” levels generally indicate that the service is

[1]In addition, we examined information on preventive health spending by the Departments of Health and Human Services, Veterans Affairs, and Defense, and the limitations of that information, and compared U.S. spending to other countries’ spending on preventive health. See GAO, *Preventive Health Activities: Available Information on Federal Spending, Cost Savings, and International Comparisons Has Limitations,* GAO-13-49 (Washington, D.C.: Dec. 6, 2012).

[2]We also examined the extent to which new Medicare beneficiaries used a preventive care examination, and whether use of that examination was associated with higher use of preventive care services. In addition, we compared the use of preventive services in fee-for-service and Medicare Advantage plans; the extent to which use varied among Medicare Advantage plans; and the practices of these plans in promoting the use of preventive services. See GAO, *Medicare: Use of Preventive Services Could Be Better Aligned with Clinical Recommendations,* GAO-12-81 (Washington, D.C.: Jan. 18, 2012).

recommended because there is moderate or high certainty the net benefit is moderately or substantially beneficial.[3] There may also be some services not characterized by the Task Force as grades "A" or "B" that have some benefits to an individual patient, or the current evidence is insufficient to assess the potential benefits or harms of the service. In addition, the Task Force does not review all services used to prevent the onset or worsening of various health conditions. The Task Force limits its review to preventive screening, counseling, and drug treatment services in a primary care setting and does not make recommendations for adults or children with no symptoms of disease. However, there are many preventive services that may be beneficial outside of the primary care setting (e.g., modifications to diet or physical activity) or that apply to individuals who already have a disease or condition.

Given the lack of readily available detailed information on the value of preventive services, you asked for additional information on the services that may be potentially cost-effective or cost saving. In this report we examined recent peer-reviewed literature to identify preventive services that were shown to be cost-effective and the extent of potential cost savings identified.

To address our research objective, we conducted a literature review and examined articles about U.S. preventive services in meta-analyses or comparative studies published in peer-reviewed journals published between January 2007 and April 2014 that addressed cost-effectiveness or cost savings.[4] For our literature review, we searched the EMBASE, MEDLINE, SciSearch, and Proquest databases using search terms, including "prevent," words relating to cost (e.g., "cost saving," "cost effective," and "cost benefit"), "health care cost," and "value." We required that articles have an abstract or executive summary, study a U.S. population, be published in English, and not duplicate the primary article. We found a total of 29 articles that met our inclusion criteria. The articles we reviewed are listed in enclosure I.

For each of the 29 articles reviewed, we identified preventive services found to be cost-effective and/or cost saving by the study authors, usually indicated by quality-adjusted life year (QALY).[5] We excluded articles where the authors did not provide a definitive conclusion on the cost-effectiveness or cost savings of a specific preventive service.[6] To determine if preventive services were cost-effective or cost saving, we used the criteria established by the authors, such as the cost per QALY or the return on investment.[7] There were some differences in how the authors of the studies determined services to be cost-effective or cost saving. In many of the studies we reviewed, the authors noted that different methodologies used for estimating cost-effectiveness or cost savings across the studies in their reviews made it difficult to develop explicit estimates of the cost impacts, and they instead provided an explanation of their

[3]ACIP takes similar benefits and risks into account in developing its recommendations.

[4]We use "meta-analysis" to mean the authors performed quantitative analysis based on data from multiple articles, and "comparative study" to mean the authors systematically reviewed the information in multiple articles to reach a conclusion.

[5]In cost-effectiveness analyses, cost and health outcomes are compared between two services or against not taking any action. The net cost to the net outcome of using one service over another forms the estimate of cost-effectiveness. A QALY measures the number and quality of years added by using a service. An estimate of cost-effectiveness using QALYs as the outcome is expressed as the cost (in U.S. dollars) per QALY. Researchers also assess cost-effectiveness using other outcomes, such as disability-adjusted life years and return on investment.

[6]In some studies, the authors recommended that more research be conducted on the potential for cost-effectiveness or cost savings of a particular preventive service. In addition, we did not consider other types of health prevention, such as policy interventions (e.g., changes to tobacco taxes).

[7]We did not independently assess the methodologies of the articles, including the reliability of the data used.

assessment. For this reason, we did not include quantified estimates of cost-effectiveness or cost savings in our results. In addition, we linked the preventive services found to be cost-effective in the articles to Task Force grade “A” or “B” or ACIP recommendations, if significant overlap existed.[8] For example, if a preventive service from an article targeted a population aged 50 to 54, we considered that linked to a Task Force grade “A” recommendation for the same service that did not specify an age range.

We conducted our work from June to August 2014 in accordance with all sections of GAO’s Quality Assurance Framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient and appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We believe that the information and data obtained, and the analysis conducted, provide a reasonable basis for any findings and conclusions. Because we did not evaluate the policies or operations of any federal agency to develop the information presented in this report, we did not seek comments from any agency.

The results of our review are presented in table 2 in enclosure II. We categorized each service identified in our review into a preventive service type (e.g., clinical intervention, screening, and vaccination), provided information on the target population (e.g., age and sex), whether a service was cost saving, and whether a service had been included as a Task Force-recommended “A” or “B” grade or recommended by ACIP.

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For further information regarding this report, please contact me at (202) 512-7114 or cosgrovej@gao.gov. In addition, the report will be available at no charge on GAO’s website at http://www.gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report were Christine Brudevold, Assistant Director; Tom Basson; George Bogart; Leia Dickerson; Beth T. Morrison; and E. Jane Whipple.

James Cosgrove
Director, Health Care

Enclosures – 2

[8]Task Force grades are current as of July 2014.

Articles Identified through Literature Review

We identified 29 articles that included peer-reviewed meta-analyses or comparative studies examining cost-effectiveness of or cost savings from health services in various preventive service types published between January 2007 and April 2014. Table 1 categorizes the articles by preventive service type with the numbers corresponding to the list of articles that follows.

Table 1: Index of Articles by Preventive Service Type

Preventive service type	Article numbers
Clinical intervention	4, 16
Drug treatment	4, 10, 12, 16, 22, 24
Lifestyle intervention	4, 5, 12, 13, 14, 16, 20, 27, 28
Screening	2, 4, 5, 6, 8, 9, 10, 12, 15, 16, 17, 29
Vaccination	1, 3, 5, 7, 11, 18, 19, 21, 23, 25, 26

Source: GAO. I GAO-14-789R

The 29 articles that GAO identified in the literature are as follows:

1. Armstrong, E.P. "Prophylaxis of Cervical Cancer and Related Cervical Disease: A Review of the Cost-Effectiveness of Vaccination Against Oncogenic HPV Types." *Journal of Managed Care Pharmacy*, vol. 16, no. 3 (2010): 217-230.
2. Asif, I.M., A.L. Rao, and J.A. Drezner. "Sudden cardiac death in young athletes: what is the role of screening?" *Current Opinion in Cardiology*, vol. 28 (2013): 55-62.
3. Babigumira, J.B., I. Morgan, and A. Levin. "Health economics of rubella: a systematic review to assess the value of rubella vaccination." *BMC Public Health*, vol. 13, no. 406 (2013).
4. Braithwaite, R.S. and S.M. Mentor. "Identifying Favorable-Value Cardiovascular Health Services." *American Journal of Managed Care*, vol. 17, no. 6 (2011): 431-438.
5. Cohen, J.T., P.J. Neumann, and M.C. Weinstein. "Does Preventive Care Save Money? Health Economics and the Presidential Candidates." *The New England Journal of Medicine*, vol. 358, no. 7 (2008): 661-663.
6. Cruzado, J., F.I. Sánchez, J.M. Abellán, F. Pérez-Riquelme, and F. Carballo. "Economic evaluation of colorectal cancer (CRC) screening." *Best Practice & Research Clinical Gastroenterology*, vol. 27 (2013): 867-880.
7. de Waure, C., M.A. Veneziano, C. Cadeddu, S. Capizzi, M.L. Specchia, S. Capri, and W. Ricciardi. "Economic value of influenza vaccination." *Human Vaccines & Immunotherapeutics*, vol. 8, no. 1 (2012): 119-129.
8. Duffus, W.A. and K.W. Kintziger. "How useful is universal screening for HIV infection? A review of the evidence." *Future Virology*, vol. 9, no. 2 (2014): 131.
9. Echouffo-Tcheugui, J.B., M.K. Ali, G. Roglic, R.A. Hayward, and K.M. Narayan. "Screening intervals for diabetic retinopathy and incidence of visual loss: a systematic review." *Diabetic Medicine*, vol. 30 (2013): 1272-1292.
10. Fleurence, R.L., C.P. Iglesias, and J.M. Johnson. "The Cost Effectiveness of Bisphosphonates for the Prevention and Treatment of Osteoporosis: A Structured Review of the Literature." *Pharmacoeconomics*, vol. 25, no. 11 (2007): 913-933.

11. Gilchrist, S.A.N., A. Nanni, and O. Levine. “Benefits and Effectiveness of Administering Pneumococcal Polysaccharide Vaccine With Seasonal Influenza Vaccine: An Approach for Policymakers.” *American Journal of Public Health*, vol. 102, no. 4 (2012): 596-605.

12. Hunt, T.L., B.R. Luce, M.J. Page, and R. Pokrzywinski. “Willingness to Pay for Cancer Prevention.” *Pharmacoeconomics*, vol. 27, no. 4: 299-312.

13. John, J., C.M. Wenig, and S.B. Wolfenstetter. “Recent economic findings on childhood obesity: cost-of-illness and cost-effectiveness of interventions.” *Current Opinion in Clinical Nutrition and Metabolic Care,* vol. 13 (2010): 305-313.

14. Kahende, J.W., B.R. Loomis, B. Adhikari, and L. Marshall. “A Review of Economic Evaluations of Tobacco Control Programs.” *International Journal of Environmental Research and Public Health*, vol. 6, no. 1 (2009): 51-68.

15. Kang, J., P. Mandsager, A.K. Biddle, and D.J. Weber. “Cost-Effectiveness Analysis of Active Surveillance Screening for Methicillin-Resistant *Staphylococcus aureus* in an Academic Hospital Setting.” *Infection Control and Hospital Epidemiology*, vol. 33, no. 5 (2012): 477-486.

16. Li, R., P. Zhang, L.E. Barker, F.M. Chowdhury, and X. Zhang. “Cost-Effectiveness of Interventions to Prevent and Control Diabetes Mellitus: A Systematic Review.” *Diabetes Care*, vol. 33, no. 8 (2010): 1872-1894.

17. Lim, L.S., L.J. Hoeksema, K. Sherin, and the ACPM Practice Committee. “Screening for Osteoporosis in the Adult U.S. Population: ACPM Position Statement on Preventive Practice.” *American Journal of Preventive Medicine*, vol. 36, no. 4 (2009): 366-375.

18. Peasah, S.K., E. Azziz-Baumgartner, J. Breese, M.I. Meltzer, and M. Widdowson. “Influenza cost and cost-effectiveness studies globally – A review.” *Vaccine*, vol. 31 (2013): 5339-5348.

19. Prescott Jr, W.A., F. Doloresco, J. Brown, and J.A. Paladino. “Cost Effectiveness of Respiratory Syncytial Virus Prophylaxis: A Critical and Systematic Review.” *Pharmacoeconomics*, vol. 28, no. 4 (2010): 279-293.

20. Saha, S., U. Gerdtham, and P. Johansson. “Economic Evaluation of Lifestyle Interventions for Preventing Diabetes and Cardiovascular Diseases.” *International Journal of Environmental Research and Public Health*, vol. 7 (2010): 3150-3195.

21. Salleras, L., E. Navas, N. Torner, A.A. Prat, P. Garrido, N. Soldevila, and A. Dominguez. “Economic benefits of inactivated influenza vaccines in the prevention of seasonal influenza in children.” *Human Vaccines & Immunotherapeutics*, vol. 9, no. 3 (2013): 707-711.

22. Schackman, B.R. and A.A. Eggman. “Cost-effectiveness of pre-exposure prophylaxis for HIV: a review.” *Current Opinion in HIV and AIDS*, vol. 7 (2012): 587-592.

23. Seto, K., F. Marra, A. Raymakers, and C.A. Marra. “The Cost Effectiveness of Human Papillomavirus Vaccines: A Systematic Review.” *Drugs*, vol. 72, no. 5 (2012): 715-743.

24. Solomon, M.D., A.J. Ullal, D.D. Hoang, J.V. Freeman, P. Heidenreich, and M.P. Turakhia. “Cost-effectiveness of pharmacologic and invasive therapies for stroke prophylaxis in atrial fibrillation.” *Journal of Cardiovascular Medicine*, vol. 13 (2012): 86-96.

25. Stupiansky, N.W., A.B. Alexander, and G.D. Zimet. “Human papillomavirus vaccine and men: what are the obstacles and challenges?” *Current Opinion in Infectious Diseases*, vol. 25, no. 1 (2012): 86-91.

26. Tom-Revzon, C. “Rotavirus Live, Oral, Pentavalent Vaccine.” *Clinical Therapeutics*, vol. 29, no. 12 (2007): 2724-2737.

27. Urbanski, P., A. Wolf, and W.H. Herman. “Cost-Effectiveness of Diabetes Education.” *Journal of the American Dietetic Association*, vol. 108, no. 4 (2008): S6-S11.

28. Vuori, I.M., C.J. Lavie, and S.N. Blair. “Physical Activity Promotion in the Health Care System.” *Mayo Clinic Proceedings*, vol. 88, no. 12 (2013): 1446-1461.

29. Waugh, N., G. Scotland, P. McNamee, M. Gillett, A. Brennan, E. Goyder, R. Williams, and A. John. “Screening for type 2 diabetes: literature review and economic modeling.” *Health Technology Assessment*, vol. 11, no. 17 (2007).

Cost-effective Preventive Services, Target Population, Cost Savings, and Task Force Recommendation Information

Table 2 presents the preventive services we identified in the literature review that were cost-effective, categorized by preventive service type, and provides information on the target population for the service, whether the service was found to be cost saving, and whether the service had been included as a U.S. Preventive Services Task Force (Task Force) recommended “A” or “B” grade or recommended by the Advisory Committee on Immunization Practices (ACIP). In some cases, the service was found by the study authors to be cost saving, but it did not fall under a current Task Force “A” or “B” grade. Some other cost-effective services were not found to be cost saving by the study authors but received a grade “A” from the Task Force, such as using aspirin to prevent stroke in persons who have had a stroke or stroke-like symptoms. For some cost-effective services, the benefit only becomes cost saving in certain populations. For example, for screening persons with known hypertension for high blood pressure and providing treatment to them to prevent myocardial infarction and stroke, the authors found the service was cost saving for persons with diabetes, but not cost saving (although still cost-effective) for persons without diabetes.

Table 2: Preventive Services Found in Literature Review to be Cost-effective

Preventive service	Target population	Cost saving	Recommendation
Clinical intervention			
Comprehensive foot care to prevent ulcers compared with usual care	Persons with type 1 and type 2 diabetes	Yes	—
Multicomponent interventions (e.g., education, drug treatment, and screening) for diabetic risk factor control and early detection of complications compared with standard glycemic control	Persons with type 2 diabetes	Yes	—
Multicomponent interventions (e.g., drug treatment and screening) for diabetic risk factor control and early detection of complications compared with conventional insulin therapy	Persons with type 1 diabetes	Yes	—
Implantable defibrillator to prevent sudden cardiac arrest	Persons who have congestive heart failure because of myocardial infarction and who do not have heart failure symptoms at rest	No	—
Small incision procedure with balloon compression and possibly stent insertion for relief of pain symptoms in lower legs with walking or exercise	Persons who have lifestyle-limiting symptoms	No	—
Immediate surgery to treat damage to the retinas caused by diabetes compared with deferred surgery	Persons with type 1 and type 2 diabetes	No	—
Intensive insulin treatment compared with conventional glycemic control	Persons with type 1 diabetes	No	—
United Kingdom Prospective Diabetes Study-like intensive glycemic control applied to the U.S. health care system compared with conventional glycemic control[a]	Persons aged 25 to 54 with newly diagnosed type 2 diabetes	No	—

Preventive service	Target population	Cost saving	Recommendation
Multicomponent interventions (e.g., drug treatment and screening) for damage to the retinas compared with intensive insulin therapy	Persons with type 1 diabetes	No	—
Drug treatment			
Use of aspirin to prevent myocardial infarction	Middle-aged men with 10-year coronary heart disease risk of greater than 5% without increased bleeding risk	Yes[b]	U.S. Preventive Services Task Force (Task Force) “A”
Drug treatment to relax blood vessels for intensive hypertension control compared with standard hypertension control	Persons with type 2 diabetes	Yes	—
Use of drug that treats blood clots to prevent blocked artery in the lungs	Persons recently diagnosed as having deep blood clot	Yes	—
Drug treatment to relax blood vessels to prevent end-stage renal disease compared with no drug treatment	Persons with type 2 diabetes	Yes	—
Early drug treatment to prevent end-stage renal disease compared with later treatment	Persons with type 2 diabetes	Yes	—
Use of aspirin to prevent stroke	Persons who have had a stroke or stroke-like symptoms	No	Task Force “A”
Use of aspirin to prevent future myocardial infarction	Persons who have coronary heart disease	No	Task Force “A”
Use of aspirin compared to use of a drug that stops blood clots (warfarin)	Persons with low stroke risk	No	Task Force “A”
Hormone-therapy drug treatment to prevent breast cancer versus no intervention	Women with a high risk for breast cancer	No	Task Force “B”
Drug treatment for prevention and treatment of osteoporosis	Women aged greater than 70, particularly in patients that have previous fractures	No	—
Use of cholesterol-lowering drugs for secondary prevention of cardiovascular disease compared with no drug treatment	Persons with type 2 diabetes and high cholesterol, with cardiovascular disease history	No	—
Preexposure drug treatment for HIV prevention	High risk men who have sex with men	No	—
Drug treatment for blood clots and necessary laboratory testing for 6 months to prevent blocked artery in the lungs	Persons with first deep blood clot without known reason	No	—
Beta-blockers to prevent future myocardial infarction	Persons who have had coronary heart disease	No	—
Use of cholesterol-lowering drugs to prevent myocardial infarction	Persons with known coronary heart disease	No	—
Use of cholesterol-lowering drugs to prevent myocardial infarction	Persons with moderately or severely high cholesterol and with 10-year coronary heart disease risk of greater than 5% (including all individuals with diabetes)	No	—

Preventive service	Target population	Cost saving	Recommendation
Use of cholesterol-lowering drugs for primary prevention of cardiovascular disease compared with no treatment	Persons with type 2 diabetes and high cholesterol, without cardiovascular disease history	No	—
Use of drug that stops blood clots for 12 months to prevent future myocardial infarction	Persons who have had myocardial infarction or other acute coronary event	No	—
Drug treatment for blood clots and necessary laboratory testing to prevent future stroke	Persons with nonvalvular irregular heartbeat and less than 1 previous stroke, aged equal to or greater than 75, hypertension, congestive heart failure, or diabetes	No	—
Use of drug that stops blood clots to prevent stroke	Persons who have had a stroke or stroke-like symptoms	No	—
Use of a drug that stops blood clots (warfarin) compared to aspirin	Persons with at least moderate stroke risk	No	—
Lifestyle intervention			
Smoking cessation with counseling, nicotine and drug treatment to stop smoking, and to reduce the risk of cardiovascular and other diseases	All smokers	Yes[b]	Task Force “A”
Physical activity combined with nutrition to prevent obesity	Children and adolescents	Yes[b]	—
Physician smoking cessation advice/booklet versus no counseling	Men aged 50-54	No	Task Force “A”
Tobacco interventions that combine therapies with some form of counseling compared with a single intervention	Pregnant women	No	Task Force “A”
Counseling and treatment for smoking cessation compared with no counseling and treatment	Persons with type 2 diabetes	No	Task Force “A”
Self-help and counseling programs, improved by the inclusion of nicotine replacement therapy	—	No	Task Force “A”
Intensive tobacco-use prevention program	Adolescents in 7th and 8th grade	No	Task Force “B”
Combined diet and physical activity interventions compared with sole dietary or physical activity interventions	School-aged children or focusing on the whole community	No	Task Force “B”[c]
Physical activity promotion in primary health care or community settings (e.g., exercise therapy prescription)	Population-based	No	—
Intensive lifestyle interventions to prevent type 2 diabetes compared with standard lifestyle recommendations	Persons with prediabetic symptoms	No	—
Intensive glycemic control by a Diabetes Prevention Program type of intensive lifestyle intervention compared with conventional glycemic control[d]	Persons with newly diagnosed type 2 diabetes	No	—
Diabetes education through self-management training	Population-based, especially for persons with poor glycemic control	No	—
Diabetes education through medical nutrition therapy	Persons with type 2 diabetes	No	—

Preventive service	Target population	Cost saving	Recommendation
Lifestyle interventions to reduce the long-term risk of type 2 diabetes and cardiovascular disease	Population-based	No	—
High-intensity smoking-relapse prevention program, as compared with a low-intensity program	—-	No	—
Screening			
One-time colonoscopy screening for colorectal cancer	Men aged 60-64	Yes	Task Force “A”
Universal bone mineral density screening combined with drug treatment	Women aged equal to or greater than 65 diagnosed with osteoporosis	Yes[e]	Task Force “B”
Screening for low bone mineral density before drug treatment	Both in postmenopausal women aged 65 or older and in women with rheumatoid arthritis taking corticosteroid drugs	Yes[e]	Task Force “B”
Targeted active surveillance screening for Methicillin-resistant *Staphylococcus aureus* (MRSA) compared with no surveillance	Hospital patients	Yes	—
Screening for high blood pressure and treating it with a drug to prevent myocardial infarction and stroke	Persons with known hypertension	No[f]	Task Force “A”
Colorectal cancer screening, regardless of approach, compared with no screening	Population-based	No	Task Force “A”
Colonoscopy once per 10 years versus no intervention	—	No	Task Force “A”
Cervical cancer screening every 3 years versus every 5 years	Women aged 20-59	No	Task Force “A”
Universal HIV screening	Persons in various clinical settings	No	Task Force “A”
Universal screening in routine medical care for undiagnosed type 2 diabetes compared with no screening	African Americans aged 45-54	No	Task Force “B”[g]
Mammography every 2 years versus observation	Women aged 40-49	No	Task Force “B”
Screening for diabetes	Persons aged 40 to 70, especially for people in hypertensive and obese subgroups	No	Task Force “B”[g]
One-time targeted screening in routine medical care for undiagnosed type 2 diabetes compared with no screening	Persons aged 45 and older with hypertension	No	Task Force “B”
Newborn screening for metabolic disorder, including being hypoglycemic	Newborns	No	—
Adding electrocardiogram alone, or with history and physical examination	Young athletes	No	—
Universal bone mineral density screening followed by drug treatment	Men aged equal to or greater than 80, or men aged equal to or greater than 65 with a prior fracture	No	—
Prostate cancer examination or test versus no screening	Persons aged 65	No	—

Preventive service	Target population	Cost saving	Recommendation
Annual screening for damage to the retinas caused by diabetes and ensuing treatment compared with no screening	Persons with type 1 and type 2 diabetes	No	—
Two-year screening interval for damage to the retinas	Persons with diabetes and no damage to the retinas at diagnosis	No	—
Vaccination			
Haemophilus influenzae type b vaccination to prevent disease (e.g., meningitis)	Toddlers	Yes	Advisory Committee on Immunization Practices (ACIP)
Rotavirus vaccination to prevent disease (e.g., inflammation of the intestines)	Infants who are not immunocompromized or have other contraindications	Yes[b]	ACIP
Influenza vaccination	Children and elderly populations	Yes[h]	ACIP
Influenza vaccination compared with no vaccination	Elderly and high-risk populations	Yes[b]	ACIP
Yearly influenza vaccination with inactivated vaccine compared with no vaccination	Children	Yes[i]	ACIP
Immunization against serious respiratory tract infections	Infants with chronic lung disease (high-risk population) during peak outbreak months	No	ACIP
Human papillomavirus (HPV) vaccination compared with cervical cancer screening alone	Females aged 12 with cervical screening intervals typically greater than 1 year	N/A[j]	ACIP
Routine HPV vaccination compared with cervical cancer screening alone	Adolescent females	No	ACIP
Rubella vaccination	Children, adolescent girls, and adult women	No	ACIP
HPV vaccination if female rates of vaccination remain fairly low	Males	No	ACIP
Pneumococcal vaccine at the same time as seasonal influenza vaccine compared to either vaccine given alone	Elderly and high-risk populations	No	—

Source: GAO. I GAO-14-789R

Notes: We used the criteria established by the authors to determine if preventive services were cost-effective or cost saving. We only included the services found to be cost-effective by the authors of the articles in our review. The majority of articles we reviewed did not quantify cost savings in their meta-analyses or comparative studies. The Task Force makes recommendations only for clinical preventive services in a primary care setting. Task Force grades of “A” or “B” levels generally mean that the service is recommended because there is moderate or high certainty the net benefit is moderately or substantially beneficial. ACIP is responsible for making recommendations on vaccinations. We did not indicate when the Task Force or ACIP recommend against a particular service.

[a]The United Kingdom Prospective Diabetes Study was a 20-year randomized control study with a 10-year post-trial monitoring period of newly diagnosed type 2 patients. The study examined intensive therapy compared with conventional therapy, and found continued risk reduction for intensive therapy patients across the entire study period.

[b]Articles note possible cost savings for the service.

[c]The Task Force recommendation is only for healthy diet counseling, not physical activity.

[d]The Diabetes Prevention Program examined the effect of lifestyle (e.g., diet and exercise) changes and drug treatment across multiple clinical centers in the United States and found that these interventions reduced the risk of developing diabetes among prediabetic patients.

[e]Articles note cost savings only for women aged 85. In addition, one article notes cost savings for women aged 95, and another article notes cost savings for women aged equal to or greater than 95.

[f]Article identifies service as cost saving for persons with diabetes, but not cost saving for persons without diabetes.

[g]The Task Force recommendation includes individuals with blood pressure over 135/80, regardless of age or race.

[h]Article notes cost savings for children.

[i]Article notes cost savings from a societal and family perspective, but no cost savings from a public or private perspective.

[j]Article methodology included a comparative review but did not seek to quantify cost-effectiveness or cost savings.

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WHITE PAPER

Addressing the Financial Impact of Renewals: Why Many Enrollees Could Benefit from Shopping

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With the first open enrollment under their belt, marketplaces now face a different set of challenges and opportunities as they prepare for open enrollment for plan year 2015. One of these challenges stems from the complicated nature of the premium subsidy calculations, leading to potentially large swings in consumers' after-subsidy premiums and tax liability implications. Marketplaces, including the Federally-Facilitated Marketplace (FFM), are taking great strides to make the process as smooth as possible for consumers, by facilitating auto-renewals into Qualified Health Plans and, in the case of the FFM, rolling over 2014 Advanced Premium Tax Credits (APTCs) into 2015. Depending on factors such as income changes, premium variation, and a change in the benchmark plan, however, this approach may be detrimental to some consumers. State agencies, marketplaces, and stakeholders (including those in states with an FFM) will want to carefully balance the competing imperatives of ensuring continuous coverage while protecting consumers from tax liability, and in some cases, avoidable premium increases. This paper explores these issues and provides suggestions for how to mitigate confusion and empower consumers. Key takeaways include:

- **State insurance departments and marketplaces should be careful when communicating individual market rate increases to the public and the media, as changes in after-subsidy premiums do not necessarily track with approved changes in insurance rates.** The subsidy dynamics are counter-intuitive, for example, the net (after subsidy) premium for a plan can increase, even when the plan's approved rate (full cost before subsidy) decreases. Communications about approved rate changes should clearly indicate that impact to a particular consumer (especially those eligible for subsidies) may vary significantly from approved rate changes.

- **State insurance departments (including those in FFM states) can modify the language included in the federally-proposed carrier notices.** Based on the specific dynamics of changes in plan rates and Marketplace offerings within a state, there may be reasons to encourage consumers, more than is recognized in the proposed notices, to shop for alternative plans and/or go to healthcare.gov or their state Marketplace website to receive a redetermination of eligibility to update their APTCs to reflect updated household information, as well as 2015, rather than 2014, premium rates.

- **State agencies and organizations assisting consumers should be equipped with messages for and tools to identify consumers expected to see large increases in their after-subsidy premiums as well as those who may be at risk of owing money when 2015 taxes come due.** To mitigate the risk of consumers dropping coverage or re-enrolling in plans that may cause additional financial burdens, education and outreach efforts should be targeted to areas of the state where consumers will encounter the largest premium increases. Those providing consumer assistance should be prepared to guide consumers through their options and help them understand the importance of shopping. Additionally, these organizations should identify areas of the state (sometimes at the county or sub-county level) where the cost of the benchmark (second-lowest cost silver) plan is decreasing and encourage those consumers to request an eligibility redetermination to avoid a tax liability at the end of the year.

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After-Subsidy Premium Changes are Not Intuitive

Subsidies are calculated based on household income and the benchmark plan rate available to each household. Consumers selecting the benchmark plan will have premiums that are solely based on income (and not tied to the cost of the plan). One complication of this provision is that the benchmark plan may change from year to year as carriers offer new, lower cost plans (e.g., with narrower networks), new carriers enter the market, and competition on price increases. Due to the uncertainty in the health of the newly enrolled populations resulting from the ACA, rates are likely to fluctuate significantly in these first few years. A recent study of proposed rate changes in the largest zip code in the largest city in each of nine states, indicated that the benchmark plan is expected to change in eight of the states.[i] This change in benchmark plan results in a potentially significant impact to consumer premiums after subsidy.

Because subsidies are tied to a benchmark plan, the only way consumers can ensure relatively stable premiums year over year is to commit to enrolling in the benchmark plan each year. The reality, however, is that (1) consumers may not necessarily want to change their plan each year, either because changing plans will impact the availability of their providers, they like their current plan, or simple inertia, and (2) consumers don't always choose the benchmark plan (and by nature of the benchmark plan being the second lowest cost silver plan, there will always be a less expensive silver plan available).

To add to the complication, consumers selecting plans other than the benchmark pay the premium they would have paid for the benchmark plan plus or minus any difference between the benchmark and their selected plan rates. As a result, even if the benchmark plan does not change, after-subsidy premiums for those enrolling in a non-benchmark plan are driven substantially by the difference in rates between two plans (or two moving targets). This creates some counter-intuitive results as demonstrated in the following simplified example.

Let's take a household of four, the Brown family, with household income of $35,000 (roughly 150% FPL). Based on the subsidy calculation, the Browns are expected to pay 4 percent of their income, or $1,400 per year (roughly $115 per month) towards the benchmark plan. In 2014, the Brown's had a choice of two silver plans, Plan A with a rate of $800 per month and Plan B (benchmark) with a rate of $850 per month. After subsidies, the Brown's had a choice of paying $115 per month for Plan B (benchmark) or $65 per month for Plan A, so they chose to enroll in Plan A.

Let's assume that in 2015, rates for Plan A and Plan B both increase by 4 percent, but New Plan C enters the market at a lower cost than Plan A. This changes the benchmark plan from Plan B in 2014 to Plan A in 2015. Assuming the Brown family would continue to have to contribute $115 per month to the benchmark plan[ii], their monthly contribution, should they be auto-renewed or choose to remain in Plan A, will increase from $65 to $115 per month, a 77 percent jump. Though this is a substantial increase, the Brown family has an alternative option, New Plan C, which has a lower premium than Plan A. The Brown family, and other households in a similar situation, should be made aware of the value of shopping for a new plan in 2015 and the fact that they may be losing out on an opportunity to enroll in a lower cost plan if they do not shop and are auto-renewed in Plan A.

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	Rate Before Subsidy			Premiums After Subsidy		
	2014	2015	Increase	2014	2015	Increase over Plan A 2014
New Plan C	N/A	$800	N/A	N/A	$83	28%
Plan A	$800	$832 (New Benchmark)	4%	$65	$115	**77%**
Plan B	$850 (Benchmark)	$884	4%	$115	$167	157%

It is important to note that this is only one example (though similar dynamics have been identified in analyses performed in multiple states). Once 2015 rates are available, states (or stakeholders where rates are public) should take the time to analyze the specific dynamics across their respective states (at the county or sometimes sub-county level depending on whether there are plans offered only in certain areas of the state) to understand the premium changes consumers will experience. Because rate increases typically reported in rate filings are averages that mask geographic variations and do not reflect the introduction of new plans to the market, a detailed analysis using rate and service area tables must be performed.

Once completed, this detailed analysis of consumer premium impact at the county level can be leveraged to develop tools for those assisting consumers, by identifying the specific plans and areas of the state where consumers may experience the greatest impact, and alternatives for mitigating premium increases. With this identification, resources can be directed and messaging can be targeted appropriately to encourage 2014 enrollees to remain covered.

Federal Approach to Renewals and 2015 Advanced Premium Tax Credits (APTCs)

Based on proposed regulations[iii] and corresponding guidance[iv], individuals and families enrolled in FFM coverage will generally be auto-renewed into their current plan (or a similar plan from the same carrier if the current plan is no longer available), unless they actively select another plan.

Additionally, the FFM (and potentially some state-based Marketplaces [SBMs] under the option allowed by proposed federal guidance) will be applying 2014 APTC amounts in 2015 for most consumers, unless the consumer goes to healthcare.gov (or their SBM) to request a redetermination of eligibility. It is critical to note that in addition to being based on old income information, the 2014 APTC amount is based on the 2014 benchmark plan rate rather than the 2015 benchmark plan rate. The actual subsidy amount due to the consumer for 2015 (and the basis for 2015 income taxes) is the 2015 benchmark plan. Thus any difference between the actual subsidy (calculated by the IRS) and the APTC claimed by the consumer must be reconciled when taxes are filed.

The implications of this approach will vary by consumer based on both income changes and changes in the benchmark plan rate. The impact to premium could be significant. Assuming no income changes,

- **An increase in the benchmark plan rate** will result in consumers receiving lower APTCs than they would if they were to request a redetermination, so while they will pay higher premiums in 2015, they will receive the difference in the form of additional tax credits when they file their 2015 taxes.

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- **A decrease in the benchmark plan rate** will result in consumers receiving higher APTCs than they would if they were to request a redetermination (resulting in lower 2015 premiums); they will need to need to pay back any amount over-credited when they file their 2015 taxes.

In the case of the Brown family, their subsidy decreased from $735 per month in 2014 to $717 per month in 2015 because of the introduction of lower cost Plan C, so if their 2014 APTC was applied in 2015, their anticipated tax refund for 2015 would be reduced by $216 (or they could owe money if they are not due a refund).

Draft standard carrier renewal notices recently released by the federal government require carriers to communicate to their enrollees any changes between their 2014 plan and the 2015 plan they will be automatically enrolled in if they take no action. The required notice will also include the 2014 APTC amount and the premium they will pay after applying the 2014 APTC amount. The notice includes language that the consumer "might be able to get a bigger tax credit or better plan for your budget" by visiting the Marketplace during open enrollment. The notice also indicates that consumers can update their information with the Marketplace "to make sure you get the full savings you deserve" and to "help make sure you get the right premium tax credit amount and don't owe money on your next tax return." The notice does not mention the option of switching plans until the second page, and nowhere does it explicitly say that individuals may be able to lower their premium if they switch to a different plan.

States enforcing the ACA[v] have the flexibility to develop their own standard notices, as long as they are at least as protective to consumers as the Federal standard. States should consider the specific after-subsidy premium and subsidy changes their individual market enrollees will encounter to determine whether they want to modify the Federal notices. States will specifically want to consider whether stronger language should be used to encourage shopping and/or seeking eligibility redeterminations.

Other Resources

- Patient Protection and Affordable Care Act; Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges, Proposed Rule. Available at: **http://www.gpo.gov/fdsys/pkg/FR-2014-07-01/pdf/2014-15362.pdf**

- Guidance on Annual Redeterminations for Coverage for 2015. Available at: **http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014-0626-Guidance-on-annual-redet-option-2015-FINAL.pdf.**

- Draft consumer notices for plan discontinuance or renewals, Available at: **http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Bulletin-on-Renewal-and-Discontinuation-Notices.pdf**

- Renewal of Eligibility for Qualified Health Plans and Insurance Affordability Programs in 2014: Eligibility and Enrollment. Available at: **http://www.statenetwork.org/wp-content/uploads/2014/07/State-Network-Manatt-Eligibility-and-Enrollment-July-2014.pdf**

- Renewal of Eligibility for Qualified Health Plans and Insurance Affordability Programs in 2014: QHP Enrollment. Available at: **http://www.statenetwork.org/wp-content/uploads/2014/07/State-Network-Manatt-QHP-Enrollment-July-2014.pdf**

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- Renewal of Eligibility for Qualified Health Plans and Insurance Affordability Programs in 2014: Marketplace and Medicaid Intersections. Available at: http://www.statenetwork.org/wp-content/uploads/2014/07/State-Network-Manatt-Marketplace-and-Medicaid-Intersections-July-2014.pdf
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- Renewal Process Flow of Information. Available at: http://www.statenetwork.org/wp-content/uploads/2014/07/State-Network-Manatt-Marketplace-Renewals-Process-Flows-July-2014.pdf
- Kaiser Family Foundation. Explaining Health Care Reform: Questions About Health Insurance Subsidies. Available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7962-02.pdf

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Please contact Julia Lerche at Julia.Lerche@wakelycom or Aree Bly at AreeB@wakely.com with any questions or to follow up on any of the concepts presented here.

[i] Avalere. Exchange Plan Renewals: Many Consumers Face Sizeable Premium Increases in 2015 Unless They Switch Plans. Available at: http://avalere.com/expertise/managed-care/insights/exchange-plan-renewals-many-consumers-face-sizeable-premium-increases-in-20. Accessed July 27, 2014.
[ii] This is a simplified example and assumes no changes for age, income and FPL.
[iii] Patient Protection and Affordable Care Act; Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges, Proposed Rule. Published July 1, 2014. Available at: http://www.gpo.gov/fdsys/pkg/FR-2014-07-01/pdf/2014-15362.pdf. Accessed July 27, 2014.
[iv] CMS Center for Consumer Information & Insurance Oversight. Draft Standard Notices When Discontinuing or Renewing a Product in the Small Group or Individual Market. June 26, 2014. Available at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Bulletin-on-Renewal-and-Discontinuation-Notices.pdf. Accessed July 27, 2014.
CMS Center for Consumer Information & Insurance Oversight. Guidance on Annual Redeterminations for Coverage for 2015. June 26, 2014. Available at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014-0626-Guidance-on-annual-redet-option-2015-FINAL.pdf. Accessed July 27, 2014.
[v] Currently all states except Alabama, Missouri, Oklahoma, Texas, and Wyoming.

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August 5, 2014

Arkansas, Kentucky Report Sharpest Drops in Uninsured Rate

Medicaid expansion, state exchanges linked to faster reduction in uninsured rate

by Dan Witters

WASHINGTON, D.C. -- Arkansas and Kentucky lead all other states in the sharpest reductions in their uninsured rate among adult residents since the healthcare law's requirement to have insurance took effect at the beginning of the year. Delaware, Washington, and Colorado round out the top five. All 10 states that report the largest declines in uninsured rates expanded Medicaid and established a state-based marketplace exchange or state-federal partnership.

10 States With Largest Reductions in Percentage Uninsured, 2013 vs. Midyear 2014

"Do you have health insurance?" (% no)

State	% Uninsured, 2013	% Uninsured, midyear 2014	Change in uninsured (pct. pts.)	Medicaid expansion AND state/partnership exchange in 2014
Arkansas	22.5	12.4	-10.1	Yes
Kentucky	20.4	11.9	-8.5	Yes
Delaware	10.5	3.3	-7.2	Yes
Washington	16.8	10.7	-6.1	Yes
Colorado	17.0	11.0	-6.0	Yes
West Virginia	17.6	11.9	-5.7	Yes
Oregon	19.4	14.0	-5.4	Yes*
California	21.6	16.3	-5.3	Yes
New Mexico	20.2	15.2	-5.0	Yes
Connecticut	12.3	7.4	-4.9	Yes

Gallup-Healthways Well-Being Index

GALLUP

As Gallup previously reported, the states that chose to expand Medicaid and set up their own health exchanges had a lower uninsured rate to begin with: 16.1% compared with 18.7% for the remaining states -- a difference of 2.6 percentage points. The already notable gap between the two groups of states widened through the first quarter to 4.3 points, as states that have implemented these core mechanisms of the Affordable Care Act reduced their uninsured rates three times more than states that did not implement these core mechanisms.

These data, collected as part of the Gallup-Healthways Well-Being Index, are based on respondents' self-reports of health insurance status based on the question, "Do you have health insurance coverage?"

Uninsured Rates Continue to Drop More in States Embracing Multiple Parts of Health Law

The uninsured rate in the states that have chosen to expand Medicaid *and* set up their own state exchange in the health insurance marketplace has declined significantly more in the first half of 2014 than in the remaining states that have not done so. The uninsured rate declined 4.0 points in the 21 states that have implemented both of these measures, compared with a 2.2-point drop across the 29 states that have implemented only one or neither of these actions.

Change in Uninsured Rate Between 2013 and Midyear 2014

Among states with Medicaid expansion AND state exchange/parternship compared with all others

State type	% Uninsured, 2013	% Uninsured, midyear 2014	Change in uninsured (pct. pcts.)
States with Medicaid expansion AND state exchange/partnerships	16.1	12.1	-4.0
States with only one or neither	18.7	16.5	-2.2

Gallup-Healthways Well-Being Index

GALLUP

Some states have chosen to implement state-federal "partnership" exchanges, where states run certain functions and make key decisions based on local market and demographic conditions. For the purposes of this analysis, these partnerships are included with the state exchanges. New Hampshire, which manages a state-based exchange but has only recently voted to expand Medicaid, is not included, as its eligible residents were not privy to expanded Medicaid through the first six months of 2014. Four states -- North Dakota, New Jersey, Ohio, and Arizona -- have decided to expand Medicaid without also administering a state-based exchange or partnership, while several others continue to debate its expansion. The District of Columbia, which has expanded Medicaid and has implemented a locally managed exchange, is not included in this analysis.

See Page 2 for a full list of the status of Medicaid expansion and state exchanges for all 50 states, and the 2013 and midyear 2014 uninsured rates for each.

Implications

While a majority of Americans continue to disapprove of the Affordable Care Act, the uninsured rate is declining, as the law intended. Nationally, 17.3% of U.S. adults reported being without health insurance in 2013, a rate that had slowly increased from 14.8% in 2008. The uninsured rate peaked at 18.0% in the third quarter of 2013 -- the three months immediately preceding the opening of the healthcare exchanges -- and has since declined to 13.4% in the second quarter of 2014, the lowest quarterly rate in more than six years of Gallup-Healthways Well-Being Index trending.

At the state level, those that have implemented two of the law's core mechanisms -- Medicaid expansion and state health exchanges -- are seeing a substantially larger drop in the uninsured rate than states that did not take both of these actions. Consequently, the gap in uninsured that existed between the two groups in 2013 has now nearly doubled through the first half of 2014.

Many states continue to debate implementing these actions. New Hampshire recently became the 26th state (plus the District of Columbia) to expand Medicaid, which takes effect this summer. Utah, a conservative state with a Republican governor, Gary Herbert, continues negotiation with the Centers for Medicare and Medicaid Services to have revised, more flexible terms than what is detailed in the Affordable Care Act. Utah expanding Medicaid could serve as a blue print for other red states to follow, as could similar scenarios playing out in Indiana and Pennsylvania.

Other states, in turn, are debating dropping their state-based exchanges and moving to the federal exchange because of technological issues or unexpected cost-related challenges. Oregon will be designated as a supported state-based marketplace in 2015 that leverages federal technology, while Maryland is modifying its troubled website to model Connecticut's. Officials from the states of Massachusetts and Hawaii -- both of which had comparatively low uninsured rates to begin with but show little or no change since 2013 -- are also considering switching to the federal exchange, indicating that locally managed exchanges are not necessarily optimal for insurance sign-ups in some states.

Editor's note: This article originally asserted that Oregon was moving from a state-based exchange to the federal exchange. It has been updated to reflect that Oregon is moving to a supported state-based marketplace.

Survey Methods

Results are based on telephone interviews conducted as part of the Gallup-Healthways Well-Being Index survey Jan. 2-Dec. 29, 2013, with a random sample of 178,068 adults, aged 18 and older, living in all 50 U.S. states and the District of Columbia. A total of 88,678 respondents were interviewed Jan. 2-June 30, 2014.

The 2013 margin of sampling error for most states is ±1 to ±2 percentage points, but it is as high as ±3.5 points for states with smaller population sizes, such as Wyoming, North Dakota, South Dakota, Delaware, and Hawaii. For midyear 2014 results, the error range increases to as high as ±5.0 points for these smallest states.

Interviews are conducted with respondents on landline telephones and cellular phones, with interviews conducted in Spanish for respondents who are primarily Spanish-speaking. Each sample of national adults includes a minimum quota of 50% cellphone respondents and 50% landline respondents, with additional minimum quotas by time zone within region. Landline telephone and cellphone numbers are selected using random-digit-dial methods. Landline respondents are chosen at random within each household on the basis of which member had the most recent birthday.

Samples are weighted to correct for unequal selection probability, nonresponse, and double coverage of landline and cell users in the two sampling frames. They are also weighted to match the national demographics of gender, age, race, Hispanic ethnicity, education, region, population density, and phone status (cellphone only/landline only/both, cellphone mostly, and having an unlisted landline number). Demographic weighting targets are based on the most recent Current Population Survey figures for the aged 18 and older U.S. population. Phone status targets are based on the most recent National Health Interview Survey. Population density targets are based on the most recent U.S. census. All reported margins of sampling error include the computed design effects for weighting.

In addition to sampling error, question wording and practical difficulties in conducting surveys can introduce error or bias into the findings of public opinion polls.

For more details on Gallup's polling methodology, visit www.gallup.com.

Change in Percentage of Uninsured by State, 2013 vs. Midyear 2014

"Do you have health insurance?" (% no)

State	% Uninsured, 2013	% Uninsured, midyear 2014	Change in uninsured (pct. pts.)	Medicaid expansion AND state/partnership exchange in 2014
Alabama	17.7	15.1	-2.6	No
Alaska	18.9	16.2	-2.7	No
Arizona	20.4	17.2	-3.2	No
Arkansas	22.5	12.4	-10.1	Yes
California	21.6	16.3	-5.3	Yes
Colorado	17.0	11.0	-6.0	Yes
Connecticut	12.3	7.4	-4.9	Yes
Delaware	10.5	3.3	-7.2	Yes
Florida	22.1	18.9	-3.2	No
Georgia	21.4	20.2	-1.2	No
Hawaii	7.1	6.9	-0.2	Yes
Idaho	19.9	16.6	-3.3	No
Illinois	15.5	12.3	-3.2	Yes
Indiana	15.3	15.0	-0.3	No
Iowa	9.7	10.3	0.6	Yes
Kansas	12.5	17.6	5.1	No
Kentucky	20.4	11.9	-8.5	Yes
Louisiana	21.7	18.4	-3.3	No
Maine	16.1	13.3	-2.8	No
Maryland	12.9	8.4	-4.5	Yes
Massachusetts	4.9	4.9	0.0	Yes

Michigan	12.5	11.9	-0.6	Yes
Minnesota	9.5	8.8	-0.7	Yes
Mississippi	22.4	20.6	-1.8	No
Missouri	15.2	15.1	-0.1	No
Montana	20.7	17.9	-2.8	No
Nebraska	14.5	13.4	-1.1	No
Nevada	20.0	16.0	-4.0	Yes
New Hampshire	13.8	12.4	-1.4	No
New Jersey	14.9	11.8	-3.1	No
New Mexico	20.2	15.2	-5.0	Yes
New York	12.6	10.3	-2.3	Yes
North Carolina	20.4	16.7	-3.7	No
North Dakota	15.0	13.0	-2.0	No
Ohio	13.9	11.5	-2.4	No
Oklahoma	21.4	17.5	-3.9	No
Oregon	19.4	14.0	-5.4	Yes*
Pennsylvania	11.0	10.1	-0.9	No
Rhode Island	13.3	9.3	-4.0	Yes
South Carolina	18.7	16.8	-1.9	No
South Dakota	14.0	11.3	-2.7	No
Tennessee	16.8	14.4	-2.4	No
Texas	27.0	24.0	-3.0	No
Utah	15.6	15.6	0.0	No
Vermont	8.9	8.5	-0.4	Yes
Virginia	13.3	13.4	0.1	No
Washington	16.8	10.7	-6.1	Yes
West Virginia	17.6	11.9	-5.7	Yes
Wisconsin	11.7	9.6	-2.1	No
Wyoming	16.6	12.8	-3.8	No

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Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans

July 2014

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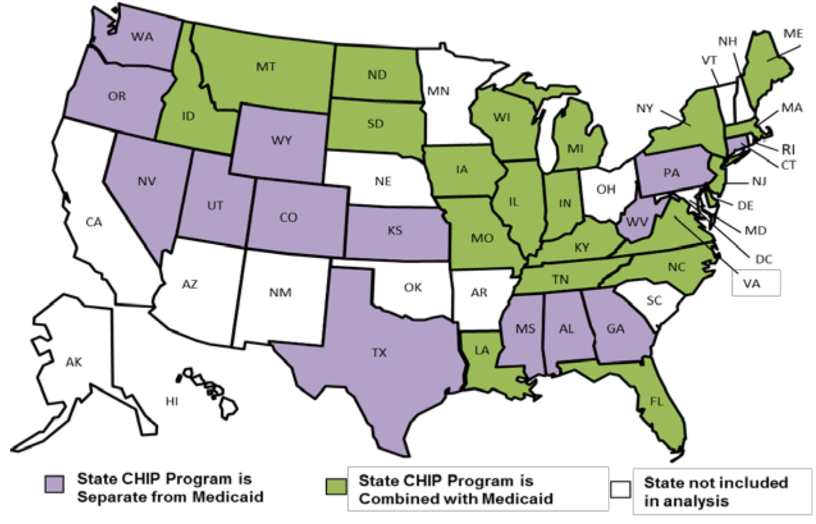
EXECUTIVE SUMMARY

Overview

The Children's Health Insurance Program (CHIP) provides health insurance coverage to an estimated 5.7 million low-income children in the United States whose families have incomes above Medicaid eligibility levels[i]. States have the flexibility to use CHIP funding to either expand coverage for children (up to age 19) through the state's Medicaid program, fund a separate program, or do a combination of the two.

Under the Affordable Care Act (ACA), CHIP was funded through September 30, 2015. The ACA also requires states to maintain the eligibility thresholds for children under Medicaid and CHIP that were in place in March 2010, through September 30, 2019.[ii] Should CHIP not be funded beyond September 2015, children in states with a separate or combined CHIP could transition to coverage through Qualified Health Plans (QHPs). Many of these children will have access to subsidized coverage through the Marketplace (both through premium subsidies and cost sharing subsidies). Some children will not have access to subsidized coverage through the Marketplace if they have access to employer-sponsored coverage, even if that coverage is unaffordable. Children transitioning from CHIP to QHPs will likely experience a reduction in covered child-specific benefits and increased cost sharing for use of medical services.

Wakely Consulting Group (Wakely) was retained by the Robert Wood Johnson Foundation (RWJF), in consultation with First Focus, to analyze the benefit and cost sharing differences of health coverage provided through CHIP and QHPs offered through the Marketplaces. The Marketplaces, a key mechanism for coverage expansion under the ACA, offers subsidized coverage to eligible individuals and families for coverage effective on or after January 1, 2014. This analysis provides information on the potential benefit and cost sharing impact to CHIP enrollees should CHIP not be continued, resulting in current enrollees migrating into QHPs available through the Marketplaces. Wakely's analysis focused on 35 states, including states that operate CHIP separate from Medicaid and states with CHIP that is combined with Medicaid, as shown in the map below.



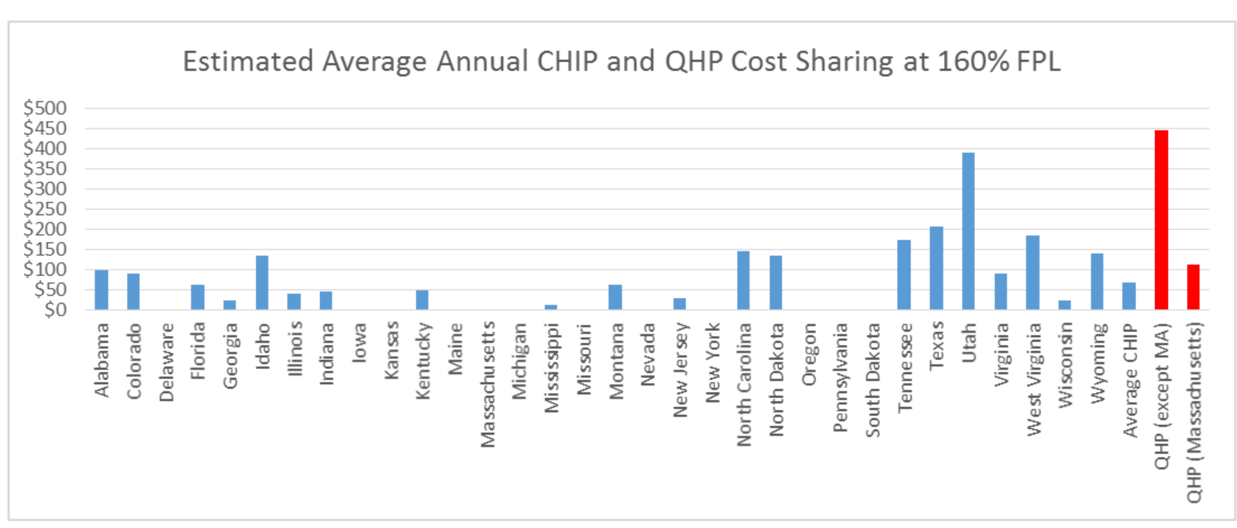
Please see the reliance and limitations section of this report for important information regarding the nature of our work. Our analysis is for purposes of comparing the estimated cost sharing and benefit coverage in CHIP plans to those that enrollees would likely encounter if they enrolled in a QHP. The analysis was only conducted for the states noted above, and results may not be extrapolated to other states. The analysis and comparisons are made to highlight key differences between the plans. Other uses may be inappropriate. We relied on publicly available information on the 2014 CHIP plans and QHPs available in each state and information supplied by First Focus. Actual results will vary for a particular individual and average results for a particular state could vary materially from the estimates included in this report.

Average Cost Sharing

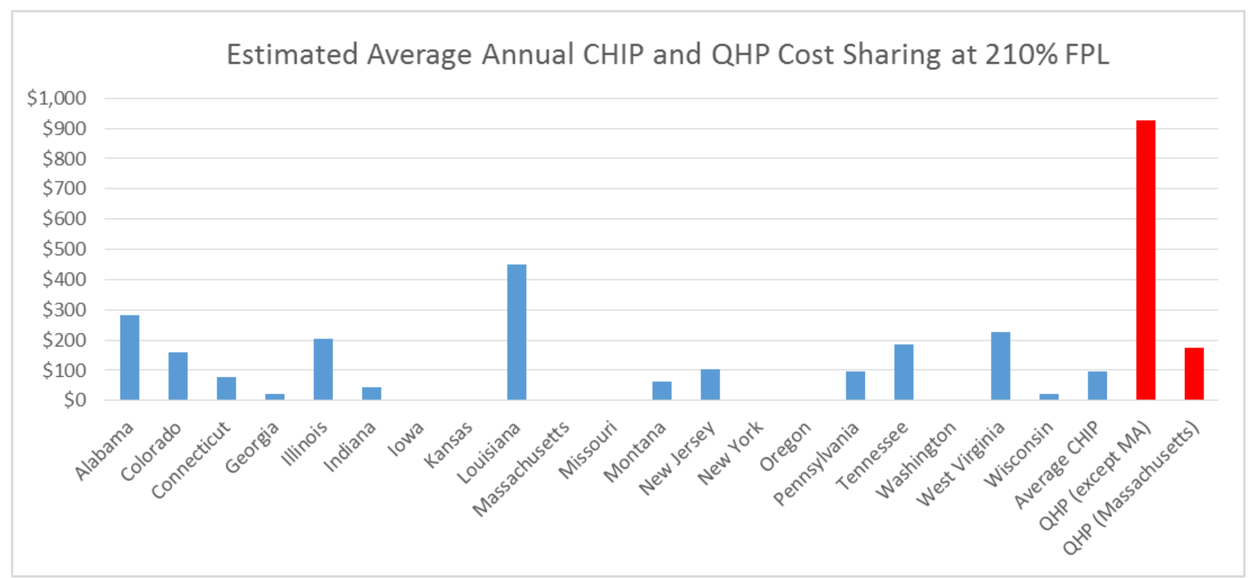
The most significant impact found for CHIP enrollees transitioning to QHPs was a substantial increase in estimated out of pocket costs at the point of care (deductibles, copays, and/or coinsurance). Because CHIP benefits vary by household income in some states, and cost sharing for QHPs on the Marketplaces also varies by household income, analysis was performed for two income levels, 160% and 210% of the Federal Poverty Level (FPL). In three states children in households with incomes of 160% FPL are eligible for Medicaid and not CHIP. Only 20 of the 35 states have a CHIP plan available for children in households at 210% FPL. Children in the other 15 states would generally be eligible for subsidized individual plans on the Exchange, assuming they were not eligible for other affordable minimum essential coverage.

We estimated the annual cost sharing for each state's CHIP plan using the actuarial value calculated for a standard population reflected in the 2015 Federal Actuarial Value Calculator. This analysis assumes no difference in provider discounts negotiated by CHIP insurers or QHPs, which may be material. We estimated the average annual cost sharing using the national QHP premium averages for 2014 in states with a Federally-Facilitated Marketplace (FFM). Graphs 1A and 1B show the estimated average CHIP annual cost sharing in 2014 by state. There were 32 states with CHIP available at 160% FPL and 20 states at 210% FPL.

Graph 1A: Estimated Average Annual CHIP Cost Sharing at 160% FPL by State



Graph 1B: Estimated Average Annual CHIP Cost Sharing at 210% FPL by State



The horizontal line in each graph indicates the estimated cost sharing for individuals enrolled in a QHP with available cost sharing subsidies. For all states except Massachusetts in our study, we estimate the average cost sharing for a child in a QHP to be $446 annually for households with incomes of 160% FPL and $926 for those with incomes of 210% FPL. We estimate the average annual cost sharing for a child in CHIP to be $66 across states with cost sharing in the study for households up to 160% FPL and $97 for households with incomes up to 210% FPL. Massachusetts CHIP enrollees would likely qualify to be enrolled in ConnectorCare plans, for which we estimate annual cost sharing to be $111 and $173 for those income levels, respectively, compared to no cost sharing in CHIP. This analysis is based on average cost sharing for a standard population. Actual cost sharing for an individual may be higher or lower than our estimates based on the medical services used during the year.

CHIP enrollees in states that currently require cost sharing could see up to a ten-fold increase in the cost sharing they are paying if they are transitioned to QHPs. For families with incomes of 210% of the FPL, all but two states that have CHIP available would see at least a four-fold increase in the estimated cost sharing. Additionally, at least one third of states at each of the income levels have no cost sharing in CHIP, but will have cost sharing if enrolled in a QHP.

Financial Exposure for Families with Children with Special Health Care Needs

The financial impact to CHIP enrollees transitioning to QHPs is especially pronounced for children with special health care needs who would likely reach the out of pocket maximum for cost sharing in a year. We categorized the CHIP plans in the states reviewed based on the structure of the out of pocket maximums. Most states include a limit on the total out of pocket cost (including premiums) of 5% of income, regardless of the number of children covered. For plans with no cost sharing, we are

considering there to be an effective limit of $0 for the cost sharing. A few CHIP plans utilize a fixed dollar limit. Table 2 shows the ranges of maximum out of pocket amounts that we identified in CHIP plans compared to QHPs.

Table 2: Comparison of Out of Pocket Cost Sharing Limits for CHIP Plans and QHPs

Type of Limit for CHIP	160% FPL			210% FPL		
	# of states	CHIP range	QHP range	# of states	CHIP range	QHP range
% of Income	15	$650-950	$1,000-$2,250	11	$1,395-$1,995	$2,500-$5,200
Fixed Dollar	5	$215-500	$1,000-$2,250	2	$215-$350	$2,650-$5,200
No Cost Sharing	12	$0	$500-$2,250	7	$0	$2,250-$5,200

The ranges for the CHIP plans that have percent of income limits are based on a three-person family with one child. For a given enrollee in a CHIP plan, the maximum out of pocket will be determined by the actual number of children and the income for the family. Children with special health care needs in some states could go from paying nothing in CHIP to over $5,000 in annual out of pocket expenditures in QHPs. All states had lower maximum out of pocket costs in CHIP compared to QHPs.

Pediatric Dental and Vision Cost Sharing

We specifically reviewed key pediatric dental and vision benefits given their importance for children. The 2015 Federal Actuarial Value Calculator that was used for estimating overall annual cost sharing does not explicitly take into consideration dental or vision cost sharing. We included a separate analysis of cost sharing for dental preventive and restorative exams, routine vision exams, and eyeglasses. The following table shows the key differences between CHIP and QHPs in terms of coverage and cost sharing requirements. CHIP plans generally use copays while QHPs more frequently utilize deductibles and coinsurance for these services. CHIP plans offer these benefits with no cost sharing in most of the states. Many of the QHPs do not cover dental as it is offered on a stand-alone basis and families are required to pay additional premiums and incur cost sharing if they purchase them.

Table 3: Number of States that Cover Pediatric Dental and Vision Services, and Use of Cost Sharing

Service	Coverage/Cost Sharing	160% FPL		210% FPL	
		CHIP	QHP	CHIP	QHP
Dental Checkup	Covered with No Cost Sharing	30	6	18	6
	Covered with Cost Sharing	2	6	2	2
	Not Covered	-	20	-	12
Routine Vision Exams	Covered with No Cost Sharing	21	20	13	11
	Covered with Cost Sharing	11	12	7	9
	Not Covered	-	-	-	-
Eyeglasses Cost Sharing	Covered with No Cost Sharing	27	14	17	9
	Covered with Cost Sharing	5	18	3	11
	Not Covered	-	-	-	-

At both income levels, the CHIP plans offer richer coverage for the key pediatric dental and vision services compared to the QHPs. In more than half the states studied, children moving from CHIP plans to QHPs would likely need to purchase separate stand-alone dental plans in order to have comparable coverage. They would also be faced with more cost sharing for the same services than was required in the CHIP plans.

Benefit Coverage

We compared the benefits (both services covered and limitations) included in CHIP to those included in QHPs (based on Essential Health Benefits (EHB)) by state. Table 4 below summarizes the average percentage of services that are covered across all states reviewed for each benefit category, core and special, or child-specific. Core benefits are those that are typically included in a major medical insurance policy. The child-specific benefits reflect additional services that are important when considering the medical needs of children. The benefits in each category are explained in more detail in the report. Note that each QHP has some flexibility to add and substitute EHB benefits when designing the plans. Overall, CHIP plans cover more child-specific services.

Table 4: Overall Coverage of Core and Child-Specific Benefits

Average % of Services Covered across All Reviewed States

Benefit Category	CHIP			QHPs		
	Covered - No Limits	Covered - Limits	Not Covered	Covered - No Limits	Covered - Limits	Not Covered
Core	94%	6%	0%	96%	4%	0%
Child-Specific	56%	26%	18%	30%	22%	48%

We found that the coverage of core benefits is comparable between CHIP and QHPs, although slightly more services were found to have limitations (such as visit limits) in CHIP plans than QHPs. However, QHPs cover fewer child-specific services than CHIP, and when the benefits are covered, there tend to be more limits imposed. An important caveat to these results is that in several cases the best available plan design document did not provide details on limits and exclusions. Our results may therefore be affected by the lack of complete information. Please find a complete list of core and child-specific services in Tables 14 and 15 starting on page 24.

INTRODUCTION

The Children's Health Insurance Program (CHIP) provides health insurance coverage to an estimated 5.7 million low-income children in the United States whose families have incomes above Medicaid eligibility levels[iii]. States have the flexibility to use CHIP funding to either expand coverage for children (up to age 19) through the state's Medicaid program, fund a separate program, or use a combination of the two.

Under the Affordable Care Act (ACA), CHIP was funded through September 30, 2015. The ACA requires states to maintain the eligibility thresholds for children under Medicaid and CHIP that were in place in March 2010, through September 30, 2019.[iv]

Should CHIP funding not be continued, children in states with separate or combined CHIP plans could transition to coverage through QHPs in the Marketplace if the Secretary of Health and Human Services (HHS) certifies that a plan on the Marketplace offers coverage that is "at least comparable" to CHIP with respect to benefits and cost sharing. While many of these children will have access to subsidized coverage through the Marketplace (both through premium subsidies and cost sharing subsidies), it is important to note that some may not be eligible for subsidized coverage if they have access to employer sponsored coverage through a parent. The Government Accountability Office (GAO) estimates that 1,900,000 children will not be able to access subsidies on the Marketplace for this reason. Whether or not children have access to subsidized coverage through the Marketplace, children transitioning from CHIP to QHPs are generally expected to experience declines in covered child-specific benefits and increased cost sharing for use of medical services.

The following provides a summary of federal requirements related to covered benefits and cost sharing for CHIP and QHPs.

Table 5: CHIP versus QHP Flexibility in Coverage and Cost Sharing

	CHIP	QHPs
Required covered benefits	State flexibility to select a benchmark plan or seek Secretary-approved coverage.	State flexibility to select a benchmark plan to define Essential Health Benefits (EHB), which must include 10 required services categories.
Cost sharing	State flexibility, within federal limits that require out of pocket costs, including premiums for a family to be no more than 5% of household income. Cost sharing requirements in some states vary by income level.	Federal requirements related to the average percent of total costs for EHB that plans must cover. These vary by income level.

ANALYSIS OF ENROLLEE OUT OF POCKET COSTS

Background

In order to assess differences in enrollee out of pocket costs between CHIP and QHPs, Wakely performed the following analyses:

1. Identified average out of pocket costs for core services.
2. Identified estimated maximum financial exposure for families with children with special health care needs.
3. Identified the cost sharing requirements for pediatric dental and vision services.

As discussed below, cost sharing for QHPs and some state CHIP plans varies by household income level, so comparisons are provided for families with household incomes of both 160% and 210% Federal Poverty Level (FPL). These levels were selected to include the most states, as income levels for CHIP eligibility vary by state. Because of this variation, it is important to note that results are not shown at both income levels for some states because families with those incomes do not qualify for CHIP (either because that income level makes them eligible for Medicaid and not CHIP, or because the income is above the maximum eligibility level for CHIP).

Average Out of Pocket Costs for Standard Medical Services

In CHIP, states have flexibility to set cost sharing provisions for covered services which enrollees would be responsible for paying, up to a federally required limit of 5% of household income (including premium costs) for families with incomes above 150% FPL[v]. Some states do not require any enrollee cost sharing for covered services. States may also vary cost sharing requirements based on a family's household income.

The ACA requires all health insurance plans in the individual market to set average cost sharing amounts to be within certain ranges based on the percent of claims paid by the plan relative to the total allowed cost of services for Essential Health Benefits (EHB) provided through a health insurance plan's network. This percent is referred to as the Actuarial Value (AV) of the plan. HHS has developed a Federal Actuarial Value Calculator that must be used by insurers to confirm that the cost sharing features of their plans conform to these metal level, or actuarial value, requirements. Allowed costs are a measure of the expected total claims cost of medical and pharmacy covered benefits after provider discounts, including both the insurer and enrollee's shares. For purposes of this analysis, we have not assumed any difference in discounts negotiated between CHIP insurers or QHPs and providers. These differences may be material, and should be recognized as an additional potential source of variation in the total cost for CHIP plans compared to QHPs (for example when a deductible or coinsurance applies). It is likely that the discounts for CHIP may be greater than those negotiated by the QHPs.

There are four metal levels for which all QHPs must generally be categorized. Platinum plans cover 90% of medical claims for EHBs on average with consumers paying 10%, gold plans cover 80% and consumers pay 20%, silver plans cover 70% with consumers paying 30% and bronze plans cover 60% while

consumers pay 40%. (Note that plans are compliant with metal level requirements if they are within 2% of the percentages defined above). Additionally, individuals and families with household incomes between 100% and 250% of the FPL are eligible for plans with reduced cost sharing if they enroll in a silver level plan. These cost sharing reduction plans are also defined based on the average percent of claims for EHB that are covered by the insurer, and are defined as shown in the following table.

Table 6: Cost Sharing Reduction Plan Actuarial Values

Household Income	Average Percent of Claims Paid by Plan	Average Percent of Claims Paid by Enrollee
100 – 150% FPL	94% (+/- 1%)	6% (+/-1%)
150 – 200% FPL	87% (+/- 1%)	13% (+/-1%)
200 – 250% FPL	73% (+/- 1%)	27% (+/-1%)

Some states, such as Massachusetts, have “wrap” or supplemental programs that further reduce enrollee cost sharing for certain incomes.

We calculated the AV for each of the CHIP plans that have cost sharing requirements using the 2015 Federal Actuarial Value Calculator. The estimated percent of total covered claims that the enrollees in CHIP plans would be responsible for is 100% minus the AV. This is an average expected percentage and will vary based on the actual services that an individual uses in a year.

We also estimated the average annual out of pocket costs by using a national average allowed claims cost of $3,429 for children, which is calculated using the national average premium for children in QHPs submitted for 2014 in the Federally-Facilitated Marketplaces.

Twelve states had no cost sharing requirements in CHIP. These states include Delaware, Iowa, Kansas, Maine, Massachusetts, Michigan, Missouri, Nevada, New York, Oregon, South Dakota and Washington. Children that are in the CHIP plans in these states would see material increases in the cost of receiving medical services if they moved into a QHP.

Table 7 shows the actuarial value and the estimated average annual enrollee cost sharing amount for QHPs (nationally) and for the CHIP plan for each state studied. States that do not offer CHIP coverage to children at that household income level are noted as “No CHIP Plan” or “Medicaid Eligible” for that income level. Children in these categories would likely be eligible to enroll in the state’s Medicaid program if they fall under the CHIP eligibility guideline or obtain insurance on the Exchange utilizing premium tax credits and cost sharing reductions. The actuarial value and the estimated annual enrollee cost sharing paid out of pocket are indicated on the “QHP on Exchange” line.

All state CHIP plans are estimated to have significantly lower average cost sharing than QHPs. Differences in cost sharing can also have an impact on the utilization of medical services as individuals may choose not to use some services due to the cost. We have not included any adjustment to the underlying utilization that may result from the higher cost sharing requirements.

Table 7: Actuarial Value and Estimated Average Enrollee Annual Cost Sharing

State Program	160% FPL		210% FPL	
	Actuarial Value	Est. Annual Cost Sharing	Actuarial Value	Est. Annual Cost Sharing
QHP on Exchange	**87.0%**	**$446**	**73.0%**	**$926**
Average CHIP	**96.6%**	**$117**	**94.0%**	**$204**
Alabama CHIP	97.2%	$97	91.8%	$281
Colorado CHIP	97.4%	$90	95.3%	$161
Connecticut CHIP	Medicaid eligible		97.8%	$77
Florida CHIP	98.2%	$62	No CHIP Plan	
Georgia CHIP	99.3%	$24	99.3%	$24
Idaho CHIP	96.1%	$135	No CHIP Plan	
Illinois CHIP	98.9%	$38	94.1%	$203
Indiana CHIP	98.7%	$44	98.7%	$45
Kentucky CHIP	98.6%	$48	No CHIP Plan	
Louisiana CHIP	Medicaid eligible		86.9%	$448
Mississippi CHIP	99.7%	$11	No CHIP Plan	
Montana CHIP	98.2%	$63	98.2%	$63
New Jersey CHIP	99.2%	$28	97.0%	$103
North Carolina CHIP	95.8%	$145	No CHIP Plan	
North Dakota CHIP	96.1%	$133	No CHIP Plan	
Pennsylvania CHIP	100.0%	$0	97.2%	$98
Tennessee CHIP	94.9%	$173	94.6%	$185
Texas CHIP	94.0%	$207	No CHIP Plan	
Utah CHIP	88.7%	$389	No CHIP Plan	
Virginia CHIP	97.4%	$89	No CHIP Plan	
West Virginia CHIP	94.6%	$184	93.4%	$227
Wisconsin CHIP	99.3%	$23	99.3%	$23
Wyoming CHIP	96.0%	$139	No CHIP Plan	

For children in households with incomes of 160% FPL, the average out of pocket costs for QHPs is estimated to be $446 per year ($111 in Massachusetts due to the wrap plan) while average CHIP cost sharing ranges from $0 (in 11 states) to $389 in Utah. The average annual enrollee cost sharing across the states studied is $66. Utah is the only state where average CHIP cost is within 50% of the average cost sharing under the QHP at this income level. For children with household incomes of 210% FPL, the average out of pocket costs for QHPs is estimated to be $926 per year ($173 in Massachusetts due to the wrap plan) while average CHIP cost sharing ranges from $0 (in 6 states) to $448 in Louisiana. The average annual enrollee cost sharing across the states studied is $97. There are no states for which CHIP

cost sharing is comparable to the level of QHP cost sharing. Estimated average cost sharing in CHIP for every state is lower than in the QHPs.

Out of Pocket Costs for Families with Children with Special Health Care Needs

Depending on the cost sharing requirements for plans, families who have children with special health care needs that likely drive high medical claims may be faced with daunting out of pocket costs in QHPs above and beyond any premiums that must be paid.

Federal requirements limit out of pocket costs for CHIP to be no more than 5% of household income, including premiums and including all children covered by the program. Some state CHIP plans do not require any cost sharing, which means there is effectively a $0 maximum out of pocket limit for cost sharing, while others have defined dollar limits or use the 5% of household income threshold. These dollar limits may be for medical and pharmacy combined, or separate.

Health insurance plans offered through Marketplaces also have maximum out of pocket costs that limit families' exposure to total copays, deductibles, and coinsurance amounts for Essential Health Benefits (including prescription drugs). The ACA limits these maximum out of pocket costs at different amounts based on the cost sharing reduction level. These limits are increased each year based on medical inflation. Health insurers can set their out of pocket maximums at amounts lower than the federal limits. The limits for 2015 are shown in Table 8.

Table 8: 2015 Maximum Cost Sharing Out of Pocket Limits for ACA Plans

Household Income	Cost sharing Reduction Actuarial Value Level for Silver Plan	Limit on Out of Pocket Maximum for Self-Only Coverage	Limit on Out of Pocket Maximum for Family Coverage
100 – 150% FPL	94% (+/- 1%)	$2,250	$4,500
150 – 200% FPL	87% (+/- 1%)	$2,250	$4,500
200 – 250% FPL	73% (+/- 1%)	$5,200	$10,400
Above 250% FPL	70% (+/- 2%)	$6,600	$13,200

The following provides a comparison of the estimated maximum financial exposure, net of premiums, which families face in the CHIP plans compared to that of QHPs available on the Marketplace in each state in 2014. Note that ranges reflecting all available QHPs are provided for states with a Federally-Facilitated Marketplace, and the out of pocket maximum for states operating their own Marketplace is based on that for an individual in the lowest cost silver plan available for the most populated county in the state as information for all QHPs was not available. The out of pocket limit may be higher or lower for other plans, as long as it is below the allowed maximum level as noted in Table 8, and the overall actuarial value meets the metal tier requirements.

For CHIP plans that use a percent of income as the basis for the maximum out of pocket, the actual maximum will depend on the household income and number of children covered under the maximum. For these states, we calculated the maximum using a 3 person household at the 160% and 210% FPL

income levels and assuming only one child. The calculated percent of income maximum at these income levels is $950 and $1,995, respectively. These amounts are reduced by the required annual premium for CHIP in each state to reflect the limit on cost sharing only. Since we are assuming one child, the full maximum out of pocket limit is assumed to be met by one child's medical and pharmacy claims. For larger families, the household income is higher for the same FPL levels, which means that the maximum out of pocket limit would also increase, but it may be split among more than one child in the family.

We have not reviewed whether and how the out of pocket limits based on percent of income are put into practice. This type of limit is difficult to adjudicate and it may be incumbent upon the enrollee to indicate to the insurer when the limit has been reached. Additionally, because household incomes may change during the year, it may be challenging to identify the limit.

Table 9A: Maximum Out of Pocket Costs (net of Premium) in CHIP Compared to QHPs

For States with 5 Percent of Household Income CHIP Limits

State	160% FPL		210% FPL	
	CHIP	**QHP**	**CHIP**	**QHP**
Alabama	$846	$1,000-$2,000	$1,891	$3,500-$5,000
Colorado	$925	$1,450	$1,970	$4,750
Connecticut	Medicaid Eligible		$1,995	$5,000
Florida	$710	$1,000-$2,250	No CHIP Plan	
Georgia	$710	$1,000-$2,250	$1,647	$3,250-$5,200
Idaho	$770	$2,250	No CHIP Plan	
Illinois*	$770	$1,100-$2,250	$1,815	$2,920-$5,200
Indiana	$686	$1,000-$2,250	$1,491	$2,650-$5,200
Louisiana	Medicaid Eligible		$1,395	$2,500-$5,200
Mississippi	$950	$1,100-$2,250	No CHIP Plan	
New Jersey	$950	$1,400-$2,000	$1,497	$3,500-$5,200
North Carolina	$900	$1,000-$2,250	No CHIP Plan	
North Dakota	$950	$1,400-$2,250	No CHIP Plan	
Pennsylvania	No Cost Sharing – in table 9C		$1,419	$3,000-$5,200
Tennessee	$950	$1,000-$2,250	$1,995	$2,750-$5,200
Texas	$915	$1,200-$2,250	No CHIP Plan	
Utah	$650	$1,000-$2,250	No CHIP Plan	
Wisconsin	$950	$1,000-$2,250	$1,875	$2,650-$5,200
Overall Range	**$650-$950**	**$1,000-$2,250**	**$1,395-$1,995**	**$2,500-$5,200**

*We are including Illinois in the states that utilize a percent of income limit on cost sharing, although a portion of the maximum out of pocket, specifically related to hospital claims, includes a specific fixed dollar limit for the CHIP plans.

Five states reflected fixed dollar maximum out of pocket limits in the CHIP plans for one or both of the reviewed income levels. Two of these states include separate dollar maximums for medical and pharmacy claims, which can offer additional protection for enrollees. The out of pocket limits for the CHIP plans in these states was significantly lower than the lowest QHP limits.

Table 9B: Maximum Out of Pocket Costs in CHIP Compared to QHPs

For States with Fixed Dollar CHIP Limits

State	160% FPL		210% FPL	
	CHIP	**QHP**	**CHIP**	**QHP**
Kentucky	$450	$1,450	No CHIP Plan	
Montana	$215	$1,000-$2,000	$215	$2,650-$5,200
Virginia	$350	$1,500-$2,250	No CHIP Plan	
West Virginia	$150 Med; $100 Rx	$1,000-$2,000	$200 Med; $150 Rx	$3,500-$5,200
Wyoming	$300 Med; $200 Rx	$1,500-$2,250	No CHIP Plan	
Overall Range	**$215-$500**	**$1,000-$2,250**	**$215-$350**	**$2,650-$5,200**

The remaining states did not have any cost sharing required in CHIP plans. In effect, this equates to a maximum out of pocket of $0 since enrollees are not paying anything at the time of service and the issuer covers the full cost for services. Enrollees in these CHIP plans would see very significant increases in the out of pocket expenses if they moved into a QHP.

Table 9C: Maximum Out of Pocket Costs in CHIP Compared to QHPs
For States with No Cost Sharing in CHIP

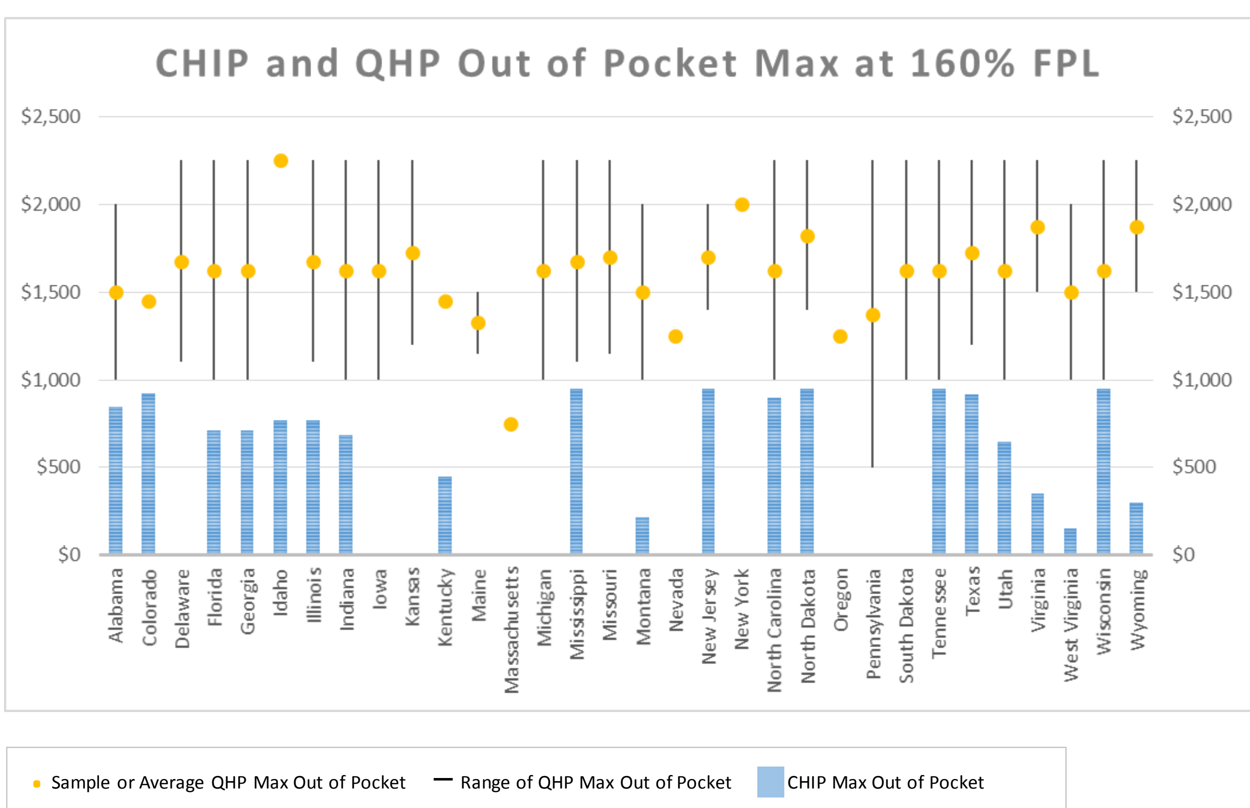
State	160% FPL		210% FPL	
	CHIP	**QHP**	**CHIP**	**QHP**
Delaware	$0	$1,100-$2,250	No CHIP Plan	
Iowa	$0	$1,000-$2,250	$0	$2,750-$5,200
Kansas	$0	$1,200-$2,250	$0	$3,125-$5,200
Maine	$0	$1,150-$1,500	No CHIP Plan	
Massachusetts	$0	$750 Med; $500 Rx	$0	$1,500 Med; $750 Rx
Michigan	$0	$1,000-$2,250	No CHIP Plan	
Missouri	$0	$1,150-$2,250	$0	$3,125-$5,200
Nevada	$0	$1,250	No CHIP Plan	
New York	$0	$2,000	$0	$4,000
Oregon	$0	$1,250	$0	$5,000
Pennsylvania	$0	$500-$2,250	% of Income – in table 9A	
South Dakota	$0	$1,000-$2,250	No CHIP Plan	
Washington	Medicaid Eligible		$0	$5,200
Overall Range	**$0-$0**	**$500-$2250**	**$0-$0**	**$2250-$5200**

In all states included in the analysis and at both income levels, the out of pocket maximum cost in QHPs far exceeds that of the CHIP plan. The lowest combined medical and pharmacy out of pocket maximum for QHPs across the states was $500 for coverage available to families with household incomes of 160% FPL, and $2,250 for families with household incomes of 210% FPL.

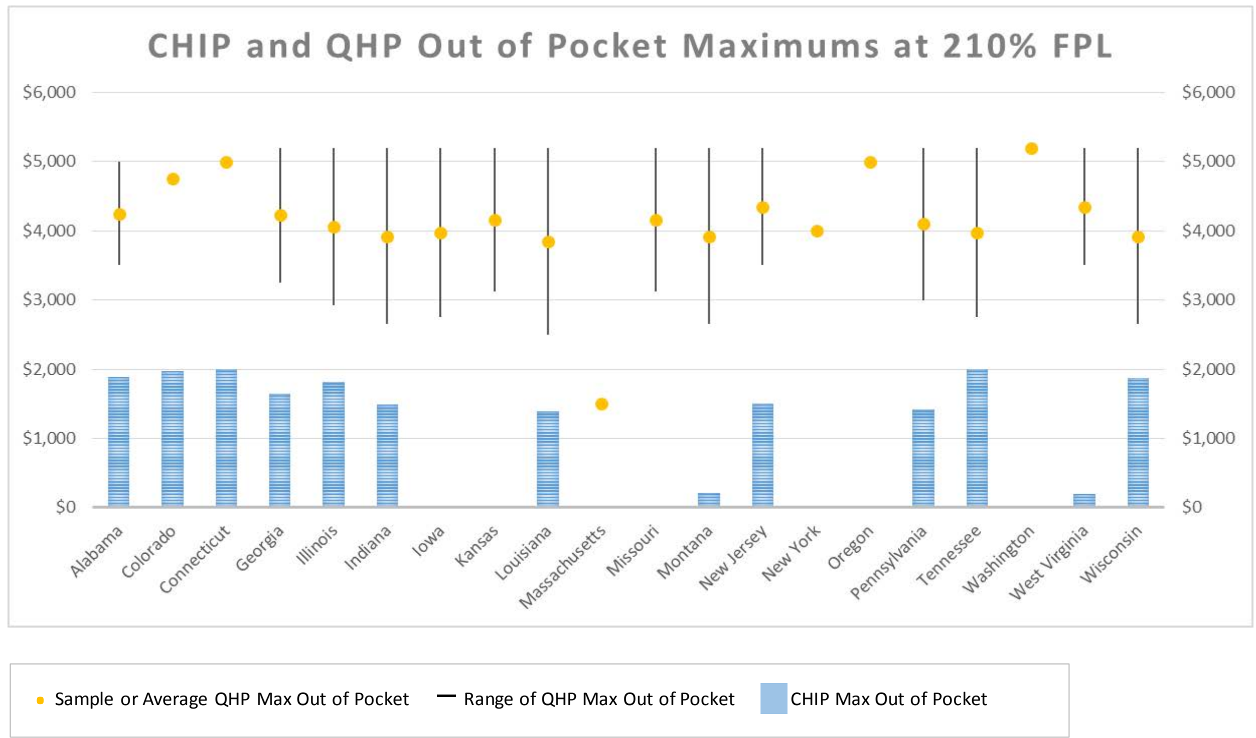
Thirteen of the 35 states do not require any cost sharing in their CHIP plans at one or both of the income levels. CHIP enrollees in these states would see very significant increases in their financial exposure should they move to a QHP.

The differences in the out of pocket maximums at each income level are shown in Graphs 9D and 9E. The specific values for each state are included in Tables 9A-9C above. The blue bars depict the CHIP out of pocket maximum while the lines and yellow dots reflect the range of out of pocket maximums identified in the study. For example, Alabama's CHIP includes an estimated $846 maximum out of pocket for a single individual in a household with an income of 160% FPL. The maximum out of pocket for a single individual in the available QHPs ranged from $1000 to $2000. In Colorado, the CHIP plan includes an estimated $925 maximum out of pocket compared to the $1450 maximum out of pocket for the QHP reviewed.

Graph 9D: CHIP and QHP Out of Pocket Maximums by State at 160% FPL



Graph 9E: CHIP and QHP Out of Pocket Maximums by State at 210% FPL



Out of Pocket Costs for Pediatric Dental and Vision Services

The 2015 Federal Actuarial Value Calculator used to calculate the average out of pocket costs for core services as outlined earlier does not account for the specific cost sharing requirements for pediatric dental and visions services. Because of the importance of these services in children's health, the cost sharing requirements for these frequently used services, including routine vision exams, eyeglasses, and dental checkups were reviewed and are summarized in detail for each state in the appendices.

Cost sharing for QHPs were reviewed for the lowest cost silver plan available either to the most people in the state (for FFM states) or in the most populous county in the state for State-Based Marketplace states. Generally, there was significant variation in the cost sharing requirements for these services in QHPs offered through the Marketplaces. Some QHPs had no cost sharing for these services, others had copayments, while others applied the plan deductible and coinsurance to these services. Pediatric dental and vision care are required EHBs per the ACA. The ACA, however, does allow QHPs to exclude pediatric dental benefits if there is a stand-alone dental plan available through the Marketplace. Depending on whether issuers decide to include pediatric dental coverage in their QHPs, families wanting to have pediatric dental in these states may have to enroll in a stand-alone dental plan, with a separate premium and benefit structure, in addition to the QHP. Table 10 shows the types of cost sharing utilized by CHIP and QHPs. It is possible that dollar limits and deductibles are used in combination with other cost sharing.

Table 10: Pediatric Dental Checkup Cost Sharing – Percent of States Using Type of Cost Sharing

	160% FPL		210% FPL	
Cost Sharing	CHIP	QHP	CHIP	QHP
No Cost Sharing	94%	19%	90%	30%
Copay	6%	9%	10%	5%
Coinsurance	0%	9%	0%	5%
Deductible	0%	13%	0%	10%
Dollar Limits	6%	0%	5%	0%
Covered	100%	37%	100%	40%

CHIP plans are much more likely than QHPs to not require any cost sharing for pediatric dental checkups. When cost sharing is required, it tends to be lower in CHIP plans compared to QHPs. Two states have CHIP plans that include dollar limits on the total claims covered for pediatric dental services. Dollar limits are not permitted in QHPs. Of the states that do have cost sharing, CHIP plans tend to include only copays while QHPs may have either copays or coinsurance, and often additionally require that a deductible be met. Table 11 shows the use and type of cost sharing by state for preventive pediatric dental visits for individuals at 160% FPL. For each plan type, an "X" indicates that the specific type of cost sharing is utilized. We have noted "N/A" when no cost sharing applies, although the dollar limit may still be applicable even if there is no cost sharing required at the time of service.

Table 11: Pediatric Dental Checkup Cost Sharing by State

State	160% FPL								210% FPL							
	CHIP				QHP				CHIP				QHP			
	Copay	Coinsurance	Deductible	Dollar Limit	Copay	Coinsurance	Deductible	Dollar Limit	Copay	Coinsurance	Deductible	Dollar Limit	Copay	Coinsurance	Deductible	Dollar Limit
Alabama	N/A				N/A				N/A				N/A			
Colorado	N/A					X	X		N/A					X	X	
Connecticut	Medicaid Eligible								N/A				N/A			
Delaware	N/A				N/A				No CHIP Plan							
Florida	N/A				Not Covered				No CHIP Plan							
Georgia	N/A				Not Covered				N/A				Not Covered			
Idaho	N/A				X				No CHIP Plan							
Illinois	X				Not Covered				X				Not Covered			
Indiana	N/A				Not Covered				N/A				Not Covered			
Iowa	N/A				Not Covered				N/A				Not Covered			
Kansas	N/A				Not Covered				N/A				Not Covered			
Kentucky	N/A					X	X		No CHIP Plan							

State	160% FPL								210% FPL							
	CHIP				QHP				CHIP				QHP			
	Copay	Coinsurance	Deductible	Dollar Limit	Copay	Coinsurance	Deductible	Dollar Limit	Copay	Coinsurance	Deductible	Dollar Limit	Copay	Coinsurance	Deductible	Dollar Limit
Louisiana	Medicaid Eligible								N/A				N/A			
Maine	N/A				Not Covered				No CHIP Plan							
Massachusetts	N/A				Not Covered				N/A				Not Covered			
Michigan	N/A				Not Covered				No CHIP Plan							
Mississippi	N/A			X	Not Covered				No CHIP Plan							
Missouri	N/A				Not Covered				N/A				Not Covered			
Montana	N/A			X	Not Covered				N/A			X	Not Covered			
Nevada	N/A				Not Covered				No CHIP Plan							
New Jersey	N/A				Not Covered				N/A				Not Covered			
New York	N/A				X		X		N/A				X		X	
North Carolina	N/A				X				No CHIP Plan							
North Dakota	N/A					X	X		No CHIP Plan							
Oregon	N/A				Not Covered				N/A				Not Covered			
Pennsylvania	N/A				N/A				N/A				N/A			
South Dakota	N/A				Not Covered				No CHIP Plan							
Tennessee	N/A				N/A				N/A				N/A			
Texas	N/A				Not Covered				No CHIP Plan							
Utah	N/A				Not Covered				No CHIP Plan							
Virginia	N/A				Not Covered				No CHIP Plan							
Washington	Medicaid Eligible								N/A				Not Covered			
West Virginia	N/A				N/A				N/A				N/A			
Wisconsin	X				Not Covered				X				Not Covered			
Wyoming	N/A				N/A				No CHIP Plan							

Routine pediatric vision services are also required to be covered in QHPs. The variety of cost sharing required for these services is reflected in Table 12. Similar to dental checkups, CHIP plans provide services with no cost sharing more frequently than QHPs. CHIP plans exclusively use copays when they do require cost sharing while QHPs may include both deductibles and coinsurance.

Table 12: Routine Pediatric Vision Services Cost Sharing – Percent of States Using Type of Cost Sharing

	160% FPL		210% FPL	
Cost Sharing	**CHIP**	**QHP**	**CHIP**	**QHP**
No Cost Sharing	66%	63%	65%	55%
Copay	34%	9%	35%	15%
Coinsurance	0%	22%	0%	15%
Deductible	0%	31%	0%	35%
Dollar Limits	0%	0%	0%	0%
Covered	100%	100%	100%	100%

In addition to routine pediatric vision exams, plans also offer coverage for eyeglasses. CHIP plans often include dollar limits so enrollees would pay any amount above the specified dollar limit. QHPs also tend to use coinsurance with deductibles if they require cost sharing.

Table 13: Pediatric Eyeglasses Cost Sharing – Percent of States Using Type of Cost Sharing

	160% FPL		210% FPL	
Cost Sharing	**CHIP**	**QHP**	**CHIP**	**QHP**
No Cost Sharing	84%	44%	85%	45%
Copay	16%	3%	15%	0%
Coinsurance	0%	47%	0%	45%
Deductible	0%	53%	0%	50%
Dollar Limits	25%	0%	35%	0%
Covered	100%	100%	100%	100%

In general CHIP plans are more generous in providing pediatric dental and vision services with no or lower cost sharing than QHPs. Enrollees would likely see increases in the cost sharing required if they move from a CHIP plan to a QHP.

ANALYSIS OF COVERED BENEFITS AND LIMITS

Background

States have flexibility, within federal guidelines, to define the benefits required to be covered under both CHIP and QHPs. Plans under both programs are generally required to provide basic services, such as inpatient and outpatient hospital, physician, laboratory and x-rays, and preventive care.

CHIP Benefit Overview

States with separate CHIP programs have several options for defining the covered benefits in their program. States can select one of three benchmark options, the standard Blue Cross Blue Shield preferred provider option plan offered to Federal employees, the benefit plan for state employees, or

the most highly enrolled commercial HMO in the state (not including Medicaid enrollment). Alternatively, states can define coverage that is actuarially equivalent to one of the benchmark plans above, so long as it includes coverage for inpatient and outpatient hospital, physician services, surgical and medical services, laboratory and x-ray services, and preventive services.[vi]

States with separate CHIP programs must also provide dental coverage that meets certain CHIP requirements or is substantially equal to either the most popular federal employee dental plan that is available to dependents, the most popular dental plan selected by dependents of state employees, or dental coverage offered through the highest enrolled commercial insurer in the state.

QHP Benefit Overview

All QHPs offered through state Marketplaces must provide Essential Health Benefits (EHB) as defined in the ACA. For the 2014 and 2015 coverage years, EHBs are based on one of a set of benchmark plans which states had the option to select. The benchmark options included the most highly enrolled commercial plan available in each of the top three products in the state's small group market, any of the three largest state employee benefit plans, any of the three largest national Federal Employees Health Benefits Program plans, and the largest insured commercial non-Medicaid HMO operating in the state. The default benchmark for states that did not make an active selection was the most highly enrolled plan in the small group market. EHBs are based on the covered benefits of the benchmark plan in 2012 and includes coverage limits with any annual or lifetime dollar limits converted to actuarially equivalent service or treatment limits.

The ACA requires EHBs to include ten service categories of benefits, including:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

State benchmarks that did not include all of the above categories were supplemented to ensure complete coverage. Supplementation was most commonly needed for pediatric oral and vision and habilitative service benefit categories.

States with benchmark plans that did not include pediatric dental and/or vision coverage could be supplemented with coverage from either the Federal Employees Dental and Vision Insurance Program (FEDVIP, which was the default for states that didn't actively make a selection) or the state's separate

CHIP plan for the eligibility group with the highest enrollment. As noted above, EHB requires pediatric dental coverage to be included, but the QHP does not need to offer it in the plan if a stand-alone dental plan is available through the Marketplace in the state.

States also had the option to define habilitative services for purposes of EHB, otherwise, issuer definitions would apply.

QHP issuers have the option to substitute benefits within EHB categories if they are actuarially equivalent. Issuers also have the option of providing benefits above EHB and must cover any state required benefits, even if they are not considered part of EHB.

Some EHBs in this report were based on state benchmarks plans and may show annual dollar limits on certain benefits. These dollar limits were common on autism and Applied Behavior Analysis (ABA) benefits. In accordance with Federal Regulation 45 CFR 147.126, these limits cannot be applied to EHBs but can be converted to actuarially equivalent service limits. Presumably, these dollar limits in QHPs were converted to visit limits which are not reflected in our report. For the purposes of comparing CHIP to QHPs, we include the dollar limits to identify potential utilization limits that may be used in the QHPs. We do not believe this lack of conversion causes any lack of accuracy as it is apparent how prevalent the use of limits may be.

Because the benchmark plans were in place prior to 2014, they did not all cover mental health benefits at parity with physical health benefits, as is required for CHIP and QHPs. In places where there were mental health coverage limits that were not in parity with physical health benefits, we removed the limits assuming that CHIP plans and the QHPs removed those limits.

Pharmacy benefits for both CHIP plans and QHPs are often subject to formularies, or specific drug lists that are covered. We have not included the use of formularies as a limitation because of the standard use across both CHIP and QHPs. We focused on the material coverage and limitation differences.

Methodology

For purposes of this analysis, benefits were determined to be either “core” or “child-specific” based on how commonly they were covered and the relative importance to children. Core benefits are those that are almost always covered in CHIP and QHPs and the differences in benefits is typically in the form of limits or cost sharing. Child-specific benefits are those that are less likely to be consistently covered and have larger variation in limits and exclusions. They are also benefits that are considered more important when considering health care for children.

CHIP benefit information collected by the National Association for State Health Policy (NASHP) and Georgetown University Health Policy Institute Center for Children and Families for the May 2014 report “Benefits and Cost Sharing in Separate CHIP Programs” was used as a starting point for this analysis. We relied on their service groupings as the basis for making comparisons with the EHBs required to be covered by QHPs. The state-specific EHB requirements were reviewed to identify additional services considered to be relevant to children, to be included in the analysis. Once those additional benefits were

identified, web searches were performed to identify whether the state CHIP plans covered those benefits and with what limitations. Note that not all benefits were explicitly addressed in either the EHB summaries or the CHIP benefit summaries.

It is important to note that for states with multiple CHIP plan options offered by insurers, results may vary by plan. For purposes of this analysis, the most highly enrolled plan was utilized rather than reviewing the spectrum of services covered across all available plans.

Additionally, results shown for QHPs are based on the EHB summaries. Insurers may either substitute required EHBs, provide additional benefits, or have broader limits that are not reflected in this report.

Core Benefits

Table 14 provides a summary of the distribution of states reviewed that cover each of the defined core benefits with no limits, with limits, or do not cover the benefit at all in their CHIP plans and QHPs (based on required EHBs). Coverage details for each of these benefits by state can be found in Appendix B.

Table 14: Percentage of States Covering Core Benefits

Benefit Category	CHIP			QHPs (Based on EHB)		
	Covered - No Limits	Covered - Limits	Not Covered	Covered - No Limits	Covered - Limits	Not Covered
Average for All Core Benefits	**95%**	**5%**	**0%**	**96%**	**4%**	**0%**
Physician Services	97%	3%	0%	100%	0%	0%
Clinic Services & Other Ambulatory Health Care Services	97%	3%	0%	100%	0%	0%
Laboratory & Radiological Services	100%	0%	0%	97%	3%	0%
Durable Medical Equipment & Other Medically-Related or Remedial Devices	82%	18%	0%	71%	29%	0%
Inpatient Services	95%	5%	0%	100%	0%	0%
Inpatient Mental Health Services	95%	5%	0%	97%	3%	0%
Surgical Services	92%	8%	0%	100%	0%	0%
Outpatient Services	97%	3%	0%	100%	0%	0%
Outpatient Mental Health Services	95%	5%	0%	97%	3%	0%
Prescription Drugs	92%	8%	0%	100%	0%	0%
Emergency Medical Transport	100%	0%	0%	97%	3%	0%

Table 15 shows the proportion of core services that are covered with no limits, covered with limits, or not covered for each state. Most states reflect consistent coverage of core benefits in CHIP plans and in QHPs. We are including two CHIP plans for New Jersey, Oregon, and Wisconsin as those states have differing levels of coverage depending on the enrollee's household income level. The Wisconsin Benchmark plan is slated to transition into the Standard plan in 2014. North Dakota and Virginia indicate more limits utilized for core services than in other states.

Pennsylvania CHIP plans reflect limits for many services. Because the Pennsylvania Medicaid program accepts children with special health care needs at all income levels, children covered through CHIP tend to be healthier than those in other state CHIP plans. As a result, these limits are likely rarely met since the Medicaid program in Pennsylvania accepts children with special health care needs at all income levels. Excluding Pennsylvania from the results in the above table would increase the percent of states that cover core benefits in CHIP plans to 97%, with only 3% reflecting limits in total.

Table 15: Percentage of Core Services Covered by State

State	CHIP			QHPs (based on EHB)		
	Covered - No Limits	Covered - Limits	Not Covered	Covered - No Limits	Covered -Limits	Not Covered
Total All States	**95%**	**5%**	**0%**	**96%**	**4%**	**0%**
Total All States without PA*	***97%***	***3%***	***0%***	***96%***	***4%***	***0%***
Alabama	100%	0%	0%	100%	0%	0%
Colorado	91%	9%	0%	100%	0%	0%
Connecticut	100%	0%	0%	100%	0%	0%
Delaware	100%	0%	0%	100%	0%	0%
Florida	100%	0%	0%	100%	0%	0%
Georgia	100%	0%	0%	100%	0%	0%
Idaho	100%	0%	0%	100%	0%	0%
Illinois	100%	0%	0%	100%	0%	0%
Indiana	91%	9%	0%	100%	0%	0%
Iowa	100%	0%	0%	100%	0%	0%
Kansas	100%	0%	0%	91%	9%	0%
Kentucky	100%	0%	0%	100%	0%	0%
Louisiana	100%	0%	0%	100%	0%	0%
Maine	100%	0%	0%	100%	0%	0%
Massachusetts	100%	0%	0%	100%	0%	0%
Michigan	100%	0%	0%	100%	0%	0%
Mississippi	100%	0%	0%	100%	0%	0%
Missouri	100%	0%	0%	100%	0%	0%
Montana	91%	9%	0%	100%	0%	0%
Nevada	100%	0%	0%	91%	9%	0%
New Jersey (Plan C/Plan D)	100%/91%	0%/9%	0%/0%	100%	0%	0%

State	CHIP			QHPs (based on EHB)		
	Covered - No Limits	Covered - Limits	Not Covered	Covered - No Limits	Covered -Limits	Not Covered
New York	100%	0%	0%	91%	9%	0%
North Carolina	100%	0%	0%	100%	0%	0%
North Dakota	73%	27%	0%	91%	9%	0%
Oregon (Plan B/Plan C)	100%/100%	0%/0%	0%/0%	91%	9%	0%
Pennsylvania	27%	73%	0%	91%	9%	0%
South Dakota	100%	0%	0%	91%	9%	0%
Tennessee	100%	0%	0%	91%	9%	0%
Texas	91%	9%	0%	100%	0%	0%
Utah	100%	0%	0%	100%	0%	0%
Virginia	82%	18%	0%	73%	27%	0%
Washington	100%	0%	0%	100%	0%	0%
West Virginia	100%	0%	0%	100%	0%	0%
Wisconsin (Standard/Benchmark)	100%/82%	0%/18%	0%/0%	91%	9%	0%
Wyoming	82%	18%	0%	82%	18%	0%

*Pennsylvania reflects high number of limits on coverage in CHIP. Total is shown with and without PA for comparison.

Child-Specific Benefits

There is much more variation in the coverage of the child-specific benefits compared to core benefits. Table 16 shows the summary of the percentage of states that cover each of the child-specific benefits without limits, with limits, or not at all in their CHIP and QHPs (based on required EHBs). Coverage details for each of these benefits, by state, and including the imposed limits can be found in Appendix B. Although pediatric dental benefits are required EHBs, for the plans reviewed in 60% of the states in this analysis, pediatric dental coverage is not included and would need to be accessed by purchasing a stand-alone dental plan (SADP).

Table 16: Percent of States Covering Child-Specific Benefits across All States Reviewed

Benefit Category	CHIP			QHPs (based on EHB)		
	Covered - No Limits	Covered - Limits	Not Covered	Covered - No Limits	Covered - Limits	Not Covered
Total All States	56%	26%	18%	30%	22%	48%
Dental - Preventive & Restorative Services	79%	21%	0%	40%	0%	60%
Dental - Orthodontics	71%	24%	5%	31%	0%	69%
Vision - Exams	97%	3%	0%	97%	3%	0%
Vision - Corrective Lenses	63%	37%	0%	91%	6%	3%

Benefit Category	CHIP			QHPs (based on EHB)		
	Covered - No Limits	Covered - Limits	Not Covered	Covered - No Limits	Covered - Limits	Not Covered
Audiology - Exams	95%	5%	0%	37%	0%	63%
Audiology - Hearing Aids	39%	55%	5%	9%	46%	46%
Autism - General	66%	16%	18%	29%	49%	23%
ABA Therapy	26%	32%	42%	9%	49%	43%
Habilitation	63%	37%	0%	31%	69%	0%
Physical Therapy, Occupational Therapy, and Speech Therapy	58%	42%	0%	20%	80%	0%
Enabling Services	32%	0%	68%	0%	0%	100%
Medical Transportation - Non-Emergency Transport	29%	26%	45%	0%	0%	100%
Over-the-Counter Medications	29%	32%	39%	3%	0%	97%

CHIP plans include coverage of these child-specific services much more frequently than QHPs. For the services that are covered, QHPs also tend to include more limits on these services. Some services, such as enabling services and non-emergency transportation are exclusively covered under CHIP plans if covered at all. The following subsections describe key differences noted for some of the specific benefits. Detailed tables for each benefit with results for all states are included in Appendices A1-A14.

Dental Benefits

Two types of pediatric dental benefits were reviewed. Pediatric dental ups are required to be included in EHB, but may be excluded from coverage by a QHP if there are stand-alone dental options available in the state. Only 40% of QHPs we reviewed offered pediatric dental as an embedded benefit in the QHP. We focused on material limitation and coverage differences. We did not consider the standard one visit every 6-12 months as a material limitation. Some CHIP plans reflect the use of dollar limits.

For states with EHB benchmark plans that covered orthodontics, only medically necessary orthodontics are considered required EHBs. Because pediatric dental does not need to be covered by QHPs in states that offer a stand-alone dental plan through the Marketplace, orthodontics are not covered at all in 69% of the states' QHPs that we reviewed, either because it is covered through a stand-alone dental plan or it is not included in the EHB benchmark. Both CHIP and QHPs generally use the medically necessary requirement. The CHIP plans often define this as a handicapping malocclusion. The definition of medically necessary for QHPs is not clearly established and issuers may interpret them widely. We have not included the medically necessary condition as a limit to the orthodontic coverage since it is standardly used across both CHIP and QHPs. More states include coverage in CHIP, sometimes with additional dollar and condition limits.

Vision Benefits

Two types of vision benefits were reviewed. Pediatric vision exams are required to be included in their EHB, although Utah does indicate that the coverage starts at age 5. Only Alabama reflects a limit in CHIP plans, with a dollar limit for the vision exam. As with pediatric dental, we focused on material limitation and coverage differences. We did not consider the standard one visit every 12 months as a material limitation, and did not include those specifics.

Eyeglasses are included in all states' EHB with the exception of Massachusetts. All states' CHIP plans include the coverage for eyeglasses, although over a third include dollar limits.

Audiology Benefits

There is no requirement in the ACA that hearing exams be covered for children. As a result, 63% of states we reviewed did not include routine hearing exams in EHB. All CHIP plans reviewed covered hearing exams. Two states, New Jersey and Wisconsin, only offer them up to age 16 or 17, respectively, for enrollees in households with incomes over 200% FPL, although they are covered with no age limit at lower income levels. We have not included utilization limits such as one visit every 1-3 years as a material limitation since it is a standard limit.

Coverage of hearing aids is also very different between CHIP plans and QHPs. Almost half of states do not include hearing aid coverage as an EHB. Of those that do, the benchmark plan reflect a wide variety of limits on age (e.g. newborn only, up to age 12, up to age 17), dollar limits ($1000-$5000), limits on type (e.g. cochlear implants only) and utilization limits (e.g. one aid every 2-5 years). It is likely that the dollar limits would be converted to a different type of limit by the QHPs. For CHIP, all state CHIP plans except for Wyoming and the Wisconsin Benchmark plans cover hearing aids. More than half of the states that cover hearing aids in CHIP plans include either dollar or age limits. Again, there is significant variation in the limits, with dollar limits ranging from $750 to $3,000, and age limits up to age 8, 12, or 16.

General Autism Services and Applied Behavioral Analysis

Services for Autism Spectrum Disorders (ASD) are necessarily varied due to the unique nature of the condition in each individual. We have included a review of general autism services, which include many of the same therapies that are considered with Physical, Occupational, and Speech Therapies. We also focus on Applied Behavioral Analysis (ABA), which has specific application to ASD. ABA is a very intensive treatment pattern of regular and frequent therapy sessions.

We found that just under a quarter of the states did not note autism coverage specifically in their EHB, and almost half of the states do not explicitly include ABA coverage. The benchmark plans for EHB frequently included dollar and age limits for these services as well. The dollar limits often cover both the general autism coverage and ABA, if it is covered. Some states have explicitly identified equivalent utilization limits that can be used in lieu of the dollar limits. Other states leave it up to the QHPs to either set comparable utilization limits or otherwise remove the dollar limits on the services. Our

comparison shows the dollar limits that were in the EHB benchmark plans with the expectation that QHPs in these states will likely utilize comparable limits. Relative to QHPs, CHIP plans tended to utilize fewer limits on both the general autism services and ABA.

Habilitation Benefits

Habilitation benefits are those that are provided to develop skills that were not learned due to developmental or medical conditions. The ACA requires that habilitation services be included in EHB, although it does not specify the types of services that would need to be included. Defining what is considered a habilitative service is left up to the states or insurers, which leaves significant room for variation between states and QHPs. Because of this limitation, for states that did not define habilitation services to be included in the EHB benchmark plan, we are assuming that the habilitation services will be comparable to the Physical, Occupational, and Speech Therapy coverage and limitations. For both the CHIP and QHPs, all states cover habilitation. More than two thirds of the states included in our analysis reflect utilization limits in the QHPs compared to just over one third in CHIP plans. So enrollees in CHIP would be able to receive more services than those in QHPs.

Physical Therapy, Occupational Therapy, and Speech Therapy services show a similar pattern. Both CHIP and QHPs in all states cover these benefits. The difference is in the use of limits, with 80% of states reflecting utilization limits in QHPs for these services compared to only 42% of state CHIP plans.

Due to the close relationship between Physical, Occupational, and Speech Therapies and habilitation services, which often overlap with each other, limits often span all types of services. Many limits are also established by condition or type of therapy. It is important to understand the unique structure of each limit to understand how the limits may impact enrollees moving from CHIP to QHPs.

Other Child-Specific Benefits

Over the counter (OTC) medications can be expensive, yet are often the first line of treatment for many conditions. Only Iowa includes coverage of OTC in the list of EHB. CHIP plans in 60% of states reviewed cover OTC, though almost half include some sort of limits. Limitations most frequently include a specific list of drugs available, although Florida uses a dollar limit and Indiana only covers OTC insulin for diabetics. Colorado, Montana, and Pennsylvania identified that OTC was covered only if prescribed by a doctor. We do not consider OTC in these three states to be covered since a prescription is required.

Non-emergency transportation can be important to CHIP enrollees and can cover services to get the enrollees to office visits as well as transfers between facilities and home. Non-emergency transportation is not covered in any state's EHB. Over half of the CHIP plans in the states reviewed do cover non-emergency transportation, with about half of those imposing some limits. The limits used reflect age and income restrictions, specific medical conditions, and types of transportation.

Enabling services, such as translation and outreach, make it easier for enrollees to utilize the medical services covered in their health plans. None of the states included in this study included enabling services in their EHB. For CHIP plans, 32% of states include some type of enabling services to enrollees.

Routine podiatry services are covered in more than one third of states' EHB. Of these states that cover routine podiatry, only Mississippi, North Carolina, and Tennessee include limits to restrict services to individuals with diabetes. In CHIP plans, 76% of states cover routine podiatry, although half of these states also have a limitation indicating coverage is only for enrollees with diabetes or a similar condition.

RELIANCE AND LIMITATIONS

Wakely relied on the following sources to inform this report:

- Covered benefits and benefit limitations for CHIP from the May 2014 report "Benefits and Cost Sharing in Separate CHIP Programs" by the National Academy for State Health Policy (NASHP) and the Georgetown University Health Policy Institute Center for Children and Families
- Essential Health Benefit summaries available on the Center for Consumer Information and Insurance Oversight (CCIIO) website for covered benefits and limitations in QHPs, available at http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html
- QHP landscape files available at https://data.healthcare.gov/ to identify the lowest cost silver plans by county for states with a Federally-Facilitated Marketplace and links to benefit summaries
- Marketplace websites and other online sources for Summary of Benefits and Coverage and Plan Brochures to identify pediatric dental and vision cost sharing.
- Census data to identify total population by county, available at http://quickfacts.census.gov/qfd/download_data.html
- CHIP premium information from 2013 as reported in a Kaiser Family Foundation 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*, available at http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8401.pdf

Wakely would also like to acknowledge the following limitations of the analysis:

- The 2015 Federal Actuarial Value Calculator is not specific to the child population and is a high level tool that does not account for cost sharing on all covered benefits. It utilizes a standard population and is a useful tool for consistent comparisons between plans.
- Average annual cost sharing dollar amounts were calculated assuming a national average claims cost of $3,429 per child.
- We focused on individual level cost sharing for review of QHPs. Family deductibles and maximum out of pockets are generally twice the individual levels.
- Dental and vision cost sharing information for the cost sharing reduction plan variations were not always available. In these cases, standard silver cost sharing for individuals was assumed.
- Wakely was directed to focus on the impact to enrollees as measured in terms of cost sharing and benefit differences (both in services covered or limitations/exclusions on covered services) but not the premiums. The premium component may also be material and we recommend analyzing it at a future time to develop a complete picture of the cost differences.

Wakely reviewed data for reasonableness, but did not audit any data used. Any errors in the data may cause material errors in our analysis. This report is developed for purpose of comparing the estimated cost sharing and benefit coverage in CHIP plans to that enrollees would likely encounter if they enrolled in a QHP. The analysis and comparisons are made to highlight key differences between the plans. Other uses may be inappropriate. We relied on publicly available information on the 2014 CHIP plans and QHPs available in each state and information supplied by First Focus. Actual results will vary for a particular individual and average results for a particular state could vary materially from the estimates included in this report. We understand that the report will be provided to state regulators and other interested parties. When shared, the report must be shared in its entirety. Many of the concepts in this report are actuarial in nature and should be reviewed and interpreted by individuals with the appropriate background.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Aree Bly, Julia Lerche, and Karan Rustagi are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

APPENDICES

Coverage codes used in all appendices are as follows:

Code	Coverage
C	Covered
C, E	Covered and exclusions apply
U	Not covered
LQ	Limited by quantity, such as number of visits or days
L$	Limited by dollar amount
LA	Limited by age
LL	Limited to a list of approved drugs or specified services
LC	Limited by condition or diagnosis

APPENDIX A: CHILD-SPECIFIC BENEFIT COVERAGE BY STATE

Appendix A1: Dental Preventive and Restorative Services

Appendix A2: Orthodontics

Appendix A3: Vision Exams

Appendix A4: Eyeglasses

Appendix A5: Audiology Exams

Appendix A6: Hearing Aids

Appendix A7: Autism

Appendix A8: Applied Behavioral Analysis

Appendix A9: Habilitation

Appendix A10: PT/OT/ST

Appendix A11: Over-the-counter Medicine

Appendix A12: Non-Emergency Transportation

Appendix A13: Enabling Services

Appendix A14: Podiatry

Dental Benefits

Table A1: Dental Preventive and Restorative Services Coverage and Limits by State

State	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
Alabama	C		C	
Colorado	L$	$600	C	
Connecticut	C		C	
Delaware	C		C	
Florida	C		U	Covered in SADP
Georgia	C		U	Covered in SADP
Idaho	C		C	
Illinois	C		U	Covered in SADP
Indiana	C		U	Covered in SADP
Iowa	C		U	Covered in SADP
Kansas	C		U	Covered in SADP
Kentucky	C		C	
Louisiana	C		C	
Maine	C		U	Covered in SADP
Massachusetts	C		U	Covered in SADP
Michigan	C		U	Covered in SADP
Mississippi	L$	Limited to $1,500/calendar year except for accidental injury	U	Covered in SADP
Missouri	C		U	Covered in SADP
Montana	C		U	Covered in SADP
Nevada	C		U	Covered in SADP
New Jersey (Plan C)	C		U	Covered in SADP
New Jersey (Plan D)	C		U	Covered in SADP
New York	C		C	
North Carolina	C		C	
North Dakota	C		C	
Oregon (Plan B)	C		U	Covered in SADP
Oregon (Plan C)	L$	$1,750/year	U	Covered in SADP
Pennsylvania	L$	$1,500/year	C	
South Dakota	C		U	Covered in SADP
Tennessee	L$	$1,000/year	C	
Texas	C		U	Covered in SADP
Utah	L$, E	$1,000/plan year; some service exclusions	U	Covered in SADP
Virginia	C		U	Covered in SADP
Washington	C		U	Covered in SADP
West Virginia	C		C	

State	CHIP Coverage	Limits	EHB Coverage	Limits
Wisconsin (Standard)	C		U	Covered in SADP
Wisconsin (Benchmark)	L$	$750/plan year; $200 deductible (preventive and diagnostic exempt) if >200% FPL	U	Covered in SADP
Wyoming	C, E	Excludes synthetic restorations on posterior teeth	C	

Table A2: Orthodontics Coverage and Limits by State

State	CHIP Coverage	Limits	EHB Coverage	Limits
Alabama	LC	Limited to certain conditions	C	
Colorado	U		U	
Connecticut	L$	$725/member (per lifetime)	U	
Delaware	C		C	
Florida	C		U	Covered in SADP
Georgia	C		U	Covered in SADP
Idaho	C		C	
Illinois	C		U	Covered in SADP
Indiana	C		U	Covered in SADP
Iowa	C		U	Covered in SADP
Kansas	C		U	Covered in SADP
Kentucky	LC	Only to correct disabling condition or for transitional or permanent dentition	U	
Louisiana	C		C	
Maine	C		U	
Massachusetts	C		U	
Michigan	C		U	
Mississippi	LC	Only covers accidental injury	U	Covered in SADP
Missouri	C		U	Covered in SADP
Montana	U		U	Covered in SADP
Nevada	C		U	Covered in SADP
New Jersey (Plan C)	C		U	Covered in SADP
New Jersey (Plan D)	C		U	Covered in SADP
New York	C		C	
North Carolina	C		C	
North Dakota	C		C	
Oregon (Plan B)	LC	Only for treatment of cleft	U	Covered in SADP

State	CHIP Coverage	Limits	EHB Coverage	Limits
		palate		
Oregon (Plan C)	LC	Only for treatment of cleft palate	U	Covered in SADP
Pennsylvania	L$	$5,200/lifetime	C	
South Dakota	C		U	Covered in SADP
Tennessee	L$	$1,250/lifetime (not subject to dental limit)	C	
Texas	C		U	Covered in SADP
Utah	C		U	
Virginia	C		U	Covered in SADP
Washington	C		U	Covered in SADP
West Virginia	C		C	
Wisconsin (Standard)	C		U	Covered in SADP
Wisconsin (Benchmark)	L$	$750/plan year; $200 deductible (preventive and diagnostic exempt) if >200% FPL	U	Covered in SADP
Wyoming	C		C	

Vision Benefits

Table A3: Vision Exam Coverage and Limits by State

State	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
Alabama	L$	$48 for new patient, $37 for established patient	C	
Colorado	C		C	
Connecticut	C		C	
Delaware	C		C	
Florida	C		C	
Georgia	C		C	
Idaho	C		C	
Illinois	C		C	
Indiana	C		C	
Iowa	C		C	
Kansas	C		C	
Kentucky	C		C	
Louisiana	C		C	
Maine	C		C	
Massachusetts	C		C	
Michigan	C		C	
Mississippi	C		C	
Missouri	C		C	
Montana	C		C	
Nevada	C		C	
New Jersey (Plan C)	C		C	
New Jersey (Plan D)	C		C	
New York	C		C	
North Carolina	C		C	
North Dakota	C		C	
Oregon (Plan B)	C		C	
Oregon (Plan C)	C		C	
Pennsylvania	C		C	
South Dakota	C		C	
Tennessee	C		C	
Texas	C		C	
Utah	C		LA	age 5-18
Virginia	C		C	
Washington	C		C	
West Virginia	C		C	
Wisconsin (Standard)	C		C	

State	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
Wisconsin (Benchmark)	C		C	
Wyoming	C		C	

Table A4: Corrective Lenses Coverage and Limits by State

State	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
Alabama	L$	$180-$250	C	
Colorado	L$	$50/year	C	
Connecticut	L$	up to $100	C	
Delaware	C		C	
Florida	C		C	
Georgia	C		C	
Idaho	C		C	
Illinois	C		C	
Indiana	L$	maximum of $20 for frames	C	
Iowa	L$	$100/year for one set of eyewear	C	
Kansas	C		C	
Kentucky	L$	$400/12 months	C	
Louisiana	C		C	
Maine	C		C	
Massachusetts	C		U	
Michigan	C		C	
Mississippi	C		C	
Missouri	C		C	
Montana	C, E	contact lenses not covered	C	
Nevada	C		C	
New Jersey (Plan C)	C		C	
New Jersey (Plan D)	C		C	
New York	C		C	
North Carolina	C		C	
North Dakota	L$	$80 limit	C	
Oregon (Plan B)	C		C	
Oregon (Plan C)	L$	$96 for single vision lenses and $96 for frames	C	
Pennsylvania	L$	Monetary cap set by insurer	C	
South Dakota	C		C	
Tennessee	L$	$85 for lenses/year; $100 for frames every 2 years; $150 for contact lenses/year	C	
Texas	C		C	

State	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
Utah	C		LA	age 5-18
Virginia	L$	Limited by dollar amount depending on lens type	C	
Washington	C		L$	$150 hardware/year
West Virginia	L$	$125/year for frames and lenses	C	
Wisconsin (Standard)	C		C	
Wisconsin (Benchmark)	C		C	
Wyoming	L$	up to $100	C	

Audiology Benefits

Table A5: Hearing Exam Coverage and Limits by State

State	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
Alabama	C		U	
Colorado	C		C	
Connecticut	C		U	
Delaware	C		C	
Florida	C		U	
Georgia	C		U	
Idaho	C		U	
Illinois	C		U	
Indiana	C		U	
Iowa	C		C	
Kansas	C		U	
Kentucky	C		C	
Louisiana	C		U	
Maine	C		U	
Massachusetts	C		U	
Michigan	C		U	
Mississippi	C		C	
Missouri	C		C	
Montana	C		U	
Nevada	C		C	
New Jersey (Plan C)	C		C	
New Jersey (Plan D)	LA	Audiology services covered for members under 16	C	
New York	C		U	
North Carolina	C		C	
North Dakota	C		U	
Oregon (Plan B)	C		U	
Oregon (Plan C)	C		U	
Pennsylvania	C		U	
South Dakota	C		U	
Tennessee	C		C	
Texas	C		C	
Utah	C		U	
Virginia	C		U	
Washington	C		U	
West Virginia	C		C	
Wisconsin (Standard)	C		U	

State	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
Wisconsin (Benchmark)	LA	Age 0-17 if > 200% FPL	U	
Wyoming	C		C	

Table A6: Hearing Aid Coverage and Limits by State

State	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
Alabama	L$, LQ	$750 per ear/2 years	U	
Colorado	C		C	
Connecticut	L$, LA	$1,000/2 years (age 0-12)	LA	Age 0-12
Delaware	C		L$, LQ	$1,000 per ear/3 years (per individual hearing aid)
Florida	LQ	1 per ear/3 years (age 1-4) Covered (age 5-18)	U	
Georgia	LQ	1/3 years	U	
Idaho	C		U	
Illinois	C		C	
Indiana	C		U	
Iowa	LQ	1 per ear/36 months	U	
Kansas	LQ	1/4 years	U	
Kentucky	L$, LQ	$800 per ear/36 months	LQ	1/36 months
Louisiana	C		LA, LQ	1 per ear/36 months (age 0-17)
Maine	C		LQ	1/3 years
Massachusetts	C		C	
Michigan	LQ	Hearing aid supplies payable once every 36 months	U	
Mississippi	LQ	1 per ear/3 years	U	
Missouri	LQ	2/4 years	LA	newborns only
Montana	LQ	1/5 years	U	
Nevada	C		L$	$5,000/year (per member)
New Jersey (Plan C)	C		LQ	1 per ear/24 months
New Jersey (Plan D)	LA	Hearing aids covered for members under 16	LQ	1 per ear/24 months
New York	LQ	1 unless medically necessary	L$	$1,500/year, limited to a single purchase (including repair/replacement) every 3 years
North Carolina	LA	Age 0-8	L$, LQ	$2,500 per ear/36 months and 1 hearing

State	CHIP Coverage	Limits	EHB Coverage	Limits
				aid per ear/36 months
North Dakota	L$, LQ	$3,000/3 years (per child)	L$	$1,500/year. Limited to a single purchase (including repair/replacement) every 3 years
Oregon (Plan B)	LQ	1/3 years for lower income group	L$	$4,000/2 years
Oregon (Plan C)	C		L$	$4,000/2 years
Pennsylvania	L$, LQ	1 per ear/2 years; certain monetary cap based on insurer	U	
South Dakota	C		U	
Tennessee	LQ	1 per ear/year (age 0-5) 1 per ear/2 years (age 5+)	L$	$1,000/year every 3 years
Texas	C		L$, LQ	$1,000/36 months
Utah	C, E	Only cochlear implants covered, not hearing aids	U	
Virginia	LQ	2/5 years	U	
Washington	C		C, E	Cochlear implants only covered type of hearing aid
West Virginia	C		U	
Wisconsin (Standard)	C, E	Only for < 200% FPL	LQ	1 per ear/3 years
Wisconsin (Benchmark)	U		LQ	1 per ear/3 years
Wyoming	U		U	

Autism and ABA

Table A7: Autism – General Services Coverage and Limits by State

State	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
Alabama	C		C	
Colorado	C		LQ	550 sessions (age 0-8) 185 sessions (age 9-19) (25-minute session increments)
Connecticut	C		L$, LA	$50,000/year (age 0-9) $35,000/year (age 9-13) $25,000/year (age 13-15)
Delaware	U		L$	$36,000
Florida	C		L$	$36,000/year, $200,000/lifetime
Georgia	C		C	
Idaho	U		U	
Illinois	L$	2012 limit was ~$40,000	L$	$36,000/year
Indiana	C		C	
Iowa	L$	$36,000/year	L$	$36,000
Kansas	C		L$	$36,000/year (age 0-6) $27,000/year (age 7-19)
Kentucky	L$	$12,000-$15,000, varies by age	L$, LA	For large group plans and SEHP: $50,000/year (age 0-6) $1,000/month (age 7-21) For individual and small group plans: $1,000/month
Louisiana	C		L$	$36,000
Maine	C		L$, LA	$36,000/year (age 0-5)
Massachusetts	C		C	
Michigan	C		L$	$50,000 (age 0-6) $40,000 (age 7-12) $30,000 (age 13-18)
Mississippi	C		U	
Missouri	L$, LA	Age 3-18, $22,000/year, limits participation to 150	C	
Montana	L$, LQ	Limits on enrollment, age 1-4,	L$	$50,000/year (age 0-8)

State	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
		20-25 hours/week, $45,000/year		$20,000/year (age 9-18)
Nevada	U		L$	$36,000/year
New Jersey (Plan C)	C		C	
New Jersey (Plan D)	C		C	
New York	C		C	
North Carolina	C		U	
North Dakota	U		U	
Oregon (Plan B)	C		C	
Oregon (Plan C)	C		C	
Pennsylvania	L$	$36,000/year (per member)	L$	$36,000/year
South Dakota	U		U	
Tennessee	U		U	
Texas	C		C	
Utah	U		LA	Age 2-10
Virginia	C		LA	Age 2-6
Washington	C		U	
West Virginia	C		LA	Age 18 months to 18 years
Wisconsin (Standard)	C		C	
Wisconsin (Benchmark)	C		C	
Wyoming	C		U	

Table A8: ABA Therapy Coverage and Limits by State

State	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
Alabama	L$	$36,000/year	U	
Colorado	U		LQ	550 sessions (age 0-8) 185 sessions (age 9-19) (25-minute session increments)
Connecticut	L$	$50,000/year (age 0-9) $35,000/year (age 9-13) $25,000/year (age 13-15) The policy may not impose limits on the number of visits to an autism services provider.	L$, LA	state req; limits vary by insurer; was $50,000 (age 0-8), $35,000 (age 9-12), $25,000 (age 13-14)
Delaware	U		L$	$36,000
Florida	C		U	
Georgia	U		U	
Idaho	U		U	
Illinois	L$	2012 limit was ~$40,000	L$	$36,000
Indiana	U		C	
Iowa	U		L$	$36,000
Kansas	L$	$36,000/year (age 0-7) $27,000/year (age 7-19)	U	
Kentucky	C		L$	$12,000
Louisiana	C		L$	$36,000
Maine	C		L$	$36,000/year
Massachusetts	C		C	
Michigan	LA	Age 18 months-5 years	L$	$50,000 (age 0-6) $40,000 (age 7-12) $30,000 (age 13-18)
Mississippi	C		U	
Missouri	L$	Age 3-18, $22,000/year, limits participation to 150	L$	$40,000/benefit period
Montana	L$, LQ	Limits on enrollment, age 1-4, 20-25 hours/week, $45,000/year	L$	$50,000/benefit period (age 0-8) $20,000/benefit period (age 9-18)
Nevada	U		L$	$36,000/year
New Jersey (Plan C)	U		LQ	$36,000 now set at standardized utilization limit
New Jersey (Plan D)	U		LQ	$36,000 now set at

State	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
				standardized utilization limit
New York	C, E	Varies by plan	LQ	680 visits/year
North Carolina	U		U	
North Dakota	U		U	
Oregon (Plan B)	LQ	25 hours/week	LQ	25 hours/week
Oregon (Plan C)	LQ	25 hours/week	LQ	25 hours/week
Pennsylvania	C		U	
South Dakota	U		U	
Tennessee	U		U	
Texas	U		LQ	varies by issuer; do not count toward rehab/hab limits
Utah	U		U	
Virginia	L$	$35,000/year (Insurer may elect to provide coverage in a greater amount)	U	
Washington	C		U	
West Virginia	L$	$30,000/year for the first 3 years and $2,000/month after 3 years	L$	$30,000/year for the first 3 years and $2,000/month after 3 years
Wisconsin (Standard)	C		C	
Wisconsin (Benchmark)	C		C	
Wyoming	U		U	

Habilitation Benefits

Table A9: Habilitation Services Coverage and Limits by State

State	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
Alabama	C		LQ	30 visits/year (combined, all therapies)
Colorado	C		LQ	20 visits/year (per type of therapy)
Connecticut	LQ	60 days (combined, all therapies); supplemental coverage may be available	LQ	40 visits/year (combined, all therapies)
Delaware	C		LQ	30 visits/year (per type of therapy)
Florida	C		LQ	35 visits/year
Georgia	C		C	
Idaho	C		LQ	20 visits/year (combined, all therapies)
Illinois	C		C, E	educational is excluded
Indiana	LQ	50 visits/year (per type of therapy)	C	
Iowa	LQ, E, LC	60 days/year (per disability); OT exclusions and ST conditions	C, E	Any habilitation not related to developmental delay is not covered.
Kansas	C		C	
Kentucky	C		LQ	20 visits/year (per type)
Louisiana	C		C	
Maine	C		LQ	60 visits/year limit applies to PT/OT/SLP combined and combined between rehab/hab
Massachusetts	C, E	Day habilitation services are not covered	LQ	60 visit/year limit applies to PT/OT/SLP combined and combined between rehab/hab
Michigan	C		LQ	30 visits/year
Mississippi	C, E	Maintenance speech, delayed language development, or	C	

State	CHIP Coverage	Limits	EHB Coverage	Limits
		articulation disorders excluded		
Missouri	C		LQ	20 visits/year
Montana	C		C	
Nevada	C		LQ	60 visits/year
New Jersey (Plan C)	LQ	60 visits/calendar year (per type of therapy and incident)	LQ	30 visits/year
New Jersey (Plan D)	LQ	60 visits/calendar year (per type of therapy and incident)	LQ	30 visits/year
New York	C		LQ	60 visits/year
North Carolina	C		LQ	30 visits/year
North Dakota	LC	No maintenance care for PT/OT/ST; need of OT services reviewed after 90 days	LQ	60 visits/condition
Oregon (Plan B)	C		LQ	30 visits/year
Oregon (Plan C)	LQ	60 visits/year	LQ	30 visits/year
Pennsylvania	LQ	60 visits/year (per type of therapy)	LQ	30 visits/year
South Dakota	C		C	
Tennessee	LQ, LC	52 visits/year (per condition); no maintenance care	C	
Texas	C		C	
Utah	LQ, E	20 visits/year (combined, all therapies); ST for developmental delays not covered	LQ	20 visits/year (combined, all therapies)
Virginia	C		C	
Washington	C		C	
West Virginia	C		LQ	30 visit PT, 30 visit OT combined
Wisconsin (Standard)	C		LQ	20 visits/year
Wisconsin (Benchmark)	LQ	20 visits/year (per type of therapy) if >200% FPL	LQ	20 visits/year
Wyoming	L$	$750 maximum benefit per year for non-rehab services	LQ	PT: 40 visits/year, ST: 20 visits/year

Table A10: Physical, Occupational, and Speech Therapies Coverage and Limits by State

State	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
Alabama	C		LQ	30 visits/year (combined, all therapies)
Colorado	LQ	No limit (age 0-3) 30 visits/year (per diagnosis, age 3+)	LQ	20 visits/year (per type of therapy)
Connecticut	LQ	60 days (combined, all therapies); supplemental coverage may be available	LQ	40 visits/year (combined, all therapies)
Delaware	C		LQ	30 visits/year (per type of therapy)
Florida	LQ, LA	Covered (age 1-4) 24 sessions/60 day period; short term rehab only (age 5-18)	LQ	35 visits/year
Georgia	C		LQ	OT/PT combined: 20 visits/year, ST: 20 visits/year
Idaho	C		LQ	20 visits/year (combined, all therapies)
Illinois	C		C	
Indiana	LQ	50 visits/year (per type of therapy)	LQ	20 visits/year (per type of therapy)
Iowa	LQ, E, LC	60 days/year (per disability); OT exclusions and ST conditions	C	
Kansas	C		C	
Kentucky	C		LQ	20 visits/year (per type)
Louisiana	C		C	
Maine	C		LQ	60 visits/year (combined, all therapies)
Massachusetts	C, E	Day habilitation services are not covered	LQ	60 visits/year
Michigan	C		LQ	30 visits/year (all rehab combined)
Mississippi	C, E	Maintenance speech, delayed language development, or articulation disorders	LQ	20 visits/year (PT and OT combined limit, ST separate limit)

State	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
		excluded		
Missouri	C		LQ	20 visits/year
Montana	C		C	
Nevada	C		LQ	60 visits/year
New Jersey (Plan C)	LQ	60 visits/calendar year (per type of therapy and incident)	LQ	30 visits/year
New Jersey (Plan D)	LQ	60 visits/calendar year (per type of therapy and incident)	LQ	30 visits/year
New York	C		LQ	60 visits/condition
North Carolina	C		LQ	30 visits/year
North Dakota	LC	No maintenance care for PT/OT/ST; need of OT services reviewed after 90 days	LQ	60 visits/condition
Oregon (Plan B)	C		LQ	30 visits/year
Oregon (Plan C)	LQ	60 visits/year	LQ	30 visits/year
Pennsylvania	LQ	60 visits/year (per type of therapy)	LQ	30 visits/year
South Dakota	C		C	
Tennessee	LQ, LC	52 visits/year (per condition); no maintenance care	LQ	20 visits/year
Texas	C		LQ	35 visits/year
Utah	LQ, E	20 visits/year (combined, all therapies); ST for developmental delays not covered	LQ	20 visits/year (combined, all therapies)
Virginia	C		LQ	30 visits/year
Washington	C		LQ	25 visits/year
West Virginia	C		C	
Wisconsin (Standard)	C		LQ	20 visits/year
Wisconsin (Benchmark)	LQ	20 visits/year (per type of therapy) if >200% FPL	LQ	20 visits/year
Wyoming	L$	$750/year for non-rehabilitative services	LQ	PT: 40 visits/year, ST: 20 visits/year

Other Child-Specific Benefits

Table A11: Over-the-Counter Medications Coverage and Limits by State

State	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
Alabama	U		U	
Colorado	U		U	
Connecticut	LC	For HUSKY Plus Physical	U	
Delaware	LL	Limited to certain drug categories	U	
Florida	L$, LA	$180/year (age 5-18)	U	
Georgia	LL, L$	Certain non-prescription drugs are covered up to an allowable cost	U	
Idaho	C		U	
Illinois	LL	Limited to list of drug types	U	
Indiana	LC	Coverage only applies to insulin	U	
Iowa	U		C	
Kansas	C		U	
Kentucky	U		U	
Louisiana	U		U	
Maine	LL	A list of covered OTC drugs	U	
Massachusetts	C		U	
Michigan	U		U	
Mississippi	U		U	
Missouri	C		U	
Montana	U		U	
Nevada	C		U	
New Jersey (Plan C)	C		U	
New Jersey (Plan D)	U		U	
New York	C		U	
North Carolina	C		U	
North Dakota	U		U	
Oregon (Plan B)	C		U	
Oregon (Plan C)	C		U	
Pennsylvania	U		U	
South Dakota	LL	Limited list of OTC medications	U	
Tennessee	U		U	
Texas	U		U	
Utah	C		U	
Virginia	U		U	

State	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
Washington	LL	Limited to a list of covered drugs	U	
West Virginia	LL	Permitted in some therapeutic classes	U	
Wisconsin (Standard)	LL	Limited generic OTC formulary	U	
Wisconsin (Benchmark)	LL	Limited generic OTC formulary	U	
Wyoming	U		U	

Table A12: Non-Emergency Transportation Coverage and Limits by State

State	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
Alabama	LC	Only for ALLKids Plus	U	
Colorado	U		U	
Connecticut	LC	Some services for HUSKY Plus Physical	U	
Delaware	U		U	
Florida	LA	Age 1-4	U	
Georgia	U		U	
Idaho	C		U	
Illinois	C, E	Provided to children with income up to 200% FPL	U	
Indiana	LC	Ambulance service for non-emergencies between medical facilities is covered when requested by a participating physician	U	
Iowa	LC	When medically necessary and ordered by a participating provider, coverage for ambulance services to a hospital, between hospitals, and between a hospital and a nursing facility	U	
Kansas	C		U	
Kentucky	U		U	
Louisiana	C		U	
Maine	C		U	
Massachusetts	U		U	
Michigan	LC	Ambulance services include transport to or from a hospital, skilled nursing facility or member's home	U	
Mississippi	U		U	
Missouri	U		U	
Montana	C		U	
Nevada	U		U	
New Jersey (Plan C)	C		U	
New Jersey (Plan D)	U		U	
New York	U		U	
North Carolina	U		U	

State	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
North Dakota	LC	Transport between hospitals and skilled nursing facilities	U	
Oregon (Plan B)	C		U	
Oregon (Plan C)	U		U	
Pennsylvania	U		U	
South Dakota	C		U	
Tennessee	U		U	
Texas	U		U	
Utah	U		U	
Virginia	LC	Available if necessary due to medical condition	U	
Washington	C		U	
West Virginia	LC	Ground or air ambulance transportation, when medically necessary, to the nearest facility able to provide necessary treatment	U	
Wisconsin (Standard)	C		U	
Wisconsin (Benchmark)	C		U	
Wyoming	U		U	

Table A13: Enabling Services Coverage and Limits by State

State	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
Alabama	C		U	
Colorado	U		U	
Connecticut	C		U	
Delaware	U		U	
Florida	U		U	
Georgia	U		U	
Idaho	C		U	
Illinois	C		U	
Indiana	U		U	
Iowa	U		U	
Kansas	C		U	
Kentucky	C		U	
Louisiana	U		U	
Maine	C		U	
Massachusetts	U		U	
Michigan	U		U	
Mississippi	U		U	
Missouri	U		U	
Montana	U		U	
Nevada	C		U	
New Jersey (Plan C)	U		U	
New Jersey (Plan D)	U		U	
New York	U		U	
North Carolina	U		U	
North Dakota	U		U	
Oregon (Plan B)	C		U	
Oregon (Plan C)	U		U	
Pennsylvania	U		U	
South Dakota	U		U	
Tennessee	U		U	
Texas	U		U	
Utah	U		U	
Virginia	U		U	
Washington	C		U	
West Virginia	U		U	
Wisconsin (Standard)	C		U	
Wisconsin (Benchmark)	C		U	
Wyoming	U		U	

Table A14: Podiatry Coverage and Limits by State

State	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
Alabama	U		U	
Colorado	LC	Routine foot care not covered except for patients with diabetes	U	
Connecticut	LC	Routine foot care not covered unless have systemic condition	U	
Delaware	LC	Routine foot care only for individuals with diabetes or circulatory/vascular disorder	U	
Florida	LQ	Covered (age 1-4) 1 visit/day, totaling 2 visits/month (age 5-18)	C	
Georgia	C		U	
Idaho	LC	Limited to treatment for chronic disease related care	U	
Illinois	C		C	
Indiana	LQ	Routine foot care visits limited to 6/year	U	
Iowa	LC	Foot care for members with diabetes	U	
Kansas	C		C	
Kentucky	C		U	
Louisiana	C		U	
Maine	C		U	
Massachusetts	C		C	
Michigan	C		U	
Mississippi	C		LQ, LC	1 visit/year if have diabetes
Missouri	C		U	
Montana	U		U	
Nevada	C		U	
New Jersey (Plan C)	U		U	
New Jersey (Plan D)	U		U	
New York	U		U	
North Carolina	U		LQ	only for those diagnosed with diabetes
North Dakota	LC	For children with diabetes or circulatory disorders of the	C	

State	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
		legs and feet		
Oregon (Plan B)	LC	Coverage for certain conditions	C	
Oregon (Plan C)	LC	Routine foot care only for individuals with diabetes	C	
Pennsylvania	LC	Foot care only related to diabetes	U	
South Dakota	U		U	
Tennessee	LC	Only if necessary to prevent complications of existing disease state	C, E	Routine foot care for the treatment of certain conditions, and as required by law for diabetic patients.
Texas	LC	Only for injury treatment or diabetes	C	
Utah	C		C	
Virginia	U		C	
Washington	C		C	
West Virginia	C, E	Routine foot care only for medically necessary services for diabetics	U	
Wisconsin (Standard)	C		U	
Wisconsin (Benchmark)	C		U	
Wyoming	U		U	

APPENDIX B: STATE-SPECIFIC RESULTS

This appendix provides detailed comparisons of covered benefits, average cost sharing, and cost sharing for pediatric vision and dental benefits by state. These should be reviewed within the context of this report, with an understanding of the methodologies, data sources and limitations of the analysis.

ALABAMA

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	160% FPL		210% FPL	
Coverage	**CHIP**	**QHP**	**CHIP**	**QHP**
Actuarial Value	97.2%	86%-88%	91.8%	72%-74%
Enrollee Average Percent of Allowed Claims	2.8%	12%-14%	8.2%	26%-28%
Average Annual Cost Sharing	$97	$411 - $480	$281	$891 - $960

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	% income	$846	$1,891
QHP	fixed dollar	$1,000-$2,000	$3,500-$5,000

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No copay	20% coinsurance after deductible	No copay	20% coinsurance after deductible
Eyeglasses Cost Sharing	No copay; $180 - $250 depending on glasses	20% coinsurance after deductible	No copay; $180 - $250 depending on glasses	20% coinsurance after deductible
Dental Checkup Cost Sharing	No copay	No copay	No copay	No copay

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	100%	0%	0%
Child-Specific	14	43%	43%	14%	36%	14%	50%

The following table shows the coverage and limits for the core benefits.

Service	CHIP Coverage	CHIP Limits	EHB Coverage	EHB Limits
Physician Services	C		C	
Clinic & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	CHIP Limits	EHB Coverage	EHB Limits
Dental - Preventive & Restorative Services	C		C	
Dental – Orthodontics	LC	Limited to certain conditions	C	
Vision – Exams	L$	$48 for new patient, $37 for established patient	C	
Vision - Corrective Lenses	L$	$180-$250	C	
Audiology – Exams	C		U	
Audiology - Hearing Aids	L$, LQ	$750 per ear/2 years	U	
ABA Therapy	L$	$36,000/year	U	
Autism – General	C		C	
Physical Therapy, Occupational Therapy, and Speech Therapy	C		LQ	30 visits/year (combined, all therapies)
Podiatry	U		U	

Habilitation	C		LQ	30 visits/year (combined, all therapies)
Enabling Services	C		U	
Medical Transportation - Non-Emergency Transport	LC	Only for ALLKids Plus	U	
Over-the-Counter Medications	U		U	

COLORADO

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	160% FPL		210% FPL	
Coverage	CHIP	QHP	CHIP	QHP
Actuarial Value	97.4%	86%-88%	95.3%	72%-74%
Enrollee Average Percent of Allowed Claims	2.6%	12%-14%	4.7%	26%-28%
Average Annual Cost Sharing	$90	$411 - $480	$161	$891 - $960

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	% of income	$925	$1,970
QHP	fixed dollar	$1,450	$4,750

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	$5 copay	50% after deductible	$10 copay	50% after deductible
Eyeglasses Cost Sharing	No copay: $50-$150	50% after deductible	No copay: $50-$150	50% after deductible
Dental Checkup Cost Sharing	No copay	50% after deductible	No copay	50% after deductible

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

Type of Benefit	Total Benefits	CHIP			QHPs (Based on EHB)		
		Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	91%	9%	0%	91%	9%	0%
Child-Specific	14	36%	29%	36%	36%	29%	36%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	L$	Certain items subject to $2,000 annual limit	C	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	L$	$600	C	
Dental - Orthodontics	U		U	
Vision - Exams	C		C	
Vision - Corrective Lenses	L$	$50/year	C	
Audiology - Exams	C		C	
Audiology - Hearing Aids	C		C	
ABA Therapy	U		LQ	550 sessions (age 0-8) 185 sessions (age 9-19) (25-minute session increments)
Autism - General	C		LQ	550 sessions (age 0-8) 185 sessions (age 9-19) (25-minute session increments)
Physical Therapy, Occupational Therapy, and Speech Therapy	LQ	No limit (age 0-3) 30 visits/year (per diagnosis, age 3+)	LQ	20 visits/year (per type of therapy)
Podiatry	LC	Routine foot care not covered except for patients	U	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
		with diabetes		
Habilitation	C		LQ	20 visits/year (per type of therapy)
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	U		U	
Over-the-Counter Medications	U		U	

CONNECTICUT

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	160% FPL		210% FPL	
Coverage	CHIP	QHP	CHIP	QHP
Actuarial Value	No CHIP Plan		97.8%	72%-74%
Enrollee Average Percent of Allowed Claims			2.2%	26%-28%
Average Annual Cost Sharing			$77	$891 - $960

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	% of income	No CHIP Plan	$1,995
QHP	fixed dollar		$5,000

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No CHIP Plan		$15 copay	$30 copay
Eyeglasses Cost Sharing			No copay: $100	No copay
Dental Checkup Cost Sharing			No copay	No copay

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	100%	0%	0%
Child-Specific	14	36%	64%	0%	21%	36%	43%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	

Medical Transportation - Emergency Transport	C	C

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	CHIP Limits	EHB Coverage	EHB Limits
Dental - Preventive & Restorative Services	C		C	
Dental – Orthodontics	L$	$725/member (per lifetime)	U	
Vision – Exams	C		C	
Vision - Corrective Lenses	L$	up to $100	C	
Audiology – Exams	C		U	
Audiology - Hearing Aids	L$, LA	$1,000/2 years (age 0-12)	LA	Age 0-12
ABA Therapy	L$	$50,000/year (age 0-9) $35,000/year (age 9-13) $25,000/year (age 13-15) The policy may not impose limits on the number of visits to an autism services provider.	L$, LA	state req; limits vary by insurer; was $50,000 (age 0-8), $35,000 (age 9-12), $25,000 (age 13-14)
Autism – General	C		L$, LA	$50,000/year (age 0-9) $35,000/year (age 9-13) $25,000/year (age 13-15)
Physical Therapy, Occupational Therapy, and Speech Therapy	LQ	60 days (combined, all therapies); supplemental coverage may be available	LQ	40 visits/year (combined, all therapies)
Podiatry	LC	Routine foot care not covered unless have systemic condition	U	
Habilitation	LQ	60 days (combined, all therapies); supplemental coverage may be available	LQ	40 visits/year (combined, all therapies)
Enabling Services	C		U	
Medical Transportation - Non-Emergency Transport	LC	Some services for HUSKY Plus Physical	U	
Over-the-Counter Medications	LC	For HUSKY Plus Physical	U	

DELAWARE

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	160% FPL		210% FPL	
Coverage	CHIP	QHP	CHIP	QHP
Actuarial Value	100.0%	86%-88%	No CHIP Plan	
Enrollee Average Percent of Allowed Claims	0.0%	12%-14%		
Average Annual Cost Sharing	$0	$411 - $480		

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	No Cost Sharing	$0	No CHIP Plan
QHP	fixed dollar	$1,100-$2,250	

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No copay	No copay	No CHIP Plan	
Eyeglasses Cost Sharing	No Copay: $100	No copay		
Dental Checkup Cost Sharing	No copay	No copay		

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	100%	0%	0%
Child-Specific	14	57%	14%	29%	36%	36%	29%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Surgical Services	C		C	
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	C		C	
Dental - Orthodontics	C		C	
Vision - Exams	C		C	
Vision - Corrective Lenses	C		C	
Audiology - Exams	C		C	
Audiology - Hearing Aids	C		L$, LQ	$1,000 per ear/3 years (per individual hearing aid)
ABA Therapy	U		L$	$36,000
Autism - General	U		L$	$36,000
Physical Therapy, Occupational Therapy, and Speech Therapy	C		LQ	30 visits/year (per type of therapy)
Podiatry	LC	Routine foot care only for individuals with diabetes or circulatory/vascular disorder	U	
Habilitation	C		LQ	30 visits/year (per type of therapy)
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	U		U	
Over-the-Counter Medications	LL	Limited to certain drug categories	U	

FLORIDA

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	**160% FPL**		**210% FPL**	
Coverage	**CHIP**	**QHP**	**CHIP**	**QHP**
Actuarial Value	98.2%	86%-88%	No CHIP Plan	
Enrollee Average Percent of Allowed Claims	1.8%	12%-14%		
Average Annual Cost Sharing	$62	$411 - $480		

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	**Type of Maximum**	**160% FPL**	**210% FPL**
CHIP	% of income	$710	No CHIP Plan
QHP	fixed dollar	$1,000-$2,250	

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	$10 copay	No copay	No CHIP Plan	
Eyeglasses Cost Sharing	No copay	No copay		
Dental Checkup Cost Sharing	No copay	Not covered		

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	100%	0%	0%
Child-Specific	14	57%	36%	7%	21%	21%	57%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	

Service	CHIP Coverage	CHIP Limits	EHB Coverage	EHB Limits
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	CHIP Limits	EHB Coverage	EHB Limits
Dental - Preventive & Restorative Services	C		U	Covered in SADP
Dental - Orthodontics	C		U	Covered in SADP
Vision - Exams	C		C	
Vision - Corrective Lenses	C		C	
Audiology - Exams	C		U	
Audiology - Hearing Aids	LQ	1 per ear/3 years (age 1-4) Covered (age 5-18)	U	
ABA Therapy	C		U	
Autism - General	C		L$	$36,000/year, $200,000/lifetime
Physical Therapy, Occupational Therapy, and Speech Therapy	LQ, LA	Covered (age 1-4) 24 sessions/60 day period; short term rehab only (age 5-18)	LQ	35 visits/year
Podiatry	LQ	Covered (age 1-4) 1 visit/day, totaling 2 visits/month (age 5-18)	C	
Habilitation	C		LQ	35 visits/year
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	LA	Age 1-4	U	
Over-the-Counter Medications	L$, LA	$180/year (age 5-18)	U	

GEORGIA

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	160% FPL		210% FPL	
Coverage	CHIP	QHP	CHIP	QHP
Actuarial Value	99.3%	86%-88%	99.3%	72%-74%
Enrollee Average Percent of Allowed Claims	0.7%	12%-14%	0.7%	26%-28%
Average Annual Cost Sharing	$24	$411 - $480	$24	$891- $960

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	% of income	$710	$1,647
QHP	fixed dollar	$1,000-$2,250	$3,250-$5,200

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	$2-$3 copay	50% coinsurance after deductible	$2-$3 copay	50% coinsurance after deductible
Eyeglasses Cost Sharing	$3 copay	50% coinsurance after deductible	$3 copay	50% coinsurance after deductible
Dental Checkup Cost Sharing	No copay	Not covered	No copay	Not covered

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	100%	0%	0%
Child-Specific	14	64%	14%	21%	29%	7%	64%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Surgical Services	C		C	
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	C		U	Covered in SADP
Dental – Orthodontics	C		U	Covered in SADP
Vision – Exams	C		C	
Vision - Corrective Lenses	C		C	
Audiology – Exams	C		U	
Audiology - Hearing Aids	LQ	1/3 years	U	
ABA Therapy	U		U	
Autism – General	C		C	
Physical Therapy, Occupational Therapy, and Speech Therapy	C		LQ	OT/PT combined: 20 visits/year, ST: 20 visits/year
Podiatry	C		U	
Habilitation	C		C	
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	U		U	
Over-the-Counter Medications	LL, L$	Certain non-prescription drugs are covered up to an allowable cost	U	

IDAHO

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	160% FPL		210% FPL	
Coverage	CHIP	QHP	CHIP	QHP
Actuarial Value	96.1%	86%-88%	No CHIP Plan	
Enrollee Average Percent of Allowed Claims	3.9%	12%-14%		
Average Annual Cost Sharing	$135	$411 - $480		

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	% of income	$770	No CHIP Plan
QHP	fixed dollar	$2,250	

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	$3.65 copay	no copay	No CHIP Plan	
Eyeglasses Cost Sharing	No copay on frames determined by provider	no copay		
Dental Checkup Cost Sharing	No copay	$20 copay		

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	100%	0%	0%
Child-Specific	14	79%	7%	14%	29%	14%	57%

The following table shows the coverage and limits for the core benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Dental - Preventive & Restorative Services	C		C	
Dental - Orthodontics	C		C	
Vision - Exams	C		C	
Vision - Corrective Lenses	C		C	
Audiology - Exams	C		U	
Audiology - Hearing Aids	C		U	
ABA Therapy	U		U	
Autism - General	U		U	
Physical Therapy, Occupational Therapy, and Speech Therapy	C		LQ	20 visits/year (combined, all therapies)
Podiatry	LC	Limited to treatment for chronic disease related care	U	
Habilitation	C		LQ	20 visits/year (combined, all therapies)
Enabling Services	C		U	
Medical Transportation - Non-Emergency Transport	C		U	
Over-the-Counter Medications	C		U	

ILLINOIS

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	**160% FPL**		**210% FPL**	
Coverage	**CHIP**	**QHP**	**CHIP**	**QHP**
Actuarial Value	98.9%	86%-88%	94.1%	72%-74%
Enrollee Average Percent of Allowed Claims	1.1%	12%-14%	5.9%	26%-28%
Average Annual Cost Sharing	$38	$411 - $480	$203	$891 - $960

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	% of income	$770	$1,815
QHP	fixed dollar	$1,100-$2,250	$2,920-$5,200

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	$5 copay	No copay	$10 copay	No copay
Eyeglasses Cost Sharing	No copay	No copay	No copay	No copay
Dental Checkup Cost Sharing	$5 copay	Not covered	$10 copay	Not covered

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	100%	0%	0%
Child-Specific	14	71%	29%	0%	36%	21%	43%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	

Service	CHIP Coverage	CHIP Limits	EHB Coverage	EHB Limits
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	CHIP Limits	EHB Coverage	EHB Limits
Dental - Preventive & Restorative Services	C		U	Covered in SADP
Dental - Orthodontics	C		U	Covered in SADP
Vision - Exams	C		C	
Vision - Corrective Lenses	C		C	
Audiology - Exams	C		U	
Audiology - Hearing Aids	C		C	
ABA Therapy	L$	$40,000	L$	$36,000
Autism - General	L$	$40,000	L$	$36,000/year
Physical Therapy, Occupational Therapy, and Speech Therapy	C		C	
Podiatry	C		C	
Habilitation	C		C, E	educational is excluded
Enabling Services	C		U	
Medical Transportation - Non-Emergency Transport	C, E	Provided to children with income up to 200% FPL	U	
Over-the-Counter Medications	LL	Limited to list of drug types	U	

INDIANA

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	160% FPL		210% FPL	
Coverage	CHIP	QHP	CHIP	QHP
Actuarial Value	98.7%	86%-88%	98.7%	72%-74%
Enrollee Average Percent of Allowed Claims	1.3%	12%-14%	1.3%	26%-28%
Average Annual Cost Sharing	$44	$411- $480	$45	$891- $960

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	% of income	$686	$1,491
QHP	fixed dollar	$1,000-$2,250	$2,650-$5,200

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No copay	No copay	No copay	No copay
Eyeglasses Cost Sharing	No copay	No copay	No copay	No copay
Dental Checkup Cost Sharing	No copay	Not covered	No copay	Not covered

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	91%	9%	0%	100%	0%	0%
Child-Specific	14	43%	43%	14%	36%	7%	57%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	L$	$2,000/year and lifetime limit of $5,000	C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	CHIP Limits	EHB Coverage	EHB Limits
Dental - Preventive & Restorative Services	C		U	Covered in SADP
Dental - Orthodontics	C		U	Covered in SADP
Vision - Exams	C		C	
Vision - Corrective Lenses	L$	maximum of $20 for frames	C	
Audiology - Exams	C		U	
Audiology - Hearing Aids	C		U	
ABA Therapy	U		C	
Autism - General	C		C	
Physical Therapy, Occupational Therapy, and Speech Therapy	LQ	50 visits/year (per type of therapy)	LQ	20 visits/year (per type of therapy)
Podiatry	LQ	Routine foot care visits limited to 6/year	U	
Habilitation	LQ	50 visits/year (per type of therapy)	C	
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	LC	Ambulance service for non-emergencies between medical facilities is covered when requested by a participating physician	U	
Over-the-Counter Medications	LC	Coverage only applies to insulin	U	

IOWA

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	**160% FPL**		**210% FPL**	
Coverage	**CHIP**	**QHP**	**CHIP**	**QHP**
Actuarial Value	100.0%	86%-88%	100.0%	72%-74%
Enrollee Average Percent of Allowed Claims	0.0%	12%-14%	0.0%	26%-28%
Average Annual Cost Sharing	$0	$411 - $480	$0	$891 - $960

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	**Type of Maximum**	**160% FPL**	**210% FPL**
CHIP	No Cost Sharing	$0	$0
QHP	fixed dollar	$1,000-$2,250	$2,750-$5,200

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No copay	No copay	No copay	No copay
Eyeglasses Cost Sharing	No copay: $100	10% coinsurance after deductible	No copay: $100	20% coinsurance after deductible
Dental Checkup Cost Sharing	No copay	Not covered	No copay	Not covered

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	100%	0%	0%
Child-Specific	14	29%	50%	21%	36%	21%	43%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	C		U	Covered in SADP
Dental - Orthodontics	C		U	Covered in SADP
Vision - Exams	C		C	
Vision - Corrective Lenses	L$	$100/year for one set of eyewear	C	
Audiology - Exams	C		C	
Audiology - Hearing Aids	LQ	1 per ear/36 months	U	
ABA Therapy	U		L$	$36,000
Autism - General	L$	$36,000/year	L$	$36,000
Physical Therapy, Occupational Therapy, and Speech Therapy	LQ, E, LC	60 days/year (per disability); OT exclusions and ST conditions	C	
Podiatry	LC	Foot care for members with diabetes	U	
Habilitation	LQ, E, LC	60 days/year (per disability); OT exclusions and ST conditions	C, E	Any habilitation not related to developmental delay is not covered.
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	LC	When medically necessary and ordered by a participating provider, coverage for ambulance services to a hospital, between hospitals, and between a hospital and a nursing facility	U	
Over-the-Counter Medications	U		C	

KANSAS

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	**160% FPL**		**210% FPL**	
Coverage	**CHIP**	**QHP**	**CHIP**	**QHP**
Actuarial Value	100.0%	86%-88%	100.0%	72%-74%
Enrollee Average Percent of Allowed Claims	0.0%	12%-14%	0.0%	26%-28%
Average Annual Cost Sharing	$0	$411 - $480	$0	$891 - $960

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	No Cost Sharing	$0	$0
QHP	fixed dollar	$1,200-$2,250	$3,125-$5,200

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No copay	No copay	No copay	No copay
Eyeglasses Cost Sharing	No copay	No copay	No copay	No copay
Dental Checkup Cost Sharing	No copay	Not covered	No copay	Not covered

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	91%	9%	0%
Child-Specific	14	86%	14%	0%	36%	7%	57%

The following table shows the coverage and limits for the core benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		LQ	500 mile radius

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	C		U	Covered in SADP
Dental - Orthodontics	C		U	Covered in SADP
Vision - Exams	C		C	
Vision - Corrective Lenses	C		C	
Audiology - Exams	C		U	
Audiology - Hearing Aids	LQ	1/4 years	U	
ABA Therapy	L$	$36,000/year (age 0-7) $27,000/year (age 7-19)	U	
Autism - General	C		L$	$36,000/year (age 0-6) $27,000/year (age 7-19)
Physical Therapy, Occupational Therapy, and Speech Therapy	C		C	
Podiatry	C		C	
Habilitation	C		C	
Enabling Services	C		U	
Medical Transportation - Non-Emergency Transport	C		U	
Over-the-Counter Medications	C		U	

KENTUCKY

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	160% FPL		210% FPL	
Coverage	CHIP	QHP	CHIP	QHP
Actuarial Value	98.6%	86%-88%	No CHIP Plan	
Enrollee Average Percent of Allowed Claims	1.4%	12%-14%		
Average Annual Cost Sharing	$48	$411- $480		

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	dollar limit	$450	No CHIP Plan
QHP	fixed dollar	$1,450	

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No copay	50% coinsurance after deductible	No CHIP Plan	
Eyeglasses Cost Sharing	No copay	50% coinsurance after deductible		
Dental Checkup Cost Sharing	No copay	50% coinsurance after deductible		

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	100%	0%	0%
Child-Specific	14	57%	29%	14%	29%	36%	36%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	C		C	
Dental – Orthodontics	LC	Only to correct disabling condition or for transitional or permanent dentition	U	
Vision – Exams	C		C	
Vision - Corrective Lenses	L$	$400/12 months	C	
Audiology – Exams	C		C	
Audiology - Hearing Aids	L$, LQ	$800 per ear/36 months	LQ	1/36 months
ABA Therapy	C		L$	$12,000
Autism - General	L$	$12,000-$15,000, varies by age	L$, LA	For large group plans and SEHP: $50,000/year (age 0-6) $1,000/month (age 7-21) For individual and small group plans: $1,000/month
Physical Therapy, Occupational Therapy, and Speech Therapy	C		LQ	20 visits/year (per type)
Podiatry	C		U	
Habilitation	C		LQ	20 visits/year (per type)
Enabling Services	C		U	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Medical Transportation - Non-Emergency Transport	U		U	
Over-the-Counter Medications	U		U	

LOUISIANA

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	**160% FPL**		**210% FPL**	
Coverage	**CHIP**	**QHP**	**CHIP**	**QHP**
Actuarial Value	No CHIP Plan		86.9%	72%-74%
Enrollee Average Percent of Allowed Claims			13.1%	26%-28%
Average Annual Cost Sharing			$448	$891- $960

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	**Type of Maximum**	**160% FPL**	**210% FPL**
CHIP	% of income	No CHIP Plan	$1,395
QHP	fixed dollar		$2,500-$5,200

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No CHIP Plan		No copay	$75 copay
Eyeglasses Cost Sharing			No copay:$50	50% coinsurance
Dental Checkup Cost Sharing			No copay	No copay

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	100%	0%	0%
Child-Specific	14	86%	0%	14%	43%	21%	36%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	
Outpatient Services	C		C	

Service	CHIP Coverage	CHIP Limits	EHB Coverage	EHB Limits
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	CHIP Limits	EHB Coverage	EHB Limits
Dental - Preventive & Restorative Services	C		C	
Dental - Orthodontics	C		C	
Vision - Exams	C		C	
Vision - Corrective Lenses	C		C	
Audiology - Exams	C		U	
Audiology - Hearing Aids	C		LA, LQ	1 per ear/36 months (age 0-17)
ABA Therapy	C		L$	$36,000
Autism - General	C		L$	$36,000
Physical Therapy, Occupational Therapy, and Speech Therapy	C		C	
Podiatry	C		U	
Habilitation	C		C	
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	C		U	
Over-the-Counter Medications	U		U	

MAINE

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	**160% FPL**		**210% FPL**	
Coverage	**CHIP**	**QHP**	**CHIP**	**QHP**
Actuarial Value	100.0%	86%-88%	No CHIP Plan	
Enrollee Average Percent of Allowed Claims	0.0%	12%-14%		
Average Annual Cost Sharing	$0	$411 - $480		

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	**Type of Maximum**	**160% FPL**	**210% FPL**
CHIP	No Cost Sharing	$0	No CHIP Plan
QHP	fixed dollar	$1,150-$1,500	

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No copay	No copay		
Eyeglasses Cost Sharing	$3 copay	50% coinsurance after deductible	No CHIP Plan	
Dental Checkup Cost Sharing	No copay	Not covered		

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
Core	11	100%	0%	0%	100%	0%	0%
Child-Specific	14	93%	7%	0%	14%	36%	50%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	
Outpatient Services	C		C	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	C		U	Covered in SADP
Dental - Orthodontics	C		U	
Vision - Exams	C		C	
Vision - Corrective Lenses	C		C	
Audiology - Exams	C		U	
Audiology - Hearing Aids	C		LQ	1/3 years
ABA Therapy	C		L$	$36,000/year
Autism - General	C		L$, LA	$36,000/year (age 0-5)
Physical Therapy, Occupational Therapy, and Speech Therapy	C		LQ	60 visits/year (combined, all therapies)
Podiatry	C		U	
Habilitation	C		LQ	60 visits/year limit applies to PT/OT/SLP combined and combined between rehab/hab
Enabling Services	C		U	
Medical Transportation - Non-Emergency Transport	C		U	
Over-the-Counter Medications	LL	A list of covered OTC drugs	U	

MASSACHUSETTS

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	160% FPL		210% FPL	
Coverage	CHIP	QHP	CHIP	QHP
Actuarial Value	100.0%	97%	100.0%	95%
Enrollee Average Percent of Allowed Claims	0.0%	3%	0.0%	5%
Average Annual Cost Sharing	$0	$111	$0	$173

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	No Cost Sharing	$0	$0
QHP	fixed dollar	$750 Med; $500 Rx	$1,500 Med; $750 Rx

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No copay	no copay	No copay	no copay
Eyeglasses Cost Sharing	No copay	30% coinsurance after deductible	No copay	30% coinsurance after deductible
Dental Checkup Cost Sharing	No copay	not covered	No copay	not covered

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	100%	0%	0%
Child-Specific	14	71%	14%	14%	36%	14%	50%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Surgical Services	C		C	
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	C		U	Covered in SADP
Dental - Orthodontics	C		U	
Vision - Exams	C		C	
Vision - Corrective Lenses	C		U	
Audiology - Exams	C		U	
Audiology - Hearing Aids	C		C	
ABA Therapy	C		C	
Autism - General	C		C	
Physical Therapy, Occupational Therapy, and Speech Therapy	C, E	Day habilitation services are not covered	LQ	60 visits/year
Podiatry	C		C	
Habilitation	C, E	Day habilitation services are not covered	LQ	60 visit/year limit applies to PT/OT/SLP combined and combined between rehab/hab
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	U		U	
Over-the-Counter Medications	C		U	

MICHIGAN

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	160% FPL		210% FPL	
Coverage	CHIP	QHP	CHIP	QHP
Actuarial Value	100.0%	86%-88%	No CHIP Plan	
Enrollee Average Percent of Allowed Claims	0.0%	12%-14%		
Average Annual Cost Sharing	$0	$411 - $480		

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	No Cost Sharing	$0	No CHIP Plan
QHP	fixed dollar	$1,000-$2,250	

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No copay	50% coinsurance after deductible	No CHIP Plan	
Eyeglasses Cost Sharing	No copay on frames determined by provider	50% coinsurance after deductible		
Dental Checkup Cost Sharing	No copay	Not covered		

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	100%	0%	0%
Child-Specific	14	64%	21%	14%	14%	29%	57%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	C		U	Covered in SADP
Dental - Orthodontics	C		U	
Vision - Exams	C		C	
Vision - Corrective Lenses	C		C	
Audiology - Exams	C		U	
Audiology - Hearing Aids	LQ	Hearing aid supplies payable once every 36 months	U	
ABA Therapy	LA	Age 18 months-5 years	L$	$50,000 (age 0-6) $40,000 (age 7-12) $30,000 (age 13-18)
Autism - General	C		L$	$50,000 (age 0-6) $40,000 (age 7-12) $30,000 (age 13-18)
Physical Therapy, Occupational Therapy, and Speech Therapy	C		LQ	30 visits/year (all rehab combined)
Podiatry	C		U	
Habilitation	C		LQ	30 visits/year
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	LC	Ambulance services include transport to or from a hospital, skilled nursing facility or member's home	U	
Over-the-Counter Medications	U		U	

MISSISSIPPI

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	160% FPL		210% FPL	
Coverage	CHIP	QHP	CHIP	QHP
Actuarial Value	99.7%	86%-88%	No CHIP Plan	
Enrollee Average Percent of Allowed Claims	0.3%	12%-14%		
Average Annual Cost Sharing	$11	$411 - $480		

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	% of income	$950	No CHIP Plan
QHP	fixed dollar	$1,100-$2,250	

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	**QHP**	**CHIP**	**QHP**
Routine Vision Exams	$0-$5 copay	$20 copay	No CHIP Plan	
Eyeglasses Cost Sharing	$0-$5 copay	$20 copay		
Dental Checkup Cost Sharing	No copay; $1500 yearly max	Not covered		

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	100%	0%	0%
Child-Specific	14	43%	36%	21%	29%	14%	57%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	
Outpatient Services	C		C	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	L$	Limited to $1,500/calendar year except for accidental injury	U	Covered in SADP
Dental - Orthodontics	LC	Only covers accidental injury	U	Covered in SADP
Vision - Exams	C		C	
Vision - Corrective Lenses	C		C	
Audiology - Exams	C		C	
Audiology - Hearing Aids	LQ	1 per ear/3 years	U	
ABA Therapy	C		U	
Autism - General	C		U	
Physical Therapy, Occupational Therapy, and Speech Therapy	C, E	Maintenance speech, delayed language development, or articulation disorders excluded	LQ	20 visits/year (PT and OT combined limit, ST separate limit)
Podiatry	C		LQ, LC	1 visit/year if have diabetes
Habilitation	C, E	Maintenance speech, delayed language development, or articulation disorders excluded	C	
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	U		U	
Over-the-Counter Medications	U		U	

MISSOURI

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	**160% FPL**		**210% FPL**	
Coverage	**CHIP**	**QHP**	**CHIP**	**QHP**
Actuarial Value	100.0%	86%-88%	100.0%	72%-74%
Enrollee Average Percent of Allowed Claims	0.0%	12%-14%	0.0%	26%-28%
Average Annual Cost Sharing	$0	$411 - $480	$0	$891 - $960

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	**Type of Maximum**	**160% FPL**	**210% FPL**
CHIP	No Cost Sharing	$0	$0
QHP	fixed dollar	$1,150-$2,250	$3,125-$5,200

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No copay	No copay	No copay	No copay
Eyeglasses Cost Sharing	No copay	No copay	No copay	No copay
Dental Checkup Cost Sharing	No copay	Not covered	No copay	Not covered

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	100%	0%	0%
Child-Specific	14	64%	21%	14%	29%	29%	43%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C	
Inpatient Services	C		C	
Inpatient Mental Health	C		C	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Services				
Surgical Services	C		C	
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	C		U	Covered in SADP
Dental - Orthodontics	C		U	Covered in SADP
Vision - Exams	C		C	
Vision - Corrective Lenses	C		C	
Audiology - Exams	C		C	
Audiology - Hearing Aids	LQ	2/4 years	LA	newborns only
ABA Therapy	L$	Age 3-18, $22,000/year, limits participation to 150	L$	$40,000/benefit period
Autism - General	L$, LA	Age 3-18, $22,000/year, limits participation to 150	C	
Physical Therapy, Occupational Therapy, and Speech Therapy	C		LQ	20 visits/year
Podiatry	C		U	
Habilitation	C		LQ	20 visits/year
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	U		U	
Over-the-Counter Medications	C		U	

MONTANA

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	**160% FPL**		**210% FPL**	
Coverage	**CHIP**	**QHP**	**CHIP**	**QHP**
Actuarial Value	98.2%	86%-88%	98.2%	72%-74%
Enrollee Average Percent of Allowed Claims	1.8%	12%-14%	1.8%	26%-28%
Average Annual Cost Sharing	$63	$411 - $480	$63	$891- $960

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	**Type of Maximum**	**160% FPL**	**210% FPL**
CHIP	dollar limit	$215	$215
QHP	fixed dollar	$1,000-$2,000	$2,650-$5,200

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	$3 copay	No copay	$3 copay	No copay
Eyeglasses Cost Sharing	No copay	30% coinsurance after deductible	No copay	30% coinsurance after deductible
Dental Checkup Cost Sharing	No copay; $1412 yearly max	Not covered	No copay; $1412 yearly max	Not covered

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	91%	9%	0%	100%	0%	0%
Child-Specific	14	43%	29%	29%	29%	14%	57%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Outpatient Services	C		C	
Outpatient Mental Health Services	LC	Extended mental health services limited to children with a severe emotional disturbance	C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	C		U	Covered in SADP
Dental - Orthodontics	U		U	Covered in SADP
Vision - Exams	C		C	
Vision - Corrective Lenses	C, E	contact lenses not covered	C	
Audiology - Exams	C		U	
Audiology - Hearing Aids	LQ	1/5 years	U	
ABA Therapy	L$, LQ	Limits on enrollment, age 1-4, 20-25 hours/week, $45,000/year	L$	$50,000/benefit period (age 0-8) $20,000/benefit period (age 9-18)
Autism - General	L$, LQ	Limits on enrollment, age 1-4, 20-25 hours/week, $45,000/year	L$	$50,000/year (age 0-8) $20,000/year (age 9-18)
Physical Therapy, Occupational Therapy, and Speech Therapy	C		C	
Podiatry	U		U	
Habilitation	C		C	
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	C		U	
Over-the-Counter Medications	U		U	

NEVADA

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	**160% FPL**		**210% FPL**	
Coverage	**CHIP**	**QHP**	**CHIP**	**QHP**
Actuarial Value	100.0%	86%-88%	No CHIP Plan	
Enrollee Average Percent of Allowed Claims	0.0%	12%-14%		
Average Annual Cost Sharing	$0	$411 - $480		

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	**Type of Maximum**	**160% FPL**	**210% FPL**
CHIP	No Cost Sharing	$0	No CHIP Plan
QHP	fixed dollar	$1,250	

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No copay	No copay	No CHIP Plan	
Eyeglasses Cost Sharing	No copay on frames determined by provider	No copay		
Dental Checkup Cost Sharing	No copay	Not covered		

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	91%	9%	0%
Child-Specific	14	79%	0%	21%	21%	36%	43%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		L$	$4,000/lifetime
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	C		U	Covered in SADP
Dental - Orthodontics	C		U	Covered in SADP
Vision - Exams	C		C	
Vision - Corrective Lenses	C		C	
Audiology - Exams	C		C	
Audiology - Hearing Aids	C		L$	$5,000/year (per member)
ABA Therapy	U		L$	$36,000/year
Autism - General	U		L$	$36,000/year
Physical Therapy, Occupational Therapy, and Speech Therapy	C		LQ	60 visits/year
Podiatry	C		U	
Habilitation	C		LQ	60 visits/year
Enabling Services	C		U	
Medical Transportation - Non-Emergency Transport	U		U	
Over-the-Counter Medications	C		U	

NEW JERSEY

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	160% FPL		210% FPL	
Coverage	CHIP	QHP	CHIP	QHP
Actuarial Value	99.2%	86%-88%	97.0%	72%-74%
Enrollee Average Percent of Allowed Claims	0.8%	12%-14%	3.0%	26%-28%
Average Annual Cost Sharing	$28	$411- $480	$103	$891- $960

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	% of income	$950	$1,497
QHP	fixed dollar	$1,400-$2,000	$3,500-$5,200

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	$5 copay	No copay after deductible	$5 copay	No copay after deductible
Eyeglasses Cost Sharing	No copay	No copay after deductible	No copay	No copay after deductible
Dental Checkup Cost Sharing	No copay	Not covered	No copay	Not covered

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP Plan C/D			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%/91%	0%/9%	0%/0%	100%	0%	0%
Child-Specific	14	64%/36%	14%/29%	21%/36%	29%	29%	43%

The following table shows the coverage and limits for the core benefits.

	CHIP Plan C		CHIP Plan D		EHB	
Service	Coverage	Limits	Coverage	Limits	Coverage	Limits
Physician Services	C		C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C		C	
Laboratory & Radiological Services	C		C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		LL	List of specified benefits covered	C	
Inpatient Services	C		C		C	
Inpatient Mental Health Services	C		C		C	
Surgical Services	C		C		C	

Service	CHIP Plan C Coverage	Limits	CHIP Plan D Coverage	Limits	EHB Coverage	Limits
Outpatient Services	C		C		C	
Outpatient Mental Health Services	C		C		C	
Prescription Drugs	C		C		C	
Medical Transportation - Emergency Transport	C		C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Plan C Coverage	Limits	CHIP Plan D Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	C		C		U	Covered in SADP
Dental – Orthodontics	C		C		U	Covered in SADP
Vision - Exams	C		C		C	
Vision - Corrective Lenses	C		C		C	
Audiology - Exams	C		LA	Audiology services covered for members under 16	C	
Audiology - Hearing Aids	C		LA	Hearing aids covered for members under 16	LQ	1 per ear/24 months
ABA Therapy	U		U		LQ	$36,000 now set at standardiz ed utilization limit
Autism - General	C		C		C	
Physical Therapy, Occupational Therapy, and Speech Therapy	LQ	60 visits/calen dar year (per type of therapy and incident)	LQ	60 visits/calendar year (per type of therapy and incident)	LQ	30 visits/year
Podiatry	U		U		U	

Service	CHIP Plan C		CHIP Plan D		EHB	
	Coverage	Limits	Coverage	Limits	Coverage	Limits
Habilitation	LQ	60 visits/calendar year (per type of therapy and incident)	LQ	60 visits/calendar year (per type of therapy and incident)	LQ	30 visits/year
Enabling Services	U		U		U	
Medical Transportation - Non-Emergency Transport	C		U		U	
Over-the-Counter Medications	C		U		U	

NEW YORK

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	**160% FPL**		**210% FPL**	
Coverage	**CHIP**	**QHP**	**CHIP**	**QHP**
Actuarial Value	100.0%	86%-88%	100.0%	72%-74%
Enrollee Average Percent of Allowed Claims	0.0%	12%-14%	0.0%	26%-28%
Average Annual Cost Sharing	$0	$411 - $480	$0	$891 - $960

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	**Type of Maximum**	**160% FPL**	**210% FPL**
CHIP	No Cost Sharing	$0	$0
QHP	fixed dollar	$2,000	$4,000

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No copay	$15 copay after deductible	No copay	$30 copay after deductible
Eyeglasses Cost Sharing	No copay on frames determined by provider	10% coinsurance after deductible	No copay on frames determined by provider	25% coinsurance after deductible
Dental Checkup Cost Sharing	No copay	$15 copay after deductible	No copay	$30 copay after deductible

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	91%	9%	0%
Child-Specific	14	64%	14%	21%	36%	29%	36%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		L$	$1,500/year for non-essential DME & Medical supplies. Braces must be standard equipment only
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	

Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	C		C	
Dental - Orthodontics	C		C	
Vision - Exams	C		C	
Vision - Corrective Lenses	C		C	
Audiology - Exams	C		U	
Audiology - Hearing Aids	LQ	1 unless medically necessary	L$	$1,500/year, limited to a single purchase (including repair/replacement) every 3 years
ABA Therapy	C, E	Varies by plan	LQ	680 visits/year
Autism - General	C		C	
Physical Therapy, Occupational Therapy, and Speech Therapy	C		LQ	60 visits/condition
Podiatry	U		U	
Habilitation	C		LQ	60 visits/year
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	U		U	
Over-the-Counter Medications	C		U	

NORTH CAROLINA

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	160% FPL		210% FPL	
Coverage	CHIP	QHP	CHIP	QHP
Actuarial Value	95.8%	86%-88%	No CHIP Plan	
Enrollee Average Percent of Allowed Claims	4.2%	12%-14%		
Average Annual Cost Sharing	$145	$411 - $480		

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	% of income	$900	No CHIP Plan
QHP	fixed dollar	$1,000-$2,250	

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	$5 copay	$25 copay	No CHIP Plan	
Eyeglasses Cost Sharing	No copay	50% coinsurance after deductible		
Dental Checkup Cost Sharing	No copay	$25 copay		

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	100%	0%	0%
Child-Specific	14	64%	7%	29%	36%	29%	36%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Surgical Services	C		C	
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	C		C	
Dental - Orthodontics	C		C	
Vision - Exams	C		C	
Vision - Corrective Lenses	C		C	
Audiology - Exams	C		C	
Audiology - Hearing Aids	LA	Age 0-8	L$, LQ	$2,500 per ear/36 months and 1 hearing aid per ear/36 months
ABA Therapy	U		U	
Autism - General	C		U	
Physical Therapy, Occupational Therapy, and Speech Therapy	C		LQ	30 visits/year
Podiatry	U		LQ	only for those diagnosed with diabetes
Habilitation	C		LQ	30 visits/year
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	U		U	
Over-the-Counter Medications	C		U	

NORTH DAKOTA

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	160% FPL		210% FPL	
Coverage	CHIP	QHP	CHIP	QHP
Actuarial Value	96.1%	86%-88%	No CHIP Plan	
Enrollee Average Percent of Allowed Claims	3.9%	12%-14%		
Average Annual Cost Sharing	$133	$411- $480		

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	% of income	$950	No CHIP Plan
QHP	fixed dollar	$1,400-$2,250	

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No copay	10% coinsurance after deductible	No CHIP Plan	
Eyeglasses Cost Sharing	No copay: $100	10% coinsurance after deductible		
Dental Checkup Cost Sharing	No copay	10% coinsurance after deductible		

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	73%	27%	0%	91%	9%	0%
Child-Specific	14	29%	43%	29%	36%	21%	43%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	L$	$6,000/member/year	L$	$1,500/year
Inpatient Services	C		C	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Inpatient Mental Health Services	C		C	
Surgical Services	C, E	Bone marrow transplants and other forms of stem cell rescue limited to certain conditions; limits on obesity surgery	C	
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C, E	Oral contraceptives not covered	C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	C		C	
Dental - Orthodontics	C		C	
Vision - Exams	C		C	
Vision - Corrective Lenses	L$	$80 limit	C	
Audiology - Exams	C		U	
Audiology - Hearing Aids	L$, LQ	$3,000/3 years (per child)	L$	$1,500/year. Limited to a single purchase (including repair/replacement) every 3 years
ABA Therapy	U		U	
Autism - General	U		U	
Physical Therapy, Occupational Therapy, and Speech Therapy	LC	No maintenance care for PT/OT/ST; need of OT services reviewed after 90 days	LQ	60 visits/condition
Podiatry	LC	For children with diabetes or circulatory disorders of the legs and feet	C	
Habilitation	LC	No maintenance care for PT/OT/ST; need of OT	LQ	60 visits/condition

Service	CHIP Coverage	Limits	EHB Coverage	Limits
		services reviewed after 90 days		
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	LC	Transport between hospitals and skilled nursing facilities	U	
Over-the-Counter Medications	U		U	

OREGON

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	160% FPL		210% FPL	
Coverage	CHIP	QHP	CHIP	QHP
Actuarial Value	100.0%	86%-88%	100.0%	72%-74%
Enrollee Average Percent of Allowed Claims	0.0%	12%-14%	0.0%	26%-28%
Average Annual Cost Sharing	$0	$411 - $480	$0	$891 - $960

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	No Cost Sharing	$0	$0
QHP	fixed dollar	$1,250	$5,000

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No copay	35% coinsurance after deductible; no copay kids aged 3-5	No copay	35% coinsurance after deductible; no copay kids aged 3-6
Eyeglasses Cost Sharing	No copay	35% coinsurance after deductible	No copay	35% coinsurance after deductible
Dental Checkup Cost Sharing	No copay	Not covered	No copay	Not covered

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP Plan B/C			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%/100%	0%/0%	0%/0%	91%	9%	0%
Child-Specific	14	71%/36%	29%/50%	0%/14%	29%	29%	43%

The following table shows the coverage and limits for the core benefits.

	CHIP Plan B		CHIP Plan C		EHB	
Service	Coverage	Limits	Coverage	Limits	Coverage	Limits
Physician Services	C		C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C		C	
Laboratory & Radiological Services	C		C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C		L$	$5,000/year
Inpatient Services	C		C		C	
Inpatient Mental Health Services	C		C		C	

Service	CHIP Plan B		CHIP Plan C		EHB	
	Coverage	Limits	Coverage	Limits	Coverage	Limits
Surgical Services	C		C		C	
Outpatient Services	C		C		C	
Outpatient Mental Health Services	C		C		C	
Prescription Drugs	C		C		C	
Medical Transportation - Emergency Transport	C		C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Plan B		CHIP Plan C		EHB	
	Coverage	Limits	Coverage	Limits	Coverage	Limits
Dental - Preventive & Restorative Services	C		L$	$1,750/year	U	Covered in SADP
Dental - Orthodontics	LC	Only for treatment of cleft palate	LC	Only for treatment of cleft palate	U	Covered in SADP
Vision - Exams	C		C		C	
Vision - Corrective Lenses	C		L$	$96 for single vision lenses and $96 for frames	C	
Audiology - Exams	C		C		U	
Audiology - Hearing Aids	LQ	1/3 years for lower income group	C		L$	$4,000/2 years
ABA Therapy	LQ	25 hours/week	LQ	25 hours/week	LQ	25 hours/week
Autism - General	C		C		C	
Physical Therapy, Occupational Therapy, and Speech Therapy	C		LQ	60 visits/year	LQ	30 visits/year
Podiatry	LC	Coverage for certain conditions	LC	Routine foot care only for individuals with diabetes	C	

Service	CHIP Plan B		CHIP Plan C		EHB	
	Coverage	Limits	Coverage	Limits	Coverage	Limits
Habilitation	C		LQ	60 visits/year	LQ	30 visits/year
Enabling Services	C		U		U	
Medical Transportation - Non-Emergency Transport	C		U		U	
Over-the-Counter Medications	C		C		U	

PENNSYLVANIA

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	**160% FPL**		**210% FPL**	
Coverage	**CHIP**	**QHP**	**CHIP**	**QHP**
Actuarial Value	100.0%	86%-88%	97.2%	72%-74%
Enrollee Average Percent of Allowed Claims	0.0%	12%-14%	2.8%	26%-28%
Average Annual Cost Sharing	$0	$411 - $480	$98	$891 - $960

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	No Cost Sharing	$0	$1,419
QHP	fixed dollar	$500-$2,250	$3,000-$5,200

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No copay	No copay	No copay	No copay
Eyeglasses Cost Sharing	No copay; $185 max	No copay	No copay; $185 max	No copay
Dental Checkup Cost Sharing	No copay	No copay	No copay	No copay

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	27%	73%	0%	91%	9%	0%
Child-Specific	14	21%	57%	21%	29%	21%	50%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	LQ	50 visits/year combined with outpatient, surgical, clinic and prepregnancy family services	C	
Clinic Services & Other Ambulatory Health Care Services	LQ	50 visits/year combined with outpatient, physician, surgical and prepregnancy family services	C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	L$	Certain monetary caps based on insurer	L$	$2,500/year
Inpatient Services	LQ	90 days/year combined for range of inpatient care; 45 days/year for inpatient rehabilitation therapy	C	
Inpatient Mental Health	LQ	90 days/year combined for range	C	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Services		of inpatient care with medical, medical inpatient rehab and skilled nursing services		
Surgical Services	LQ	50 visits/year	C	
Outpatient Services	LQ	50 visits/year combined with physician, surgical, clinic and prepregnancy family services	C	
Outpatient Mental Health Services	LQ	50 visits/year	C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	L$	$1,500/year	C	
Dental - Orthodontics	L$	$5,200/lifetime	C	
Vision - Exams	C		C	
Vision - Corrective Lenses	L$	Monetary cap set by insurer	C	
Audiology - Exams	C		U	
Audiology - Hearing Aids	L$, LQ	1 per ear/2 years; certain monetary cap based on insurer	U	
ABA Therapy	C		U	
Autism - General	L$	$36,000/year (per member)	L$	$36,000/year
Physical Therapy, Occupational Therapy, and Speech Therapy	LQ	60 visits/year (per type of therapy)	LQ	30 visits/year
Podiatry	LC	Foot care only related to diabetes	U	
Habilitation	LQ	60 visits/year (per type of therapy)	LQ	30 visits/year
Enabling Services	U		U	

Service	CHIP		EHB	
	Coverage	Limits	Coverage	Limits
Medical Transportation - Non-Emergency Transport	U		U	
Over-the-Counter Medications	U		U	

SOUTH DAKOTA

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	**160% FPL**		**210% FPL**	
Coverage	**CHIP**	**QHP**	**CHIP**	**QHP**
Actuarial Value	100.0%	86%-88%	No CHIP Plan	
Enrollee Average Percent of Allowed Claims	0.0%	12%-14%		
Average Annual Cost Sharing	$0	$411 - $480		

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	**Type of Maximum**	**160% FPL**	**210% FPL**
CHIP	No Cost Sharing	$0	No CHIP Plan
QHP	fixed dollar	$1,000-$2,250	

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No copay	No copay	No CHIP Plan	
Eyeglasses Cost Sharing	No copay	No copay		
Dental Checkup Cost Sharing	No copay	Not covered		

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	91%	9%	0%
Child-Specific	14	64%	7%	29%	29%	0%	71%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C, E	Excludes orthotics, wigs or hair pieces, pools, whirlpools, spas, common first-aid supplies, and health club memberships.
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Surgical Services	C		C	
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	C		U	Covered in SADP
Dental - Orthodontics	C		U	Covered in SADP
Vision - Exams	C		C	
Vision - Corrective Lenses	C		C	
Audiology - Exams	C		U	
Audiology - Hearing Aids	C		U	
ABA Therapy	U		U	
Autism - General	U		U	
Physical Therapy, Occupational Therapy, and Speech Therapy	C		C	
Podiatry	U		U	
Habilitation	C		C	
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	C		U	
Over-the-Counter Medications	LL	Limited list of OTC medications	U	

TENNESSEE

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	160% FPL		210% FPL	
Coverage	CHIP	QHP	CHIP	QHP
Actuarial Value	94.9%	86%-88%	94.6%	72%-74%
Enrollee Average Percent of Allowed Claims	5.1%	12%-14%	5.4%	26%-28%
Average Annual Cost Sharing	$173	$411 - $480	$185	$891 - $960

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	% of income	$950	$1,995
QHP	fixed dollar	$1,000-$2,250	$2,750-$5,200

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No copay	No copay	No copay	No copay
Eyeglasses Cost Sharing	$15 copay	No copay	$15 copay	No copay
Dental Checkup Cost Sharing	No copay	No copay	No copay	No copay

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	91%	9%	0%
Child-Specific	14	14%	50%	36%	43%	21%	36%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C, E	Excludes unnecessary repair or replacement of equipment, as well as: motorized scooters, exercise equipment, hot tubs, pool, saunas, computerized or gyroscopic mobility systems, roll about

Service	CHIP Coverage	Limits	EHB Coverage	Limits
				chairs, geriatric chairs, hip chairs, seat lifts, patient lifts, auto tilt chairs, air fluidized beds, and air flotation beds
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	L$	$1,000/year	C	
Dental - Orthodontics	L$	$1,250/lifetime (not subject to dental limit)	C	
Vision - Exams	C		C	
Vision - Corrective Lenses	L$	$85 for lenses/year; $100 for frames every 2 years; $150 for contact lenses/year	C	
Audiology - Exams	C		C	
Audiology - Hearing Aids	LQ	1 per ear/year (age 0-5) 1 per ear/2 years (age 5+)	L$	$1,000/year every 3 years
ABA Therapy	U		U	
Autism - General	U		U	
Physical Therapy, Occupational Therapy, and Speech Therapy	LQ, LC	52 visits/year (per condition); no maintenance care	LQ	20 visits/year
Podiatry	LC	Only if necessary to prevent complications of existing disease state	C, E	Routine foot care for the treatment of certain conditions, and as required by law for

Service	CHIP Coverage	Limits	EHB Coverage	Limits
				diabetic patients.
Habilitation	LQ, LC	52 visits/year (per condition); no maintenance care	C	
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	U		U	
Over-the-Counter Medications	U		U	

TEXAS

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	**160% FPL**		**210% FPL**	
Coverage	**CHIP**	**QHP**	**CHIP**	**QHP**
Actuarial Value	94.0%	86%-88%	No CHIP Plan	
Enrollee Average Percent of Allowed Claims	6.0%	12%-14%		
Average Annual Cost Sharing	$207	$411- $480		

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	**Type of Maximum**	**160% FPL**	**210% FPL**
CHIP	% of income	$915	No CHIP Plan
QHP	fixed dollar	$1,200-$2,250	

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No copay	No copay	No CHIP Plan	
Eyeglasses Cost Sharing	No copay on frames determined by provider	No copay		
Dental Checkup Cost Sharing	No copay	Not covered		

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	91%	9%	0%	100%	0%	0%
Child-Specific	14	64%	7%	29%	43%	21%	36%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	L$	$20,000/term of coverage	C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	
Outpatient Services	C		C	
Outpatient Mental Health	C		C	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Services				
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	C		U	Covered in SADP
Dental - Orthodontics	C		U	Covered in SADP
Vision - Exams	C		C	
Vision - Corrective Lenses	C		C	
Audiology - Exams	C		C	
Audiology - Hearing Aids	C		L$, LQ	$1,000/36 months
ABA Therapy	U		LQ	varies by issuer; do not count toward rehab/hab limits
Autism - General	C		C	
Physical Therapy, Occupational Therapy, and Speech Therapy	C		LQ	35 visits/year
Podiatry	LC	Only for injury treatment or diabetes	C	
Habilitation	C		C	
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	U		U	
Over-the-Counter Medications	U		U	

UTAH

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	**160% FPL**		**210% FPL**	
Coverage	**CHIP**	**QHP**	**CHIP**	**QHP**
Actuarial Value	88.7%	86%-88%	No CHIP Plan	
Enrollee Average Percent of Allowed Claims	11.3%	12%-14%		
Average Annual Cost Sharing	$389	$411- $480		

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	**Type of Maximum**	**160% FPL**	**210% FPL**
CHIP	% of income	$650	No CHIP Plan
QHP	fixed dollar	$1,000-$2,250	

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	$40 copay	50% coinsurance after deductible	No CHIP Plan	
Eyeglasses Cost Sharing	No copay on frames determined by provider	50% coinsurance after deductible		
Dental Checkup Cost Sharing	No copay	Not covered		

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	100%	0%	0%
Child-Specific	14	43%	29%	29%	7%	36%	57%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	L$, E	$1,000/plan year; some service exclusions	U	Covered in SADP
Dental - Orthodontics	C		U	
Vision - Exams	C		LA	age 5-18
Vision - Corrective Lenses	C		LA	age 5-18
Audiology - Exams	C		U	
Audiology - Hearing Aids	C, E	Only cochlear implants covered, not hearing aids	U	
ABA Therapy	U		U	
Autism - General	U		LA	Age 2-10
Physical Therapy, Occupational Therapy, and Speech Therapy	LQ, E	20 visits/year (combined, all therapies); ST for developmental delays not covered	LQ	20 visits/year (combined, all therapies)
Podiatry	C		C	
Habilitation	LQ, E	20 visits/year (combined, all therapies); ST for developmental delays not covered	LQ	20 visits/year (combined, all therapies)
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	U		U	
Over-the-Counter Medications	C		U	

VIRGINIA

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	160% FPL		210% FPL	
Coverage	CHIP	QHP	CHIP	QHP
Actuarial Value	97.4%	86%-88%	No CHIP Plan	
Enrollee Average Percent of Allowed Claims	2.6%	12%-14%		
Average Annual Cost Sharing	$89	$411 - $480		

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	dollar limit	$350	No CHIP Plan
QHP	fixed dollar	$1,500-$2,250	

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No copay	No copay	No CHIP Plan	
Eyeglasses Cost Sharing	No copay on frames determined by provider	No copay		
Dental Checkup Cost Sharing	No copay	Not covered		

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	82%	18%	0%	73%	27%	0%
Child-Specific	14	50%	29%	21%	29%	14%	57%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C, E	Excludes items that have both a therapeutic and non-therapeutic use including exercise equipment; foot orthotics;
Inpatient Services	LQ	365 days per hospitalization	C	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Inpatient Mental Health Services	LQ	365 days per hospitalization	C, E	Excludes Cognitive rehab therapy; Educational therapy; Vocational and recreational activities; Coma stimulation therapy; Services for sexual dysfunction and sexual deviation; Treatment of social maladjustment without signs of psychiatric disorder; Remedial or special education services.
Surgical Services	C		C	
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C, E	Excludes Cognitive rehab therapy; Educational therapy; Vocational and recreational activities; Coma stimulation therapy; Services for sexual dysfunction and sexual deviation; Treatment of social maladjustment without signs of psychiatric disorder; Remedial or special education services.
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	C		U	Covered in SADP
Dental – Orthodontics	C		U	Covered in SADP
Vision – Exams	C		C	
Vision - Corrective Lenses	L$	Limited by dollar amount depending on lens type	C	
Audiology – Exams	C		U	
Audiology - Hearing Aids	LQ	2/5 years	U	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
ABA Therapy	L$	$35,000/year (Insurer may elect to provide coverage in a greater amount)	U	
Autism - General	C		LA	Age 2-6
Physical Therapy, Occupational Therapy, and Speech Therapy	C		LQ	30 visits/year
Podiatry	U		C	
Habilitation	C		C	
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	LC	Available if necessary due to medical condition	U	
Over-the-Counter Medications	U		U	

WASHINGTON

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	160% FPL		210% FPL	
Coverage	**CHIP**	**QHP**	**CHIP**	**QHP**
Actuarial Value	No CHIP Plan		100.0%	72%-74%
Enrollee Average Percent of Allowed Claims			0.0%	26%-28%
Average Annual Cost Sharing			$0	$891 - $960

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	No Cost Sharing	No CHIP Plan	$0
QHP	fixed dollar		$5,200

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No CHIP Plan		No copay	No copay
Eyeglasses Cost Sharing			No copay on frames determined by provider	No copay
Dental Checkup Cost Sharing			No copay	Not covered

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	100%	0%	0%
Child-Specific	14	93%	7%	0%	21%	21%	57%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	C		U	Covered in SADP
Dental - Orthodontics	C		U	Covered in SADP
Vision - Exams	C		C	
Vision - Corrective Lenses	C		L$	$150 hardware/year
Audiology - Exams	C		U	
Audiology - Hearing Aids	C		C, E	Cochlear implants only covered type of hearing aid
ABA Therapy	C		U	
Autism - General	C		U	
Physical Therapy, Occupational Therapy, and Speech Therapy	C		LQ	25 visits/year
Podiatry	C		C	
Habilitation	C		C	
Enabling Services	C		U	
Medical Transportation - Non-Emergency Transport	C		U	
Over-the-Counter Medications	LL	Limited to a list of covered drugs	U	

WEST VIRGINIA

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	160% FPL		210% FPL	
Coverage	CHIP	QHP	CHIP	QHP
Actuarial Value	94.6%	86%-88%	93.4%	72%-74%
Enrollee Average Percent of Allowed Claims	5.4%	12%-14%	6.6%	26%-28%
Average Annual Cost Sharing	$184	$411 - $480	$227	$891 - $960

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	dollar limit	$150 Med; $100 Rx	$200 Med; $150 Rx
QHP	fixed dollar	$1,000-$2,000	$3,500-$5,200

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No copay	No copay	No copay	No copay
Eyeglasses Cost Sharing	No copay; $125 limit	No copay	No copay; $125 limit	No copay
Dental Checkup Cost Sharing	No copay	No copay	No copay	No copay

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%	0%	0%	100%	0%	0%
Child-Specific	14	57%	36%	7%	43%	21%	36%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	

Service	CHIP Coverage	CHIP Limits	EHB Coverage	EHB Limits
Prescription Drugs	C		C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	CHIP Limits	EHB Coverage	EHB Limits
Dental - Preventive & Restorative Services	C		C	
Dental - Orthodontics	C		C	
Vision - Exams	C		C	
Vision - Corrective Lenses	L$	$125/year for frames and lenses	C	
Audiology - Exams	C		C	
Audiology - Hearing Aids	C		U	
ABA Therapy	L$	$30,000/year for the first 3 years and $2,000/month after 3 years	L$	$30,000/year for the first 3 years and $2,000/month after 3 years
Autism - General	C		LA	Age 18 months to 18 years
Physical Therapy, Occupational Therapy, and Speech Therapy	C		C	
Podiatry	C, E	Routine foot care only for medically necessary services for diabetics	U	
Habilitation	C		LQ	30 visit PT, 30 visit OT combined
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	LC	Ground or air ambulance transportation, when medically necessary, to the nearest facility able to provide necessary treatment	U	
Over-the-Counter Medications	LL	Permitted in some therapeutic classes	U	

WISCONSIN

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	160% FPL		210% FPL	
Coverage	CHIP	QHP	CHIP	QHP
Actuarial Value	99.3%	86%-88%	99.3%	72%-74%
Enrollee Average Percent of Allowed Claims	0.7%	12%-14%	0.7%	26%-28%
Average Annual Cost Sharing	$23	$411 - $480	$23	$891 - $960

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	% of income	$950	$1,875
QHP	fixed dollar	$1,000-$2,250	$2,650-$5,200

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	$2-$3 copay	0% coinsurance after deductible	$2-$3 copay	0% coinsurance after deductible
Eyeglasses Cost Sharing	$3 copay	0% coinsurance after deductible	$3 copay	0% coinsurance after deductible
Dental Checkup Cost Sharing	$2-$3 copay	Not covered	$2-$3 copay	Not covered

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP – Std/Bnch			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	100%/82%	0%/18%	0%/0%	91%	9%	0%
Child-Specific	14	86%/50%	14%/43%	0%/7%	29%	21%	50%

The following table shows the coverage and limits for the core benefits.

	CHIP Std		CHIP Bnch		EHB	
Service	Coverage	Limits	Coverage	Limits	Coverage	Limits
Physician Services	C		C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C		C	
Laboratory & Radiological Services	C		C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		L$	$2,500/plan year if >200% FPL	L$	$2,500/plan year
Inpatient Services	C		C		C	
Inpatient Mental Health Services	C		C		C	
Surgical Services	C		C		C	

Service	CHIP Std Coverage	Limits	CHIP Bnch Coverage	Limits	EHB Coverage	Limits
Outpatient Services	C		C		C	
Outpatient Mental Health Services	C		C		C	
Prescription Drugs	C		LL	Generic-only formulary if >200% FPL	C	
Medical Transportation - Emergency Transport	C		C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Std Coverage	Limits	CHIP Bnch Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	C		L$	$750/plan year; $200 deductible (preventive and diagnostic exempt) if >200% FPL	U	Covered in SADP
Dental - Orthodontics	C		L$	$750/plan year; $200 deductible (preventive and diagnostic exempt) if >200% FPL	U	Covered in SADP
Vision - Exams	C		C		C	
Vision - Corrective Lenses	C		C		C	
Audiology - Exams	C		LA	Age 0-17 if > 200% FPL	U	
Audiology - Hearing Aids	C, E	Only for < 200% FPL	U		LQ	1 per ear/3 years
ABA Therapy	C		C		C	
Autism – General	C		C		C	
Physical Therapy, Occupational Therapy, and Speech Therapy	C		LQ	20 visits/year (per type of therapy) if >200% FPL	LQ	20 visits/year

Service	CHIP Std Coverage	Limits	CHIP Bnch Coverage	Limits	EHB Coverage	Limits
Podiatry	C		C		U	
Habilitation	C		LQ	20 visits/year (per type of therapy) if >200% FPL	LQ	20 visits/year
Enabling Services	C		C		U	
Medical Transportation - Non-Emergency Transport	C		C		U	
Over-the-Counter Medications	LL	Limited generic OTC formulary	LL	Limited generic OTC formulary	U	

WYOMING

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level	**160% FPL**		**210% FPL**	
Coverage	**CHIP**	**QHP**	**CHIP**	**QHP**
Actuarial Value	96.0%	86%-88%	No CHIP Plan	
Enrollee Average Percent of Allowed Claims	4.0%	12%-14%		
Average Annual Cost Sharing	$139	$411 - $480		

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	**Type of Maximum**	**160% FPL**	**210% FPL**
CHIP	dollar limit	$300 Med; $200 Rx	No CHIP Plan
QHP	fixed dollar	$1,500-$2,250	

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL		210% FPL	
	CHIP	QHP	CHIP	QHP
Routine Vision Exams	No copay	No copay	No CHIP Plan	
Eyeglasses Cost Sharing	No copay: $100	10% coinsurance after deductible		
Dental Checkup Cost Sharing	No copay	No copay		

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

		CHIP			QHPs (Based on EHB)		
	Total Benefits	Covered	Limited	Not Covered	Covered	Limited	Not Covered
Core	11	82%	18%	0%	82%	18%	0%
Child-Specific	14	29%	29%	43%	36%	14%	50%

The following table shows the coverage and limits for the core benefits.

	CHIP		EHB	
Service	Coverage	Limits	Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C, E	Benefits are not available for all forms of thermography for all uses and indicators
Durable Medical Equipment & Other Medically-Related or Remedial Devices	C		C, E	Excludes support devices for the foot, deluxe motorized equipment, electronic speech aids; robotization devices, robotic prosthetics, dental

Service	CHIP Coverage	Limits	EHB Coverage	Limits
				appliances, artificial organs, personal hygiene and convenience items, wigs, and hair transplants or implants.
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C, E	No coverage for transplants	C	
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	LL	No coverage for non-preferred brand prescriptions	C	
Medical Transportation - Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental - Preventive & Restorative Services	C, E	Excludes synthetic restorations on posterior teeth	C	
Dental - Orthodontics	C		C	
Vision - Exams	C		C	
Vision - Corrective Lenses	L$	up to $100	C	
Audiology - Exams	C		C	
Audiology - Hearing Aids	U		U	
ABA Therapy	U		U	
Autism - General	C		U	
Physical Therapy, Occupational Therapy, and Speech Therapy	L$	$750/year for non-rehabilitative services	LQ	PT: 40 visits/year, ST: 20 visits/year
Podiatry	U		U	
Habilitation	L$	$750 maximum	LQ	PT: 40 visits/year,

Service	CHIP Coverage	Limits	EHB Coverage	Limits
		benefit per year for non-rehab services		ST: 20 visits/year
Enabling Services	U		U	
Medical Transportation - Non-Emergency Transport	U		U	
Over-the-Counter Medications	U		U	

APPENDIX C: CHIP INFORMATION RELIED ON

State	CHIP Name
Alabama	ALL Kids
Colorado	Child Health Plan Plus (CHP+)
Connecticut	HUSKY (Part B)
Delaware	Healthy Children
Florida	Florida KidCare
Georgia	PeachCare for Kids
Idaho	Idaho Health Plan
Illinois	ALL Kids
Indiana	Hoosier Healthwise
Iowa	Healthy and Well Kids in Iowa (Hawk-I)
Kansas	Healthwave
Kentucky	KCHIP
Louisiana	LaCHIP
Maine	MaineCare
Massachusetts	MassHealth
Michigan	MIChild
Mississippi	CHIP
Missouri	MO HealthNet for Kids
Montana	Healthy Montana Kids
Nevada	Nevada Check Up
New Jersey	NJ Family Care
New York	Child Health Plus (CHPlus)
North Carolina	NC Health Choice for Children (NCHC)
North Dakota	Healthy Steps
Oregon	Healthy Kids
Pennsylvania	CHIP
South Dakota	CHIP
Tennessee	CoverKids
Texas	CHIP
Utah	CHIP
Virginia	Family Access to Medical Insurance Security (FAMIS)
Washington	Apple Health for Kids
West Virginia	CHIP
Wisconsin	BadgerCare Plus
Wyoming	KidCare CHIP

APPENDIX D: SPECIFIC PLAN INFORMATION USED FOR ANALYSIS

[i] http://kff.org/other/state-indicator/monthly-chip-enrollment-june/

[ii] http://kff.org/health-reform/issue-brief/childrens-health-coverage-medicaid-chip-and-the-aca/

[iii] http://kff.org/other/state-indicator/monthly-chip-enrollment-june/

[iv] http://kff.org/health-reform/issue-brief/childrens-health-coverage-medicaid-chip-and-the-aca/

[v] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-Cost-Sharing.html

[vi] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-Benefits.html

Realizing Health Reform's Potential

JULY 2014

Implementing the Affordable Care Act: State Action on Quality Improvement in State-Based Marketplaces

Sarah J. Dash, Sabrina Corlette, and Amy Thomas

Abstract Under the Affordable Care Act, the health insurance marketplaces can encourage improvements in health care quality by: allowing consumers to compare plans based on quality and value, setting common quality improvement requirements for qualified health plans, and collecting quality and cost data to inform improvements. This issue brief reviews actions taken by state-based marketplaces to improve health care quality in three areas: 1) using selective contracting to drive quality and delivery system reforms; 2) informing consumers about plan quality; and 3) collecting data to inform quality improvement. Thirteen state-based marketplaces took action to promote quality improvement and delivery system reforms through their marketplaces in 2014. Although technical and operational challenges remain, marketplaces have the potential to drive systemwide changes in health care delivery.

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OVERVIEW

Health care quality in the United States is widely recognized to be highly variable, with many Americans not receiving needed care and others receiving uncoordinated, unnecessary, or even harmful services.[1] While public and private health care purchasers have taken promising steps to achieve the three-part aim of improved health, better quality, and lower health care costs, their success to date has been inconsistent.[2] The new health insurance marketplaces created by the Affordable Care Act have the potential to improve the quality and cost-effectiveness of health care in the individual and small-group markets by establishing a common set of quality improvement requirements for participating insurers and creating a competitive shopping experience in which consumers can more easily compare plans on quality and value.[3]

The Affordable Care Act includes a number of standards intended to encourage private health insurers to improve quality of care and develop innovative delivery system reforms (Exhibit 1).[4] These include requirements

that insurers selling plans in the marketplaces be accredited, report on quality and performance metrics, and implement quality improvement strategies.[5] However, there are challenges to implementing these and other quality requirements: difficulty comparing pre-marketplace health plans with marketplace plans because of potentially different provider networks, benefit structures, and patient populations; the emergence of new commercial insurers for which no quality data exist; the lag time involved in quality data reporting; and the need for adequate enrollment in marketplace plans to ensure the statistical validity of quality measurement and reporting.[6] The U.S. Department of Health and Human Services is phasing in the quality requirements, but states may implement them earlier or tailor them to achieve state-specific goals.[7]

Exhibit 1. Affordable Care Act Quality Requirements for Qualified Health Plans

Requirement	Description	Effective Date
Accreditation	• Marketplace insurers must be accredited on the basis of local performance of their qualified health plans (QHPs) in categories including clinical quality measures (as measured by HEDIS) and patient experience ratings (as measured by CAHPS).[a]	Fully accredited by fourth year of certification as a qualified health plan
Quality improvement strategy	• Qualified health plans must implement a quality improvement strategy to prevent hospital readmissions, improve health outcomes, reduce health disparities, and achieve other quality improvement goals.	2013 for the 2014 plan year
Quality reporting	• Qualified health plans must report to the marketplace, enrollees, and prospective enrollees on health plan performance quality measures. • All nongrandfathered plans inside and outside the marketplace must submit an annual report to HHS and to enrollees regarding whether benefits under the coverage or plan satisfy quality elements similar to those in the quality improvement strategy.[b]	2016 for the 2017 plan year
Quality rating system	• Secretary of HHS must develop a rating system and enrollee satisfaction survey system for qualified health plans. • Marketplace websites must display federally developed quality ratings and enrollee satisfaction information to consumers. • State marketplaces may display their own quality rating systems prior to 2016; beginning in 2016, they may display a state-specific quality rating system in addition to the required uniform federal quality rating system.	2016 for the 2017 plan year
Additional quality requirements	• Medical loss ratio: health insurers must spend at least 80 percent to 85 percent of revenue on health care and quality improvement.[c] • Patient safety: qualified health plans must comply with patient safety regulations.[d]	2012 (medical loss ratio) 2015 (patient safety)

[a] Healthcare Effectiveness Data and Information Set (HEDIS) is a registered trademark of the National Committee for Quality Assurance (NCQA) and is included in NCQA accreditation. HEDIS shows how often health insurance plans provide scientifically recommended tests and treatments for more than 70 aspects of health. Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a registered trademark of the Agency for Healthcare Research and Quality and is included in NCQA and URAC (formerly known as the Utilization Review Accreditation Commission) accreditation. CAHPS surveys patients' own experiences of care, including timely access to care and overall views of health plans and doctors.

[b] Nongrandfathered plans are health plans created after March 23, 2010, or those that were in existence on or before March 23, 2010 but did not meet regulatory criteria for remaining grandfathered.

[c] Under the Affordable Care Act, health plans in the individual and small-group markets must spend at least 80 percent of revenues on health care and quality improvement; for large-group plans, the minimum medical loss ratio is 85 percent.

[d] Beginning in 2015, QHPs may only contract with hospitals with greater than 50 beds if they use a patient safety evaluation system and health care providers that implement quality improvement mechanisms.

Source: Authors' analysis.

This brief reviews action taken by state-based marketplaces to implement the law's quality requirements, as well as other efforts to improve health care quality. It focuses on three areas: 1) selectively contracting only with insurers that advance marketplace goals by implementing quality and delivery system reforms; 2) informing consumers about health plan quality; and 3) collecting data to inform quality improvement. Thirteen state-based marketplaces took one or more of these steps in 2014. Some states with federally facilitated marketplaces also may be pursuing similar strategies, but this is outside the scope of this brief.[8] States are in different stages of progress. Some are opting for a more proactive approach, while others are deferring quality improvement efforts to focus on immediate operational issues, avoid requirements that might deter insurers from participating, or await further federal guidance. Efforts to drive quality improvement and broader payment and delivery system reforms through the marketplaces are still in their infancy and can be expected to evolve significantly in the future.[9]

FINDINGS

Promoting Quality Improvement and Delivery System Reforms

Thirteen state-based marketplaces took one or more steps to promote quality improvement and delivery system reforms through their marketplaces in 2014. Of these, four selectively contracted with health plans based on quality and value, nine publicly displayed or linked to quality information in 2014, and 11 took action to collect quality information from insurers (Exhibit 2).[10] Of the states reporting public quality data, eight used some form of a star rating system.

Exhibit 2. Summary of State Action on Quality Improvement and Delivery System Reforms, 2014

State	Using Selective Contracting Based on Health Plan Quality and Value	Publicly Reporting Quality Information on Marketplace Plans	Collecting Quality Information from Marketplace Insurers
California	X	X	X
Colorado	–	X	X
Connecticut	–	X	X
Kentucky	–	–	X
Maryland	–	X	X
Massachusetts	X	X	–
Nevada	–	–	X
New York	–	X	X
Oregon	–	X	X
Rhode Island	X	–	X
Utah	–	X*	–
Vermont	X	–	X
Washington	–	X	X

Notes: Quality information includes clinical quality and patient experience metrics as well as quality improvement strategy summaries.

* In Utah, the marketplace includes a link to quality reports but does not directly incorporate quality information in the overall display of health plan information. In addition, quality information is available only for the SHOP marketplace.

Source: Authors' analysis.

Using a Selective Contracting Approach

The Affordable Care Act granted states significant discretion in determining whether and how to approve plans that apply to be sold on their state marketplaces.[11] States can allow any plan meeting basic criteria to be sold on their marketplaces or can be more selective by approving only those health plans that meet criteria set by the state, such as the plan's ability to promote quality and value.[12] The latter approach is known as "selective contracting" or "active purchasing." In 2014, four states—California, Massachusetts, Rhode Island, and Vermont—adopted a selective contracting approach (Exhibit 3).[13]

Exhibit 3. State Approaches to Selecting Marketplace Plans for 2014

Plan Selection Approach	Definition	States
Selective contracting	State contracts only with insurers that advance marketplace goals; state may manage plan choices by limiting the number or type of plans that an insurer can offer.	CA, MA, RI, VT
Market organizer	State manages plan choices by limiting the number or type of plans that an insurer can offer but does not selectively contract with insurers.	CT,[a] KY, MD,[b] NV, NY, OR[c]
Clearinghouse	State allows all plans meeting minimum criteria to participate on the marketplace; state does not selectively contract with insurers or manage plan choices.	CO,[d] DC, HI, MN,[e] NM, UT, WA

Note: These data reflect state-based marketplace design decisions for policy or plan years beginning on or after January 1, 2014. These data do not identify the options that a state-based marketplace may be considering for future years. The federally facilitated marketplace operated as a clearinghouse in 2014.

[a] In Connecticut, the marketplace will contract with any carrier that meets the standards for qualified health plan (QHP) certification. Nothing precludes the marketplace from selectively contracting and not offering for sale one or more otherwise certified QHPs on the basis of price if there is an adequate number of QHPs available to allow for sufficient consumer choice.

[b] In Maryland, the marketplace has the authority to employ selective contracting strategies beginning in 2016.

[c] Oregon had legislative authority to pursue an active purchaser model but chose not to adopt this in 2014.

[d] Colorado law prohibits the marketplace from serving as an active purchaser.

[e] Minnesota's marketplace had statutory authority to pursue an "active purchaser" model beginning in 2015. In January 2014, the board for MNSure, Minnesota's health insurance marketplace, considered whether to pursue an active purchaser model in 2015 as allowed by law, but decided not to do so.

Source: Authors' analysis.

Marketplaces that used selective contracting evaluated and selected plans based on factors like affordability, use of team-based care, prevention and wellness programs, and participation in statewide payment reforms.[14] Massachusetts, for example, required insurers to develop plans to shift provider contracts from fee-for-service to risk-based payment models, like global or bundled payments.[15] Covered California—California's health insurance marketplace—evaluated and selected plans based on factors such as affordability, patients' access to high quality care, and efforts to reduce health disparities.[16]

Providing Public Information on Health Plan Quality or Consumer Satisfaction

Reporting on health plan quality can encourage consumers to select health plans with high scores on measures of quality and consumer satisfaction.[17] Under the Affordable Care Act, health plans sold on the marketplaces are not required to do so until 2016. However, nine states made quality or consumer satisfaction information for marketplace health plans publicly available this year (Exhibit 4). Of these, eight states made quality or consumer satisfaction data available directly on their marketplace web site, while one state, Utah, linked to external quality data.

Exhibit 4. State Action to Report Health Plan Quality Information to Consumers, 2014

State	Displayed Quality Data in 2014	Star Rating System	Quality Rating Score Metrics	Other Quality Information Displayed
Federally facilitated marketplace	–	–	–	–
California	X	4 stars	CAHPS	–
Colorado	X	5 stars	CAHPS	Accrediting agency, accreditation type, accreditation status, detailed ratings for those plans that are currently NCQA accredited, Consumer Complaints Index, free text section outlining quality improvement strategy, individual HEDIS metrics
Connecticut	X	4 stars	NCQA accreditation	–
District of Columbia	–	–	–	–
Hawaii	–	–	–	–
Kentucky	–	–	–	–
Maryland	X	5 stars	CAHPS, HEDIS, state-specific metrics	–
Massachusetts	X	4 stars	NCQA accreditation	–
Minnesota	–	–		–
Nevada	–	–	–	–
New Mexico	–	–	–	–
New York	X	4 stars	CAHPS, HEDIS, state-specific metrics	–
Oregon	X	4 stars	CAHPS, HEDIS	–
Rhode Island	–	–	–	–
Utah	X	3 stars	CAHPS	–
Vermont	–	–	–	–
Washington	X	–	–	Quality improvement strategy summary

Notes: The data reflect state-based marketplace design decisions and currently available information on state-based marketplace websites as of February 1, 2014. The data do not identify the options that a state-based marketplace may be considering for future years. For more detail on state public quality reporting strategies, see the Appendix. HEDIS = Healthcare Effectiveness Data and Information Set; NCQA = National Committee for Quality Assurance; CAHPS = Consumer Assessment of Healthcare Providers and Systems.

Source: Authors' analysis.

Beginning in 2016, all marketplaces will be required to display quality metrics using a federal quality rating system, developed by the U.S. Department of Health and Human Services, that aggregates multiple metrics into scores depicted as a star rating.[18] Most of the states displaying quality information in 2014 used a state-specific star rating system, though states differed in terms of data sources, numbers and types of metrics, and methodologies. Five states converted a single source of data—such as accreditation status or consumer satisfaction data—into a star rating, while three states—Maryland, New York, and Oregon—implemented comprehensive quality rating systems that incorporated multiple data sources (Exhibit 5).

Exhibit 5. Comparison of Selected Quality Rating System Structures

	Federally Facilitated Marketplace[a,b]	Maryland	New York	Oregon
Global rating	Five-star scale	Five-star scale	Four-star scale	Four-star scale
Summary ratings	• Clinical quality management • Member experience • Plan efficiency, affordability, and management	• HEDIS • CAHPS • Other state-specific metrics	–	–

Domains	• Clinical effectiveness
	• Patient safety[b]
	• Care coordination
	• Prevention
	• Access
	• Doctor and care
	• Efficiency and affordability
	• Plan services
		• Indicators of clinical performance (HEDIS)
		• Enrollee satisfaction measures (CAHPS)
		• Other state-specific metrics:
		  • Maryland Behavioral Health Assessment
		  • Maryland Health Plan Quality Profile
		  • Qualified Health Plan Focus on Cultural and Ethnic Diversity of Membership
			• Satisfaction
			• Children
			• Pregnancy
			• Adult health conditions[c]
				• Preventive care
				• Complex care
				• Patient experience

Composites	• Clinical effectiveness: behavioral health, cardiovascular care, diabetes care • Prevention: cancer screens, maternal health, adult health, child health • Access: access to preventive visits, composite scores of access to care • Doctor and care composite measure • Plan efficiency: efficient care, members' experiences with health plan	• HEDIS: women's health, primary care, and wellness for children and adolescents, behavioral health • CAHPS: rating of health plan, customer service composite score, getting needed care composite score • Behavioral Health Assessment: number of Maryland providers, network provider locations • Quality Profile: quality assurance and quality improvement initiatives • Race/Ethnicity, Language, Interpreters, and Cultural Competency (RELICC) survey: diversity of enrollees, provider network and carrier staff languages	–	–
Number and examples of individual metrics	42 metrics for adults, 25 for children[d] Examples: • Follow-up after hospitalization for mental illness • Controlling high blood pressure • Medication management for people with asthma (ages 5–18) • Childhood immunization status (child only) • Breast cancer screening	100+ measures of plan performance[e] Examples: • Well-child visits in the first 15 months of life • Child immunization services • Adolescent well-care visits • Human Papillomavirus vaccine (female adolescents) • Use of appropriate medications for people with asthma • Breast cancer screening	12 HEDIS and CAHPS measures Examples: • Rating of health plan • Immunization • Timeliness of prenatal care • Breast cancer screening • Advising smokers to quit	Examples: • Breast cancer screenings • Flu shots • Diabetes screenings • Avoidable hospital stays • Overall rating of health care

Notes: Reflects federal quality rating system and proposed New York quality rating system, as well as quality rating systems currently in use for marketplace plans in Maryland and Oregon. HEDIS = Healthcare Effectiveness Data and Information Set; CAHPS = Consumer Assessment of Healthcare Providers and Systems.

[a] In the proposed federally facilitated marketplace, the qualified health plan-specific quality rating will be available for display in the 2016 open enrollment period for the 2017 coverage year. The federally facilitated marketplace website, healthcare.gov, is not currently displaying quality metrics for participating plans.

[b] In the federal quality rating system, child-only measure sets do not include patient safety as a domain, but use the same three summary indicators as for adults (clinical quality management, member experience, and plan efficiency, affordability, and management).

[c] In New York, five domains provide information about categories of care; two domains focus on overall performance of Child Health Plus plans.

[d] The proposed federal quality rating system will use 42 total measures including 29 clinical measures and 13 CAHPS survey measures. The child-only quality rating system consists of 25 total measures, including 15 clinical measures and 10 CAHPS survey measures.

[e] Maryland does not have a separate child-only rating system.

Source: Authors' analysis.

States had strong interest in moving forward with quality reporting, but some chose instead to focus on immediate operational needs or proceeded in a more limited way than originally planned because of technical challenges.[19] California, for example, altered its original plan to display comprehensive quality ratings incorporating both clinical quality and consumer satisfaction data, partly because the best available performance information for the majority of plans participating in the marketplaces would have reflected significantly different products, provider networks, and populations than non-marketplace plans. Instead, for plan year 2014, California opted to display a simplified rating system encompassing 10 survey questions on consumer satisfaction based on services delivered in 2011.[20]

Reporting Quality Information to the Marketplace

Ongoing data collection and evaluation of health plan quality and costs will be critical to developing marketplace strategies aimed at improving quality and reforming the delivery system.[21] In 2014, 11 states required insurers to report quality information to their marketplaces to inform the 2014 plan selection and quality reporting process, as well as to aid future decision-making on quality initiatives (Exhibit 6). However, states varied in the level of specificity required. While most states required insurers to report measures from national data sets such as Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS), others required more extensive data reporting. California, for the initial plan selection and certification process, required insurers to submit detailed information on plan performance and quality improvement through the eValue8 survey, a value-based purchasing tool that collects standardized data on hundreds of quality and performance metrics.[22] Additionally, California requires insurers to submit HEDIS and CAHPS data for use in future comprehensive quality rating system development. Other marketplaces, such as those in Maryland, New York, and Vermont, drew on long-standing quality reporting requirements in their states.[23] California and New York specified that insurers should have adequate infrastructure to collect, report, and analyze health care quality data and carry out quality improvement activities.[24] In addition, eight states required insurers to provide a written report of their quality improvement strategies.

To maximize the effectiveness of quality and delivery system reform efforts and ease the burden of reporting requirements, marketplaces can align their quality improvement strategies, measurements, and programs with other payers.[25] Such efforts could be facilitated by statewide collection of cost, utilization, and other data through tools like all-payer claims databases.[26] Twelve of the study states have or are implementing such a database.[27]

DISCUSSION

Health insurance marketplaces are a potential vehicle for improving the quality and cost-effectiveness of care delivered to millions of people in the individual and small-group markets.[28] To do so, they must address the fragmentation that has previously characterized these markets by setting common, evidence-based standards and expectations for quality improvement, delivery system reform, and population health. Quality improvement efforts must overcome challenges like the need for effective IT systems, sufficient enrollment to make quality measurement statistically meaningful, selecting among the most effective quality measures and delivery system reforms, and technical complexities like lag times in data reporting and a lack of data for new plans in the market.

Exhibit 6. Health Insurance Marketplace Internal Reporting Requirements for 2014

State	Requiring Qualified Health Plans to Report Quality Information Beyond Accreditation Status to Marketplace in 2014[a]	Type of Quality Reporting Information			
		CAHPS	HEDIS	State-Specific Metrics	Quality Improvement Strategy[b]
Federally facilitated marketplace	–	–	–	–	–
California*	X	X	X	–	X
Colorado*	X	X	X	–	–[c]
Connecticut*	X	X	–	–	X
District of Columbia	–	–	–	–	–
Hawaii	–	–	–	–	–
Kentucky	X	–	–	–	X
Maryland*	X	X	X	X	–
Massachusetts*	–	–	–	–	–
Minnesota*	–	–	–	–	–
Nevada	X	–	–	–	X
New Mexico	–	–	–	–	–
New York*	X	X	X	X	X
Oregon*	X	X	X	–	X
Rhode Island*	X	–	–	–	X
Utah*	–	–	–	–	–
Vermont*	X	–	–	X	–
Washington*	X	–	–	–	X

* State has or is implementing an all-payer claims database (APCD). In Connecticut, the marketplace administers the APCD and an advisory group drafts the policies and procedures. New York's APCD will support the business operations of the marketplace, including providing the marketplace with quality and price data. Minnesota is prohibited by statute from using its APCD for purposes of developing quality metrics.

Notes: HEDIS = Healthcare Effectiveness Data and Information Set; CAHPS = Consumer Assessment of Healthcare Providers and Systems.

[a] Reflects reporting requirements in addition to the insurer's accreditation status, which is a required reporting requirement in all marketplaces.

[b] State requires a written narrative regarding the insurers' quality improvement strategy (QIS). States requiring issuers to attest to their QIS, without requiring reporting on its contents, were not included. In 2014, insurers must implement a QIS to reduce readmissions, improve health outcomes, and achieve other goals. In 2016, insurers must submit an annual report to HHS and to enrollees regarding whether benefits under the coverage or plan satisfy quality elements similar to those in the QIS.

[c] Insurers in Colorado must attest to having a QIS; a narrative is optional. If completed, the QIS will be displayed to consumers.

Source: Authors' analysis.

Health insurance marketplaces allow consumers to compare plans side by side based on variables like cost, benefits, and quality ratings. While there is some evidence that consumers use quality information to guide coverage decisions, there are also limitations to its usefulness, particularly in the initial years. Many consumers are navigating the complexities of selecting a private insurance plan for the first time this year, and are likely to be more focused on factors like premiums and cost-sharing.[29] Efforts to display public quality information also were hindered by the limitations of the marketplace information technology infrastructure during the 2014 open enrollment season. As a result, consumers lacked the tools to make plan choices informed by quality data. Because marketplace health plans are new entities that must build experience to accurately report on quality, and all states must

implement the federal quality rating system in 2016, consumers also should be educated on year-to-year differences in health plan quality scores. States can help consumers better understand the value and limitations of quality data by providing web-based decision-support software and clear explanations and by training call center staff, navigators, assisters, and brokers to answer consumers' questions. In addition, states can enhance the value of their public quality reporting by evaluating how consumers used available information to make purchasing decisions, and by considering additional features such as the ability to drill down to individual quality metrics.

A health insurance marketplace is just one of many purchasers and payers operating in an environment crowded with diverse quality measure sets and initiatives.[30] Although many states took action to display quality information to consumers in 2014, their efforts reflected a variety of methodologies, performance metrics, and data sources. While this diversity allows for innovation, the lack of alignment among goals and metrics can burden providers and insurers, dilute efforts to bring evidence-based reforms to their maximum potential, and make comparisons more challenging. Final regulations require states to display a federally developed quality rating system in 2016, while allowing them to also display their own metrics pursuant to forthcoming guidance.[31] State health insurance marketplaces will need to weigh the value of adding state-specific metrics to the federally required quality rating system, particularly if they have limited resources or other operational challenges.

Marketplace quality improvement efforts in most states have primarily focused on displaying data for consumers, with only a few states setting additional requirements for insurers' quality improvement efforts. Insurers may be encouraged to improve their performance simply because quality data is made public. But even the most robust public quality reporting system is limited in its ability to drive competition based on quality, partly because consumers will be comparing plans based on other factors, such as cost, covered benefits, and provider networks. Policymakers also will need to consider the infrastructure, such as information technology systems, needed by marketplaces and insurers to conduct quality improvement activities. A foundation of reliable, timely, and comparable performance data for all marketplace health plans will be essential for analyzing the effect of quality improvement efforts on outcomes and costs. It also will be critical in deciding on next steps—for instance, approving plans based on quality and performance or tying financial incentives to plan performance—which may further drive plans to compete on quality.

The Affordable Care Act offers state health insurance marketplaces a foundation for promoting quality improvement and delivery system reform and most state marketplaces are working toward these goals. Recent federal regulations requiring uniformity in quality reporting in all marketplaces also may help consumers compare plans based on quality, although it will be important to educate consumers on the differences between quality rating systems that states may be using this year and the federal system yet to be put in place. States' initial efforts offer an important learning opportunity for evaluating the effect of quality improvement initiatives in health insurance marketplaces on the delivery of high-quality care.

Methodology

This issue brief examines policy and design decisions made by the 16 states (California, Colorado, Connecticut, Hawaii, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, and Washington) and the District of Columbia that chose to establish and operate a state-based individual or Small Business Health Options Program (SHOP) marketplace for 2014. Idaho's individual and SHOP marketplaces, along with New Mexico's individual marketplace, are operating as a "supported state-based marketplace" in 2014, borrowing the federal information technology infrastructure as the states build their own IT systems. Although not reviewed for purposes of this paper, states in which the federal government is managing the marketplace, including state-partnership marketplaces, have discretion over certain policy decisions affecting the operation of the marketplace in their state, including setting standards to promote quality and delivery system reforms.

Our findings are based on public information—such as state laws, regulations, subregulatory guidance, marketplace solicitations, and other materials related to marketplace development—and interviews with state regulators. Data on public quality metrics were confirmed, where possible, by browsing the available plan offerings on state marketplace websites. The resulting assessments of state action were confirmed by state officials. These features may change or be periodically unavailable as states continue to develop their marketplaces.

Appendix. State-Based Marketplace Action on Health Plan Quality Reporting, 2014

Marketplace	Public Quality Reporting for 2014
Federally facilitated marketplace	Did not publicly display health plan quality performance data in 2014. Beginning in 2016, all marketplaces must display quality data. Insurers must submit quality data beginning in 2015 to use in beta testing, but this will not be publicly reported.
California	Publicly displayed health plan quality performance data in 2014. Used a 4-star quality rating score reflecting 10 CAHPS measures based on services delivered in 2011. For initial plan selection and certification, California's marketplace also required insurers to report eValue8 scores. For recertification, California required completion of select eValue8 modules as well as commitments to provide additional potential quality metrics that could be reported on and measured in the future.
Colorado	Publicly displayed health plan quality performance data in 2014. Used a 5-star quality rating score reflecting health plans' response to the "overall rating of health plan" CAHPS question based on services delivered in 2011. Plans without a score were labeled "rating in progress."
Connecticut	Publicly displayed health plan quality performance data in 2014. Used 4-star quality rating score based on insurers' NCQA accreditation status converted into star rating, with 4 stars reflecting an "excellent" rating, 3 stars reflecting "commendable," 2 stars reflecting "accredited," and 1 star reflecting "provisional." If NCQA accreditation has not been achieved by a plan, "not yet rated" is displayed.
District of Columbia	Did not publicly display health plan quality performance data in 2014.
Hawaii	Did not publicly display health plan quality performance data in 2014.
Kentucky	Did not publicly display health plan quality performance data in 2014. Kentucky had initially planned to display a 5-star quality rating score based on NCQA accreditation in 2014, but did not do so.
Maryland	Publicly displayed health plan quality data in 2014. Used a 5-star quality rating score incorporating measures from CAHPS, HEDIS, and state-specific quality reporting systems based on services provided in 2012. These values are run through a formula created by the Maryland Health Care Commission in which the total scores are then given a star value, with 1 star representing the 0–10th percentile, 2 stars representing the 11th–25th percentile, 3 stars representing the 26th–50th percentile, 4 stars representing the 51st–75th percentile, and 5 stars representing performance above the 75th percentile.
Massachusetts	Publicly displayed health plan quality performance data in 2014. Used a 4-star quality rating system reflecting NCQA accreditation scores.
Minnesota	Did not publicly display health plan quality performance data in 2014, although it had plans to do so. Minnesota pursued, but did not implement, development of a state-specific quality rating system methodology in 2014.
Nevada	Did not publicly display health plan quality performance data in 2014.
New Mexico	Did not publicly display health plan quality performance data in 2014. In New Mexico, insurers are expected to begin reporting quality data to the marketplace in 2014.
New York	Publicly displayed health plan quality performance data in 2014. Used a 4-star quality rating score based on a combination of approximately 20 HEDIS and CAHPS measures. The New York State Department of Health displays "new plan quality data not yet available" for those plans without reportable quality data. The New York Office of Quality and Patient Safety is developing a quality rating system aggregated into five domains contributing to an overall rating for each insurer or product (i.e., type of health insurance, such as HMO or PPO). The five domains are consumer satisfaction, children's health, pregnancy care, adult health, and health conditions.
Oregon	Publicly displayed health plan quality performance data in 2014. Used a 4-star quality rating score incorporating CAHPS and HEDIS health plan performance measures in three domains: preventive care, complex care, and patient experience. Star rating is determined by comparing the insurers' scores on various metrics within these domains compared with the Oregon average, the national average, and the national 90th percentile. Four stars reflects performance above all three benchmarks, 3 stars reflects performance above two benchmarks, 2 stars reflects performance above one benchmark, and 1 star reflects that performance does not exceed any benchmarks.
Rhode Island	Did not publicly display health plan quality performance data in 2014, although it had plans to do so.
Utah	Linked to health plan quality performance data in 2014, but did not embed quality data in marketplace health plan display.
Vermont	Did not publicly display health plan quality performance data in 2014. All marketplace health plans must comply with existing state regulations for managed care organizations, including reporting to the state on HEDIS, CAHPS, and state-specific performance measures.
Washington	Publicly displayed quality improvement strategy summary, but not other performance data, in 2014. Washington expects to display quality measures, beyond the quality improvement strategy, as early as the 2015 open enrollment period for the 2016 plan year. Insurers are expected to begin reporting quality data to the exchange in 2014.

Source: Authors' analysis of regulations, public state documents, marketplace websites, and interviews with state regulators.

Notes

1. See, e.g., Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century.* (Washington, D.C.: National Academies Press, March 2001).

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3. J. Volk and S. Corlette, *The Role of Exchanges in Quality Improvement: An Analysis of the Options.* (Washington, D.C.: Georgetown University Health Policy Institute, Sept. 2011).

4. Ibid.

5. 45 C.F.R. §156.275, §155.1045, §155.200, §155.205.

6. Volk and Corlette, *Role of Exchanges in Quality Improvement,* 2011.

7. Center for Consumer Information and Insurance Oversight, *General Guidance on Federally Facilitated Exchanges* (Washington, D.C.: U.S. Department of Health and Human Services, CCIIO, May 16, 2012); Center on Consumer Information and Insurance Oversight, *Letter to Issuers* (Washington, D.C.: U.S. Department of Health and Human Services, CCIIO, April 5, 2013); and U.S. Department of Health and Human Services, *Request for Information Regarding Health Care Quality for Exchanges (CMS–9962–NC)* (Washington, D.C.: DHHS, Nov. 27, 2012).

8. See, e.g., Arkansas Insurance Department, *Bulletin No. 9-2014: 2015 Plan Year Requirements for Qualified Health Plan Certification in the Arkansas Federally-Facilitated Partnership Marketplace* (April 11, 2014).

9. See, e.g., S. Delbanco, "The Payment Reform Landscape: Pay-for-Performance," *Health Affairs Blog,* March 4, 2014, http://healthaffairs.org/blog/2014/03/04/the-payment-reform-landscape-pay-for-performance/; and C. L. Damberg, E. M. Sorbero, S. L. Lovejoy et al., *Measuring Success in Health Care Value-Based Purchasing Programs: Findings from an Environmental Scan, Literature Review, and Expert Panel Discussions* (Santa Monica, Calif.: RAND Corporation, 2014).

10. In Utah and Vermont the exchange will include a link to quality reports but will not incorporate quality information in the search function for Qualified Health Plans in 2014. In Utah, quality information is available in the SHOP marketplace only.

11. S. Dash, K. Lucia, K. Keith et al., *Implementing the Affordable Care Act: Key Design Decisions for State-Based Exchanges* (New York: The Commonwealth Fund, July 2013).

12. Volk and Corlette, *Role of Exchanges in Quality Improvement,* 2011; and Dash, Lucia, Keith et al., *Implementing the Affordable Care Act: Key Design,* 2013.

13. Dash, Lucia, Keith et al., *Implementing the Affordable Care Act: Key Design,* 2013.

14. Vermont Health Connect, *Request For Proposals: Selection of Qualified Health Plans* (Williston, Vt.: Vermont Health Connect, Dec. 21, 2012); Covered California, *Qualified Health Plan Contract for 2014* (Sacramento, Calif.: Covered California, July 3, 2013); and Rhode Island Executive Order 11-09, Sept. 19, 2011 §11; 33 VSA Sec. 1806(a).

15. In Massachusetts, participating insurers must work with the Health Connector to develop a specific plan to transition its provider contracts over a defined time frame, with the specific goal being that at least 25 percent of its membership would be covered under provider contracts based

on alternative payment models. Alternative payment models include methods of payment that are not solely based on fee-for-service reimbursements including, but not limited to, shared-savings arrangements, bundled payments, and global payments. Alternative payment methodologies may also include fee-for-service payments, which are settled or reconciled with a bundled or global payment.

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[20] Covered California, *Memorandum: Health Plan Quality Rating Systems for 2013*, (Sacramento, Calif.: Covered California, Aug. 2, 2013); Covered California, *Covered California Exchange Board Meeting Minutes* (Sacramento, Calif.: Covered California, Nov. 21, 2013); and Covered California, *Covered California Executive Directors Report* (Sacramento, Calif.: Covered California, Aug. 22, 2013).

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[22] National Business Group on Health, About eValue8, http://www.nbch.org/eValue8; and Covered California, *QHP Issuer 2015 Renewal Application* (Sacramento, Calif.: Covered California, draft Jan. 2013).

[23] Personal correspondence with exchange official, New York Health Benefit Exchange (May 15, 2013) (on file with authors); and personal correspondence with exchange official, Vermont Health Benefit Exchange (May 14, 2013) (on file with authors).

[24] California Health Benefit Exchange, *2012–2013 Initial Qualified Health Plan Solicitation to Health Issuers and Invitation to Respond, Redline Version: Companion to QHP New Entrant Application for Plan Year 2015 Draft, January 23, 2014* (Sacramento, Calif.: Covered California, Jan. 2014); and Office of the New York Health Benefit Exchange, *Invitation to Participate in the New York Health Benefit Exchange, January 31, 2013* (Albany, N.Y.: New York State Department of Health, Jan. 31, 2013).

[25] Volk and Corlette, *Role of Exchanges in Quality Improvement,* 2011.

[26] J. Porter, D. Love, A. Peters et al., *The Basics of All-Payer Claims Databases: A Primer for States* (Princeton, N.J.: Robert Wood Johnson Foundation, Jan. 2014).

[27] Ibid.; and authors' analysis.

[28] J. Banthin and S. Masi, *Updated Estimates of the Insurance Provisions of the Affordable Care Act* (Washington, D.C.: Congressional Budget Office, March 4, 2014).

[29] C. H. Monahan, S. J. Dash, K. W. Lucia et al., *What States Are Doing to Simplify Health Plan Choice in the Insurance Marketplaces* (New York: The Commonwealth Fund, Dec. 2013).

[30] A. Higgins, G. Veselovskiy, and L. McKown, "Provider Performance Measures in Private and Public Programs: Achieving Meaningful Alignment with Flexibility to Innovate," *Health Affairs,* Aug. 2013 32(8):1453–61.

[31] 45 C.F.R. §155.1400, §156.1120; and U.S. Department of Health and Human Services, *Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond: Final Rule* (Washington, D.C.: DHHS, May 2014).

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United States Government Accountability Office

Report to Congressional Requesters

July 2014

HEALTHCARE.GOV

Ineffective Planning and Oversight Practices Underscore the Need for Improved Contract Management

GAO-14-694

GAO Highlights

Highlights of GAO-14-694, a report to congressional requesters

July 2014

HEALTHCARE.GOV

Ineffective Planning and Oversight Practices Underscore the Need for Improved Contract Management

Why GAO Did This Study

In March 2010, the Patient Protection and Affordable Care Act required the establishment of health insurance marketplaces by January 1, 2014. Marketplaces permit individuals to compare and select insurance plans offered by private insurers. For states that elected not to establish a marketplace, CMS was responsible for developing a federal marketplace. In September 2011, CMS contracted for the development of the FFM, which is accessed through Healthcare.gov.

When initial enrollment began on October 1, 2013, many users encountered challenges accessing and using the website. GAO was asked to examine various issues surrounding the launch of the Healthcare.gov website. Several GAO reviews are ongoing.

This report assesses, for selected contracts, (1) CMS acquisition planning activities; (2) CMS oversight of cost, schedule, and system capability changes; and (3) CMS actions to address contractor performance. GAO selected two task orders and one contract that accounted for 40 percent of CMS spending and were central to the website. For each, GAO reviewed contract documents and interviewed CMS program and contract officials as well as contractors.

What GAO Recommends

GAO recommends that CMS take immediate actions to assess increasing contract costs and ensure that acquisition strategies are completed and oversight tools are used as required, among other actions. CMS concurred with four recommendations and partially concurred with one.

View GAO-14-694. For more information, contact William T. Woods at (202) 512-4841 or woodsw@gao.gov.

What GAO Found

The Centers for Medicare & Medicaid Services (CMS) undertook the development of Healthcare.gov and its related systems without effective planning or oversight practices, despite facing a number of challenges that increased both the level of risk and the need for effective oversight. CMS officials explained that the task of developing a first-of-its-kind federal marketplace was a complex effort with compressed time frames. To be expedient, CMS issued task orders to develop the federally facilitated marketplace (FFM) and federal data services hub (data hub) systems when key technical requirements were unknown, including the number and composition of states to be supported and, importantly, the number of potential enrollees. CMS used cost-reimbursement contracts, which created additional risk because CMS is required to pay the contractor's allowable costs regardless of whether the system is completed. CMS program staff also adopted an incremental information technology development approach that was new to CMS. Further, CMS did not develop a required acquisition strategy to identify risks and document mitigation strategies and did not use available information, such as quality assurance plans, to monitor performance and inform oversight.

CMS incurred significant cost increases, schedule slips, and delayed system functionality for the FFM and data hub systems due primarily to changing requirements that were exacerbated by oversight gaps. From September 2011 to February 2014, FFM obligations increased from $56 million to more than $209 million. Similarly, data hub obligations increased from $30 million to nearly $85 million. Because of unclear guidance and inconsistent oversight, there was confusion about who had the authority to approve contractor requests to expend funds for additional work. New requirements and changing CMS decisions also led to delays and wasted contractor efforts. Moreover, CMS delayed key governance reviews, moving an assessment of FFM readiness from March to September 2013—just weeks before the launch—and did not receive required approvals. As a result, CMS launched Healthcare.gov without verification that it met performance requirements.

Late in the development process, CMS identified major performance issues with the FFM contractor but took only limited steps to hold the contractor accountable. In April and November 2013, CMS provided written concerns to the contractor about product quality and responsiveness to CMS direction. In September 2013, CMS program officials became so concerned about the contractor's performance that they moved operations to the FFM contractor's offices to provide on-site direction. At the time, CMS chose to forego actions, such as withholding the payment of fee, in order to focus on meeting the website launch date. Ultimately, CMS declined to pay about $267,000 in requested fee. This represents about 2 percent of the $12.5 million in fees paid to the FFM contractor. CMS awarded a new contract to another firm for $91 million in January 2014 to continue FFM development. As of June 2014, costs on the contract had increased to over $175 million due to changes such as new requirements and other enhancements, while key FFM capabilities remained unavailable. CMS needs a mitigation plan to address these issues. Unless CMS improves contract management and adheres to a structured governance process, significant risks remain that upcoming open enrollment periods could encounter challenges.

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Abbreviations

CCIIO	Center for Consumer Information and Insurance Oversight
CHIP	State Children's Health Insurance Program
CGI Federal	CGI Federal Inc.
CMS	Centers for Medicare & Medicaid Services
COR	contracting officer's representative
data hub	federal data services hub
DOD	Department of Defense
FAR	Federal Acquisition Regulation
FFM	federally facilitated marketplace
GTL	government task leader
HHS	Department of Health and Human Services
HHSAR	Department of Health and Human Services Acquisition Regulation
IT	Information technology
IRS	Internal Revenue Service
OAGM	Office of Acquisition and Grants Management
OCIIO	Office of Consumer Information and Insurance Oversight
OIS	Office of Information Services
OPM	Office of Personnel Management
PPACA	Patient Protection and Affordable Care Act
QSSI	QSSI, Inc.
VA	Department of Veterans Affairs

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GAO U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
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July 30, 2014

Congressional Requesters

The Patient Protection and Affordable Care Act (PPACA), enacted in March 2010, made fundamental changes to the availability and affordability of health insurance coverage.[1] A central provision of the law required the establishment of state health insurance exchanges, now commonly referred to as marketplaces, by January 1, 2014. Marketplaces permit individuals to compare and select private health insurance plans. For states that elected not to establish a marketplace, PPACA required the federal government to establish and operate a federal marketplace.[2]

The Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS) was responsible for designing, developing, and implementing the information technology (IT) systems needed to support the federal marketplace which users access via the Healthcare.gov website. CMS largely relied on contractors to develop, build, and operate the necessary information technology systems. When initial enrollment began on October 1, 2013, many users were unable to successfully access and use the Healthcare.gov website to obtain health insurance information due to problems such as website failures, errors, and slow response times.

Given the high degree of congressional interest in examining the development, launch, and other issues associated with accessing the federal marketplace through the Healthcare.gov website, GAO is conducting a body of work in order to assist Congress with its oversight responsibilities. This report examines selected contracts and task orders central to the development and launch of the Healthcare.gov website by assessing (1) CMS acquisition planning activities; (2) CMS oversight of cost, schedule, and system capability changes; and (3) actions taken by CMS to identify and address contractor performance issues.

[1]Pub. L. No. 111-148, 124 Stat. 119 (2010).

[2]PPACA also requires the creation of Small Business Health Options Program exchanges, where small businesses can shop for and purchase health coverage for their employees.

To address these objectives, we reviewed the Federal Procurement Data System-Next Generation, which is the government's procurement database, to identify CMS contracts and task orders related to the IT systems supporting the Healthcare.gov website and amounts obligated from fiscal year 2010 through March 2014. We performed data reliability assessments and confirmed that the data were sufficiently reliable for our purposes. Based on this information as well as interviews with CMS contracting and program officials, we selected one contract and two task orders issued under an existing 2007 contract for our review.[3] The contract and task orders combined accounted for more than 40 percent of the total CMS reported obligations related to the development of Healthcare.gov and its supporting systems as of March 2014. Specifically, we selected the task orders issued to CGI Federal Inc. (CGI Federal) for the development of the federally facilitated marketplace (FFM) system and to QSSI, Inc. (QSSI) for the development of the federal data services hub (data hub) in September 2011—and the contract awarded to Accenture Federal Services in January 2014 to complete FFM development and enhance existing functionality.

To assess CMS acquisition planning activities, we reviewed the Federal Acquisition Regulation (FAR) and relevant HHS/CMS policies and guidance and evaluated contract file documents. To assess CMS oversight of cost, schedule, and system capability changes, we reviewed contract modifications, contract deliverables, contractor monthly status reports, and other documents. To assess actions taken by CMS to identify and address contractor performance issues, we identified monitoring requirements and analyzed contract file documentation. To support work on all three objectives, we interviewed contracting officials in CMS's Office of Acquisition and Grants Management and program officials in CMS's Office of Information Services. In addition, we interviewed the contractors to obtain their perspective on CMS's oversight of cost, schedule, and system capabilities. Appendix I provides additional details about our scope and methodology.

[3]The existing contract is a multiple-award, indefinite-delivery, indefinite-quantity contract (hereinafter referred to as the 2007 contract). This contract type provides for an indefinite quantity, within stated limits, of supplies or services during a fixed period. The Government places orders for individual requirements. Quantity limits may be stated as number of units or as dollar values. FAR § 16.504.

We conducted this performance audit from January 2014 to July 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.

Background

Each marketplace created under PPACA is intended to provide a seamless, single point of access for individuals to enroll in qualified health plans,[4] apply for income-based financial subsidies established under the law and, as applicable, obtain an eligibility determination for other health coverage programs, such as Medicaid or the State Children's Health Insurance Program (CHIP).[5] To obtain health insurance offered through the marketplace, individuals must complete an application and meet certain eligibility requirements defined by PPACA, such as being a U.S. citizen or legal immigrant. For those consumers determined eligible, the marketplaces permit users to compare health plans and enroll in the plan of their choice. States had various options for marketplace participation, including (1) establishing their own state-based marketplace, (2) deferring to CMS to operate the federal marketplace in the state, or (3) participating in an arrangement called a partnership marketplace in which the state assists with some federal marketplace operations.[6]

In our June 2013 report on CMS efforts to establish the federal marketplace, we concluded that certain factors—such as the evolving scope of marketplace activities required in each state—suggested the

[4]A qualified health plan is an insurance plan that is certified by a marketplace to offer coverage through that marketplace.

[5]Medicaid is a joint federal-state program that finances health care coverage for certain low-income individuals. CHIP is a federal-state program that provides health care coverage to children 18 years of age and younger living in low-income families whose incomes exceed the eligibility requirements for Medicaid.

[6]States seeking to operate a state-based marketplace were required to submit an application to CMS in December 2012. States electing not to establish a state-based marketplace, but seeking to participate in a partnership marketplace were required to complete an abbreviated version of that application by February 2013. States electing not to establish a state-based exchange or participate in a partnership exchange were not required to submit an application to CMS.

potential for implementation challenges going forward.[7] In comments on a draft of that report, HHS emphasized the progress it had made since PPACA became law and expressed its confidence that marketplaces would be open and functioning in every state on October 1, 2013.

Timeline of Key Events

PPACA required the establishment of marketplaces in each state by January 2014. Based on the expectation that individuals and families would need time to explore their coverage options and plan issuers would need time to process plan selections, HHS established October 1, 2013, as the beginning of the enrollment period for all marketplaces, including the federal marketplace.[8] Figure 1 shows a timeline of major contracting, legal or regulatory, and organizational events during that development period, as well as future milestones through the beginning of open enrollment for 2015.

[7]GAO, *Patient Protection and Affordable Care Act: Status of CMS Efforts to Establish Federally Facilitated Health Insurance Exchanges*, GAO-13-601 (Washington, D.C.: June 19, 2013).

[8]HHS proposed October 1, 2013, as the start of the initial open enrollment period in a July 2011 proposed rule and included this date in the statement of work for both the FFM and data hub task orders. 76 Fed. Reg. 41866 (July 15, 2011). CMS issued a final rule adopting this date in March 2012. 77 Fed. Reg. 18310 (Mar. 27, 2012) (codified at 45 C.F.R. § 155.410(b)).

Figure 1: Timeline of Key Healthcare.gov Events

2010

March
The Patient Protection and Affordable Care Act (PPACA) signed into law requiring establishment of operational marketplaces by January 1, 2014

April
Department of Health and Human Services (HHS) established the Office of Consumer Information and Insurance Oversight (OCIIO) to implement certain PPACA requirements including marketplace provisions.

September
HHS awarded a contract on behalf of OCIIO to develop the business architecture for the federally faciliated marketplace (FFM) system and federal data services hub (data hub).

2011

January
OCIIO moved to the Centers for Medicare & Medicaid Services (CMS) and becomes the Center for Consumer Information and Insurance Oversight.

July
CMS issued the final Request for Proposal for FFM and data hub development.

September
Task orders issued for FFM and data hub development.

2012

January
Task order for data hub develoment finalized after bid protest.

March
HHS issued a final rule establishing October 1, 2013 as the beginning of the initial enrollment period and providing details regarding exchange establishment and operation.

December
Deadline for states establishing a state-based marketplace to submit a declaration of intent and blueprint to CMS.

2013

February
Deadline for states seeking to participate in federally-facilitated partnership marketplaces to submit a declaration of intent and blueprint to CMS.

July
Consumers began to set up initial Healthcare.gov accounts.

October
Initial open enrollment began.

Events after the October 1 launch of Healthcare.gov

2014

January
CMS awarded a letter contract to further develop FFM functionality.[a]

March
Deadline for 2014 enrollment. In some cases, this deadline was extended.

April
CMS definitized the January 2014 letter contract.[b]

November
Open enrollment for 2015 coverage scheduled to begin.

Contracting

Legislation/regulation

Organization

Source: GAO analysis of the Patient Protection and Affordable Care Act, federal regulations, and Centers for Medicare & Medicaid Services data. | GAO-14-694

Notes:

[a]A letter contract is a written preliminary contractual instrument that authorizes the contractor to begin work immediately. FAR § 16.603.

[b]A contract is considered definitized when final agreement on contract terms and conditions is reached.

Healthcare.gov and Supporting Systems

The Healthcare.gov website is supported by several systems, including the FFM and the federal data services hub. Additional components include the Enterprise Identity Management System that confirms the consumer's identity when entering the system.[9]

Healthcare.gov Website

Healthcare.gov is the Internet address of a federal government-operated website that serves as the online user interface for the federal marketplace. The website allows the consumer to create an account, input required information, view health care plan options and make a plan selection.

FFM System

The FFM accepts and processes data entered through the website and was intended to provide three main functions:

- **Eligibility and enrollment.** This module guides applicants through a step-by-step process to determine their eligibility for coverage and financial assistance, after which they are shown applicable coverage options and have the opportunity to enroll.
- **Plan management.** This module interacts primarily with state agencies and health plan issuers. The module is intended to provide a suite of services for activities such as submitting, monitoring, and renewing qualified health plans.
- **Financial management.** This module facilitates payments to issuers, including premiums and cost-sharing reductions, and collects data from state-based marketplaces.

Other FFM functions include services related to system oversight, communication and outreach strategies, and customer service.

Federal Data Services Hub

The data hub routes and verifies information among the FFM and external data sources, including other federal and state sources of information and

[9]GAO, *Patient Protection and Affordable Care Act: Preliminary Results of Undercover Testing of Enrollment Controls for Health Care Coverage and Consumer Subsidies Provided Under the Act*, GAO-14-705T (Washington, D.C.: July 23, 2014). GAO is also conducting additional work that will provide information on Healthcare.gov and its supporting systems.

issuers.[10] For example, the data hub confirms an applicant's Social Security number with the Social Security Administration and connects to the Department of Homeland Security to assess the applicant's citizenship or immigration status.

The data hub's connection with other federal and state databases enables exchanges to determine whether an applicant is eligible for or enrolled in some other type of health coverage, such as the Department of Defense's (DOD) TRICARE program or Medicaid—and therefore ineligible for subsidies to offset the cost of marketplace plans.[11] The data hub also communicates with issuers by providing enrollment information and receiving enrollment confirmation in return. See figure 2 for an overview of Healthcare.gov and selected supporting systems.

[10]The federal sources of information include data sources at the Social Security Administration, the Internal Revenue Service, the Department of Homeland Security, the Department of Veterans Affairs (VA), the Department of Defense, the Peace Corps, and the Office of Personnel Management.

[11]These subsidies include premium tax credits to offset qualified health plan premium costs and cost-sharing reductions to reduce policyholders' out-of-pocket payments, including deductibles and co-payments, for covered services.

Figure 2: Overview of Healthcare.gov and Selected Supporting Systems

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-14-694

Federal Implementation Costs

While CMS was tasked with oversight of marketplace establishment, several other federal agencies also have implementation responsibilities. Three agencies—CMS, the Internal Revenue Service (IRS), and the Department of Veterans Affairs (VA)—reported almost all of the IT-related obligations supporting the implementation of the Healthcare.gov and its supporting systems.[12] IT-related obligations include funds committed for the development or purchase of hardware, software, and system integration services, among other activities. These obligations totaled approximately $946 million from fiscal year 2010 through March 2014, with CMS obligating the majority of this total.

CMS Contracts and Task Orders for Healthcare.gov and Its Supporting Systems

As of March 2014, CMS reported obligating $840 million for the development of Healthcare.gov and its supporting systems, over 88 percent of the federal total. According to agency data, these obligations were spread across 62 contracts and task orders. We focused our review on two CMS task orders issued under an existing 2007 contract. The task orders were for the development of two core Healthcare.gov systems—the FFM and the data hub. We also reviewed a letter contract awarded by CMS in January 2014 to continue FFM development. The two task orders and the additional contract account for $369 million, or more than 40 percent, of the total CMS reported obligations as of March 2014.

Acquisition Process

The contract and task orders we examined are subject to the Federal Acquisition Regulation System, which provides uniform policies and procedures for acquisition by all executive agencies. The system includes the HHS acquisition regulation, which implements or supplements the FAR. HHS's supplement to the FAR, which contain additional HHS policies and procedures, is referred to as the Department of Health and Human Services Acquisition Regulation (HHSAR). The FAR and HHSAR address issues pertaining to the contracting process and include activities related to three phases: pre-award, competition and award, and post-award. See figure 3 for an overview of these phases and selected activities related to each.

[12] An obligation is a definite commitment that creates a legal liability of the government for the payment of goods and services ordered or received, or a legal duty on the part of the United States that could mature into a legal liability by virtue of actions of another party.

Figure 3: Key Contract Phases and Selected Activities

Pre-award	Competition and award	Post-award
• Acquisition planning • Requirements analysis • Solicitation preparation	• Evaluation of offers • Negotiation and discussion • Selection of awardees	• Contract administration • Performance and monitoring • Termination and closeout

Source: GAO analysis of Federal Acquisition Regulation. | GAO-14-694

To implement and oversee PPACA's marketplace and private health insurance requirements, HHS established the Office of Consumer Information and Insurance Oversight (OCIIO) in April 2010 as part of the HHS Office of the Secretary. In January 2011, the OCIIO moved to CMS and became the Center for Consumer Information and Insurance Oversight (CCIIO). Within CMS, establishment of the federal marketplace was managed by CCIIO, with responsibilities shared with the Office of Information Services (OIS), and the Office of Acquisition and Grants Management (OAGM). HHS's acquisition process for the data hub and FFM task orders involved multiple participants, including:

- **The contracting officer.** The contracting officer has the authority to enter into, administer, and/or terminate contracts and make related determinations. The contracting officer is responsible for ensuring performance of all necessary actions for effective contracting, ensuring compliance with the terms of the contract, and safeguarding the interests of the United States in its contractual relationships.
- **The contracting officer's representative (COR).** The COR—also referred to as the contracting officer's technical representative—is designated in writing by the contracting officer to perform specific technical or administrative functions. Unlike the contracting officer, a COR has no authority to make any commitments or changes that affect price, quality, quantity, delivery, or other terms and conditions of the contract and cannot direct the contractor or its subcontractors to operate in conflict with the contract terms and conditions.
- **The government task leader (GTL).** The GTL is a representative of the program office who assists the COR and is responsible for day-to-day technical interaction with the contractor. The GTL is also responsible for monitoring technical progress, including the

surveillance and assessment of performance, and performing technical evaluations as required, among other responsibilities.

Oversight Weaknesses and Lack of Adherence to Planning Requirements Compounded Acquisition Planning Challenges

CMS undertook the development of Healthcare.gov and its related systems without effective planning or oversight practices, despite facing a number of challenges that increased both the level of risk and the need for oversight. According to CMS program and contracting officials, the task of developing a first-of-its-kind federal marketplace was a complex effort that was exacerbated by compressed time frames and changing requirements. CMS contracting officials explained that meeting project deadlines was a driving factor in a number of acquisition planning activities, such as the selection of a cost-reimbursement contract, the decision to proceed with the contract award process before requirements were stable, and the use of a new IT development approach. These actions increased contract risks, including the potential for cost increases and schedule delays, and required enhanced oversight. However, CMS did not use information available to provide oversight, such as quality assurance surveillance plans. CMS also missed opportunities to consider the full range of risks to the acquisition by not developing a written acquisition strategy, even though the agency was required to do so. As a result, key systems began development with risks that were not fully identified and assessed.

Acquisition Planning Activities Carried High Levels of Risk for the Government

Meeting project deadlines was a driving factor in a number of acquisition planning activities. HHS had 15 months between enactment of PPACA and the agency's request for proposal to develop requirements for the FFM and data hub. In a prior report on acquisition planning at several agencies, including HHS, we found that the time needed to complete some pre-solicitation planning activities—such as establishing the need for a contract, developing key acquisition documents such as the requirements document, the cost estimate, and, if required, the acquisition plan; and obtaining the necessary review and approvals—could be more than 2 years. The time needed depended on factors that were present for this acquisition including complexity of the requirements,

political sensitivity, and funding.[13] CMS program officials noted challenges developing requirements for a complex, first-of-its-kind system in these compressed time frames and indicated that more time was needed.

The FFM and data hub task orders were issued under an existing 2007 contract for enterprise system development. This approach was reasonable in these circumstances because, according to contracting officials, the task orders could be issued more quickly than using a full and open competitive approach. The 2007 contract had been awarded to 16 vendors who were then eligible to compete for individual task orders. The 2007 contract was specifically established to improve efficiency when new IT requirement arose—such as the federal marketplace development. The 16 eligible contractors had experience with CMS's IT architecture and could come up to speed quickly. The solicitation for the 2007 contract sought contractors with experience in software design, development, testing and maintenance in complex systems environments to provide a broad range of IT services including planning, design, development, and technical support, among others. Of the 16 eligible contractors, four contractors responded with proposals for each system.

CMS used a source selection process that considered both cost and non-cost factors. This type of source selection process is appropriate when it may be in the best interest of the agency to consider award to other than the lowest priced offer or the highest technically rated offer.[14] In this case, the request for proposals indicated that cost and non-cost factors were weighted equally. The non-cost factors for technical evaluation included logical and physical design, project plan, and staffing plan, among others. In addition, CMS considered contractor past performance, but did not include that factor in the technical evaluation. CMS determined that the selected contractors for both task orders offered the most advantageous combination of technical performance and cost.

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[13]In an August 2011 report, GAO recommended that HHS collect information about the time frames needed for pre-solicitation acquisition planning activities to establish time frames for when program officials should begin acquisition planning. This recommendation has not yet been implemented. A second recommendation from this report—that HHS ensure that agency and component guidance clearly define the role of cost estimating and incorporating lessons learned in acquisition planning, as well as specific requirements for what should be included in documenting these elements in the contract file—has been implemented. See GAO, *Acquisition Planning: Opportunities to Build Strong Foundation for Better Services Contracts*, GAO-11-672 (Washington, D.C.: Aug. 9, 2011).

[14]FAR § 15.101-1(a).

Requirements for Developing the FFM System Were Not Well Defined When the Task Order Was Issued

The FAR requires that agencies ensure that requirements for services are clearly defined.[15] In addition, in our August 2011 review of opportunities to build strong foundations for better services contracts, we found that well-defined requirements are critical to ensuring the government gets what it needs from service contractors. We also found that program and contracting officials at the four agencies we reviewed—which included HHS—noted that defining requirements can be a challenging part of acquisition planning and is a shared responsibility between program and contracting officials.[16] Further, our March 2004 report on software-intensive defense acquisitions found that while requirements for a project can change at any point, officials must aggressively manage requirements changes to avoid a negative effect on project results, such as cost increases and schedule delays.[17]

In order to begin work quickly, CMS proceeded with the award process before FFM contract requirements, which included general technical requirements for system development, were finalized. For example, at the time the task order was issued, CMS did not yet know how many states would opt to develop their own marketplaces and how many would participate in the federally facilitated marketplace, or the size of their uninsured populations.[18] CMS also had not completed rulemaking necessary to establish key marketplace requirements. The statement of work for the FFM acknowledged a number of these unknown requirements, for example, stating that requirements for state support were not fully known and the FFM system "must be sufficiently robust to provide support of state exchange requirements at any point in the life cycle." In addition, the FFM statement of work noted that the requirements related to a number of FFM services would be finalized after contract award, including services related to all three main functional areas—eligibility and enrollment, financial management, and plan management—as well as system oversight, communication, and customer service.

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[15]FAR § 37.503(a).

[16]GAO-11-672.

[17]GAO, *Defense Acquisitions: Stronger Management Practices Are Needed to Improve DOD's Software-Intensive Weapon Acquisitions.* GAO-04-393 (Washington, D.C.: Mar. 1, 2004).

[18]Under PPACA, states had to obtain CMS approval to establish and operate their own marketplaces for 2014 by January 1, 2013. 42 U.S.C. § 18041(c)(1)(B).

The technical requirements for both the FFM and data hub were developed by CMS staff with contractor support[19] and documented in a statement of work for each task order.[20] Both statements called for the contractor to design a "solution that is flexible, adaptable, and modular to accommodate the implementation of additional functional requirements and services." However, according to CMS program officials, requirements for data hub development were more clearly defined at the time that task order was issued than FFM requirements. These officials also stated that, prior to issuing the task order, CMS was able to develop a prototype for the data hub and a very clear technical framework to guide the contractor, but due to still-changing requirements, CMS could not provide the same guidance for FFM development. We have previously found that unstable requirements can contribute to negative contract outcomes, including cost overruns and schedule delays.[21]

CMS Used a Contract Type That Carried Risk for the Government and Required Additional Oversight

In response to unsettled requirements, CMS contracting officials selected a type of cost reimbursement contract known as a cost-plus-fixed-fee contract for both the FFM and data hub task orders. According to the FAR, these contracts are suitable when uncertainties in requirements or contract performance do not permit the use of other contract types.[22] Under a cost reimbursement contract, the government pays all of the contractor's allowable incurred costs to the extent prescribed in the contract. These contracts are considered high risk for the government because of the potential for cost escalation and because the government pays a contractor's allowable cost of performance regardless of whether the work is completed. In recent years, the federal government has taken

[19]The Program Support Center in the Office of the Secretary awarded a contract in September 2010 on behalf of OCIIO to develop the business architecture for the FFM and data hub. This contract was transferred to CMS when OCIIO became CCIIO within CMS.

[20]According to CMS contracting and program officials, requirements development was done simultaneously for the two task orders, with the potential for both task orders to be awarded to the same contractor.

[21]See, for example, GAO-11-672 and GAO, *Department of Homeland Security: Better Planning and Assessment Needed to Improve Outcomes for Complex Service Acquisitions*, GAO-08-263 (Washington, D.C.: Apr. 22, 2008). In this report GAO made three recommendations to the Secretary of Homeland Security to achieve improved outcomes for its service acquisitions.

[22]FAR §16.301-2(a)(1) & (2).

steps to minimize the use of cost reimbursement contracts.[23] While CMS's use of the cost-plus-fixed-fee contract type may have been a reasonable choice under the circumstances, the related risks increased the need for oversight.

In our November 2007 report on internal control deficiencies at CMS, we found that certain contracting practices, such as the frequent use of cost reimbursement contracts, increased cost risks to CMS because CMS did not implement sufficient oversight for cost reimbursement contracts at that time.[24] However, in planning documents for the two task orders, CMS acknowledged the increased responsibilities and risks associated with managing a cost reimbursement contract and included a number of oversight elements in the task orders to support contract oversight and manage risks. These elements included contract deliverables such as earned value management reports,[25] monthly financial and project status reports, and a quality assurance surveillance plan.[26]

Both task orders required that a quality assurance surveillance plan be provided within 45 days after award. This plan is intended to ensure that systematic quality assurance methods are used in administration of the contract and provides for government oversight of the quality, quantity, and timeliness of contractor performance. The FAR requires that contract quality assurance be performed as may be necessary to determine that

[23] In 2009, the President released a Memorandum (M-09-25) calling for a reduction in the use of high-risk contracts. In 2012, DOD, GSA, and NASA adopted as final rule amending the FAR to implement a section of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 that addresses the use and management of cost-reimbursement contracts. 77 Fed. Reg. 12925 (Mar. 2, 2012).

[24] See GAO, *Centers for Medicare and Medicaid Services: Internal Control Deficiencies Resulted in Millions of Dollars of Questionable Contract Payments*, GAO-08-54 (Washington, D.C.: Nov. 15, 2007). We made nine recommendations to the Administrator of CMS to improve internal control and accountability in the contracting process and related payments to contractors. All nine recommendations have been implemented.

[25] Earned value management is a project management tool that integrates project scope with cost, schedule and performance elements for purposes of project planning and control. FAR § 2.101.

[26] The task orders also required additional oversight mechanisms, such as CMS governance milestone reviews. These included a Project Baseline Review intended to assess the project plan's scope, schedule and risk, and an Operational Readiness Review to determine if the product was ready to support business operations.

the supplies or services conform to contract requirements.[27] However, we found that the quality assurance surveillance plans were not used to inform oversight. For example, contracting and program officials, including the COR and contracting officer, were not sure if the quality assurance surveillance plan had been provided as required by the FFM and data hub task orders. Although a copy was found by CMS staff in June 2014, officials said they were not aware that the document had been used to review the quality of the contractor's work. Instead, CMS program officials said they relied on their personal judgment and experience to determine quality.

CMS Selected a New IT Development Approach to Save Time, but Increased Risks

To help manage compressed time frames for FFM and data hub development, CMS program officials adopted an iterative IT development approach called Agile that was new to CMS. Agile development is a modular and iterative approach that calls for producing usable software in small increments, sometimes referred to as sprints, rather than producing a complete product in longer sequential phases.[28] The Office of Management and Budget issued guidance in 2010 that advocated the use of shorter delivery time frames for federal IT projects, an approach consistent with Agile.[29] However, CMS program officials acknowledged that when FFM and data hub development began in September 2011, they had limited experience applying an Agile approach to CMS IT projects. In 2011, CMS developed updated guidance to incorporate the Agile IT development approach with its IT governance model, but that model still included sequential reviews and approvals and required deliverables at pre-determined points in the project. In our July 2012 report, we found a number of challenges associated with introducing Agile in the federal environment.[30] Specifically, we found that it was difficult to ensure that iterative projects could follow a standard, sequential approach

[27]FAR § 46.401.

[28]In 2012, GAO reported on the use of Agile methods in the Federal government. See GAO, *Software Development: Effective Practices and Federal Challenges in Applying Agile Methods*, GAO-12-681 (Washington, D.C.: July 27, 2012). In this report we made one recommendation to the Federal CIO Council to encourage the sharing of these practices.

[29]OMB, *25 Point Implementation Plan to Reform Federal Information Technology Management* (Washington, D.C.: Dec. 9, 2010) and *Immediate Review of Financial Systems IT Projects,* M-10-26 (Washington, D.C.: June 28, 2010).

[30]GAO-12-681.

and that deviating from traditional procedural guidance to follow Agile methods was a challenge. We also reported that new tools and training may be required, as well as updates to procurement strategies. Therefore, the new approach that CMS selected in order to speed work also carried its own implementation risks.

CMS Did Not Fully Adhere to HHS Acquisition Planning Requirements and Missed Opportunities to Capture and Consider Risks Important to the Program's Success

While a number of CMS's acquisition planning actions were taken in an effort to manage acquisition challenges, CMS missed opportunities to fully identify and mitigate the risks facing the program. HHS acquisition policy requires the development of a written acquisition strategy for major IT investments, such as the FFM system.[31] According to HHS policy, an acquisition strategy documents the factors, approach, and assumptions that guide the acquisition with the goal of identifying and mitigating risks.[32] HHS provides a specific acquisition strategy template that requires detailed discussion and documentation of multiple strategy elements, including market factors and organizational factors, among others.

According to program officials, the acquisition planning process for the FFM and data hub task orders began in 2010, prior to HHS's decision to move its Office of Consumer Information and Insurance Oversight (OCIIO) to CMS, and continued into early 2011. Program officials stated that the planning process included discussions of an acquisition strategy. However, CMS program and contracting staff did not complete the required acquisition strategy for FFM and data hub development. According to contracting and program officials, CMS has not been preparing acquisition strategies for any of its major IT acquisitions, not just those related to systems supporting Healthcare.gov. This is a longstanding issue. In November 2009 we found deficiencies in CMS contract management internal controls practices such as the failure to follow existing policies and the failure to maintain adequate

[31]HHS defines a major IT investment as an IT investment that involves one or more of the following: (1) has total planned outlays of $10 million or more in the budget year; (2) is for financial management and obligates more than $500,000 annually; (3) is otherwise designated by the HHS CIO as critical to the HHS mission or to the administration of HHS programs, finances, property or other resources; (4) has life-cycle costs exceeding $50 million.

[32]HHS Acquisition Policy Memorandum 2009-05, Attachment A.

documentation in contract files.[33] According to CMS contracting officials, CMS is planning steps to strengthen the agency's program and project management, including training related to the acquisition strategy requirement.

Contracting officials from OAGM explained that at CMS the majority of acquisition planning is done by the program office and OAGM began discussions of the upcoming task orders related to Healthcare.gov and its supporting systems with program officials in February 2011. In June 2011, OAGM accepted a Request for Contract package—a set of documents used to request and approve a contract action—from the program office. The package documents some elements of an acquisition strategy. Specifically, it indicated the type of contract to be used and the selected contract approach; however, the documents do not include the rationale for all decisions and did not address a number of planning elements required in HHS acquisition strategy, such as organizational factors, technological factors, and logistics.

In the absence of an acquisition strategy, key risks and plans to manage them were not captured and considered as required. The acquisition strategy provides an opportunity to highlight potential risk areas and identify ways to mitigate those risks. For example, the strategy guidance requires the consideration of organizational factors that include management and their capabilities, available staff and their skills, and risks associated with the organizational structure. Organizational factors were a potential risk area for these projects because the CMS organizations responsible for the FFM and data hub experienced significant changes just prior to and during the planning period. Specifically, OCIIO was established in 2010 and integrated into CMS in January 2011, just prior to the beginning of planning discussions with OAGM. According to CMS contracting and program officials, some of the 246 OCIIO staff transitioned to the new CCIIO and others joined CMS's Office of Information Services (OIS) and OAGM. In the context of these organizational changes and the other considerable project risks, the

[33]GAO, *Centers for Medicare and Medicaid Services: Deficiencies in Contract Management Internal Control Are Pervasive*, GAO-10-60 (Washington, D.C.: Oct. 23, 2009) and GAO-08-54. In GAO-10-60 we made 10 recommendations to the Administrator of CMS, OAGM management, and the Secretary of HHS to ensure adherence to FAR requirements and other control objectives. Nine of the 10 recommendations have been implemented.

acquisition strategy could have been a powerful tool for risk identification and mitigation. By failing to adhere to this requirement, CMS missed opportunities to explain the rationales for acquisition planning activities and to fully capture and consider risks important to the success of the program.

Changing Requirements and Oversight Gaps Contributed to Significant Cost Growth, Schedule Delays, and Reduced Capabilities during FFM and Data Hub Development

CMS incurred significant cost increases, schedule slips, and reduced system functionality in the development of the FFM and data hub systems—primarily attributable to new and changing requirements exacerbated by inconsistent contract oversight. From September 2011 to February 2014, estimated costs for developing the FFM increased from an initial obligation of $56 million to more than $209 million; similarly, data hub costs increased from an obligation of $30 million to almost $85 million. New and changing requirements drove cost increases during the first year of development, while the complexity of the system and rework resulting from changing CMS decisions added to FFM costs in the second year. In addition, required design and readiness governance reviews were either delayed or held without complete information and CMS did not receive required approvals. Furthermore, inconsistent contractor oversight within the program office and unclear roles and responsibilities led CMS program staff to inappropriately authorize contractors to expend funds.

FFM and Data Hub Task Orders Experienced Significant Increases

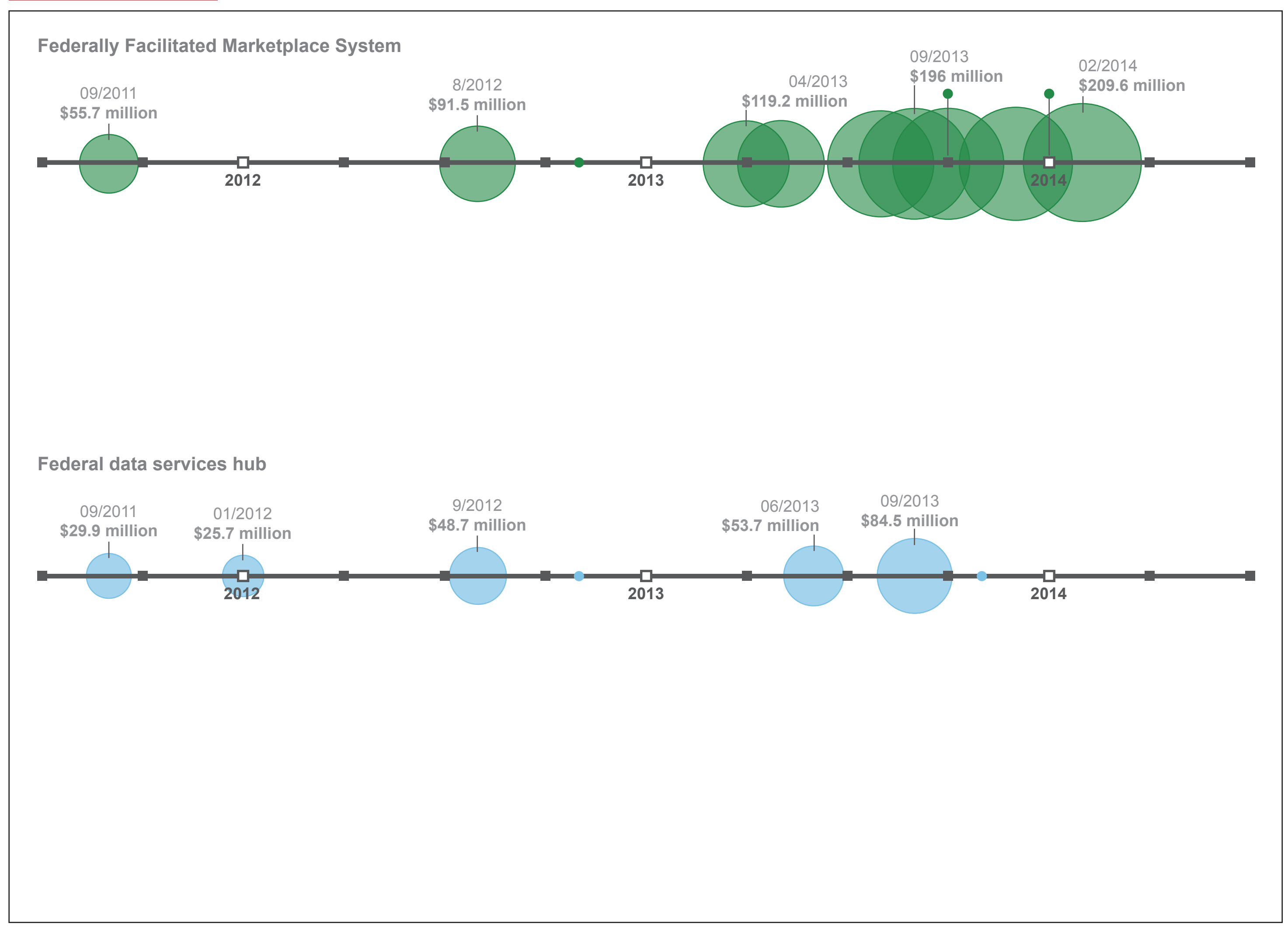
Obligations for both the FFM and data hub rose significantly during the two-and-a-half-year development period, with the FFM task order increasing almost four-fold, from $55.7 million obligated when issued in late 2011 to more than $209 million obligated by February 2014. Similarly, the data hub task order almost tripled, increasing from $29.9 million to $84.5 million during the same period.[34] Figure 4 shows FFM and data hub obligation growth during this time.

[34] As of April 2014, CMS had obligated more than $103 million for the data hub, which includes post-development operational and maintenance functions.

Figure 4: Cumulative Obligation Increases for the Task Orders for Developing the Federally Facilitated Marketplace System and Federal Data Services Hub

Interactive Graphic

Rollover green and light blue circles for more information. Please see appendix II for the print version.



Dollars obligated

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-14-694

New and Changing Requirements Drove Cost Increases throughout System Development

Development cost increases for the FFM and data hub were due to a combination of factors, including costs associated with adding or changing requirements. For example, CMS was aware that a number of key business requirements for the FFM and data hub would not be known until after the task orders were issued in September 2011, and it acknowledged some of these uncertainties in the statements of work, such as noting that the actual number of states participating in the federal marketplace and the level of support each state required was not expected to be known until January 2013. We previously found in March 2004 that programs with complex software development experienced cost increases and schedule delays when they lacked controls over their requirements, noting that leading software companies found changing requirements tend to be a major cause of poor software development outcomes.[35]

Subsequent modifications to the FFM and data hub task orders show the costs associated with adding requirements beyond those initial uncertainties. For example, CMS obligated an additional $36 million to the FFM and $23 million to the data hub in 2012, in large part to address requirements that were added during the first year of development, such as increasing infrastructure to support testing and production and adding a transactional database. Some of these new requirements resulted from regulations and policies that were established during this period. For example, in March 2012, federal rulemaking was finalized for key marketplace functions, resulting in the need to add services to support the certification of qualified health plans for partnership marketplace states. Other requirements emerged from stakeholder input, such as a new requirement to design and implement a separate server to process insurance issuers' claims and enrollment data outside of the FFM. CMS program officials said that this resulted from health plan issuers' concerns about storing proprietary data in the FFM. The FFM and data hub task orders were both updated to include this requirement in 2012, which was initially expected to cost at least $2.5 million.

System Complexities and Rework Further Added to FFM Costs in the Second Year

During the second year of development, from September 2012 to September 2013, the number of task order modifications and dollars obligated for the development of the FFM and data hub continued to increase. New requirements still accounted for a portion of the costs, but

[35] GAO-04-393.

the second-year increases also reflected the previously unknown complexities of the original requirements and associated rework, particularly for the FFM. For example, according to the FFM contractor, one of the largest unanticipated costs came from CMS' directions to purchase approximately $60 million in software and hardware that was originally expected to be provided by another Healthcare.gov contractor. Most of these costs were added through task order modifications in 2013.

In April 2013, CMS added almost $28 million to the FFM task order to cover work that that was needed because of the increasingly complex requirements, such as additional requirements to verify income for eligibility determination purposes. The FFM contractor said some of these costs resulted from CMS's decisions to start product development before regulations and requirements were finalized, and then to change the FFM design as the project was ongoing, which delayed and disrupted the contractor's work and required them to perform rework. In addition, CMS decisions that appeared to be final were reopened, requiring work that had been completed by the contractor to be modified to account for the new direction. This included changes to various templates used in the plan management module and the application used by insurance issuers, as well as on-going changes to the user interface in the eligibility and enrollment module. According to the FFM contractor, CMS changed the design of the user interface to match another part of the system after months of work had been completed, resulting in additional costs and delays. In November 2012, the contractor estimated that the additional work in the plan management module alone could cost at least $4.9 million.

By contrast, CMS program officials explained that the data hub generally had more stable requirements than the FFM, in part due to its functions being less technically challenging and because CMS had had more time to develop the requirements. While the obligations for the data hub also increased at the same rate as the FFM in the first year of development, they did so to a lesser degree during the second year. According to the data hub contractor, these increases were due to CMS-requested changes in how the work was performed, which required additional services, as well as hardware and software purchases.

CMS Experienced Schedule Delays, Conducted Incomplete Governance Oversight Reviews, and Delayed Some Capabilities for the FFM and Data Hub

In addition to increased costs, the FFM and data hub experienced schedule delays, which contributed to CMS holding incomplete governance oversight reviews and eventually reduced the capabilities it expected the FFM contractor to produce by the October 1, 2013, deadline.

CMS Delayed Scheduled Governance Reviews, Reducing Time Available for FFM and Data Hub Testing and Implementation Reviews

CMS initially established a tight schedule for reviewing the FFM and data hub development in order to meet the October 1, 2013, deadline for establishing enrollment through the website. Each task order lists the key governance reviews that the systems were required to meet as they progressed through development.

The FFM and data hub task orders initially required the contractors to be prepared to participate in most of the CMS governance reviews—including a project baseline and final detailed design reviews—within the first 9 months of the awards. This would allow CMS to hold the final review needed to implement the systems—operational readiness—at least 6 months before the Healthcare.gov launch planned for October 1, 2013. In April 2013, CMS extended the requirements analysis and design phase. According the CMS program officials, requirements were still changing and more time was needed to finalize the FFM design. As a result, CMS compressed time frames for conducting reviews for the testing and implementation phases. Under the revised schedule, the contractor had until the end of September 2013—immediately prior to the date of the planned launch—to complete the operational readiness review, leaving little time for any unexpected problems to be addressed despite the significant challenges the project faced. Figure 5 shows the schedule of planned and revised development milestone reviews in the FFM and data hub task orders.

Figure 5: Planned Schedule of Development Milestone Reviews in the Federally Facilitated Marketplace System and Federal Data Services Hub Task Orders

Federal data services hub

Initiation, concept and planning | Requirements, analysis and design | Development and test | Implementation | Open enrollment begins 10/2013

Architecture review **03/2012**
Project baseline review **03/2012**
Final detailed design review **06/2012**
Operational readiness review **09/2012**

Federally Facilitated Marketplace System – Initial plan (September 2011)

Initiation, concept and planning | Requirements, analysis and design | Development and test | Implementation | Open enrollment begins 10/2013

Architecture review **10/2011**
Project baseline review **03/2012**
Final detailed design review **06/2012**
Operational readiness review **03/2013**

Federally Facilitated Marketplace System – Revised plan (April 2013)

Initiation, concept and planning | Requirements, analysis and design | Development and test | Implementation | Open enrollment begins 10/2013

Architecture review **12/2011**
Project baseline review **03/2012**
Final detailed design review **03/2013**
Operational readiness review **09/2013**

1. Architecture review
Ensures that business needs are sound and conform to the Centers for Medicare & Medicaid Services (CMS) information technology architecture before design begins. This review also examines the proposed projects' relationship with existing systems and determines if they can be leveraged.

2. Project baseline review
Obtain management approval that the project's scope, cost, and schedule have been established and an appropriate management strategy is in place. This review also includes an assessment of risks to each baseline.

3. Final detailed design review
Ensures that the proposed design meets the stated business needs and is complete according to CMS standards prior to development. This review also raises and resolves any issues that might pose risks during subsequent phases, such as testing and implementation, and which may be more costly or require additional time to correct in the later stages.

4. Operational readiness review
Ensures that a system has completed its implementation process according to plan and is ready to enter the operations and maintenance phase. Security is a significant component of this review.

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-14-694

The four reviews shown in figure 5—architecture, project baseline, final detailed design, and operational readiness— are among those required under the exchange life cycle framework, the governance model CMS specifically designed to meet the need to quickly develop the FFM and data hub using the Agile development approach.[36] The life cycle framework requires technical reviews at key junctures in the development process, such as a final detailed design review to ensure that the design meets requirements before it is developed and tested. To accommodate different development approaches, the life cycle framework allows program offices leeway regarding how some reviews are scheduled and conducted, permitting more informal technical consultations when holding a formal review would cause delays. However, the framework requires that the four governance or milestone reviews be approved by a CMS governance board.

Some Governance Reviews Were Not Fully Conducted or Approved

Despite the revised FFM schedule, it is not clear that CMS held all of the governance reviews for the FFM and data hub or received the approvals required by the life cycle framework. The framework was developed to accommodate multiple development approaches, including Agile. A senior CMS program official said that although the framework was used as a foundation for their work, it was not always followed throughout the development process because it did not align with the modified Agile approach CMS had adopted. CMS program officials explained that they held multiple reviews within individual development sprints—the short increments in which requirements are developed and software is designed, developed, and tested to produce a building block for the final system. However, CMS program officials indicated that they were focused on responding to continually changing requirements which led to them participating in some governance reviews without key information being available or steps completed. Significantly, CMS held a partial operational readiness review for the FFM in September 2013, but development and testing were not fully completed and continued past this date. As a result, CMS launched the FFM system without the required verification that it met performance requirements.

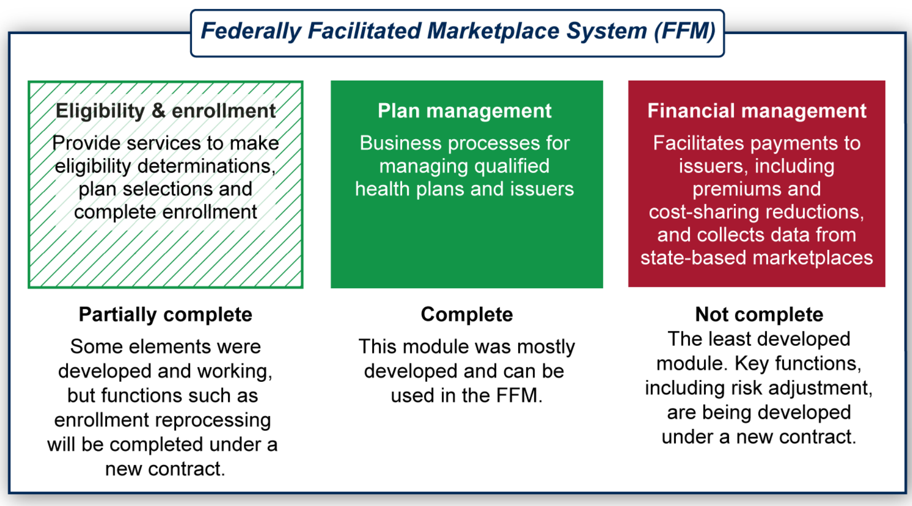
[36]The Exchange Life Cycle framework was also designed to support other IT efforts for the marketplaces, such as state-based exchanges. This framework was derived from CMS's Integrated IT Investment & System Life Cycle Framework and HHS's Enterprise Performance Life Cycle. During the course of the contracts, the Exchange Life Cycle Framework was replaced with CMS's Expedited Life Cycle process.

Furthermore, the life cycle framework states that CMS must obtain governance-board approval before the systems proceed to the next phase of development, but we did not see evidence that any approvals were provided. CMS records show that CMS held some governance reviews, such as design readiness reviews. However, the governance board's findings identified outstanding issues that needed to be addressed in subsequent reviews and they were not approved to move to the next stage of development.

CMS Postponed Some FFM Capabilities to Meet Deadlines

By March 2013, CMS recognized the need to extend the task orders' periods of performance in order to allow more time for development. CMS contract documents from that time estimated that only 65 percent of the FFM and 75 percent of the data hub would be ready by September 2013, when development was scheduled to be completed. Recognizing that neither the FFM nor the data hub would function as originally intended by the beginning of the initial enrollment period, CMS made trade-offs in an attempt to provide necessary system functions by the October 1, 2013, deadline. Specifically, CMS prioritized the elements of the system needed for the launch, such as the FFM eligibility and enrollment module, and postponed the financial module, which would not be needed until post-enrollment. CMS also delayed elements such as the Small Business Health Options Program marketplace, initially until November 2013, and then until 2015. See figure 6 for the modules' completion status as of the end of the task order in February 2014.

Figure 6: Completion Status of Federally Facilitated Marketplace System Modules at the End of the Task Order, February 2014



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-14-694

In September 2013, CMS extended the amount of time allotted for development under the FFM and data hub task orders, which accounted for the largest modifications. The additional obligations—$58 million for the FFM and $31 million for the data hub—included some new elements, such as costs associated with increasing FFM capacity needed to support anticipated internet traffic, but our review of the revised statements of work show that the additional funding was primarily for the time needed to complete development work rather than new requirements.

After the FFM was launched on October 1, 2013, CMS took a number of steps to respond to system performance issues through modifications to the FFM task order. These efforts included adding more than $708,000 to the FFM task order to hire industry experts to assess the existing system and address system performance issues. CMS also greatly expanded the capacity needed to support internet users, obligating $1.5 million to increase capacity from 50 terabytes to 400 terabytes for the remainder of the development period. While CMS program officials said that the website's performance improved, only one of the three key components specified in the FFM task order was completed by the end of the task order's development period. (See figure 6.) According to program officials, the plan management module was complete, but only some of the elements of the eligibility and enrollment module were provided and the financial management remained unfinished.

Unclear Contract Oversight Responsibilities Exacerbated FFM and Data Hub Cost Growth

We identified approximately 40 instances during FFM development in which CMS program staff inappropriately authorized contractors to expend funds totaling over $30 million because those staff did not adhere to established contract oversight roles and responsibilities. Moreover, CMS contract and program staff inconsistently used and reviewed contract deliverables on performance to inform oversight.

CMS Staff Inappropriately Authorized Contractors to Expend Funds

The FFM task order was modified in April 2013 to add almost $28 million to cover cost increases that had been inappropriately authorized by CMS program officials in 2012.[37] This issue also affected the data hub task order, which had an estimated $2.4 million cost increase over the same period. In November 2012, the FFM contractor informed CMS of a

[37]The cost increase was originally estimated to be $32 million in December 2012, but was negotiated to the lesser figure in the subsequent contract modification.

potential funding shortfall due to work and hardware that CMS program officials had directed the contractor to provide. The FAR provides that the contracting officer is the only person authorized to change the terms and conditions of the contract. Further, other government personnel shall not direct the contractor to perform work that should be the subject of a contract modification.[38] The federal standards for internal control also state that transactions and significant events need to be authorized and executed by people acting within the scope of their authority, to ensure that only valid transactions to commit resources are initiated.[39]

CMS documents show that the cost growth was the result of at least 40 instances in which work was authorized by various CMS program officials, including the government task leader (GTL)—who is responsible for day-to-day technical interaction with the contractor—and other staff with project oversight responsibilities, who did not have the authority to approve the work. This was done without the knowledge of the contracting officer or the contracting officer's representative. This inappropriately authorized work included adding features to the FFM and data hub, changing designs in the eligibility and enrollment module, and approving the purchase of a software license. CMS later determined that the work was both necessary and within the general scope of the task order but the cost of the activities went beyond the estimated cost amount established in the order and thus required a modification.

Inappropriate Authorizations Due to Unclear Oversight Responsibilities

A senior CMS program official described a three-pronged approach to contract oversight that involved various CMS offices, including the COR and GTL in the program offices, and the contracting officer in OAGM. The COR and GTL were assigned overlapping responsibilities for monitoring the contractor's technical performance, but CMS's guidance to clarify their roles did not fully address the need to ensure that directions given to contractors were appropriate. CMS program officials said the guidance was issued in 2006, several years before the FFM and data hub task orders were issued. The guidance generally noted that CORs are responsible for financial and contractual issues while GTLs have day-to-day technical interactions with the contractors. However, the guidance did not clarify the limitations on COR's and GTL's authorities, such as not

[38]FAR § 43.102(a).

[39]GAO, *Standards for Internal Control in the Federal Government.* GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

providing contractors with technical direction to perform work outside the scope of the contract.

CMS program officials also described difficulties clarifying oversight responsibilities in organizations that were new to CMS, which contributed to the inappropriately authorized work. Program responsibilities were shared between CCIIO, which was primarily responsible for developing business requirements, and the information technology staff in OIS, where the GTL and COR were located. CCIIO was relatively new to CMS, having been incorporated shortly before the FFM and data hub task orders were issued. OIS program officials explained that CCIIO was not as experienced with CMS's organization and did not strictly follow their processes, including for oversight. CMS documents show that there were concerns about inappropriate authorizations prior to the cost growth identified in late 2012, as officials in the OIS acquisition group had repeatedly cautioned other OIS and CCIIO staff about inappropriately directing contractors.

Furthermore, CMS program officials said that CCIIO staff did not always understand the cost and schedule ramifications associated with the changes they requested. As the FFM in particular was in the phase of development in which complexities were emerging and multiple changes were needed, there were a series of individual directions that, in sum, exceeded the expected cost of the contract. As a result of the unauthorized directions to contractors, the CMS contracting officer had to react to ad hoc decisions made by multiple program staff that affected contract requirements and costs rather than directing such changes by executing a contract modification as required by the FAR.

In April 2013, shortly after the inappropriate authorizations and related cost increases for the FFM and data hub task orders were identified, a senior contracting official at CMS sent instructions on providing technical directions to contractors to the program offices that had been involved in the authorizations and to CMS directors in general. Specifically, the program offices were reminded to avoid technical direction to contractors—particularly when there is an immediate need for critical functions—which might constitute unauthorized commitments by the government. This instruction has not been incorporated into existing guidance on the roles and responsibilities of the CORs and GTLs. CMS contracting and program officials also reported additional steps to bolster contract oversight such as reminding the FFM contractor not to undertake actions that result in additional costs outside of the statement of work without specific direction from the contracting officer.

CMS Provided Inconsistent Oversight of Contract Performance

It was not always clear which CMS officials were responsible for reviewing and accepting contractor deliverables, including items such as the required monthly status and financial reports and the quality assurance surveillance plan that aid the government in assessing the costs and quality of the contractor's work. According to contracting officials, reviewing such deliverables helped to provide the additional oversight that cost-reimbursable task orders require per the FAR to reduce risks of cost growth. However, particularly in the first year of FFM development, contract documentation shows repeated questions about who was responsible for reviewing the deliverables and difficulties finding the documents. Both task orders were ultimately modified to require that deliverables be provided to the contracting officer, who had previously just been copied on transmittal letters, in addition to the program office.

In September 2012, the COR oversight function transferred to the acquisition group within CMS's OIS and a new COR was assigned to manage both the FFM and data hub task orders. A CMS program official explained that the acquisition group typically fulfills the COR role for CMS contracts and that it had been unusual for those functions to be provided by another office. Upon assuming oversight responsibilities, the new COR could not locate a complete set of FFM and data hub deliverables and the original COR was unable to provide them. Instead, the new COR had to request all monthly status and financial reports directly from the contractors. When the new COR began reviewing the reports in the fall of 2012, he said he noticed that the FFM contractor had not been projecting the burn rate, a key measure that shows how quickly money is being spent. The COR asked the contractor to provide the figures in November 2012, at which point the cost growth was identified, even though the contract had been modified in August 2012 to add almost $36 million to the task order. We found that the burn rate was not included in earlier reports, but its absence had gone unnoticed due to ineffective contract oversight. In November 2007, we had found internal control deficiencies at CMS related to the inadequate review of contractor costs.[40]

[40]GAO-08-54

CMS Identified Significant Contractor Performance Issues for the FFM Task Order but Took Limited Action

CMS took limited action to address significant FFM contractor performance issues as the October 1, 2013, deadline for establishing enrollment through the website neared, and ultimately hired a new contractor to continue FFM development. Late in the development process, CMS became increasingly concerned with CGI Federal's performance. In April and November 2013, CMS provided written concerns to CGI Federal regarding its responsiveness to CMS's direction and FFM product quality issues. In addition, in August 2013, CMS was prepared to take action to address the contractor's performance issues that could have resulted in withholding of fee; however, CMS ultimately decided to work with CGI Federal to meet the deadline. CMS contracting and program officials stated that the contract limited them to only withholding fee as a result of rework. Ultimately, CMS declined to pay only about $267,000 of requested fee. This represented about 2 percent of the $12.5 million in fee paid to CGI Federal. Rather than pursue the correction of performance issues with CGI Federal, in January 2014 CMS awarded a new one-year contract to Accenture Federal Services for $91 million to continue FFM development. This work also has experienced cost increases due to new requirements and other enhancements, with costs increasing to over $175 million as of June 2014.

CMS Deemed Early Contractor Performance Satisfactory and Took Limited Action to Address Significant Contractor Performance Issues as the Deadline Neared

CMS generally found CGI Federal and QSSI's performance to be satisfactory in September 2012, at the end of the first year of development. CMS noted some concerns related to FFM contractor performance, such as issues completing development and testing on time; however, CMS attributed these issues to the complexity of the FFM and CMS's changing requirements and policies.[41] Further, according to program officials, during the first year of FFM development, few defined products were to be delivered as requirements and the system's design were being finalized. For example, as previously identified in this report, under the revised FFM development schedule the final detailed design

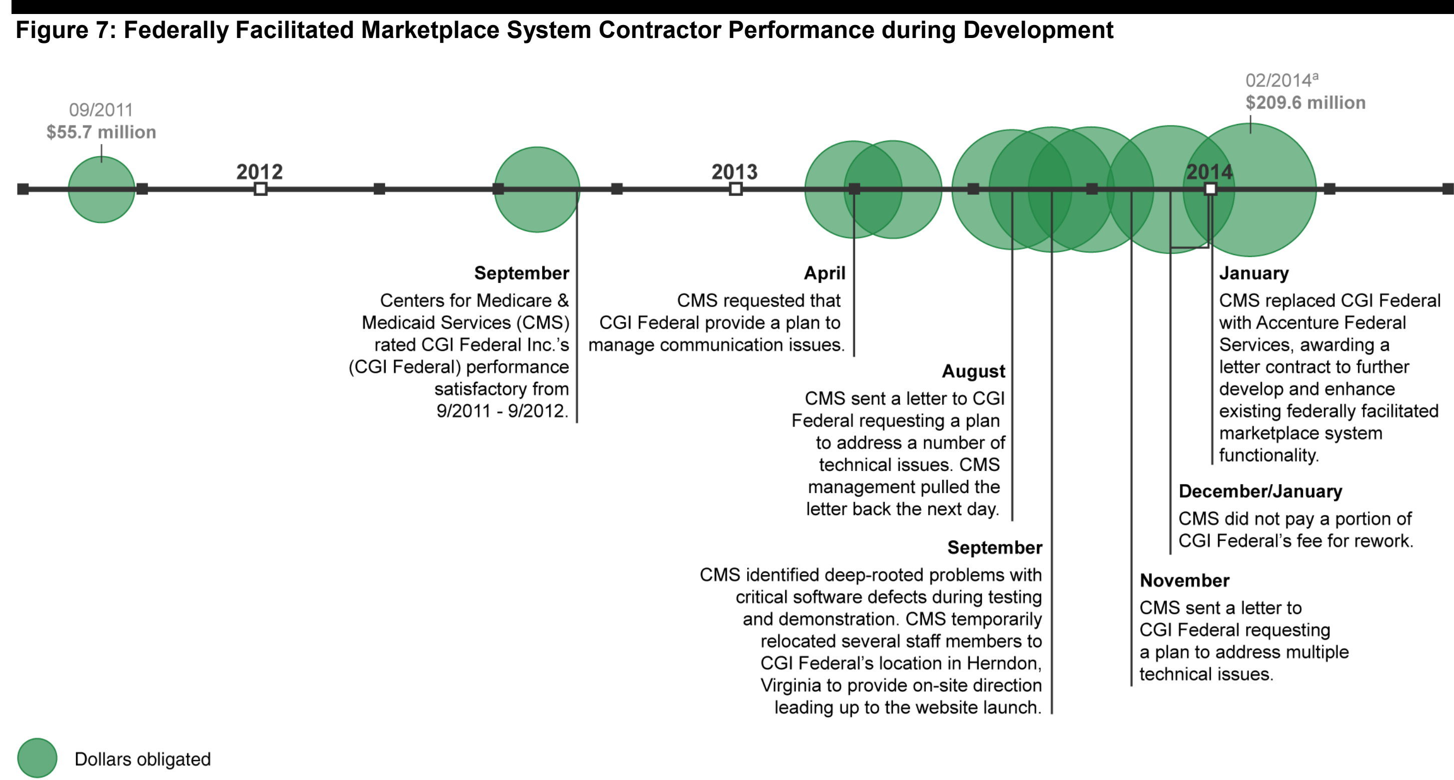
[41]CMS reported this information in the Contractor Performance Assessment Reporting System —the government-wide evaluation reporting tool for all past performance reports on contracts and orders. This report card assesses a contractor's performance and provides a record, both positive and negative, on a given contractor during a specific period of time. Each assessment is based on objective facts and supported by program and contract management data, such as cost performance reports, customer comments, quality reviews, technical interchange meetings, financial solvency assessments, construction/production management reviews, contractor operations reviews, functional performance evaluations, and earned contract incentives.

review for the FFM—a key development milestone review to ensure that the design meets requirements before it is developed and tested, was delayed from June 2012 to March 2013. Therefore, CMS had limited insight into the quality of CGI Federal's deliverables during the first year as development and testing of certain FFM functionality had not yet been completed. CMS found QSSI's performance satisfactory in September 2012. CMS program officials told us that they did not identify significant contractor performance issues during data hub development, and that the data hub generally worked as intended when Healthcare.gov was launched on October 1, 2013.

CMS Identified Significant FFM Contractor Performance Issues as the Deadline Approached, but CMS Opted Against Taking Remedial Contractual Actions at That Time

During the second year of development, which began in September 2012, CMS identified significant FFM contractor performance issues as the October 1 deadline approached (see figure 7). In April 2013, CMS identified concerns with CGI Federal's performance, including not following CMS's production deployment processes and failing to meet established deadlines, as well as continued communication and responsiveness issues. To address these issues, the contracting officer's representative (COR) sent an email to CGI Federal outlining CMS's concerns and requesting that CGI Federal provide a plan for correcting the issues moving forward. CMS accepted CGI Federal's mitigation plan. The plan included changes, according to CGI Federal officials, to accommodate CMS' communication practices, which CGI Federal believed to be the root cause of some of the CMS-identified issues. CMS contracting officials said that they were satisfied with CGI Federal's overall mitigation approach, which seemed to address the performance issues that CMS had identified at that time.

Figure 7: Federally Facilitated Marketplace System Contractor Performance during Development



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-14-694

Notes:

[a] The development period of performance ended in February 2014, and CMS chose not to exercise option years provided for in the task order.

According to CMS program officials, they grew increasingly concerned with CGI Federal's performance late in the development process in June and July 2013 as the scheduled launch date approached. Specifically, CMS program officials identified concerns with FFM technical and code quality during early testing of the enrollment process. The initial task order schedule had called for the FFM's development and test phase to be complete by this point, but these efforts were delayed in the revised schedule. CMS program officials explained that they identified issues such as inconsistent error handling, timeouts, and pages going blank. Overall, more than 100 defects were identified, which resulted in delays while CGI Federal worked to correct them. According to CGI Federal officials, the code reflected the instability of requirements at that time. However, once requirements were more stable, after October 2013, the

contractor was able to quickly make improvements to the FFM's performance.

In August 2013, CMS contracting and program officials decided to take formal action to address their concerns with CGI Federal's performance by drafting a letter to the contractor. Specifically, CMS identified concerns with the contractor's code quality, testing, failure to provide a key deliverable, and scheduled releases not including all agreed upon functionality. The letter further stated that CMS would take aggressive action, such as withholding fee in accordance with the FAR, if CGI Federal did not improve or if additional concerns arose. However, the contracting officer withdrew the letter one day after it was sent to CGI Federal, after being informed that the CMS Chief Operating Officer preferred a different approach. CMS contracting and program officials told us that, rather than pursue the correction of performance issues, the agency determined that it would be better to collaborate with CGI Federal in completing the work needed to meet the October 1, 2013, launch. CMS contracting officials told us that the agency did not subsequently take any remedial actions to address the issues outlined in the August 2013 letter.

By early September 2013, CMS program officials told us that they became so concerned about the contractor's performance that CMS program staff moved their operations to CGI Federal's location in Herndon, Virginia to provide on-site direction leading up to the FFM launch. CMS had identified issues such as deep-rooted problems with critical software defects during testing and demonstration of the product and CGI Federal's inability to perform quality assurance adequately including full testing of software. According to CMS program officials, CMS staff members worked on-site with CGI Federal for several weeks to get as much functionality available by October 1, 2013, as possible, deploying fixes and new software builds daily.

CMS Took Some Actions to Hold the FFM Contractor Accountable after the Healthcare.gov Launch

After the Healthcare.gov launch on October 1, 2013, CMS contracting officials began preparing a new letter detailing their concerns regarding contractor performance which was sent to CGI Federal in November 2013. In its letter, CMS stated that CGI Federal had not met certain requirements of the task order statement of work, such as FFM infrastructure requirements including capacity and infrastructure environments, integration, change management, and communication issues—some of which had been previously expressed in writing to CGI Federal. In addition, CMS stated that some of these issues contributed to problems that Healthcare.gov experienced after the October 1, 2013

launch. CMS's letter also requested that CGI Federal provide a plan to address these issues. CGI Federal responded in writing, stating that it disagreed with CMS's assertion that CGI Federal had not met the requirements in the FFM statement of work. In its letter, CGI Federal stated that delays in CMS's establishment and finalization of requirements influenced the time available for development and testing of the FFM. CGI Federal further stated that disruptions to its performance as a result of delays in finalizing requirements were compounded by the scheduled launch date, which resulted in CMS reprioritizing tasks and compressing time frames to complete those tasks. CGI Federal officials said they did not provide a formal plan for addressing CMS's concerns because they regarded them as unfounded, but agreed to work with CMS to avoid future issues and optimize the FFM's performance.[42]

In addition, after the October 1, 2013, launch, CMS contracting officials told us that they provided additional FFM oversight by participating in daily calls with CGI Federal on the stability of the FFM and the status of CGI Federal's work activities. Contracting officials told us that the increased oversight of FFM development helped to fix things more quickly. Further, the COR increasingly issued technical direction letters to clarify tasks included in the FFM statement of work and focus CGI Federal's development efforts. [43] For example, CMS issued several technical direction letters to CGI Federal in October 2013, directing CGI Federal to follow the critical path for overall performance improvement of the FFM, purchase software licenses, and collaborate with other stakeholders, among other things. According to program officials, written technical direction letters issued by the COR had more authority than technical direction provided by the GTL.

CMS Declined to Pay FFM Contractor Fee for Rework

CMS contracting and program officials explained that they found it difficult to withhold the contractor's fee under FAR requirements. As discussed earlier in this report, the development work for the FFM was conducted through a cost-plus-fixed-fee task order, through which the government

[42]CMS and CGI Federal exchanged a series of letters regarding CGI Federal's performance under the FFM task order in November 2013. In its initial response to CMS's November 2013 letter, CGI Federal addressed each issue identified by CMS and provided additional context on a variety of factors that CGI Federal believed influenced the FFM's development.

[43]Technical direction letters provide supplementary guidance to contractors regarding tasks contained in their statements of work or change requests.

pays the contractor's allowable costs, plus an additional fee that was negotiated at the time of award. This means that despite issues with CGI Federal's performance, including CGI Federal's inability to deliver all functionality included in the FFM statement of work, CMS was required to pay CGI Federal for allowable costs under the FFM task order. CGI Federal's task order provides that, if the services performed do not conform with contract requirements, the government may require the contractor to perform the services again for no additional fee.[44] If the work cannot be corrected by re-performance, the government may, by contract or otherwise, perform the services and reduce any contractor's fee by an amount that is equitable under the circumstances, or the government may terminate the contract for default.[45]

Even though CMS was obligated to pay CGI Federal's costs for the work it had performed for the FFM, CMS contracting and program officials said they could withhold only the portion of the contractor's fee that it calculated was associated with rework to resolve FFM defects. Ultimately, CMS declined to pay about $267,000 of the fixed fee requested by CGI Federal. This is approximately 2 percent of the $12.5 million in fixed fee that CMS paid to CGI Federal. Officials from CGI Federal said that they disagreed with the action and that the CMS decisions were not final and they could reclaim the fee by supplying additional information. CMS contracting and program officials told us that it was difficult to distinguish rework from other work. For example, program officials explained that it was difficult to isolate work that was a result of defects versus other work that CGI Federal was performing, and then calculate the corresponding portion of fee to withhold based on hours spent correcting defects.

Contractor's Total Fee Increased during Development

Through each contract modification, as CMS increased the cost of development, it also negotiated additional fixed fee for the FFM and data hub contractors. Under the original award of $55.7 million, CGI Federal would have received over $3.4 million in fee for work performed during the development period. As of February 2014, when CMS had obligated over $209 million dollars for the FFM effort, CMS negotiated and CGI

[44]FAR Clause 52.246-5(d). In addition, CGI Federal's task order also provides that failure of the contractor to submit required reports when due or failure to perform or deliver required work, supplies, or services, may result in the withholding of payments under the contract unless such failure arises out of causes beyond the control, and without the fault or negligence of the contractor. HHSAR Clause 352.242-73.

[45]FAR Clause 52.246-5(e).

Federal was eligible to receive more than $13.2 million in fee.[46] As of May 2014, CMS had paid CGI Federal $12.5 million in fee. Likewise, CMS negotiated additional fixed fee for the data hub task order, QSSI's eligible fee rose from over $716,000 under the original $29.9 million award to more than $1.3 million for work performed through February 2014.

Costs Continue to Increase with New FFM Contractor

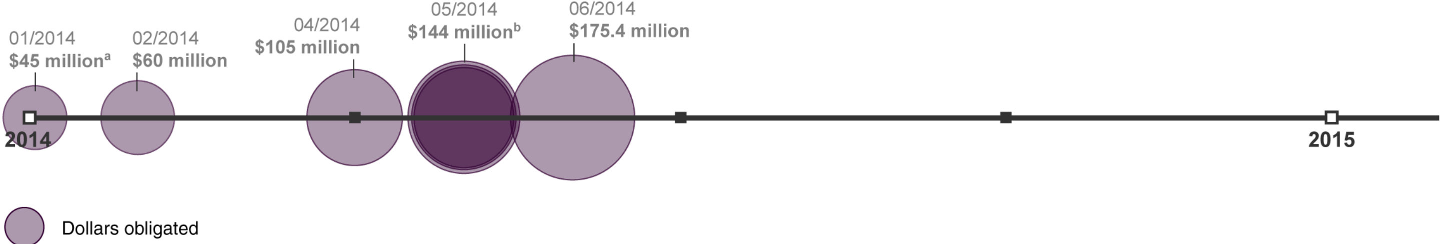
Rather than pursue the correction of performance issues and continuing FFM development with CGI Federal, CMS determined that its best chance of delivering the system and protecting the government's financial interests would be to award a new contract to another vendor. In January 2014, CMS awarded a one-year sole source contract (cost-plus-award-fee) with an estimated value of $91 million to Accenture Federal Services to transition support of the FFM and continue the FFM development that CGI Federal was unable to deliver.[47] CMS's justification and approval document for the new award states that the one-year contract action is an interim, transitory solution to meet CMS's immediate and urgent need for specific FFM functions and modules—including the financial management module.[48] This work has also experienced cost increases. Figure 8 shows increases in obligations for the Accenture Federal Services contract since award in January 2014.

[46]The over $13.2 million in fee CGI Federal was eligible to receive includes fee for work performed during development and for post-transition support and consulting services from March to April 2014.

[47]Under a cost-plus-award-fee contract, an award fee is intended to provide an incentive for excellence in such areas as cost, schedule, and technical performance; award of the fee is a unilateral decision made solely by the government. FAR § § 16.401(e)(2) and 16.405-2.

[48]Contracts awarded on other than a full and open competitive basis must be justified and approved. FAR § 6.303.

Figure 8: Cumulative Obligations for Accenture Federal Services Contract to Continue FFM Development as of June 5, 2014



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-14-694

Notes:

[a]The total contract value was initially estimated to be $91 million, but CMS obligated $45 million at the time of award.

[b]CMS modified the Accenture Federal Services contract three times in May 2014.

The financial management module of the FFM includes the services necessary to spread risk among issuers and to accomplish financial interactions with issuers. Specifically, this module tracks eligibility and enrollment transactions and subsidy payments to insurance plans, integrates with CMS's existing financial management system, provides financial accounting and outlook for the entire program, and supports the reconciliation calculation and validation with IRS.

According to the CMS justification and approval document, CMS estimated that it would cost $91 million over a one-year period for Accenture Federal Services to complete the financial management module and other FFM enhancements. As of June 5, 2014, the one-year contract had been modified six times since contract award and CMS had obligated more than $175 million as a result of new requirements, changes to existing requirements, and new enhancements. For example, CMS modified the contract to incorporate additional work requirements and functionality related to the Small Business Health Options Program marketplace, state-based marketplace transitions, and hardware acquisition.

CMS had yet to fully define requirements for certain FFM functionality, including the financial management module, when the new contract to continue FFM development was awarded in January 2014. Accenture Federal Services representatives told us that while they had a general understanding of requirements at the time of award, their initial focus during the period January through April 2014 was on transitioning work

from the incumbent contractor and clarifying CMS' requirements. Accenture Federal Services representatives attributed contract increases during this period to their increased understanding of requirements, as well as clarifying additional activities requested under the original contract. Further, although the justification and approval document stressed that delivery of the financial management module was needed by mid-March 2014, contracting and program officials explained that time frames for developing the module were extended post-award, and as of June 2014, the financial management module was still under development. Financial management module functionality is currently scheduled to be implemented in increments from June through December 2014.

Conclusions

CMS program and contracting staff made a series of planning decisions and trade-offs that were aimed at saving time, but which carried significant risks. While optimum use of acquisition planning and oversight was needed to define requirements, develop solutions, and test them before launching Healthcare.gov and its supporting systems, the efforts by CMS were plagued by undefined requirements, the absence a required acquisition strategy, confusion in contract administration responsibilities, and ineffective use of oversight tools. In addition, while potentially expedient, CMS did not adhere to the governance model designed for the FFM and data hub task orders, resulting in an ineffectual governance process in which scheduled design and readiness reviews were either diminished in importance, delayed, or skipped entirely. By combining that governance model with a new IT development approach the agency had not tried before, CMS added even more uncertainty and potential risk to their process. The result was that problems were not discovered until late, and only after costs had grown significantly.

As FFM contractor performance issues were discovered late in development, CMS increasingly faced a choice of whether to stop progress and pursue holding the contractor accountable for poor performance or devote all its efforts to making the October deadline. CMS chose to proceed with pursuing the deadline. After October 1, 2013, CMS decided to replace the contractor, but in doing so had to expend additional funds to complete essential FFM functions. Ultimately, more money was spent to get less capability.

Meanwhile, CMS faces continued challenges to define requirements and control costs to complete development of the financial management module in the FFM. Unless CMS takes action to improve acquisition

oversight, adhere to a structured governance process, and enhance other aspects of contract management, significant risks remain that upcoming open enrollment periods could encounter challenges going forward.

Recommendations for Executive Action

In order to improve the management of ongoing efforts to develop the federal marketplace, we recommend that the Secretary for Health and Human Services direct the Administrator of the Centers for Medicare & Medicaid Services to take the following five actions:

- Take immediate steps to assess the causes of continued FFM cost growth and delayed system functionality and develop a mitigation plan designed to ensure timely and successful system performance.
- Ensure that quality assurance surveillance plans and other oversight documents are collected and used to monitor contractor performance.
- Formalize existing guidance on the roles and responsibilities of contracting officer representatives and other personnel assigned contract oversight duties, such as government task leaders, and specifically indicate the limits of those responsibilities in terms of providing direction to contractors.
- Provide direction to program and contracting staff about the requirement to create acquisition strategies and develop a process to ensure that acquisition strategies are completed when required and address factors such as requirements, contract type, and acquisition risks.
- Ensure that information technology projects adhere to requirements for governance board approvals before proceeding with development.

Agency Comments, Third-Party Views, and Our Evaluation

We provided a draft of this product to the Department of Health and Human Services and the Centers for Medicare & Medicaid Services for review and comment.

In its written comments, which are reprinted in appendix III, HHS concurred with four of our five recommendations and described the actions CMS is taking to improve its contracting and oversight practices. HHS partially concurred with our recommendation that CMS assess the causes of continued FFM cost growth. The agency says that CMS already has assessed the reasons for cost growth under the CGI Federal task order and that any increase in costs since the contract with Accenture Federal Services for continued development of the FFM was

finalized is attributable to additional requirements, not cost overruns. We recognize that much of the increase in costs under the Accenture Federal Services contract is due to new requirements or enhancements. Nevertheless, based on our review of the contract modifications, not all the increase in costs from $91 million to more than $175 million, when measured from the initial projection, is attributable to new requirements. For example, as CMS stated in its comments, after additional analysis CMS determined a $30 million cost increase was needed to complete the contract's original scope of work. We continue to believe that a further assessment is needed to ensure that costs as well as requirements are under control and that the development of the FFM is on track to support the scheduled 2015 enrollment process.

All three contractors, as well as HHS, provided additional technical comments, which we incorporated in the report where appropriate.

We are sending copies of this report to the Secretary of Health and Human Services and the Administrator of the Centers for Medicare & Medicaid Services. In addition, the report is available at no charge on the GAO website at http://www.gao.gov/.

If you or your staff have any questions about this report, please contact William T. Woods at (202) 512-4841 or woodsw@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.

William T. Woods

William T. Woods
Director, Acquisition and Sourcing Management

Valerie C. Melvin

Valerie C. Melvin
Director, Information Management and Technology Resources Issues

List of Congressional Requesters

The Honorable Ron Wyden
Chairman
The Honorable Orrin Hatch
Ranking Member
Committee on Finance
United States Senate

The Honorable Thomas R. Carper
Chairman
The Honorable Tom Coburn, M.D.
Ranking Member
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Lamar Alexander
Ranking Member
Committee on Health, Education, Labor and Pensions
United States Senate

The Honorable Charles E. Grassley
Ranking Member
Committee on the Judiciary
United States Senate

The Honorable Jon Tester
Chairman
Subcommittee for Efficiency and Effectiveness of Federal Programs and the Federal Workforce
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Claire McCaskill
Chairman
Subcommittee on Financial and Contracting Oversight
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
House of Representatives

The Honorable Darrell Issa
Chairman
The Honorable Elijah E. Cummings
Ranking Member
Committee on Oversight and Government Reform
House of Representatives

The Honorable Dave Camp
Chairman
The Honorable Sander M. Levin
Ranking Member
Committee on Ways and Means
House of Representatives

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

The Honorable Joseph R. Pitts
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

The Honorable Tim Murphy
Chairman
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
House of Representatives

The Honorable Mike Coffman
Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

The Honorable Charles Boustany, Jr.
Chairman
The Honorable John Lewis
Ranking Member
Subcommittee on Oversight
Committee on Ways and Means
House of Representatives

The Honorable Mark Begich
United States Senate

The Honorable Michael Bennet
United States Senate

The Honorable Richard Blumenthal
United States Senate

The Honorable Robert P. Casey, Jr.
United States Senate

The Honorable Al Franken
United States Senate

The Honorable Kay R. Hagan
United States Senate

The Honorable Tim Kaine
United States Senate

The Honorable Amy Klobuchar
United States Senate

The Honorable Mary Landrieu
United States Senate

The Honorable Joe Manchin, III
United States Senate

The Honorable Jeffrey A. Merkley
United States Senate

The Honorable Bill Nelson
United States Senate

The Honorable Mark Pryor
United States Senate

The Honorable Jeanne Shaheen
United States Senate

The Honorable Mark Udall
United States Senate

The Honorable Mark R. Warner
United States Senate

The Honorable Ron Barber
House of Representatives

The Honorable John Barrow
House of Representatives

The Honorable Tulsi Gabbard
House of Representatives

The Honorable Pete P. Gallego
House of Representatives

The Honorable Duncan Hunter
House of Representatives

The Honorable Mike Kelly
House of Representatives

The Honorable Ann McLane Kuster
House of Representatives

The Honorable Daniel W. Lipinski
House of Representatives

The Honorable Patrick E. Murphy
House of Representatives

The Honorable Scott Peters
House of Representatives

The Honorable Kyrsten Sinema
House of Representatives

The Honorable Filemon Vela
House of Representatives

Appendix I: Objectives, Scope, and Methodology

This report examines selected contracts and task orders central to the development and launch of the Healthcare.gov website by assessing (1) Centers for Medicare & Medicaid Services (CMS) acquisition planning activities; (2) CMS oversight of cost, schedule, and system capability changes; and (3) actions taken by CMS to identify and address contractor performance issues.

To address these objectives, we used various information sources to identify CMS contracts and task orders related to the information technology (IT) systems supporting the Healthcare.gov website. Specifically, we reviewed data in the Federal Procurement Data System-Next Generation, which is the government's procurement database, to identify CMS contracts and task orders related to the IT systems supporting the Healthcare.gov website and amounts obligated for fiscal years 2010 through March 2014. In addition, we reviewed CMS provided data on the 62 contracts and task orders related to the IT systems supporting the Healthcare.gov website and amounts obligated as of March 2014. To select contracts and task orders to include in our review, we analyzed Federal Procurement Data System-Next Generation and CMS data to identify contracts and task orders that represent large portions of spending for Healthcare.gov and its supporting systems. We then selected one contract and two task orders issued under an existing 2007 contract and interviewed contracting officials in CMS's Office of Acquisition and Grants Management and program officials in CMS's Office of Information Services to confirm that these contracts are central to development of Healthcare.gov and its supporting systems.[1] The contract and task orders combined accounted for more than 40 percent of the total CMS reported obligations related to the development of Healthcare.gov and its supporting systems as of March 2014. Specifically, we selected the task orders issued to CGI Federal Inc. (CGI Federal) for the development of the federally facilitated marketplace (FFM) system and to QSSI, Inc. QSSI for the development of the federal data services hub (data hub) in September 2011—and the contract awarded to Accenture Federal Services in January 2014 to continue FFM development and enhance existing functionality.

[1]The existing contract is a multiple-award, indefinite-delivery, indefinite-quantity contract (hereinafter referred to as the 2007 contract). This contract type provides for an indefinite quantity, within stated limits, of supplies or services during a fixed period. The Government places orders for individual requirements. Quantity limits may be stated as number of units or as dollar values. FAR § 16.504.

To describe federal implementation costs for Healthcare.gov and its supporting systems, we interviewed program officials and obtained relevant documentation to identify eight agencies that reported IT-related obligations or used existing contracts and task orders or operating budgets to support the development and launch of the Healthcare.gov website. These eight agencies include the Centers for Medicare & Medicaid Services (CMS), Internal Revenue Service (IRS), Social Security Administration, Veterans Administration (VA), Peace Corps, Office of Personnel Management, Department of Defense (DOD), and Department of Homeland Security. We then obtained and analyzed various types of agency-provided data to identify overall IT-related costs for Healthcare.gov and its supporting systems. Three agencies, including CMS, IRS, and VA reported almost all of the IT-related obligations supporting the implementation of Healthcare.gov and its supporting systems as of March 2014. We performed data reliability checks on contract obligation data provided by these three agencies, such as checking the data for obvious errors and comparing the total amount of funding obligated for each contract and task order as reported by each agency to data on contract obligations in Federal Procurement Data System-Next Generation or USASpending.gov.[2] We found that these data were sufficiently reliable for the purpose of this report.

To assess CMS acquisition planning activities, we reviewed Federal Acquisition Regulation (FAR) and relevant Department of Health and Human Services (HHS)/CMS policies and guidance. We also evaluated contract file documents for three selected contracts and task orders, including acquisition planning documentation, request for proposal, statements of work, cost estimates, and technical evaluation reports to determine the extent to which CMS's acquisition planning efforts met FAR and HHS/CMS requirements. In assessing CMS's acquisition planning efforts, we looked for instances where CMS took steps to mitigate acquisition program risks during the acquisition planning phase, including choice of contract type and source selection methodology. In addition, we interviewed CMS contracting and program officials to gain a better understanding of the acquisition planning process for select contracts and

[2]USAspending.gov is a free, publicly accessible website established by the Office of Management and Budget containing data on federal awards (e.g., contracts, loans, and grants) across the government. The Federal Procurement Data System-Next Generation, the primary government-wide contracting database, is one of the main data sources for this website.

task orders including the rationale for choosing the selected contract type and the analysis conducted to support the source selection process. We also reviewed prior GAO reports on CMS contract management to assess the extent to which CMS's acquisition planning activities addressed issues previously identified by GAO.

To assess CMS oversight of cost, schedule, and system capability changes, we analyzed contract file documents for one selected contracts and two task orders. As part of our assessment of the selected contracts and task orders, we reviewed contract modifications, contractor monthly status and financial reports, statements of work, contractor deliverables, schedule documentation, and contracting officer's representative files, and meeting minutes to determine if there were any changes and whether system development proceeded as scheduled. We performed a data reliability check of cost data for selected contracts and task orders by comparing contract modification documentation to contract obligation data in Federal Procurement Data System-Next Generation. To evaluate the extent to which CMS adhered to its governance process, we compared the governance model the agency intended would guide the design, development, and implementation of Healthcare.gov and its supporting systems, to the development process the agency actually used for the FFM and data hub. We also obtained and analyzed documentation from governance reviews to identify the date and content of the reviews to determine if key milestone reviews were held in accordance to the development schedule. In addition, we reviewed FAR and federal standards for internal control for contract oversight to evaluate the extent to which CMS's approach to contract oversight for the selected contracts and task orders met FAR and federal internal control standards. We interviewed CMS contracting and program officials to gain a better understanding of FFM and data hub cost, schedule, and system capabilities, and to obtain information on the organization and staffing of offices and personnel responsible for performance monitoring for selected contracts and task orders. We also interviewed contractors to obtain their perspective on CMS's oversight of cost, schedule, and system capabilities. Further, as part of our assessment of CMS's development approach for the FFM and data hub, we reviewed prior GAO work regarding information technology and development.

To assess actions taken by CMS to identify and address contractor performance issues, we reviewed relevant FAR and HHS guidance for contract monitoring and inspection of services to identify steps required for selected contracts and task orders and recourse options for unsatisfactory performance. In addition, we obtained and analyzed

contract file documentation including contracting officer's representative files, contractor deliverables, contractor monthly status and financial reports, contractor performance evaluations, and meeting minutes to determine the extent to which performance was reported and what steps, if any, were taken to address any issues. To determine contractor fee not paid during development, we obtained and analyzed CMS contractor invoice logs and contract payment notifications. We also interviewed CMS contracting and program officials to obtain additional information regarding contractor performance and actions taken by CMS, if any, to address contractor performance issues.

We conducted this performance audit from January 2014 to July 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.

Appendix II: Cumulative Cost Increases for the Task Orders for Developing the Federally Facilitated Marketplace System and Federal Data Services Hub Task Orders

Task order issued/ modified	Date	Obligation	Total obligated to date	Description
Federally Facilitated Marketplace System (FFM)				
Issuance	9/30/2011	$55,744,082	$55,744,082	FFM task order issued to CGI Federal
Modification 1	8/26/2012	$35,771,690	$91,515,772	Obligates an additional **$35.8 million**, primarily to provide for new and increased system requirements resulting from program office decisions and finalized regulations.
Modification 2	11/16/2012	0	$91,515,772	No cost modification for administrative purposes, including identifying a new contracting officer's representative.
Modification 3	4/30/2013	$27,688,008	$119,203,779	Obligates an additional **$27.7 million** needed to avert a potential cost overrun. The funding supports an increased level of effort to add system functionality not included in the statement of work and increased infrastructure needs.
Modification 4	5/10/2013	$474,058	$119,677,837	Obligates approximately **$474,000** for additional infrastructure requirements, specifically requirements for the content delivery network that delivers web services.
Modification 5	9/1/2013	$58,143,472	$177,821,309	Modified to extend the period of performance for FFM development until February 28, 2014, and obligate an additional **$58.1 million**, primarily to support the extension.
Modification 6	9/19/2013	$18,215,807	$196,037,116	Obligates an additional **$18.2 million** to purchase a software license.
Modification 7	10/4/2013	0	196,037,116	Modified to issue a change order directing the contractor to develop and implement an identity management software solution.
Modification 8	10/21/2013	$1,479,309	$197,516,425	Obligates **$1.5 million** to increase capacity of the content delivery network from 50 terabytes to 400 terabytes.
Modification 9	12/24/2013	$6,981,666	$204,498,091	Obligates **$7.0 million** to definitize the change order issued under Modification 7. It also funds software licenses and the industry experts hired to improve system performance.
Modification 10	1/10/2014	0	$204,498,091	Modified to issue a change order directing the contractor to begin transitioning services to a new contractor.
Modification 11	2/21/2014	$5,133,242	$209,631,333	Obligates **$4.8 million** to definitize the change order issued under Modification 10 and fund post-transition consulting services through April 30, 2014.
Data Hub				
Issuance	9/30/2011	$29,881,693	$29,881,693	Data hub task order issued to QSSI
Modification 1	1/18/2012	($4,180,786)	$25,700,907	Modified to cancel a stop work order that was issued due to a GAO bid protest and direct the contractor to continue performance of the task order. Obligations are reduced by **$4.2 million** in accordance with the contractor's revised task order proposal (submitted as part of the bid protest process).

Task order issued/ modified	Date	Obligation	Total obligated to date	Description
Modification 2	9/4/2012	$23,017,077	$48,717,984	Obligates an additional **$23.0 million,** primarily to provide for new and increased system requirements resulting from program office decisions and finalized regulations.
Modification 3	11/16/2012	0	$48,717,984	No cost modification for administrative purposes, including identifying a new contracting officer's representative.
Modification 4	6/1/2013	$4,991,614	$53,709,598	Obligates **$5.0 million** to fund an electronic data interchange tool and related labor to support enrollment services.
Modification 5	9/1/2013	$30,817,530	$84,527,128	Modified to extend the period of performance for data hub development until February 28, 2014, and obligate an additional **$30.8 million**, primarily to support the extension.
Modification 6	11/15/2013	0	$84,527,128	No cost modification to transfer funds among contract line items and revise personnel.
Modification 7	2/25/2014	$15,130,711	$99,657,839	Modified to exercise option year 1: Operations and Maintenance.

Source: GAO analysis of Centers for Medicaid & Medicare Services data | GAO-14-694

Appendix III: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES   OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

JUL 25 2014

William T. Woods
Director, Acquisition and Sourcing Management
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Woods:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "Healthcare.gov: Ineffective Planning and Oversight Practices Underscore the Need for Improved Contract Management" (GAO-14-694).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "HEALTHCARE.GOV: INEFFECTIVE PLANNING AND OVERSIGHT PRACTICES UNDERSCORE THE NEED FOR IMPROVED CONTRACTS" (GAO-14-694)

The Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the GAO draft report. The draft report contains five recommendations for the Secretary of HHS to direct to the Administrator of CMS. HHS and CMS respond to the recommendations below.

HHS and CMS are committed to expanding affordable, comprehensive health coverage to more Americans through the establishment and operation of the Federally-facilitated Marketplace (FFM or Marketplace). The success of the Marketplace depends on effective planning and contract management, and CMS is focused on improving Marketplace operations and contractor oversight through strong governance, defined authorities, and clear requirements. CMS appreciates the GAO recommendations, which will further assist CMS in implementing innovative, consumer-facing IT projects that serve millions of Americans.

After the enactment of the Affordable Care Act in March 2010, HHS and CMS faced a unique and difficult challenge – to establish a first-of-its-kind online Marketplace to determine consumers' eligibility for coverage and insurance affordability programs, and enroll them in coverage beginning January 1, 2014. With that broad goal, and facing limited time and resources, as well as changing requirements in response to input from, states, issuers, and consumers, as well as rulings from the U.S. Supreme Court, HHS and CMS launched the FFM and the Data Services Hub on October 1, 2013. While the initial launch and the user experience were unacceptable, the functionality of the Marketplace steadily improved through strong management oversight and additional technical expertise. By the end of the open enrollment period, the FFM had helped over 5.4 million consumers select private health insurance coverage and assisted millions more in getting coverage through Medicaid.

CMS is improving the management of the Marketplace and is confident that its contractors will deliver the needed capabilities for the 2015 open enrollment period in a timely and cost-efficient manner. CMS has already assessed the causes of cost growth and schedule delays with its CGI contract. In response to that assessment, CMS ended its cost plus fixed fee contract with CGI and awarded a new cost plus award fee contract with Accenture. In addition, CMS modified its definitive one-year agreement with Accenture to incorporate additional work requirements and functionality related to items such as the Small Business Health Options Program (SHOP), State Based Marketplace (SBM) transitions, and hardware acquisition. These represent new requirements and additional functionality rather than cost overruns. CMS will use required contract deliverables to track continued performance and mitigate the need for additional funding. This continuous oversight will help limit any unanticipated costs that may arise as we continue to develop the system for the next open enrollment. CMS is committed to improving the management of the Marketplace to ensure that this investment will serve consumers for years to come.

1

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "HEALTHCARE.GOV: INEFFECTIVE PLANNING AND OVERSIGHT PRACTICES UNDERSCORE THE NEED FOR IMPROVED CONTRACTS" (GAO-14-694)

CMS is building on the lessons learned during the launch of the FFM and the first open enrollment period to ensure effective management of the Marketplace that is focused on clear lines of authority, prioritization of requirements and deliverables, and metric-driven quality reviews for its Healthcare.gov contracts and for contracts across the agency. This improvement is organized around three core supports – a strong management structure within CMS, the improved structure of Marketplace contracts, and a strengthened acquisition workforce supported by clear strategy, policy, and training.

The strong management structure, which will focus priorities and provide clear direction, includes:

- A new operations-focused CMS Principal Deputy Administrator for agency-wide policy and operational program coordination.
- A new, permanent Marketplace CEO with responsibility and accountability for leading the FFM, managing relationships with SBMs, and running the Center for Consumer Information and Insurance Oversight (CCIIO), which is the program office mainly responsible for the implementation of the FFM.
- A new, permanent Marketplace Chief Technology Officer who will report to the new Marketplace CEO and work closely with the Deputy Chief Operating Officer and the Office of Information Services within CMS in order to ensure proper alignment of project milestones and deliverables.
- A program manager for the FFM that is responsible for overseeing contractor performance and governance reviews.

The improved structure of Marketplace contracts includes:

- The end of CMS's contract with CGI and a new cost plus award fee contract with Accenture to continue building and operating the FFM through the 2015 enrollment period. This contract is defined by clear deliverables and deadlines, as well as improved communication structures. The contract is structured to incentivize exceptional performance and control costs by basing the award fee upon Accenture's performance.
- A systems integrator contract with QSSI which provides program expertise and coordinates the work with CMS and its contractors to ensure clear accountability, efficient use of resources, and prioritization of deliverables.
- Continued support for QSSI as it operates the Data Services Hub, which as the GAO noted in the draft report, worked as intended when launched on October 1, 2013.

2

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "HEALTHCARE.GOV: INEFFECTIVE PLANNING AND OVERSIGHT PRACTICES UNDERSCORE THE NEED FOR IMPROVED CONTRACTS" (GAO-14-694)

The strengthened acquisition workforce is being improved through collaboration with HHS and cross-department efforts, and it includes:

- Additional training for CMS acquisition personnel including program and project managers, contracting officers, and contracting officer's representatives (CORs).
- Dissemination of best practices for contract/program management across the Agency.
- Establishment of a CMS enterprise-wide approach to program and project management through the initiatives that improve the coordination of program managers and other members of the acquisition team.

GAO Recommendation

The Administrator of CMS take immediate steps to assess the causes of continued FFM cost growth and schedule delays and develop a mitigation plan designed to ensure timely and successful system performance.

HHS Response

HHS partially concurs with the GAO recommendation. CMS has already assessed the causes of cost growth and schedule delays with its CGI contract, and in response to that assessment, CMS ended its cost plus fixed fee contract with CGI, and awarded a new cost plus award fee contract with Accenture. CMS awarded this type of contract because it better controls costs and rewards performance. Additionally, CMS and Accenture, through a series of multi-day meetings in early 2014, finalized a definitive one-year agreement with well-defined requirements and ensured that both CMS and Accenture staff understood these requirements and their scope. This clear understanding of requirements limits the possibility of inappropriate authorizations that could lead to out-of-scope work, reduces risk, and allows CMS to conduct more stringent oversight. CMS is using the required contract deliverables to routinely track Accenture's performance and to identify performance issues quickly and take effective remedial action, if necessary.

CMS disagrees with GAO's assertion in the draft report that there has been "continued cost growth" since the Accenture agreement was finalized. The increases since the initial estimate of $91 million reflect a thorough analyses and finalization of the requirements as the letter contract was negotiated, along with contract changes that have added additional requirements and functionality. As noted in the draft report, in the CMS justification and approval document, CMS estimated that it would cost $91 million over a one-year period for Accenture to complete the FFM and support the 2015 enrollment period. After thorough analysis to assess needs, CMS determined that $121 million was a more appropriate amount to complete this work. In addition, CMS has modified that definitive one-year agreement to incorporate additional work requirements and functionality related to the SHOP, SBM transitions, and hardware acquisition. These represent new requirements and additional functionality rather than cost overruns.

3

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "HEALTHCARE.GOV: INEFFECTIVE PLANNING AND OVERSIGHT PRACTICES UNDERSCORE THE NEED FOR IMPROVED CONTRACTS" (GAO-14-694)

GAO Recommendation

The Administrator of CMS ensure the quality assurance surveillance plans and other oversight documents are collected and used to monitor contractor performance.

HHS Response

HHS concurs with this recommendation. CMS has policies and procedures in place to monitor contractor performance and has taken steps to better enforce those policies. CMS has a quality assurance surveillance plan in place for the Marketplace contract with Accenture and is currently using it to monitor performance. CMS has also implemented several other strategies to monitor Marketplace contractors' performance including requiring greater collaboration and coordination between CMS and its contractors, increasing the number and frequency of contract deliverables, and instituting value measures to more effectively monitor cost control within the contract.

GAO Recommendation

The Administrator of CMS formalize existing guidance on the roles and responsibilities of a Contracting Officer Representatives (CORs) and other personnel assigned contract oversight duties, such as Government Task Leaders, and specifically indicate the limits of those responsibilities in terms of providing direction to contractors.

HHS Response

HHS concurs with this recommendation and is currently working with its acquisition personnel to ensure there is a clear understanding of roles and responsibilities. In April 2013, CMS issued an internal memorandum that reminded all staff of the roles and responsibilities of acquisition personnel and provided guidance on what constitutes proper technical direction and ways to avoid unauthorized commitments. This informal guidance stopped inappropriate authorizations by individuals who did not have specific delegated contracting authority. CMS is currently formalizing this guidance to remind personnel of appropriate roles and responsibilities.

HHS and CMS are also implementing initiatives to improve training for contract and program personnel. HHS established acquisition Learning Communities to provide integrated training for members of the acquisition community. This training is designed to assist participants in understanding the acquisition lifecycle for various goods and services. These sessions outline the roles and responsibilities of each member of the acquisition workforce through the entire acquisition lifecycle, and provide hands-on experience through HHS-specific training scenarios. Along with the HHS training, CMS offers extensive training in for its contracting officers, CORs, and program and project managers. This additional training includes classes focused on strategic planning and implementation and risk management. Specifically, this includes approximately 140 classes that provide staff the opportunity to complete the training requirements for certification in contract and program management. CMS is also providing training for program managers who oversee CMS' major IT investments that will detail certification requirements, the roles and responsibilities of the program manager, including the preparation of an acquisition strategy.

4

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "HEALTHCARE.GOV: INEFFECTIVE PLANNING AND OVERSIGHT PRACTICES UNDERSCORE THE NEED FOR IMPROVED CONTRACTS" (GAO-14-694)

Furthermore, CMS is currently developing initiatives where program managers and other members of the acquisition team can share best practices and ideas with each other, coordinate the program management efforts between the key program offices within CMS, and establish an enterprise-wide approach to program and project management.

GAO Recommendation
The Administrator of CMS provide direction to program and contracting staff about the requirement to create acquisition strategies and develop a process to ensure that acquisition strategies are completed when required and address factors such as requirements, contract type, and acquisition risks.

HHS Response
HHS concurs with this recommendation and is currently taking steps to insure that Program Managers fully understand their roles and responsibilities, including the requirement to prepare an Acquisition Strategy. The Federal Acquisition Regulation (FAR) requires acquisition strategies and plans for all programs or projects that are augmented by acquiring contractor support or services. HHS is currently updating guidance on the use of acquisition strategies and expects to have that guidance issued in late summer 2014. HHS is also providing a series of training opportunities to the HHS operating and staff divisions to ensure that the roles and responsibilities of all involved in the acquisition lifecycle are aware of requirements to develop and execute quality acquisition strategies for approved projects.

Additionally, CMS has reassessed its program managers' assignments for each of its major IT investments. In late August 2014, the Office of Acquisition and Grants Management will be conducting a Learning Community meeting for assigned program managers to insure that they understand their roles and responsibilities, requirements for certification, and the importance of preparing an acquisition strategy.

GAO Recommendation
The Administrator of CMS ensure that information technology projects adhere to requirements for governance board approvals before proceeding with development.

HHS Response
CMS concurs with this recommendation, and adopted and enforced a strict governance structure to manage the scope and quality of Marketplace deliverables. CMS oversees Marketplace development through weekly senior leadership meetings as well as weekly management meetings. In addition, changes to priorities or requirements must be approved by a specific change control board that ensures requirements are carefully aligned and prioritized.

5

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "HEALTHCARE.GOV: INEFFECTIVE PLANNING AND OVERSIGHT PRACTICES UNDERSCORE THE NEED FOR IMPROVED CONTRACTS" (GAO-14-694)

Functional and technical teams collaborate and coordinate on planning and execution through daily meetings staffed with development, operations, and maintenance contractors, lead federal policy, operations and technical staff, and representatives from the Systems Integrator. In order to ensure there is integration at the staff level, CMS has also increased coordination and collaboration across functional, technical, and program areas through designated primary and secondary staff members who are held responsible and accountable from each of the business and technical teams.

The Systems Integrator works with these teams to monitor, assess, and identify potential technical and operations issues. They work with CMS staff to develop solutions and ensure that effective and timely decisions are made to meet Marketplace deadlines. Through constant process improvement, the current management oversight and decision-making governance structure represents the application of key lessons learned and best practices for policy, requirements management, operations, technology implementation, contracts, and schedule.

6

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, W. William Russell, Assistant Director; Jennifer Dougherty; Elizabeth Gregory-Hosler; Andrea Yohe; Susan Ditto; Julia Kennon; John Krump; Ken Patton; Roxanna Sun; and Kevin Walsh made key contributions to this report .

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Key Lessons for LGBT Outreach and Enrollment

Under the Affordable Care Act

July 2014

Executive Summary

The Affordable Care Act presents an unprecedented opportunity to improve the wellbeing and economic security of millions of Americans, including lesbian, gay, bisexual, and transgender (LGBT) people and their families. In particular, health reform has the potential to help close LGBT health disparities by improving access to quality, affordable health insurance coverage that connects LGBT people with the care they need to stay healthy. However, this opportunity may not be fully realized if outreach and enrollment efforts do not effectively engage LGBT communities.

Out2Enroll is a national campaign that serves as a key link between LGBT communities and the Affordable Care Act by connecting LGBT people with information about their new coverage options. Based on Out2Enroll's experience and interviews with key stakeholders, this report identifies key lessons for LGBT outreach and enrollment learned during the initial open enrollment period from October 2013 to March 2014. We found that:

- **The visibility and effectiveness of LGBT-oriented outreach and enrollment varied significantly by state.** These variations largely arose from the level of formal marketplace commitment to LGBT inclusion and the extent to which LGBT community and allied organizations were able to participate in the health reform effort.

- **Stakeholders—including federal and state marketplaces, assisters,* community leaders, and Out2Enroll—took advantage of a variety of opportunities to engage LGBT people.** These opportunities included the development of LGBT-specific messaging and education materials and dissemination by trusted messengers; targeted efforts to engage LGBT community members at outreach and enrollment events; and a consistent presence at community events and locations where LGBT people congregate.

- **LGBT outreach was complicated in many states by uncertainty surrounding outstanding policy issues related to relationship recognition, transgender health, HIV coverage, and plan transparency.** Specifically, stakeholders in a variety of states reported significant confusion about the treatment of legally married same-sex spouses, domestic partners, and people in civil unions, particularly in light of the federal government's implementation of the Supreme Court's decision in *Windsor***; the continued prevalence of transgender-specific insurance exclusions; and insurance carrier practices that discourage enrollment of those with chronic conditions such as HIV. Federal and state officials have taken steps to address some of these issues, but many uncertainties remain.

* Throughout this report, we use the term "assister" to refer to all entities that formally assisted consumers with outreach and enrollment, including navigators, in-person assisters, certified application counselors, community health centers, and other consumer assistance personnel.

** The *Windsor* decision invalidated Section 3 of the Defense of Marriage Act, which had previously prevented the federal government from recognizing same-sex spouses.

Moving Forward

The initial open enrollment period offered significant opportunities to raise awareness and promote LGBT health equity. Yet more must be done to ensure that LGBT people fully understand and take advantage of their new coverage options under the Affordable Care Act.

Looking ahead to the 2015 open enrollment period, Out2Enroll makes the following recommendations:

- **Outreach and enrollment efforts in every state should explicitly include LGBT communities.** Federal and state marketplaces should create and disseminate education and outreach materials that explicitly address LGBT-specific issues. Marketplaces should also fund or encourage the development of assister coalitions that include LGBT organizations. These coalitions can increase outreach opportunities in LGBT communities and enhance the ability of non-LGBT organizations and allies to engage LGBT people effectively.

- **Assisters should receive LGBT-specific cultural competency training.** Assisters reported receiving numerous questions during the 2014 open enrollment period regarding LGBT-specific concerns, such as the treatment of same-sex relationships in the marketplaces and the availability of marketplace coverage without transgender-specific exclusions. Many stakeholders expressed a desire for training opportunities around these issues and guidance on ways to effectively engage LGBT community members.

- **All marketplaces should collect voluntary demographic information on sexual orientation and gender identity.** Federal regulations permit the marketplaces to collect a range of demographic information, as long as the disclosure of this information is optional for applicants. The collection of voluntary data on LGBT status is a critical part of ensuring that the marketplaces understand and address LGBT needs. These data are important for informing marketplace outreach and enrollment efforts among LGBT communities and assessing the effectiveness of LGBT-inclusive cultural competency and nondiscrimination requirements.

LGBT people are—and will continue to be—part of the success story of the Affordable Care Act. Out2Enroll will build on the successes of 2014 and continue to do its part by developing LGBT-specific resources, working closely with our partners to spread the word about the importance of health reform for LGBT communities, and ensuring that outreach and enrollment efforts effectively connect with LGBT people in every state.

LGBT people are—and will continue to be—part of the success story of the Affordable Care Act.

Introduction

To help connect LGBT people with their new coverage options, Out2Enroll—in conjunction with partners across the country—developed a national campaign to serve as a key link between LGBT communities and the Affordable Care Act during the initial enrollment period from October 2013 to March 2014. This report identifies key lessons learned from these efforts and ways to build upon this success to maximize future LGBT outreach and enrollment. This report reflects Out2Enroll's experiences as well as those of key stakeholders from across the country. We are extremely grateful to the representatives from the following organizations who shared their insights, reviewed our findings, and contributed thoughtful comments on strategies for ensuring that the benefits of health reform reach LGBT communities across the country:

California LGBT Health & Human Services Network • DC Health Link
Equality NC • Georgia Equality • Lesbian Health Initiative of Houston
National Center for Transgender Equality • NY State of Health
Northern Colorado AIDS Project* • PFLAG National
Tennessee Primary Care Association • The Health Initiative
Washington Healthplanfinder

* Supported by a grant from the GLBT Community Center of Colorado

Background

LGBT communities face significant poverty, discrimination, and health disparities. Contrary to popular stereotypes, LGBT people are disproportionately likely to live in poverty, particularly if they are parents, women, or people of color. Nationwide, one in five gay and bisexual men and one in four lesbian and bisexual women live in poverty, and the 2011 report Injustice at Every Turn found that more than 25 percent of transgender respondents had an annual household income under $20,000.[1,2] In addition to economic disparities, LGBT individuals frequently face systemic obstacles to quality health care such as refusals of care, substandard care, inequitable policies and practices in health care settings, and exclusion from health outreach and education efforts.[3] These experiences of discrimination correlate with significant health disparities in LGBT communities, including greater exposure to violence and higher rates of tobacco and other substance use, mental health concerns such as depression, HIV and other sexually transmitted infections, and cancer.[4] These disparities are even more pronounced for LGBT people who are also members of other groups that are disadvantaged because of their race, ethnicity, or other aspects of identity.

LGBT communities are disproportionately uninsured. LGBT people are more likely than the general population to lack health insurance coverage, and more than one in three LGBT people with incomes under 400 percent of the poverty level—those potentially eligible for Medicaid coverage or financial assistance to purchase a new health plan under the Affordable Care Act—were uninsured in 2013.[5] Sixty-seven percent of these uninsured LGBT individuals had been uninsured for two or more years, and 40 percent carried medical debt that they could not afford to pay off. Reasons why LGBT people are more likely to be uninsured include a lack of relationship recognition for same-sex couples in the majority of states, which makes it difficult for these couples to cover each other with employer-sponsored coverage, and widespread employment discrimination against LGBT people, which traps many LGBT people in poverty and lower-wage jobs that do not offer benefits such as health insurance coverage.[6]

Many LGBT people live in states where few legal protections currently exist for LGBT individuals and their families—and where states have declined to fully implement health reform. There are at least nine million LGBT individuals, including almost 650,000 same-sex couples raising two million children, living in every corner of the U.S.[7,8] The majority of LGBT people do not live in the handful of major cities that are well-known for their LGBT populations, such as San Francisco, Chicago, or New York. Instead, like millions of other Americans, they live predominantly in the most populous region of the country: the South. Millions of LGBT people—and half of low- and middle-income LGBT people without health insurance—live in the states that span from Texas to Florida and north to Missouri and Virginia, where they enjoy no legal relationship recognition, extremely limited legal protections from discrimination in areas of everyday life such as employment, and inconsistent implementation of national initiatives such as the Affordable Care Act. For example, as of late 2013, an estimated three million LGBT people live in states that have declined to expand their Medicaid programs to cover low-income adults or operate their own marketplaces.[9]

Many LGBT people are uninformed about their new coverage options under the Affordable Care Act. Before the start of open enrollment in October 2013, many LGBT people had not heard of the new coverage options available under the Affordable Care Act. In particular, 70 percent of low- and middle-income LGBT people—those potentially eligible for financial assistance under the law—reported being unaware of their new options for accessing coverage through the marketplaces or Medicaid. Even among those who had heard of the health reform law, LGBT people overwhelmingly expressed skepticism about whether it would address their concerns and meet their needs.[10] This is particularly true for transgender people, many of whom have experienced discrimination throughout the healthcare system, from insurance companies that refuse to insure them or cover the care they need to providers who lack cultural competency in providing treatment in an appropriate and respectful way.

Where LGBT People Live, 2013

500K–1.2M+

200K–499K

50K–199K

8K–49K

Source: Data from Movement Advancement Project *LGBT Populations* (last visited July 6, 2014)
https://www.lgbtmap.org/equality-maps/lgbt_populations

The State of LGBT Outreach and Enrollment

Health reform presents a significant opportunity to address LGBT health disparities and improve the wellbeing and economic security of LGBT people and their families. To help make this opportunity a reality, Out2Enroll, state and national partners, and communities across the country adopted innovative strategies to spread the word about new coverage options for LGBT people. This section identifies these strategies, lessons learned during the initial open enrollment period, and outstanding policy issues that affected LGBT outreach and enrollment.

The visibility and effectiveness of LGBT-oriented outreach and enrollment varied significantly by state. Although LGBT people are disproportionately uninsured across the country, outreach to LGBT communities varied significantly by state based on the formal commitment of the marketplaces to LGBT inclusion and the degree to which LGBT organizations were able to successfully engage with assister coalitions and other outreach efforts.

Marketplace Commitment to Ensuring LGBT Inclusion. In approaching outreach and enrollment, state marketplace officials consistently stressed the importance of reaching uninsured individuals where they are. DC Health Link, for example, adopted a philosophy of meeting uninsured people "where they live, work, play, and pray." State marketplace officials also emphasized the importance of adopting strategies that reflect each state's diversity and leveraging trusted relationships that community organizations already have with the populations they serve.

Leading up to the launch of the marketplaces in October 2013 and throughout the initial open enrollment period, the U.S. Department of Health and Human Services (HHS) published several blog pieces and fact sheets regarding the importance of the Affordable Care Act for LGBT communities.[11] However, HHS did not explicitly identify the LGBT population among the vulnerable and underserved populations that potential navigator grantees needed to reach.[12] As a result, many marketplaces and assister coalitions adopted definitions of diversity that did not incorporate a specific effort to reach out to LGBT communities.

In contrast, some state marketplaces—such as Covered California and DC Health Link—clearly identified LGBT communities as an underserved population and intentionally engaged local LGBT organizations in conducting outreach and enrollment. Covered California, for example, awarded a $1 million grant to the Los Angeles LGBT Center and the California LGBT Health & Human Services Network—a statewide coalition of organizations that includes community centers, researchers, advocates, and providers—for LGBT-specific outreach and education.[13] This dedicated funding was crucial to helping Covered California reach out to LGBT communities across the state, including hard-to-reach populations such as transgender people, rural LGBT people, and immigrants. DC Health Link assisters included local institutions such as the DC Center for the LGBT Community, La Clinica Del Pueblo, Us Helping Us, and Whitman-Walker Health, a federally qualified health center that has a long history of working with LGBT people.

Out2Enroll includes both a national campaign and state-based outreach dedicated to promoting LGBT enrollment; disseminating targeted health reform information to LGBT communities; and developing innovative initiatives to engage LGBT people through strategic partnerships, public events, and marketing campaigns.

The Out2Enroll Campaign at a Glance

Here are some key ways Out2Enroll connected with LGBT communities during the initial open enrollment period:

- Launched the campaign on September 12, 2013 at a White House event featuring keynote remarks from Secretary of Health and Human Services Kathleen Sebelius and Senior Advisor to the President Valerie Jarrett, and insights from LGBT community leaders from across the country.
- Developed a consumer-friendly website—the core of a branded campaign that provides evidence-based messaging information and materials on LGBT-specific health reform issues—that was launched on National Coming Out Day in October 2013.
- Produced original, shareable LGBT-specific content for social media platforms, including blog pieces, photo memes, and videos, to engage LGBT consumers across the country.
- Produced public service announcements featuring prominent LGBT people, such as NBA star Jason Collins, and testimonials from LGBT people who got covered under the Affordable Care Act.
- Created LGBT-specific materials, including posters, postcards, flyers, and application guides, to support the efforts of our wide range of partner organizations.
- Distributed new resources, including media toolkits, community event toolkits, and regional event toolkits, to help partners tailor their outreach to LGBT communities.
- Co-sponsored regional events and trained assisters in cities across the country to raise awareness of enrollment opportunities among LGBT communities and to promote LGBT cultural competency.

Out2Enroll by the Numbers

- Convened more than 200 LGBT leaders from 23 states at the White House to launch Out2Enroll.
- Engaged 36 LGBT and health advocacy organizations to serve as advisory committee members.
- Received over 65,000 views on the Out2Enroll website, which includes more than 40 questions and answers on health reform issues.
- Distributed public service announcements reaching over 400,000 people.
- Secured over 150 earned media pieces on LGBT outreach and enrollment.
- Developed an LGBT cultural competency training curriculum and trained more than 200 assisters in 5 states to date.
- Worked with partner organizations to direct $70,000 to local LGBT organizations in Florida, Michigan, Pennsylvania, and Texas.

“Affordable health care and coverage are LGBT equality issues” —La’Tasha’s Story

Growing up, La’Tasha did not think she could ever visit the White House as a proud, out, black lesbian. But, in March 2014, she joined other LGBT consumers from across the country to speak with Dr. Jill Biden, the Second Lady of the United States, and share how health reform has impacted her life. Through her work as executive director of New Voices Pittsburgh, La’Tasha has advocated fiercely to promote the well-being of black women and girls in the greater Pittsburgh region. However, the high cost of health care was prohibitive for her small organization and, for the past four years, La’Tasha lived with the uncertainty of not having health insurance coverage. But that all changed on January 1, 2014. Thanks to the Affordable Care Act, La’Tasha signed up for a plan through HealthCare.Gov and got the care she needs for her preexisting conditions. La’Tasha noted that her visit to the White House showed that “I am part of a large and growing community of LGBT people who have seen our lives changed for the better by the Affordable Care Act.”

Adapted from: La’Tasha Mayes, “Op-Ed: Getting Health Insurance Matters to Equality,” *Advocate* (2014). http://www.advocate.com/commentary/2014/03/28/op-ed-getting-health-insurance-makes-difference-lgbt-equality

Other state marketplaces—such as NY State of Health and Washington Healthplanfinder—did not identify LGBT communities as a specific target but partnered with local LGBT organizations that could effectively reach LGBT people. For example, through a competitive procurement open to all eligible entities, NY State of Health awarded $2.4 million over five years to Community Health Project Inc. (also known as Callen-Lorde Community Health Center) in New York City. Callen-Lorde has substantial experience serving LGBT people and conducting enrollment for Medicaid and the state’s AIDS Drug Assistance Program. NY State of Health also includes representatives from LGBT communities in its regional advisory committee, which advises state officials and makes ongoing recommendations on the operation of the state’s marketplace.

State marketplace officials also committed to reaching LGBT people through direct advertising in online and print media outlets, engaging trusted local leaders as community ambassadors, conducting word-of-mouth campaigns, participating in community events, and visiting locations where LGBT people gather. In conducting these activities, officials emphasized that LGBT communities themselves are very diverse. As one official put it, “we recognized that the community was not monolithic, so we could not have a monolithic approach—we made a point to address sub-communities, such as the transgender community and the leather community.” State marketplaces also focused on groups that included LGBT communities of color and LGBT young people.

Participation by LGBT Community Organizations in Outreach and Enrollment Efforts. The success of LGBT-specific outreach was also affected by the ability of LGBT community organizations to participate in health reform efforts. As one interviewee put it, “it is very important to make sure that LGBT community groups are at the table—being at the table means you are actual partners, so LGBT people trusted the information we were bringing.”

A major factor limiting the participation of LGBT organizations was funding, particularly in the 34 states with federal marketplaces that had to share a total of $67 million in grants for outreach and enrollment.[14] To help achieve enrollment goals with these limited resources, HHS emphasized the importance of forming

As one marketplace official put it, "we recognized that the community was not monolithic, so we could not have a monolithic approach—we made a point to address sub-communities, such as the transgender community and the leather community."

broad-based coalitions and partnerships—but most states did not have coalitions that included LGBT community organizations.

Some coalitions did make specific efforts to reach LGBT communities by engaging trusted LGBT organizations. In Georgia, for example, statewide LGBT advocacy organizations and health organizations leveraged their longstanding relationship to make the case that the state's assister coalition needed to include targeted outreach to LGBT people.[15] The coalition's activities, funded as part of a four-state initiative overseen by the Structured Employment Economic Development Corporation (SEEDCO), included a grant to The Health Initiative, a nonprofit dedicated to improving the health and wellbeing of Georgia's LGBT community. With this grant, The Health Initiative hired three staff members dedicated to LGBT-specific outreach efforts and enrollment assistance.

Further, HHS awarded $150 million in 2013 and $58 million in 2014 to more than 1,000 community health centers nationwide to help fund enrollment efforts.[16] Several of these grantees, such as Boston's Fenway Health, Baltimore's Chase Brexton Health Services, and Houston's Legacy Health Services, have historically served LGBT communities and have been able to share this expertise with others.

LGBT Health Centers: Helping Reach Those Most in Need

Fenway Health's new Manager for Outreach and Insurance Engagement, Coco Alinsug, supervises a group of four assisters at the health center. Coco's past experience in outreach to primarily LGBT communities is informing his team's approach to insurance enrollment, which is to be out in the community as much as possible. He emphasizes the fact that organizations targeting LGBT communities must reach beyond large events like annual LGBT Pride parades; rather, organizations must be present in many places throughout the year.

"We are considering the role of the insurance navigators and thinking about how they can be out in the communities, not just behind their desks in the health center. We need to think differently about enrollment," Alinsug says. The ultimate goal is to balance *inreach* with *outreach.* For example, in addition to having patients enroll in coverage using computers when inside the health center, the team is also bringing iPads and other mobile technology to LGBT-friendly environments, such as gay and lesbian clubs and bars. "We know that we can't only wait for new enrollees to come to us. We have to get out there and educate people about the changes and show them that there are so many options for insurance now," Alinsug says.

Source: *Optimizing LGBT Health Under the Affordable Care Act: Strategies for Health Centers* (National LGBT Health Education Center & Center for American Progress, November 2013). http://www.lgbthealtheducation.org/wp-content/uploads/Brief-Optimizing-LGBT-Health-Under-ACA-FINAL-12-06-2013.pdf

In addition to federal and state funds, other initiatives contributed resources to support LGBT participation in outreach and enrollment activities. In particular, the Black Civic Engagement Project, the Latino Civic Engagement Project, and the Service Employees International Union (SEIU) partnered with Out2Enroll to support outreach efforts in African American, Latino, and LGBT communities in Florida, Michigan, Pennsylvania, and Texas.[17] This partnership funded five LGBT community organizations—Equality Pennsylvania, Michigan's KICK, the Lesbian Health Initiative of Houston, New Voices Pittsburgh, and Miami's Save DADE—to work in coalitions to promote LGBT enrollment, particularly among LGBT people of color, and conduct targeted outreach to LGBT people through events such as community-oriented information sessions and wellness fairs.

In Texas, for example, the Lesbian Health Initiative of Houston partnered with a variety of stakeholders—including Get Covered America, One Voice Texas, Gateway to Care, and Young Invincibles—to elevate

It's Good to Have Friends!

Out2Enroll is incredibly grateful to the members of its advisory committee and community partners that held or supported LGBT-specific events across the country. These partners include:

7 Rivers LGBT Resource Center Afiya Center AID Atlanta AIDS Resource Center of Wisconsin Atlanta Pride Committee Be Magazine Beth Israel Medical Center Black Transmen Black Transwomen Center for Black Equity CenterLink Cimarron Alliance Equality Center Community Catalyst Congregation Beth El Binah Cream City Foundation DC Center Diverse & Resilient DVIS Empire State Pride Agenda Equality Arizona Equality California Equality Louisiana Equality Pennsylvania Fair Wisconsin Family Safety Center Tulsa FORGE Forward Gay & Lesbian Community Center of Southern Nevada Gay and Lesbian Medical Association Georgia Equality Get Covered America Grady Health System HIV Prevention Justice Alliance HIVHealthReform.org HOPE Hope for Peace & Justice Howard Brown Health Center Human Rights Campaign Interfaith Alliance of Tulsa Kentucky Health Justice Network Lambda Legal Legacy Community Health Services Lesbian Health and Research Center Lesbian Health Initiative of Houston LGBT Center of Raleigh LGBT Elder Initiative LGBT Health & Human Services Network LULAC Mazzoni Center National Black Justice Coalition National Latina Institute for Reproductive Health NC State GLBT Center New Voices Pittsburgh Oklahomans for Equality One in Ten OneColorado OSU Center for Health Sciences Our Family Coalition OutCentral Parkland Pennsylvania Association of Community Health Centers Pennsylvania Health Access Network PFLAG National PFLAG Tulsa Chapter Phillips Theological Seminar Planned Parenthood of Greater Texas Planned Parenthood of the Heartland Planned Parenthood of Western Pennsylvania Project TurnAround Foundation PROMO Protecting Arizona's Family Coalition Raising Women's Voices Resource Center Rutgers School of Nursing Southwest Center for HIV/AIDS Stonewall Columbus Street Works The Center The Equality Network The Health Initiative Trans Pride Initiative Transgender Education Network of Texas Transgender Law Center Tulsa CARES United Way of America Vanderbilt University School of Medicine William Way LGBT Community Center Young Invincibles

the need to reach the uninsured LGBT population and deliver LGBT-specific information to a diverse group of constituents, including community-based organizations; federally qualified health centers; safety net clinics; hospitals; specialty care providers; assisters; and city, county, state, and federal officials. Through these partnerships, the Lesbian Health Initiative of Houston helped ensure that LGBT communities had a representative at local Affordable Care Act implementation meetings and events and broadened its own reach by, for example, joining the Cancer Alliance of Texas as its first LGBT community organization member and taking a seat on the Alliance's Affordable Care Act Priority Focus Area workgroup.

Even in the absence of dedicated funding, LGBT and allied organizations across the country—including many that do not focus primarily on health—pitched in to assist with promoting outreach and enrollment and to help make sure that the benefits of the Affordable Care Act reach the LGBT communities they serve. Advocacy organizations with large national networks, such as CenterLink, PFLAG National, the National Center for Transgender Equality, the National Gay and Lesbian Task Force, and the Human Rights Campaign, partnered with Out2Enroll to promote the importance of health reform through blog posts, mailings, webinars, social media, newsletters, national and local meetings, and community events. The Strong Families Coalition worked with Out2Enroll and LGBT organizations across the country to ensure that LGBT individuals and their families were aware of their new coverage options through the marketplaces. And state-based LGBT advocacy organizations leveraged their relationships with local LGBT communities to promote education and enrollment in states such as Michigan, North Carolina, Utah, and Wisconsin.

The Utah Pride Center, for instance, partnered with the Utah Health Policy Project to put on the Q Health Initiative, a multi-day event in September 2013 focusing on LGBTQ (the Q stands for "queer") health and the Affordable Care Act. The Q Health Initiative included community information sessions about the upcoming open enrollment period and an LGBT cultural competency training session for assisters. On the other side of the country, Equality NC connected LGBT community members with assisters across the state, including in conservative rural areas, and distributed health reform information at its community events. The organization also launched a campaign in early 2014 to highlight insurance discrimination that was preventing legally married same-sex couples from enrolling in family coverage offered through the marketplace. Thanks to efforts that included media outreach and a Twitter Town Hall, the state's largest insurer soon reversed its policies and agreed to cover these couples.

Stakeholders—including federal and state marketplaces, assisters, community leaders, and Out2Enroll—took advantage of a variety of opportunities to engage LGBT people. Stakeholders identified a variety of opportunities to inform LGBT community members about their new coverage options, including developing and sharing LGBT-specific materials using culturally relevant messengers, organizing outreach and enrollment events, and establishing a consistent presence at community events and locations where LGBT people congregate.

Even in the absence of dedicated funding, LGBT and allied organizations across the country pitched in to assist with promoting outreach and enrollment and to help make sure that the benefits of the Affordable Care Act reach the LGBT communities they serve.

LGBT-Specific Materials and Messengers. LGBT people, like the general population, have many questions about what health reform is and how it might affect them. Many LGBT people express additional skepticism because of the exclusion and discrimination they have experienced in many areas of their lives, including in health insurance and health care. Understanding that relevant and accurate information is key to overcoming this skepticism and motivating LGBT people to enroll in coverage, Out2Enroll developed a website with more than 40 questions and answers in the following categories: "Considering Coverage," "Weighing Your Options," "What's Covered?" and "From Coverage to Care." Out2Enroll also developed fact sheets, toolkits, and other resources to help assisters and LGBT organizations conduct successful outreach and enrollment efforts.

Federal officials and state marketplace officials also used LGBT-specific images and messaging to reach LGBT people via social media and print advertisements. For example, in December 2013, Covered California highlighted LGBT-themed advertising on billboards and in print advertising to help ensure that LGBT communities felt included in the marketplace's marketing and outreach efforts.[18] Billboard advertisements were displayed in the Bay Area, San Diego, and Los Angeles.

Source: Healthcare.gov

Federal officials and state marketplace officials also used LGBT-specific images and messaging to reach LGBT people via social media and print advertisements.

Got Questions? We've Got Answers

LGBT people have specific questions. These questions were consistently the most viewed questions on the Out2Enroll website:

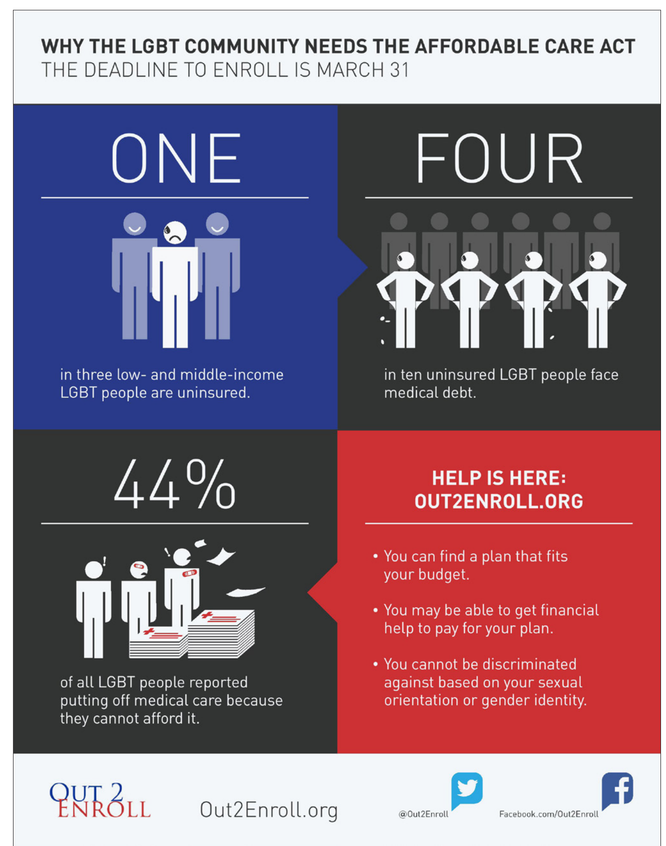
- What if I'm transgender?
- Can I enroll in family coverage with my same-sex spouse or partner?
- Why should getting covered matter to the LGBT community?
- How can I find an LGBT-friendly provider who takes my insurance?
- Can I get financial assistance?
- Can I get financial assistance with my same-sex spouse?

See these answers and even more LGBT-specific questions at www.out2enroll.org

Skepticism among LGBT people also underscores the need for trusted organizations and individuals to undertake highly visible efforts to deliver information about health reform. One state marketplace official observed that LGBT people were much more likely to engage with assisters who were clearly LGBT-identified; as she put it, "people would be like magnets to our assisters once they saw they were part of the community, because they felt a sense of trust and solidarity."

To reflect the importance of community members as trusted messengers, the Out2Enroll website also features video messages from prominent LGBT community members such as NBA star Jason Collins; personal video testimonials from LGBT people who got covered; and a blog featuring articles by LGBT activists, assisters who are working with LGBT people, and LGBT community members who wanted to share their stories.

Some assisters and LGBT organizations developed and distributed their own LGBT-specific content through blogs, Facebook, and Twitter; online enrollment centers; digital newsletters; blog posts; and email blasts. The National Center for Transgender Equality, for example, regularly posted blog pieces about the benefits of health reform and sent emails to its members sharing personal stories of transgender individuals who had enrolled. Other organizations developed resources that could be easily distributed at community events or shared online.



Source: Out2Enroll

Out2Enroll produced original, shareable LGBT-specific content for social media platforms, including blog pieces, photo memes, and videos, to engage LGBT consumers across the country.

The Health Initiative in Georgia, for example, printed cards that included their own and Georgia Equality's logos, while PFLAG National developed template health reform graphics and resources that were readily shareable by its regional networks and local chapters.

Meeting LGBT People Where They Are. Assisters and LGBT organizations adopted a variety of approaches to meeting LGBT people where they are, including participation in community events and a consistent presence at prominent community venues. For example, DC Health Link assisters distributed information at AIDS Walk Washington, ManDate DC, the Miss DC Transgender Pageant, and the Mid-Atlantic Leather Weekend, among other events. Other assisters disseminated enrollment information at pride festivals, health fairs, National Black HIV Awareness Day events, and state equality events; wrote articles and op-eds for local LGBT media; and gave presentations via webinars and at community centers, churches, and partner assistance sites.

Source: Washington Healthplanfinder

Source: Strong Families Coalition

Stakeholders used a variety of tools to raise LGBT awareness about their options and the need to get covered.

Assisters also maintained a consistent presence at venues where LGBT people gather, such as LGBT community centers, colleges and universities, places of worship, public libraries, and HIV/AIDS service organizations. For example, assisters from the Tennessee Primary Care Association—one of two main assister entities in Tennessee—partnered with the state's Ryan White Program and the AIDS service organization Nashville CARES to help with enrollment for six hours a day, three days a week. Assisters in Colorado, the District of Columbia, and Tennessee particularly noted the importance of partnering with churches and other faith communities to promote outreach and enrollment. DC Health Link assisters, for example, held monthly events at Inner Light Ministries and the Metropolitan Community Church of Washington to engage LGBT communities about health reform and to provide other assistance as needed, such as help with legal name changes for transgender people.

LGBT-specific assisters also frequently served non-LGBT populations and partnered with non-LGBT organizations to staff events and other activities. For example, The Health Initiative in Georgia often participated in enrollment events that were not specific to LGBT communities. As an organization representative explained, "I did an event at a church last week after they sought us out—all our materials identify us as an LGBT organization, but it wasn't a hindrance because they know they need people to provide quality information." The same was true for DC Health Link, where Us Helping Us—an organization that focuses on improving the health and wellbeing of gay black men—provided enrollment services to LGBT and non-LGBT people alike by working closely with ex-offenders and assisting at enrollment events linked with tax services.

LGBT outreach was complicated in many states by uncertainty surrounding outstanding policy issues related to relationship recognition, transgender health, HIV coverage, and transparency. Research in 2013 clearly showed that an overwhelming majority of LGBT people who are eligible for financial assistance say they are curious about the health reform law and describe health insurance as either very important or as a necessity they would not give up.[19] However, outreach to and enrollment of LGBT community members has been complicated by unanswered questions related to issues such as relationship recognition for legally married same-sex couples and those in domestic partnerships or civil unions; the continued prevalence of transgender-specific insurance exclusions; insurance carrier practices that discourage enrollment by those with chronic conditions such as HIV; and a lack of plan transparency.

Federal and state officials have taken steps to address some of these issues, but uncertainty remains. As one LGBT organization, put it, "we tell people to contact us if they have any problems with discrimination, but there is definitely uncertainty, which makes it hard to put out accurate messaging."

Coverage for Same-Sex Couples. Because of the current patchwork of marriage equality and relationship recognition laws across the United States, some legally married same-sex couples have faced barriers to enrolling in family coverage. The issue was first raised in North Carolina after a same-sex couple was told that the family policy they had purchased together through the marketplace was invalid because the policy's definition of "spouse" did not include same-sex couples. Equality NC and partners helped elevate this issue in the media in early 2014, and the insurance company eventually

LGBT-specific assisters also frequently served non-LGBT populations and partnered with non-LGBT organizations to staff events and other activities.

The initial open enrollment period offered numerous opportunities to identify promising practices that effectively connected LGBT people with new coverage options. Here are the key lessons that Out2Enroll identified:

Lessons Learned: Eight Ways to Promote LGBT Outreach and Enrollment

1. **Engage LGBT and ally organizations and community leaders in outreach and enrollment efforts.** Every marketplace and assister coalition should engage with LGBT organizations, allies, and community leaders. Develop an advisory committee on LGBT outreach and actively work with the committee on an ongoing basis to develop strategies for how best to reach LGBT people.
2. **Embed enrollment and LGBT cultural competency in your institution's culture.** Every interaction with a client or community member is an opportunity to learn if they have health insurance and to direct them to appropriate resources. And word of mouth about this experience—positive or negative—spreads quickly through the community. Train every staff member or volunteer on LGBT cultural competency and the importance of letting community members know that your organization can assist with enrollment.
3. **Put enrollment in the broader context of people's lives.** Seize opportunities for engagement when people are already focused on their health, such as staffing a table at a community health fair or providing materials at HIV testing sites. Emphasize that health insurance is an important component of a healthy lifestyle.
4. **Reflect the diversity of LGBT communities.** LGBT communities include individuals and families of every race, ethnicity, religion, ability, age, primary language, immigrant experience, and socioeconomic level. And LGBT people live everywhere, including rural areas. Help ensure that assisters reflect this diversity by hiring staff and volunteers from a variety of backgrounds and making sure that materials are broadly accessible, particularly for people with disabilities and those whose primary language is not English.
5. **Collaborate with trusted organizations.** Identify and partner with organizations that have established networks that incorporate and overlap with LGBT communities. Among others, these organizations may include faith communities, immigrant advocacy organizations, reproductive health advocates, racial and economic justice advocates, AIDS service organizations, campus student groups, ex-offender programs, mental and behavioral health providers, legal service organizations, community health centers, and state LGBT equality organizations.
6. **Personalize your messages.** LGBT individuals need to know that health reform reflects their specific needs and takes these needs seriously. Personalize your content by incorporating LGBT-friendly language and images; including state-specific information; and tailoring information to specific groups such as transgender people, LGBT people of color, and LGBT young people.
7. **Be out and proud of your efforts.** Let LGBT individuals know they can trust your organization to help them. Be vocal and visible about your interest in reaching LGBT people and key influencers, and distribute branded materials, such as brochures, condoms, stickers, or pens, at LGBT events and social spaces.
8. **Share success stories of LGBT enrollment.** Put a human face on the need for LGBT people to enroll by sharing success stories from your community. Reach out to the media, write an editorial, or connect with Out2Enroll to make your voice heard.

Federal and state officials have taken steps to address some of these issues, but uncertainty remains.

decided to amend its definition of "spouse" to cover legally married same-sex couples. Out2Enroll heard similar stories from families across the country, and the issue received attention in national media outlets such as the *Washington Post* and LGBT-specific publications such as the *Advocate.*[20] In response, HHS issued guidance in spring 2014 requiring insurers in every state to make spousal coverage equally available to same-sex and different-sex spouses starting on January 1, 2015.[21]

The guidance does not, however, clarify nationwide rules on domestic partnerships or civil unions for purposes of family coverage. Further, additional HHS guidance from spring 2014 explicitly allows states to refuse to recognize same-sex married couples as a family for purposes of Medicaid coverage, meaning that low-income couples will continue to face eligibility and access rules that vary significantly based on where they live, particularly while many states continue to reject the Medicaid expansion.[22]

Transgender-Specific Insurance Exclusions. Prior to health reform, discrimination was rife in insurance markets. The Affordable Care Act introduced significant new standards designed to limit such practices, including new prohibitions on discrimination on the basis of gender identity and sexual orientation by qualified health plans and all other new health insurance plans that include the essential health benefits.[23] Despite these new requirements, however, the continued widespread use of discriminatory transgender-specific exclusions in insurance plans persists.

These exclusions explicitly discriminate on the basis of gender identity by denying transgender people coverage for medically necessary health services—including hormone therapy, mental health services, and surgeries—that are covered for non-transgender consumers on the same plans.[24] Exclusions are significant barriers to enrollment for transgender people, who see them as a breach of the promise that the Affordable Care Act will help them receive the health care they need. As a transgender man in Virginia noted, "what [the plan is] telling me is not that a service isn't provided to any of its members…it's that any care provided to treat [gender dysphoria***] is 'not medically necessary' and not covered. If, in fact, such a denial of coverage doesn't violate nondiscrimination policies, those policies are broken." Another transgender consumer, upon receiving conflicting and inaccurate information from the Michigan marketplace about the availability of coverage without transgender exclusions, said bluntly: "Why bother with insurance at all?"

Since the passage of the Affordable Care Act, there have been several significant policy advances that are helping to open access to insurance coverage for transgender people. For instance, federal regulators concluded in May 2014 that Medicare, which already covered hormone therapy and mental health services for transgender people, cannot categorically exclude coverage for surgeries related to gender transition.[25] Shortly afterwards, the federal Office of Personnel Management also removed a general exclusion for transition-related care in coverage offered in all states through the Federal Employee Health Benefits program.[26] As of July 2014, insurance commissioners in eight states and the District of Columbia have issued guidance clarifying that gender identity and sex nondiscrimination protections in state insurance law prohibit transgender-specific exclusions. And some new insurance plans, such as the health insurance co-op established in Colorado under the Affordable Care Act, have adopted a policy from the very beginning of not using discriminatory transgender exclusions.

*** Gender dysphoria is a medical term that describes the need that many transgender people have for medical services related to gender transition.

“I no longer need to sell my home to pay for my health expenses” —Regina’s Story

When Regina made the courageous decision to live her life as the woman she has always known herself to be, she lost a lot: Her marriage dissolved, and with it went her insurance coverage, which had been through her wife’s employer. As an older transgender woman who had been a stay-at-home parent for many years, she struggled to find a job while paying over $1100 per month in health care costs –$440 for her insurance premium plus $700 for a hormone therapy prescription and asthma medications that her insurance didn’t cover. By the time October 2013 rolled around, Regina was on the verge of having to sell her house to pay off her medical debts. But once the GLBT Community Center of Denver helped her navigate Colorado’s health insurance marketplace, she was able to find a cheaper plan from the new nonprofit Colorado Health Co-Op that not only covers her prescriptions but doesn’t exclude coverage for any of the health care she needs as part of her gender transition. For Regina, as for so many other transgender, gay, lesbian, and bisexual people across the country, the Affordable Care Act is more than a law – it’s a gift.

Adapted from: Regina Gray, “Health Access: Full Exposure – A Pathway to Better Health,” *Colorado Consumer Health Initiative Full Coverage* (2014). http://cohealthinitiative.org/blog/2014-05-07/health-access-full-exposure-pathway-better-health

Despite these advances, however, too many plans—including marketplace plans in most states and the majority of state Medicaid programs—continue to exclude coverage for the medically necessary care many transgender people need. Until these exclusions are clearly and consistently treated as a prohibited form of discrimination by both federal and state regulators, their continued prevalence in plans across the country will continue to bar transgender people from getting coverage under the Affordable Care Act.

Discrimination Against People With HIV. Stakeholders in states across the country also raise significant concerns about insurer policies and practices that discourage the enrollment of LGBT individuals with significant health needs, such as HIV. The issue came to a head in early 2014 when the LGBT legal advocacy organization Lambda Legal won an injunction against insurers in Louisiana for endangering the life of a man with HIV by refusing to accept third-party premium payments from the Ryan White Program, which provides vital coverage for lower-income people living with HIV or AIDS.[27] Though HHS released new guidance requiring insurers to accept these payments, insurers in numerous states quickly began a race to the bottom to find new ways to discourage people with HIV from purchasing their policies. For example, in a practice that has already resulted in a legal challenge via the HHS Office for Civil Rights, many insurers are covering HIV medications, including generics, at the highest cost-sharing tiers, which requires new enrollees to pay thousands of dollars a month in out-of-pocket costs.[28]

Lack of Plan Transparency. These outstanding policy questions and continuing concerns about discrimination have a chilling effect on successful outreach and enrollment for LGBT communities. These concerns are often exacerbated by a widespread lack of transparency in plan offerings. Like other consumers with specific health needs, many LGBT people want to know the details of the coverage they are considering buying. They want to be able to compare drug formularies, review policy language to understand whether plans have transgender-specific exclusions or other limits on benefits, and ensure that LGBT-friendly providers are included in their plan’s network.

As an outreach grantee in California noted, for instance, assisters frequently had to explain California's requirements regarding coverage for gender transition, which are among the strongest in the nation. As she put it, "knowing these protections were out there was not enough to overcome the historical discrimination that people experienced. People still wanted to see the plan documents." In most cases, however, plan documents with benefits and coverage information are inadequate, difficult to obtain, or entirely unavailable. Access to adequate information about covered benefits and services, including exclusions, formularies, and cost-sharing structures, will continue to be critical to ensuring that LGBT people understand their options and enroll in coverage that meets their needs.

Federal and state officials have addressed some, but not all, of the outstanding policy issues that pose barriers to effective LGBT outreach and enrollment. Unanswered questions, such as those identified above, will continue to cause confusion and could compromise efforts to reach LGBT people. Federal and state officials should prioritize the need to resolve these issues ahead of the 2015 open enrollment period.

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2015: Next Steps for LGBT Outreach and Enrollment

The 2014 open enrollment period offered significant opportunities to connect LGBT communities with their new coverage options under the Affordable Care Act. Yet more must be done to ensure that LGBT people fully understand their new options and are able to take advantage of them. Indeed, LGBT-specific outreach and education must be an ongoing priority for marketplaces, particularly given opportunities for special enrollment, year-round eligibility for Medicaid, and the approach of the 2015 open enrollment period. This section identifies several high-priority issues, with an emphasis on engagement of LGBT and allied organizations, LGBT-specific cultural competency training for assisters, and LGBT data collection.

Outreach and Enrollment Ahead of the 2015 Open Enrollment Period

Stakeholders reported a variety of approaches and activities to continue LGBT engagement between spring 2014 and the next open enrollment period, which begins on November 15, 2014. These activities include:

- Distributing information at LGBT Pride events, music and art festivals, fairs, health and wellness clinics, and adoption agencies
- Hosting LGBT-specific enrollment events and continuing to support LGBT enrollment centers
- Educating community members at events and through presentations, with an emphasis on special enrollment periods and Medicaid coverage
- Training partners on LGBT cultural competency and enrollment issues
- Providing additional training opportunities for assisters
- Developing additional LGBT-specific content, such as fact sheets on how to file a complaint in the face of discrimination
- Promoting digital resources and continuing social media campaigns

Outreach and enrollment efforts in every state should explicitly include LGBT communities. LGBT outreach varied largely on the basis of each marketplace's commitment to reaching LGBT community members and was more rare and more difficult in states with a federal marketplace. Gaps in LGBT outreach and enrollment arose from funding limitations, the limited timeframe in which local organizations could apply for navigator grants, limited existing partnerships between LGBT organizations and consumer health advocacy organizations, and the fact that state social and political environments hostile to health reform are also frequently those that tolerate and sometimes actively promote discrimination against LGBT people and their families.

For the 2015 open enrollment period, federal and state marketplaces can help narrow gaps in LGBT outreach and enrollment by funding or encouraging the development of assister coalitions that include LGBT organizations. These coalitions will increase opportunities for outreach to LGBT communities and promote a greater degree of LGBT cultural competence among non-LGBT organizations.

Assisters can also partner with LGBT organizations in every state to support outreach and enrollment efforts: Numerous stakeholders noted the value of coordination and regular communication between LGBT and non-LGBT organizations. And LGBT organizations themselves have a significant role to play in incorporating information about the Affordable Care Act into their work with LGBT community members.

Some LGBT organizations—such as The Health Initiative, members of the California LGBT Health & Human Services Network, and the Northern Colorado AIDS Project—hired dedicated staff for LGBT outreach and enrollment efforts. Others, including those that did not receive state or federal funding, successfully incorporated health reform information into their regular activities. For example, Equality NC included enrollment information in its existing campaigns and directed LGBT people to culturally competent assisters. PFLAG National similarly committed to distributing and sharing LGBT-specific content about health reform with its members; as a PFLAG representative said, "it became embedded—if we were putting something out, it was going to include the Affordable Care Act."

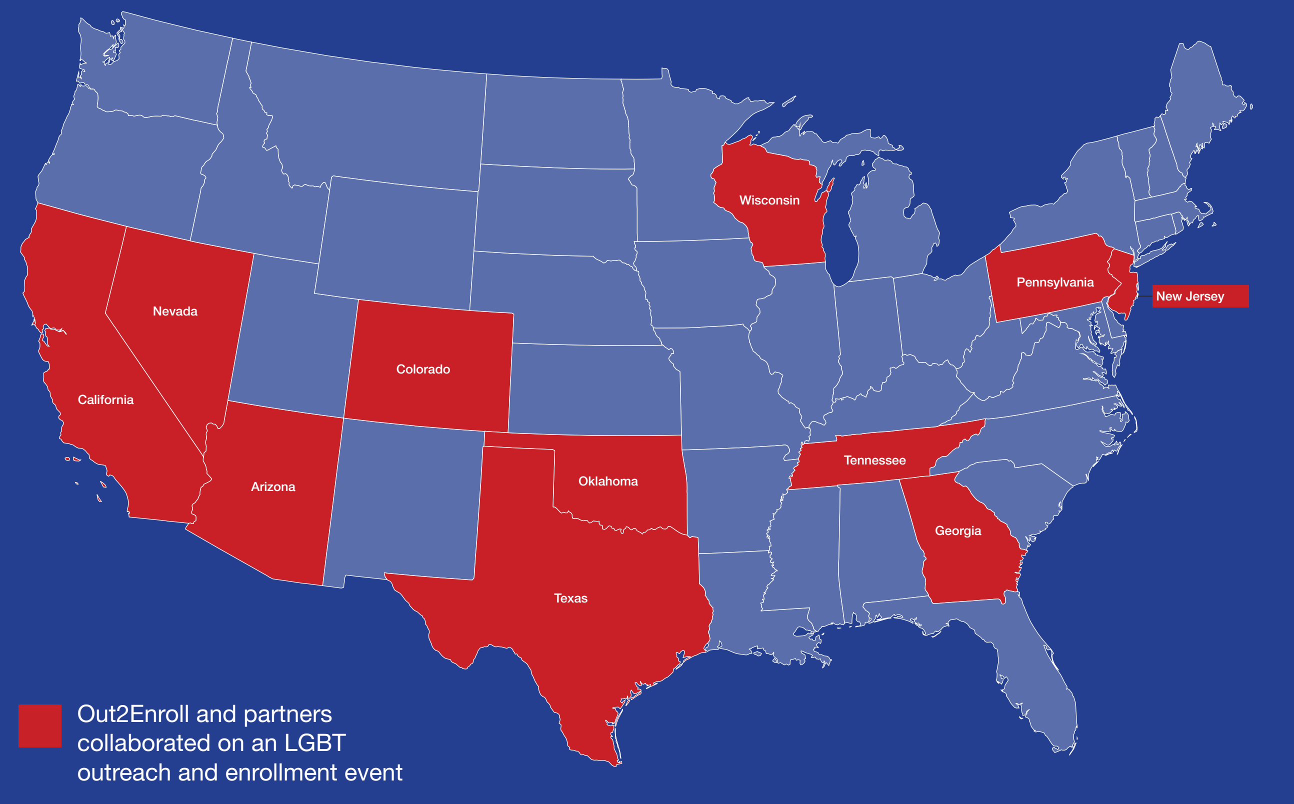
To help facilitate such efforts, Out2Enroll plans to establish a digital working group where LGBT organizations communicate regularly with each other about content and ways to spread the word about health reform. Organizations that want to support outreach and education efforts to LGBT communities can also join or establish coalitions with groups that are already doing so. Through the "Get Answers" section of its website, Out2Enroll offers event and messaging toolkits to help support organizations that want to engage LGBT community members.

Assisters should receive LGBT cultural competency training. Particularly for marginalized populations such as LGBT communities, trusted messengers are key to the success of outreach and enrollment. LGBT people overwhelmingly report a desire for culturally competent assistance from organizations and individuals that are knowledgeable about LGBT concerns: Nearly 7 in 10 low- and middle-income LGBT people indicated that it is very important to them that assisters understand LGBT issues around health insurance.[29] Ongoing training will be critical to meet this need.

For the 2015 open enrollment period, federal and state marketplaces can help narrow gaps in LGBT outreach and enrollment by funding or encouraging the development of assister coalitions that include LGBT organizations.

Out2Enroll on the Road

Out2Enroll—in conjunction with HHS, the White House, and local partners—collaborated on 25 outreach and enrollment events in 11 states during the initial open enrollment period. At each event, participants heard remarks from local partners and national officials and had the opportunity to participate in an educational town hall about what the Affordable Care Act means for LGBT communities. Attendees were also able to enroll in coverage with the help of local assisters. At many events, Out2Enroll also provided cultural competency training on LGBT-specific enrollment issues for local assisters.



The degree to which assister training included LGBT-specific information in the initial enrollment period varied by state. DC Health Link and NY State of Health, for example, incorporated LGBT-specific information within their broader training on cultural competency, including case studies with LGBT-specific scenarios such as enrollment for a same-sex couple. As one state marketplace official noted, "incorporating LGBT-specific scenarios addressed the issue more than saying, 'you need to be aware of the concerns of the LGBT community.'" Some state marketplace officials also solicited stakeholder feedback on training and outreach strategies. In New York, for example, marketplace officials solicited input from a statewide network of LGBT leaders on the content of the marketplace's assister training manual.

Out2Enroll offers training to assisters on working with LGBT people and answering LGBT-specific questions and has already delivered this training to a variety of assisters in Oklahoma, Pennsylvania, Tennessee, Texas, and Wisconsin.

In the training for navigators in the 34 states with federal marketplaces, HHS identified a handful of LGBT-specific policy issues, such as the fact that legally married same-sex couples can jointly apply for financial assistance. However, the majority of stakeholders reported interest in additional LGBT-specific training opportunities. Even in states that were highly intentional in their efforts to reach out to LGBT communities, stakeholders wanted more access to ongoing training and education opportunities to help promote LGBT outreach and enrollment. Moreover, continuing training will be particularly important in light of ongoing changes to federal and state rules on policy issues that affect LGBT outreach and enrollment.

Given the lack of LGBT-specific training ahead of the initial open enrollment period, assisters in many states reported a lack of awareness about certain LGBT health issues, such as transgender-specific insurance exclusions. As one interviewee put it, "I will be the first to admit that there are a lot of things that may impact the LGBT community that we may just not know…for instance, we learned that some plans don't cover gender reassignment surgery or hormones, and we would not have learned this unless there were specific questions."

Where formal training was not available, some LGBT community organizations stepped forward to help fill the gap. In Georgia, The Health Initiative responded to questions raised by coalition partners and proactively disseminated information about issues related to the Ryan White Program.

Yet stakeholders in many states raised concerns that outreach and enrollment would have been insufficient if LGBT organizations had not stepped forward to be part of state coalitions or to engage as key community partners. As one interviewee put it, "as we got deeper into the open enrollment period, we realized that some of the people who identified as uninsured could be grouped into categories, and one of the categories we were missing the LGBTQ community." Another noted the importance of referring people to organizations that are familiar with LGBT issues; as she put it, "it was extremely important to know that we could make referrals to culturally competent organizations."

Out2Enroll offers training to assisters on working with LGBT people and answering LGBT-specific questions and has already delivered this training to a variety of assisters in Oklahoma, Pennsylvania, Tennessee, Texas, and Wisconsin. We continue to offer this training, as well as LGBT-specific messaging and technical assistance, to assisters across the country. More information about this training and technical assistance is available by at www.out2enroll.org.

To bolster these efforts and help meet the demand for LGBT cultural competency training, HHS should incorporate additional LGBT cultural competency information, such as LGBT-specific scenarios, into its training materials.

All marketplaces should collect voluntary demographic information on sexual orientation and gender identity. Data collection is a critical part of informing marketplace outreach and enrollment efforts among LGBT communities, assessing the effectiveness of LGBT-inclusive cultural competency and nondiscrimination requirements, and ensuring that LGBT needs are understood and addressed.

Unfortunately, only one interviewee, DC Health Link, noted that its assisters were encouraged, but not required, to report the gender identity of the individuals they served. Because no marketplaces reliably collected data on LGBT identity during the initial open enrollment period—despite clear indications that LGBT people are disproportionately uninsured—policymakers, researchers, and advocates lack even the most basic information about how many LGBT people have enrolled in coverage and the degree to which the Affordable Care Act may be helping close LGBT health disparities.

The lack of LGBT data also seriously hampers efforts to conduct effective outreach to LGBT communities. Covered California, for example, used enrollment data to prioritize outreach and enrollment efforts to particularly underserved segments of the population and to identify which types of population-specific materials to develop. When enrollment data revealed a significant gap in Latino enrollment, Covered California increased its efforts to reach this community.[30] Yet without similar data on sexual orientation and gender identity, LGBT organizations and their partners face substantial obstacles in making the case for similar efforts to reach underserved LGBT people. As one interviewee put it, “the lack of any actual data on uninsured LGBT people meant we could tell Covered California who we were reaching, but we did not have the data to prove it.”

Federal regulations permit the marketplaces to collect demographic information, as long as the disclosure of any information not expressly related to eligibility determination is optional for applicants.[31] And research shows that questions on sexual orientation and gender identity do not discourage individuals from completing demographic and other surveys.[32] Federal and state marketplace officials should start collecting voluntary information on LGBT identity in the 2015 enrollment period by adding optional sexual orientation and gender identity questions to the existing optional demographic questions on race and ethnicity on marketplace applications.

Data collection is a critical part of informing marketplace outreach and enrollment efforts among LGBT communities, assessing the effectiveness of LGBT-inclusive cultural competency and nondiscrimination requirements, and ensuring that LGBT needs are understood and addressed.

Conclusion

Health reform is an unprecedented opportunity to address LGBT health disparities and improve the wellbeing and economic security of LGBT people and their families. To help deliver on this promise, Out2Enroll and partners across the country joined forces to inform LGBT communities about new coverage options. Although the initial open enrollment period offered significant opportunities to connect LGBT community members with their new coverage options, more must be done to effectively reach LGBT people and trusted messengers in states across the country. Stakeholders such as marketplace officials, federal officials, LGBT leaders, consumer health advocates, assisters, LGBT allies, and LGBT community members have a crucial role to play in increasing awareness about health reform and helping ensure that the benefits of the Affordable Care Act reach everyone who needs them.

About Out2Enroll

Out2Enroll is a consortium of organizations led by a steering committee comprised of the Center for American Progress, the Federal Agencies Project, and the Sellers Dorsey Foundation. Out2Enroll includes a national campaign and state-based outreach to promote enrollment of the LGBT community, the development of targeted information about health reform for the LGBT community, and innovative opportunities to engage the community through strategic partnerships and high-profile events and marketing campaigns. Through these efforts, Out2Enroll serves as a key link between LGBT communities and new coverage options available under the Affordable Care Act.

We wish to express our gratitude to the members of our advisory committee, our community partners, and our funders. Out2Enroll could not do this work without their unwavering support.

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Out 2 Enroll

TAKE TWO ASPIRIN...

An Examination of Physician Visit Cost Sharing and Benefit Design in the New Health Insurance Marketplaces

Monitoring the ACA's Health Insurance Marketplaces | July 2014

SUMMARY OF FINDINGS

To better understand the nature of coverage available to consumers through the Exchanges, Breakaway Policy Strategies (Breakaway) partnered with the Robert Wood Johnson Foundation (RWJF) to collect detailed information on premiums, network composition, deductibles, out-of-pocket limits, and cost sharing for every 2014 Silver Exchange plan in all 50 states and the District of Columbia, and made it available as Health Insurance Exchange (HIX) Compare, a comprehensive data set that enables researchers to monitor aspects of the Affordable Care Act's (ACA) implementation.

In this report, Breakaway and RWJF take a closer look at cost sharing for primary care physician (PCP) and specialist visits, including application of plan deductibles, copayment and coinsurance amounts, and the unique plan design features that may lead some enrollees to think twice before scheduling their next appointment with a doctor.[1] Key takeaways include:

- Like premiums and deductibles, cost sharing for PCP and specialist visits vary substantially among and within states. Nationwide, copayments for PCP visits range from $0 to $75 with a median of $35. Coinsurance ranges from 0 percent to 50 percent with a median of 25 percent. For specialist visits, copayments range from $10 to $150 with a median of $75. Coinsurance ranges from 8 percent to 100 percent with a median of 40 percent.

- Unlike most employer-sponsored insurance (ESI) plans, many Exchange plans subject PCP and specialist visits to a deductible.

- In an effort to comply with new ACA requirements while keeping premiums low enough to attract enrollees, some insurers are including unique plan design features that utilize copayment/coinsurance combinations, limited numbers of free or discounted visits, and visit limitations.

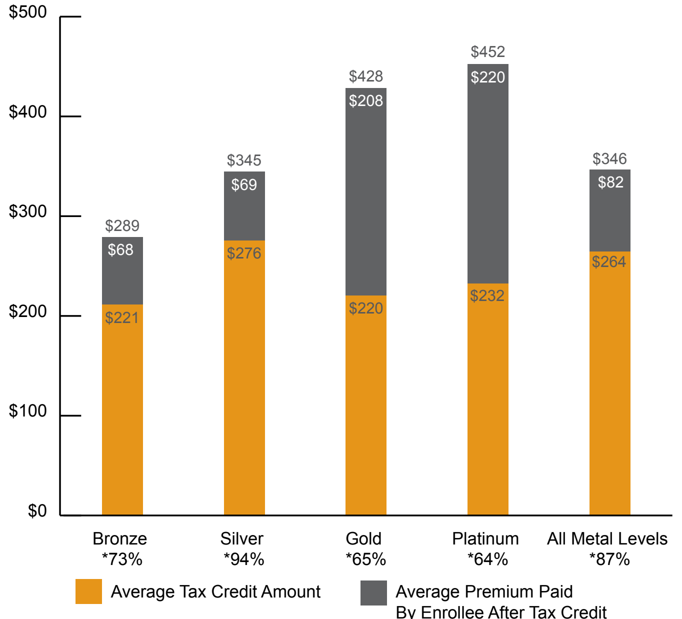
- In evaluating whether a plan meets their health care needs, consumers need to consider whether their current physicians are in the plan's provider network and whether the plan's network includes the type and number of providers sufficient to meet their needs. Difficulty accessing accurate information regarding provider networks can complicate that task.

A Note on Premium Tax Credits and Cost Sharing Reductions

The premium and cost sharing figures included in the HIX Compare dataset and this report do not reflect the cost sharing reductions (CSRs) or the premium tax credits[2] for which many enrollees are eligible and which may substantially reduce some individuals' out-of-pocket costs. Specifically, under the ACA, individuals with incomes up to 250 percent of the federal poverty level (FPL) who purchase a Silver-level plan through an Exchange are eligible to receive CSRs that will reduce their out-of-pocket spending. Particularly for individuals with lower incomes, these CSRs can substantially reduce cost sharing amounts by effectively increasing the plan's actuarial value (AV). In addition to CSRs, according to a recent report published by the Department of Health and Human Services (HHS)[3], the average Silver plan premium for someone receiving a premium subsidy is $69, $276 less than the average premium paid by an individual who does not receive a subsidy ($345). (See Figure 1, below).

We make some comparisons here between the cost sharing requirements of Exchange plans and ESI plans. Since many of the new Exchange plan enrollees previously were uninsured or were insured through the individual market, which looked fundamentally different from the ACA Exchanges, we certainly cannot make "apples to apples" comparisons between the ACA Exchange and ESI markets[4]. We believe, however, that ESI figures are relevant because there is likely to be more crossover between the two markets in the coming years. In addition, latest estimates by the Congressional Budget Office project that the number of Exchange plan enrollees will increase up to 25 million by 2017.[5] This growth, coupled with the possibility that some of these design features will migrate to the ESI market, means that substantially more individuals could find themselves in plans with cost sharing designs similar to those that have emerged in the ACA market.

Figure 1. Average Premiums Before and After Tax Credits; 2014 Federally Facilitated Exchange Plans



*Share of Plan Enrollees Determined Eligible for Federal Tax Credits

Application of Deductibles

When considering the cost of visiting a doctor, the copayment amount is often foremost in the minds of many. In 32 percent of Silver Exchange plans, however, PCP visits are subject to an overall plan deductible, meaning that individuals must pay 100 percent of the costs for services out-of-pocket until they satisfy their deductible. Similarly, 39 percent of Silver plans subject specialist physician visits to a plan deductible.

The median combined deductible for Silver plans is $2,267, but deductibles can run as high as $5,000 under some plans. Some stakeholders have expressed concern that with deductibles at that level, even enrollees who qualify for premium subsidies and CSRs may not be able to afford the amounts that they would have to pay out-of-pocket before their plans begin to pay benefits for physician visits. It is worth noting that the ACA requires plans to provide certain preventive services such as immunizations, well woman visits and blood pressure screenings to enrollees free of charge when obtained from an in-network provider (i.e., such services would not be subject to the plan deductible or any other cost sharing requirements).[6] However, for all other services, high deductibles could prove to be a barrier to people obtaining not only the care of a physician, but also to obtaining treatments and/or drugs that must be prescribed by a physician.[7]

Unlike Exchange plan enrollees, the majority of workers covered by ESI plans having a deductible do not have to meet that deductible before basic services, such as physician office visits, are covered.

Copayments and Coinsurance

PCP Visits

Median copays for physician office visits tend to be higher than average copays in the ESI market. Of the 1,208 Silver plans examined, approximately 68 percent of plans (819) charge a copayment before the deductible for a PCP visit, while about 23 percent of plans (283) utilize coinsurance to determine an individual's cost sharing. Nationwide, copayments for PCP visits range from $0 to $75 with a median of $35. Coinsurance ranges from 0 percent to 50 percent with a median of 25 percent.

Figure 2. In-Network PCP Cost Sharing Ranges and Medians Across the U.S. and in the Top 10 States by 2014 Exchange Enrollment

	Minimum Cost Sharing		Maximum Cost Sharing		Median Cost Sharing	
State	**Copay**	**Coinsurance**	**Copay**	**Coinsurance**	**Copay**	**Coinsurance**
USA	$0	0%	$75	50%	$35	25%
California	$45	N/A	$45	N/A	$45	N/A
Florida	$0	10%	$75	40%	$50	40%
Texas	$10	50%	$50	50%	$30	50%
New York	$0	0%	$35	20%	$30	15%
North Carolina	$10	50%	$30	50%	$25	50%
Pennsylvania	$0	10%	$50	20%	$30	20%
Georgia	$25	10%	$50	25%	$50	18%
Michigan	$20	20%	$60	20%	$30	20%
Illinois	$10	20%	$40	30%	$25	30%
Virginia	$10	25%	$45	25%	$25	25%

As with premiums and deductibles, cost sharing for physician visits varies substantially among, and even within, states. For example, as shown in Figure 2 above, median copayments for PCP visits in the 10 states with the highest 2014 Exchange enrollment vary from $25 in Virginia and $30 in New York, to $50 in Florida and Georgia.

Specialist Visits

For specialist visits, 60 percent of plans (729) charge a copayment before deductible; approximately 25 percent of plans (299) utilize coinsurance after the deductible. Nationwide, copayments for specialist visits range from $10 to $150 with a median of $75. Coinsurance ranges from 8 percent to 100 percent with a median of 40 percent. Like cost sharing for PCP visits, copayments for specialist visits also vary within and among states. As shown in Figure 3 below, median copayments for specialist visits in the 10 states with the highest 2014 Exchange enrollment vary from $50 in Michigan and Virginia, to $75 in Florida and Georgia.

Unique Cost Sharing Features

In addition to application of the deductible, Breakaway's research revealed that a small portion of Silver plans include certain new or otherwise unique cost sharing features for physician office visits that consumers may not have encountered before.

For example, approximately 4 percent of plans cover up to five PCP visits at no cost or do not charge a fee if the patient sees a particular PCP. In the case of specialist visits, slightly less

Figure 3. In-Network Specialist Cost Sharing Ranges and Medians Across the U.S. and the Top 10 States by 2014 Exchange Enrollment

	Minimum Cost Sharing		Maximum Cost Sharing		Median Cost Sharing	
State	**Copay**	**Coinsurance**	**Copay**	**Coinsurance**	**Copay**	**Coinsurance**
USA	$10	8%	$150	100%	$75	40%
California	$65	N/A	$65	N/A	$65	N/A
Florida	$35	10%	$75	40%	$75	30%
Texas	$0	50%	$75	50%	$60	50%
New York	$50	8%	$75	50%	$50	20%
North Carolina	$50	30%	$75	50%	$55	40%
Pennsylvania	$0	10%	$90	50%	$50	20%
Georgia	$35	10%	$75	25%	$75	20%
Michigan	$20	20%	$85	20%	$50	20%
Illinois	$35	20%	$75	30%	$55	30%
Virginia	$10	15%	$75	30%	$50	23%

than 4 percent of plans require no charge. This includes plans that do not charge for up to three visits. For example, in some plans, the first five PCP visits are free, with all visits thereafter subject to a $10 copay. In many cases, free visits generally are a combination of PCP, specialist and other (e.g., chiropractor, physical therapist) visits.

Additional examples of cost sharing features that appear to be unique to Exchange plans include:

- **Copayment/Coinsurance Combination**
  - Example: First three illness-related office visits subject to $30 copay per visit, with all visits thereafter subject to 20 percent coinsurance and a deductible requirement.
- **Waiver of Deductible for Limited Number of Visits**
  - Example: First two specialist visits subject to $75 copay, with all visits thereafter subject to $75 copay and a deductible requirement.
- **Visit Limits**
  - Example: Practitioner visits (other than PCP/ specialist) limited to 15 per year.

To be offered through the Exchanges, plans must meet the ACA's benefit requirements and have actuarial values sufficient to meet a metal level. The unique plan features described above likely reflect insurers' efforts to control costs and keep premiums low enough to attract enrollees.

Out-of-Network Services

Not surprisingly, Exchange plan coverage of out-of-network services is less generous than coverage of in-network services. Of the 1,028 unique Silver plans, 618 (60 percent) cover PCP visits. Of those plans, 549 (88 percent) require coinsurance after the deductible is met. This is in sharp contrast with the 23 percent of plans that require coinsurance for in-network PCP visits. As noted above, the majority of plans charge copayments for in-network services.

For enrollees who seek services from an out-of-network provider, liability for the cost of those services will vary depending on the plan type:

- **HMO/EPO:** In most cases, out-of-network services are not covered, and enrollees are responsible for paying 100 percent of out-of-network costs.
- **PPO:** As noted above, some PPO plans cover out-of-network services. However, even if a plan does provide for out-of-network benefits, consumers will likely incur substantially higher out-of-pocket costs if they use an out-of-network provider.

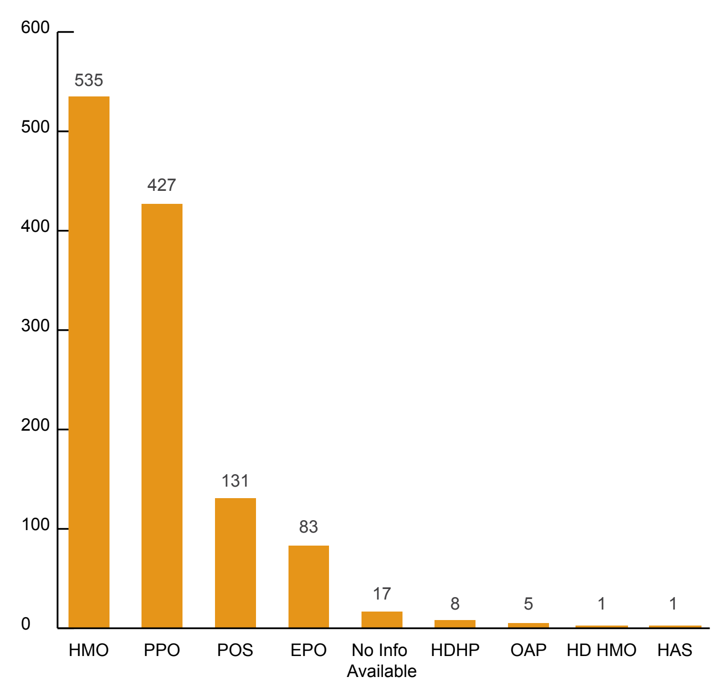
It is also important to note that plans are not required to count enrollees' expenditures on out-of-network services toward the plans' out-of-pocket maximum.[8] So amounts that enrollees spend on out-of-network services do not help to reduce their ultimate liability under the plan, and there is no limit on how much an enrollee may have to pay out-of-pocket for out-of-network services. Obviously, an enrollee can avoid these costs by seeking care only from in-network providers. But what if an enrollee has difficulty accessing necessary care within the plan's provider network? As discussed below, this is the question that some consumers and health care stakeholders are grappling with when it comes to so-called "narrow" provider networks.

Provider Networks

As shown in Figure 4 below, of the 1,028 unique Silver plans, more than half are either HMOs (535) or EPOs (83), meaning that, in many cases, an enrollee who seeks care from a provider outside of a plan's network will be responsible for the entire cost of the physician's services. Most of the remaining plans (427) are PPOs, which, as noted above, may provide some coverage of services provided by out-of-network providers, albeit at a higher cost.

Whether out-of-network services are covered, and if so, the extent to which they are covered can have a substantial impact on enrollees' out-of-pocket costs. This, along with concerns regarding enrollees' access to providers, has drawn increased attention to the adequacy of some Exchange networks. One recent study looked at 120 Silver-level Exchange plans and found that 70 percent of the plans

Figure 4. Exchange Plan Types by Number of Unique Plans (Nationwide)



offered networks in which only 31-70 percent of the largest 20 hospitals in an area participated.[9] The researchers characterized these networks as "narrow." An earlier 2013 study also found that many insurers in states such as California, Illinois, Indiana, Kentucky and Tennessee, among others, did not include major medical centers in their networks.[10]

Many enrollees, especially those who were previously uninsured, may not fully understand their new coverage and may not have realized that their plans only pay benefits if they obtain services from network providers.[11] Provider directories can be difficult to access (and not always accurate), so enrollees may not know whether their preferred doctors are included in their new plan networks. In addition, it has recently been reported that in some areas of the country, such as Texas, PCPs seeking to refer patients to specialists are being turned away by specialists who are in-network, but not accepting additional patients.[12]

Another Variation on the Theme…

Consumers must look well beyond premiums and consider other cost sharing requirements to determine which Exchange plan best meets their health care needs and budget. This certainly holds true when it comes to evaluating a plan's coverage of PCP and specialist visits.

To accurately assess potential out-of-pocket costs, consumers must not only consider copayment and coinsurance amounts, but also must determine whether physician visits are subject to the plan's deductible, and whether the plan includes any other unique design features (e.g., limited numbers of free or discounted visits, visit limits) that could affect costs.

Evaluating a plan's coverage of PCP and specialist visits can be even more complicated, however, as it requires individuals to determine whether their physicians of choice are in a plan's provider network and to assess whether they will have sufficient access to the types of providers necessary to meet their health care needs (which may also be difficult to identify/predict). Difficulty accessing provider directories, which may or may not be accurate, can make this a challenging task, particularly for previously uninsured consumers who may not be familiar with provider network limitations.

With November just around the corner, it will soon be time to focus attention on what the 2015 open enrollment period will bring. Breakaway and RWJF will again be compiling Exchange plan cost sharing and benefit design information to update and expand HIX Compare. We fully expect that the HIX Compare dataset will serve as a valuable resource to researchers, consumers and other healthcare stakeholders for years to come.

Notes

1 Except as otherwise noted, all cost sharing amounts are for in-network services. Where plans reported cost sharing information for more than one in-network tier, amounts for the first tier were utilized.

2 Premium tax credits are determined by calculating the maximum percentage of income that an individual must pay toward health insurance, which is based on a sliding scale for people earning up to 400 percent of the federal poverty level (FPL) - $46,680 for an individual and $95,400 for a family of four in 2014. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2014 Federal Poverty Guidelines. This amount is then subtracted from the second lowest cost Silver plan (SLCSP) in the individual's rating area.

3 ASPE Research Brief, "Premium Affordability, Competition and Choice in the Health Insurance Marketplace, 2014, June 18, 2014, http://aspe.hhs.gov/health/reports/2014/Premiums/2014MktPlacePremBrf.pdf.

4 As noted in the HIX Compare Report, at least one study has found that more than half of the plans sold through the pre-ACA individual market would not have satisfied ACA requirements. Health Affairs, "More than Half of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold Through Exchanges As Of 2014," May 2012, http://content.healthaffairs.org/content/early/2012/05/22/hlthaff.2011.1082.abstract.

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8 Department of Labor Frequently Asked Questions, "Limitations on Cost Sharing Under the Affordable Care Act," May 2, 2014, http://www.dol.gov/ebsa/faqs/faq-aca19.html.

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About Breakaway Policy Strategies

Breakaway Policy Strategies is a health policy firm that provides research, analysis, practical advice and strategic solutions to a wide range of health care stakeholders. Breakaway's health care experts offer creative, sophisticated guidance to help hospitals, health plans, physicians, employers, consumers, patients, government agencies, biopharmaceutical and device companies, foundations and investors successfully navigate the transformative changes taking place in the American health care system. Learn more at www.breakawaypolicy.com.

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Milliman Healthcare Reform Briefing Paper

The proposed federal exchange auto-enrollment process: Implications for consumers and insurers

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Susan E. Pantely, FSA, MAAA

EXECUTIVE SUMMARY

The U.S. Department of Health and Human Services (HHS) has proposed, for the federal health exchange, that the majority of policyholders receiving premium subsidy assistance will be automatically reenrolled in the same plan unless they elect otherwise during the 2015 open enrollment period.[1] State-run exchanges may follow this guidance but also have the option of requiring consumers to reenroll through the exchange or proposing an alternative reenrollment methodology. Approximately 83% of enrollees on the exchanges receive federal subsidies. Policyholders who are automatically reenrolled will receive the same dollar-amount subsidy for 2015 as they did in 2014. *In most cases, this will be less than the advanced subsidy that would be applicable if the policyholder enrolls through the exchange in 2015 through the "redetermination" process. The proposed federal exchange auto-enrollment process only impacts a policyholder's net premium contribution–total premium less Advanced Premium Tax Credit (APTC)–prior to the reconciliation process.* Regardless of how a policyholder enrolls in a plan in 2015, the final premium subsidy will be reconciled with enrollees' 2015 tax returns to ensure consistency with the prescribed subsidy formula of the Patient Protection and Affordable Care Act (ACA).

The implications for policyholders and insurance companies related to changes in federal subsidies and the renewal process are plentiful. The following summarizes several of the potential implications.

Potential increased 2015 premium expenditures to low-income policyholders

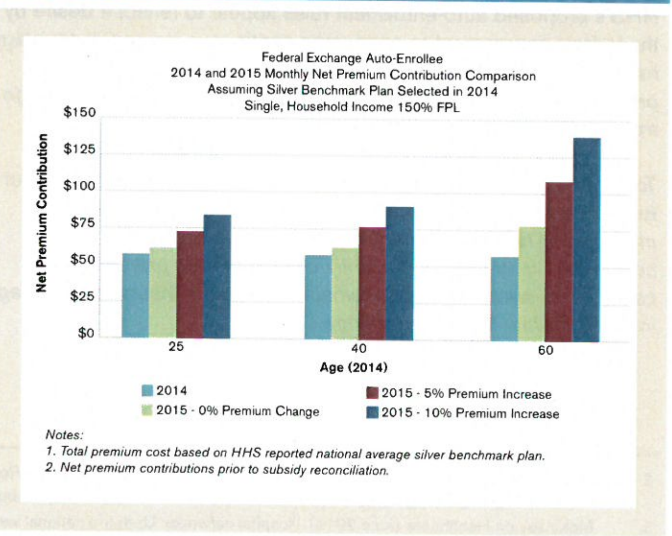
The standard notices sent to policyholders by the federal exchange will list the current subsidy but are not required to disclose the 2015 net premium contribution for the plan being enrolled. Consumers will also receive a notice from their current insurers regarding their 2015 net premium contributions based on the 2014 subsidy dollar amount.

Given the glitches in the enrollment process last year, many policyholders may choose the path of least resistance and be automatically reenrolled.

- However, even modest increases in premium by market leaders of 5% could lead to materially higher net premium contribution increases of 30% to near 100% for low-income enrollees during 2015 (prior to subsidy reconciliation).
- As the result of the ACA's permissible age rating, the highest net premium contribution increases will be experienced by enrollees over the age of 50.

Advanced Premium Tax Credit vs. Final Premium Tax Credit

When a household's subsidy eligibility was determined during the 2014 open enrollment period, qualifying households received an Advanced Premium Tax Credit (APTC) based on projected 2014 household income and size. However, the final Premium Tax Credit (PTC) amount will be determined when the household completes its 2014 tax filing. To the extent that the APTC was less than the final calculated PTC, the household will receive a tax refund. However, if the APTC was greater than the final PTC, the household will need to make an additional tax payment. This same reconciliation process will occur in years after 2014. *The proposed federal exchange auto-enrollment process only impacts a policyholder's net premium contribution (total premium less APTC) prior to the reconciliation process.*



Notes:
1. Total premium cost based on HHS reported national average silver benchmark plan.
2. Net premium contributions prior to subsidy reconciliation.

1 Radnofsky, L. (June 26, 2014). Federal health-exchange plans to automatically renew. *Wall Street Journal.* Retrieved July 4, 2014, from http://online.wsj.com/articles/obama-administration-to-allow-automatic-health-insurance-renewals-1403809048.

Consumers will be unable to compare the financial implications of renewing their current coverage against choosing a new plan unless they go to the federal health exchange.

- If consumers choose to auto-enroll because of the simple process versus evaluating their options by going to the federal health exchange, individuals who auto-enroll may have unexpected materially higher net premium contributions relative to payments in 2014 for the same plan.
- Insurer notices detailing 2015 auto-enrollment net premium contributions may prompt individuals with significant net premium contribution increases from 2014 to 2015 to elect to go through the redetermination process.
- While consumers may have the option of lowering their monthly net premium contributions through the redetermination process, historically redetermination rates for enrollees have been low in programs such as Medicaid.
- If the exchange redetermination process mirrors Medicaid experience, many enrollees may not elect to gain a larger advanced premium subsidy by going through the redetermination process.

The potential 2015 increased net premium contributions resulting from consumers avoiding the redetermination process may produce increased policy lapses during the course of calendar year 2015.

- Increased policy lapses not only affect the insurers, but also impact providers, which is due to the 90-day grace period provisions.[2]
- Navigators, insurers, and government entities need to educate health plan enrollees on the ability to potentially lower net premium contributions in 2015 by going through the redetermination process.

Impact to insurers' 2015 exchange renewal rates

HHS's proposed auto-enrollment rules appear to reflect a desire by the federal government to encourage continuous insurance coverage for enrollees. *However, most policyholders will have higher net premium contributions for 2015 coverage if they do not elect to go through the redetermination process.*

To the extent that a large portion of 2014 exchange enrollees elect to go through the redetermination process in 2015, enrollees may choose to select the same plan or insurer. However, market competition may also significantly change the net premium contribution enrollees pay to remain in the same insurance coverage in 2015 for low-income exchange enrollees.

The exchange consumer may exhibit a greater price sensitivity toward premium changes relative to other health insurance markets for two reasons:

1. *First, the premium subsidy structure exposes all enrollees, regardless of income, to the full premium differences between plans on the exchange.* The net cost of exchange coverage for subsidy-eligible enrollees is dependent on an insurance company's pricing position to the silver benchmark plan. To the extent that an insurance company's silver plan costs more than the silver benchmark plan, the enrollee pays the difference, dollar for dollar. An increase in a policyholder's plan's premium relative to the silver benchmark plan may result in the policyholder selecting a different plan for 2015. As the population purchasing insurance coverage through the exchange has significantly lower income relative to other commercial health insurance populations, insurers should anticipate heightened sensitivity to enrollee premium contribution increases.
2. Second, by design, the exchange offers products in one of four metallic tiers that cover a common set of essential health benefits. Additionally, as there is no medical underwriting process to go through, consumers have access to the final premium rates for all available plans. *As the ACA has simplified the consumer shopping experience, it is natural that consumer price sensitivity will increase.*

However, counteracting consumer price sensitivity, nearly half of the plans on the marketplace are narrow network plans.[3] Therefore, some enrollees who chose their current plans based on providers may show greater inelasticity toward increased premiums and a preference for continuity of care.

It is possible that some market leaders in 2014 may benefit from the auto-enrollment process, even with increased competition.

- This may be contingent on the ability of these insurers to maintain or decrease current rates for 2015. Policyholders receiving notices that indicate no increase in premium are likely less inclined to shop for 2015 coverage.
- As marketplace enrollment has shown strong consumer preference for the lowest-cost plans, the market leaders in 2014 that may have sacrificed profit margin in an attempt to gain market share may also have the greatest pressure to increase premiums for 2015.[4] However, sacrificing a rate increase will likely solidify their holds on the market for 2015—but with risk to their bottom lines.

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Long-term impact to the exchange health insurance market

While the auto-enrollment process may enable some insurers to retain enrollment from year to year more easily, we expect that the insurance company pricing in relation to the silver benchmark plan and consumer price sensitivity will result in exchange business being significantly more volatile for insurers relative to their traditional lines of business.

- Insurers' pricing strategies should include an additional consideration regarding the auto-enrollment process and its implications on consumer health plan selection.
- Pricing uncertainty combined with consumer price sensitivity will likely result in the exchange being more volatile for insurers relative to their traditional lines of business for many years to come.
- The auto-enrollment process may not promote the intended maintenance of coverage if consumers choosing to auto-enroll lapse when faced with higher premium contributions relative to the prior year.

INTRODUCTION

On June 26, the Center for Consumer Information and Insurance Oversight (CCIIO) released new guidance on annual redeterminations for marketplace coverage in 2015, corresponding with the publishing of the proposed rule, "Patient Protection and Affordable Care Act; Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges."[5] The guidance and proposed regulations address how 2014 federal health exchange enrollees will have current qualified health plans (QHPs) renewed in 2015. State-run exchanges may follow the proposed federal exchange auto-enrollment process but also have the option of requiring consumers to reenroll through the exchange or proposing an alternative reenrollment methodology.

Health exchange enrollees in 2014 have two options for purchasing coverage. First, they can enroll in a manner identical to a new enrollee. In this case, the advanced premium tax credit (APTC) is determined based on:

- Updated 2014 federal poverty level (FPL) thresholds (2013 FPL thresholds were used in determining the APTC for the 2014 coverage year)
- Applicable silver benchmark plan for *calendar year 2015*
- Indexed premium tax credit percentages for 2015[6]

For a 2014 enrollee electing to change QHPs, update eligibility information, or use updated tax return information, the APTC would be determined in this manner.[7]

However, if a 2014 federal health exchange enrollee does not elect to enroll for 2015, had previously authorized the exchange to access updated tax return information for the redetermination process,[8] and does not have income above 500% of FPL, *the enrollee will be auto-enrolled into the same QHP in 2015[9] with the same APTC dollar amount as received for calendar year 2014.* In guidance released by CCIIO, it is stated that the goal of this procedure is to enable *"that an enrollee may take no action and still have his or her coverage renewed for 2015, which is important in promoting continuity of coverage while limiting administrative burden for enrollees, issuers, and Marketplaces."[10]*

The new auto-enrollment policies raise several questions for insurers and consumers:

- How will consumers' out-of-pocket costs for 2015 change as a result of the proposed auto-enrollment rules?
- Will insurers that captured significant market share in the 2014 federal exchange be able to more easily retain that market share in 2015?
- Will the auto-enrollment policies achieve the stated goal of retaining enrollees and reducing the administrative burden on the federal health exchange?
- Do the proposed auto-enrollment rules change an insurer's pricing strategy for its exchange products in 2015 and beyond?

This paper will address each of these issues. However, first we will revisit the calculation of the premium tax credit subsidy, and the market dynamics that are created as a result of how the calculation impacts consumers' net costs after application of the premium subsidy.

This paper does not consider any impacts related to the availability of premium subsidies due to *Halbig v. Burwell*.

5 Cohen, M. (June 26, 2014). Guidance on Annual Redeterminations for Coverage for 2015. CCIIO. Retrieved July 4, 2014, from http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-on-annual-redet-option-2015-6-26-14.pdf.
U.S. Department of Health and Human Services (June 19, 2014). Patient Protection and Affordable Care Act; Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges. Retrieved July 4, 2014, from http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/508_CMS-9941-P-OFRv-6-26-14.pdf.

6 After 2014, the premium tax credit percentages are scheduled to be adjusted to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year. Please see http://www.law.cornell.edu/uscode/text/26/36B for more information.

7 Cohen, M., ibid., p. 5.

8 Reportedly 95% (approximately 5.1 million) of federal market enrollees authorized the release of updated tax information. For more information, see http://www.cnbc.com/id/101793283#.

9 To the extent that the 2014 plan is not available, CCIIO has outlined rules for the auto-enrollment process. Please see http://healthaffairs.org/blog/2014/06/27/implementing-health-reform-exchange-eligibility-redeterminations-small-employer-tax-credit/ for a summary of this process.

10 Cohen, M., ibid., p. 1.

REVISITING THE PREMIUM SUBSIDY CALCULATION: AN ELABORATELY CALCULATED DEFINED CONTRIBUTION

While each specific premium subsidy amount will depend on the household's size, income, and the cost of the second-lowest-cost silver plan, the subsidy structure effectively creates a defined contribution from the federal government for the purchase of health insurance. While the federal government's contribution is defined by the prescribed subsidy formula, the consumer, whether having a household income of $15,000 or $150,000, is fully exposed to all of the premium differences between QHPs.

To illustrate this effect, let's examine the hypothetical insurance choices made available to an individual with an income of 150% FPL. The subsidy formula indicates this individual will pay a maximum of 4% of household income for the second-lowest-cost silver QHP. Figure 1 illustrates the calculation of the premium subsidy value and corresponding consumer costs (net of subsidy) for three available plans. After application of the premium subsidy, the consumer cost for Plan 3 is two and half times that of Plan 1.

FIGURE 1: SILVER QHP CONSUMER CHOICES, 2014 SINGLE HOUSEHOLD, 150% FPL

	PLAN 1	PLAN 2	PLAN 3
FULL PREMIUM	$300	$325	$350
SUBSIDY AMOUNT	$268	$268	$268
MONTHLY NET PREMIUM	$32	$57	$82
% OF INCOME	2.2%	4.0%	5.7%

During the 2014 open enrollment period, 87% of individuals selecting a plan in the federal health exchange qualified for premium assistance,[11] with an average out-of-pocket premium for silver coverage of $69 per month.[12] This information suggests that the vast majority of exchange enrollees have household incomes below 400% FPL, with average household income ranging from 150% to 200% FPL. This is in stark contrast to the employer health insurance market, where more than half of insured individuals are estimated to have incomes above 400% FPL.[13] Because of the concentration of low-income households in the federal exchange, consumer price sensitivity may be heightened relative to an insurer's traditional individual or group lines of business.

ADVANCED PREMIUM TAX CREDIT AND THE RECONCILIATION PROCESS

When a household's subsidy eligibility was determined during the 2014 open enrollment period, qualifying households received an Advanced Premium Tax Credit (APTC) based on projected 2014 household income and size. However, the final Premium Tax Credit (PTC) amount will be determined when the household completes its 2014 tax filing. To the extent that the APTC was less than the final calculated PTC, the household will receive a tax refund. However, if the APTC was greater than the final PTC, the household will need to make an additional tax payment. These tax payments are capped for low-income households by the amounts shown in Figure 2.[14] *It should be noted that proposed auto-enrollment rules do not impact this reconciliation process.*

FIGURE 2: LIMITS ON REPAYMENT OF EXCESS PREMIUM TAX CREDITS, CALENDAR YEAR 2014

HOUSEHOLD INCOME FPL%	SINGLE FILERS	JOINT FILERS
LESS THAN 200%	$300	$600
AT LEAST 200% BUT LESS THAN 300%	750	1,500
AT LEAST 300% BUT LESS THAN 400%	1,250	2,500

Note: Limits will be indexed by inflation.

THE MARKET DYNAMICS BETWEEN AGGREGATE PREMIUM CHANGES AND CONSUMER'S NET COST

In 2014 insurers developed premiums without reference to what other insurers were pricing in the market, without existing claims experience, and with significant uncertainty regarding the number of individuals that would purchase coverage. In some geographic areas, large premium differences existed between one insurer and other insurers in the market. For insurers that have significant market share in 2014 that is due to being priced attractively relative to other insurers, existing or new insurers in the market may eliminate or reverse this advantage in 2015. Even if 2014 market leaders do not increase premiums at all, the net premium contribution a subsidy-eligible consumer pays in 2015 may increase dramatically if that person's relative position to the subsidy benchmark plan changes unfavorably. Therefore, for the premium subsidy-eligible population, a plan's pricing relative to the silver benchmark plan highly leverages net premium contributions.

To illustrate this effect, let's return to the three silver plans, shown above in Figure 1, with hypothetical 2015 premiums. The insurer offering Plan 3 makes a strategic decision to develop its 2015 plans at a significantly lower price point in an attempt to gain market share. A decrease may be achieved by modifying the provider network, gaining more favorable provider reimbursement terms, enhanced managed care, or a lower assumed profit margin.

11 Burke, A., Misra, A., & Sheingold, S. (June 18, 2014). Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014. HHS ASPE Research Brief, p. 5. Retrieved July 4, 2014, from http://aspe.hhs.gov/health/reports/2014/Premiums/2014MktPlacePremBrf.pdf.

12 Burke et al., ibid., p. 6, Table 2.

13 Kaiser Family Foundation. State Health Facts: Distribution of the Nonelderly with Employer Coverage by Federal Poverty Level (FPL). Retrieved July 4, 2014, from http://kff.org/other/state-indicator/distribution-by-fpl-3/.

14 Fernandez, B. (March 12, 2014). Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA), pp. 12-13. Congressional Research Service. Retrieved July 4, 2014, from http://fas.org/sgp/crs/misc/R41137.pdf.

FIGURE 3: SILVER QHP CONSUMER CHOICES, 2015, SINGLE HOUSEHOLD, 150% FPL

	PLAN 1	PLAN 2	PLAN 3
FULL PREMIUM	$320	$325	$295
PERCENT CHANGE FROM 2014	7%	0%	-16%
SUBSIDY AMOUNT	$263	$263	$263
2015 NET PREMIUM	$57	$62	$32
2014 NET PREMIUM	$32	$57	$82
% NET PREMIUM CHANGE	78%	9%	-61%

Note: Indexing of FPL and premium tax credit subsidies in 2015 have not been reflected.

The revised pricing strategy for Plan 3 allows the insurer to have the lowest-cost plan in 2015, with Plan 1 becoming the subsidy benchmark plan. As the premium for the subsidy benchmark plan has decreased from $325 to $320, the dollar value of the premium subsidy correspondingly decreased by $5.

While the full premium changes for each plan ranged from a significant decrease to a moderate increase (-16% to 7%), the reordering of the relative premium between plans creates significant net premium contribution swings for the subsidy-eligible consumer who had selected either Plan 1 or Plan 3 in 2014. For example, if a consumer wanted to renew Plan 1 for 2015, that person would be faced with a net premium 78% greater than in 2014.

In the absence of the auto-enrollment rules (as illustrated in Figure 3), it may be expected that significant market share swings would occur from 2014 to 2015, as health exchange enrollees migrate from Plan 1 and Plan 2 to Plan 3. However, do the proposed auto-enrollment rules change this consumer dynamic?

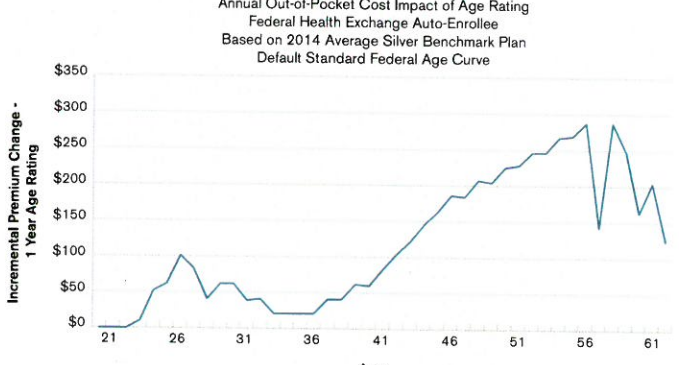
THE PROPOSED FEDERAL EXCHANGE AUTO-ENROLLMENT PROCESS

As stated in the Introduction above, federal health exchange enrollees auto-enrolling into the same QHP in 2015 will receive an APTC dollar amount identical to that received in calendar year 2014. What does that mean in terms of a consumer out-of-pocket cost change from 2014 to 2015? Because the APTC is set equal to its 2014 amount, consumers' net premium contributions will be subject to the full dollar amount of premium changes between 2014 and 2015, resulting from age rating and an insurer's 2015 pricing decisions.

Age rating

Regarding age rating, because the ACA permits age rating in the individual health insurance market by a 3:1 age ratio, this will result in most enrollees' premiums increasing as they turned a year older during calendar year 2014. Figure 4 illustrates the incremental premium increase in 2015 based on the enrollee's 2014 age and the reported national average silver benchmark plan ($226 for a 27-year-old, adjusted by the standard federal age curve for other ages).[15]

FIGURE 4



Notes:
1. Age 20 not illustrated. A person turning 21 would experience a $945 premium increase (not including the impact of premium subsidies).
2. Age reflects age as of January 1, 2014. Incremental premium change reflects 2015 age rating impact.

As shown in Figure 4, the incremental impact of age rating varies significantly between the ages of 21 and 64. Adults under the age of 40 have substantially lower premium increases relative to adults over age 50, resulting from the slope of the standard 3:1 age curve being flatter at younger ages. Figure 4 provides the incremental age-rated premium change if an insurer does not change its base premium rates from 2014 to 2015. Therefore, even if an insurer had a 0% premium increase in 2015 relative to 2014, many eligible enrollees would need to pay $200 or more annually in additional net premium contributions to remain on the plan (and prior to a reconciliation of the APTC to PTC during tax filing). HHS reported that the average net cost for individuals receiving premium assistance and selecting a silver plan in the federal exchange was approximately $830.[16] Therefore, even if insurers elected to keep 2014 pricing in place for 2015, many eligible auto-enrollees may have a 2015 net premium increase approaching or exceeding 20% before potentially receiving a tax refund during the reconciliation process. For example, an individual who turned age 61 in 2014 would have a $248 annual net premium increase, resulting from the monthly premium increasing from $585 (60-year-old) to almost $606 (61-year-old).[17]

Insurer 2015 pricing

With regard to insurer pricing levels in 2015 relative to 2014, it is important to remember that consumers have gravitated heavily toward the lowest-cost plans in 2014. Based on HHS reported data, almost two-thirds of federal exchange enrollees selecting the silver metallic tier chose the plan with the lowest or second-lowest cost. Our analysis of federal exchange premium data indicates the median premium differential between the lowest-cost and second-lowest-cost silver plan is approximately $11 on a monthly basis for a single 40-year-old (based on the national average silver benchmark premium). This pricing advantage grows to approximately $20 and $40 on a monthly basis relative to the third- and fourth-lowest-cost silver plans offered, respectively. As stated previously, because of the premium subsidy structure, households at all income levels are fully exposed to these premium differentials.

15 Burke et al., ibid., p. 10, Section II Highlights.
16 Burke et al., ibid., p. 6, Figure 1.
17 Based on national average silver benchmark premium of $226 for a 27-year-old.

FIGURE 5: HHS-REPORTED QHP SELECTION BY RELATIVE PLAN COST, FEDERAL HEALTH EXCHANGE, INDIVIDUAL HEALTH INSURANCE MARKET

METALLIC TIER	PERCENT WHO SELECTED PLAN WITH LOWEST OR SECOND-LOWEST COST	PERCENT WHO SELECTED LOWEST-COST PLAN	PERCENT WHO SELECTED PLAN WITH SECOND-LOWEST COST	PERCENT WHO SELECTED OTHER PLANS	MEDIAN NUMBER OF QHPS AVAILABLE TO CONSUMERS
BRONZE	60%	39%	21%	40%	11
SILVER	65%	43%	22%	35%	13
GOLD	54%	37%	16%	46%	10
PLATINUM	69%	50%	19%	31%	1

Sources:

1) Plan selection excerpted from Table 4 of June 18 HHS ASPE Research Brief, Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014.[18]

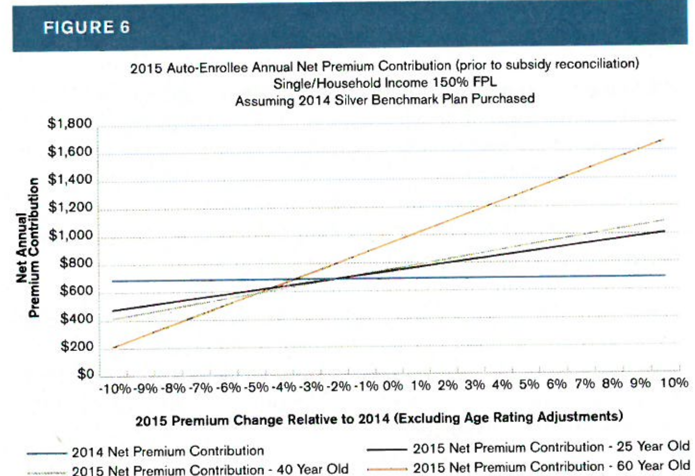
2) Values for median number of QHPs available to consumers taken from Milliman research report: 2014 Federal Insurance Exchange: Evaluation of Insurer Participation and Consumer Choice.[19]

While it may be expected that insurers in the marketplace will have a large variance in premium rate changes from 2014 to 2015, the impact to the auto-enrollment process is heavily focused on the 2015 pricing decisions of the insurers that offered the lowest-cost plans in 2014. While these insurers may have developed lower-priced plans based on network and provider reimbursement strategies, along with enhanced managed care efficiencies, it may also be possible that insurers offering the lowest-cost plans assumed lower profit margins relative to other insurers in the market. Therefore, if 2015 pricing results in a "regression to the mean," where the variance across insurers' premium levels is reduced, the lowest-cost plans in 2014 may have larger premium increases relative to insurers that were more conservative in 2014.

Figure 6 illustrates the combined effects of age rating and insurer pricing decisions for a single individual with household income of 150% FPL who in 2014 selected the silver benchmark plan (premiums based on national HHS-reported average), and elected to auto-enroll into the same QHP in 2015. In 2014, individuals at this income level regardless of age would pay $689 (12 months of premium) for the silver benchmark plan.

As Figure 6 indicates, the combined effects of age rating and an insurer's pricing decisions may result in auto-enrollees being faced with prohibitively high net costs after APTC is applied. Particularly for older individuals who have low income, it may be a financial necessity to go through the normal exchange enrollment process rather than face significantly higher 2015 net premium contributions. While the subsidy reconciliation process may result in a refund to the household when 2015 taxes are filed, the APTC under the auto-enrollment process may result in the household having insufficient funds to pay for the coverage during the year.

FIGURE 6



Notes:
1. Calculations based on national average second-lowest-cost silver plan adjusted by the federal age curve.
2. Illustrated age reflects age as of January 1, 2014.

For insurers that have even nominal premium increases for 2015, the auto-enrollment process may deliver few 2015 enrollees, as members will have significant financial incentives to purchase coverage using the normal application process. To the extent that the majority of insurers that offered the most affordable plans in 2014 file premium increases for 2015, the federal exchange should not anticipate a large percentage of members eligible for the auto-enrollment process to renew coverage in this manner.

For insurers that have no rate increases or decrease rates, there is the potential for the auto-enrollment process to result in a high renewal rate.

18 Burke et al., ibid.

19 Clarkson, J., Sturm, M.J., & Houchens, P.R. (December 2, 2013). 2014 Federal Insurance Exchange: Evaluation of Insurer Participation and Consumer Choice. Milliman Healthcare Reform Briefing Paper. Retrieved July 4, 2014, from http://www.milliman.com/uploadedFiles/insight/2013/2014-federal-insurance-exchange-insurer-participation.pdf.

SHORT-TERM IMMUNITY FROM MARKETPLACE COMPETITION?

As illustrated in Figure 6, it is possible for consumers who selected a 2014 QHP that had a rate decrease to experience a net cost decrease when the APTC (based on the 2014 APTC) is applied to 2015 premiums. In this situation, how could 2015 health plan selection be influenced by the auto-enrollment process? To illustrate this effect, let's return to the example used in Figure 3 above, but add a fourth competing insurer, Plan 4, which is new to the marketplace in 2014.

As illustrated in Figure 7, the insurer offering Plan 3 reduced its premium significantly from 2014 to 2015 in an attempt to gain market share. However, the plan offered by a new market entrant, Plan 4, was priced $5 lower than Plan 3. For 2015 auto-enrollees, the APTC is set at $268, the premium subsidy value for 2014. This results in the following consumer pricing dynamics:

- For new enrollees or enrollees going through the redetermination process, Plan 3 and Plan 4 are $25 to $35 cheaper on a monthly basis than purchasing Plan 1 or Plan 2. *Therefore, among new enrollees, Plan 3 and Plan 4 are likely to capture the greatest market share if initial 2014 consumer pricing preferences continue to hold.*
- However, within the auto-enrollee cohort, the renewal rates between the three 2014 plans may vary drastically.
  - Plan 1 was the least expensive plan in 2014, as enrollees only had to pay $32 on a monthly basis relative to $57 for the silver benchmark plan. However, because Plan 1 filed a 7% increase, net premiums for auto-enrollees increase by 60%. This price jump may result in many Plan 1 enrollees shopping for new coverage in 2015.
  - Plan 2 did not increase its premiums, and therefore the net premium for auto-enrollees is the same as it was in 2014. Enrollees may renew their plans at high rates, which is due to the price stability.
  - Plan 3 is likely to auto-enroll many of its enrollees because their net premium costs would decrease from $82 to $27 as a result of a 16% premium decrease. In addition to high renewal rates, it may gain market share in 2015 from new enrollees and enrollees who enrolled in Plan 1 in 2014.

Because Plan 2 did not increase its premium in 2014, it may be able to retain its market share despite the increased competition from Plan 3 and Plan 4. However, consumers that enrolled in Plan 2 will experience the unpleasantness of owing $300 when they file their taxes for calendar year 2015. This subsidy repayment may not occur until April 2016, after the *2016* open enrollment period has finished.

FIGURE 7: SILVER QHP CONSUMER CHOICES, 2015, SINGLE HOUSEHOLD, 150% FPL
CONSUMER IMPACT OF AUTO-ENROLLMENT VS. REDETERMINATION

	PLAN 1	PLAN 2	PLAN 3	PLAN 4
2014 FULL PREMIUM	$300	$325	$350	NA
2015 FULL PREMIUM	$320	$325	$295	$290
PERCENT CHANGE FROM 2014	7%	0%	-16%	NA
2015 SUBSIDY AMOUNT (2014 SUBSIDY AMOUNT $268)	$238	$238	$238	$238
2015 NET PREMIUM NEW ENROLLEES/REDETERMINATION	$82	$87	$57	$52
2015 NET PREMIUM AUTO-ENROLLEES	$52	$57	$27	NA
2014 NET PREMIUM	$32	$57	$82	NA
AUTO-ENROLLEE NET PREMIUM CHANGE	63%	0%	-67%	NA
SUBSIDY RECONCILIATION TAX CREDIT (PAYMENT)*	($300)	($300)	($300)	NA

Notes:

1. *Subsidy tax credit repayment capped at $300 annually for single household with income under 200% FPL (see Figure 2 above).*
2. *Premium and out-of-pocket cost values shown on a monthly basis.*
3. *Impact of age rating not reflected.*

CONCLUSION

HHS's proposed auto-enrollment rules appear to reflect a desire by the federal government to promote continuous insurance coverage and provider networks for enrollees. However, for many of them, required net premiums for 2015 coverage may be significantly higher if they do not elect to go through the redetermination process. The potential fluctuations in net premiums created by the auto-enrollment process may create financial barriers in the maintenance of insurance coverage during 2015 for low-income enrollees. *There is a significant need for insurance navigators, brokers, and government entities to clearly explain the available 2015 insurance choices to consumers through the redetermination process, which may result in lower monthly out-of-pocket health insurance costs during 2015 relative to plan auto-enrollment.* However, in some cases, consumers may have to change plans or insurers to lower their costs.

For insurers in the federal exchange, the auto-enrollment process requires a reevaluation of the 2015 competitive landscape. The new market dynamics of the auto-enrollment process create an added layer of complexity to predicting consumers' 2015 health plan selections. While insurers have likely already developed their 2015 rates, consideration of the auto-enrollment process should be reflected in projections of 2015 membership and future pricing strategies.

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Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

The analyses presented in this paper are based on proposed federal regulations as of June 2014. To the extent future regulations materially modify these proposed regulations, the statements and conclusions in this paper may require modification. The views expressed in this report are made by the authors of this report and do not represent the collective opinions of Milliman, Inc. Other Milliman consultants may hold different views and reach different conclusions. Materials may not be reproduced without the express consent of Milliman.

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Navigating the Marketplace: How Uninsured Adults Have Been Looking for Coverage

Stephen Zuckerman, Michael Karpman, Fredric Blavin, and Adele Shartzer
July 29, 2014

At A Glance

- As of June 2014, almost 6 in 10 adults who were uninsured for some or all of the previous 12 months but are now insured looked for health plan information through Marketplaces, compared with just over 3 in 10 of those who remain uninsured.
- Uninsured adults who gained coverage, but not necessarily through Marketplaces, were less likely to use a website as an information source and more likely to use direct assistance than adults who sought information but remain uninsured.
- Even after looking for information, 7 in 10 adults who remain uninsured cited financial barriers as a reason for not signing up for coverage.

A growing body of evidence shows that the number of uninsured adults declined significantly since the Affordable Care Act's (ACA's) open enrollment period started in October 2013 (Long et al. 2014; Blumenthal and Collins 2014; Carman and Eibner 2014).[1] This decline was achieved despite many widely publicized early problems with health insurance Marketplace websites. Although the vast majority of people turned to websites for information on the federal or state Marketplaces (Blavin et al. 2014a), many consumers used, and will likely continue to use, other sources for health insurance plan information (Blavin et al. 2014b). With the second open enrollment period on the horizon, new research is beginning to examine the paths people followed to (1) get information on Medicaid eligibility or Marketplace health plans and subsidies and (2) ultimately gain insurance coverage (PerryUndem 2014). These new findings provide guidance for refining outreach and education strategies.

In this brief, we focus on adults who were uninsured for some or all of the 12 months before June 2014. We consider the share who looked for information on health plans in the Marketplaces, comparing the approaches used by those who obtained coverage with those who remained uninsured as of June 2014. Our objective is to identify which approaches to obtaining Marketplace information are more likely to be associated with gaining insurance coverage. We also report on why the remaining uninsured who had looked for Marketplace information said they remained uninsured.

What We Did

This brief draws on data collected from the Health Reform Monitoring Survey (HRMS) in June 2014, well after the completion of the ACA's first open enrollment period. We define our sample of uninsured adults as nonelderly adults (ages 18–64) who were uninsured for

some or all of the 12 months prior to the June 2014 survey. At the time of the survey, 57 percent of these adults remained uninsured and 43 percent had insurance coverage. The insured adults include (1) adults who used the Marketplaces to obtain coverage through Medicaid or a qualified health plan and (2) adults who had been uninsured during the year but obtained coverage outside the Marketplaces (for example, from their employer, Medicaid, or directly from an insurer). Thus, not all the insured necessarily sought information on health plans through the Marketplaces, and many may not be enrolled in a Marketplace plan.

We examine how the insured and uninsured adults in the sample differed in their awareness of the Marketplaces and in their efforts to seek information on health plans. We also identify differences between insured and uninsured adults in the sources used to obtain information on, or assistance enrolling in, health insurance plans through the Marketplaces. For this analysis, we group nine sources of Marketplace information used into the following three categories:

- websites, including online chat options
- direct assistance (from call centers; navigators, application assisters, certified application counselors or community health workers; Medicaid or other program agencies; or insurance agents and brokers)
- indirect or informal assistance (from family or friends; employers; tax preparers; or hospitals, doctors' offices, and clinics)

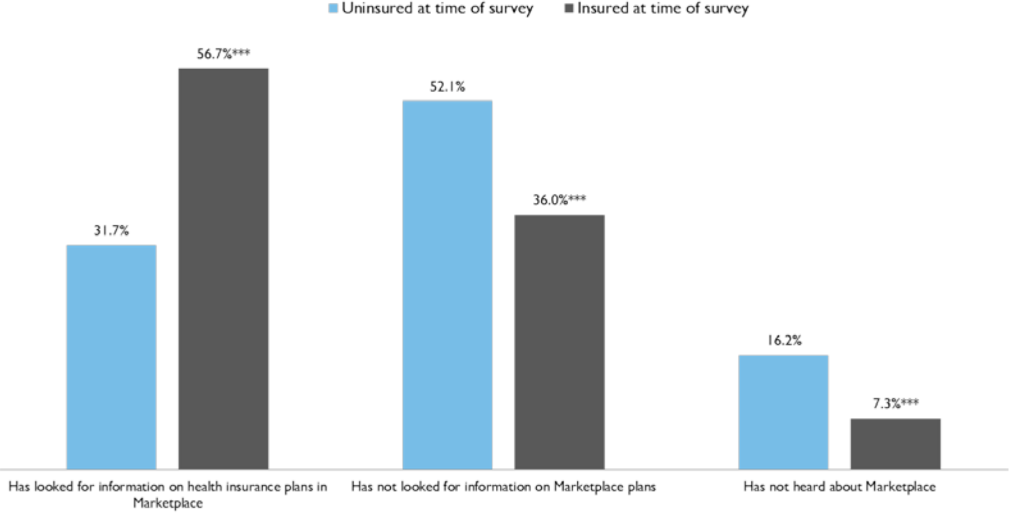
Because some people used multiple sources of information, we also create a measure that captures the source of information used into four mutually exclusive categories: (1) website only; (2) website and other sources; (3) other sources only; and (4) none of the above or not reported.

What We Found

As of June 2014, 56.7 percent of insured adults who had been uninsured for some or all of the previous 12 months had looked for information on Marketplace health plans, compared with only 31.7 percent of those who remained uninsured (figure 1). Just over half (52.1 percent) of those remaining uninsured had not looked for information, and the remainder (16.2 percent) still had not heard about the Marketplaces. In contrast, only 36.0 percent of insured adults who had been uninsured for some or all of the previous 12 months but had gained coverage as of June 2014 had not looked for information, and only 7.3 percent had not heard about the Marketplaces.

Neither those adults who remained uninsured nor those who gained coverage were just window-shopping when they looked for information in the Marketplaces. For both groups, over 85 percent of those who looked for information indicated that they were seeking to purchase health insurance or find out if they were eligible for subsidies or Medicaid (data not shown).

Figure 1. Use of Marketplaces among Adults Ages 18–64 Who Were Uninsured for Some or All of the Prior 12 Months, by Insurance Status at the Time of the Survey



Source: Health Reform Monitoring Survey, quarter 2 2014.
Notes: The category "has looked for information on health insurance plans in Marketplace" includes insured respondents who reported enrolling or being in the process of enrolling in a health insurance plan through the Marketplace. Estimates do not include 0.3 percent of adults who were uninsured for some or all of the past 12 months who refused to answer whether they looked for information on health plans in the Marketplace.
*** Estimate differs significantly from those who were uninsured at the time of the survey, denoted by ^, at the 0.01 level, using two-tailed tests. No estimates differed at the .10/.05 (*/**) levels.

Adults who had been uninsured for some or all of the previous 12 months and had gained coverage as of June 2014 were less likely to use a website as a source of information and more likely to use direct assistance than adults who remained uninsured (table 1). About half of the insured subgroup (51.1 percent) used a website (including an online chat option) compared with 60.3 percent of the uninsured. However, the insured were more likely to use direct assistance than the uninsured (45.9 percent versus 32.1 percent). These differences in the use of direct assistance were the result of greater use of navigators and application assisters by the insured than the uninsured subgroup (11.2 percent versus 6.4 percent) as well as greater use of insurance agents and brokers (12.4 percent versus 5.1 percent).

Using a mutually exclusive classification of information sources, we find that adults who had been uninsured for some or all of the previous 12 months and had gained coverage as of June 2014 were less likely to use websites exclusively and more likely to use only other sources than those who remained uninsured (figure 2). Over one-third (35.5 percent) of adults who gained coverage looked for information without using a website compared with only 22.2 percent of those who remained uninsured. Those who remained uninsured were also significantly more likely to use a website exclusively (40.1 percent) than adults who had gained coverage (29.3 percent). About the same proportions of the two groups were unable to identify their source of information from the choices provided in the survey.

Table 1. Sources Used to Obtain Information on or Assistance Enrolling in Health Plans in the Marketplaces among Adults Ages 18–64 Who Were Uninsured for Some or All of the Prior 12 Months, Overall and by Insurance Status at the Time of the Survey

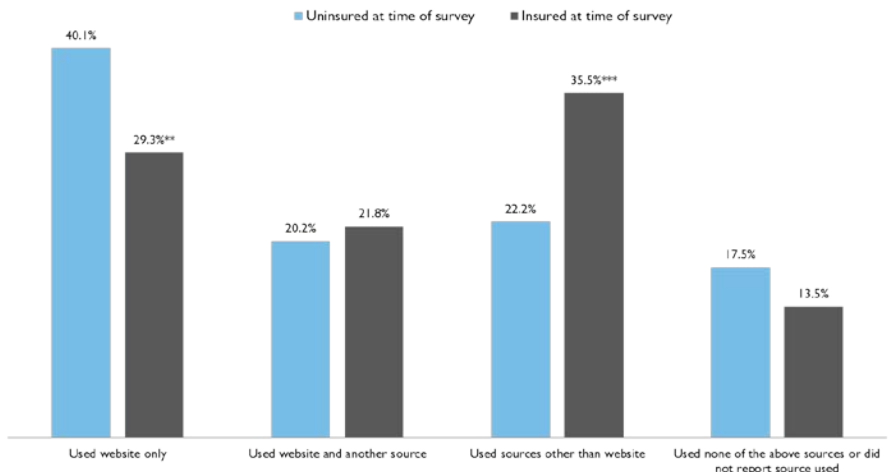
	All adults who were uninsured for part or all of the prior 12 months	By Insurance Status at the Time of the Survey		
		Uninsured	Insured	
Website, including online chat option	55.0%	60.3%	51.1%	**
Direct assistance (all aggregated)	40.0%	32.1%	45.9%	***
Call center	22.5%	20.7%	23.9%	
Navigators, application assisters, certified application counselors, or community health workers	9.1%	6.4%	11.2%	**
Medicaid or another program agency such as TANF, SNAP, or WIC	7.7%	7.8%	7.6%	
Insurance agent, broker, or company	9.3%	5.1%	12.4%	***
Indirect or informal assistance	16.1%	16.2%	16.1%	
Other, none of the above, or not reported	16.7%	18.6%	15.4%	
Sample size	**723**	**288**	**435**	

Source: Health Reform Monitoring Survey, quarter 2 2014.

Notes: Estimates do not total 100 percent because respondents could identify multiple sources used to obtain information on health plans in the Marketplace. The category for indirect or informal assistance includes respondents who reported obtaining information or assistance from family or friends; an employer; a tax preparer; or a hospital, doctor's office, or clinic.
/* Estimate differs significantly from those who were uninsured at the time of the survey at the 0.05/0.01 level, using two-tailed tests. No estimates differed at the .10 (*) level.

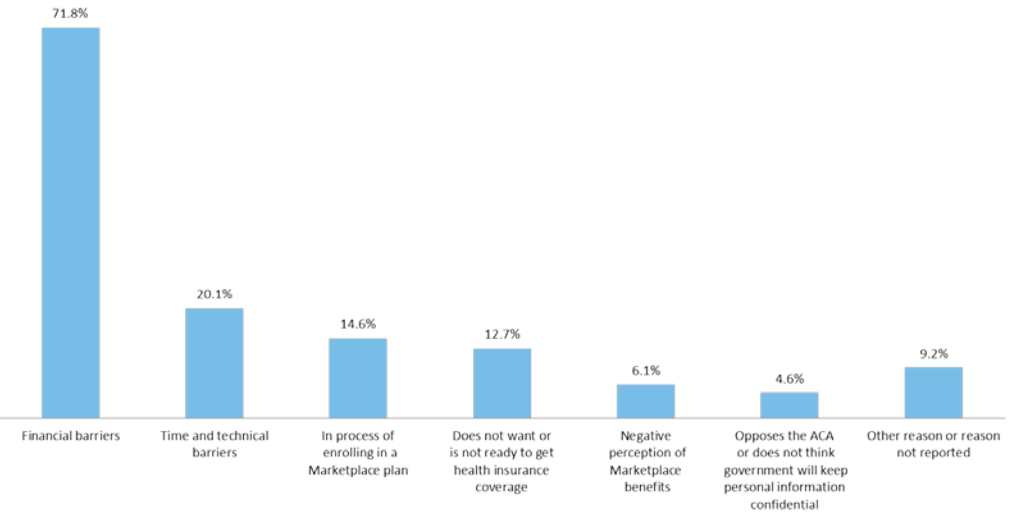
Even after looking for information, 71.8 percent of the adults who remained uninsured cited financial barriers as a reason for not signing up for coverage (figure 3). Other barriers to enrollment were cited much less frequently. Although the websites had well-documented problems, only 1 in 5 cited time and technical barriers as a reason for remaining uninsured. Some (14.6 percent) of the adults who remained uninsured as of June 2014 indicated that they had enrolled and their application was still being processed. Federal policymakers clearly recognize such processing delays as a real problem, because the Centers for Medicare and Medicaid Services has issued a letter to six states, including California, requiring them to come up with a plan to ease their Medicaid enrollment backlogs.[2]

Figure 2. Sources Used to Obtain Information on or Assistance Enrolling in Health Plans in the Marketplace, among Adults Age 18–64 Who Were Uninsured for Some or All of the Prior 12 Months, by Insurance Status at the Time of the Survey



Source: Health Reform Monitoring Survey, quarter 2 2014.
/* Estimate differs significantly from those who were uninsured at the time of the survey, at the 0.05/0.01 level, using two-tailed tests.
No estimates differed significantly at the .10 (*) level.

Figure 3. Reasons for not Enrolling in the Marketplace among Uninsured Adults Ages 18–64 who Looked for Information on Health Plans in the Marketplace



Source: Health Reform Monitoring Survey, quarter 2 2014.
Notes: Estimates do not total 100 percent because respondents could identify multiple reasons for not enrolling through the Marketplace. ACA is Affordable Care Act. The "financial barriers" category includes those who reported the cost is too high or they cannot afford the insurance, did not qualify for subsidized coverage, or enrolled but lost coverage because of not paying the premium. "Time and technical barriers" includes those who tried to enroll but the website was not working; found the enrollment process too complicated or difficult; or did not have time, missed the open enrollment period, or recently lost coverage. "Negative perception of Marketplace benefits" includes those who did not find plans that covered desired benefits or reported that the choice of doctors, hospitals and other providers in the plans' networks was too limited.

What It Means

Even among adults who had been uninsured for some or all of the previous 12 months—a group with strong incentives to understand and act on the ACA's coverage expansion provisions—only about 40 percent had looked for coverage through the Marketplaces as of June 2014. The remainder had either not heard about the Marketplaces, had decided not to seek information, or had simply let the opportunity pass. Compared with adults who were still uninsured at the time of the survey, previously uninsured adults who had gained coverage as of June 2014 were more likely to have sought information from the Marketplaces, even though the coverage they gained may not have been from a Marketplace qualified health plan.

Among those who remain uninsured, some may have had the information they needed on health plan options available through the Marketplaces but do not yet have coverage because they (1) live in a Medicaid nonexpansion state and therefore are ineligible for Medicaid, (2) are not eligible for subsidies because of their immigration status or other reasons, or (3) consider the costs of coverage too high. For many who remain uninsured, however, our findings suggest that more effective motivation to seek information from the Marketplaces may be a necessary first step toward increasing enrollment in a Marketplace plan or Medicaid. Given all the publicity around the ACA, it is somewhat surprising that 1 in 6 adults who were uninsured for some or all or the 12 months before the survey and remain uninsured had not heard about the Marketplaces even at this late date.

Even motivating more uninsured adults to visit the Marketplace is unlikely to be enough, however. Some who remained uninsured and sought information on Marketplace health plans may have been much harder to reach with information they understood during the initial open enrollment period. For both the uninsured who did not visit the Marketplace and for those who visited but may not have understood the information available, a different and more aggressive outreach and education plan is clearly necessary.

The findings reported here suggest that a nonwebsite approach may work better for many people. Adults who got beyond websites and received help from navigators, application assisters, and insurance agents, for example, were more prevalent among those who gained coverage than among those who remained uninsured. A particularly dramatic finding is that adults who said they never used a website—working solely through other sources of information—represented the largest share of adults who had been uninsured for some or all or the 12 months before the survey but had gained insurance as of June 2014. This strongly suggests that next year's open enrollment period should recognize the important role played by direct assistance and include enough resources of this type in the application process, as opposed to simply making sure the websites are functioning.

It is also noteworthy that a large share of those who remain uninsured still perceives the costs of coverage as a major barrier. For many, this perception may be correct. For example, they may live in a state that has not chosen to expand Medicaid and therefore does not offer a no-cost option to poor uninsured adults. Alternatively, they may be in a family in which there is an employer offer that is affordable for the covered worker but precludes other family members from seeking subsidies, even if they have low incomes.

But two other reasons must also be considered: (1) information about Medicaid eligibility or Marketplace subsidies may be hard to communicate and is still not getting

through to some; and (2) even the subsidies available in the Marketplaces may not make health insurance affordable for everyone.

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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.

About the Authors

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The authors gratefully acknowledge the suggestions and assistance of Katherine Hempstead and Sharon K. Long.

Notes

1. Jenna Levy, "U.S. Uninsured Rate Holds Steady at 13.4%," *Gallup*, June 5, 2014.

2. Associated Press, "States Told to Find Way to Clear Medicaid Backlog," *Washington Post*, July 14, 2014.

Who Are the Remaining Uninsured as of June 2014?

Adele Shartzer, Genevieve M. Kenney, Sharon K. Long, Katherine Hempstead,
and Douglas Wissoker

July 29, 2014

At a Glance

- Compared with the uninsured population in September 2013, uninsured adults were more concentrated in Medicaid nonexpansion states in June 2014.
- Two-thirds of uninsured adults in June 2014 had family incomes at or below 138 percent of the federal poverty level. Two-fifths were both low-income and lived in Medicaid nonexpansion states.
- Three out of five uninsured adults in June 2014 had heard some or a lot about the Marketplaces and the individual mandate, but fewer than two out of five had heard about the Marketplace subsidies.
- Most uninsured said they were uninsured for financial reasons.

It is now widely agreed that the number of nonelderly (age 18–64) uninsured adults has fallen dramatically since the Affordable Care Act's (ACA's) Marketplace open enrollment began.[1] The relevant ACA-related changes included the expansion of Medicaid in 25 states and DC as of June 2014 and the new financial assistance for health insurance coverage through the federal and state Marketplaces in all states. According to the June 2014 Health Reform Monitoring Survey (HRMS), the number of uninsured adults fell by an estimated 8 million (95% CI [5.1 million, 10.8 million]) between September 2013 and June 2014, with proportionately larger coverage gains among low- and middle-income adults (the group particularly targeted by the ACA's Medicaid and Marketplace provisions) and in states that implemented the ACA's Medicaid expansion (Long, Kenney, Zuckerman, Wissoker, et al. 2014).

However, three months after the first Marketplace open enrollment period closed, 13.9 percent of adults still remain uninsured (referred to here as "the remaining uninsured") as of June 2014. In this brief, we use data from the June 2014 wave of the HRMS to assess the characteristics of those who remain uninsured. How the uninsured population has changed since September 2013 helps pinpoint the types of outreach and enrollment strategies that need to be pursued if the pool of remaining uninsured is to continue to shrink. We assess the demographic and socioeconomic characteristics of the remaining uninsured, their access to employer-sponsored insurance (ESI), their awareness of key ACA provisions, and the reasons they say they remain uninsured. This early look at the characteristics of the remaining uninsured provides valuable information for ongoing Medicaid outreach and enrollment efforts, as well as preparations for the next open enrollment period in the Marketplaces. More robust data from the relevant federal health surveys will not begin to be released until later in 2014 and into 2015 (Long, Kenney, Zuckerman, Goin, et al. 2014).

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What We Did

Using data collected during the June 2014 round of the HRMS, we classify individuals as uninsured at the time of the survey if they did not report having any of the types of insurance coverage asked about in the HRMS (mainly ESI, Medicare, or Medicaid) and did not report having valid insurance in a follow-up verification question.

In this analysis, we compare the remaining uninsured in June 2014 to those adults who were uninsured in September 2013, just before Marketplace open enrollment began. Because our goal is to measure how the composition of the uninsured has changed, we have not used regression analysis to stabilize the composition of the sample over time, unlike the HRMS analysis of changes in insurance coverage over time. Consequently, some small portion of the estimated difference in the uninsured population between September 2013 and June 2014 may be attributable to differences between the two periods in the proportion of the nationally representative HRMS survey sample living in the Medicaid expansion states versus those living in nonexpansion states.

We define states expanding Medicaid as those with income eligibility thresholds for adults greater than or equal to 138 percent of the federal poverty level (FPL) as of June 2014, based on data reported by states to CMS.[2] New Hampshire has also elected to expand Medicaid coverage, but not until August 2014. To measure access to ESI, we asked the uninsured if their employer or a family member's ESI could cover them. Those who said yes are recorded as having an ESI offer.

Respondents' awareness of key ACA provisions was measured by several questions asking whether the respondent had heard a lot, some, only a little, or nothing at all about three particular provisions: the Marketplaces, the subsidies, and the individual mandate.[3] We group those who reported having heard "some" or "a lot" together as having heard about the provision; we group those who reported having heard "only a little" or "nothing at all" together as having not heard about the provision.

We also include estimates from two survey questions that ask respondents about potential barriers to coverage. The first asks, "which of the following are reasons you are uninsured?" and allows respondents to select one or more options from a list of eight, along with an option to write in another response. On the basis of these write-in responses, we recoded some respondents to the pre-existing categories; when multiple respondents gave a reason not included in the specified options, we created new analytic categories. After applying the recodes, we collapsed the categories into groups with similar themes—including financial reasons, time or information barriers, not wanting coverage, being in the process of enrolling in coverage (transitioning), or other reasons.[4] The second question occurs later in the survey in a series of questions focused on the Marketplaces and asks all uninsured respondents, "which of the following are reasons why you have not enrolled in a health insurance plan in the Marketplace?" This question included 12 specified options and a write-in option. We used a similar process to the first question in which we recoded some write-in responses and collapsed them into related categories. For the second question, the categories include financial barriers, time or technical reasons, a negative perception of benefits, in the process of obtaining coverage (transitioning), opposition to the ACA, and other reasons.[5]

The HRMS, as noted, was designed to provide early feedback on ACA implementation as health reform proceeds, preceding more robust information from federal surveys with larger sample sizes. We will use information from other surveys and from future waves of the HRMS to assess the findings reported here for consistency of patterns in the remaining uninsured and the challenges they face.

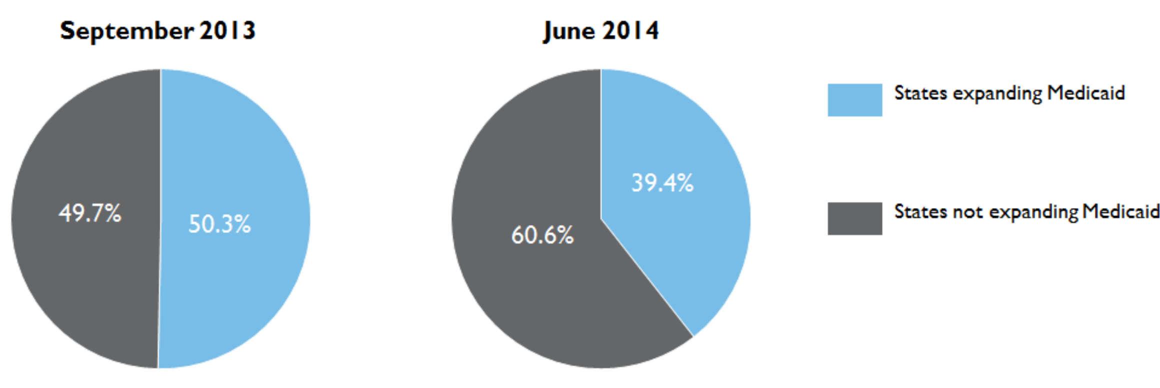
What We Found

Compared with the adult population without insurance in September 2013—just before the ACA's Marketplaces began the first open enrollment period—uninsured adults are more concentrated in Medicaid nonexpansion states and the South and are more likely to be Spanish Speakers, unmarried, and to have less than a high school education. Two out of five are both low-income and live in states that chose not to expand their Medicaid programs.

About one-third (36.8%) of uninsured adults who remain uninsured are age 18–30, 41.5 percent are age 31–49, and 21.7 percent are age 50–64. (See table 1 for these and other characteristics). They are also diverse in health status, race and ethnicity, and gender. Though the declines in the rate of uninsurance between September 2013 and June 2014 covered by Long, Kenney, Zuckerman, Wissoker, and colleagues (2014) occurred across the spectrum of uninsured, we now see modest shifts toward a group that is less educated, more likely to be unmarried, for whom English is not the primary language—suggesting that not all groups gained equally from health reform.

As reported previously (Kenney et al. 2014), the uninsured are increasingly concentrated in states that have not expanded Medicaid following the Supreme Court's June 2012 decision to leave the Medicaid expansion choice up to the states (figure 1). In September 2013, 49.7 percent of uninsured adults lived in states that have not expanded Medicaid. This share increased to 60.6 percent as of June 2014. Very few states in the South have opted to expand Medicaid.[6] Consistent with the increased concentration of remaining uninsured adults in nonexpansion states, the share of uninsured adults living in the South has increased. As of June 2014, 48.9 percent of the remaining uninsured lived in the South, up from 41.5 percent in September 2013 (figure 2).

Figure 1. Distribution of Uninsured Adults Ages 18–64 by State Medicaid Expansion Status, September 2013 and June 2014



Source: Health Reform Monitoring Survey, quarter 3 2013 and quarter 2 2014.
Notes: States expanding Medicaid are those with income eligibility levels for adults at or above 138 percent of the federal poverty level as of June 2014, based on Centers for Medicare and Medicaid Services, "State Medicaid and CHIP Income Eligibility Standards," accessed July 8, 2014, http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf.

Table 1. Characteristics of Adults Age 18–64 Who Are Uninsured, Quarter 2 2014 versus Quarter 3 2013

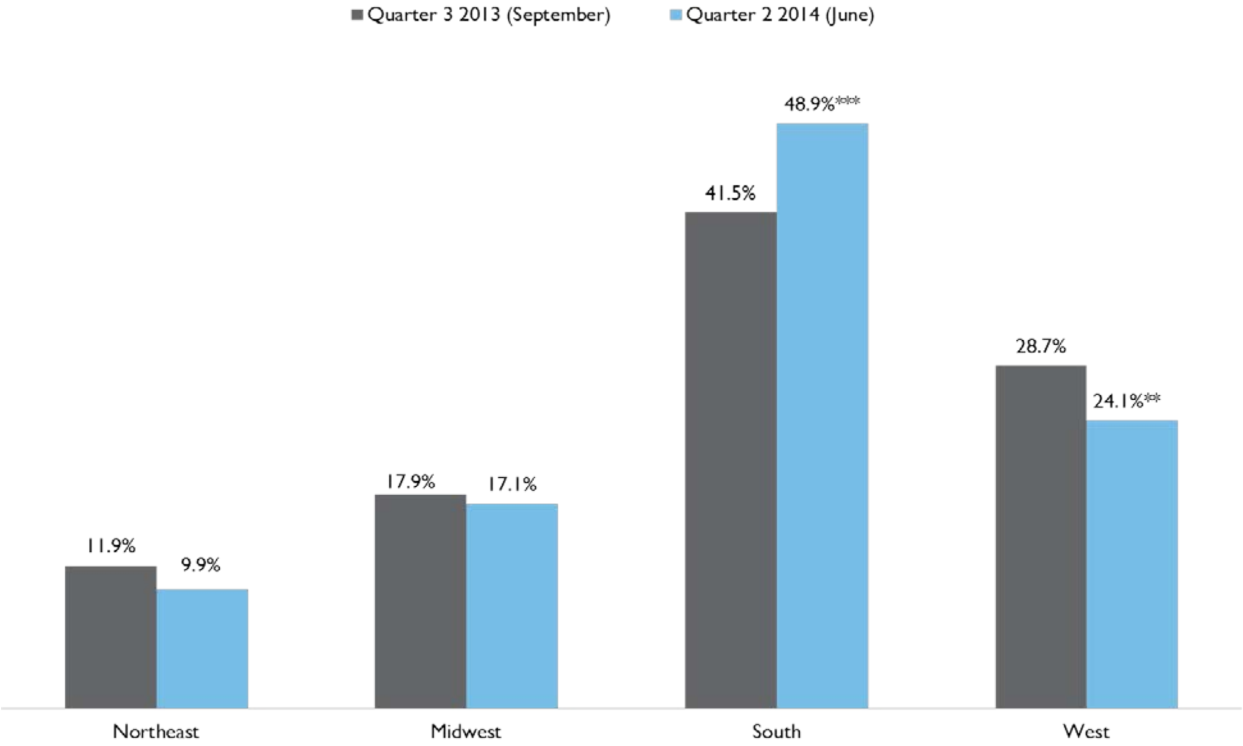
	All remaining uninsured adults in June 2014 (Q2 2014) (%)	All remaining uninsured adults in September 2013 (Q3 2013) (%)	
Age			
18–30	36.8	36.6	
31–49	41.5	39.9	
50–64	21.7	23.5	
Gender (%)			
Male	51.1	51.8	
Female	48.9	48.2	
Race or ethnicity			
White, non-Hispanic	44.2	43.8	
Other, non-Hispanic	18.6	22.4	**
Hispanic	37.1	33.8	
Primary language spoken			
Primary English speaker	67.0	71.5	*
Primary Spanish speaker	19.9	17.0	
Bilingual, English/Spanish	13.1	11.5	
Health status (%)			
Excellent or very good	43.0	39.9	
Good	38.7	40.4	
Fair or poor	18.1	19.1	
Education			
Less than high school	28.1	23.8	**
High school graduate or some college	63.9	66.2	
College graduate	8.0	10.0	*
Marital status			
Married	34.5	37.9	**
Widowed, separated, or divorced	12.7	12.1	
Never married	37.2	34.8	
Lives with partner	15.6	15.2	
Family income category			
At or Below 138% of FPL	65.3	62.1	
139–399% of FPL	28.5	32.2	*
400% of FPL and higher	6.1	5.7	

Employment status			
Employed	52.7	52.4	
Unemployed	22.0	25.8	*
Not in labor force	25.3	21.8	**
Access to employer-sponsored insurance (ESI)			
Share reporting has ESI offer, or has ESI	16.7	19.3	
State Medicaid expansion status			
Expanding Medicaid	39.4	50.3	***
Not expanding Medicaid	60.6	49.7	***
Region			
Northeast	9.9	11.9	
Midwest	17.1	17.9	
South	48.9	41.5	***
West	24.1	28.7	**
Urban			
In metropolitan area	82.5	82.6	
Not in metropolitan area	17.5	17.4	
Sample size	797	1,130	

Source: Health Reform Monitoring Survey, quarter 3 2013 and quarter 2 2014.

Notes: FPL is the federal poverty level. Data for those who did not report or refused to report are not shown. States are categorized as having expanded Medicaid as of June 2014 if the income eligibility threshold for "other adults" is 138% of FPL or higher based on data provided to CMS from the states, as reported at Centers for Medicare and Medicaid Services, "State Medicaid and CHIP Income Eligibility Standards," accessed July 17, 2014, http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf.
*/**/*** Estimates differ significantly from quarter 2 2014 at the 0.1/ 0.05/0.01 levels, using two-tailed tests.

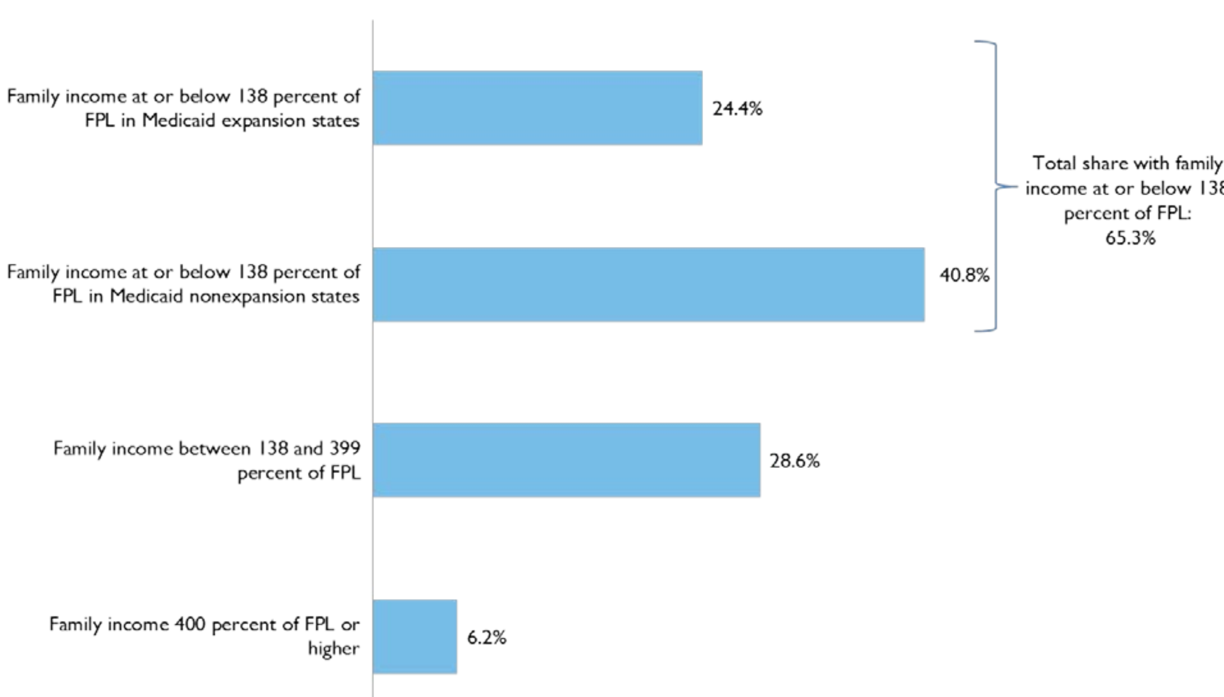
Figure 2. Distribution of Uninsured Adults Ages 18–64 in September 2013 and June 2014, by Region



Source: Health Reform Monitoring Survey, Quarter 2 2014.
/* Estimate differs significantly from September 2013 at the 0.05/0.01 levels, using two-tailed tests. No estimates differ at the 0.10 (*) level.

Nationally, adults with incomes at or below 138 percent of FPL constitute almost two-thirds (65.3 percent) of all remaining uninsured adults (figure 3). Fully 40.8 percent of all remaining uninsured adults in June 2014 are adults living in Medicaid nonexpansion states with family incomes at or below 138 percent of FPL, the income group targeted by the Medicaid expansion and whom we refer to as "low-income," (figure 3). In contrast, only 24.4 percent of the remaining uninsured are low-income adults living in Medicaid expansion states. Consistent with the large share of the uninsured with low family incomes, just 16.7 percent have access to ESI, through either their own job or a family member's job (table 1).

Figure 3. Distribution of Remaining Uninsured Adults Ages 18–64 by Income Category and State Medicaid Expansion Status

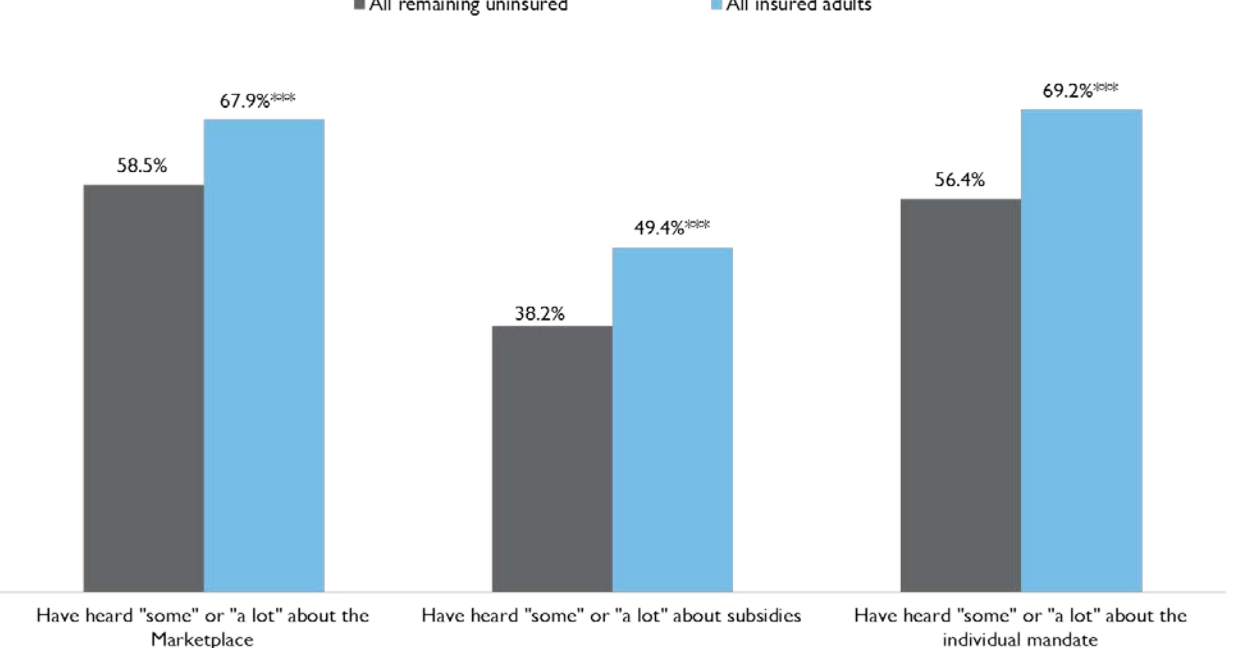


Source: Health Reform Monitoring Survey, quarter 2 2014.
Notes: FPL is federal poverty level. States expanding Medicaid are those with income eligibility levels for adults at or above 138% of FPL as of June 2014, based on http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf

Three out of five the remaining uninsured have heard some or a lot about the Marketplaces and about the individual mandate requiring everyone to have health insurance. But fewer than two out of five have heard some or a lot about subsidies available in the Marketplaces for premiums and out-of-pocket health care costs.

As of June 2014, 58.5 percent of remaining uninsured adults say they have heard about the Marketplaces and about the same (56.4 percent) say they have heard "some" or "a lot" about the individual mandate (figure 4). Perhaps contributing to the continued uninsurance of many low- and middle-income adults potentially eligible for Medicaid or Marketplace subsidies, awareness of financial assistance for Marketplace coverage among uninsured adults is more limited—with only 38.2 percent reporting having heard about the availability of subsidies for premiums or out-of-pocket costs. This limited awareness is only modestly less pervasive among uninsured adults with family incomes between 139 and 399 percent of FPL, the primary income range targeted by the subsidies. Among that group, 44.1 percent report having heard about coverage subsidies available through the Marketplaces (data not shown).

Figure 4. Awareness of Uninsured Adults Ages 18–64 of Key ACA Coverage Provisions, by Insurance Status



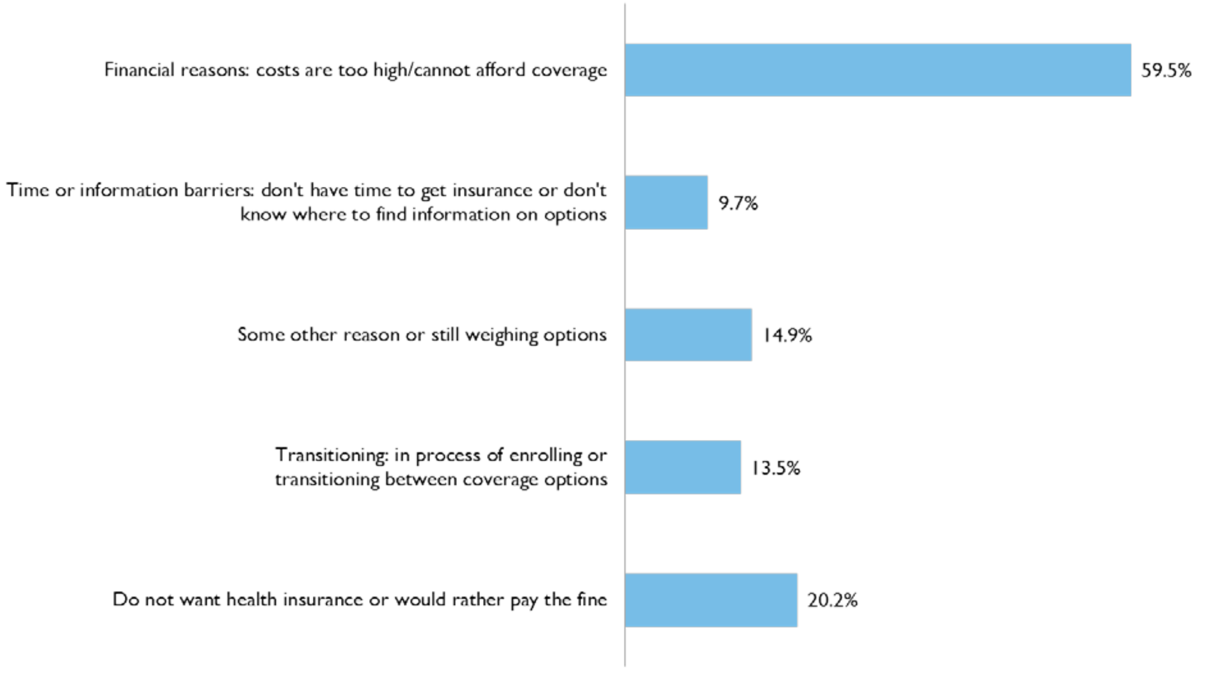
Source: Health Reform Monitoring Survey, Quarter 2 2014.
Note: Data for those who did not report or refused to report are not shown.
*** Estimate differs significantly from uninsured at the 0.01 level, using a two-tailed test.

For all three awareness measures, the remaining uninsured are consistently less likely than those who have coverage to say they have heard of a particular ACA provision. For example, over 67.9 percent of insured adults say they have heard some or a lot about the Marketplaces, significantly higher than the share (58.5 percent) among the remaining uninsured.

Three out of five of the currently uninsured say they remain uninsured because of high insurance costs or other affordability issues. Fewer than one out of five give one of the reasons they are uninsured as not wanting health insurance coverage or preferring to pay the fine.

Lack of interest in being covered is not a major contributing factor (figure 5). Just 20.2 percent give as one of the reasons they are not insured that they do not want coverage or would rather pay the fine than be covered. A somewhat smaller share (13.5 percent) say they are currently in the process of enrolling in coverage or transitioning between health insurance plans. Only 9.7 percent cite time or information barriers, including not having time to get health insurance or not knowing where to find information on available insurance options.

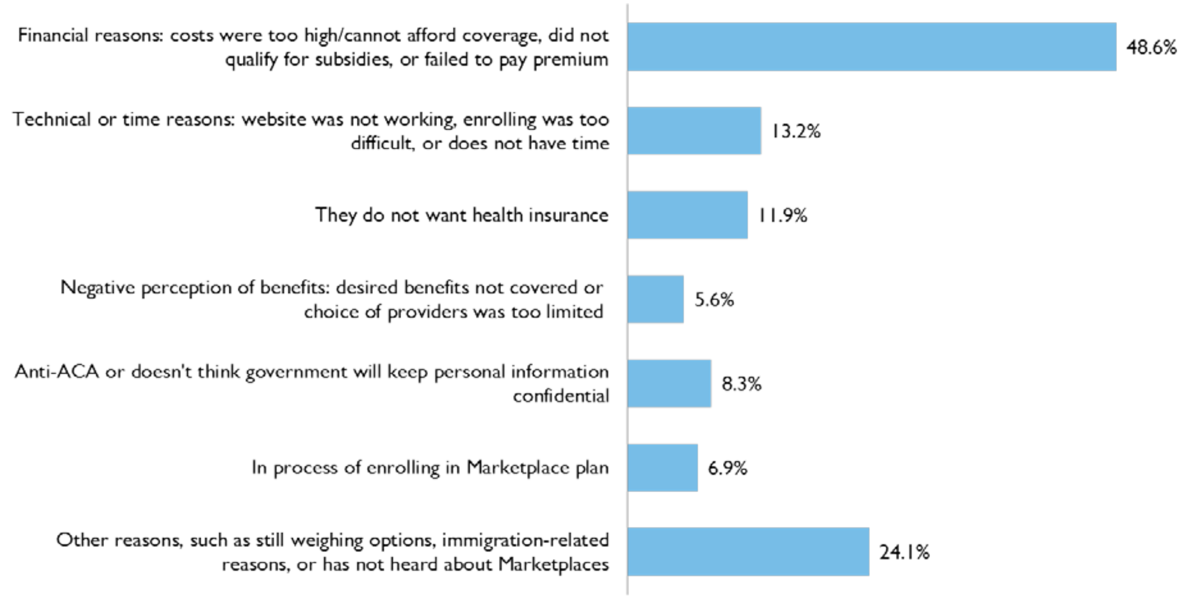
Figure 5. Reasons Uninsured Adults Ages 18–64 Give for Why They Do Not Have Insurance Coverage



Source: Health Reform Monitoring Survey, quarter 2 2014.
Notes: Data for those who did not report or refused to report are not shown.

Adults most commonly say they are uninsured for financial reasons, ascribed to those who say the costs of insurance are too high or that they cannot afford coverage, with 59.5 percent noting this as one of the reasons they are uninsured; 37.0 percent give it as the only reason (data not shown). Financial barriers are also a common reason given for why the uninsured are not enrolling in Marketplace coverage (figure 6). About half (48.6 percent) say they did not enroll in Marketplace coverage for financial reasons, which includes high costs, not qualifying for subsidized coverage, or failure to pay the premium.

Figure 6. Reasons Uninsured Adults Ages 18–64 Give for Not Enrolling in Marketplace Coverage

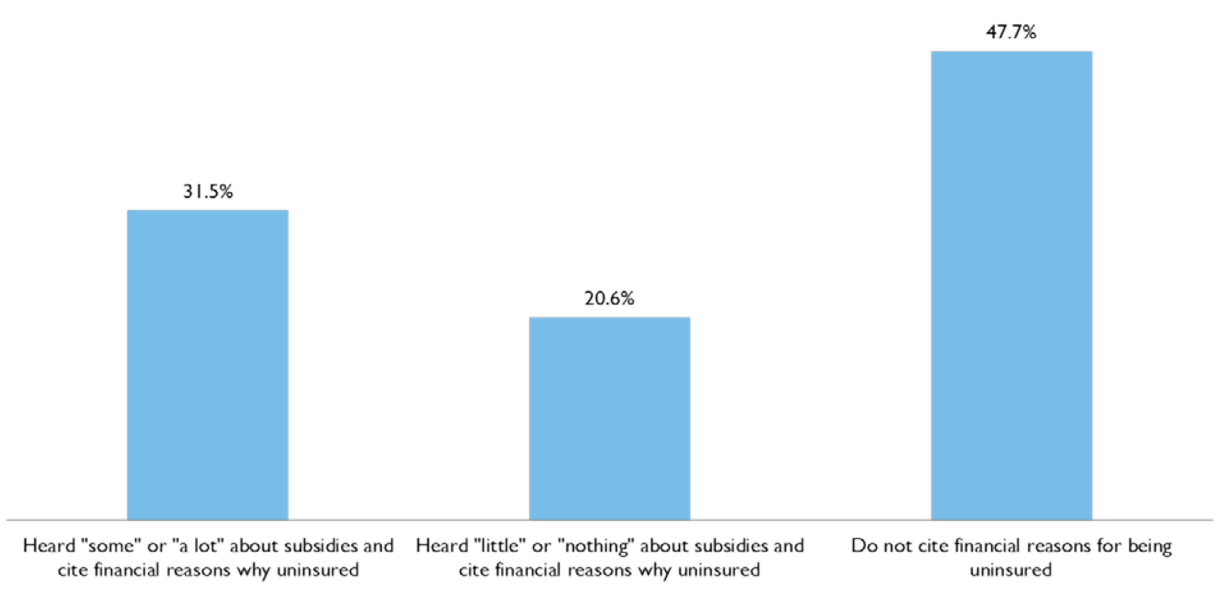


Source: Health Reform Monitoring Survey, quarter 2 2014.
Notes: Data for those who did not report or refused to report are not shown. Respondents could select more than one reason for not enrolling. See brief methods and notes for information on categorization of responses.

Knowledge gaps about the availability of subsidies for Marketplace coverage noted above may contribute to the perception that Marketplace coverage is too expensive. For example, among the primary target population for Marketplace subsidies—uninsured adults with incomes between 139 and 399 percent of FPL—20.6 percent have heard little or nothing about the subsidies and cite financial reasons for not enrolling (figure 7). However, one-third (31.5 percent) of uninsured adults with subsidy-eligible income report more familiarity with the Marketplace subsidies and give financial reasons as one reason they did not enroll in Marketplace coverage, though it is not clear whether these individuals know the level of subsidies available to them personally and still find coverage unaffordable.

Financial barriers are also a common concern reported by low-income uninsured adults living in nonexpansion states, of whom 66.5 percent note a financial barrier as one reason they are uninsured and 44.8 percent as the only reason (data not shown). These are substantially higher than the shares of uninsured low-income adults living in Medicaid expansion states who cite financial barriers as a reason or the only reason they are uninsured (53.1 and 30.1 percent, respectively—data not shown).

Figure 7. Financial Barriers as a Reason for Uninsurance and Awareness of Subsidies among Uninsured Adults Ages 18–64 with Family Income between 139 and 399 Percent of the Federal Poverty Level



Source: Health Reform Monitoring Survey, quarter 2 2014.
Note: Data for those who did not report or refused to report are not shown.

What It Means

Even with the growing evidence of significant health coverage gains under the ACA, a substantial share of the population remained uninsured as of June 2014. For the quarter of the remaining uninsured who live in states that have expanded Medicaid and have incomes at or below 138 percent of FPL, the prospect of further reducing their numbers is good if effective outreach and enrollment strategies are implemented that target Medicaid-eligible adults. While some may not be eligible for coverage on the basis of immigration status, most could qualify for fully or almost-fully subsidized coverage. The shifts toward those for whom health insurance literacy may be more limited (educationally and in English proficiency) highlight the need for consumer-friendly information in an array of formats and languages. States have the option to link outreach and enrollment efforts among this eligible population to participation in other public benefits programs, such as SNAP or the earned income tax credit, or to a family member already enrolled in Medicaid (Dorn et al 2013; Goodwin and Tobler 2014).

Nationally, for the remaining uninsured with family incomes in the range potentially eligible for subsidized coverage through the Marketplaces, limited knowledge is one of the barriers—with only three of five having heard of the Marketplaces and only two in five having heard about the subsidies. The uninsured adults in this income range who are unaware of Marketplace subsidies commonly cite financial barriers as a reason for being uninsured and a reason for not enrolling in Marketplace coverage. For these uninsured adults who report being unaware of the assistance

available, arming them with knowledge of the financial benefits of Marketplace coverage could greatly increase coverage rates. Others, in sharp contrast, report being aware of the available financial assistance and still note financial reasons for being uninsured. Perhaps their information is not accurate. But this finding could also reveal that current Marketplace subsidies for low- and moderate-income individuals in fact may not be adequate to encourage participation.[7]

Financial issues are the not the only barrier to coverage uninsured adults face. The substantial group who give time, information, or technical reasons why they are uninsured, or who have not enrolled for some other reason, could be helped by improved in-person assistance, decision supports, and easier-to-use enrollment technology (Pollitz, Tolbert, and Ma 2014). Faster and more trouble-free application processing could also facilitate the enrollment of those who say they are in the process of enrolling but are not currently covered. For some adults, immigration status is also a barrier to coverage—one in ten report they know someone who did not look for health insurance through Medicaid or the Marketplaces because of concerns about negative effects on their immigration status.

The prospects for gaining coverage are much less promising for the two out of five of the nation's uninsured who have family incomes at or below 138 percent of FPL but live in states that have not chosen the Medicaid option. Most are likely to remain uninsured, given the lack of subsidized coverage options for them. While some may qualify for Medicaid or subsidized coverage through the Marketplaces, most low-income adults in states that have not opted to expand Medicaid fall into the "coverage gap" between very low Medicaid income eligibility levels and minimum income levels for Marketplace subsidies (Kenney et al. 2012).[8] For these adults, cost remains an often insuperable barrier to coverage.

This brief provides a snapshot of a population that will fluctuate over the coming months. Though the first open enrollment in the Marketplaces ended on March 31, 2014, some applications are still being processed and enrollment in Medicaid is ongoing, with some states continuing to grapple with an applications backlog.[9] In addition, the first wave of renewals in the coming year for coverage through the Marketplaces will also affect the size and profile of the uninsured population, as people make decisions about renewal based on their early experiences gaining and using their coverage. Future work will examine churning in coverage as well as persistent uninsurance to gain a better sense of those who are at risk of not realizing potential benefits from the ACA coverage expansion provisions.

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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. Chris Gay, "Surveys Show Shrinking Ranks of Uninsured," *Wall Street Journal*, July 20, 2014; Bruce Japsen, "Number of Americans Without Health Insurance Falling Rapidly," *Forbes,* July 13, 2014; Paul Krugman, "Obamacare Fails to Fail," *New York Times,* July 13, 2014; David Nather, "The Verdict Is In: Obamacare Lowers Uninsured," *Politico,* July 10, 2014.

2. Centers for Medicare and Medicaid Services, "State Medicaid and CHIP Income Eligibility Standards," accessed July 13, 2014.

3. The Marketplace is described in the question as "health insurance exchanges or Marketplaces where people can shop for insurance and compare prices and benefits." Subsidies are described as "some lower-income Americans are able to get subsidies for premiums and out-of-pocket health care costs in the health insurance marketplaces." The individual

mandate is described in the question as "the health care law requires nearly all Americans to have health insurance by 2014 or else pay a fine. This is sometimes referred to as the 'individual mandate."

4. The reason "financial barriers" is ascribed to those who say they are uninsured because the cost of insurance is too high or they cannot afford health insurance; the reason "time or information challenges" is ascribed to those who say they do not have time to get insurance and those who say they do not know how to find information on available health insurance options; the reason "transitioning between coverage" is ascribed to those who are in the process of enrolling in coverage but are not currently covered and those who are transitioning between health insurance plans; the reason "not wanting coverage" is ascribed to those who say they do not want coverage and those who would rather pay the penalty; and the reason "other" is ascribed to those who are still weighing options and not ready to get health insurance coverage and those who say some other reason.

5. For the question on not enrolling in the Marketplaces, the reason "financial barriers" is ascribed to those who say the cost is too high or they cannot afford coverage, those who did not qualify for subsidized coverage, and those who enrolled but lost the coverage because they did not pay the premium. The reason "time or technical reasons" is ascribed to those who tried to enroll but the website was not working, who say enrolling in a plan was too complicated or difficult, or whose write-in response mentioned not having time or missing open enrollment. The reason "negative perception of benefits" includes those who say the plans do not cover the benefits they are looking for and those who say the choice of doctors, hospitals, and other providers in the plans' networks is too limited. The reason "oppose the ACA" is ascribed to those who say the government will not keep personal information confidential and those whose write-in responses were anti-ACA. Those in the process of enrolling in coverage but are not currently covered are in one category alone, as are those who say they do not want insurance. The reason "other" is ascribed to those who cite some other reason, such as not hearing about the Marketplaces, still weighing options, having immigration concerns, or having other coverage options in the near future (such as Medicare).

6. Centers for Medicare and Medicaid Services, "State Medicaid and CHIP Income Eligibility Standards."

7. Forthcoming HRMS analyses will examine the uninsured population's willingness to pay various specified premiums levels.

8. See also "10.3 Million Poor Uninsured Americans Could Be Eligible for Medicaid if States Opt for ACA Expansion," Urban Institute, accessed July 18, 2014.

9. Phil Galewitz, "Long Waits Persist for Those Applying for Medicaid Coverage in Many States," *Washington Post,* June 7, 2014.

State Health Reform Assistance Network
Charting the Road to Coverage

ISSUE BRIEF
June 2014

Understanding the Potential Role Web Brokers Can Play in State-Based Marketplaces

*Prepared by **Joel Ario** and **Allison Garcimonde**, Manatt Health Solutions and **Jon Kingsdale**, Wakely Consulting Group*

Executive Summary

The Affordable Care Act (ACA) is already greatly expanding individual health insurance coverage, particularly among lower-income uninsured individuals. However, this is neither easy nor inexpensive to sustain, and it will require ongoing, effective public-private partnerships on multiple levels. One such partnership opportunity is with "web brokers," who have been selling individual health insurance online since eHealth opened for business in 1997. Web brokers function as private distribution channels in a fashion similar to the new Marketplaces, offering a choice of health plans from multiple insurers, relying primarily on web sites and call centers for customer service.

In March 2012, the U.S. Department of Health and Human Services (HHS) provided the opportunity for Marketplaces to capitalize on web broker experience by authorizing Marketplaces to partner with web brokers in enrolling individuals (including those eligible for subsidies) as long as those web brokers met certain consumer protection standards. The Federally-Facilitated Marketplace (FFM) embraced the web broker policy in May 2012, and the Centers for Medicare & Medicaid Services (CMS) began signing contracts with web brokers in July 2013. The agency has signed agreements with more than 30 web brokers, though technology problems limited their role during the 2014 open enrollment period.

Some leading web brokers have sought similar partnerships with states and, while there has been some state interest, no State-Based Marketplace (SBM) has fully embraced the federal model for contracting with web brokers. This may be changing now that the first open enrollment period has closed and states are looking ahead to crafting sustainable models for reaching as many consumers as possible.

The purpose of this executive summary and its associated comprehensive issue brief is to help SBMs think about how they might work with web brokers. The paper is divided into three sections.

ABOUT STATE NETWORK
State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit *www.statenetwork.org.*

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WHO ARE THE WEB BROKERS?

Section one describes web brokers, which come in different flavors, but share a common goal with the Marketplaces: to use the internet as a distribution channel that makes it easier, cheaper, and faster to purchase health insurance in a consumer-oriented Marketplace. The mutual benefit of a partnership can be explained as such: Marketplaces have achieved considerable public

awareness and may attract issuers that web brokers hope to represent, while web brokers can provide technology tools, consumer-friendly innovations, and marketing and sales capacity that may be of increasing value as Marketplaces must become self-sustaining.

Five leading web brokers, each with its own business model, are profiled:

- **eHealth, Inc.:** Founded in 1997, eHealth (aka eHealthInsurance) offers more than 10,000 products from 180 insurance companies, has affinity relationships with nearly 1,000 businesses, and reports having enrolled over four million individuals in health insurance to date. The company focuses on providing a self-executing online experience for web-savvy consumers.
- **Getinsured:** Founded in 2005, Getinsured's national web-based platform supports over 110 carriers and 6,748 health plans. Getinsured has also contracted as an information technology (IT) vendor with several states and offers various "off-the-shelf" solutions for both the individual and small business (SHOP) Marketplaces.
- **GoHealth:** GoHealth has operated a "consumer health insurance exchange" since 2002, assisting individual purchasing online, through its agent network, or directly through a major health insurance company. GoHealth was an early partner of the FFM by using a combination of online and call center capabilities.
- **OneExchange:** Towers Watson's exchange division includes ExtendHealth, the largest private Medicare exchange, and Liazon Corporation, a leading private exchange for mid-sized employers. The company is particularly interested in part-time and other employee classes that may be best served by individual coverage.
- **Quotit:** Part of Word & Brown Companies, Quotit is an internet application service provider that has relationships with over 300 insurance carriers representing more than 40,000 plan designs in the health, life, dental, and vision insurance markets. Quotit's software enables independent brokers and retail consumers to generate insurance quotes.

EVOLUTION OF FEDERAL POLICY ON WEB BROKERS

Section two chronicles the evolution of the federal web broker policy, describing how the federal government established a web broker policy for public Marketplaces, and then adopted an "open competition" version of that policy for the FFM and the 36 states that operated as FFM states in 2014. Under the federal regulation, web brokers can enroll consumers through their own websites only if there are both appropriate connections to the relevant state or federal Marketplace and if the web broker signs an agreement and abides by the following consumer protections:

- Registers with the Exchange and receives training in the range of Qualified Health Plan (QHP) options;
- Complies with the Exchange's privacy and security standards;
- Complies with state laws, including laws related to confidentiality and conflicts of interest;
- Meets all standards for disclosure and display of QHP information;
- Provides consumers with the ability to view all QHPs offered through the Exchange and displays all QHP data provided by the Exchange;
- Provides consumers with the ability to withdraw from the process and use the Exchange website instead at any time; and,
- Maintains electronic records for audit purpose for at least 10 years.

In July 2013, web brokers began signing agreements with CMS, and by late 2013, CMS had entered into agreements with more than 30 web brokers. However, the "double redirect" technology used to connect the FFM with web brokers (as well as carriers for direct enrollment) proved difficult to use without consumer assistance during the 2014 enrollment process. Because the consumer was redirected from the web broker's site to the FFM for eligibility determination, then back to the web broker's site to shop and choose a QHP, there were many opportunities for delays and disruption. Web brokers estimate that relatively little of this traffic succeeded in achieving electronic enrollment, and most web brokers did not rely on the automated enrollment process, preferring instead to provide telephonic assistance to their customers.

CMS has considered a set of web services that would be built on top of the double redirect process and provide a seamless enrollment experience for the consumer enrolling through a web broker. The new services, which have been referred to as the Eligibility Verification as a Service (EVaaS) application program interface (API), would be an enhancement to the direct enrollment capacities of the current process, but there is no timeline for these new services. Web brokers believe that EVaaS would significantly improve the consumer experience and their ability to connect electronically to the FFM. They are hoping it will be developed and tested in time for the 2015 open enrollment season. In recent interviews, however, several web brokers expressed skepticism about CMS meeting this timetable given the agency's many IT priorities.

STATE OPTIONS FOR WORKING WITH WEB BROKERS

Section three describes two models for how SBMs can work with web brokers:

- **Open Competition:** The Marketplace contracts with all web-based entities that meet basic consumer protection and operational performance standards; or,
- **Managed Contracting:** The Marketplace contracts selectively and/or in special partnerships with one or more web brokers to achieve specific goals.

The case for open competition starts with consumer choice and maximizing enrollment. Consumer buying habits vary, so offering consumers as many ways as possible to shop for coverage options will make it easier for them to enroll, especially with several of the leading web brokers further down the learning curve than the Marketplaces on how to sell health insurance online. Expanding enrollment options may be most attractive at this early stage in the development of consumer choice tools, when no one knows which tools will turn out to be most helpful to consumers. Public Marketplaces will have strong appeal to certain types of consumers, but private web brokers will appeal to other consumers and may be able to experiment with consumer shopping enhancements in ways that public agencies find more difficult. In essence, open competition boils down to giving those that qualify for subsidized coverage the same access to multiple distribution channels as all other consumers.

The case for managed competition starts with the fact that SBMs offer a unique benefit—Advanced Premium Tax Credits (APTCs)—and therefore are in a position to select and "partner" with those web brokers who are most aligned with the SBM's objectives; and some SBMs may find that selective contracting provides more value than offering a "vanilla" contract to all web brokers that meet minimum standards of consumer protection and interoperability. Moreover, public Marketplaces and web brokers "compete" for unsubsidized enrollees. The substantial value that public Marketplaces can offer web brokers suggests that, rather than "give away" that value, they bargain for significant marketing commitments in return. For example, an SBM might structure a bid process, whereby web brokers propose marketing resources aimed at tough-to-reach segments.

With the 2014 open enrollment experience behind them, SBMs are in a better position to set longer term objectives, with different objectives suggesting different approaches to web brokers:

- To learn from as many different web brokers as possible how to reach enrollees, to attract as much enrollment of any kind as possible, and to avoid any suspicion of favoritism. This objective suggests the value of casting a very wide net for web brokers.
- To leverage tax credits, brand awareness, and a wide range of participating issuers to make the Marketplace the primary destination for all individual buyers, whether subsidized or not. This objective suggests favoring web brokers that agree to place subsidized and non-subsidized individual business through the Marketplace.
- To target for special outreach efforts particular linguistic, professional, or demographic groups (e.g., Hispanics, Native Americans, entrepreneurs, solo professionals, etc.). This objective suggests partnering with selected web brokers—by, for example, matching the web broker's dollar outlays for targeted advertising and community events.
- To help bridge discontinuities and different rules between Medicaid and QHPs for the lower-income applicants who may turn out to be eligible for Medicaid. This objective suggests partnerships with brokers, web-based or otherwise, that have relationships with a state's Medicaid program, and that are committed to assisting low-income applicants.
- To provide customers with a truly objective choice of issuers and equally robust access to all QHPs on the Marketplace. This objective suggests favoring web brokers who have appointments from all the issuers or commit to equally promote those issuers that have not appointed the web broker by including them in its decision-support tools.
- To minimize the Marketplace's cost and time for establishing and managing relationships with web brokers. Depending on the marginal cost of adding web brokers, this objective may suggest the open competition model or, if marginal costs are high, this objective may suggest limiting the number of web brokers with which the Marketplace contracts.

While Marketplaces may initially gravitate toward one strategy, a Marketplace's needs and web broker capabilities will probably evolve over time, and so should its strategies. For example, a Marketplace may initially want to learn from as many web brokers as possible or it may not have the resources to negotiate individual contracts. This Marketplace may wish to follow the federal open competition model. Over time, the same Marketplace may find a better return from selectively partnering only with those web brokers who make a major commitment to promoting the Marketplace and its priorities.

Introduction

Web-based brokers have been using the internet to enroll consumers in health plans since 1997. In March 2012, the U.S. Department of Health and Human Services (HHS) sought to capitalize on that experience by promulgating a regulation that allowed public Marketplaces to partner with web brokers in enrolling subsidy-eligible individuals as long as those web brokers met certain consumer protection standards.[1] The Federally-Facilitated Marketplace (FFM) embraced the web broker policy in May 2012[2], and the Centers for Medicare & Medicaid Services (CMS) began signing contracts with web brokers in July 2013. To date, the agency has signed contracts with more than 30 web brokers, though various problems impeded the effective use of web brokers during the 2014 open enrollment period.

Some leading web brokers have sought similar partnerships with states and, while there has been some state interest and a few alternative forms of collaboration between states and web brokers, no state has embraced the federal web broker policy. This may be changing now that the first open enrollment period has closed and states are beginning to look ahead to 2015. Covered California recently issued a request for information (RFI) from web brokers. AccessHealthCT was hoping to do a "pilot" with web brokers, and it is reasonable to expect that other State-Based Marketplaces (SBMs) will show increasing interest in this channel.

The purpose of this issue brief is to help SBMs think about how they might work with web brokers. The paper has three sections. First, the brief describes web brokers, who come in different flavors, but share a common goal with the public Marketplaces: to use the internet as a distribution channel that makes it easier, cheaper, and faster to purchase health insurance in a consumer-oriented marketplace. Five leading web brokers are profiled, each with its own particular business model.

Second, the paper chronicles the evolution of the federal web broker policy, describing how the federal government established a web broker policy, including basic consumer protection standards as an option for public Marketplaces, and then adopted an "open competition" version of that policy for the FFM and the 36 states that operated as FFM states in 2014.

Third, the brief offers two models for how the SBMs can work with web brokers, recognizing that actual state choices will fall along a continuum and that the two models can be mutually exclusive or mutually reinforcing, depending on how they are implemented:

- **Open Competition**: The Marketplace contracts with all web-based entities that meet basic consumer protection and operational performance standards; or
- **Managed Contracting**: The Marketplace contracts selectively and/or in special partnerships with one or more web brokers to achieve specific goals.

The paper continues discussing the strategic considerations for SBMs in deciding whether to lean toward one or the other web broker models, focusing on both the operational and strategic challenges. The operational challenge for Marketplaces and web brokers is to integrate technology and functionality for an optimal customer experience. Even with an optimal customer experience, Marketplaces and their partners (including web brokers) will still face the strategic business challenge of achieving the enrollment and other goals of the Affordable Care Act (ACA) in the most cost-effective way.

I. Who are the Web Brokers?

For purposes of this issue brief, "web brokers" are defined as a web-based channel, including its own or contracted brokers, to sell health insurance from multiple insurers to individual consumers.[3] Private exchanges could be seen as a form of web broker, but private exchanges, such as those run by Aon Hewitt, Mercer, and Towers Watson, primarily focus on the group employer market, while the leading web brokers primarily focus on the individual market.

However, it is important to recognize that this distinction may well disappear over time as web brokers and private exchanges diversify and/or partner with each other to add complementary capabilities and focus. For example, Towers Watson serves large employers as human resources consultant and a private exchange, but reports interest from these clients in having the company help their part-time, seasonal, COBRA-eligible, and other "associated" employees or ex-employees qualify for subsidies and find affordable coverage in the individual market. Having acquired ExtendHealth, Towers Watson also operates a private exchange serving Medicare enrollees.

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[1] *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers*, Final Rule and Interim Final Rule. 77 Fed. Reg, 18335, (March 27, 2012).

[2] Department of Health and Human Services. "General Guidance on Federally-facilitated Exchanges." May 16, 2012. (p. 16) http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ffe-guidance-05-16-2012.

[3] Though HHS uses the term "web-based entities" ("WBEs") rather than "web brokers," this brief uses the latter, more common term to avoid another acronym.

The success of the public Marketplaces depends on effective public-private partnerships on multiple levels, including with web brokers. Web brokers function as private distribution channels in a fashion similar to Marketplaces, offering a choice of health plans primarily to individuals, and relying primarily on web sites and call centers for customer service. The standardization of covered services (Essential Health Benefits) and actuarial values (four metal levels) also mean that the choice of offerings on private and public Marketplaces may be fairly similar.

Some differences exist as well, the most obvious of which are that only public Marketplaces can offer tax credits, and web brokers also sell their own selection of unsubsidized health plans outside the Marketplace. The selection of issuers (i.e., carriers) on a public Marketplace may well differ from the selection of carriers that appoint any particular web broker. Carriers that appoint web brokers typically pay them on a commission schedule, and most issuers will also pay Marketplaces some kind of "user fee," typically based on business volume. As a result, the contractual and financial relationships among the three sets of entities—Marketplaces, web brokers, and carriers—can be overlapping, or mutually exclusive, or some complex combination of the two. [4]

WHY SHOULD MARKETPLACES AND WEB BROKERS WORK TOGETHER AND ON WHAT TERMS?

Working in tandem, the Marketplace offers web brokers access to subsidized coverage to sell, and web brokers are organized to process many individual buyers efficiently. Public Marketplaces are projected to double the size of the individual market nationally, so web-based brokers have a powerful incentive to tap into that growth.[5] Moreover, the Marketplaces have achieved considerable public awareness, which can benefit web brokers as well. Finally, the Marketplaces attract issuers that web brokers hope to represent. All these elements make Marketplaces attractive to web brokers.

For a public Marketplace, web brokers can provide technology tools, consumer-friendly innovations, and additional marketing and sales capacity. These assets may be of increasing value as SBMs convert from federal grant support to self-sustaining finances and may encounter various financial and other limitations on their ability to innovate in ways available to the private market. Direct sales is very expensive and, absent ongoing grant support, must be tightly managed to be cost-effective. Web brokers already have a customer base, and generally have an advertising budget and/or affiliations to reach customers for the Marketplace. They may even be interested in joint efforts to reach targeted populations.

Like pure technology vendors, web brokers can also supply Marketplaces with core systems. For example, Getinsured has contracted with California and several other states to provide services as a vendor. SBMs can use web brokers as vendors for core functions in different ways, as outlined in Appendix B, but the vendor arrangements are outside the focus of this study. Instead, this brief focuses on state use of web brokers as additional or complementary enrollment channels.

Insurers also are accelerating their web-based selling and direct enrollment through "issuer specific" web sites. The issue brief references federal policy on direct enrollment through issuers since it has implications for web broker policy, including the fact that both issuers and web brokers rely on the same federal technology solution. But for the purposes of this analysis, the term "web brokers" will be limited to those online brokers who offer broad choice among insurers in a given Marketplace. In other words, the value proposition they offer to consumers is similar to that offered by the public Marketplaces, except that they cannot offer tax credits (absent a partnership with the Marketplace) and do not have all the other responsibilities that SBMs have beyond selling individual health insurance products to consumers.

The 30-plus web brokers that have signed agreements with CMS reflect a broad diversity of business models, and many of them may end up collaborating with other web brokers rather than working independently with Marketplaces. Appendix A provides detailed profiles of five leading web brokers which are briefly overviewed here:

- **eHealth, Inc.:** Founded in 1997, eHealth (aka eHealthInsurance) offers more than 10,000 products from 180 insurance companies, has affinity relationships with nearly 1,000 businesses and nonprofits, and reports having enrolled over four million individuals in health insurance to date. The company focuses on providing a self-executing online experience for web-savvy consumers.

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[4] The relationships here suggest that states should be wary of requiring carriers to appoint web brokers, since this adds a web broker commission from the carrier to whatever fees the Marketplace may charge the carrier for the enrollment. This will not change the premium for the consumer but it is an added cost and explains why carriers will generally be opposed to appointed brokers bringing unsubsidized business through the Marketplace, unless the fees that finance the Marketplace apply to sales on and off Exchange, which is not true for the FFM. There are many additional wrinkles here that will have to be thought through by the states, but are beyond the purview of this issue brief.

[5] Congressional Budget Office. "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, 2014." April 2014. Available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf

- **Getinsured:** Founded in 2005, Getinsured's national web-based platform supports over 110 carriers and 6,748 health plans.[6] Like eHealth, it has enrolled online, primarily in the individual market, across the country. Getinsured has also contracted as an information technology (IT) vendor with several states and offers various "off-the-shelf" solutions for both the individual and small business (SHOP) Marketplaces.
- **GoHealth:** GoHealth has operated a "consumer health insurance exchange" since 2002, assisting individual purchasing online, through its agent network, or directly through a major health insurance company.[7] In addition to its own agents, some 20,000 independent brokers use its quoting platform.[8] GoHealth was an early partner of the FFM by using a combination of online and call center capabilities.
- **OneExchange:** Towers Watson's exchange division includes ExtendHealth, the largest private Medicare exchange, which works with large employers to allow retirees to shop among health plans on a website [9], and Liazon Corporation, a leading private exchange for small employers and their active employees.[10] The company is particularly interested in part-time and other employee classes that may be best served by individual coverage.
- **Quotit:** Part of Word & Brown Companies, Quotit is an internet application service provider that has established relationships with over 300 insurance carriers representing more than 40,000 plan designs in the health, life, dental, and vision insurance markets.[11] Quotit's software enables independent brokers and retail consumers to generate insurance quotes, including comparative information on rates and benefits.

II. Evolution of Federal Policy on Web Brokers

In July 2011, CMS published its first proposed Marketplace regulation and asked whether there was a role for "web-based entities with experience in health plan enrollment that are seeking to assist in QHP enrollment."[12] Some of those firms pointed to more than a decade of online experience selling a multi-insurer suite of products to individual consumers and suggested that their experience could be helpful to the new Marketplaces. Several forms of partnership were suggested and the July 2011 proposed regulation called out two models for comment:

- **Vendor model:** CMS defined this model as "contracting with an Exchange to carry out outreach and enrollment functions."[13]
- **Independent model:** CMS defined this model as "acting independently of an Exchange to perform similar outreach and enrollment functions to the Exchange."[14]

CMS did not propose any regulatory language for the web broker model in July 2011, but did ask for public comment on what kind of regulation might make sense: "We seek comment on the functions that such entities could perform, the potential scope of how these entities would interact with the Exchanges and what standards should apply to an entity performing functions in place of, or on behalf of, an Exchange."[15]

In March 2012, CMS regulations embraced an expanded role for web brokers, as well as other agents and brokers, in the eligibility and enrollment process. The preamble to 45 CFR 155.220 describes the goal as "ensur[ing] that consumers enjoy a seamless experience with appropriate consumer protections if an Exchange chooses to allow web brokers to participate in Exchange enrollment activities."[16]

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[6] https://www.getinsured.com/exchange/about.html

[7] http://exchange.gohealth.com/about-us/

[8] Ibid.

[9] Jones, Kristen. "Towers Watson to buy Extend Health for $435mln." *Wall Street Journal MarketWatch*. May 14, 2012. http://www.marketwatch.com/story/towers-watson-to-buy-extend-health-for-435-mln-2012-05-14

[10] Towers Watson Press Release. "Towers Watson Acquires Liazon to Expand Private Benefit Exchange Offerings Through Multiple Channels." November 22, 2013. http://www.towerswatson.com/en-US/Press/2013/11/towers-watson-acquires-liazon-to-expand-private-benefit-exchange-offerings-through-multiple-channels

[11] Ibid.

[12] *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans* Proposed Rule. 76 Fed. Reg, 41878, (July 15, 2011).

[13] Ibid.

[14] Ibid.

[15] Ibid.

[16] *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers*, Final Rule and Interim Final Rule. 77 Fed. Reg, 18335, (March 27, 2012).

The preamble also discusses consumer protection concerns, and the regulation allows web brokers to enroll consumers through their own web sites only if there are both appropriate connections to the relevant state or federal Marketplace and if the web broker signs an agreement and abides by the following consumer protections:[17]

- Registers with the Exchange and receives training in the range of QHP options;
- Complies with the Exchange's privacy and security standards;
- Complies with state laws, including laws related to confidentiality and conflicts of interest;
- Meets all standards for disclosure and display of QHP information;[18]
- Provides consumers with the ability to view all QHPs offered through the Exchange and displays all QHP data provided by the Exchange;
- Provides consumers with the ability to withdraw from the process and use the Exchange website instead at any time; and,
- Maintains electronic records for audit purpose for at least 10 years.

The web broker must also ensure the applicant completes an eligibility verification and enrollment application through the Exchange, and the Exchange must transmit the enrollment information to the QHP issuer.[19] As discussed below, these last two requirements create a challenge—defining the precise role that a state or federal Marketplace must play in eligibility verification and enrollment—while meeting the goal of the rule which is a "seamless experience" for the consumer. Though the regulation did not address the vendor model, as described above and illustrated in Appendix B, the use of web brokers as vendors continues to be a viable approach as well.

FFM ADOPTS WEB BROKER POLICY

In May 2012, CMS announced that the FFM would adopt the web broker policy and allow web brokers to partner with the FFM in FFM states: "To the extent permitted by a State, an FFE will permit agents and brokers to enroll individuals in a QHP 'through an Exchange' if the agent or broker ensures that an individual completes the eligibility verification and enrollment application using the Exchange internet site or the agent or broker's site that meets certain conditions; the Exchange transmits the enrollment information to the QHP issuer; and the agent or broker meets other applicable requirements (an agreement, training, and registration)."[20]

In May 2013, CMS reiterated that it planned to work with all web brokers meeting applicable requirements.[21] CMS also indicated that integration between the web brokers' websites and the FFM's website would be facilitated via secure redirect and applicationprogram interface (API) mechanisms.[22]

CMS DEVELOPS WEB BROKER AGREEMENT AND ESTABLISHES TRAINING AND TESTING REQUIREMENTS

In the summer of 2013, CMS made available the web broker agreement required by 45 CFR 155.220.[23] The agreement cites section 1312 (e) of the ACA as the authority for Marketplaces using web brokers and defines rules of conduct, including consumer protection and privacy and security standards, that web brokers must meet.[24]

The agreement is standardized (not subject to any customization) and detailed as to the authorized functions for which a web broker may "create, disclose, access, maintain, store, and use" Personally Identifiable Information (PII), the specific types of PII that a web broker may employ to carry out authorized functions, permissible information sharing, and the applicable consumer protection,

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[17] 45 C.F.R.§ 155.520(c)

[18] This provision was modified in the Exchange Program Integrity Final Rule to require that, to the extent that not all QHP information is displayed on the agent or broker's web site, web brokers must prominently display a standardized disclaimer provided by HHS stating that required QHP information is available on the Exchange web site and provide a link to the Exchange web site (45 C.F.R. 155.220 (c)(3)(i) and (vii). *Patient Protection and Affordable Care Act*; *Program Integrity: Exchange, SHOP, and Eligibility Appeals* Final Rule. 78 Fed. Reg, 54076, (August 30, 2013).

[19] Ibid.

[20] Department of Health and Human Services. "General Guidance on Federally-facilitated Exchanges." May 16, 2012. (p. 16) http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ffe-guidance-05-16-2012.pdf

[21] Department of Health and Human Services. "Role of Agents, Brokers and Web-brokers in Health Insurance Marketplaces." May 1, 2013. http://www.cms.gov/CCIIO/resources/regulations-and-guidance/downloads/agent-broker-5-1-2013.pdf

[22] Ibid

[23] CMS has made several iterations of the web broker agreement available to stakeholders but to date has not made a version publicly available via the CMS website. The agreement described herein made available online by the Maryland Health Benefit Exchange at the following link: http://marylandhbe.com/wp-content/uploads/2013/08/Web-broker-Agreement_071913.pdf

[24] Ibid.

privacy, and security standards, as well as standards for communication with the Federal Data Services Hub. The agreement also specifies the effective date and term of the contract, as well as provisions for renewal and termination.[25]

In July and August 2013, a number of web brokers, including eHealth, Getinsured, and GoHealth, announced that they had signed the CMS agreement. CMS has not released the list of web brokers who have signed agreements, but news reports indicated that by late 2013, the FFM had entered into agreements with more than 30 web brokers.[26]

Once a senior representative of the web broker has signed and submitted a web broker agreement to CMS, the next step in the process for web brokers is training and testing. A web broker representative must first register on the Medicare Learning Network in order to complete a series of training courses, pass a number of related exams, and execute additional Federally-Facilitated Individual Marketplace agreements related to standards of participation.[27, 28] Similar to the testing process required of states connecting to the FFM, web brokers' technology platforms must then undergo extensive testing to ensure secure communication and business logic interoperability between the broker website and the FFM, as well as end-to-end testing to verify system functionality and interoperability across a multi-partner environment. Unlike state partner websites, web brokers are also required to test the secure redirect process with the FFM.[29] Web brokers are allowed to "lease" out their connections to affiliated agents and other business partners with certain protections in place.

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[25] Ibid.

[26] Bidgood, Jess. "More than One Way to Buy a Plan." *New York Times*. March 6, 2014. http://www.nytimes.com/news/affordable-care-act/2014/03/06/more-than-one-way-to-buy-a-plan/?_php=true&_type=blogs&_r0

Mangan, Dan. "eHealth CEO's Obamacare fix: Let us run HealthCare.gov." CNBC. October 30, 2013. http://www.cnbc.com/id/101153131

[27] CMS. "Participating in the Federally-facilitated Marketplaces: Registration Process for Agents and Brokers." August 16, 2013. http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/agent-broker-registration-webinar.pdf

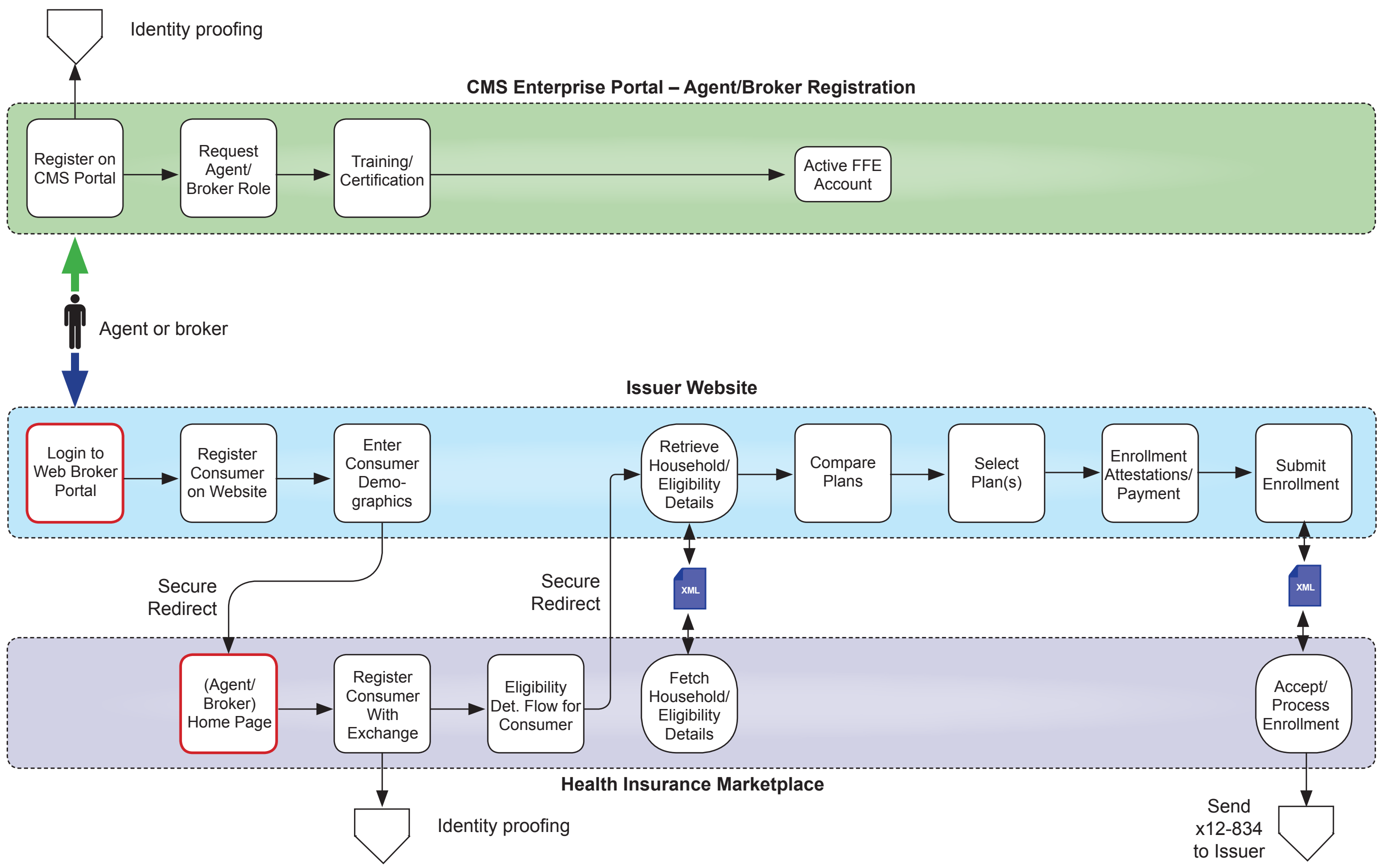
[28] Individual agents or brokers affiliated with a web broker are not required to sign a Web-broker Agreement but must complete the registration steps required for the FFM and comply with state licensure requirements. (CMS, August 2013 Webinar).

[29] CMS. "CMS State Testing Handbook." June 2013; CMS. "CMS Zone Direct Enrollment Testing with the FFM."

OPERATIONALIZING THE FEDERAL POLICY

To meet the regulatory requirements for the Marketplace to verify eligibility and enrollment, CMS initially designed a "double redirect" process where the person starting out on a web broker site was "handed-off" to the FFM for eligibility determination and then redirected back to the web broker site for plan selection. The web broker then uses a web service to submit the enrollment to the FFM so that the FFM can notify the carrier and the IRS.[30] This process was supposed to be seamless, yet has proved to be anything but seamless in practice, according to leading web brokers. The more critical among them have characterized the double redirect system initially designed by CMS as "byzantine."[31] See Diagram A for a schematic representation of the double redirect process.

Diagram A: Direct Enrollment Process Flow[32]



As one stakeholder put it, "any redirect is a red flag for eCommerce," so the double redirect has been highly problematic. Because the consumer is redirected from the web broker's site to the FFM for eligibility determination, there are many opportunities for delays and disruption. Inefficiencies resulting from the double redirect process include delays, lost contact with the consumer, duplicate data requests of the applicant because the full information on one site does not transfer to the other, having to start over because of time outs after 30 minutes, and so forth.[33]

As a result of these flaws, web brokers estimate that relatively little of this traffic succeeds in achieving electronic enrollment. While web brokers have taken different approaches to use of the double redirect process, most have not implemented the automated

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[30] The FFM notifies the carrier via an 834 transaction that contains enrollment information and, if an APTC is involved, the FFM notifies the IRS via an 820 transaction that contains the amount owed to the carrier.

[31] *Aigner-Treworgy*, Adam. "Private Exchanges: Obamacare Shopping Still Not Ready." *CNN PoliticalTicker*. December 17, 2013. http://www.cnn.com/2013/12/17/politics/obamacare-private-exchanges/

[32] Department of Health and Human Services. "Role of Agents, Brokers and Web-brokers in Health Insurance Marketplaces." May 1, 2013. http://www.cms.gov/CCIIO/resources/regulations-and-guidance/downloads/agent-broker-5-1-2013.pdf

[33] While some web brokers have been quite critical of the double redirect process, there are competing considerations which led CMS to develop a process in which the application was completed on the FFM site. These considerations include shielding web brokers from the restrictive policies of the IRS and other federal agencies, and protecting the privacy and other rights of consumers.

enrollment process, preferring instead to provide telephonic assistance to customers. Similarly, all agree there is room for improvement and there is strong support for moving from the double redirect process to a web services approach in order to avoid the many problems they claim to have experienced to date on the FFM.

NEW WEB SERVICES SOLUTION UNDER CONSIDERATION

While CMS has not publicly confirmed that a new solution is under consideration, multiple sources have said that CMS has explored a set of web services that would be built on top of the double redirect process and provide a seamless enrollment experience for the consumer enrolling through a web broker.[34] The new services, which have been referred to as the Eligibility Verification as a Service (EVaaS) application program interface (API), would be an enhancement to the direct enrollment capacities of the current process, but there is no timeline for these new services. Web brokers believe that EVaaS would significantly improve the consumer experience and their ability to connect electronically to the FFM. They are hoping it will be developed and tested in time for the 2015 open enrollment season. In recent interviews, however, several web brokers expressed skepticism about CMS meeting this timetable given the agency's many IT priorities.

Issuer-Specific Websites Given Same Rights as Web Brokers

While CMS was working out the details of its web broker policy, the agency was also working with the insurance industry to address the concern of insurers with significant subsidy-eligible business. They stood to lose significant portions of that business when current enrollees were converted to ACA-compliant plans if consumers had to purchase their QHPs on the Marketplace web site, rather than directly through the incumbent insurer, in order to access federal subsidies. The result of those discussions was to allow "issuer-specific" web sites to have the same rights as web brokers, and as shown in Diagram A, the double redirect process was designed to be a single interface for issuers and web brokers, as well as the primary means for other agents and brokers to work with the FFM. Some of the carriers report better results with the "double redirect" technology than web brokers, partly because they can do their own enrollments.

Erosion of the Consumer Right to See All QHPs

The extension of the web broker policy to issuers has several implications, including erosion of the principle that all "independent" web sites enrolling consumers in subsidized coverage would be required to display all QHP options. Issuers were exempted from this requirement on the grounds that consumers already enrolled with them (or visiting their websites) had made their decision and should not be required to revisit their selection of an issuer. While carriers have the obligation to inform consumers of their right to shop on the public Marketplaces, they do not have an obligation to display their competitors' products.

By contrast, CMS continues to require web brokers to display all QHPs, but here, too, there has been some erosion from the ideal of full choice. A web broker will not necessarily have full product information for QHPs offered by issuers that have not appointed that web broker. While some state Marketplaces have done so, to date CMS has not required issuers and web brokers to contract with each other, and insurers have balked at non-appointed web brokers providing detailed product information to consumers. The result is that where web brokers are not appointed, the product information they provide is very basic information with the consumer given the option to click a button and go to the relevant Marketplace to get the full picture.

The policy decision to allow direct enrollment through issuer sites illustrates that consumer choice is only one of several priorities in the effort to achieve universal coverage. If choice were the only priority, Marketplaces might require that consumers make an active selection of a health plan each anniversary in order to remain covered. Rather, we expect that Marketplaces will allow enrollees to default to their existing QHPs, absent an active selection, in order to maintain coverage. There are good reasons why Marketplaces and carriers will, wherever possible, make the default be continued enrollment. Moreover, many Marketplaces are exploring policies that might allow consumers to keep their current plans, even when their circumstances change, such as when they churn from Medicaid to tax credit eligibility. The bottom line is that stability in any insurance market depends on making it as easy as possible for consumers to keep the coverage they have, a point that should be kept in mind when debating the importance of choice for web brokers and other ports of entry.

[34] Aigner-Treworgy, February 2014.

III. State Options for Working with Web Brokers

Although many of the SBMs have been approached by web brokers, no state has established a web broker policy similar to the federal one. Responses from a brief survey of the 14 SBMs indicate that this issue has yet to receive much attention, with the exception of a 2013 review process in Maryland. This section begins with a summary of the Maryland review and some highlights from other states that are starting to look at the issue. It then turns to an analysis of two models—open competition and managed competition—to illustrate the range of options for states.

MARYLAND POLICY WITH WEB BROKERS

Maryland formed a Web Broker Advisory Committee[35] in mid-2013 to explore the value proposition offered by web brokers, the consumer protections that should be included in any web broker policy, the feasibility of contracting with web brokers, and various technical issues associated with web brokers.

The Advisory Committee met three times over the summer of 2013, and presented its findings to the Maryland Health Benefit Exchange Board in September 2013. The Advisory Committee found that there were potential benefits to partnering with web brokers. Among the benefits cited were:

- Applications for mobile devices and other consumer enhancements targeted to the young invincibles;
- A range of tools to help with plan selection;
- Additional assistance to consumers post enrollment; and,
- Assistance to employers enrolling part-time workers into individual plans.

The Advisory Committee also found that "any partnership must include extensive consumer protections" and noted that SBMs could go beyond the federally-required protections.

Turning to partnership options, the Advisory Committee cited 'limited resources and oversight" in recommending that Maryland "start with a limited number of web brokers and expand overtime."

Based on these Advisory Committee recommendations, the staff recommended "clarifying the outstanding technical, staffing, timing, and cost issues," and "reporting back to a future Board meeting."

Action is still pending in Maryland since the Marketplace encountered substantial IT challenges when open enrollment began in October 2013, resulting in the web broker issue being put on the back burner. In February 2014, Maryland issued a Request for Applications for web brokers interested in participating in a pilot program with the Maryland Health Benefit Exchange.[36] Further action has been delayed by Maryland's decision to reuse IT components from AccessHealthCT.

APPROACH TO WEB BROKERS FOR 2015 AND BEYOND

As states look forward to the 2015 open enrollment period, they will have a more realistic opportunity to consider web broker policy than they had during 2014 open enrollment, especially given the technology problems that the FFM experienced in trying to execute the federal open competition model. In fact, there already are some signs of SBMs moving forward: Connecticut has expressed interest in a pilot; Colorado has signed agreements with several web brokers as part of its broader agent and broker outreach program and is considering enhanced partnerships similar to the federal model; and California has released a request for information, indicating that Covered California may contract with web brokers in 2015.[37]

THE CASE FOR OPEN COMPETITION

The case for opening up the enrollment process to web brokers starts with consumer choice and maximizing enrollment. Consumer buying habits vary, so offering consumers as many ways as possible to shop for coverage options will make it easier for them to enroll, especially with several of the leading web brokers further down the learning curve than the public Marketplaces on how to sell health insurance online. The case for expanding enrollment options may be most attractive at this early stage in the development of consum-

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[35] http://marylandhbe.com/committees/web-based-wbe-advisory-committee/

[36] Maryland Health Benefit Exchange. "Request for Applications, Web-Based Entities Pilot Program." February 3, 2014. http://marylandhbe.com/wp-content/uploads/2014/02/WBE-PILOT-RFP.pdf

[37] Covered California and the California Department of Health Care Services. "Web-Based Entity – Request for Information." March 18, 2014. http://www.hbex.ca.gov/solicitations/RFI-Web-Based-Entity/Request%20for%20Information%20(WBE)%20Final.pdf

er choice tools, when no one knows which tools will turn out to be most helpful to consumers. Public Marketplaces will have strong appeal to certain types of consumers, but private web brokers will appeal to other consumers, and web brokers will be able to experiment with consumer shopping enhancements in ways that public agencies may find more difficult, politically or technically. In essence, open competition boils down to giving those that qualify for subsidized coverage the same access to multiple distribution channels as all other consumers.

Marketplaces that are open to all web brokers who meet minimum standards for consumer protection, interoperability, and service have much to gain since every web broker will be additive in at least some respects—each has its own approaches, marketing partnerships, advertising spend, consumer experience, etc. Also, the web broker revenue model, based on commissions paid by the carriers that appoint them, gives them an advantage as a sales vehicle after federal grants end. By supplementing a lesser spend on mass media with "free" sales efforts, Marketplaces can continue to add enrollees at a lower average cost of acquisition.

Web brokers may also be helpful in reaching certain target populations. For example, some web brokers may have the capacity to reach certain desired demographics, such as the young, Hispanics, or other underinsured groups. Other types of web brokers, such as private employer-oriented exchanges, are growing rapidly and may be able to refer part-timers and others associated with their client employers to the local Marketplace.[38] If it makes sense for Marketplaces to cooperate with one private exchange in order to reach its client's COBRA-eligibles, seasonal workers, and part-timers, then each additional connection simply opens access to additional groups through a channel that is especially well-positioned to reach qualified individuals associated with employers.

Even the caveat that such affiliations must justify the resources required of public Marketplaces to establish and maintain them may be "self-regulating," in that web brokers that cannot deliver much volume to a public Marketplace will probably not find it cost-effective to establish (or maintain) the relationship. And since it is hard to predict at this stage which affiliations will prove most (or least) productive, there is a good case for public Marketplaces to be open to all web brokers willing and able to dedicate the resources required to connect with public Marketplaces.

In addition, web brokers can provide an alternative enrollment path to SBM's own web portal and call center when the SBM is either overloaded by high volume or, at least for non-subsidized enrollees, has been taken down for a fix or for routine maintenance.

Finally, for states that also are considering direct enrollment through insurers, it is worth noting that web brokers will have an advantage, from a consumer choice perspective, over direct enrollment with an individual carrier to the extent they display multiple insurer choices. This requirement is built into the minimum federal standards for web brokers, and states may want to further define what a fair comparison shopping requirement entails.

States that generally favor the open competition model may nevertheless prefer to begin small with a pilot project, especially if the operational challenges to achieve a good customer service experience require significant resources to connect each additional web broker. It remains to be seen whether that will be true with the evolving federal solution, or whether that solution will substantially reduce the marginal costs for bringing on new web brokers. On the other hand, states that start with an open competition model may choose to add complementary partnerships and/or pare down the number of web brokers over time, as it becomes clear which are most productive.

THE CASE FOR MANAGED CONTRACTING

State Marketplaces vary in objectives and political constraints, but for those with the interest and will to do so, some may find that selective contracting provides more value than offering a "vanilla" contract to all web brokers that meet minimum standards of consumer protection and interoperability. Because low- and modest-income enrollees can access federal subsidies only through a public

Marketplace, it enjoys a unique advantage in attracting issuers and enrollees alike, and therefore some leverage in selectively contracting with web brokers. Moreover, public Marketplaces and web brokers "compete" for unsubsidized enrollees. So, having invested hundreds of millions of dollars to build brand awareness over the past year, SBMs may be hesitant to simply "give" that away to private exchanges and dilute their own brand.

The substantial value that public Marketplaces can offer web brokers suggests that, rather than give it away, they bargain for significant marketing commitments in return. Because web brokers may differ in their strategies, including their commitment to public

[38] For example, Aon Hewitt recently announced that more than 600,000 employees and their family members enrolled in group health benefits for 2014 during the Fall 2013 open enrollment period through its Aon Active Health Exchange. Aon Hewitt Press Release. March 6, 2014. http://www.prnewswire.com/news-releases/aon-hewitt-year-two-enrollment-results-show-private-health-exchanges-can-mitigate-costs-and-create-greater-individual-accountability-248731331.html

Marketplaces, and because they target various segments in partnership with different commercial and membership entities, some may be more adept than others in reaching a Marketplace's target populations. It may take more analysis, negotiation, and investment to customize relationships with web brokers, but it may also deliver greater benefits than doing a "vanilla" contract with all of them.

Most of the arguments in favor of contracting with any qualified web broker—rather than none at all—apply as well to a more discretionary contracting strategy. The arguments in favor of open competition that do not apply to managed contracting are that more (web brokers) is better and that a "level playing field" is the only fair one. Arguably, there are several reasons not to contract with any willing web broker, at least initially, but to "partner" with some web brokers.

First, establishing and maintaining additional web broker relationships is not completely cost-free. For example, each broker needs to be on-boarded, a connection must be established, and troubleshooting must occur when there are problems. There is a learning curve for working with web brokers, and some Marketplaces may prefer to learn with just a few than with many. Covered California seems to be headed in this direction, based on its intentions as described in a recent RFI.[39]

Over time, the annual changes in QHPs (issuers, benefits, network, pricing, etc.) must be transmitted and tested for each affiliated web broker. A change in policy, such as which entity collects the first month's premium, would affect each web broker differently, requiring prior consultation with each one and complicating decision-making.

Second, there is the cost of commissions associated with all brokered enrollments, even if they do not show up on the Marketplace's books. The Marketplace itself adds costs, typically supported by "user fees," which (like broker commissions) add to the cost of health insurance. This means an additional cost to issuers for enrollments that come in through a broker, web-based or otherwise, as opposed to those coming directly through the Marketplace.

A cost-accounting question of considerable relevance is whether the commission for a web broker is more or less than the variable cost to the Marketplace of handling the enrollment directly. To the extent that web brokers efficiently perform functions that the Marketplace would have had to supply, and are thereby able to reduce Marketplace costs, then the web broker's cost is instead of, not in addition to, Marketplace costs.

Another empirical question is whether and when continuing to add more web brokers takes more enrollments away from existing brokers and unbrokered enrollments than it adds to total enrollments. That is, at what point does the market become saturated by "me, too" web brokers, and adding more would simply take away from others? (As both questions involve complex and imprecise analyses, answering them would add to the Marketplace's workload, as would conducting a competitive bidding and selection process.)

Third, there is the classic problem of channel conflict and consumer confusion with multiple web brokers selling the same Marketplace. To the extent that a Marketplace in effect "licenses" multiple web brokers to use its brand and promote access to subsidies, do the web brokers confuse the public or, worse still, "cherry-pick" the non-subsidized enrollees, while using the Marketplace to serve only the subsidy-eligible? (Of course, a Marketplace may not be concerned about brand confusion or "cherry-picking," as long as it is confident that total enrollment grows as a result of such affiliations.)

Fourth, joint efforts between a Marketplace and select web brokers may produce results more efficiently than many separate efforts, especially if each party brings complementary resources to marketing and sales. While all web brokers share an efficient technology for business-to-consumer sales, they will differ in their marketing efforts, including partnerships with retail and membership organizations, and the consumer experience. They will also likely differ in their strategies for working with public Marketplaces. Some web brokers may be more capable of, and interested in, committing resources to promote public Marketplaces than others. Depending on the focus of a Marketplace and different web brokers, the Marketplace may be able to leverage its own spend by joining in partnership with select web brokers.

In this regard, it is worth asking whether all enrollment is of equal value to the Marketplace. For example, enrolling the uninsured, the unsubsidized, and/or younger lives may be priorities for a Marketplace. Because web brokers have a volume of lives already enrolled, they are likely to "deliver" to the Marketplace the subsidy-eligible ones among them, but those same enrollees are also reasonably likely to find their way to the public Marketplace on their own. It is not yet clear that web brokers will "deliver" many formerly uninsured individuals or enrollees above 400 percent of the federal poverty level (FPL). A Marketplace might decide to work exclusively with those web brokers that make a commitment to "deliver" target segments of particular interest.

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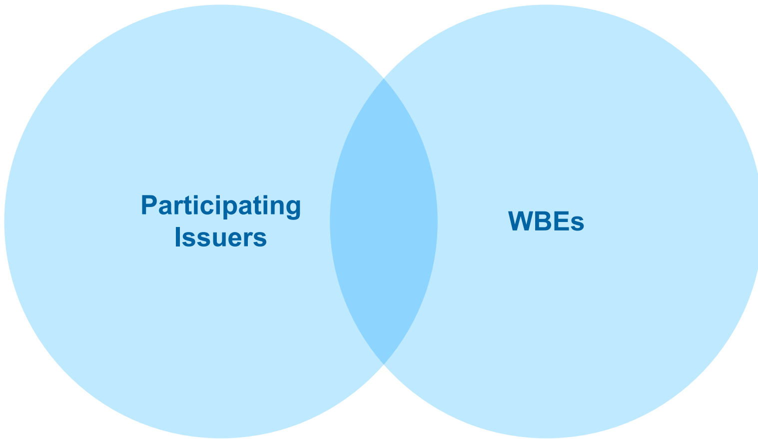
[39] Covered California and the California Department of Health Care Services. "Web-Based Entity – Request for Information." March 18, 2014. http://www.hbex.ca.gov/solicitations/RFI-Web-Based-Entity/Request%20for%20Information%20(WBE)%20Final.pdf

A "complicating" factor in contracting with web brokers is the dependence of the broker's revenue model on having appointments from the issuers. One of the attractions of working with brokers, web-based or otherwise, is that this is a self-sustaining sales model, insofar as issuers build broker commissions into their premiums. Ideally, web brokers should mirror offerings on the Marketplace, and be compensated for enrollment in all issuers.

However, this may not happen on its own. If not, the Marketplace can work with web brokers that are not appointed by all issuers, or it can actively encourage (or even require) all participating issuers to work with its participating web brokers. Several Marketplaces currently require or encourage brokers to obtain appointment by all participating issuers that work with any brokers. State Marketplaces may be in a better position to require issuers to contract with web brokers as they know their local markets better than the FFM across 36 states. Of course, issuers appoint brokers for all their clients, not just the Marketplace, so forcing issuers to appoint all the web brokers that a Marketplace uses may meet resistance from issuers, and raises questions as to what terms will govern these "forced marriages."

The more web brokers that the Marketplace uses, the more burden it imposes on issuers to contract with agents not of an issuer's choosing. The "sweet spot" for contracting with issuers and web brokers may be, as illustrated below, to do so selectively with those web brokers that already overlap with most participating issuers, and to encourage the other participating issuers to appoint these same web brokers. Connect for Health Colorado, which has contracted with six web brokers, adopted a policy of requiring all its brokers to work with all those issuers who appoint brokers.[40]



For Marketplaces interested in selective contracting, a few hypothetical illustrations are suggested below of how and why public Marketplaces might manage contracting. These considerations and examples are simply illustrative, and might apply to traditional agents as well:

1. A Marketplace that prioritizes target market segments may decide to focus its limited resources on joint efforts with those web brokers that share this focus. For example, if the priority is outreach to the low- and modest-income uninsured, it might partner with the web broker that proposes to spend the most in-state for direct outreach to uninsured households earning less than 400 percent FPL, and that also proposes credible plans for targeting that population. Or it might propose to match any web brokers' proposal to spend a minimum amount on billboards and direct mail in modest-income neighborhoods in the state. The Marketplace might also persuade QHP issuers that also serve the Medicaid market, but have never worked with brokers, to appoint these kinds of web brokers. Something similar could be developed for reaching Spanish-speaking Americans—the Marketplace might co-fund Spanish language advertising for any web brokers that customize their web enrollment tools for Hispanics, or promote the web broker that proposes the most effective outreach and servicing program for Hispanics.

2. A Marketplace that prioritizes equal promotion of all issuers as a key element of competition might include in its selection criteria that the web broker should already have letters of appointment from many of the larger issuers in that Marketplace. In return, the Marketplace might require carrier appointments or, if this is not palatable, help web brokers win letters of appointment from all issuers in the Marketplace. This may be easier to accomplish in competitive markets than those dominated by one

[40] Connect for Health Colorado. "Broker Appointments with Web Brokers." Memo. March 11, 2013. http://connectforhealthco.com/wpfb-file/20130311_broker-appointments_board-approved.pdf

or two resistant carriers.

3. A Marketplace that prioritizes scale in order to achieve economies and self-sufficiency might require that contracting web brokers enroll all or most of their new individual households, whether eligible for subsidies or not, through the Marketplace. Or it might exclude those market segments, such as small employers, where it competes with the private web entity. For example, private exchanges such as Towers Watson's OneExchange can reach employers' early retirees, seasonal workers, COBRA-eligibles, and part-time workers who are ineligible for group benefits. If total enrollment, including in the Small Business Health Options Program (SHOP), is important to a public Marketplace, it might contract with such private exchanges for this targeted enrollment from large employer clients, but carve out small employers, where the public and private exchanges compete with each other.
4. A Marketplace that prioritizes Medicaid enrollment as much as QHP enrollment and bridging the discontinuities of "churn," might insist that web brokers also establish relationships and referral patterns with navigators, in-person assisters, and/or certified application counselors to handle enrollees who are eligible for Medicaid or are transferring between the two coverage programs.

CRITERIA FOR SELECTING A MARKETPLACE STRATEGY

A Marketplace that wants web brokers to add as much value as possible would do well to consider what kind of enrollment it needs most, which web brokers can be most productive in the target segments, and how it can work jointly with some or all web brokers to achieve its objectives. Now that SBMs have substantial experience in outreach, can identify the most promising, hard-to-reach market segments based on initial enrollment results, and must carefully budget their own spend with an eye to sustainability, they should revise marketing priorities no matter what contracting strategy is adopted. Below is a starting list of plausible strategic objectives for public Marketplaces that may suggest various approaches to web brokers:

1. Learn from as many different web brokers as possible how to reach enrollees to attract as much enrollment of any kind as possible, and avoid any suspicion of favoritism. This objective suggests the value of casting a very wide net for web brokers.

2. Leverage APTCs, Cost-Sharing Reductions (CSRs), brand awareness, and a wide range of participating issuers to make the Marketplace the primary destination for all individual buyers, whether subsidized or not. This objective may be a reason for the Marketplace to require that participating brokers place most of their non-group health business through the Marketplace, and that web brokers that refuse to do so be excluded from representing the public Marketplace. (Issuers that would have to pay both the web broker and the Marketplace may oppose this direction.)

3. Target special outreach efforts to particular linguistic, professional, or demographic groups (e.g., Hispanics, Native Americans, entrepreneurs, solo professionals, etc.). This objective suggests the possibility of special partnership arrangements with selected web brokers—by, for example, matching the web broker's dollar outlays for targeted advertising and community events. "Partnering" can encompass diverse activities, ranging from co-branding promotional activities, to joint funding of advertising, to preference in referring qualified leads from a linguistic group to web brokers specially set up to handle that linguistic group, or preference in referring prospects to selected brokers who "produce" the most enrollees (overall or of a certain type).

4. Help bridge discontinuities and different rules between Medicaid and QHPs for the lower-income applicants who may turn out to be eligible for Medicaid, or a household split between the Children's Health Insurance Program (CHIP) for kids and QHPs for adults, or enrollees moving from Medicaid to a QHP. This objective suggests partnerships with brokers, web-based or otherwise, that have relationships with a state's Medicaid program, Medicaid MCOs, and/or navigators, and that are committed to assisting very low-income applicants. The Marketplace may have a strong interest in providing extra services tied to bridging the Medicaid and QHP worlds, and so may seek special relationships with such brokers, whether web-enabled or not.

5. Provide customers with a truly objective choice of issuers and equally robust access to all QHPs on the exchange. This objective suggests using as a criterion that the web broker have appointments from all the issuers or commit to equally promote those issuers that have not appointed the web broker as a broker of record by including them in its decision-support tools. For example, all web brokers could be required to show detailed description and price—attainable from the Marketplace, if not from the issuer—for all QHPs, with their websites ranking all QHPs on comparative metrics for price, network breadth, and quality.[41] Of course, direct enrollment by issuers is even more at odds with full choice of QHPs, so the SBM that permits direct enrollment by carriers may not be as focused on promoting broad choice through web brokers.

[41] This approach will depend on state laws governing appointments and may encounter objections from carriers over what they regard as proprietary information.

6. Minimize the Marketplace's cost and time for establishing and managing relationships with web brokers. Depending on the marginal cost of adding web brokers, this objective may suggest the open competition model or, if marginal costs are high, this objective may suggest limiting the number of web brokers with which the Marketplace contracts initially, and/or of winnowing down the number of participating web brokers over time, based on their productivity (for the Marketplace). Marketplaces may be especially interested in "piloting" relationships with a limited number of web brokers of diverse types to gain more experience before committing to all or specifying long-term selection criteria.

Various web brokers will have their particular objectives for working with Marketplaces. Some may simply wish to retain customers who now qualify for APTCs. They may also be looking to grow their penetration and volume substantially by offering new individual clients a special service (access to subsidies). Or, they may be competing for group clients by helping their COBRA-eligibles and part-time workers access subsidized coverage in the Marketplace. Again, the difference in capabilities and objectives among web brokers suggests the value in considering selective contracting; "raising the bar" may filter out those web brokers with only a minimal commitment to working with public Marketplaces, while generating more value for the selected web brokers willing to commit more resources.

IV. Bringing it All Together

The ACA has made it possible and desirable to greatly expand individual coverage, particularly among lower-income uninsured individuals. However, this is neither easy nor inexpensive to sustain. Web brokers promise the efficiencies of eCommerce in the difficult and expensive business of selling insurance to individual households. This potential is of increasing value to Marketplaces as they overcome the problems of start-up and turn their focus to self-sustainable outreach and enrollment. However, taking advantage of the potential value of web brokers in the enrollment process does require establishing efficient, customer-friendly electronic connections, and this has yet to be worked out in practice. Once it has been, there appears to be a substantial advantage to working with web brokers.

Beyond representing a source of "free" outreach and servicing, how do web brokers fit the sales strategy of Marketplaces? To answer this question, each Marketplace must prioritize its own enrollment objectives, and develop an understanding of the various capabilities and interests among the web brokers with which it might engage. Based on its own priorities—which may range from casting a wide net through multiple channels that are self-sustaining to spending what is needed to attract mostly lower-income uninsured among certain hard-to-reach segments—and the interests of various web brokers, each Marketplace should develop its own strategy for dealing with web brokers.

While these Marketplace strategies are characterized into two categories, a Marketplace's needs and web broker capabilities will probably evolve over time, and so should their strategies. For example, a Marketplace may initially want to learn from as many web brokers as possible or it may not have the resources to negotiate individual contracts. This Marketplace may wish to follow the federal open competition model. Over time, the same Marketplace may find a better return from selectively partnering only with those web brokers who make a major commitment to marketing the Marketplace.

Appendix A: Profiles of Five Leading Web Brokers

eHealth, Inc.: eHealthInsurance.com was founded in 1997 by Vip Patel and in 1998, became responsible for the first ever online sale of a health insurance policy. eHealth maintains partnerships with over 180 insurance companies, offers more than 10,000 health insurance products online, and boasts having enrolled over four million people in health insurance to date.[42] Of particular importance to Marketplaces that seek to attract and enroll young and healthy individuals, eHealth reports that more than half of its 20 million visitors are between 18 to 34 years old[43], as were 40 percent of the customers who submitted health insurance applications on the site inthe fourth quarter of 2014 (compared to, for example, only 28 percent of applicants at Healthcare.gov).[44]

Since enactment of the ACA, the company, and in particular its CEO, Gary Lauer, has been a vocal proponent of the FFM and SBMs forging partnerships with web brokers that would allow these web brokers to enroll subsidy-eligible individuals into QHPs.[45] On July 31, 2013, eHealth was one of a handful of web brokers to sign agreements with CMS to enroll subsidy-eligible individuals in QHPs in FFM states.[46,47] As of early 2014, the company had yet to launch a fully online enrollment process due to what it deemed as insufficient stability and usability of the federal platform, instead adopting a call center workaround process in which customers receive subsidy estimates and browse plans online but enrollment is finalized by phone.[48] eHealth has also actively pursued similar agreements with SBMs, most notably in California. In March 2014, news outlets reported that eHealth may have been selected to participate in a pilot program with the Maryland Marketplace to enroll subsidy-eligible QHPs offered on the state's Marketplace.[49]

Getinsured: Getinsured was founded in 2005 by Chini Krishnan and Shankar Srinivasan and launched its first comparison shopping tool for health care services and insurance products in 2006.[50] Headquartered in Mountain View, California, Getinsured's national private exchange supports over 110 carriers and 6,748 health plans.[51] In late February 2014, after signing an agreement with CMS in early August 2013 to serve as a web broker for the FFM, Getinsured was the first web broker to announce that it was successfully using the double redirect process to enroll subsidy-eligible individuals into QHPs via an entirely online process.[52] Getinsured has also contracted with several state Marketplaces that use the company's Getinsured exchange technology platform. For example, the Covered California site was partially built off of Getinsured's exchange software, and the company is serving as a cloud provider for New Mexico's and Mississippi's SHOP Marketplaces.[53] The company recently was tapped by Idaho's Marketplace, Your Health Idaho, to build the technology platform for the state.[54]

GoHealth: GoHealth has operated a "consumer health insurance exchange" since 2002 and in that time has helped more than 2 million consumers compare health insurance quotes and purchase individual coverage online, through its agent network, or directly through a major health insurance company. GoHealth boasts having built the first nationwide insurance quote engine software and notes that its technology has since been integrated with over 125 top insurance carriers and more than 20,000 brokers—mostly independent agents, but nearly 1,000 of whom are employed by GoHealth—are supported by its platform.[55] One of the early web brokers to sign an agreement with CMS, in late November 2013 GoHealth announced it was the first web broker to have activated

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[42] http://www.ehealthinsurance.com/about-ehealth/our-story

[43] Mangan, Dan. "eHealth CEO's Obamacare fix: Let us run HealthCare.gov." *CNBC*. October 30, 2013. http://www.cnbc.com/id/101153131

[44] eHealth Insurance Press Release. "18-to-34 Year Olds Generate 40% of Submitted Health Insurance Applications at eHealthInsurance.com in 4th Quarter of 2013." February 26, 2014. http://phx.corporate-ir.net/phoenix.zhtml?c=198312&p=irol-newsArticle&ID=1903714&highlight

[45] eHealth Investor Relations News Release. "Obamacare at Risk Without Full Embrace and Utilization of Private Sector Exchange Like eHealth, Says CEO Gary Lauer." October 30, 2013. http://news.ehealthinsurance.com/news/obamacare-at-risk-without-full-embrace-and-utilization-of-private-sector-exchanges-like-ehealth-says-ceo-gary-lauer

[46] eHealth Investor Relations News Release. "Federal Government Signs Web-Broker Agreement with eHealth." July 31, 2013. http://phx.corporate-ir.net/phoenix.zhtml?c=198312&p=irol-newsArticle&ID=1842800&highlight

[47] Whitney, Eric. "Obamacare Will Be Both Ally and Rival to eHealthInsurance." *Kaiser Health News*. September 17, 2013. http://www.kaiserhealthnews.org/stories/2013/september/17/ehealthinsurance.aspx

[48] Aigner-Treworgy, Adam. "Obamacare customers get alternative to Healthcare.gov." *CNN PoliticalTicker*. February 21, 2014. http://politicalticker.blogs.cnn.com/2014/02/21/obamacare-customers-get-alternative-to-healthcare-gov/

[49] Mangan, Dan. "Maryland Obamacare site eyes eHealth deal, Oregon next?" *CNBC.* March 6, 2014. http://www.cnbc.com/id/101472688

[50] https://www.getinsured.com/exchange/about.html

[51] Ibid.

[52] Getinsured Press Release. "Getinsured Announces Online Alternative to Healthcare.gov." February 19, 2014. http://www.marketwired.com/press-release/getinsured-announces-online-alternative-to-healthcaregov-1880378.htm

[53] Carr, David F. "Getinsured Wants to be Cloud Provider to State Exchanges." *Health Care Information Week*. September 30, 2013. http://www.informationweek.com/regulations/getinsured-wants-to-be-cloud-provider-to-state-exchanges/d/d-id/1111741

[54] Your Health Idaho Press Release. "Your Health Idaho Announces Selection of Technology Vendors." February 2014. http://www.yourhealthidaho.org/your-health-idaho-announces-selection-of-technology-vendors/

[55] http://exchange.gohealth.com/about-us/

their integration with the FFM thereby allowing customers to calculate subsidies and choose a plan online on the GoHealth Marketplace website before finalizing enrollment by phone with a GoHealth licensed advisor.[56] GoHealth reports that it began giving subsidy-eligible individuals the option to directly enroll using an unassisted online process near the close of the 2014 open enrollment period.

OneExchange: OneExchange was established following Towers Watson's acquisition in June 2012 of ExtendHealth, the largest private Medicare exchange in the United States working with private clients (such as Caterpillar and Ford Motors), as well as municipalities and state governments, to allow retirees to shop among health plans.[57] In an effort to expand capacity in the private exchange market, in November 2013 Towers Watson acquired Liazon Corporation, a leading company in the development of private exchanges for active employees.[58] Towers Watson signed a web broker agreement with CMS in August 2013. The company has stated it intends to use the agreement to integrate its technology platform with the federal eligibility system and help employers offer education and enrollment services to part-time and seasonal employees, retirees, and their dependents by supporting them as they select and evaluate ACA coverage options.[59]

Quotit: Quotit Corporation, part of the Word & Brown Companies, is an internet application service provider for the health insurance and employee benefits industry.[60] Quotit has established relationships with over 300 insurance carriers representing more than 40,000 plan designs in the health, life, dental, and vision insurance markets and its database of carriers and plans extends to 50 states and the District of Columbia.[61] Quotit's software enables independent brokers and retail consumers to generate insurance quotes, including comparative information on rates and benefits, online and in real time. The Quotit subscription-based WBE technology platform allows licensed, certified community-based brokers to access WBE technology, security, and efficiencies if they cannot make the investment on their own. Brokers who subscribe to the Quotit software service can use the technology platform to assist consumers in enrolling in QHPs and can also establish a broker-branded, consumer-facing portal where individuals can shop and enroll in a plan using an entirely online process. In September 2013, Quotit entered into a web broker agreement with CMS.[62] Under the agreement, Quotit has stated that it will provide compliant technology to independent, licensed agents to empower them in assisting consumers in enrolling in QHPs and receiving available tax credits.[63]

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[56] GoHealth Press Release. "Through GoHealth, America Can Now Complete Full Enrollment and Obtain Tax Credits in 2014 Health Insurance." November 23, 2013. http://www.gohealthinsurance.com/media-center/press-release/through-gohealth-america-can-now-complete-full-enrollment-and-obtain-tax-credits-in-2014-health-insurance/

[57] Jones, Kristen. "Towers Watson to buy Extend Health for $435mln." *Wall Street Journal MarketWatch.* May 14, 2012. http://www.marketwatch.com/story/towers-watson-to-buy-extend-health-for-435-mln-2012-05-14

[58] Towers Watson Press Release. "Towers Watson Acquires Liazon to Expand Private Benefit Exchange Offerings Through Multiple Channels." November 22, 2013. http://www.towerswatson.com/en-US/Press/2013/11/towers-watson-acquires-liazon-to-expand-private-benefit-exchange-offerings-through-multiple-channels

[59] Towers Watson Press Release. "Towers Watson Signs Agreement With Federal Government to Facilitate Public Exchange Enrollments." August 9, 2013. http://www.towerswatson.com/en-US/Press/2013/08/Towers-Watson-Signs-Agreement-With-Federal-Government-to-Facilitate-Public-Exchange-Enrollments

[60] http://www.quotit.com/about-corporatebio.asp

[61] Ibid.

[62] Quotit Press Release. "Quotit Awarded Web Broker Entity Agreement with Federal Government for Affordable Care Act Enrollments." September 5, 2013. http://www.quotit.com/news-detail.asp?id=115

[63] Ibid.

Appendix B: Use of Web Brokers as Vendors for Core Functions

Three examples illustrate the range of possibilities for web brokers serving as a core vendor:

- **Component of a broader IT system:** Accenture, as a leading system integrator, is the major IT vendor for the California Marketplace (Covered California), with Getinsured providing some of the front end technology for plan selection and enrollment.[64,65] eHealth provides similar technology support for the Washington state Marketplace (Washington Healthplanfinder), working with Deloitte, another leading system integrator.
- **Full service solution:** Getinsured has expanded its business model to include a full service solution for states choosing to outsource their SHOP Marketplaces. Mississippi and New Mexico have contracted with Getinsured to operate their SHOP Marketplaces.[66] New Mexico subsequently awarded their individual Marketplace contract to Getinsured over several more-established system integrators. Idaho recently followed suit, selecting Getinsured as their lead IT vendor, with support from Accenture.[67]
- **Filling a niche:** eHealth has shifted away from being a technology vendor, but as part of its efforts to build support for the market model among SBMs, eHealth has offered to help states with dysfunctional web sites find temporary solutions.

[64] Accenture Press Release. “Accenture Selected to Implement California Health Insurance Exchange.” June 27, 2012. http://newsroom.accenture.com/news/accenture-chosen-to-implement-california-health-insurance-exchange.htm

[65] Carr, David F. “Getinsured Wants to be Cloud Provider to State Exchanges.” Health Care Information Week. September 30, 2013. http://www.informationweek.com/regulations/getinsured-wants-to-be-cloud-provider-to-state-exchanges/d/d-id/1111741

[66] Carr, 2013.

[67] Your Health Idaho Press Release. “Your Health Idaho Announces Selection of Technology Vendors.” February 2014. http://www.yourhealthidaho.org/your-health-idaho-announces-selection-of-technology-vendors/