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September 2014 | Issue Brief

Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces

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Introduction

In the first year of full implementation, enrollment in the Affordable Care Act's (ACA) health insurance exchanges largely fulfilled expectations, following a rocky beginning. Now, attention is turning to 2015, and one of the first tangible tests of how well the ACA is working is how much premiums rise in the new health insurance marketplaces (also known as exchanges). This tells us how much coverage will cost enrollees and the federal government, which contributes towards premiums through tax credits for low- and middle-income people, and could influence public perception of the law as well.

This brief presents an initial analysis of premium changes for marketplace plans for individuals in 15 states plus the District of Columbia, where we were able to find comprehensive data on rates or rate filings for all insurers. It follows a similar approach to our September 2013 analysis of 2014 marketplace premiums.

Approach

We look at the change in the premium for the lowest-cost options available in each state. Since premiums vary substantially across geographic rating areas even within a state – there are 500 rating areas nationwide – we examine premium changes in the rating area that includes a major city in each state.

For each area, we look at premium changes for the lowest-cost bronze plan and the two lowest-cost silver plans. Bronze plans have an actuarial value of 60%, meaning they cover 60% of enrollees' health expenses on average for a typical population. They typically have the highest deductibles and copays and the lowest premiums (except for catastrophic plans, which are only available to young people and those who have no other affordable options). Silver plans have an actuarial value of 70%. Most marketplace enrollees (65%) have chosen silver plans this year, while 20% have chosen bronze, according a report from the federal Department of Health and Human Services.

The lowest-cost bronze and silver options are particularly noteworthy for a number of reasons:

- The lowest-cost bronze plan in an area is generally the least expensive option someone without employer-based coverage can choose to satisfy the ACA's requirement to have insurance or pay a penalty.
- The second-lowest-cost silver plan is the benchmark for tax credits provided to people buying in the marketplaces who have incomes of 100% to 400% of the federal poverty level ($23,850 to $95,400 for a family of four). Through these tax credits, eligible individuals pay 2% to 9.5% of income on a sliding

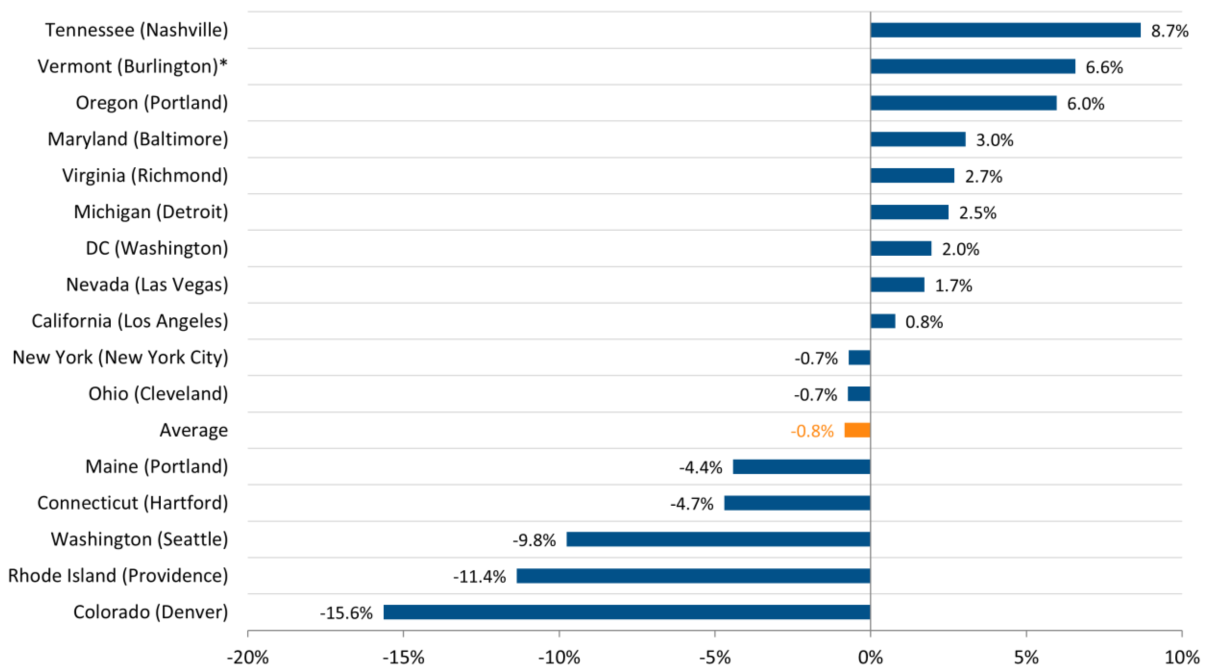
scale to enroll in the second-lowest-cost silver plan and the federal government covers the difference. Tax credits are portable, meaning they can also be used in other marketplace plans. 85% of people signing up for a plan through the marketplaces are receiving tax credits.

- People with incomes up to 250% of the federal poverty level are also eligible for cost-sharing subsidies that lower their deductibles and copays, but only if they enroll in a silver plan. Therefore, the lowest-cost silver plan is the option with the lowest premium that gives lower-income individuals access to cost-sharing subsidies.
- People buying coverage in marketplaces this year gravitated towards lower premium plans.

In preparation for open enrollment for coverage in 2015 – which begins November 15 – insurers have filed rates with state insurance departments. States vary in whether and when they release those filings. Our analysis is based on the 15 states plus the District of Columbia where we were able to find comprehensive filings or other information about the rates of the lowest cost plans. Other states have released summary information, but not sufficient detail to identify the lowest-cost bronze and silver plans. In some cases, rates are still under review by insurance departments and may change prior to the start of open enrollment.

Analysis of Marketplace Premium Changes and Insurer Participation

As shown in the chart below, across the 15 cities we examined, the premium for the second-lowest-cost silver plan in the marketplaces – before taking any income-related tax credits into account – is decreasing by an average of -0.8%.



Source: Kaiser Family Foundation analysis of insurance company rate filings to state regulators for 2015 Marketplace premiums.
Notes: Vermont rates do not reflect modifications from the state's review (2015 rates were lowered on September 2, but final filings are not yet available). Filings in CA, CO, CT, MD, MI, OH, OR, RI, TN, and most of WA are final; other state's filings are still preliminary and may be subject to change. Premium changes are at the rating area level (groups of neighboring counties) and some plans may not be available in all cities or counties within the rating area.

Taking income-related tax credits into account shows how the subsidies have the effect of cushioning eligible individuals from premium increases. In nearly all of the 15 cities – even those that had a large increase before tax credits – a single 40-year old with an income of $30,000 per year would pay 0.8% less in 2015 than in 2014 to enroll in the second-lowest-cost silver plan (Table 1). (Note that the 0.8% decrease here is unrelated to the 0.8% average decrease in unsubsidized premiums; it is merely coincidental that the two numbers are similar).

Table 1: Monthly Silver Premiums for a 40 Year Old Non-Smoker Making $30,000 / Year

State	Rating Area (Major City)	2nd Lowest Silver **Before** Tax Credit			2nd Lowest Silver **After** Tax Credit		
		2014	2015	% Change from 2014	2014	2015	% Change from 2014
California	15 (Los Angeles)	$255	**$257**	0.8%	$209	**$208**	-0.8%
Colorado	3 (Denver)	$250	**$211**	-15.6%	$209	**$208**	-0.8%
Connecticut	2 (Hartford)	$328	**$313**	-4.7%	$209	**$208**	-0.8%
DC	1 (Washington)	$242	**$247**	2.0%	$209	**$208**	-0.8%
Maine	1 (Portland)	$295	**$282**	-4.4%	$209	**$208**	-0.8%
Maryland	1 (Baltimore)	$228	**$235**	3.0%	$209	**$208**	-0.8%
Michigan	1 (Detroit)	$224	**$230**	2.5%	$209	**$208**	-0.8%
Nevada	1 (Las Vegas)	$238	**$242**	1.7%	$209	**$208**	-0.8%
New York	4 (New York City)	$365	**$363**	-0.7%	$209	**$208**	-0.8%
Ohio	11 (Cleveland)	$249	**$247**	-0.7%	$209	**$208**	-0.8%
Oregon	1 (Portland)	$201	**$213**	6.0%	$201	**$208**	3.3%
Rhode Island	1 (Providence)	$293	**$260**	-11.4%	$209	**$208**	-0.8%
Tennessee	4 (Nashville)	$188	**$205**	8.7%	$188	**$205**	8.7%
Vermont*	1 (Burlington)	$413	**$440**	6.6%	$209	**$208**	-0.8%
Virginia	7 (Richmond)	$253	**$260**	2.7%	$209	**$208**	-0.8%
Washington	1 (Seattle)	$281	**$254**	-9.8%	$209	**$208**	-0.8%
Average % change from 2014				**-0.8%**			**0.1%**

SOURCE: Kaiser Family Foundation NOTES: Vermont rates do not reflect modifications from the state's review. Filings in CA, CO, CT, MD, MI, OH, OR, RI, TN, and most of WA are final; other state's filings are still preliminary and may change. Premium changes are at the rating area level.

This is true even in cities where the premium for the second-lowest-cost silver plan increased, due to how the tax credit is calculated. An individual who is eligible for a tax credit and enrolls in the second-lowest-cost silver plan pays a defined percentage of their income, ranging from 2% to 9.5% in 2014 (depending on income as a percentage of the poverty level). Those percentages increase slightly in 2015, to 2.01% to 9.56% (see Table 3). However, poverty levels have also increased, meaning that someone with the same dollar income as in 2014 will be at a lower percentage of poverty in 2015 and will therefore pay a smaller share of their income towards the premium.

The net result of changes to tax credit calculation and poverty guidelines is that a subsidy-eligible individual whose income does not change will generally pay a little less to enroll in the second-lowest cost silver plan in 2015 than they did if they enrolled in the second-lowest cost plan in 2014. There are exceptions to this pattern– e.g., in Portland, Oregon and Nashville, Tennessee – where the premiums in 2014 were so low that a 40 year-old making $30,000 was not eligible for a tax credit. (An interactive calculator from the Kaiser Family Foundation provides 2014 premium and tax credit estimates for people in different circumstances by zip code.)

As shown in Table 2, the lowest-cost bronze option across the marketplaces is increasing by an average of 3.3%, ranging from a low of -15.7% in Hartford, Connecticut to a high of 13.3% in Baltimore, Maryland.

Table 2: Monthly Bronze Premiums for a 40 Year Old Non-Smoker Making $30,000 / Year

State	Rating Area (Major City)	Lowest Bronze **Before** Tax Credit			Lowest Bronze **After** Tax Credit		
		2014	2015	% Change from 2014	2014	2015	% Change from 2014
California	15 (Los Angeles)	$188	**$210**	11.7%	$142	**$161**	12.9%
Colorado	3 (Denver)	$186	**$167**	-10.0%	$145	**$164**	13.0%
Connecticut	2 (Hartford)	$232	**$196**	-15.7%	$113	**$91**	-19.9%
DC	1 (Washington)	$166	**$180**	8.2%	$133	**$141**	5.4%
Maine	1 (Portland)	$235	**$213**	-9.1%	$149	**$139**	-6.7%
Maryland	1 (Baltimore)	$146	**$165**	13.3%	$127	**$138**	8.4%
Michigan	1 (Detroit)	$168	**$181**	7.8%	$153	**$159**	3.8%
Nevada	1 (Las Vegas)	$183	**$206**	12.5%	$154	**$171**	11.1%
New York	4 (New York City)	$307	**$319**	3.8%	$151	**$164**	8.3%
Ohio	11 (Cleveland)	$185	**$196**	5.5%	$146	**$156**	7.1%
Oregon	1 (Portland)	$165	**$175**	6.1%	$165	**$170**	2.8%
Rhode Island	1 (Providence)	$210	**$201**	-4.4%	$126	**$149**	17.8%
Tennessee	4 (Nashville)	$139	**$153**	10.1%	$139	**$153**	10.1%
Vermont*	1 (Burlington)	$336	**$358**	6.4%	$132	**$125**	-5.5%
Virginia	7 (Richmond)	$170	**$173**	1.7%	$126	**$121**	-4.5%
Washington	1 (Seattle)	$186	**$194**	4.3%	$114	**$148**	29.7%
Average % change from 2014				**3.3%**			**5.9%**

SOURCE: Kaiser Family Foundation NOTES: Vermont rates do not reflect modifications from the state's review. Filings in CA, CO, CT, MD, MI, OH, OR, RI, TN, and most of WA are final; other state's filings are still preliminary and may change. Premium changes are at the rating area level.

While the tax credits may cushion the effect of premium increases, subsidized enrollees could still face large premium increases if they are enrolled in a plan that is no longer a low-cost plan and they fail to switch during open enrollment. In 12 of the 16 cities, at least one of the insurers that had offered one of the two lowest-cost silver plans in 2014 is no longer offering a low-cost silver plan in 2015.

For example, in Denver, Colorado, Humana offered the second-lowest-cost silver plan in 2014 at a premium of $250 per month for a single 40 year-old. Humana is actually lowering its premium to $249 per month for 2015, but another insurer (Colorado Health Insurance) is undercutting it and offering a plan for $211 per month. A 40 year-old making $30,000 pays $209 per month for the Humana plan in 2014 and the federal government covers the rest through a tax credit. If she switched to the Colorado Health Insurance Plan, she would pay $208 under the tax credit schedule. However, if she stayed in the Humana plan, she would have to pay $208 plus the premium difference between the Humana and Colorado, Health Insurance Cooperative plans, or a total of $246 (an increase of 17.7%). Even though her plan's premium has decreased, what she pays is higher because the premium for the second-lowest-cost plan has gone down. To be held harmless, she has to be willing to switch plans. Similar situations arise in the 12 cities where a low-cost insurer is raising its premiums faster than other carriers, or where a new insurer is entering the market with a lower premium.

Table 3: Premium Subsidies, by Income in 2014 and 2015				
Income % Poverty	Income Range in Dollars for a single individual in 48 states + DC		Premium Cap max % of income for 2nd lowest silver plan	
	2014 benefit year	2015 benefit year	2014	2015
Under 100%	Less than $11,490	Less than $11,670	No Cap	No Cap
100% - 133%	$11,490 - $15,281	$11,670 - $15,521	2%	2.01%
133% - 150%	$15,282 – $17,234	$15,522 – $17,507	3% - 4%	3.02% - 4.02%
150% - 200%	$17,235 - $22,979	$17,508 - $23,345	4% - 6.3%	4.02% - 6.34%
200% - 250%	$22,980 – $28,724	$23,346 – $29,184	6.3% - 8.05%	6.34% - 8.1%
250% - 300%	$28,725 – $34,469	$29,185 – $35,024	8.05% - 9.5%	8.1% - 9.56%
300% - 400%	$34,470 – $45,959	$35,025 – $46,708	9.5%	9.56%
Over 400%	More than $45,960	More than $46,708	No Cap	No Cap
NOTES: Alaska and Hawaii have different poverty guidelines.				

Insurer participation has increased or remained stable in all of the cities but Portland, Oregon, where the number dropped from 10 to 8. On average, 6 insurers (grouped by parent company) will offer coverage in these cities in 2015, compared to an average of 5 in 2014. The number of insurers participating in the marketplaces ranges from 2 in Burlington, Vermont to 11 in New York City, New York; and Detroit, Michigan.

Full results for all 16 cities are presented in the Appendix.

Discussion

Premium changes for 2015 will vary substantially across areas and across insurers within a given region. There are a variety of factors that may influence variations in premium changes, including:

- **Accuracy in forecasting the health needs of enrollees.** Insurers faced a great deal of uncertainty in setting premiums for 2014. While they know more about the demographics of enrollees, they still only have incomplete information about the health care use of those who have purchased plans, particularly those who were previously uninsured.
- **The composition of the risk pool.** Insurers generally expected enrollees would be disproportionately sicker, but how their actual experience (to the extent they can measure it at this

point) matches up with their expectations will vary. Insurers also vary in how they expect the risk pool to change as enrollment ramps up in the second year; second-year enrollees are likely to be healthier on average than those who enrolled in the first year. States where enrollment was strong in the first year may tend to have risk pools that are more balanced. Conversely, states that permitted non-compliant plans to continue under a federal transition policy may have less balanced risk pools since healthier-than-average individuals likely stayed in those non-compliant plans.

- **Competitive dynamics.** Now that insurers have been able to see what their competitors are charging and how market share is distributed, they are making strategic adjustments in how they price relative to other carriers.

In general, premium changes for 2015 are quite modest when looking at the low-cost insurers in the marketplaces, which is where enrollment is concentrated. On average, the premium for the second-lowest-cost plan is decreasing in the major cities in states with comprehensive public data available. This points to strong competitive forces in the marketplaces, though still a wide range of experiences, with premium changes for the second-lowest-cost silver plan ranging from a low of -15.6% to a high of 8.7%. Since tax credits are keyed to the second-lowest-cost silver plans, this is good news from a budgetary perspective. Our analysis is based on less than one-third of states, and the overall picture could change as more premium data becomes available.

While competitive forces are often driving premiums down, they are also resulting in significant volatility. People who were price-conscious and chose low premium plans this year – which was the norm – may find that their plan is no longer a low-cost option. Income-related tax credits protect low- and middle-income enrollees from substantial premium increases, but enrollees may need to switch plans to benefit from that protection.

These findings highlight the importance of shopping around for marketplaces enrollees during the next open enrollment period, which runs from November 15, 2014 to February 15, 2015. While the marketplaces will auto-renew enrollees in their current plans and generally continue their estimated tax credits at the same level as in 2014, many enrollees may be able to lower their premiums substantially by switching plans. Effective communication to enrollees and consumer assistance will be key to helping people understand their options. Even so, people may be "sticky" in their behavior and reluctant to switch plans, particularly if it requires changing doctors. How willing people are to switch plans will not only affect what they pay next year, but also how strong competitive forces are in the future and how much pressure insurers feel to keep premium increases modest.

Methods

Data were collected from health insurer rate filing submitted to state regulators. These submissions are publicly available for the states we analyzed and can be found on the state websites listed in the Appendix. Most rate information is available in the form of a SERFF filing (System for Electronic Rate and Form Filing) that includes a base rate and other factors that build up to an individual rate. In states where filings were unavailable, we gathered data from tables released by state insurance departments. Filings in DC, ME, NV, NY, VA, and some in WA are still preliminary and rates for VT do not reflect recent reductions. All premiums in this analysis are at the rating area level, and some plans may not be available in all cities or counties within the rating area. Rating areas are typically groups of neighboring counties, so a major city in the area was chosen for identification purposes.

APPENDIX

California
(Los Angeles)

2015 Marketplace Overview*

California has 10 insurers participating in its Marketplace (statewide), down from 11 in 2014

- 6 insurers offering coverage in rating area 15 (Los Angeles), same as in 2014
- 7 silver plans offered in rating area 15 (Los Angeles), down from 8 in 2014
- 9 bronze plans offered in rating area 15 (Los Angeles), same as in 2014

Marketplace Premiums Before Tax Credit
California Rating Area 15 (Los Angeles)

	2014			2015		
	Insurer	**Plan**	**40 yo /month**	**Insurer**	**Plan**	**40 yo /month**
Lowest **Bronze**	L.A. Care	004 Std Coins.	$188	Kaiser	KP HMO HSA	$210 (+11.7%)
Lowest **Silver**	Health Net	008 Std Copay	$224	Health Net	Health Net HMO	$230 (+2.7%)
2nd Lowest **Silver**	Blue Shield of CA	003 Std Coins.	$255	Anthem BC	Anthem HMO	$257 (+0.8%)

Marketplace Premiums After Tax Credit
California Rating Area 15 (Los Angeles)

	Single Adult 25 years old $25,000/year		Family of Four 40 year olds & two kids $60,000/year		Retired Couple 60 year olds $30,000/year	
	2014	**2015**	**2014**	**2015**	**2014**	**2015**
2nd Lowest Silver Before Tax Credit	$200	$202	$763	$769	$1,083	$1,092
Tax Credit Amount	$56	$59	$354	$362	$933	$944
2nd Lowest **Silver After Tax Credit**	**$144**	**$143** (-1.1%)	**$409**	**$407** (-0.5%)	**$150**	**$148** (-1.5%)
Lowest Bronze Before Tax Credit	$148	$165	$563	$629	$798	$892
Lowest **Bronze After Tax Credit**	**$91**	**$106** (+15.5%)	**$209**	**$267** (+27.6%)	**$0**	**$0** (N/A)

*NOTES: Premiums are at rating area level and insurers are grouped by parent company. Contra Costa Health Plan left the CA Marketplace in 2015. SOURCE: http://www.coveredca.com/PDFs/CC-health-plans-booklet-2015.pdf

Colorado
(Denver)

2015 Marketplace Overview*

Colorado has 10 insurers participating in its Marketplace (statewide), same as in 2014

10 insurers offering coverage in rating area 3 (Denver), same as in 2014

63 silver plans offered in rating area 3 (Denver), up from 40 in 2014

52 bronze plans offered in rating area 3 (Denver), up from 33 in 2014

Marketplace Premiums Before Tax Credit
Colorado Rating Area 3 (Denver)

	2014			2015		
	Insurer	Plan	40yo/month	Insurer	Plan	40yo/month
Lowest **Bronze**	Kaiser	5000/30%/HSA	$186	Colorado Hlth Ins Coop.	Bear HSA EPO	$167 (-10.0%)
Lowest **Silver**	Kaiser	1750/25%/HSA	$245	Colorado Hlth Ins Coop.	Bison Flex EPO	$207 (-15.7%)
2nd Lowest **Silver**	Humana	Connect 4600/6300	$250	Colorado Hlth Ins Coop.	Bison HSA EPO	$211 (-15.6%)

Marketplace Premiums After Tax Credit
Colorado Rating Area 3 (Denver)

	Single Adult 25 years old $25,000/year		Family of Four 40 year olds & two kids $60,000/year		Retired Couple 60 year olds $30,000/year	
	2014	2015	2014	2015	2014	2015
2nd Lowest Silver Before Tax Credit	$196	$166	$748	$631	$1,062	$896
Tax Credit Amount	$52	$23	$339	$224	$912	$748
2nd Lowest **Silver After Tax Credit**	**$144**	**$143** (-1.1%)	**$409**	**$407** (-0.5%)	**$150**	**$148** (-1.5%)
Lowest Bronze Before Tax Credit	$146	$132	$557	$501	$790	$711
Lowest **Bronze After Tax Credit**	**$94**	**$108** (+15.5%)	**$218**	**$277** (+27.2%)	**$0**	**$0** (N/A)

*NOTES: Premiums are at rating area level and insurers are grouped by parent company. Rocky Mountain Hospital & Medical Service, Inc. (Anthem) entered the Colorado Marketplace in 2015; it is under the Wellpoint Grp parent, which also offered coverage in 2014 through HMO Colorado.
SOURCE: http://healthinsurance.colorado.gov/pages/filingsSearch.aspx#

Connecticut
(Hartford)

2015 Marketplace Overview*

Connecticut has 4 insurers participating in its Marketplace (statewide), up from 3 in 2014

- 4 insurers offering coverage in rating area 2 (Hartford), up from 3 in 2014
- 17 silver plans offered in rating area 2 (Hartford), up from 4 in 2014
- 15 bronze plans offered in rating area 2 (Hartford), up from 8 in 2014

Marketplace Premiums Before Tax Credit
Connecticut Rating Area 2 (Hartford)

	2014			2015		
	Insurer	**Plan**	**40 yo /month**	**Insurer**	**Plan**	**40 yo /month**
Lowest **Bronze**	Anthem BCBS	86545CT123000 1 Bronze	$232	ConnectiCare	Bronze Select HSA	$196 (-15.7%)
Lowest **Silver**	ConnectiCare	Standard Silver	$316	Anthem BCBS	PPO Multi State Plan	$297 (-6.1%)
2nd Lowest **Silver**	Anthem BCBS	86545CT133000 1 Silver	$328	HealthyCT	CO-OPtions Enhanced Silver 1, MSP	$313 (-4.7%)

Marketplace Premiums After Tax Credit
Connecticut Rating Area 2 (Hartford)

	Single Adult 25 years old $25,000/year		**Family of Four 40 year olds & two kids $60,000/year**		**Retired Couple 60 year olds $30,000/year**	
	2014	**2015**	**2014**	**2015**	**2014**	**2015**
2nd Lowest Silver Before Tax Credit	$258	$246	$982	$936	$1,393	$1,328
Tax Credit Amount	$114	$103	$573	$528	$1,243	$1,180
2nd Lowest **Silver After Tax Credit**	**$144**	**$143** (-1.1%)	**$409**	**$407** (-0.5%)	**$150**	**$148** (-1.5%)
Lowest Bronze Before Tax Credit	$182	$154	$695	$586	$985	$831
Lowest **Bronze After Tax Credit**	**$69**	**$51** (-26.2%)	**$122**	**$57** (-53.1%)	**$0**	**$0** (N/A)

*NOTES: Premiums are at rating area level and insurers are grouped by parent company. UnitedHealth entered the Connecticut Marketplace in 2015.
SOURCE: http://www.catalog.state.ct.us/cid/portalApps/RateFilingDefault.aspx

DC
(Washington)

2015 Marketplace Overview*

DC has 3 insurers participating in its Marketplace (statewide), same as in 2014

- 3 insurers offering coverage in rating area 1 (Washington), same as in 2014
- 9 silver plans offered in rating area 1 (Washington), down from 10 in 2014
- 9 bronze plans offered in rating area 1 (Washington), down from 11 in 2014

Marketplace Premiums Before Tax Credit

DC Rating Area 1 (Washington)

	2014			2015		
	Insurer	**Plan**	**40 yo /month**	**Insurer**	**Plan**	**40 yo /month**
Lowest **Bronze**	CareFirst BlueChoice	HSA Bronze $6000	$166	CareFirst BlueChoice	HSA Bronze $6000	$180 (+8.2%)
Lowest **Silver**	CareFirst BlueChoice	HSA Silver $1300	$238	Kaiser	KP DC Silver	$242 (+1.5%)
2nd Lowest **Silver**	CareFirst BlueChoice	Silver $2000	$242	CareFirst BlueChoice	HSA Silver $1300 Base	$247 (+2.0%)

Marketplace Premiums After Tax Credit

DC Rating Area 1 (Washington)

	Single Adult 25 years old $25,000/year		Family of Four 40 year olds & two kids $60,000/year		Retired Couple 60 year olds $30,000/year	
	2014	**2015**	**2014**	**2015**	**2014**	**2015**
2nd Lowest Silver Before Tax Credit	$180	$184	$809	$824	$1,042	$1,062
Tax Credit Amount	$36	$41	$399	$417	$892	$915
2nd Lowest **Silver After Tax Credit**	**$144**	**$143** (-1.1%)	**$409**	**$407** (-0.5%)	**$150**	**$148** (-1.5%)
Lowest Bronze Before Tax Credit	$124	$134	$555	$600	$715	$773
Lowest **Bronze After Tax Credit**	**$87**	**$92** (+5.8%)	**$155**	**$183** (+17.8%)	**$0**	**$0** (N/A)

*NOTES: Premiums are at rating area level and insurers are grouped by parent company. DC has a single rating area that applies to the entire district. Filings are under review and subject to change.

SOURCE: http://disb.dc.gov/page/health-insurance-rate-review-district

Maine
(Portland)

2015 Marketplace Overview*
Maine has 3 insurers participating in its Marketplace (statewide), up from 2 in 2014 3 insurers offering coverage in rating area 1 (Portland), up from 2 in 2014 12 silver plans offered in rating area 1 (Portland), up from 6 in 2014 9 bronze plans offered in rating area 1 (Portland), up from 7 in 2014

Marketplace Premiums Before Tax Credit
Maine Rating Area 1 (Portland)

	2014			2015		
	Insurer	**Plan**	**40 yo /month**	**Insurer**	**Plan**	**40 yo /month**
Lowest **Bronze**	Anthem	Bronze Guided Access - caaa	$235	Anthem	Bronze X HMO 0% for HSA	$213 (-9.1%)
Lowest **Silver**	Maine Community Health Options	Community Value	$284	Anthem	Silver X HMO 3500/20%	$269 (-5.2%)
2nd Lowest **Silver**	Maine Community Health Options	Community Choice	$295	Maine Community Health Options	Community Value	$282 (-4.4%)

Marketplace Premiums After Tax Credit
Maine Rating Area 1 (Portland)

	Single Adult 25 years old $25,000/year		Family of Four 40 year olds & two kids $60,000/year		Retired Couple 60 year olds $30,000/year	
	2014	**2015**	**2014**	**2015**	**2014**	**2015**
2nd Lowest Silver Before Tax Credit	$232	$221	$883	$844	$1,253	$1,197
Tax Credit Amount	$88	$79	$474	$437	$1,103	$1,050
2nd Lowest **Silver After Tax Credit**	**$144**	**$143** (-1.1%)	**$409**	**$407** (-0.5%)	**$150**	**$148** (-1.5%)
Lowest Bronze Before Tax Credit	$184	$168	$702	$639	$997	$906
Lowest **Bronze After Tax Credit**	**$97**	**$89** (-8.4%)	**$229**	**$202** (-11.8%)	**$0**	**$0** (N/A)

*NOTES: Premiums are at rating area level and insurers are grouped by parent company. Harvard Pilgrim entered the Maine Marketplace in 2015. Filings are under review and subject to change.
SOURCE: http://www.maine.gov/pfr/insurance/PPACA/HFAI.htm#

Maryland
(Baltimore)

2015 Marketplace Overview*

Maryland has 5 insurers participating in its Marketplace (statewide), up from 4 in 2014

- 5 insurers offering coverage in rating area 1 (Baltimore), up from 4 in 2014
- 18 silver plans offered in rating area 1 (Baltimore), up from 16 in 2014
- 17 bronze plans offered in rating area 1 (Baltimore), up from 11 in 2014

Marketplace Premiums Before Tax Credit

Maryland Rating Area 1 (Baltimore)

	2014			2015		
	Insurer	Plan	40 yo /month	Insurer	Plan	40 yo /month
Lowest **Bronze**	BlueChoice	HSA Bronze $6000	$146	BlueChoice	HSA Bronze $6000	$165 (+13.3%)
Lowest **Silver**	BlueChoice	Plus Silver $2500	$214	Kaiser	1750/25%/ HSA/ Dental/ Ped Dental	$226 (+5.8%)
2nd Lowest **Silver**	BlueChoice	HSA Silver $1300	$228	Evergreen	HMO Silver HSA 1700	$235 (+3.0%)

Marketplace Premiums After Tax Credit

Maryland Rating Area 1 (Baltimore)

	Single Adult 25 years old $25,000/year		Family of Four 40 year olds & two kids $60,000/year		Retired Couple 60 year olds $30,000/year	
	2014	2015	2014	2015	2014	2015
2nd Lowest Silver Before Tax Credit	$179	$185	$683	$703	$968	$998
Tax Credit Amount	$35	$42	$273	$296	$818	$850
2nd Lowest **Silver After Tax Credit**	**$144**	**$143** (-1.1%)	**$409**	**$407** (-0.5%)	**$150**	**$148** (-1.5%)
Lowest Bronze Before Tax Credit	$115	$130	$437	$495	$620	$702
Lowest **Bronze After Tax Credit**	**$80**	**$88** (+10.3%)	**$164**	**$199** (+21.4%)	**$0**	**$0** (N/A)

*NOTES: Premiums are at rating area level and insurers are grouped by parent company. Cigna and UnitedHealthcare entered in 2015. UnitedHealthcare and All Savers are grouped under the parent company UnitedHealth Grp. CareFirst, BlueChoice, and Group Hospitalization are grouped as CareFirst.

SOURCE: http://www.healthrates.mdinsurance.state.md.us/

Michigan
(Detroit)

2015 Marketplace Overview*

Michigan has 13 insurers participating in its Marketplace (statewide), up from 9 in 2014

11 insurers offering coverage in rating area 1 (Detroit), up from 8 in 2014

57 silver plans offered in rating area 1 (Detroit), up from 20 in 2014

45 bronze plans offered in rating area 1 (Detroit), up from 12 in 2014

Marketplace Premiums Before Tax Credit

Michigan Rating Area 1 (Detroit)

	2014			2015		
	Insurer	**Plan**	**40 yo /month**	**Insurer**	**Plan**	**40 yo /month**
Lowest **Bronze**	Humana	Connect Bronze 6300/ 6300	$168	Blue Care Network	Metro Detroit HMO Bronze	$181 (+7.8%)
Lowest **Silver**	Humana	Connect Silver 4600/6300	$190	Humana	4600/Detroit HMOx	$222 (+16.4%)
2nd Lowest **Silver**	Total Health Care	Totally You	$224	UnitedHealth	SilverCompass	$230 (+2.5%)

Marketplace Premiums After Tax Credit

Michigan Rating Area 1 (Detroit)

	Single Adult 25 years old $25,000/year		Family of Four 40 year olds & two kids $60,000/year		Retired Couple 60 year olds $30,000/year	
	2014	2015	2014	2015	2014	2015
2nd Lowest Silver Before Tax Credit	$176	$180	$671	$687	$951	$975
Tax Credit Amount	$32	$38	$261	$280	$801	$827
2nd Lowest **Silver After Tax Credit**	**$144**	**$143** (-1.1%)	**$409**	**$407** (-0.5%)	**$150**	**$148** (-1.5%)
Lowest Bronze Before Tax Credit	$132	$142	$503	$542	$713	$769
Lowest **Bronze After Tax Credit**	**$100**	**$104** (+4.3%)	**$242**	**$262** (+8.4%)	**$0**	**$0** (N/A)

*NOTES: Premiums are at rating area level and insurers are grouped by parent company. Time, UnitedHealth, Harbor Health, and Physicians Health Plan entered the Michigan Marketplace in 2015. The Consumers Mutual filing did not have sufficient detail to calculate premiums, but was counted in the number of insurers above.

SOURCE: http://www7.dleg.state.mi.us/SerffPortal/

Nevada
(Las Vegas)

2015 Marketplace Overview*

Nevada has 5 insurers participating in its Marketplace (statewide), up from 4 in 2014

- 4 insurers offering coverage in rating area 1 (Las Vegas), up from 3 in 2014
- 18 silver plans offered in rating area 1 (Las Vegas), up from 16 in 2014
- 13 bronze plans offered in rating area 1 (Las Vegas), up from 11 in 2014

Marketplace Premiums Before Tax Credit
Nevada Rating Area 1 (Las Vegas)

	2014			2015		
	Insurer	**Plan**	**40 yo /month**	**Insurer**	**Plan**	**40 yo /month**
Lowest **Bronze**	Nevada Health CO-OP	Southern Simple	$183	Nevada Health CO-OP	Southern Simple	$206 (+12.5%)
Lowest **Silver**	Health Plan of Nevada	MyHPN Silver 4	$237	Health Plan of Nevada	MyHPN Silver 5	$241 (+1.9%)
2nd Lowest **Silver**	Health Plan of Nevada	MyHPN Silver 3	$238	Health Plan of Nevada	MyHPN Silver 3	$242 (+1.7%)

Marketplace Premiums After Tax Credit
Nevada Rating Area 1 (Las Vegas)

	Single Adult 25 years old $25,000/year		Family of Four 40 year olds & two kids $60,000/year		Retired Couple 60 year olds $30,000/year	
	2014	**2015**	**2014**	**2015**	**2014**	**2015**
2nd Lowest Silver Before Tax Credit	$187	$190	$713	$725	$1,011	$1,028
Tax Credit Amount	$43	$48	$303	$317	$861	$881
2nd Lowest **Silver After Tax Credit**	**$144**	**$143** (-1.1%)	**$409**	**$407** (-0.5%)	**$150**	**$148** (-1.5%)
Lowest Bronze Before Tax Credit	$144	$162	$548	$616	$777	$874
Lowest **Bronze After Tax Credit**	**$101**	**$114** (+13.0%)	**$245**	**$299** (+22.0%)	**$0**	**$0** (N/A)

*NOTES: Premiums are at rating area level and insurers are grouped by parent company. Assurant Inc. (Time) entered in 2015 and Nevada Health CO-OP expanded offerings by adding a Multi-State plan. Filings are under review and subject to change.
SOURCE: http://doi.nv.gov/Health-Rate-Review/Review-Process/

New York
(New York City)

2015 Marketplace Overview*

New York has 15 insurers participating in its Marketplace (statewide), down from 16 in 2014

11 insurers offering coverage in rating area 4 (New York City), same as in 2014

55 silver plans offered in rating area 4 (New York City), up from 44 in 2014

45 bronze plans offered in rating area 4 (New York City)

Marketplace Premiums Before Tax Credit

New York Rating Area 4 (New York City)

	2014			2015		
	Insurer	Plan	40 yo /month	Insurer	Plan	40 yo /month
Lowest **Bronze**	Health Republic	Bronze Standard	$307	Health Republic	Active Living Basic (Bronze)	$319 (+3.8%)
Lowest **Silver**	MetroPlus Health Plan	NYHX Indiv St Silver with Ped Dental	$359	Health Republic	Active Living Plus (Silver)	$363 (+1.0%)
2nd Lowest **Silver**	Health Republic	NYHX Indiv NS Silver 2	$365	Health Republic	Active Living Plus (Silver) Age 29 Option	$363 (-0.7%)

Marketplace Premiums After Tax Credit

New York Rating Area 4 (New York City)

	Single Adult 25 years old $25,000/year		Family of Four 40 year olds & two kids $60,000/year		Retired Couple 60 year olds $30,000/year	
	2014	2015	2014	2015	2014	2015
2nd Lowest Silver Before Tax Credit	$287	$285	$1,094	$1,086	$1,551	$1,540
Tax Credit Amount	$143	$142	$684	$678	$1,402	$1,393
2nd Lowest **Silver After Tax Credit**	**$144**	**$143** (-1.1%)	**$409**	**$407** (-0.5%)	**$150**	**$148** (-1.5%)
Lowest Bronze Before Tax Credit	$241	$250	$919	$954	$1,304	$1,354
Lowest **Bronze After Tax Credit**	**$98**	**$108** (+9.7%)	**$235**	**$276** (+17.1%)	**$0**	**$0** (N/A)

*NOTES: Premiums are at rating area level and insurers are grouped by parent company. New York's Marketplace has 15 parent companies participating in 2015, down from 16 in 2014 (Universal Amer. Fin. Grp exited). Filings are under review and subject to change.

SOURCE: https://myportal.dfs.ny.gov/web/prior-approval/rate-applications-by-company

Ohio
(Cleveland)

2015 Marketplace Overview*

Ohio has 14 insurers participating in its Marketplace (statewide), up from 11 in 2014

- 9 insurers offering coverage in rating area 11 (Cleveland), up from 8 in 2014
- 62 silver plans offered in rating area 11 (Cleveland), up from 15 in 2014
- 43 bronze plans offered in rating area 11 (Cleveland), up from 17 in 2014

Marketplace Premiums Before Tax Credit
Ohio Rating Area 11 (Cleveland)

	2014			2015		
	Insurer	Plan	40 yo /month	Insurer	Plan	40 yo /month
Lowest **Bronze**	Kaiser	5000/30%/HSA	$185	Buckeye	Ambetter Essential Care 1	$196 (+5.5%)
Lowest **Silver**	Kaiser	1750/25%/HSA	$246	Buckeye	Ambetter Balanced Care 2	$242 (-1.6%)
2nd Lowest **Silver**	CareSource	Just4me Healthcare w/ Heart	$249	Buckeye	Ambetter Balanced Care 2 + Vision	$247 (-0.7%)

Marketplace Premiums After Tax Credit
Ohio Rating Area 11 (Cleveland)

	Single Adult 25 years old $25,000/year		Family of Four 40 year olds & two kids $60,000/year		Retired Couple 60 year olds $30,000/year	
	2014	2015	2014	2015	2014	2015
2nd Lowest Silver Before Tax Credit	$195	$194	$744	$739	$1,056	$1,048
Tax Credit Amount	$51	$51	$335	$331	$906	$900
2nd Lowest **Silver After Tax Credit**	**$144**	**$143** (-1.1%)	**$409**	**$407** (-0.5%)	**$150**	**$148** (-1.5%)
Lowest Bronze Before Tax Credit	$146	$154	$555	$585	$787	$830
Lowest **Bronze After Tax Credit**	**$94**	**$102** (+8.3%)	**$220**	**$254** (+15.3%)	**$0**	**$0** (N/A)

*NOTES: Premiums are at rating area level and insurers are grouped by parent company. Kaiser Permanente exited and four insurers entered in 2015 (Assurant, Coordinated Health, Premier, UnitedHealth).
SOURCE: http://www.insurance.ohio.gov/Company/Pages/RecordsRequest.aspx

Oregon
(Portland)

2015 Marketplace Overview*

Oregon has 10 insurers participating in its Marketplace (statewide), down from 11 in 2014

8 insurers offering coverage in rating area 1 (Portland), down from 10 in 2014

40 silver plans offered in rating area 1 (Portland), up from 32 in 2014

31 bronze plans offered in rating area 1 (Portland), up from 27 in 2014

Marketplace Premiums Before Tax Credit

Oregon Rating Area 1 (Portland)

	2014			2015		
	Insurer	Plan	40 yo /month	Insurer	Plan	40 yo /month
Lowest **Bronze**	Moda	Be Savvy	$165	LifeWise	Exclusive Provider Bronze 5250 HSA	$175 (+6.1%)
Lowest **Silver**	Moda	Be Aligned – Rose City	$194	Providence	Connect 2000 Silver	$212 (+9.4%)
2nd Lowest **Silver**	Moda	Be Aligned	$201	Moda	Be Aligned - Rose City	$213 (+6.0%)

Marketplace Premiums After Tax Credit

Oregon Rating Area 1 (Portland)

	Single Adult 25 years old $25,000/year		Family of Four 40 year olds & two kids $60,000/year		Retired Couple 60 year olds $30,000/year	
	2014	2015	2014	2015	2014	2015
2nd Lowest Silver Before Tax Credit	$158	$167	$602	$638	$854	$905
Tax Credit Amount	$14	$25	$192	$230	$704	$757
2nd Lowest **Silver After Tax Credit**	**$144**	**$143** (-1.1%)	**$409**	**$407** (-0.5%)	**$150**	**$148** (-1.5%)
Lowest Bronze Before Tax Credit	$130	$137	$494	$524	$701	$743
Lowest **Bronze After Tax Credit**	**$116**	**$113** (-2.7%)	**$302**	**$294** (-2.7%)	**$0**	**$0** (N/A)

*NOTES: Premiums are at rating area level and insurers are grouped by parent company. HealthNet exited the Oregon Marketplace in 2015.

SOURCE: http://www.oregonhealthrates.org/

Rhode Island
(Providence)

2015 Marketplace Overview*

Rhode Island has 3 insurers participating in its Marketplace (statewide), up from 2 in 2014

- 3 insurers offering coverage in rating area 1 (Providence), up from 2 in 2014
- 10 silver plans offered in rating area 1 (Providence), up from 4 in 2014
- 9 bronze plans offered in rating area 1 (Providence), up from 3 in 2014

Marketplace Premiums Before Tax Credit
Rhode Island Rating Area 1 (Providence)

	2014			2015		
	Insurer	**Plan**	**40 yo /month**	**Insurer**	**Plan**	**40 yo /month**
Lowest **Bronze**	BCBS of RI	BlueSolutions for HSA Direct 5000	$210	Neighborhood	Secure	$201 (-4.4%)
Lowest **Silver**	BCBS of RI	VantageBlue SelectRI Direct 3000	$272	Neighborhood	Community	$244 (-10.2%)
2nd Lowest **Silver**	BCBS of RI	VantageBlue Direct 3000	$293	Neighborhood	Value	$260 (-11.4%)

Marketplace Premiums After Tax Credit
Rhode Island Rating Area 1 (Providence)

	Single Adult 25 years old $25,000/year		Family of Four 40 year olds & two kids $60,000/year		Retired Couple 60 year olds $30,000/year	
	2014	**2015**	**2014**	**2015**	**2014**	**2015**
2nd Lowest Silver Before Tax Credit	$230	$204	$877	$778	$1,244	$1,103
Tax Credit Amount	$86	$62	$468	$370	$1,095	$955
2nd Lowest **Silver After Tax Credit**	**$144**	**$143** (-1.1%)	**$409**	**$407** (-0.5%)	**$150**	**$148** (-1.5%)
Lowest Bronze Before Tax Credit	$165	$158	$629	$601	$892	$853
Lowest **Bronze After Tax Credit**	**$79**	**$96** (+22.1%)	**$161**	**$231** (+43.5%)	**$0**	**$0** (N/A)

*NOTES: Premiums are at rating area level and insurers are grouped by parent company. Rhode Island has a single rating area that applies to the entire state. UnitedHealth entered the Rhode Island Marketplace in 2015.
SOURCE: http://www.ohic.ri.gov/Fed_HFAI_SERFF%202011.php#

Tennessee
(Nashville)

2015 Marketplace Overview*

Tennessee has 5 insurers participating in its Marketplace (statewide), up from 4 in 2014

- 5 insurers offering coverage in rating area 4 (Nashville), up from 4 in 2014
- 50 silver plans offered in rating area 4 (Nashville), up from 30 in 2014
- 28 bronze plans offered in rating area 4 (Nashville), up from 14 in 2014

Marketplace Premiums Before Tax Credit

Tennessee Rating Area 4 (Nashville)

	2014			2015		
	Insurer	Plan	40 yo /month	Insurer	Plan	40 yo /month
Lowest **Bronze**	BCBS of TN	BlueCross Bronze B02E	$139	BCBS of TN	BlueCross Bronze B07E	$153 (+10.1%)
Lowest **Silver**	BCBS of TN	BlueCross Silver S04E	$181	Community Health Alliance	Select Nash Silver 15	$195 (+8.1%)
2nd Lowest **Silver**	BCBS of TN	BlueCross Silver S09E	$188	Community Health Alliance	Select Nash Silver 17	$205 (+8.7%)

Marketplace Premiums After Tax Credit

Tennessee Rating Area 4 (Nashville)

	Single Adult 25 years old $25,000/year		Family of Four 40 year olds & two kids $60,000/year		Retired Couple 60 year olds $30,000/year	
	2014	2015	2014	2015	2014	2015
2nd Lowest Silver Before Tax Credit	$148	$161	$564	$612	$800	$869
Tax Credit Amount	$4	$18	$154	$205	$650	$721
2nd Lowest **Silver After Tax Credit**	**$144**	**$143** (-1.1%)	**$409**	**$407** (-0.5%)	**$150**	**$148** (-1.5%)
Lowest Bronze Before Tax Credit	$109	$120	$415	$458	$589	$649
Lowest **Bronze After Tax Credit**	**$105**	**$102** (-3.2%)	**$261**	**$252** (-3.4%)	**$0**	**$0** (N/A)

*NOTES: Premiums are at rating area level and insurers are grouped by parent company. Assurant (Time) entered the Tennessee Marketplace in 2015.

SOURCE: http://www.tn.gov/insurance/consumerRes.shtml

Vermont
(Burlington)

2015 Marketplace Overview*

Vermont has 2 insurers participating in its Marketplace (statewide), same as in 2014

2 insurers offering coverage in rating area 1 (Burlington), same as in 2014

6 silver plans offered in rating area 1 (Burlington), same as in 2014

6 bronze plans offered in rating area 1 (Burlington), same as in 2014

Marketplace Premiums Before Tax Credit

Vermont Rating Area 1 (Burlington)

	2014			2015		
	Insurer	**Plan**	**40 yo /month**	**Insurer**	**Plan**	**40 yo /month**
Lowest **Bronze**	MVP	Standard Non-High Ded	$336	BCBS of VT	Blue Rewards Non-Std Bronze CDHP	$358 (+6.4%)
Lowest **Silver**	BCBS of VT	Non-Standard Silver	$395	BCBS of VT	Blue Rewards Non-Std Silver	$430 (+9.0%)
2nd Lowest **Silver**	BCBS of VT	Std Silver High Ded.	$413	BCBS of VT	EPO Std Silver CDHP Plan 2	$440 (+6.6%)

Marketplace Premiums After Tax Credit

Vermont Rating Area 1 (Burlington)

	Single Adult 25 years old $25,000/year		Family of Four 40 year olds & two kids $60,000/year		Retired Couple 60 year olds $30,000/year	
	2014	**2015**	**2014**	**2015**	**2014**	**2015**
2nd Lowest Silver Before Tax Credit	$324	$346	$1,236	$1,318	$1,754	$1,869
Tax Credit Amount	$180	$203	$827	$910	$1,604	$1,722
2nd Lowest **Silver After Tax Credit**	**$144**	**$143** (-1.1%)	**$409**	**$407** (-0.5%)	**$150**	**$148** (-1.5%)
Lowest Bronze Before Tax Credit	$264	$281	$1,006	$1,070	$1,427	$1,518
Lowest **Bronze After Tax Credit**	**$84**	**$78** (-7.1%)	**$179**	**$160** (-10.6%)	**$0**	**$0** (N/A)

*NOTES: The premiums above do not reflect modifications from the state's rate review, as final filings have not yet been posted. The state lowered BCBS's rate average increase from 9.8% to 7.7% and MVP's from 15.3% to 10.9%. Premiums are at rating area level and insurers are grouped by parent company. Vermont has a single rating area that applies to the entire state.

SOURCE: http://ratereview.vermont.gov/view_filings

Virginia
(Richmond)

2015 Marketplace Overview*

Virginia has 6 insurers participating in its Marketplace (statewide), up from 5 in 2014

5 insurers offering coverage in rating area 7 (Richmond), up from 4 in 2014

20 silver plans offered in rating area 7 (Richmond), up from 16 in 2014

25 bronze plans offered in rating area 7 (Richmond), up from 24 in 2014

Marketplace Premiums Before Tax Credit

Virginia Rating Area 7 (Richmond)

	2014			2015		
	Insurer	**Plan**	**40 yo /month**	**Insurer**	**Plan**	**40 yo /month**
Lowest **Bronze**	Coventry Health Care	Deductible Only HMO Carelink	$170	Coventry	HSA-Eligible Bon Secours	$173 (+1.7%)
Lowest **Silver**	Coventry	$10 Copay POS Carelink Bon Secours	$230	Coventry	$10 Copay Bon Secours	$241 (+5.2%)
2nd Lowest **Silver**	HealthKeepers	Anthem DirectAccess cbau	$253	Coventry	$5 Copay 2750 Bon Secours	$260 (+2.7%)

Marketplace Premiums After Tax Credit

Virginia Rating Area 7 (Richmond)

	Single Adult 25 years old $25,000/year		Family of Four 40 year olds & two kids $60,000/year		Retired Couple 60 year olds $30,000/year	
	2014	**2015**	**2014**	**2015**	**2014**	**2015**
2nd Lowest Silver Before Tax Credit	$199	$204	$758	$778	$1,075	$1,104
Tax Credit Amount	$55	$62	$348	$371	$925	$956
2nd Lowest **Silver After Tax Credit**	**$144**	**$143** (-1.1%)	**$409**	**$407** (-0.5%)	**$150**	**$148** (-1.5%)
Lowest Bronze Before Tax Credit	$134	$136	$509	$518	$722	$734
Lowest **Bronze After Tax Credit**	**$79**	**$74** (-5.9%)	**$161**	**$147** (-8.7%)	**$0**	**$0** (N/A)

*NOTES: Premiums are at rating area level and insurers are grouped by parent company. Piedmont Community Healthcare Inc. entered the Virginia Marketplace in 2015. Filings are under review and subject to change.

SOURCE: http://www.scc.virginia.gov/boi/SERFFInquiry/LHAccessPage.aspx

Washington
(Seattle)

2015 Marketplace Overview*

Washington has 11 insurers participating in its Marketplace (statewide), up from 7 in 2014

8 insurers offering coverage in rating area 1 (Seattle), up from 6 in 2014

28 silver plans offered in rating area 1 (Seattle), up from 14 in 2014

26 bronze plans offered in rating area 1 (Seattle), up from 13 in 2014

Marketplace Premiums Before Tax Credit

Washington Rating Area 1 (Seattle)

	2014			2015		
	Insurer	Plan	40 yo /month	Insurer	Plan	40 yo /month
Lowest **Bronze**	Coordinated Care	Ambetter Bronze	$186	Coordinated Care	Ambetter Essential Care	$194 (+4.3%)
Lowest **Silver**	Coordinated Care	Ambetter Silver	$245	Coordinated Care	Ambetter Balanced Care	$235 (-4.2%)
2nd Lowest **Silver**	Group Health Cooperative	Core Silver	$281	BridgeSpan	HSA UW Medicine	$254 (-9.8%)

Marketplace Premiums After Tax Credit

Washington Rating Area 1 (Seattle)

	Single Adult 25 years old $25,000/year		Family of Four 40 year olds & two kids $60,000/year		Retired Couple 60 year olds $30,000/year	
	2014	2015	2014	2015	2014	2015
2nd Lowest Silver Before Tax Credit	$221	$199	$841	$759	$1,193	$1,077
Tax Credit Amount	$77	$57	$432	$352	$1,044	$929
2nd Lowest **Silver After Tax Credit**	**$144**	**$143** (-1.1%)	**$409**	**$407** (-0.5%)	**$150**	**$148** (-1.5%)
Lowest Bronze Before Tax Credit	$146	$152	$556	$580	$789	$823
Lowest **Bronze After Tax Credit**	**$69**	**$96** (+38.1%)	**$124**	**$229** (+83.8%)	**$0**	**$0** (N/A)

*NOTES: Premiums are at rating area level and insurers are grouped by parent company. Columbia, UnitedHealth, Health Alliance, and Moda entered the Washington Marketplace in 2015. Some filings are under review and subject to change. SOURCE: http://www.insurance.wa.gov/your-insurance/health-insurance/health-rates/

Early 2014 Stakeholder Experiences with Small Business Marketplaces (SHOP) in State-Based Marketplace States

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Introduction

While 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 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 and sometimes only in the hundreds. But while the SHOP marketplaces have emerged sluggishly, the various reasons for this are largely consistent across the states, and many of them lend themselves to reversal or improvement. Significant challenges remain, yet 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 an array of case study interviews with state based marketplace states. Researchers at the Urban Institute, Georgetown University's Health Policy Institute, Institute for Health Policy Solutions, and Econometrica conducted a project to assess stakeholder experiences with implementation of the ACA in its first year. In the study, researchers conducted interviews with health plans, health care provider organizations, small-business representatives, brokers and agents, consumer advocates, and Marketplace assisters in the 16 states and the District of Columbia running their own marketplace, as well as 5 Partnership states.[1] Respondents were asked a broad set of questions relating to the design, launch, and operation of the marketplaces. In each case, respondents were promised confidentiality. The general consistency of information provided across these different states suggests a significant degree of generalizability.

The Early SHOP Experience and Challenges Faced

Across the study states there was a widespread perception 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 states studied.

The 1-year delay in the introduction of the federal on-line 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. As such, a significant marketing/sales effort is required to engage employers, but such an effort has yet to materialize to a significant degree. A clear, concise description of the SHOP and the value added it brings to the existing small group market seems not to have been elucidated or communicated. But developing an accurate, convincing description of the value added of SHOP has been challenging due to 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, with isolated exceptions, largely irrelevant. 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 (FTEs) and with an average wage of $25,000 per year or less. At larger sizes and/or higher average wage levels, the credit phases down, disappearing for employers of 25 and/or an average wage of $50,000 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. As a consequence of the narrow targeting of the credit and the phase-out schedule, small numbers of employers are eligible for sizable credits, and this is particularly true in high cost of living areas where wages are higher.

A source in Illinois (a Partnership state), for example, noted that almost no small employers that offer or want to offer 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 like they had to engage an accountant to explore their eligibility, the cost of which sometimes exceeded the value of the credit. Sources in California noted that the two-year time limit dissuaded some eligible small employers from taking advantage of the credit and beginning to offer, since they knew they would not be able to continue to offer once the two years had gone by.

Sources in Connecticut and Massachusetts noted that the lack of an online calculator for the small business tax credit made it difficult for brokers to show the financial advantage of marketplace coverage to their clients. In Vermont, some interviewed noted that the tax credits were downplayed in training, as they were considered cumbersome to calculate and very narrowly applicable.

Off-SHOP Plan Options

The coverage options available to small employers outside of SHOP for the 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 related to the continuation of non-grandfathered non-ACA compliant small group and non-group insurance plans, some insurers were already encouraging their 2013 customers to renew their existing plans early, prior to 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 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. While 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, and in some cases the information technology (IT) problems were sufficiently serious that they all but prohibited enrollment. In Hawaii, for example, lags of three months between application and enrollment were noted. Multiple sources noted that small employers were much faster to abandon an on-line enrollment process when they ran into problems, than individual purchasers seemed to be, a phenomenon that was noted particularly frequently by sources in California. Major IT problems in Maryland and Oregon created tremendous barriers for SHOP enrollment, no online enrollment was available, and SHOP plans could only be obtained via brokers and without employee choice. Major SHOP website glitches were reported in Kentucky, Vermont, and California as well.

In some sub-state areas, no plans provided coverage for providers outside of the plan's designated network, and in some areas in California and Connecticut, the lack of broad preferred provider organization (PPO) networks were noted as significantly lowering interest in the SHOP. Multiple informants saw these types of circumstances, where they occurred, as particularly unattractive to small employer groups, especially those who had provided broader coverage in the past. Some sources in Minnesota feared that the slow start for SHOP there would discourage some of the carriers currently participating not to do so in the future.

Future Competitive Challenges Facing SHOPs

In several states, sources reported potential competition for the SHOP coming from private insurance exchanges. While 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 choice of plans only among those sold 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 they are not thought to have achieved substantial market share at this point.

In some states, such as Colorado and New Mexico, informants were unaware of any new private exchanges, but in other states, like Minnesota, New York, and Rhode Island, the advent of private exchanges is seen as a threat to the viability of the SHOP. Sources in California noted that California Choice is a longstanding private exchange that offers employee choice and has strong agent ties and a proven performance record. The Connecticut Business and Industry Association (CBIA) offers similar services through a longstanding purchasing pool, which is better known in the state and considered to be well run.

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).[2] The issues associated with these employer coverage options have been discussed in depth elsewhere.[3] 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 prior to 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 has been the case in the past. In Oregon, many of the small employer associations that offered association health plan (AHP) coverage prior to the ACA are now claiming status as bona fide employer groups under ERISA.[4] Under federal law, an AHP 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 large employer groups under ERISA were not reportedly widespread at this point, although 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, yet 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.[5] In contrast, 79.0 percent of employers in firms of 1,000 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. While the employee choice model may eventually encourage larger numbers of small employers to explore the 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 made it clear early on that they were concerned 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 (some examples of the number of carriers participating in the first year among our study states include: 6 in Colorado, 3 in Illinois, 13 in Maryland, 3 in Minnesota, 3 in New Mexico, 9 in New York, 8 in Oregon, and 3 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 as they believe it will be more cost efficient given the significant time it could take to assist employees in selecting a plan (Colorado offers SHOP participating employers 3 options, including employer choice of one plan

(no employee choice), employee choice of any plan within a single actuarial value tier (bronze, silver, gold, platinum), or employee choice of a single plan in any actuarial value tier). Sources in Kentucky noted that, while choice is good in theory, it is complex to administer, especially when website glitches occur. 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, something that is not yet a reality in most states. In Vermont, employers see employee choice as ultimately an opportunity to accommodate employees in different circumstances, although for now, continuity often trumped choice.

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 metal level or any plan offered by one carrier at different metal levels. Employees will likely choose varying plans, and as a result, 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 towards healthcare, come tax season, they may end up with more taxable income than expected.

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] While this was believed to be a major setback for the SHOP, delaying employee choice likely helped the federal government focus on the non-group marketplace, repairing IT problems, and maximizing enrollment. Small employers who did purchase coverage through the SHOP in any of the 34 federally facilitated marketplaces (FFMs, with this count including the Partnership 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] Fourteen states have decided to implement employee choice through the FFM-SHOP in 2015, avoiding further delay.[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 as well as 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, which they consistently reported as much greater than the time to sell outside products. As a result, even brokers certified to sell coverage in 2014 generally stated that they did little 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." Sources in many states, including Hawaii, California, Kentucky, and Nevada reported that agents directed enrollment through carriers instead of through the SHOP. In Nevada, reports were that the brokers were skeptical of SHOP at first, then became more supportive, but then were ultimately discouraged by the technical problems with it.

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. Since this incorrect information was also reflected in questions on the certification test, instructors had to teach false information in order that the group would pass the test, hopefully correcting the group after the fact. In Colorado, the broker training session was held before the website was functional, leaving many feeling like the training was impractical, as they were unable to learn how to interact with the marketplace system. In Minnesota, two of the true/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 SHOP and so 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 the fact 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. As a result, 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, leading to some being uncompensated for work completed. 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 in addition to 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.

Impact on the Small Business Environment

Due to the slow start of the SHOP, it has had very little impact on the small business environment thus 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.

For example, 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 due to the availability of subsidized coverage for their dependents. One source expressed concern with regards to employers that drop coverage and add a health coverage stipend to their employees' wages as it may adversely affect the employee, as the employee 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.

Considerations for the Future

Sources had a number of suggestions that could lead to more successful SHOP experiences in the future. The highest priority item for many was well-functioning SHOP websites with improved online experiences. Other website related suggestions included the development of a

"quick proposal" tool that would allow employers to assess costs without inputting individual employee data. Such a tool could be used directly by small employers or by their brokers. As noted previously, a small business tax credit calculator available online that employers and brokers could use to compute even rough estimates of eligibility and potential credits would constitute a significant advance. Many brokers voiced their desire for online tools that would allow them to monitor their book of SHOP business (sign-ups, payment information, etc.), with features and functionalities that they are accustomed to having through their direct dealings with insurers.

Education and marketing is another high priority area for future improvements. Stakeholders were unified in feeling the need for a clear, concise, and convincing explanation of the added value of SHOP to the traditional small group insurance market. Such an explanation would be applicable to SHOP marketplaces nationwide, but could be tailored to specific circumstances in certain state or local markets as well. It could then be incorporated into a well-organized, aggressive education and marketing effort targeted to small employers and the brokers selling in the small group market.

There was also broad agreement that ongoing SHOP training of brokers, agents, and other enrollment assisters was needed, and that training materials in many areas needed additional attention and improvements. Many also believed that the marketplaces should work hard to improve relationships with brokers and agents, more clearly acknowledging the central role that they must play if SHOPs are to be successful. Plus, dedicated hotlines to SHOP knowledgeable marketplace staff for the brokers and agents could go far in increasing interest in selling the SHOP products.

Regulatory options are also available to help strengthen the SHOP marketplaces as attractive coverage options and prevent the small group insurance market reforms from being undermined. First, the federal government or state governments could prohibit the sale of reinsurance to small employers or require high minimum attachment points for private

reinsurance plans. Doing so would eliminate or greatly reduce the threat of self-insurance drawing the healthier groups out of the SHOP and off-SHOP commercial small group insurance pool. At a minimum, states and the federal government monitoring the sales of reinsurance to small firms and the nature of these policies would allow earlier detection of substantial market shifts that could threaten the stability of the fully insured small group insurance markets. In addition, the federal government could narrowly define the characteristics of a bona fide association of employers under ERISA, making it less likely that coverage through these entities could draw enrollment and healthier individuals out of the nongroup and small group markets and thereby threaten their long term stability.

More than one source urged marketplace staff to recognize that many small employers that currently do not offer insurance coverage to their workers will not begin to offer under almost any circumstance, but that fact provides an important opportunity. The nongroup portion of the marketplaces could reach out to and partner with small, non-offering employers as an approach to pull more young adult workers into coverage.

Conclusion

There is no doubt that the ACA SHOP marketplaces have a long way to go in order to become successful. However, their current status is due in significant degree to the focus of resources and attention in the first year paid to the nongroup marketplaces. This approach can be altered as the nongroup marketplaces continue to increase in enrollment and stability. In order 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 SHOP is particularly critical, and is an effort that can be taken jointly by the state based marketplaces and the federally managed ones. Administrative simplification, employee choice, and market transparency 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 vis-à-vis 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, for the individuals upon whom they have traditionally relied to sell them insurance coverage and other business services.

Endnotes

[1] This analysis focuses almost exclusively on state based marketplace states since on-line SHOPs were not yet implemented in 2014 for the Partnership and fully federally administered marketplaces.

[2] An association health plan (AHP) 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 with regard to deciding which applicants are and are not to be classified as bona fide association health plans under ERISA.

[3] See: Kevin Lucia, Christine Monahan and Sabrina Corlette, Factors Affecting Self-Funding by Small Employers: Views from the Market, Washington, DC: The Urban Institute, 2013, http://www.urban.org/UploadedPDF/412799-Factors-Affecting-Self-FundingbySmall-Employers.pdf; Matthew Buettgens and Linda J. Blumberg, Small Firm Self-Insurance Under the Affordable Care Act, The Commonwealth Fund, November 2012, http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2012/nov/1647_buettgens_small_firm_self_insurance_under_aca_ib.pdf; and Kevin Lucia, Sabrina Corlette, and Sandy Ahn, "Federal and State Policy Towards Association Health Plans In Oregon Could Extend Risk Segmentation In The Small Group Market," forthcoming.

[4] Kevin Lucia, Sabrina Corlette, and Sandy Ahn, "Federal and State Policy Towards Association Health Plans In Oregon Could Extend Risk Segmentation In The Small Group Market," forthcoming.

[5] Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey*, "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," 2012, Accessed November 7, 2013. http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2012/tia2d.pdf

[6] Robert Pear, "Small Firms' Offer of Plan Choices Under Health Law Delayed," *New York Times*, April 1, 2013, accessed November 7, 2013, http://www.nytimes.com/2013/04/02/us/politics/option-for-small-business-health-plan-delayed.html

[7] The Center for Consumer Information & Insurance Oversight, Small Business Health Options Program (SHOP), 2014, http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/2015-Transition-to-Employee-Choice-.html

[8] The 14 FFM states that will implement employee choice in 2015: Arkansas, Florida, Georgia, Indiana, Iowa, Missouri, Nebraska, North Dakota, Ohio, Tennessee, Texas, Virginia, Wisconsin, and Wyoming.

Early Implementation of the Affordable Care Act: Cross-State Analysis of Stakeholder Views and Recommendations

Provider Networks and Provider-Insurer Relationships

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Introduction

State and federal officials operating the new health insurance marketplaces met numerous challenges during the initial roll out in late 2013 and early 2014. While most were focused on operational readiness and consumer outreach and enrollment, they also had to address early concerns about the adequacy of the provider networks in marketplace plans. Many officials and stakeholders were surprised by widespread changes in the networks of commercial health plans. Early anecdotal reports garnered attention from local and national media outlets.[1]

Researchers at the Urban Institute, Georgetown University's Health Policy Institute, Institute for Health Policy Solutions, and Econometrica conducted a project to assess stakeholder experiences with implementation of the Affordable Care Act (ACA) in its first year. In the study, researchers conducted interviews with health plans, health care provider organizations, small-business representatives, brokers and agents, consumer advocates, and marketplace assisters in the 16 states and the District of Columbia running their own marketplace, as well as 5 Partnership states.[2] Respondents were asked a broad set of questions relating to the design, launch, and operation of the marketplaces, including questions about the availability of network plan information and the adequacy of marketplace plan networks. In each case, respondents were promised confidentiality.

This paper provides an overview of stakeholders' responses relating to marketplace plan networks. These include insurers' reports about network design strategies, provider and consumer concerns, likely challenges ahead, and recommendations from respondents and the research team.

Overview

Insurers in 10 of the 17 state-based marketplaces studied reported making changes to their networks in preparation for 2014. Among the 7 states in which network changes were not reported, two – Maryland and Rhode Island – reported expected changes with 2015 plans. In general, insurers reported that they made changes to their marketplace plans (also known as

Qualified Health Plans (QHPs)) networks in order to reduce their provider costs and thus offer more competitive prices on the marketplaces. There was a general consensus among insurer respondents that consumers shopping on the marketplaces would be price sensitive.
At the same time plans were offering narrower networks than some consumers had previously been used to; many consumer and provider respondents complained about insufficient and inadequate information about plan networks. These complaints encompassed two main shortcomings of the QHP shopping experience: (1) that consumers had difficulty determining the nature of a plan network, i.e., whether it was broad or narrow, and (2) that the required provider directories were either not always easily accessible or, when they were, proved inaccurate or out-of-date.

Cross-Cutting Findings

Changing Networks

Of the 17 state-based marketplace states we studied, 10 reported changes to provider networks for their 2014 QHPs (Table 1). Of the seven states not reporting any changes to plan networks, two – Maryland and Rhode Island – reported that they expected participating insurers to offer narrower networks in 2015.

Table 1. States Experiencing Network Changes for QHPs

State	2014 Network Change?	State	2014 Network Change?
California	Yes	Minnesota	Yes
Colorado	Yes	Nevada	Yes
Connecticut	Yes	New Mexico	Yes
District of Columbia	No	New York	Yes
Hawaii	No	Oregon	Yes
Idaho	No	Rhode Island	No*
Kentucky	Yes	Washington	Yes
Maryland	No*	Vermont	No
Massachusetts	No		

*Maryland and Rhode Island stakeholder reported that insurers would likely offer narrower networks with their 2015 plans.

Insurers took different approaches in different markets. These network design strategies included: moving from offering Preferred Provider Organization (PPO) products to only Health Maintenance Organization (HMO) products for their QHPs, moving to tiered networks, moving to a "gatekeeper" model, excluding some higher-cost providers from networks, asking existing network providers to accept lower rates, and providing no out-of-network coverage (Table 2). Insurers in two states – Massachusetts and Rhode Island – reported that state officials were encouraging them to narrow their networks in order to achieve more affordable premiums for marketplace plans.

Table 2. Network Design Strategies: Key Terms Defined

Strategy	Description
Preferred Provider Organization (PPO)	Health care services are provided by a network of contracted providers who agree to provide services at no or lower cost-sharing. Consumers can go out of network, but have to pay higher cost-sharing amounts.
Health Maintenance Organization (HMO)	Consumers receive health care services from providers that the HMO employs or contracts with to provide services. An HMO product generally does not cover services that a consumer receives outside of the HMO.
Tiered networks	Consumers face lower cost-sharing when they obtain care from an inner tier of preferred providers and higher cost-sharing for care obtained from another tier of less-preferred (but still in-network) providers. Such networks can have two, three, even four cost-sharing tiers.
Gatekeeper	Consumers may obtain care from specialist providers only after receiving a referral from their primary care provider (PCP).

Insurers reported pursuing a narrow network strategy more in the nongroup than the group market, and they did so both inside and outside the marketplace. By far the most cited goal was to reduce per-unit costs in order to offer a lower premium to non-group consumers, who are believed to be more price sensitive than traditional group and non-group consumers. Few insurers reported using quality metrics or provider performance to re-design their networks –

the top motivation for excluding a provider was price. However, one insurer in Oregon did report that they are interested in adopting the medical home model of care delivery and they believe it can be more easily accomplished with a smaller, “tightly managed” network.

Insurers did not universally narrow their networks, even in states that reported significant network changes. Insurers in California, Colorado, Maryland, Minnesota, and Rhode Island reported that they adopted or maintained a broad network strategy. And insurers in two states – Kentucky and Vermont – believed they gained a competitive advantage over other insurers by offering a cross-border network for consumers who live and work in different states.

Consumer Concerns

Consumer advocate stakeholders and consumer assistance providers reported numerous concerns about both the availability of network information on the marketplaces and the adequacy of QHP provider networks. We heard in almost every state about inaccurate provider directories and problems with the provider search functionality on the marketplace websites. In addition, respondents complained about a lack of consumer-friendly information with which to assess plan networks, and in some cases network information was provided too late in the plan selection process to be helpful to the consumer.

A commonly cited consumer complaint was surprise after enrolling in a plan to learn that a certain desired provider was not in their plan network. It was not clear, however, how many of those complaints were attributable to a lack of research about the plan by the consumer or whether because of inaccurate information in the plan directory. In several states, consumer groups also raised concerns that QHPs had an inadequate number of mental health and substance use providers to meet the needs of enrollees, but some noted that this had been a problem prior to 2014. In states with QHPs that provided no out-of-network coverage, consumers reported concerns that the plan networks would not have a sufficient choice of providers with the requisite training and expertise to meet the needs of people with complex health problems, such as cancer and transplant patients.

While consumer respondents generally expressed concerns about QHP network adequacy, none reported specific complaints from enrollees about a lack of access to necessary health care services. This may be because most of our interviews took place before the end of April, too soon for most people to attempt to use the benefits under their new plans.

Provider Concerns

Provider stakeholders reported many of the same concerns reported by consumer advocates, with a similar focus on the lack of reliable information about which providers were in which networks, as well as questions about the capacity of networks to meet enrollees' needs. In particular, many providers reported inadequate communication from insurers about whether they were in or out of plan networks. One respondent reported: "Physicians are having a difficult time trying to find out what networks they are in." As did consumer advocates, provider groups raised concerns about the lack of access to mental health and substance use service providers, although they noted it was not a new problem and that many mental health providers have not traditionally participated in insurance company networks. Provider respondents also highlighted the lack of capacity in rural areas, but again noted that this was a problem that pre-dates the ACA. Physician respondents conveyed a high level of frustration with insurers and their contracting practices, with some reporting that insurers did not give them an opportunity to participate in QHP networks "at any price;" others reported that insurers approached rate negotiations with a "take it or leave it" attitude; others complained about the use of "any product" contractual clauses to avoid re-negotiation of rates. However, similar to the consumer respondents, none of our provider respondents reported hearing specific complaints from QHP enrollees being unable to access necessary medical care.

Respondents had mixed views about the experience of essential community providers (ECPs). The dominant concern was ECP inexperience working with private insurers and engaging in contract negotiations. Others noted that ECPs may have difficulty meeting insurers' requirements regarding quality reporting or participation in other quality improvement

initiatives. Several respondents called for more training and technical assistance to ECPs on contracting with insurers.

Provider Networks: Challenges Ahead

For states reviewing their standards and oversight of network adequacy, the primary challenge cited by stakeholders will be balancing price and access. Insurer respondents reported that premiums will rise if states strengthen their network adequacy requirements and limit insurers' flexibility to negotiate with providers. At the same time, providers and consumer advocates report concerns about QHP networks' capacity to meet patients' needs, particularly in rural areas.

Another significant challenge is the current lack of transparency and consumer-friendly information about networks to help people make educated plan decisions, and the lack of consumer understanding of how plan networks work. Respondents reported problems with provider search functions, provider directories, and the lack of a clear visual sign denoting when a plan has a "narrow" network and when it has a "broad" network.

More concerning over the long term is an emerging perception among at least some consumer, broker and small business respondents that QHPs are "sub-par" or lower quality compared to traditional commercial coverage. While other factors, such as reports of high cost-sharing, may have contributed to this perception, media coverage of the narrower provider networks likely had an impact.

Provider Networks: State Responses

State marketplaces were primarily focused on operational readiness during the first months of open enrollment, but some did respond to emerging consumer and provider concerns about network adequacy. For example, upon hearing complaints about the functionality of their provider search tool, stakeholders reported that the Kentucky marketplace quickly implemented the necessary technical fixes. In California, insurers were encouraged to – and did

– expand their provider networks as enrollment grew.[3] Other states responded with a review of their network adequacy standards. For example, Washington promulgated new network adequacy rules and Oregon has convened stakeholder groups to help draft legislation to grant state regulators greater ability to oversee plan networks. New York enacted legislation extending its network adequacy standards for HMOs to all network based plans. The New York marketplace has also toughened its requirements for insurers, requiring them to update their provider directories within 15 days of a change.

Recommendations from Respondents and the Research Team

Respondents recommended that states prioritize building a more effective way to display network information to consumers at a plan level, and to work harder to ensure that provider directories are accurate and up to date. They also recommended that directories display providers' language proficiencies, disabled access, and whether they are open to new patients. Consumer and provider respondents encouraged states to more clearly define what it means to have an "adequate" network, particularly regarding enrollees' access to specialty care. They also asked their state officials to engage in more proactive monitoring of network adequacy, with a focus on enrollees' ability to access needed care without excessive out-of-network cost-sharing.

The research team generally concurs with the above recommendations, and also encourages state marketplaces to conduct and publish consumer surveys that assess network access and consumer satisfaction with their coverage. Such data, as well as other obtained data, i.e., from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, should be used to inform consumers about relative plan quality.

States will also need to invest in improved network information and plan selection tools to allow consumers to make the most optimal choices for themselves and family members. Health insurance literacy support should also extend to post-enrollment issues, such as how to access

care in the most appropriate setting and how to determine whether a provider is in- or out-of-network.

As did New York, the marketplaces should require insurers to regularly update their provider directories and they should be held accountable for inaccuracies. For example, if a provider is incorrectly included in a directory as in-network, plans should be required to hold consumers harmless for any out-of-network or balance billing charges.

State legislatures and regulatory agencies should also consider revising current standards to more clearly define an “adequate” network; plans both inside and outside the marketplace should be held to that standard. States should conduct post-marketing oversight to monitor consumers’ access to care, such as through the use of data collection on the use of out-of-network services, the review of consumer survey data, the analysis of consumer complaints, analysis of disenrollment patterns by diagnosis, and the use of “secret shopper” calls or other audits to assess whether the provider network operates for enrollees as promised. Data from all of these efforts should be combined, analyzed and used in the recertification process and in plans’ quality rating scores.

Lastly, in order to counter perceptions that QHPs are low-quality plans, states should create greater incentives for insurers to contract with providers based on the quality of their performance and the health outcomes of their patients, not just on their cost.

Endnotes

[1] *See e.g.*, Hancock, J, "'Narrow Networks' Trigger Push-Back from State Officials," *Kaiser Health News*, Monday, November 25, 2013, http://www.kaiserhealthnews.org/stories/2013/november/25/states-balk-at-narrow-networks.aspx; Jan T, "With Health Law, Less-Easy Access in New Hampshire," *Boston Globe*, Monday, January 20, 2014, http://www.bostonglobe.com/news/nation/2014/01/20/narrow-hospital-networks-new-hampshire-spark-outrage-political-attacks/j2ufuNSf9J2sdEQBpgIVqL/story.html; and Gottlieb L, "Daring to Complain About Obamacare," *New York Times*, Sunday, November 10, 2013, http://www.nytimes.com/2013/11/11/opinion/daring-to-complain-about-obamacare.html?_r=0.

[2] Data from the Partnership states was not collected in time for inclusion in this report.

[3] Shortly after the conclusion of our data collection under this project, California insurer Anthem was sued for misleading consumers about the size of its plan networks, and for failing to disclose that some of its plans would not cover care if obtained outside of the plan network. The lawsuit is pending in state court. *See* Appleby J. "Lawsuit Accuses Anthem Blue Cross of 'Fraudulent' Enrollment Practices," *Kaiser Health News*, July 9, 2014. http://www.kaiserhealthnews.org/stories/2014/july/09/anthem-lawsuit-over-enrollment-practices.aspx.

Early Implementation of the Affordable Care Act: Cross-State Analysis of Stakeholder Views and Recommendations

Provider Supply and Demand

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Introduction

Implementation of new insurance marketplaces in late 2013 and early 2014 was accompanied by concerns that an influx of newly insured consumers might create new demands on the health care system. Maintaining an adequate supply of health care providers was already an issue in some parts of the country, raising questions of whether that supply could be increased or whether it could meet any new demand that materialized. Some new initiatives – both those already under way and those encouraged by the Affordable Care Act (ACA) – have the potential to help meet any new demand.

Researchers at the Urban Institute, Georgetown University's Health Policy Institute, Institute for Health Policy Solutions, and Econometrica conducted a project to assess stakeholder experiences with implementation of the ACA in its first year. In the study, researchers conducted interviews with health plans, health care provider organizations, small-business representatives, brokers and agents, consumer advocates, and marketplace assisters in the 16 states and the District of Columbia running their own marketplace, as well as 5 Partnership states.[1] Respondents were asked a broad set of questions relating to the design, launch, and operation of the marketplaces, including questions about the provider supply and demand. In each case, respondents were promised confidentiality.

Broad Observations about Provider Supply and Demand

Provider supply has been a significant issue in some states and some sub-state areas predating the broader insurance coverage expected under the ACA. But the story varies considerably from state to state and within states. Many, but not all, informants indicated their concerns about whether the current supply of providers can meet the new demand. Informants in some states pointed to the potential for new ACA-based insurance coverage to exacerbate the impact of existing provider shortages. Those in states with high levels of pre-ACA coverage were generally less concerned, because the change in insurance levels are smaller and thus will create less new demand than in states that started with more uninsured consumers. In all

states, however, most informants generally agreed that it is to too early to observe the specific impact of pent-up demand or even to cite specific evidence on whether there has been more use of hospital emergency departments (EDs) or safety-net providers.

In states where at least some plans are introducing narrow provider networks, there is a greater potential for capacity issues for the enrollees of those plans. Some informants were concerned that if plans using narrow networks gain substantial enrollment, the networks could turn out to be inadequate to serve the new enrollees.

Informants offered a variety of views on the dimensions of existing provider shortages. Not surprisingly, the story varied considerably from state to state. Overall, stakeholders were more concerned about shortages of physicians, nurses, and other types of clinicians than about institutional providers. In particular, informants in many but not all states indicated the greatest worries relate to adequate availability of primary care providers. One factor noted by informants in several states was the impact of retirements by an aging physician workforce that may coincide with the growing demand.

We heard more often about problems in rural areas, especially remote rural areas, than in urban areas. Although primary care physicians are often in short supply in rural areas, access to specialists can often require travel to nearby urban areas. We also heard numerous comments about shortages of mental health and substance abuse providers, and availability of these providers can be a problem in both urban and rural areas. Informants noted that some behavioral health providers do not accept any insurance, which can exacerbate the problems for newly insured consumers as well as for plans recruiting providers to join their networks.

Although concerns about the supply of institutional providers arose less often, one exception was the role of hospital emergency departments, a subject that generated differing opinions. Some thought ED use could decline if newly insured consumers have better access to primary care. In particular, some thought (or hoped) that inappropriate ED use, seen as too high today,

could go down. But others worried, that with more insurance coverage, levels of overall ED use could actually increase. These informants cited the potential for a short-term increase in ED use, based on pent-up demand. Although treatments might be better provided by primary care providers, some of the newly insured would not have a primary care provider or might not yet understand how best to use the system. Over the longer term, some informants thought that ED use might increase, because those previously without insurance would have the means to pay, whereas other informants thought ED use could decrease over time as newly insured individuals learn to use the system.

The Impact of Delivery System Innovations on Provider Supply

In recent years, there have been numerous initiatives to develop innovations in health care delivery. Some initiatives have come from health systems and other health care providers attempting to improve their competitive position by delivering higher quality care at a lower overall cost. Health plans have created incentives for other delivery system innovations. Still other changes have been initiated with the support and funding of federal and state programs, including those with funding from the federal Center for Medicare and Medicaid Innovation.

In several states, we heard reports that new models of care have been playing a larger role. Among those mentioned by multiple informants were patient-centered medical homes and accountable care organizations (ACOs). By better organizing existing medical providers, the expectation is that these organizations will be able to meet a higher level of demand for care. In some states, we also heard reports that hospital-based clinics have expanded hours or may do so in the near future. Retail clinics may be another means of expanding the capacity of the health system.

Greater use of physician assistants (PAs), nurse practitioners (NPs) and other advanced practice nurses, and other non-physician providers was viewed by a number of informants as a potential route to make care available to a greater number of patients in the short term and thus to reduce the impact of physician shortages. Several informants report on more hiring of NPs and

PAs within all types of practices. In addition, according to some of those involved in delivery system innovations, more use of these new models and other types of team-based care tend to increase use of nurses and other non-physician providers. Similarly, retail clinics have tended to make greater use of NPs and PAs than more traditional health care delivery settings. Expanded roles for NPs and PAs, however, are harder to accomplish in some states due to more restrictive scope of practice laws.

Some informants also thought the newer payment methodologies, such as greater use of bundled payments or patient-centered medical homes, could attract and increase retention of physicians. The idea is if physicians find these newer approaches more compatible with the way they prefer to practice, they may delay retirements or maintain positions in direct patient care. Other informants mentioned that a greater role for telemedicine could help with supply issues. For example, primary care physicians would gain more ability to consult specialists who are located elsewhere. Not only will these increase access for rural consumers, but it might ease the burdens on physicians and other providers in these areas.

Policy Changes Addressing Provider Supply Issues

Informants were asked whether actions were being taken in their states and communities to help address the concerns about provider supply. Their responses reflected specific experiences in these states and communities, and the actions they described were not necessarily commonplace around the country.

Several informants commented on the pipeline of new physicians (and less frequently on new nurse practitioners or physician assistants). In several states, we heard that federal limits on the number of residency spots made it more difficult to bring new physicians into their areas. Some states have created additional seats for medical schools, and some have created more residency slots.

Some informants noted that a greater role for non-physician providers can be a key part of the solution. But issues around the legal scope of practice can complicate the ability of these providers to take on more responsibilities. Informants in several states pointed to action by state legislatures or other agencies to increase the allowed scope of practice for NPs and PAs.

A few informants called attention to steps taken to increase the role for telemedicine in their communities. Others pointed to grants that have been obtained to create new federally qualified health centers (FQHCs) or expand scope of existing FQHCs, as described in more detail in the next section.

Use of the Safety Net and Provider Supply

Many uninsured Americans receive medical care through safety-net providers, especially FQHCs and other types of clinics. In fact, some informants suggested that safety-net providers already play a major role in ameliorating provider shortages in the areas they serve. Many informants expect those same consumers to continue receiving much of their care through the same safety-net providers after gaining insurance coverage through the marketplaces. If this happens, it may help to alleviate concerns about increased demand.

Nevertheless, some informants raised concerns that current FQHC capacity may be insufficient to meet new demands, particularly if their previous patient caseload uses more services given their new health insurance coverage. The ACA provides new funds for FQHC expansion, and clinics in some states have used that opportunity to expand capacity. In other states, clinics have been less aggressive in going after new funding. In one state, informants reported that a health system is opening neighborhood clinics that will compete with FQHCs. This action should provide new capacity in these particular neighborhoods, although there may be concern from the competing FQHCs that it could threaten their long-term viability, especially if new coverage does not create much new demand.

One issue raised by several informants was the ability of FQHCs to negotiate favorable rates with insurers. Prior to the ACA, FQHCs tended to have few patients with private insurance; instead, most patients were either uninsured or had coverage through Medicaid. As more of their uninsured patients gain insurance through the marketplaces, these FQHCs need contracts with the qualified health plans (QHPs) participating in their communities. QHPs may also need the FQHCs to meet requirements for inclusion of essential community providers. But FQHCs are not experienced with these types of contract negotiations, a situation that has at least delayed their inclusion in networks in some communities. Some informants also reported issues for FQHCs in how Medicaid payment rates are being handled under Medicaid expansions. Plans in one state, for example, sought to contract with individual providers, rather than with the clinic as an institution. This may have been a means to avoid paying higher rates to FQHCs and was viewed by clinics as in conflict with their agreement with the state.

Other informants raised issues with the scheduled changes in Medicare and Medicaid uncompensated care funding and expressed a concern that these issues could affect the ability of safety-net providers to provide care. Specifically, some informants are worried that cuts in uncompensated care funding will be evenly distributed across providers even though some providers are less likely to see reductions in charity care. Examples include those providers that treat many who are undocumented or providers located in states without Medicaid expansion. From this perspective, the ability of these safety-net providers to continue filling this role in their communities may be threatened.

Provider Participation in Medicaid

Most states with state-based marketplaces have also enacted Medicaid expansions under the ACA. Thus most of our interviews were in states with an expanded Medicaid program. Informants generally thought it was too early to tell whether Medicaid expansion will have an impact on provider participation. Typically, informants reported that most or all hospitals and all FQHCs in their communities participate in Medicaid. Problems with low rates of physician participation were more widespread for Medicaid. Some informants also raised concerns about

"phantom networks" where providers listed in network directories (whether traditional Medicaid or Medicaid managed-care plans) either do not participate or do not take new patients.

Medicaid fee-for-service physician fees historically have been low in many states, and this was regularly cited as an impediment to maintaining an adequate supply of physicians for Medicaid beneficiaries. The ACA included a mandatory increase in primary care payment rates for 2013 and 2014. Informants generally saw the increase as a positive step, but suggested it was too early to understand its impact on physician participation in the program. In particular, some pointed out that implementation by states was uneven and was not always effective in the early months of 2013. Some informants also pointed out that where primary care is mostly provided through community clinics, the increase does not apply because clinics are paid through a separate payment system.

The ACA requires that physicians participating with Medicaid managed care organizations must receive the full benefit of the fee increase, regardless of whether they are paid on a fee-for-service, capitation, or other basis. Some informants, however, were concerned that the higher physician fees do not always end up applying in these situations. But in one state, a plan official observed that increased rates were used by that plan to help them keep their Medicaid network broad and to prevent providers from leaving.

Other factors may be helping to increase provider participation in Medicaid in different parts of the country. In some states, informants suggested that more use of managed care is increasing Medicaid participation by providers. Higher payment rates by these managed-care plans are seen as one factor. But in addition, some plans use contract negotiations with physicians to ensure that network physicians participate in Medicaid plans in order to be included in their private plans. Similarly, when insurers that previously operated as Medicaid-only plans decide to participate in marketplaces as well, they tend to look at options for broadening their provider networks in order to market themselves to a broader population. However, Medicaid-only

plans are not participating in marketplaces in all states. And some of these plans are participating in the marketplaces with substantially different networks than for their Medicaid business.

In a few states, informants pointed to new affiliations between hospitals and physicians, typically through hospitals acquiring physician practices, as a means to increase acceptance of Medicaid patients. Where these organizations (or the hospitals at their center) have made a commitment to Medicaid participation, that commitment is extended to their newly acquired physician practices.

Provider Supply and Demand: Recommendations

We asked all informants about their recommendations to address concerns about maintaining an adequate supply of providers. Some informants addressed ways in which delivery system reforms could make more efficient use of the existing supply of providers, some raised specific measures to increase the number of providers serving their community, and others spoke about issues specific to Medicaid.

In the domain of delivery system reform, several informants recommended that encouraging more creative use of new models of care, such as patient-centered medical homes and ACOs, would make health care delivery operate more efficiently. Changes encouraging providers to deliver team-based care should help them meet increased demand for care. For example, these reorganized systems should be able to identify better means of directing care to appropriate settings. In particular, they can help educate consumers on how to use their newly obtained insurance to seek health care in the most appropriate settings, for example, by avoiding unnecessary use of hospital EDs. Systems such as medical homes may also make better use and expanded use of NPs and PAs, with the potential for both improving the quality of care and lowering demand on physicians. Other informants called for expanded use of new delivery modes, ranging from retail clinics to nurse-run clinics to expanded roles for hospital-based clinics and FQHCs.

Other recommendations focused on calls for continued funding of expansions for FQHCs or for existing FQHCs to take advantage of currently available funding opportunities to expand sites or services. Some informants called for training more clinicians through both creating more positions in medical schools or schools for NPs and PAs and establishing more residency positions for training new clinicians in their particular communities. Some informants pointed to the need for legislative action to expand the scope of practice for NPs and PAs, while acknowledging the political obstacles that can make this step hard to accomplish. Finally, some informants called for streamlining quality reporting requirements for providers to reduce burden and thus encourage more providers to stay in the system.

For some informants, Medicaid was the focus for their recommendations. For those in the few states in this study that have not already expanded Medicaid, many informants were eager to see their legislatures take up the expansion options under the ACA. Although expansion might exacerbate the demand on providers, it would also bring more revenue to providers, especially safety-net providers, which would in turn help these providers stay in business. Other informants called for increasing Medicaid payment rates or at least maintaining the higher primary care fees in effect through the end of 2014. Other informants pointed more broadly to expanding Medicaid delivery system reforms, including patient-centered medical homes and ACOs, or to increasing the use of well-designed Medicaid managed care systems.

Endnote

[1] Data from the Partnership states was not collected in time for inclusion in this report.

Education, Outreach, and Application Assistance: Stakeholder Reports from State-Based Marketplace (SBM) States

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Introduction

This paper focuses on state efforts to educate eligible consumers about individual coverage offered through health insurance marketplaces under the Affordable Care Act (ACA), reach out to them, and help them enroll. Researchers at the Urban Institute, Georgetown University's Health Policy Institute, Institute for Health Policy Solutions, and Econometrica conducted a project to assess stakeholder experiences with implementation of the ACA in its first year. In the study, researchers conducted interviews with health plans, health care provider organizations, small-business representatives, brokers and agents, consumer advocates, and marketplace assisters in the 16 states and the District of Columbia running their own marketplace, as well as five Partnership states.[1] Respondents were asked a broad set of questions relating to the design, launch, and operation of the marketplaces. In each case, respondents were promised confidentiality. The stakeholders whose views are synthesized here consisted primarily of navigators, in-person application assisters, consumer advocacy groups, insurance brokers, and, to some degree, health plans and providers. This paper covers two general topics: (1) public education and outreach; and (2) application assistance. Within each area, we discuss general trends, promising practices implemented by particular states, and other suggestions from stakeholders or the research team.

Public Education and Outreach

Overall trends

Almost without exception, informants reported that the general public learned that marketplaces were a place to get health coverage and that health coverage was important. Beyond those key facts, initial public education efforts rarely communicated much. That minimalist approach made sense, however. The ACA is complex, mass media cannot effectively deliver fine-grained information, and the target audience includes many people with little knowledge of such basic health insurance concepts as deductibles, premiums, and copayments. Accordingly, many interviewees felt that a reasonable goal of initial mass media campaigns was simply to encourage the uninsured to go to the right place to obtain detailed information about their coverage options.

However, public education and outreach efforts faced challenges. The constant barrage of anti-ACA misinformation led to confusion that was hard to overcome. Moreover, consumers were often confused about the difference between federal and state websites. In many states, State Based Marketplace (SBM) messages were not tailored to meet the needs of low-income consumers and those who qualified for Medicaid. This was problematic, since the marketplace was typically the main portal through which consumers could enroll into expanded Medicaid. Some SBMs undermined their own credibility early on through ad campaigns of unrelenting cheerfulness that contrasted with newspaper headlines decrying dysfunctional rollouts. One particular issue on which most consumers received little information involved tax reconciliation for claimants of advance payment of premium tax credits (PTCs). In most (but not all) states, interviewees reported that, unless PTC claimants were helped by brokers or unusually sophisticated application assisters, they rarely learned that when they file their federal income tax returns, they could lose anticipated tax refunds or even incur tax debts if they turn out to have claimed excess PTCs because they underestimated their 2014 income.

Promising practices

In several states, particular messages galvanized sign-ups, often late in the open enrollment period:

- Minnesota informants reported that the most powerfully motivating message for most uninsured was, “If you don’t sign up by March 31, you can’t get coverage until January.”
- In both Minnesota and Colorado , advertisements in which real people told how they had been helped by the ACA persuaded many to explore their options and then enroll.
- Many states reported that the legal requirement to obtain coverage was motivating for numerous consumers who wanted to see themselves as law-abiding citizens.
- Kentucky’s motto—“Kentucky Proud”—illustrates a branding strategy that differentiated the state’s marketplace from national reform, lessening the effects of anti-ACA misinformation.

Other promising state strategies involved methods, rather than messages:

- *Washington allowed regional tailoring to fit local conditions*, which informants found quite effective. A bus tour, with highly publicized local events was well-received. Notably, the state gave local navigators materials that navigators could modify to fit local circumstances and perspectives, which varied considerably in different parts of the state.
- *Kentucky and Minnesota used "grass-tops" education strategies.* These efforts focused on clergy and other community leaders, who in turn educated their "grass roots" constituents.
- *Many states used trusted community groups to reach immigrant and Native American communities* that can be hard to reach through other methods.
- *California law requires situational targeting during life transitions*. For example, people going through divorce, job loss, or other life changes that often cause coverage losses must be given information about available health insurance options.

Suggestions

Some interviewees suggested innovative methods of communicating with QHP enrollees about renewals, including text messages from marketplaces; and using brokers and QHPs, which have a financial stake in continued enrollment, to contact enrollees and encourage renewal. Other interviewees noted the importance of communicating simply, without jargon and educating consumers about the value of health insurance and about basic health insurance concepts.

Consumers who are affected by a local change in benchmark plans could be targeted for special communication efforts from marketplace call centers. For example, someone enrolled in a plan that was one of the two lowest-price silver plans in 2014 may find that plan to be the third- or fourth-lowest price silver plan in 2015. Unless they receive proactive communications and hands-on help, such consumers are likely to remain with their former plans, only to be surprised by increased premium costs in January 2015. Many could drop coverage, particularly if they do not have serious health problems, increasing the number of uninsured and worsening risk pools. Both to prevent such losses in coverage and to address information technology (IT) problems, Maryland is engaged in an intensive effort to contact all marketplace enrollees, help them reestablish eligibility, and make sure those facing premium hikes due to a change in

benchmark premiums understand their available options as well as the financial consequences of staying in the same plan. Other innovative state strategies using behavioral economics methods could also be used.[2]

To address tax reconciliation issues, several strategies are possible:

- Marketplaces can educate PTC claimants about tax reconciliation and the importance of reporting changed circumstances.
- Other public education efforts can focus on tax preparers. Many tax preparers are worried about the burden of ACA-related tax filings this coming tax season, including time required by tax reconciliation. Making correct initial PTC claims and then adjusting such claims to fit changing circumstances reduces the later need for reconciliation, saving the preparer precious time the following tax season. Also, PTC claimants and tax preparers can be encouraged to work together at the end of 2014 to implement tax planning strategies that prevent potential tax reconciliation problems.[3]

Application Assistance

This section begins by discussing general application assistance, centering on navigators and in-person assisters (IPAs). It then focuses on issues unique to brokers and marketplace call centers.

Navigators, IPAs, and general application assistance

Overall trends

One-on-one application assistance made an important difference helping consumers enroll. Such assistance helped address the ACA's complexity and many consumers' ignorance about the basics of health insurance as well as the procedural "glitches" often created by marketplace websites. Many consumers with health problems had the grim determination to persist and enroll, even without help. But for the healthy uninsured, application assistance was often essential to participation, according to many interviewees. It thus played a role lowering average risk levels within individual markets as well as increasing coverage.

Certain groups had particularly great needs for in-person help. Our informants found this to be the case for many Latinos, for people with complex health conditions or eligibility situations, people uncomfortable with computers, and people without easy internet access. Many states did not fully meet consumers' need for assistance, resulting in waiting lists for IPAs and navigators, particularly during high-demand periods. Most states underestimated the average time applications would require and thus provided insufficient resources for application assisters. Some states did not pay assisters in advance, instead reserving payment until after successful enrollment; this prevented many undercapitalized community groups from serving their uninsured constituents. Interviewees in some states reported assister gaps in rural areas.

Immigrant communities faced unique issues requiring additional application assistance resources that few states provided. With many immigrants, assisters must address anxieties about whether health coverage applications will be used against them or family members in immigration enforcement. Many immigrants cannot have their identity verified via the Federal Data Services Hub, forcing assisters to use more time-consuming methods. Documenting immigration status can require much more effort than verifying citizenship. Moreover, assisters must often take the time needed to explain the ACA's complex rules involving immigration.[4]

Several problems affected both for-profit brokers and non-profit groups furnishing application assistance. Interviewees in nearly every state described training as substantially deficient. In some states, concerns about consumer privacy led officials to bar assisters and brokers from accessing consumer records unless consumers were physically present with the assisters. As a result, consumers having trouble enrolling on-line could not get help by calling their assister. And when obstacles to enrollment arose after applications were filed, consumers often did not understand what was happening. Assisters and brokers frequently did not learn about such obstacles, could not diagnose them, and could not proactively intervene to solve them. As a result, some eligible consumers needlessly remained uninsured, according to interviewees.

Promising practices

Several structural approaches appeared effective. For example:

- Minnesota pursued a multifaceted strategy of engaging consumer groups that resulted in application assisters being deeply committed to enrollment efforts, helping that state cut uninsurance by 40.6 percent during open enrollment, despite a deeply flawed roll-out.[5] The strategy began with engaging consumer groups to shape application assistance programs long before open enrollment began. During open enrollment, weekly conference calls between assisters and the marketplace let assisters flag problems as officials noted new developments and explained future changes. The marketplace appointed a special liaison to application assisters, selected from that community, who spotted issues and brokered solutions.
- Contracting with established and trusted community-based groups, including "up-front" payments that allowed the hiring of dedicated staff, proved effective in furnishing immigrants and other underserved populations with education and application assistance.
- Connecticut employed a regional structure, through which one "navigator" managed a small number of "assisters." Multiple community organizations within a relatively homogenous region employed both navigators and assisters. Navigators convened assisters regularly, used web tools to coordinate work, identified poor performers, and helped them improve.
- In Minnesota, highly expert community groups, often with legal services background, were funded to train less expert assisters. Afterwards, when consumers came to the latter groups with hard questions, the expert trainers were available to provide technical assistance.

Particular application practices also proved helpful:

- In several states, assisters or marketplaces developed "what to bring to your appointment" materials that equipped consumers so that enrollment occurred in one session rather than two.
- Interviewees in several states reported that scenario-based training of assisters was effective.
- Successful non-traditional settings for outreach and enrollment included libraries in Minnesota and bus stops, bars, and Laundromats in DC.

- DC's other innovative strategies included a smart-phone "app" for enrollment; and combining tax preparers and application assisters at a single site, so consumers could get their tax refunds and enroll in health coverage at one time.
- Assisters in several states found it useful to convene three to six consumers at computers and circulate among them, providing help as consumers completed applications.
- Many successful assisters report that achieving high enrollment numbers requires going out into the community, investing significant time in advance to ensure successful events.

Suggestions

Most interviewees recommended continued use of application assisters, both to enroll the remaining uninsured and to help new QHP members learn how to use coverage effectively. Application assistance may also be important at renewal, particularly to address changes in benchmark premiums, discussed above.

In states that limited assisters' and brokers' ability to access client records, interviewees recommended modifying those limits. Given consent, assisters and brokers could access client records, co-log-in to help clients on the phone, receive notice that lets them help solve problems (like non-payment of premiums or missing verification), track the status of their clients' applications, diagnosis and overcome enrollment obstacles proactively, etc. Several states have thus created special portals through which assisters and brokers can access their clients' "back end" eligibility records.[6] Such portals could potentially be used with new applications as well, letting assisters and brokers avoid inevitable glitches afflicting consumer-facing websites by avoiding those websites altogether.

Informants in numerous states urged marketplace officials to engage front-line assisters, navigators, and brokers in designing future enrollment campaigns, including for 2015. Such engagement could increase the effectiveness with which officials can diagnose problems and devise solutions that realistically address the circumstances of low- and moderate-income consumers. Engagement could also promote "buy-in" of consumer groups that increases assister commitment, hence potential enrollment levels.

Brokers and agents (“producers”)

Overall trends

Insurance brokers and agents (sometimes called “producers”)[7] played different roles in different states. In states like California, Connecticut, and Kentucky, they enrolled numerous consumers into QHPs. In other states, their contribution to QHP enrollment was modest. In most states, marketplace staff came to acknowledge the value of producers by the end of open enrollment, even where that understanding was not evident at the start. Almost universally, brokers did not feel particularly valued by marketplaces, including through communications to the public.

Funding was typically a problem. Private insurers pay producers by commission, generally as a percentage of premiums. However, a broker who spends time enrolling a client in Medicaid goes unpaid for that time, in most circumstances (although some state Medicaid programs pay brokers a small per capita fee for each successful Medicaid or CHIP enrollee). Moreover, whether a client enrolls with a carrier inside or outside the marketplace, the producer’s compensation is the same. Much more time is typically spent when assisting with marketplace enrollment, however, than when agents enroll clients directly through carriers. The marketplace process often includes an application for insurance affordability programs, which takes extra time to complete. Also, marketplace IT systems in 2014 were unfamiliar to brokers and, in many states, system glitches were common. As a result, brokers can see more clients and thus make more money selling products outside than inside the marketplace. Moreover, brokers in numerous states reported that marketplace glitches sometimes made it hard to attribute particular sales to particular brokers, interfering with and delaying payment.

Promising practices

Kentucky, where more than 40 percent of QHP enrollees used brokers and agents, took several important steps to facilitate their effective involvement:

- Some brokers established relationships with firms not offering employer-sponsored insurance (ESI) and helped their workers enroll into individual coverage. Employers were delighted, brokers earned significant amounts, and many uninsured not offered ESI received coverage.
- As Minnesota did with application assisters, Kentucky officials partnered with brokers in designing marketplace mechanisms. This promoted buy-in and resulted in systems that brokers found effective.

Connecticut likewise achieved significant success with brokers:

- The marketplace hired a liaison to the broker community, who was himself a well-known broker. The liaison in turn recruited brokers, who played a major role in QHP enrollment.
- Consumer groups uniformly reported positive experiences with brokers, despite their considerable initial skepticism. With marketplace encouragement, application assisters and brokers developed strong local partnerships, with referral relationships that took advantage of complementary areas of expertise.

Suggestions

Many interviewees recommended having Medicaid programs reimburse brokers for successfully enrolling their clients into Medicaid programs. Some suggested that insurers should be required to pay brokers and agents more for QHPs than for insurance outside the marketplace, given the additional work required to complete marketplace applications.

Marketplace call centers

Overall trends

Call centers played a central role as the initial contact point for consumers seeking information about marketplace coverage and enrollment, including those having difficulty applying for coverage. In almost every state, consumers encountered serious problems with call centers early during open enrollment. States greatly underestimated consumer demand for call center services and so allotted insufficient resources. As a result, callers experienced long delays. Inadequate training also led to consumers often receiving inconsistent or mistaken answers.

In nearly all states, interviewees also reported significant improvement over the following months, as added resources greatly cut wait times. In some states, however, consumers still encountered significant delays during periods of peak demand. Answer quality likewise improved in most states, though it remained inconsistent in a number of states, according to informants.

In some states, callers who did not speak English had difficulty finding staff who both knew the right answers to callers' questions and were linguistically and culturally competent.
In many states, the staff who answered the phone had limited authorization to take action. As a result, they promised to call back, but they often failed to do so.

In some states, multiple call centers obstructed enrollment. One center might handle Medicaid calls, while another helped with marketplace questions. Some states had separate federal and state call centers. Either way, consumers calling the wrong center were told to call the other number. Rather than being seamlessly transferred, such consumers would need to make a second call, perhaps experiencing two waits before speaking to someone at the right call center. In some cases, the division of responsibilities between centers was unclear, adding confusion and delay.

Promising practices

Most states developed special call center lines available for application assisters and brokers, which leveraged marketplace resources efficiently. In states that structured these lines to guarantee short waits and strong expertise, numerous consumers received help as call centers provided the necessary information efficiently to the consumers' assisters and brokers.

Other effective strategies included the following:

- In Minnesota, call center staff developed specialized areas of expertise. Calls requiring such expertise were routed to the relevant staff.

- Most states kept call centers open on weekends, on holidays, and in the evening, particularly during periods of peak demand.
- Colorado's call center made outbound calls that finished the enrollment process for consumers whose applications remained incomplete.
- Colorado also kept brokers on staff at the call center to answer questions about plan choice.
- DC used video conferencing to link call centers to marketplace IT staff, so call centers could address the consumer's IT issues during the call.

Suggestions

Interviewees suggested that states with multiple call centers could provide for "warm hand-offs." Consumers who call the wrong center would not be required to re-dial. Instead, they would be transferred to the other center, after the first call center provided the second with a brief summary of the purpose of the call, thus expediting subsequent call handling.

A second suggestion is far broader—that is, federal officials or others could provide states with best practices options for call centers. Using existing literature as a starting point,[8] this information could include elements like the following:

- *Model RFP documents for vendor contracting*. These documents would be accompanied by analyses of strategies for dealing with state competitive procurement laws so that high-performing vendors can retain contracts in preference to new bidders who offer lower prices based on an inadequate understanding of performance needs.
- *Rubrics for analyzing trade-offs* offered by (1) operating call centers in-house, rather than through outsourcing; and (2) sharing call-center operations among multiple marketplaces.
- *Staffing structures*, including policies for triaging complex problems to the most knowledgeable staff, and ensuring linguistic/cultural competence.
- *Protocols* for training, performance measurement, performance reporting, quality assurance, contact management and ticket tracking, and knowledge management.
- *Careful design of metrics to avoid untoward incentives*. For example, some interviewees reported that call centers were rewarded for hanging up on callers, because that could count as resolving a call promptly.

- *Plans for addressing variable demand*, avoiding the need to recruit and retrain inexperienced staff before each peak period. Options include:
    - Retaining core staff during slow periods, during which they provide consumer assistance (e.g., helping consumers use coverage appropriately, expediting early renewals, helping consumers enroll during special enrollment periods); and
    - Developing an ongoing cadre of largely seasonal skilled workers, perhaps using the tax preparer industry as a model.

Conclusion

No leaders of state-based or federally-facilitated marketplaces are under the illusion that, "if you build it, they will come." Long years of effort by Medicaid and CHIP programs, now followed by one open enrollment season with ACA marketplaces, has driven home basic lessons about the need for effective community education and, above all, the enormous difference in participation that results when knowledgeable, effective human beings work with eligible consumers and eliminate their need to complete forms independently before they receive health coverage. The unhealthy uninsured will often persist and enroll without help, even in the face of IT challenges. The individual coverage mandate will motivate others. But enrolling most of the remaining healthy uninsured who qualify for subsidies is likely to depend, in significant part, on developing an effective network of application assisters who proactively engage eligible consumers and complete the work needed to sign them up for coverage. The successful strategies discussed in this paper suggest reason for hope that the coming years can see significant progress towards achieving these goals.

Endnotes

[1] Data from the Partnership states was not collected in time for inclusion in this report.

[2] HHS's current approach—auto-renewal—is textbook behavioral economics, intended to maximize retention. It recognizes that if consumers must act to remain insured, many will fail to do so and lose coverage, even though they want to be insured and qualify for assistance. When the identity of benchmark coverage changes, however, such continuity of coverage *at the same QHP* has a trade-off—namely, consumer premiums will rise when the new plan year begins, which itself can result in coverage losses.

At a minimum, SBMs could provide PTC beneficiaries with notices if they are enrolled in a plan that: (1) during the current year, was at or below the benchmark premium but (2) during the coming year, will charge a premium above the benchmark. Such notices would clarify the cost implications of this change and encourage beneficiaries to consider their options. If enrollees have appointed an assister or broker to act on their behalf, such assister or broker would receive the notice as well.

Unfortunately, one cannot be optimistic that such notices will achieve their goal with the majority of those who receive them. As an additional step, SBMs might give PTC beneficiaries the option to change the default from one that prioritizes enrollment in the same plan to one that avoids increased premium costs to the extent possible. For example, either a written or telephonic notice from the SBM, or an outbound live call from the SBM call center, or an application assister might say something like the following: "If you stay in your current plan, your monthly payments will go up. There are other options that could reduce your costs this year. If you would like to explore these, call our toll-free number: XXX-XXX-XXXX or visit us on-line at www.XXXX.XXX. If the SBM doesn't hear from you, we'll keep you enrolled in the same plan you have today."

[3] Going forward, marketplaces could give consumers the option to reduce reconciliation risks. Such an option would authorize the marketplace to lower the consumer's PTC based on data matches or consumer information. The marketplace would provide notice of such reductions, which the consumer could revoke. But unless they are revoked, they would go into effect quickly, avoiding delays that otherwise could worsen reconciliation problems. See, e.g., 45 CFR §§155.330(c)(1), (e)(2)(i)(B), (e)(2)(ii)(A) and (C), (f)(1)(i), (f)(2) and (3); see also 45 CFR § 155.315 (f)(2)(ii), cross-referenced in §155.330.

[4] For example, young people whose deportation been suspended because of their arrival in the U.S. as children may not enroll in marketplaces and are not penalized if they are uninsured; immigrants with pending, unresolved asylum applications can enroll in marketplaces and be penalized if they are uninsured; and undocumented parents of U.S. citizen children are not penalized if they are uninsured themselves but are penalized if their children are uninsured.

[5] Julie Sonier, Elizabeth Lukanen, and Lynn Blewett. *Early Impacts of the Affordable Care Act on Health Insurance Coverage in Minnesota.* June 2014, Minneapolis, MN: State Health Access Data Assistance Center (SHADAC), http://shadac.org/MinnesotaCoverageReport.

[6] Karen Pollitz, Jennifer Tolbert, and Rosa Ma. Survey of Health Insurance Marketplace Assister Programs: *A First Look at Consumer Assistance under the Affordable Care Act*, July 2014, Washington, DC: Kaiser Family Foundation.

[7] Technically, an "agent" sells for a particular insurance company at which he or she is "appointed." A "broker" sells for multiple insurers at which he or she is appointed. The term, "producer," covers both groups.

[8] See, e.g., Penny Reynolds. "Call Center Metrics: Best Practices in Performance Measurement and Management to Maximize Quitline Efficiency and Quality," *NAQC Issue Paper*, 2010, Phoenix, AZ: North American Quitline Consortium, http://c.ymcdn.com/sites/www.naquitline.org/resource/resmgr/issue_papers/callcentermetricspaperbestpr.pdf; Penny Reynolds. "Call Center Metrics: Fundamentals of Call Center Staffing and Technologies," *NAQC Issue Paper*, 2010, Phoenix, AZ: North American Quitline Consortium, http://c.ymcdn.com/sites/www.naquitline.org/resource/resmgr/issue_papers/callcentermetricspaperstaffi.pdf. See also David Holman , Rosemary Batt , and Ursula Holtgrewe . *The Global Cal Center Report: International Perspectives on Management and Employment* , 2007, Ithaca, NY: Cornell University, Global Call Center Research Network, http://www.ilr.cornell.edu/globalcallcenter/upload/gcc-intl-rept-us-version.pdf.

Enrollment into Insurance Affordability Programs in State-Based Marketplace States: Early Barriers to Participation and Options for Surmounting Them

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Introduction

This paper analyzes eligibility and enrollment issues affecting two insurance affordability programs (IAPs) under the Affordable Care Act (ACA): expanded Medicaid eligibility to serve adults with incomes up to 138 percent of the federal poverty level (FPL); and a combination of premium tax credits (PTCs) and cost-sharing reductions (CSRs) to subsidize the purchase of qualified health plans (QHPs) in health insurance marketplaces.

The end of the ACA's first open enrollment period saw better-than-expected participation and a significant drop in the number of uninsured, particularly in states that expanded Medicaid.[1] However, most Medicaid and marketplace subsidy eligible uninsured have not yet signed up. Based on the country's experience with CHIP, years may be needed to accomplish the ACA's enrollment goals, as states learn from each other's successes and failures, eventually migrating towards a general consensus about effective practice.[2]

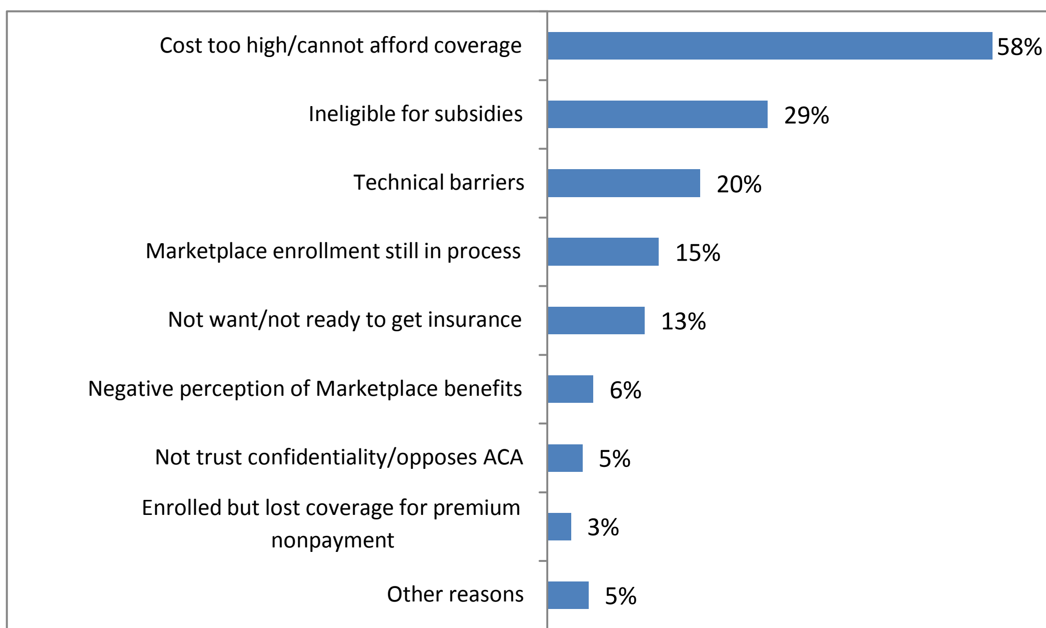
To facilitate that process, this paper begins by analyzing some of the most important obstacles to participation that emerged during the 2014 open enrollment. The paper then describes promising practices implemented by particular states as well as other options for overcoming those obstacles. Researchers at the Urban Institute, Georgetown University's Health Policy Institute, Institute for Health Policy Solutions, and Econometrica conducted a project to assess stakeholder experiences with implementation of the ACA in its first year. In the study, researchers conducted interviews with health plans, health care provider organizations, small-business representatives, brokers and agents, consumer advocates, and marketplace assisters in the 16 states and the District of Columbia running their own marketplace, as well as 5 Partnership states.[3] Respondents were asked a broad set of questions relating to the design, launch, and operation of the marketplaces. In each case, respondents were promised confidentiality.

Obstacles to Participation

Affordability of coverage

One of the most serious obstacles to enrollment involved the cost of coverage. In many states, interviewees reported that consumers who had not previously purchased individual coverage generally found subsidized QHP coverage very costly. Sometimes these consumers chose plans with higher out-of-pocket cost sharing levels than they would have preferred, but many remained uninsured. By contrast, consumers who had previously purchased individual coverage were often pleased with the cost of subsidized QHPs.

Figure 1. Why uninsured adults who visited the marketplace did not enroll: June 2014



Source: HRMS, Quarter 2, 2014. *Note:* Total reasons exceed 100 percent, because respondents could give more than one reason for not enrolling.

Our informants' reports about the centrality of affordability concerns were confirmed by results from the Health Reform Monitoring Survey (HRMS), a quarterly national survey of the nonelderly population conducted to analyze the ACA's effects.[4] According to HRMS results for the second quarter of 2014, financial barriers were the most frequently cited reason why

uninsured adults who investigated their coverage options during open enrollment ultimately chose not to enroll. Unaffordable costs were mentioned by 58 percent of non-enrolling, uninsured adults, compared to 29 percent and 20 percent, who cited ineligibility for financial assistance and technical barriers to participation, respectively, as the second and third-most-common reasons for remaining uninsured (Figure 1).[5]

Disconnection between marketplaces and Medicaid

In many states, significant problems emerged when uninsured consumers who applied for coverage through the marketplace and were classified as eligible for Medicaid had their applications forwarded to the Medicaid program for final processing. Many consumers waited months before hearing from Medicaid. When word came, Medicaid often requested information that consumers had already provided to the marketplace. Sometimes Medicaid caseworkers used pre-ACA verification methods, denying coverage unless consumers furnished pay stubs or other documentation, without first assessing whether available data was reasonably compatible with attestations of financial eligibility. A number of interviewees believed that such procedural obstacles may have prevented some eligible, uninsured consumers from receiving coverage.

This problem had both legal and technological roots. SBMs run by quasi-public agencies or non-profit corporations must have their states' Medicaid programs make the final determination of eligibility, under CMS regulations.[6] Further, in states that are still using outdated information technology (IT) for Medicaid eligibility purposes, the marketplace and Medicaid can use computer systems from different generations that do not communicate. This can cause Medicaid staff to take manual action that could otherwise be automated, such as inputting information received from the marketplace.

New York and Kentucky avoided such problems by using state agencies to administer both Medicaid and the marketplace. Using a single, integrated system for all IAPs, applicants' eligibility was usually determined in "real time"—i.e., while the applicant was still on line—for

Medicaid, CHIP, and QHP subsidies, without further processing. However, SBMs that are not run by state agencies cannot use this approach.

Procedural challenges for immigrants, people with limited English proficiency, and people with complex or non-traditional family situations

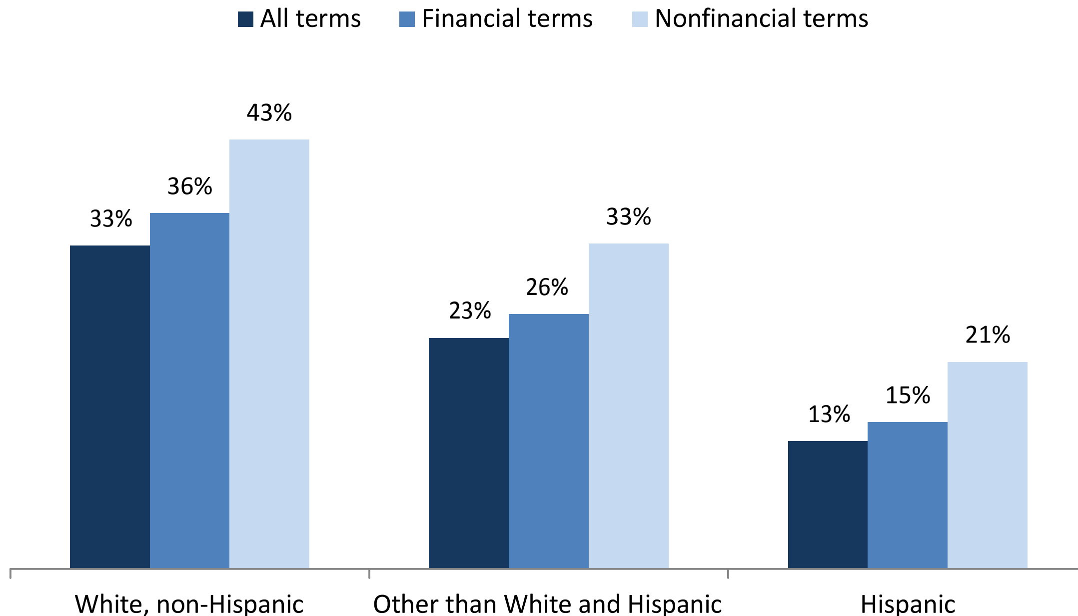
Interviewees reported particularly troublesome technical barriers to enrollment for immigrants, people with limited English proficiency, and people with complex family situations. Marketplace enrollment systems did not appear designed with such consumers in mind. For example:

- Applicants' identity, during open enrollment 2014, was verified via the Federal Data Services Hub using Experian, one of the country's major credit agencies. This made it hard for low- and moderate-income consumers who lacked significant credit history, including many immigrants, to establish their identity. Skilled application assisters could often overcome these obstacles, but not all consumers received such help.
- In some states that expanded Medicaid eligibility, marketplace rules engines automatically classified lawfully present immigrants with incomes at or below 138 percent FPL as Medicaid-eligible. In fact, welfare reform legislation passed in 1996 forbids a federal Medicaid match for many lawfully resident immigrants, including many adults whose lawful status was granted within the past five years. Under the ACA, they can qualify for marketplace-based QHP subsidies, but not Medicaid. Fixing these errors was a high priority for application assisters and community groups, as the wrongful receipt of Medicaid, even if due to a consumer's innocent mistake, can endanger an immigrant's ability to remain in the U.S.
- Linguistic access posed a problem in many states. Websites were typically unavailable in languages other than English and Spanish. Moreover, forms and notices were often written in English only. For example, they might inform an applicant that coverage would be denied unless the applicant provided certain information to the marketplace. Consumers who did not understand those notices and did not take the required steps could remain uninsured.
- Applicants with complex or unusual family situations were sometimes ill-served by website business rules. For example, those rules often assumed that children under age 18 lived with their parents, which complicated applications for homeless and foster children.

Difficulty choosing a QHP

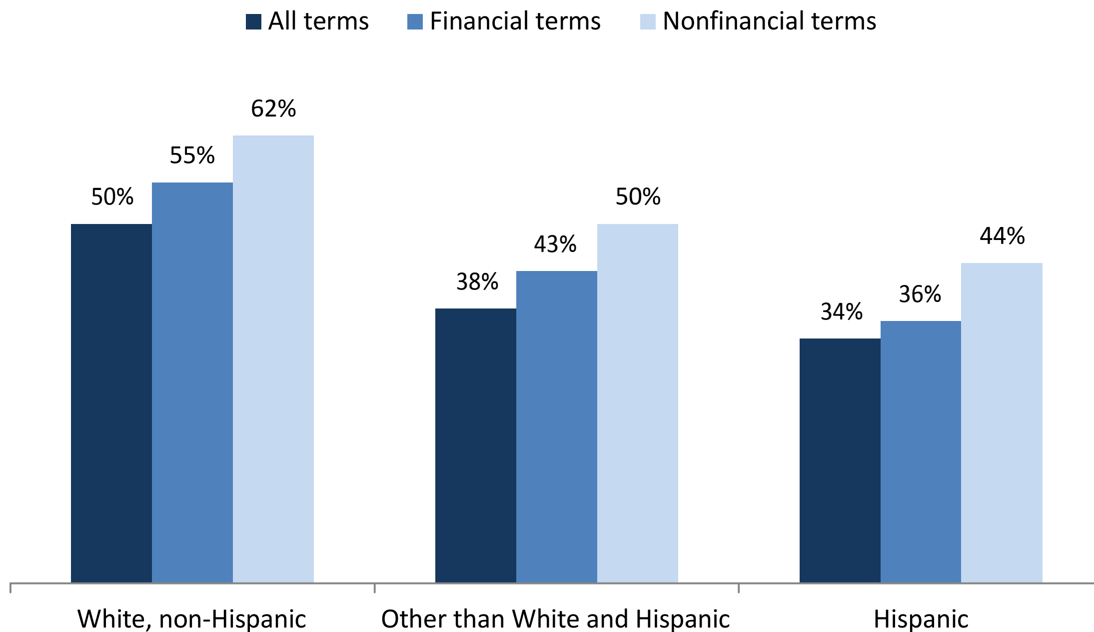
Many application assisters reported that, after qualifying for QHP subsidies, consumers in geographic areas with numerous options often found it difficult to select a plan. QHP selection could take twice as long as the IAP application process, according to interviewees. Plan selection was further complicated by many consumers' unfamiliarity with such basic financial health insurance terms as "premiums," "deductibles," and "co-insurance," as well as such basic non-financial terms as "provider network" and "covered services." Before the start of open enrollment, HRMS data showed that, for example, simple financial vocabulary words for health insurance were confidently understood by only 36 percent of white uninsured, 15 percent of Hispanic uninsured, and 26 percent of other uninsured consumers (Figure 2); and only 55 percent of white adults at 138 to 400 percent FPL (including both insured and uninsured), 36 percent of Hispanics in this income range, and 43 percent of other adults (Figure 3).

Figure 2. Percentage of uninsured adults, including all income levels, who were somewhat or very confident they understood the meaning of specified health insurance terms, by race/ethnicity: January-June 2013



Source: Long and Goin 2014.[7]
Note: Results are regression-adjusted. Financial terms include premium, deductible, co-payments, coinsurance, and maximum annual out-of-pocket spending. Nonfinancial terms include provider network, covered services, annual limits on services, and excluded services. Estimates are regression adjusted and those for Hispanics and adults other than White and Hispanic differ significantly from white, non-Hispanic adults at the 0.01 level, using a two-tailed test. No estimate differed significantly at the 0.10/0.05 levels.

Figure 3.Percentage of adults at 138-400 percent FPL, both insured and uninsured, who were somewhat or very confident they understood the meaning of specified health insurance terms, by race/ethnicity: January-June 2013



Source: Long and Goin 2014.
Note: See figure 2.

In some states, website displays made choices harder. Some states did not let consumers eliminate irrelevant plan views. For example, single adults in one state could have child-only plans listed last but not screened out of those presented for consideration. In almost every state, consumers could not obtain information about QHP provider networks from the marketplace website. Instead, they had to go to plan websites, and even there often could not distinguish between providers included in insurers' pre-ACA networks and those participating in new QHP networks.[8]

Overcoming These Obstacles to Participation

Affordability

States used two very different strategies to make coverage more affordable to low- and moderate-income consumers. Minnesota covered consumers with incomes up to 200 percent FPL outside the marketplace, using a modified version of the state's longstanding "MinnesotaCare" or "MNCare" program.[9] Operated through a Medicaid waiver, MNCare charges much lower premiums and out-of-pocket costs than would apply to subsidized QHPs.[10] Without exception, interviewees reported that these lower costs led to much higher enrollment levels than with federally subsidized QHP coverage. Starting in 2015, the state plans to continue covering low-income adults through a separate program outside the marketplace using more generous federal funding available through the ACA's Basic Health Program (BHP) option. Unlike the current Medicaid waiver, which pays standard Medicaid matching rates, BHP provides funding equal to 95 percent of what the federal government would have spent on PTCs and CSRs had BHP enrollees received QHP coverage. New York State also plans to implement BHP, anticipating state budget savings from transferring state-funded health care costs for indigent, immigrant adults to federally-funded BHP, without consumers losing services or incurring increased costs.[11]

Taking a different approach that keeps consumers in the marketplace, Vermont supplements federal QHP subsidies. The state obtained a Medicaid waiver to help pay the cost of supplementing PTCs for consumers with incomes at or below 300 percent FPL. Federal officials were not willing to share the cost of supplementing CSRs, however. As a result, Vermont's supplements greatly lower premium costs up to 300 percent FPL; but the state lowers out-of-pocket cost-sharing only slightly for consumers between 200 and 300 percent FPL, smoothing out what would otherwise be an abrupt drop in actuarial value.[12]

Almost certainly, Vermont's supplementation of federal subsidies was an important reason the state's QHP enrollment levels exceeded those of any other state, whether benchmarked against eligibility or projected participation.[13] The state's prohibition against purchasing individual

coverage outside the marketplace was obviously another important factor, but that was not relevant to the 67 percent of Vermont's QHP enrollees who received tax credits,[14] whom federal law forbade from using their credits to buy insurance outside the marketplace. Massachusetts took an approach like Vermont's, retaining more generous subsidy levels from prior state reforms.

Disconnection between marketplaces and Medicaid

Washington State avoided the kinds of backlogs and delays that have posed a problem in other states, despite its use of a quasi-public entity to administer the marketplace. Washington's Medicaid program built a "rules engine" to automatically qualify consumers for Medicaid when, based on the state's "business rules," data matches have sufficiently verified applicant attestations to establish eligibility. In Washington, Medicaid "lends" its rules engine to the shared eligibility service that evaluates IAP applications in the marketplace. As a result, if the rules engine finds an applicant eligible for Medicaid based on available data, such a finding constitutes a final determination by the Medicaid program. No further referrals to Medicaid are required.[15] In Washington, most Medicaid-eligible applicants have relatively straightforward circumstances and qualify based on data matches, without needing later manual processing.

Addressing challenges that face immigrants, people with limited English proficiency, and complex or non-traditional households

One promising practice that, for some populations, has helped overcome these barriers involves targeting significant application assistance resources to immigrant communities. However, additional steps can lower the particular barriers:

- Eligibility rules that automate the treatment of immigrants with incomes at or below 138 percent FPL can incorporate the immigration status characteristics that distinguish Medicaid from QHP-subsidy eligibility. This will require customization to reflect both federal law and state variations, such as the extent to which particular states have implemented available options to qualify children and pregnant women for CHIP and Medicaid based on lawful presence, without satisfying such additional requirements as residence for at least five years.

- Marketplace rules engines could add identity proofing methods that do not depend on credit history, using information provided by certified assisters who work with applicants in person.
- Websites need to be translated into languages other than English and Spanish that are spoken by numerous low- and moderate-income residents. However, an equally urgent if not more pressing priority involves translating forms and notices that, without an appropriate response, can prevent eligible consumers from receiving or retaining coverage.

Two more systemic steps can address multiple barriers. First, marketplace leadership can engage seriously with community-based organizations that, during open enrollment 2014, worked closely with immigrants and low-income households. Such organizations can provide useful information about the specific "glitches" that created problems, spot unforeseen problems with proposed solutions, and develop more realistic strategies for overcoming key challenges. Such engagement can also increase buy-in by community groups, with resulting enhanced commitment to help the marketplace achieve its participation goals.

Second, each marketplace can explore two questions:

- When during application and enrollment did consumers give up and stop moving forward?
- What were the main *procedural* defects that led to the rejection of IAP applications, without determining applicants' final eligibility for assistance?

By sampling two sets of applications—those that were abandoned before completion, and those that were rejected for procedural reasons—officials are likely to see the places where applicants frequently gave up and the common reasons for procedural denials. Based on Medicaid and CHIP programs' past use of these strategies, they may help marketplaces diagnose the underlying causes of procedural obstacles that are needlessly obstructing enrollment and devise effective solutions.

Facilitating QHP choice

California and Connecticut took two steps that made it much easier for consumers to choose between available QHP options. According to application assisters in these states, consumers generally found it simple and straightforward to pick a plan.

First, marketplace websites showed default views to subsidy-eligible consumers that were limited to silver plans offering the type of coverage requested by the consumer, displaying the impact of PTCs and CSRs. Consumers could opt to see other available plans, but the initial, default view made choices more manageable by showing the relatively small number of options that were likely to be of greatest interest. Second, plan design was standardized within each metal tier. As a result, consumers were not asked to compare multiple insurance products with minor differences that were hard to assess.

States could pursue a more modest standardization strategy that requires insurers to meet a high threshold for proving that plan variations within a single tier offer significantly different choices. For example, carriers could offer (1) closed-panel HMOs and (2) preferred provider organizations that provide access to both network and non-network providers (with different cost-sharing levels). Carriers could likewise offer plans that offer significantly different trade-offs between deductibles and co-payment or co-insurance levels, on the one hand, and out-of-pocket cost-sharing maximums, on the other.

Eliminating insignificant plan variations within metal tiers would prevent a kind of carrier “gaming” that our informants reported in some states, where insurers offered numerous QHPs that are only slight variants of one another. If a consumer asks to see available “silver level” plans ranked based on premium cost, all the plans shown on the first browser screen—or even the first several screens—are sponsored by a single carrier, even if only a few dollars separates the price of those plans from those of other carriers. As a practical matter, such multiplicity of plan options inhibits rather than facilitates meaningful competition between insurers.

Endnotes

[1] Sharon K. Long, et al. *Taking Stock at Mid-Year: Health Insurance Coverage under theACA as of June 2014.* July 29, 2014, Washington, DC: Urban Institute, http://hrms.urban.org/briefs/taking-stock-at-mid-year.pdf; Linda J. Blumberg, et al. *Measuring Marketplace Enrollment Relative to Enrollment Projections: Update.* May 1, 2014, Washington, DC: Urban Institute, http://www.urban.org/UploadedPDF/413112-Measuring-Marketplace-Enrollment-Relative-to-Enrollment-Projections-Update.pdf.

[2] Along with Medicaid coverage of children, CHIP is now one of the country's most successful need-based programs, reaching an estimated 87 percent of its target population Genevieve M. Kenney, et al. "Medicaid/CHIP Participation Rates among Children: An Update." Washington, DC: Urban Institute, 2013. http://www.urban.org/uploadedpdf/412901-%20Medicaid-CHIP-Participation-Rates-Among-Children-An-Update.pdf . During its first few years, however, CHIP was viewed with "general disappointment … due to low enrollment rates," according to the Congressional Research Service. Herz E and Baumrucker EP. "Reaching Low-Income, Uninsured Children: Are Medicaid and SCHIP Doing the Job?" Washington, DC: Congressional Research Service, 2001. http://www.policyarchive.org/handle/10207/bitstreams/1043.pdf.

[3] Data from the Partnership states was not collected in time for inclusion in this report.

[4] Funding for the core HRMS is provided by RWJF, the Ford Foundation, and the Urban Institute. For further information, see http://hrms.urban.org/.

[5] The perceived unaffordability of coverage was also the most common reason for *not* seeking information about coverage among the uninsured who made that choice, mentioned by 49 percent. As the second-most-commonly cited reason the uninsured did not seek information about marketplace coverage, 22 percent said they were satisfied with their current coverage status.

[6] 42 CFR 431.10(c)(2) requires eligibility decisions to be made by "a government agency which maintains personnel standards on a merit basis."

[7] Sharon Long and Dana Goin. *Large Racial and Ethnic Differences in Health Insurance Literacy Signal Need for Targeted Education and Outreach*. Feb. 6, 2014.Washington, DC: Urban Institute, http://hrms.urban.org/briefs/literacy-by-race.html.

[8] See also, Linda J. Blumberg, Rebecca Peters, Erik Wengle, and Rachel Arnesen. *Physician Network Transparency: How Easy Is It for Consumers To Know What They Are Buying?* August 2014, Washington, DC: Urban Institute, http://www.urban.org/UploadedPDF/1001746-Physician-Network-Transparency.pdf

[9] Although Minnesota's coverage was provided pursuant to state waiver, Medicaid coverage for adults over 138 percent FPL can also be implemented through state plan amendment, pursuant to 42 CFR 435.21.

[10] A single adult with income at 170 percent FPL, for example, pays $33 a month for MNCare and receives coverage with a $2.75 monthly deductible and copays that do not exceed $3 per physician office visit or prescription. With federal QHP subsidies, the adult would be charged $80 a month in premiums for benchmark coverage and could enroll in a CSR-subsidized plan with a $750 annual deductible, physician office copays of $10 and $30 for primary and specialty care, respectively, and prescription drug copays or coinsurance of $10, $50, and 50% for generics, name-brand formulary drugs, and off-formulary name-brand drugs, respectively.

[11] Affected adults are lawfully present immigrants with incomes below 138 percent FPL who are ineligible for federally-matched Medicaid that goes beyond emergency services.

[12] For example, single adult Vermonters with incomes of 150 percent FPL pay $39 rather than $57 a month; those at 200 percent FPL pay $96 rather than $121; and those at 250 percent FPL pay $161 instead of $193. Between 201 and 250 percent FPL, Vermont increases actuarial value (AV) from 73 to 77 percent, so that an individual deductible might be $1,500 rather than $1,900; and between 251 and 300 percent FPL, the state boosts AV from 70 to 73 percent, so that with a $1,900 deductible, the out-of-pocket maximum for medical care might be $4,000 rather than $5,100. All out-of-pocket cost-sharing examples in this section of the paper are taken from Vermont QHPs. See, e.g., Vermont Health Connect. *Cost-Sharing Reduction (CSR) Tier II (87% AV) Silver Plans; Cost-Sharing Reduction (CSR) Tier III (77% AV) Silver Plans*; *Cost-Sharing Reduction (CSR) Tier IV (73% AV) Silver Plans*; *Vermont Health Connect Silver Plans.*

[13] Linda J. Blumberg, John Holahan, Genevieve M. Kenney, Matthew Buettgens, Nathaniel Anderson, Hannah Recht, and Stephen Zuckerman. *Measuring Marketplace Enrollment Relative to Enrollment Projections: Update*. May 1, 2014, Washington, DC: Urban Institute, http://www.urban.org/UploadedPDF/413112-Measuring-Marketplace-Enrollment-Relative-to-Enrollment-Projections-Update.pdf.

[14] Vermont Health Connect. *Vermont Health Connect Update, Medicaid and Exchange Advisory Board, Monday, May 12*, May 12, 2014, http://info.healthconnect.vermont.gov/sites/hcexchange/files/Vermont%20Health%20Connect%20Update_MEAB_5%2012%2014.pdf.

[15] Another option would have the marketplace's rules engine incorporate the Medicaid program's rules and verification procedures, which eliminates the need for the Medicaid program to revisit the rules engine's findings. CMS, Center for Medicaid and CHIP Services. *Medicaid and CHIP FAQs: Coordination between Medicaid/CHIP and the Federally-Facilitated Marketplace.* Originally released May 2012 and April 2013. http://www.medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-Implementation/Downloads/FAQs-by-Topic-Coordination-with-Marketplace.pdf. Only if the application of the Medicaid program's eligibility rules and verification procedures leaves an uncertain outcome would the state Medicaid agency need to take any further steps, other than to affirm Medicaid as a formality—a function that could be automated, via the Medicaid rules engine.

Insurer Participation and Competition in Selected Marketplaces

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Introduction

Researchers at the Urban Institute, Georgetown University's Health Policy Institute, Institute for Health Policy Solutions, and Econometrica conducted a project to assess stakeholder experiences with implementation of the Affordable Care Act (ACA) in its first year. In the study, researchers conducted interviews with health plans, health care provider organizations, small-business representatives, brokers and agents, consumer advocates, and marketplace assisters in the 16 states and the District of Columbia running their own marketplace, as well as 5 Partnership states. Respondents were asked a broad set of questions relating to the design, launch, and operation of the marketplaces. In each case, respondents were promised confidentiality. In this paper, we summarize the findings on insurance plan participation, marketplace competition, and premiums. We rely primarily on discussions with two to five health plans or health insurance associations in each state.

This paper provides a synthesis of responses. In virtually every instance, there are states that differ from the general conclusions we draw. To the degree possible, we have supplemented this with an examination of information on carrier participation and premiums, collected by Breakaway Policy Solutions and available on the Robert Wood Johnson Foundation website.[1] In Table 1, we show the carriers' participating in each state. In Table 2, we show premiums for the lowest cost carriers in at least two markets in each state.

Plan Participation and Premiums

In most states, several insurers participated in the marketplaces, often with more participating in urban markets than in rural, and more tended to participate in larger states than smaller. For example, New York had 16 carriers, California and Oregon 11, and Colorado and Massachusetts 10. hile most states had robust competition among several insurers, several states were still dominated by BlueCross BlueShield plans which had a significant market share prior to the ACA and which continued post reform. These states include Arkansas, Delaware, Maryland, New Hampshire, Rhode Island, Vermont, and West Virginia. In several instances, however, the

dominant BlueCross BlueShield plan in the state faced more competition than they did prior to the ACA (e.g. Kentucky, Nevada, Maryland).

We generally found that premiums were lower than expected prior to implementation, though there was considerable variation across carriers at each metal tier (Table 2). Premiums were particularly low in California, Colorado, Hawaii, Idaho, Kentucky, Minnesota, New Mexico, and Oregon. They were significantly higher in Connecticut, New Hampshire, and Vermont. Premiums set by carriers vary for a number of reasons. There are strong incentives to bid aggressively because marketplace-based financial assistance (a.k.a. subsidies) are tied to the premiums for the second lowest cost silver plan in a particular area. An individual choosing a more expensive silver plan or a gold or platinum plan would have to pay the full marginal cost of the higher premium. Still, in some cases, there was limited competition in the marketplace.

A major factor affecting premiums is the ability of carriers to negotiate with providers. This is an important issue in areas like Rhode Island where there are two dominant hospital systems that have proven difficult for insurers to negotiate with. It is also often a problem in small towns and rural areas where there are relatively few providers, thus leaving insurers with little-to-no negotiating power. One result is that premiums in less populated rural areas are often higher than in urban areas, with Illinois, Nevada, and New Mexico being examples.

Respondents reported that while individuals were attracted to low cost plans, they often went with brand names, even if these plans had higher premiums. This occurred, for example, in New York with Empire Blue Cross achieving a significant market share in the marketplace despite higher premiums than several competitors. But in other states (e.g. California and Maryland) brand names were often the lowest priced plans, so individuals were offered the choice of a well-known insurer at a low price. As will be discussed below, these insurers often offered more limited networks through their marketplace plans than they did in the off-marketplace commercial market.

The high level of participation by carriers is expected to continue in 2015. There are indications in several states that there will be new entry by additional carriers, including United, Aetna, and Cigna. Often, new entrants include carriers that already have a presence in the state insurance market, but did not participate in the state's marketplace.

We found that BlueCross BlueShield participated in most marketplaces and were very competitive in most, but not all markets. For example, BlueCross BlueShield often had the lowest premiums or close to the lowest in several markets because of their preexisting market share and resulting ability to negotiate with providers (e.g., Delaware, Idaho, Illinois, Maryland, and New Mexico). But there are other markets such as New York and Colorado where there were several carriers offering premiums in the marketplace at lower cost than BlueCross.

Many of the large commercial carriers (e.g. Aetna, Cigna, and United) either didn't participate in the marketplaces or participated only in a limited number of them. Frequently, these carriers had very high premiums and seemed to be offering products in the marketplace as a way to have a presence but while taking a very risk adverse pricing strategy. Local commercial carriers were important in some states. For example, Oregon, Minnesota, and Washington had a large number of local carriers that were among the most competitive in their markets.

Interestingly, managed care plans that previously had only served Medicaid recipients often participated in the new marketplaces. In some cases, these were local managed care plans. For example in New York, many of the prepaid health systems offered coverage with the lowest premiums in the marketplace and gained significant market share as a result. The Fidelis plan had the lowest or close to the lowest priced premiums in most markets throughout the state. National chains, such as Molina and Centene, participated in many states as well. Frequently, they did not have particularly low premiums (e.g. California), but in some cases they did (e.g. Washington). Medicaid plans participating in the marketplace usually had to agree to pay providers higher rates in that market than they did for their Medicaid business in order to

obtain the same providers' participation. In response to competition from Medicaid plans, commercial plans offered more limited provider networks in order to hold down costs.

Medicaid plans often participated in the marketplaces in anticipation of "churn"; that is, the movement of low-income individuals between Medicaid and marketplace subsidy eligibility due to income fluctuations. This was the case, for example, with Coordinated Care in a Washington and Neighborhood Health Plan in Rhode Island. The Medicaid plans wanted to ensure that they would maintain access to the individuals who tended to churn between program eligibility during the course of the year. But many Medicaid plans saw the ACA as an opportunity to grow and marketed actively to all those eligible for premium subsidies. For example, in Rhode Island, the Neighborhood Health Plan marketed to individuals up to 250 percent of the federal poverty level; however, they are planning to market to all subsidy eligible individuals for the 2015 plan year. In other markets, Medicaid plans marketed to those with higher incomes as well. The pricing of Medicaid plans often forced a competitive response from commercial insurers, but not always. For example, in California, Medicaid plans simply were not price competitive.

Co-ops also developed for participation in many marketplaces. In general, they had broad networks, typically rented from a commercial carrier and offered relatively high premiums. However, there are several markets in which their premiums were low. Whether some of these very low premiums are sustainable in the long-term was a question raised in several states.

Networks

The competition in the market has resulted in an increase in the availability of narrow provider network plans. These can take the form of either limited networks that have a constrained set of providers without non-network coverage or tiered networks in which individuals would have to pay more to go to more expensive providers, all of whom participate with the plan. Often, the providers that end up in a limited network are those that agree to reduce provider payment rates, better manage care (in some places), and allow the carrier to reduce premiums.

Respondents in these states gave the following reasons for the increase in narrow networks plans:

- **California**: QHP's provider networks are narrow as a result of carriers' competitive efforts to achieve lower premiums by limiting their respective networks to providers accepting lower payment levels.
- **Massachusetts**: Narrow networks are being driven by the desire to exclude very pricey academic health centers from networks, by desire to select physicians/providers with lower service use performance, and by supporting new risk arrangements with particular providers. It is official state policy now to promote narrow networks.
- **Washington**: There is broad agreement that the dominant reason plans are moving toward narrow or tiered networks is to have greater leverage over pricing, to offer volume in the marketplace for discounts and to have a credible threat of exclusion or placement in a disadvantageous tier as a way to discipline negotiations over prices.

The narrowing of networks did not begin with the Affordable Care Act but is clearly accelerating because of it. Some states (e.g. Massachusetts and Rhode Island) are beginning to encourage narrow networks.

The states without narrow networks are often states where there is less competition. For example, BlueCross dominated states, such as Maryland and West Virginia, tend to have broader networks. Surprisingly, narrow networks were not viewed unfavorably by consumer advocates because they resulted in lower premiums. However, there is increasing concern over access to care in limited network products. The pressure to lower premiums is also resulting in alliances between carriers and provider systems or the offering of an insurance product by a major provider (e.g. North Shore LIJ in New York State).

In addition to market competition, respondents indicated that risk adjustment, risk corridors, and reinsurance were reasons for lower premium bids. The "three Rs" gave carriers some protection against risks. This allowed them to bid more aggressively, knowing that if they ended up with higher enrollment of sicker individuals there would be some financial offsets. We

generally found that essential community providers were widely available in carriers' networks. There were widespread reports of states' leadership working well with carriers. Carriers often praised the openness, transparency, and communication that they had with state officials.

Challenges Going Forward

Respondents reported several challenges going forward. The first is whether enrollment, which is necessary to continue active insurer participation, will increase as predicted and whether first year enrollees will be retained at high rates. Second, there is considerable concern that premiums, while heavily subsidized, are still too high for many low income individuals. There is also concern that many marketplace purchasers have low levels of health insurance literacy, and likely did not understand many insurance concepts like deductibles, copayments, and out of pocket limits. Recognition during the first year of coverage that they pay the full cost of services before meeting a high deductible could, for example, lead to dissatisfaction and, ultimately, disenrollment. In addition, there are concerns about how individuals, particularly those who have had insurance in the past, will react to narrow provider networks and the potential difficulty in obtaining access to familiar providers. Will this affect the perception of the plan offerings and reduce enrollment and re-enrollment?

A third issue is whether narrow networks and the lower premiums they engender are sustainable in the long run. One issue is whether the market itself will generate pressure to expand networks. For example, if plans with broader networks gain market share, e.g. large numbers of individuals choose to pay more to enroll in broader network plans, this could force other low premium plans to expand their networks. A second force is enrollment increases themselves. As plan enrollment increases, narrow networks may not have the capacity to serve the expanded enrollment base. Plans may have to expand networks which may well require paying more to additional providers to get them to participate. This, in turn, will result in higher premiums. Or alternatively, there could be political pressure to more strictly regulate network adequacy or to require payments for out-of-network options. Again, this pressure could lead to higher premiums. Provider consolidation could also increase in response to carrier efforts to

narrow networks. If hospitals, for example, purchase physician practices and offer themselves as a single entity to carriers, the providers gain leverage and it becomes more difficult to develop limited networks at lower payment rates.

Fourth, in some states were surprised by the lack of entry by large commercial carriers. Reportedly, a barrier to national carriers such as Aetna, Cigna, and United is the state to state differences in marketplace participation requirements. A fifth issue that was raised by some sources is the role of rate review. In highly competitive markets, rate review seems less necessary. If plans' bids are too high in a competitive environment, individuals will gravitate to lower cost premiums and thus the higher priced plans will achieve little market share. But as we have noted, not all markets are competitive. In these markets dominated by a very small number of carriers, rate review could be essential in keeping premium growth modest.

Sixth, many respondents raised the issue of whether there are too many plan choices. Many carriers participating in marketplaces offer large numbers of plans in the same metal tier. These often have only slight variations in deductibles, copays, and out of pocket limits. In other cases, choice is more meaningful, such as between a broad or limited network. Respondents thought that the large number of plans became overwhelming and made it hard for individuals to choose among them effectively. This was similar in effect to reducing meaningful competition. Some thought that the number of plans at each metal level for a particular carrier should be limited and some felt that benefit packages should be standardized.

Seventh, there is some concern that less competitive carriers will exit the marketplaces, thus reducing competition. Some new entrants in the markets have very limited market share (e.g. on the order of 1%). So far, the carriers with low market share seem to be continuing to participate in 2015, but how long they will continue to do so is uncertain.

Eighth, some sources raised the issue of whether carriers that bid low can sustain these low premiums. There is already some evidence of some low premium plans submitting fairly

dramatic increases in rates (e.g. CareFirst in Maryland). A related concern is whether low premium plans will go bankrupt. Finally, there is the question of whether the three R's will protect insurers sufficiently and if they do not, the consequences for plan participation in the marketplaces. Risk corridors and reinsurance are scheduled to be phased out after the first three years of the reforms. As these phase out, will insurers increase premiums to protect themselves against excess risk or will market competition force insurers to bear more of these risks themselves.

Recommendations

The respondents in this study made a number of recommendations. One is to continue to improve websites; major strides have been made in this area but more is needed, virtually everywhere. There is also the need to improve the human capacity to help individuals enroll. There is widespread criticism of call centers, in many cases, the call centers were inaccessible and often those manning the call centers were ill-informed. Easy opportunities for enrollment are necessary to attract carriers to participate and to engender competition.

Second, there is a need to make information on the network's list of providers up to date and easy to access. Often individuals had to go to carriers' sites to obtain information and often the information was hard to find and was not kept up to date. Providers often did not know they were in networks. Carriers had contracted with providers for off marketplace plans in previous years and assumed the same providers would be in the networks they were offering for marketplace plans, but never verified that. Providers were not made aware and some objected to being included. Lack of accurate and accessible provider network information also hampers competition, with consumers unable to assess the true nature of products offered.

A third recommendation is to let carriers handle the billing and collection of premiums in states that do not do this already. This approach is felt to bypass the complexity of the marketplaces' involvement in some areas. A fourth recommendation is to reduce the number of plans offered by each carrier. Some recommended requiring each carrier to offer a standard plan while

allowing each to also offer a limited number of nonstandard plans that provided meaningfully different options from each other.

Fifth, states need to address the issue of access to out of network providers. While narrow networks are seen as essential to keeping premiums low, at a minimum, there are circumstances in which access to out of network providers is critical to receiving adequate care. States need to establish clear guidelines on when access to out of network providers needs to be made available and at what cost to consumers.

Endnote

[1] The data are available at: http://www.rwjf.org/en/research-publications/find-rwjf-research/2014/03/breakaway-policy-dataset.html

Table 1: Insurers and Silver Plans by States and Number of Counties Served

Insurer Name	Types of Products Offered	Number of Rating Areas Where Insurer is Offering Silver Plans	Number of Plans Offered Statewide by Insurer (not including "child only" plans)	Notes
Arkansas (3 insurers statewide)				
Ambetter of Arkansas	PPO	3 of 7	6	
Arkansas Blue Cross Blue Shield	PPO	7 of 7	3	
QualChoice Health Insurance	POS	5 of 7	4	
California (11 insurers statewide)				
Anthem Blue Cross	EPO/HMO/PPO	19 of 19	3*	*Depending on the rating area, plans can be an EPO, HMO or PPO (and some areas have multiple available)
Blue Shield of California	EPO/PPO	18 of 19	2*	*Depending on the rating area plans are either an EPO or PPO
Chinese Community Health Plan	HMO	1 of 19	1	
Contra Costa Health Plan	HMO	1 of 19	1	
Health Net	HMO/PPO	13 of 19	2*	*Depending on the rating area plans are either an HMO or PPO
Kaiser Permanente	HMO	16 of 19	1	
L.A. Care Health Plan	HMO	2 of 19	1	
Molina Healthcare	HMO	3 of 19	1	
SHARP Health Plan	HMO	1 of 19	2	
Valley Health Plan	HMO	1 of 19	1	
Western Health Advantage	HMO	2 of 19	1	
Colorado (10 insurers statewide)				
Access Health Colorado	PPO	11 of 11	2	
Anthem	HMO	11 of 11	5	
Cigna	OAP	1 of 11	5	
Colorado Choice Health Plan	HMO	5 of 11	5	
Colorado HealthOP	EPO/PPO	11 of 11	2*	*Depending on the area, the plan may be offered as a PPO and/or an EPO
Denver Health and Medical Plan	HMO	1 of 11	2	
Humana	HMO	2 of 11	2	
Kaiser Permanente	HMO	6 of 11	3	
Rocky Mountain Health Plans	HMO/PPO	11 of 11	23	
UnitedHealthcare	EPO	4 of 11	2	
Connecticut (3 insurers statewide)				
Anthem Blue Cross and Blue Shield	PPO	8 of 8	2	
ConnectiCare Benefits Inc.	POS	8 of 8	1	
HealthCT Inc.	PPO	8 of 8	1	
Delaware (2 insurers statewide)				
Highmark Blue Cross Blue Shield DE	EPO	1 of 1	3	
CoventryOne	HMO/PPO	1 of 1	2*	*The plan is offered as an HMO and PPO

Insurer Name	Types of Products Offered	Number of Rating Areas Where Insurer is Offering Silver Plans	Number of Plans Offered Statewide by Insurer (not including "child only" plans)	Notes
District of Columbia (3 insurers statewide)				
Aetna	POS	1 of 1	3	
CareFirst BlueCross BlueShield	HMO/POS/PPO	1 of 1	4	
Kaiser Permanente	HDHP/HMO	1 of 1	3	
Hawaii (2 insurers statewide)				
Hawaii Medical Service Association	HMO/PPO	1 of 1	6	
Kaiser Permanente	N/A	1 of 1	4	
Idaho (4 insurers statewide)				
Blue Cross of Idaho	PPO/POS	7 of 7	6	
BridgeSpan Health Company	PPO	7 of 7	1	
PacificSource Health Plans	HMO	7 of 7	6	
SelectHealth	POS	5 of 7	7	
Illinois (6 insurers statewide)				
Aetna	PPO	4 of 13	2	
Blue Cross Blue Shield of Illinois	HMO/PPO	13 of 13	7*	*Only 4 plans (all PPO) are available in all 13 rating areas
Coventry Health Care	PPO	11 of 13	6*	*No one plan is available in all 11 rating areas served by Coventry
Health Alliance Medical Plans	HMO/POS	9 of 13	4	
Humana Health Plan, Inc.	HMO	5 of 13	2	
Humana Insurance Company	PPO	4 of 13	2	
Land of Lincoln Mutual Health Insurance Co.	PPO	13 of 13	7*	*Two of the plans (Choice, Freedom) are only offered in rate areas 1-3; the other 5 are offered in all rate areas
Kentucky (3 insurers statewide)				
Anthem BlueCross BlueShield	PPO	8 of 8	5	
Humana	HMO	3 of 8	2	
Kentucky Health Cooperative	PPO	8 of 8	1	
Maryland (4 insurers statewide)				
CareFirst BlueChoice/CareFirst Blue Cross Blue Shield	HMO/POS/PPO	4 of 4	5	
Evergreen Health	HMO/POS	4 of 4	4*	*Only one plan available in all 4 rating areas
Kaiser Permanente	HDHP/HMO	2 of 4	3	
UnitedHealthcare	EPO	4 of 4	4	
Massachusetts (10 insurers statewide)				
Ambetter	HMO	7 of 7	2	
BlueCross BlueShield Massachusetts	HMO	7 of 7	2	
Boston Medical Center HealthNet Plan	HMO	7 of 7	1	

Insurer Name	Types of Products Offered	Number of Rating Areas Where Insurer is Offering Silver Plans	Number of Plans Offered Statewide by Insurer (not including "child only" plans)	Notes
Massachusetts, cont'd				
Fallon Community Health Plan	HMO	6 of 7	3	
Harvard Pilgrim Health Care	HMO/PPO	7 of 7	3	
Health New England	HMO	2 of 7	1	
Minuteman Health	HMO	5 of 7	2	
Neighborhood Health Plan	HMO	7 of 7	1	
Network Health	HMO	7 of 7	1	
Tufts Health Plan	HMO	7 of 7	1	
Minnesota (5 insurers statewide)				
Blue Cross Blue Shield Minnesota	HSA/PPO	9 of 9	2	
HealthPartners	HMO	7 of 9	2	
Medica	PPO	8 of 9	4	
PreferredOne	PPO	7 of 8	6	
Ucare	HMO	3 of 8	2	
Nevada (4 insurers statewide)				
Anthem Blue Cross Blue Shield	HMO	3 of 4	7	
Health Plan of Nevada	HMO	2 of 4	6	
Nevada Health CO-OP	POS	4 of 4	5	
Saint Marys HealthFirst	HMO	2 of 4	3	
New Hampshire (1 insurer statewide)				
Anthem Blue Cross and Blue Shield	HMO	1 of 1	3	
New Mexico (4 insurers statewide)				
Blue Cross Blue Shield of New Mexico	HMO/PPO	5 of 5	7	
Molina Marketplace	HMO	5 of 5	1	
New Mexico Health Connections	HMO/PPO	5 of 5	3	
Presbyterian Health Plan, Inc.	HMO	5 of 5	4	
New York (16 insurers statewide)				
Affinity - All Standard Benefits	HMO	3 of 7	2	
American Prog - Today's Options	N/A	6 of 7	2	
BlueCross BlueShield of Western NY	POS	1 of 7	4	
BlueShield of Northeastern New York	EPO	2 of 7	4	
CDPHP	HMO	4 of 7	3	
Emblem	HMO	3 of 7	1	
Empire BCBS	N/A	4 of 7	6	
Excellus	HDHP/EPO	5 of 7	2	
Health Republic Insurance of New York - Freelancers	EPO	7 of 8	4	
Healthfirst	HMO	2 of 8	1	
Metro Plus	HMO	1 of 8	2	
MVPHP	HMO/HDHMO	5 of 8	4	
New York Fidelis	HMO	8 of 8	1	
Northshore LIJ	EPO	2 of 8	2	
Oscar	N/A	2 of 8	3	

Insurer Name	Types of Products Offered	Number of Rating Areas Where Insurer is Offering Silver Plans	Number of Plans Offered Statewide by Insurer (not including "child only" plans)	Notes
Oregon (11 insurers statewide)				
ATRIO Health Plans	EPO/PPO	2 of 7	2	
BridgeSpan Health Company	PPO	7 of 7	1	
Health Net Health Plan of Oregon, Inc.	EPO/POS	1 of 7	3	
Health Republic Insurance	EPO	7 of 7	3	
Kaiser Permanente	HMO	2 of 7	3	
LifeWise Health Plan of Oregon	PPO	7 of 7	3	
Moda Health	PPO	7 of 7	5	
Oregon's Health CO-OP	PPO	7 of 7	2	
PacificSource Health Plans	PPO	7 of 7	6	
Providence Health Plans	EPO	5 of 7	4	
Trillium Community Health Plan	PPO	2 of 7	1	
Rhode Island (1 insurer statewide)				
BlueCross BlueShield of Rhode Island	HDHP/PPO	1 of 1	3	
Neighborhood Health Plan of Rhode Island		1 of 1*		*Only offered to those within 250% of FPL
Vermont (2 insurers statewide)				
BCBSVT	EPO	1 of 1	3	
MVPHP	HMO	1 of 1	3	
Washington (8 insurers statewide)				
BridgeSpan	N/A	2 of 5	1	
Community Health Plans	PPO	3 of 5	1	
Coordinated Care	HMO	2 of 5	1	
Group Health	HMO	2 of 5	1	
Kaiser Permanente	HMO	1 of 5	3	
Lifewise	HDHP/PPO	5 of 5	3	
Molina HealthCare	HMO	2 of 5	1	
Premera	HDHP/PPO	4 of 5	6	
West Virginia (2 insurers statewide)				
Highmark Blue Cross Blue Shield	PPO	11 of 11	1	
Highmark Blue Cross Blue Shield West Virginia	PPO	11 of 11	3	

Table 2: Monthly Premiums for the Lowest Cost Silver Plan (Before Subsidies) for Each Insurer in Selected Rating Area

State	Location	Insurer	Plan Type	Premium: 27-year-old	Premium: 50-year-old
AR	Rating Area 1: Little Rock	Arkansas Blue Cross Blue Shield[1]	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 SE part of the state	Arkansas Blue Cross Blue Shield[1]	PPO	$238.48	$406.42
CA	Rating Area 16: Los Angeles	Health Net	HMO	$200.00	$341.00
		Anthem Blue Cross	HMO	$215.00	$366.00
		Molina Healthcare	HMO	$215.00	$366.00
	Rating Area 4: San Francisco	Chinese Community Health Plan	HMO	$269.00	$458.00
		Anthem Blue Cross	EPO	$309.00	$526.00
		Blue Shield of California	PPO	$310.00	$529.00
	Rating Area 11: Fresno	Anthem Blue Cross	PPO	$239.00	$407.00
		Blue Shield of California	PPO	$235.00	$400.00
		Kaiser Permanente	HMO	$272.00	$464.00
CO	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
	Rating Area 5: Grand Junction	Rocky Mountain Health Plans[2]	HMO	$233.91	$398.64
		Anthem	HMO	$294.46	$501.81
		Colorado HealthOP	PPO	$334.44	$569.95
CT	Rating Area 1: Bridgeport, Stamford	ConnectiCare Benefits Inc.	POS	$313.89	$534.92
		Anthem Blue Cross and Blue Shield	PPO	$344.93	$587.83
		HealthyCT Inc.	PPO	$357.72	$609.62
	Rating Area 2: Hartford	ConnectiCare Benefits Inc.	POS	$259.26	$441.84
		Anthem Blue Cross and Blue Shield	PPO	$269.33	$458.98
		HealthyCT Inc.	PPO	$297.61	$507.19
DE	Rating Area 1: Entire state	Highmark Blue Cross Blue Shield Delaware[3]	EPO	$234.37	$399.42
		CoventryOne	HMO	$261.91	$446.34
DC	Rating Area 1: Entire State	CareFirst BlueCross BlueShield[4]	HMO	$177.75	$349.88
		Kaiser Permanente	HDHP	$181.01	$355.19
		Aetna	POS	$227.82	$448.43
HI	Rating Area 1: Entire state	Kaiser Permanente[5]	N/A	$144.68	$246.57
		Hawaii Medical Service Association	HMO	$199.47	$339.93
ID	Rating Area 6: Boise, Meridian	Blue Cross of Idaho	POS	$178.65	$304.45
		SelectHealth[6]	POS	$189.22	$322.45
		PacificSource Health Plans	HMO	$208.00	$355.00
	Rating Area 4: 4 rural counties at the bottom of the panhandle	Blue Cross of Idaho	PPO	$210.05	$357.97
		PacificSource Health Plans	HMO	$221.00	$376.00
		BridgeSpan Health Company	PPO	$236.90	$403.72
IL	Rating Area 1: Chicago	Blue Cross Blue Shield of Illinois[7]	PPO	$172.41	$293.81
		Humana Health Plan, Inc.	HMO	$215.16	$366.68
		Land of Lincoln Mutual Health Insurance Co.	PPO	$257.10	$438.14
	Rating Area 13: 28 rural counties in the S-SE part of the state	Blue Cross Blue Shield of Illinois[7]	PPO	$227.56	$387.81
		Health Alliance Medical Plans	POS	$246.81	$420.61
		Coventry Health Care	PPO	$274.10	$467.13

State	Location	Insurer	Plan Type	Premium: 27-year-old	Premium: 50-year-old
KY	Rating Area 1: Louisville	Kentucky Health Cooperative	PPO	$160.46	$273.46
		Anthem BlueCross BlueShield	PPO	$234.43	$399.51
	Rating Area 3: Lexington	Kentucky Health Cooperative	PPO	$174.98	$298.20
		Humana	HMO	$150.83	$257.05
		Anthem BlueCross BlueShield	PPO	$215.42	$367.11
MD	Rating Area 1: Baltimore[8]	CareFirst BlueChoice/CareFirst Blue Cross Blue Shield[9]	HMO	$187.00	$319.00
		Kaiser Permanente	HMO	$221.28	$377.11
	Rating Area 3: DC suburbs[8]	CareFirst BlueChoice/CareFirst Blue Cross Blue Shield[9]	HMO	$174.00	$297.00
		Kaiser Permanente	HMO	$221.28	$377.11
MA	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
	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
MN	Rating Area 8: Minneapolis, St. Paul, Bloomington	PreferredOne[10]	PPO	$126.21	$215.09
		HealthPartners	HMO	$135.99	$231.75
		Blue Cross Blue Shield Minnesota	HAS	$164.48	$312.05
	Rating Area 2: Duluth	HealthPartners[11]	HMO	$174.48	$297.35
		Ucare	HMO	$191.31	$326.03
		Blue Cross Blue Shield Minnesota	HAS	$192.71	$365.60
NV	Rating Area 1: Las Vegas, Henderson, North Las Vegas	Health Plan of Nevada[12]	HMO	$194.00	$331.00
		Nevada Health CO-OP	POS	$199.00	$339.00
		Anthem Blue Cross Blue Shield	HMO	$225.00	$383.00
	Rating Area 4: 10 rural counties in the NE part of the state	Nevada Health CO-OP	POS	$374.00	$637.00
		Anthem Blue Cross Blue Shield	HMO	$390.00	$664.00
NH	Rating Area 1: Entire state	Anthem Blue Cross and Blue Shield[13]	HMO	$236.46	$402.98
NM	Rating Area 1: Alburquerque, Rio Ranchero	Blue Cross Blue Shield of New Mexico[14]	HMO	$154.60	$263.46
		Molina Marketplace	HMO	$174.11	$296.72
		New Mexico Health Connections	HMO	$178.80	$304.71
	Rating Area 5: 27 rural counties	Blue Cross Blue Shield of New Mexico	HMO	$214.33	$365.25
		Presbyterian Health Plan, Inc.	HMO	$216.98	$369.78
		New Mexico Health Connections	HMO	$217.97	$371.45
NY	Rating Area 4: New York City	Metro Plus	HMO	$359.26	$359.26
		Health Republic Insurance of New York – Freelancers[15]	EPO	$365.00	$365.00
		Oscar	N/A	$385.00	$385.00
	Rating Area 8: Long Island	New York Fidelis	HMO	$360.00	$360.00
		Health Republic Insurance of New York - Freelancers	EPO	$365.00	$365.00
		Empire BCBS	N/A	$384.34	$384.34

State	Location	Insurer	Plan Type	Premium: 27-year-old	Premium: 50-year-old
NY	Rating Area 2: Buffalo	Health Republic Insurance of New York - Freelancers	EPO	$275.00	$275.00
		New York Fidelis	HMO	$338.11	$338.11
		BlueCross BlueShield of Western NY	POS	$371.71	$371.71
	Rating Area 7: 13 rural counties upstate[16]	New York Fidelis	HMO	$337.37	$337.37
		MVPHP	HMO	$372.61	$372.61
		Excellus	HDHP	$442.61	$442.61
OR	Rating Area 1: Portland, Gresham, Hillsboro	Moda Health[17]	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
	Rating Area 3: Salem	Moda Health[17]	PPO	$165.00	$281.00
		Health Republic Insurance	EPO	$183.00	$311.82
		PacificSource Health Plans	PPO	$203.00	$347.00
RI	Rating Area 1: Entire state	BlueCross BlueShield of Rhode Island[18]	HDHP	$224.64	$382.83
		Neighborhood Health Plan of Rhode Island[19]			
VT	Rating Area 1: Entire state	BCBSVT[20]	EPO	$395.26	$395.26
		MVP	HMO	$419.17	$419.17
WA	Rating Area 1: Seattle, Bellevue	Coordinated Care	HMO	$200.69	$342.02
		Group Health	HMO	$230.16	$392.24
		Premera	PPO	$231.75	$394.95
	Rating Area 4: Spokane	Coordinated Care	HMO	$192.46	$328.00
		Premera	PPO	$213.21	$363.36
		Lifewise	PPO	$213.41	$363.69
WV	Rating Area 2: Charleston	Highmark Blue Cross Blue Shield	PPO	$236.50	$403.05
		Highmark Blue Cross Blue Shield West Virginia	PPO	$250.19	$426.37
	Rating Area 9: 9 rural counties in the middle-eastern part of the state	Highmark Blue Cross Blue Shield	PPO	$215.22	$366.77
		Highmark Blue Cross Blue Shield West Virginia	PPO	$215.22	$366.77

[1] BCBS has the lowest 3 plans in Little Rock (rating area 1) and the only 3 plans in the 13 rural counties in the SE part of the state (rating area 5)

[2] Rocky Mountain has the lowest 16 plans in Grand Junction (rating area 5)

[3] Highmark BCBS Delaware has the lowest 3 plans in the state (rating area 1)

[4] CareFirst BCBS has the lowest 3 plans in DC (rating area 1)

[5] Kaiser Permanente has the lowest 5 plans in the state (rating area 1)

[6] SelectHealth has 7 of the 9 lowest plans in Boise/Meridian, though not the lowest one (rating area 6)

[7] BCBS has the 3 lowest plans and 7 of the 9 lowest in Chicago (rating area 1) and the 4 lowest plans in the 28 rural counties in the S-SE part of the state (rating area 13)

[8] Two of the insurers, Evergreen Health and UnitedHealthcare, do not have their premiums available in Baltimore (rating area 1) or the DC suburbs (rating area 3)

[9] CareFirst BCBS has the lowest 5 plans in Baltimore (rating area 1) and the DC suburbs (rating area 3)

[10] PreferredOne has the lowest 3 plans and 6 of the lowest 8 in Minneapolis/St. Paul/Bloomington (rating area 8)

[11] HealthPartners has the lowest 2 plans in Duluth (rating area 2)

[12] Health Plan of Nevada has the lowest 2 plans in Las Vegas/Henderson/N. Las Vegas (rating area 1)

[13] Anthem BCBS has the only 4 plans in the state (rating area 1)

[14] BCBS has the lowest 2 plans in Albuquerque/Rio Ranchero (rating area 1)

[15] Health Republic Insurance of New York - Freelancers has the lowest 2 plans (they both cost the same) in Syracuse (rating area 6)

[16] One of the insurers, American Prog - Today's Options, does not have its premiums available

[17] Moda has the lowest 3 plans in Portland/Gresham/Hillsboro (rating area 1) and in Salem (rating area 3)

[18] BCBS has the only 3 plans available regardless of income in the state (rating area 1)

[19] Neighborhood health plan only offers plans to those below a certain income level

[20] BCBSVT has the lowest 2 plans in the state (rating area 1)

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Little Evidence of the ACA Increasing Part-Time Work So Far

Bowen Garrett and Robert Kaestner

Timely Analysis of Immediate Health Policy Issues

SEPTEMBER 2014

In-Brief

There has been considerable public policy debate and media attention over the employment effects of the Affordable Care Act (ACA), and one of the most contentious issues has been whether the ACA has, or will, increase part-time work at the expense of full-time employment. This brief provides new evidence on the question using the latest available data from the Current Population Survey (CPS).

We find no evidence that the ACA had already started increasing part-time work before 2014. We find a small increase in part-time work in 2014 beyond what would be expected at this point in the economic recovery based on prior experience since 2000. This increase in part-time work is fully attributable to an increase in involuntary part-time work. The increase in involuntary part-time work, however, is not specific to the category of part-time work defined by the ACA (i.e., less than 30 hours per week), but applies to part-time work more broadly (also between 30 and 34 hours per week). Moreover, transitions between full-time and part-time work in 2014 are in line with historic patterns. These findings suggest that the increase in part-time work in 2014 is not ACA related, but more likely due to a slower than normal recovery of full-time jobs following the Great Recession.

Part-Time Work by Year...

Looking at trends over time

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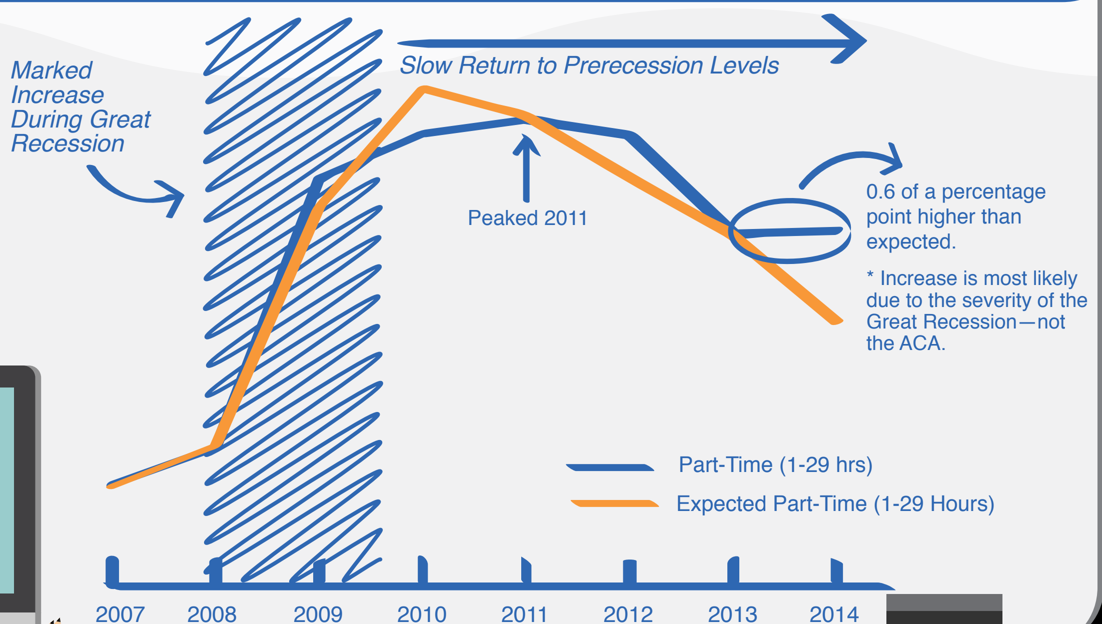
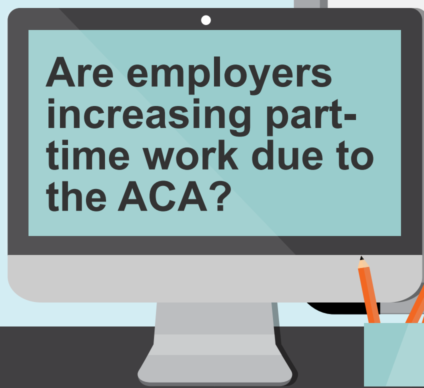




Why the ACA Could Affect Part-Time Work

There are two main channels through which the ACA could increase part-time work. First, employers with 50 or more employees will face financial penalties if they do not offer adequate and affordable coverage, and at least one of their full-time employees receives a subsidy for the purchase of individual coverage in a health insurance Marketplace. These penalties, often referred to as the "employer mandate" or the "employer responsibility requirement," encourage employers to provide or maintain health insurance coverage, thus limiting the cost of subsidies (tax credits) to assist individuals with incomes below 400 percent of the federal poverty level in purchasing insurance coverage independently.[1]

For the purpose of the ACA, a full-time worker is defined as one who works 30 or more hours in a typical week. An employer could reduce or avoid the risk of penalties by replacing full-time workers with more part-time workers or reducing part-time workers' hours below 30 per week.[2] If employers restrict the number of hours employees can work or increase hiring of people into part-time positions who were looking for full-time work, the amount of involuntary part-time work would increase.

Second, some people may have been working full time largely to obtain access to health insurance coverage through an employer because many employers do not offer health insurance benefits to part-time workers.[3] Availability of individual health insurance coverage through Medicaid or the Marketplaces, with subsidies available for workers with family incomes under 400 percent of the federal poverty level, could create incentives for some full-time workers to voluntarily scale back their hours to part-time. Thus, the ACA could increase voluntary part-time work by reducing the need for employer-sponsored coverage.[4] The Congressional Budget Office (CBO) and others have suggested that the potential effect of the ACA on voluntary part-time work could be larger than the potential effects on involuntary part-time work that have been the main focus of media attention.[5]

Widespread Reports of Employers Reducing Worker Hours as Early as 2013 Did Not Materialize in Economic Data

The Obama administration twice delayed the employer requirements—first in July 2013 and again in February this year. At this point, the employer penalties are delayed until 2016 for employers with 50 to 99 workers and until 2015 for larger employers (with softer requirements for larger employers that first year). Even though employer penalties have yet to take effect, it is possible that they have already affected part-time work because of anticipatory actions by employers, perhaps even as early as 2013, before the first delay of the mandate. This is because determining whether a worker counts as a full-time employee may be made by averaging past hours over a "look-back" period of 3 to 12 months.[6]

Widespread media reports suggest many employers have already reduced work hours in response to the ACA, and that even more plan to do so.[7] A Mercer survey conducted in 2012 found that 51 percent of employers that did not currently offer coverage to all employees working 30 hours or more per week said they would likely change workforce strategy so that fewer employees worked 30 or more hours per week.[8] A CNBC feature suggested that 27 percent of franchised businesses had replaced full-time workers with part-time workers and 31 percent reduced work hours in response to the ACA, stating "this is happening now, with more than a year before the mandate goes into effect; and undoubtedly, the number will rise as we approach next July's 'look back' period for tabulating workers' hours."[9] In February of this year, the *New York Times* reported several instances of local government entities (e.g., cities, counties, and community colleges) limiting or reducing work hours of part-time employees to keep workers under the threshold of 30 hours per week.[10] A *Wall Street Journal* op-ed suggested that a rise in part-time work from January 2013 to July 2013 was unprecedented and attributed the rise to the ACA.[11]

Are Media Reports Correct?

The CBO addressed the issue directly by undertaking a systematic analysis of the evidence, announcing in February of this year that: "In CBO's judgment, there is no compelling evidence that part-time work has increased as a result of the ACA." The CBO also acknowledged that the "current lack of direct evidence may not be very informative about the ultimate effects of the ACA."[12]

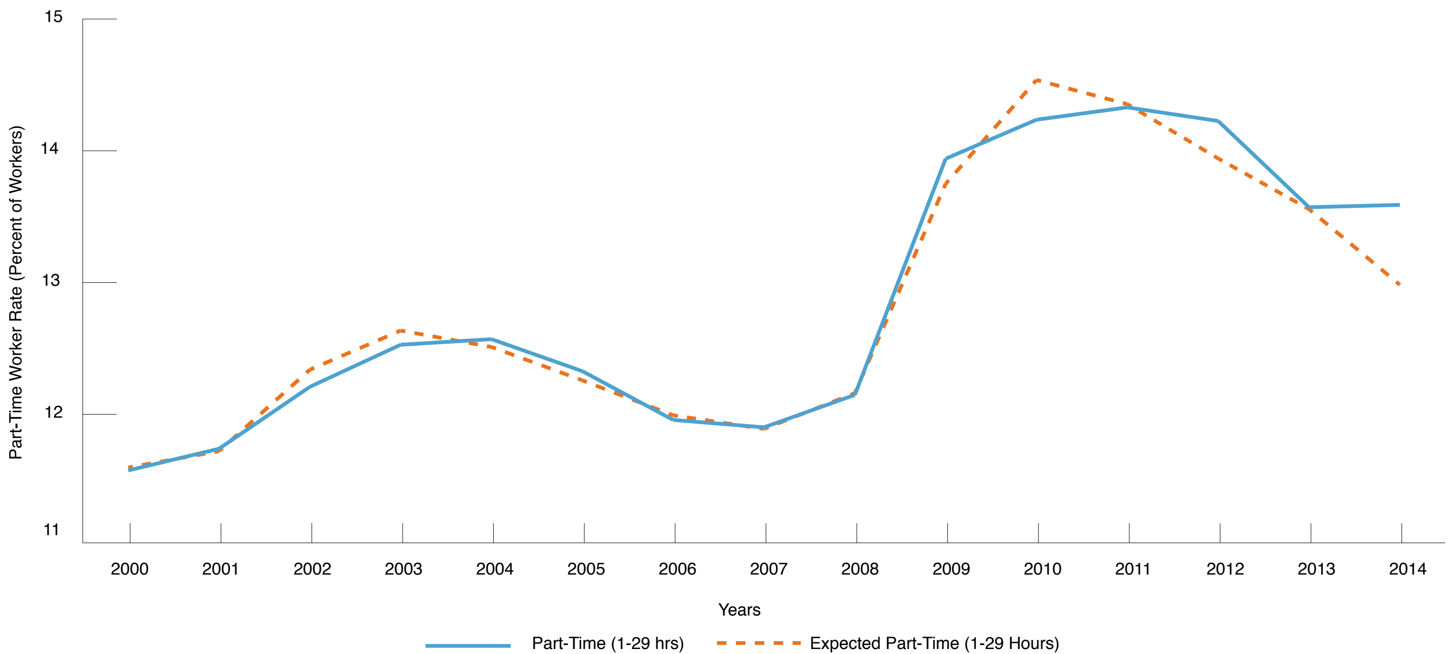
Similarly, previous studies have found little evidence of a shift toward part-time work in aggregate data. A study from the Federal Reserve Bank of San Francisco examined CPS data since 1976 and showed that the recent trend in part-time work and its current level are not unusual relative to past experience.[13] The study concluded that the effect of the ACA on part-time work (up to June 2013) had been small and would likely remain small in the future.[14]

Though it holds limited applicability to the entire United States, a study of labor market trends in Hawaii after it implemented employer mandate legislation in the 1970s may provide a relevant data point. Compared with the rest of the United States, the study found only a small increase on part-time work in Hawaii.[15] Under Hawaii's mandate, part-time employees working less than 20 hours per week are exempted.[16] The study found no detectable effect on either the likelihood of being employed or on wages, but it did find evidence of an increase on the rate of part-time work (less than 20 hours per week).[17] Over a period of about 23 years, the change in the rate of part-time work in Hawaii was a modest 1.4 percentage points higher than the change for the rest of the United States.

Recent Evidence on Trends in Part-Time Work

In the remainder of this brief, we update the findings of previous studies on

Figure 1. Part-Time Work (1-29 Hours) by Year



Source: Authors' analysis of Current Population Survey data from 2000-2014.
Notes: Part-time work defined as working 1-29 hours per week. Calculations for previous years use data from January – July to be consistent with available 2014 data. Expected rates are from a regression using the unemployment rate and its one-year lag as predictors.

potential effects of the ACA on part-time work by examining CPS data up to July 2014. We report trends separately for all part-time work and involuntary part-time work below the ACA threshold of 30 hours per week. We extend the previous research on trends in part-time work in two ways. First, we examine trends in the rate of work between 30 and 34 hours per week, which we would expect to fall if employers are reducing the hours of traditional part-time workers below the ACA threshold of 30 hours per week. Second, we examine actual transitions between full-time and part-time work. We compare year-to-year transitions in recent years, which could be affected by the ACA, to average transition rates from earlier years before the ACA's major provisions would have any effect. By examining transition patterns, we can better distinguish whether the recent trend in part-time work is related to the ACA rather than broader employment trends. Higher rates of transition from full-time work to part-time work than in previous years would be consistent with anticipatory actions by employers to reduce the number of full-time workers who may trigger penalties.

We first examine whether the share of those employed who worked part-time changed noticeably in 2014 relative to previous years. Data for the analysis come from the CPS, which is the primary source for labor force statistics in the United States. We use data from the January through July monthly surveys of the CPS for each year from 2000 to 2014. We chose January through July of each year because these are the months available for 2014 at this point in time, and we wanted to define a consistent period in each year to eliminate any seasonality differences. The sample is limited to those who report usual weekly hours of work and earnings, which is approximately 25 percent of the total monthly CPS sample. In addition, the sample is limited to adults age 18 to 64.

Figure 1 presents the share of those employed who worked part-time, which is defined as less than 30 hours per week (the ACA definition of part-time), from 2000 to 2014 (solid blue line). The figure also shows the share of workers that we should expect to work part-time given the unemployment rate. We use a simple regression model to obtain the expected amount of part-time work. Specifically, we estimate the relationship between part-time work and the unemployment rate and plot the predicted (expected) levels of part-time work (dashed orange line). We include the expected level to assess whether there is a noticeable deviation in the rate of part-time work from what we would expect to see in the absence of any potential effect because of the ACA.[19]

The first point to note about Figure 1 is the cyclicality of part-time work in the United States. There was a marked increase in part-time work during the Great Recession (which officially ran from December 2007 to June 2009). The return to prerecession levels of part-time work has been slow and incomplete as of 2014. In absolute terms, Figure 1 shows that the rate of part-time work peaked in 2011, declined from 2012 to 2013, and held steady from 2013 to 2014.

More importantly for the research question we focus on, for 2013, the rate of part-time work was exactly what we would expect it to have been given unemployment rate trends up to that

point. Thus, we see no evidence of an ACA effect on part-time work as of 2013.

There was a small, but statistically significant, increase in part-time work in 2014 relative to what we would expect given the economic recovery and associated recent declines in overall unemployment. The rate of part-time work is 0.6 of a percentage point higher than expected (based on historical patterns) for the first seven months of 2014. The gap of 0.6 of a percentage point is small relative to the high degree of variability in part-time work observed over the past 8 years, which ranged from a low of 11.9 percent to a high of 14.3 percent.

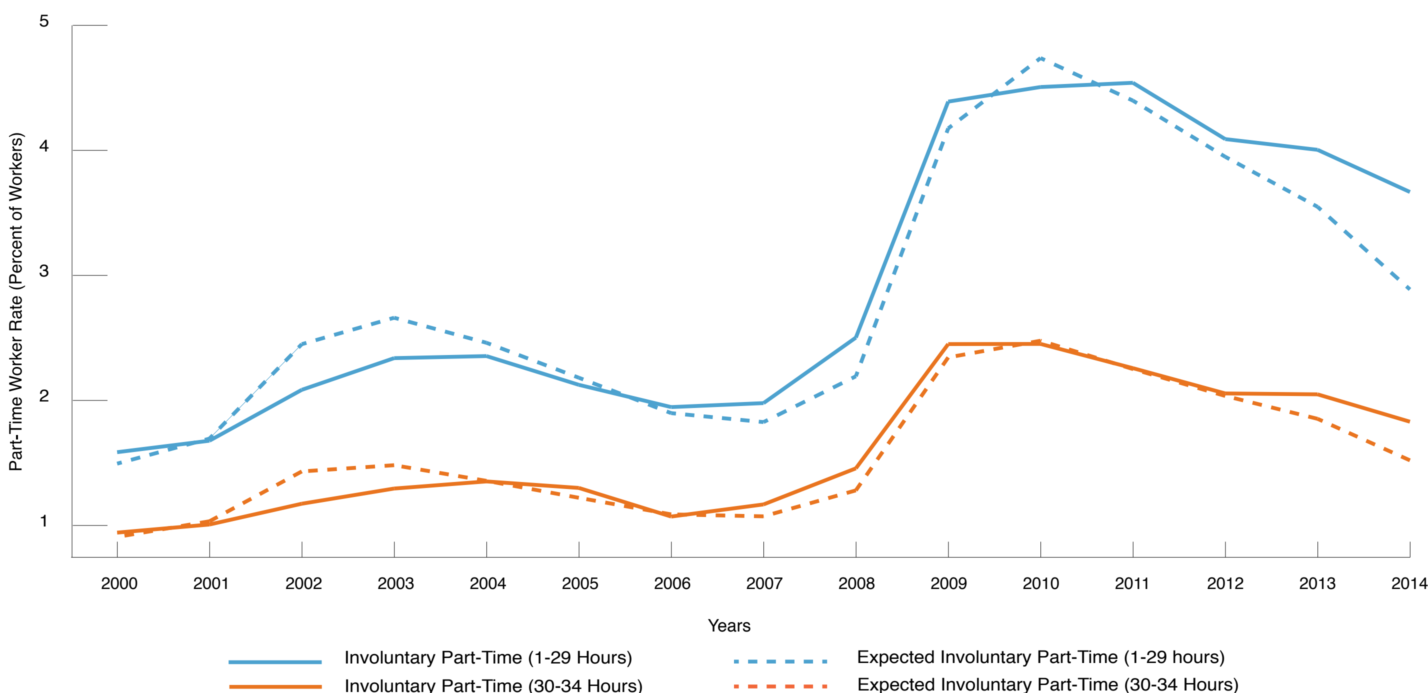
Figure 2 provides a similar analysis, but focuses on involuntary part-time work (e.g., due to slack work or inability to find a full-time job). Involuntary part-time work is useful to examine because it is this outcome that should be affected if employers are reducing workers' hours to avoid employer mandate penalties. The solid and dashed lines at the top of Figure 2 show the rates of actual and expected involuntary part-time work of 1 to 29 hours per week over time. The solid and dashed lines at the bottom show the rates of actual and expected involuntary part-time work (as traditionally defined) of 30 to 34 hours per week. If employers were reducing workers' hours from above the 30-hour threshold to below, we should see the amount of part-time work of 30 to 34 hours per week fall below its expected value, while the amount of part-time work below 30 hours per week rises above its expected value.

Figure 2 shows that involuntary part-time work of 1 to 29 hours per week peaked in 2011, and has declined in absolute terms in every year since—consistent with economic recovery—and continued to decline from 2013 to 2014. In the last two years, however, the rate of involuntary part-time work has fallen by less than would be expected given declining rates of unemployment. For 2014, the rate of involuntary part-time work (1 to 29 hours per week) is 0.8 percentage points higher than expected. This indicates that the gap between actual and expected part-time work of 0.6 of percentage point shown in Figure 1 is fully accounted for by the gap in involuntary part-time work relative to what is expected.

Is the gap in involuntary part-time work in 2014 attributable to employers reducing workers' hours because of the ACA? Or does it reflect a sluggish recovery of full-time jobs following an unusually deep recession? In the bottom two lines in Figure 2, we find evidence more consistent with the second explanation. If employers were reducing workers hours from above the 30-hour threshold to below, we should see the amount of involuntary part-time work of 30 to 34 hours per week lie below its expected value in 2014. Instead, we find the share of employees working 30 to 34 hours per week involuntarily is also higher than expected in 2014.[20] This suggests the excess part-time work of 1 to 29 hours relative to expectation is part of a broader trend that also leads to more involuntary part-time work of 30 to 34 hours per week.[21]

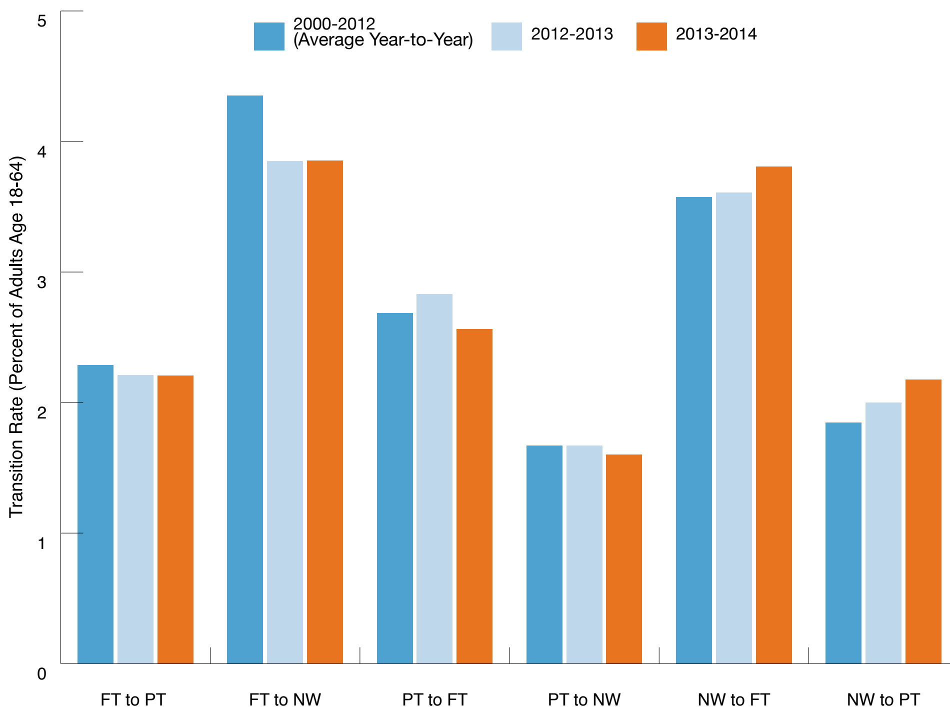
Also, because the excess gap in overall part-time work is fully explained by

Figure 2. Involuntary Part-Time Work by Year



Source: Authors' analysis of Current Population Survey data from 2000-2014.
Notes: Calculations for previous years use data from January –July to be consistent with available 2014 data. Expected rates are from regressions using the unemployment rate and its one-year lag as predictors.

Figure 3. Transitions Among Full-Time Work, Part-Time Work, and Not Working, by Time Period



Source: Authors' analysis of Current Population Survey data from 2000-2014.

Notes: FT refers to full-time work status (working 30 or more hours per week). PT refers to part-time work status (working 1-29 hours per week). NW refers to not working. FT to PT, for example, indicates transitions from full-time to part-time status.

the rise in involuntary part-time work, there seems to be no evidence to date that people have voluntarily reduced their hours of work in response to the availability of health insurance and subsidies for that insurance in the health insurance Marketplaces.

Year-to-Year Transitions Show No Recent Shifts from Full-Time Work to Part-Time Work above What Would Be Expected from Prior Years

The increase in part-time work in 2014 relative to expectation, revealed by Figure 1, is most likely attributable to greater entry of people into the workforce as employment picks up with economic recovery, but not enough to absorb all who want to work full time. To further test whether the relative increase in part-time work is related to the ACA, we examined actual work status transitions of workers between two consecutive years. We used the same data as in Figure 1, but for a subsample of persons that we could follow over two years.[22] For each pair of years between 2000 and 2014, we calculated transition rates (the share of individuals changing work-status category) between full-time work, part-time work, and non-work. We collapsed the year-to-year transitions observed over the period from 2000 to 2012 into one to serve as a comparison for transitions that occurred from 2012 to 2013 and from 2013 to 2014.

Figure 3 presents the transition rates. There is very little change in transition rates between full-time and part-time work between the long-term average (2000 to 2012, which spans two business cycles) and the recent years after ACA enactment. This pattern is inconsistent with anticipatory efforts by employers to reduce the number of full-time workers to avoid penalties under the ACA. If the ACA were causing the relative increase in part-time work, we would expect transitions from full-time to part-time to increase and transitions from part-time to full-time to decrease. Instead, as noted, we see little change in transition rates between these categories.[23] The largest changes in transitions are between non-work and work (in both directions). Transitions from non-work to part-time work are consistent with the growth in involuntary part-time work as people enter the labor force seeking full-time work, but have to settle for part-time work because of inadequate employer demand for workers.

Conclusion

Based on our analysis, we find no evidence that the ACA affected part-time employment in 2013 before the implementation of the major ACA provisions. There were no apparent anticipatory effects of the ACA's employer mandate provisions on this measure. However, data indicate that among all workers, there has been a small, statistically significant, increase in part-time work in 2014 (relative to what would be expected given the decline in the unemployment rate). The increase is entirely due to an increase in involuntary part-time work—workers preferring to work full-time but who cannot find such employment. However, similar growth in involuntary part-time work at and above the ACA threshold of 30 hours per week, and evidence of transitions between full-time and part-time work that are in line with historic patterns, suggest the increase in involuntary part-time work is most likely due to the severity and depth of the Great Recession—not the ACA.[24] Although we find little evidence consistent with anticipatory effects of the ACA's employer mandate on part-time work to date, our analysis does not rule out the possibility of effects in the future if the mandate goes into effect in 2015 as scheduled and as other ACA provisions are more fully implemented. We will continue monitoring the consequences of the ACA on part-time work and other labor market outcomes as more data become available.

The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees, or its funders.

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Bowen Garrett is a senior fellow at the Urban Institute's Health Policy Center. Robert Kaestner is a professor in the Institute of Government and Public Affairs of the University of Illinois and a professor in the Department of Economics of the University of Illinois at Chicago. The authors thank Anuj Gangopadhyaya for excellent research assistance and Linda Blumberg, Genevieve Kenney, John Holahan, and Robert Valletta for helpful comments and suggestions. The authors are grateful to the Robert Wood Johnson Foundation for supporting this research.

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Notes

1 Employees that are offered employer coverage are only eligible for subsidized coverage in the health insurance Marketplaces if the employee's share of the lowest-cost option provided by their employer for single (worker only) coverage exceeds 9.5 percent of the employee's income or if, on average, the plan reimburses less than 60 percent of covered expenses—conditions designed to protect most employers offering coverage from facing any penalties.

2 For an employer that does not offer coverage, if at least one full-time employee receives a subsidy in a Marketplace, the employer is subject to a penalty of $2,000 per full-time worker minus the first 30 workers. For an employer that does offer coverage, if a full-time employee receives a subsidy in a Marketplace, the employer is subject to a penalty equivalent to the lesser of $3,000 for each full-time subsidized employee or $2,000 per full-time worker minus the first 30 workers.

3 Kaiser Family Foundation. *2013 Employer Health Benefits Survey*. Menlo Park, CA: Kaiser Family Foundation, 2013, http://kff.org/report-section/ehbs-2013-section-2/ (accessed August 2014).

4 Congressional Budget Office. "Labor Market Effects of the Affordable Care Act: Updated Estimates." In *The Budget and Economic Outlook*: 2014 to 2024. Washington: Congressional Budget Office, 2014, http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-breakout-AppendixC.pdf (accessed August 2014).

5 ibid. Also see Mulligan C. *Is the Affordable Care Act Different From Romneycare? A Labor Economics Perspective.* Cambridge, MA: National Bureau of Economic Research, 2013.

6 Gordon AM, Mattinson J, Nash SM and Weyeneth JA. *Final Regulations Issued Regarding Employer Shared Responsibility Under the ACA*. Chicago: McDermott, Will, and Emery, 2014, http://www.mwe.com/Final-Regulations-Issued-Regarding-Employer-Shared-Responsibility-Under-the-ACA-02-18-2014/ (accessed August 2014).

7 Noguchi Y. "As Health Law Changes Loom, a Shift to Part-Time Workers," *National Public Radio*, April 23, 2013, http://www.npr.org/2013/04/29/179864601/as-health-law-changes-loom-a-shift-to-part-time-workers (accessed August 2014).

8 Watts T and Gaertner S. "Health Care Reform and the Hourly Challenge." *Benefits Quarterly*, 29(2): 26–29. 2013. http://www.ifebp.org/inforequest/0163661.pdf (accessed August 1, 2014).

9 Caldeira S and Josten B. "Business Backlash: Obamacare's Part-Time Jobs Problem," *CNBC*, November 14, 2013, http://www.cnbc.com/id/101196459 (accessed August 2014).

10 Pear R. "Public Sector Cuts Part-Time Shifts to Bypass Insurance Law," *New York Times*, February 20, 2014.

11 Puzder A. "ObamaCare and the Part-Time Economy," *Wall Street Journal*, October 10, 2013, http://online.wsj.com/news/articles/SB10001424052702303382004579127162339871336 (accessed August 2014).

12 Congressional Budget Office, "Labor Market Effects."

13 Valletta RG and Bengali L. "What's Behind the Increase in Part-Time Work?" Federal Reserve Bank of San Francisco Economic Letter, August 26, 2013, http://www.frbsf.org/economic-research/publications/economic-letter/2013/august/part-time-work-employment-increase-recession/ (accessed August 2014).

14 Also see Graham-Squire D and Jacobs K. *Which Workers Are Most at Risk of Reduced Work Hours under the Affordable Care Act?* Berkeley: University of California at Berkeley Labor Center, 2013, http://laborcenter.berkeley.edu/healthcare/reduced_work_hours13.pdf (accessed August 2014); and Bernstein J, "The Affordable Care Act and Part-Time Work," *Economix*, August 22, 2013, http://economix.blogs.nytimes.com/2013/08/22/the-affordable-care-act-and-part-time-work/?_php=true&_type=blogs&_r=0 (accessed August 2014).

15 Buchmueller TC, DiNardo J, and Valletta RG. 2011. "The Effect of an Employer Health Insurance Mandate on Health Insurance Coverage and the Demand for Labor: Evidence from Hawaii." *American Economic Journal: Economic Policy*, 3(4): 25–51.

16 Unlike the ACA, small employers are not exempted under Hawaii's mandate. A business that does not comply with the mandate within 30 days may be closed until it comes into compliance. Employee premium contributions are limited to 1.5 percent of an employee's wages, and as such are stronger than the ACA's requirement limiting contributions to 9.5 percent of an employee's wages.

17 The effect on part-time work was statistically significant at the 10 percent level, but not at the 5 percent level.

18 The expected rate of part-time work was estimated using a regression analysis to predict the share of part-time work using the average monthly unemployment rate (January-July, not seasonally adjusted) of the current year and the previous year as explanatory variables. We only use data before 2013 to compute the expected values; as such, they do not reflect potential effects of the ACA in 2013 or 2014.

19 This approach only considers the association between part-time work and unemployment, and does not include other factors that may affect part-time work, which is a limitation of this analysis we will address in future work. However, our simple model fits the data closely with the unemployment rate explaining 98 percent of the variability in part-time work over this period.

20 We also find that the share of all part-time work from 30 to 34 hours per week is higher than expected in 2014 (not shown in figure).

21 A fraction of workers who are considered full-time because they work 35 or more hours per week overall may actually hold multiple part-time jobs. We will examine trends in multiple jobholding among full-time workers in future work.

22 The overlap sample may not be representative of the general population as it may underrepresent people who move over the period, possibly due to unstable job situations, which would underestimate the full extent of work status transitions.

23 Transition rates between full-time and part-time work (in both directions) in the 2012-2013 and 2013-2014 periods are very similar to those in the most recent prior periods (e.g., 2009–2010, 2010–2011, and 2011–2012) as well the average rates over the years prior to the Great Recession (2000–2007) (not shown in table).

24 Cajner T, Mawhirter D, Nekarda C and Ratner D. "Why is Involuntarily Part-Time Work Elevated?" Washington: Board of Governors of the Federal Reserve System, 2014, http://www.federalreserve.gov/econresdata/notes/feds-notes/2014/why-is-involuntary-part-time-work-elevated-20140414.html (accessed August 2014).

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National Health Expenditure Projections, 2013–23: Faster Growth Expected With Expanded Coverage And Improving Economy

ABSTRACT In 2013 health spending growth is expected to have remained slow, at 3.6 percent, as a result of the sluggish economic recovery, the effects of sequestration, and continued increases in private health insurance cost-sharing requirements. The combined effects of the Affordable Care Act's coverage expansions, faster economic growth, and population aging are expected to fuel health spending growth this year and thereafter (5.6 percent in 2014 and 6.0 percent per year for 2015–23). However, the average rate of increase through 2023 is projected to be slower than the 7.2 percent average growth experienced during 1990–2008. Because health spending is projected to grow 1.1 percentage points faster than the average economic growth during 2013–23, the health share of the gross domestic product is expected to rise from 17.2 percent in 2012 to 19.3 percent in 2023.

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There has been a strong historical relationship between spending on health care and economic growth,[1] and it is anticipated that economics will continue to play a major role in the outlook for national health expenditures through 2023. The recent period is marked by a four-year historically low rate of health spending growth, which was primarily attributable to the sluggish economic recovery and constrained state and local government budgets following the 2007–09 recession. In addition, increases in cost sharing for people with private health insurance and a few notable one-time factors, such as the effect of having several top-selling brand-name drugs lose patent protection, contributed to the slow overall spending growth.[2]

For 2013, national health spending growth is expected to remain low, at 3.6 percent. This is mainly because of continued modest economic growth; the impacts of sequestration and continued slow growth in the use of Medicare services; and additional increases in cost-sharing requirements, including continuing increases in the adoption of high-deductible health plans.[3,4]

In addition to the short-term increase in spending growth associated with the coverage expansions in the Affordable Care Act (ACA) in 2014 and beyond, economic growth during the next decade is projected to be faster than it has been since 2007. These more favorable economic conditions are expected to result in greater demand for health care goods and services; increases in health coverage; and faster rates of health spending growth, particularly for private health insurance. However, these rates of increase are expected to be dampened somewhat by the slower growth in Medicare payment rates mandated by the ACA and the ongoing trend toward higher cost-sharing requirements for the privately insured.

During the full projection period (2013–23) national health expenditures are projected to increase at an average rate of 5.7 percent per year, or 1.1 percentage points more rapidly than the average annual growth rate in nominal (that is, not adjusted for inflation) gross domestic product (GDP). As a result, the share of GDP

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devoted to health care is projected to rise from 17.2 percent in 2012 to 19.3 percent by 2023.[5]

This projected average health spending growth trend is faster relative to growth in recent history. However, it is comparatively slower than the 7.2 percent average annual growth experienced in 1990–2008, which was 2.0 percentage points faster than growth in GDP. The 5.7 percent annual growth in overall health spending through 2023 is occurring as additional baby boomers continue to age into Medicare and as the number of uninsured people is projected to fall from roughly forty-five million in 2012[2] to about twenty-three million by 2023.

This article provides a summary of the most recent health expenditure projections prepared by the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary, for the period 2013–23.

Year-By-Year Overview Of The Projection Period

2013 In 2013 national health spending is anticipated to have increased by 3.6 percent, which would mark the fifth consecutive year of spending growth under 4.0 percent (Exhibit 1).[2] For 2013 this is attributable to slow growth both in the economy and in Medicare spending.

The pace of the economic recovery continues to be modest. Growth in GDP was 3.4 percent in 2013 (Exhibit 2). In response to this moderate economic growth, as well as moderate employment growth, private health insurance enrollment is expected to have remained nearly unchanged, and consumers are expected to have continued to limit their use of health care services.[3]

Additionally, Medicare spending growth also slowed in 2013. It decelerated from 4.8 percent to 3.3 percent because of budget sequestration requirements;[6] other payment adjustments, such as multiple procedure payment reductions for physician services; and slower growth in utilization across all services.

Medicaid expenditure growth is expected to have accelerated in 2013 (from 3.3 percent in 2012 to 6.7 percent), nearly offsetting the deceleration in spending from other payers. The rebound of Medicaid spending growth includes the effect of a temporary payment increase for primary care physicians mandated by the ACA, as well as states' increasing provider reimbursement rates and expanding benefits.[7]

2014 Growth in national health spending is projected to increase to 5.6 percent in 2014 as nine million uninsured Americans gain health insurance, largely through Medicaid and private health insurance plans—including those available through the health insurance Marketplaces. In addition, expected changes to insurance markets in 2014, such as the availability of more generous coverage options for people who were previously insured, will likely contribute significantly to projected accelerations in spending growth for Medicaid (12.8 percent) and private health insurance (6.8 percent) and to a slight decline in projected out-of-pocket spending (−0.2 percent in 2014, down from 3.2 percent in 2013).

While these enrollment shifts play a significant role in the overall and underlying per enrollee spending trends in 2014, changing demographics also factor in, because of the effect of the ongoing shift of the baby-boomer generation from private health insurance to Medicare. This occurs because people with private insurance who age into Medicare go from being among the highest spenders in the private health insurance enrollment population (where average spending was $4,876 in 2012) to among the lowest spenders in the Medicare beneficiary population (where average spending was $11,522 in 2012).

As a result, demographic shifts alone are projected to contribute just 0.1 percentage point to the 6.0 percent growth in per enrollee private health insurance spending in 2014, down from a 0.6-percentage-point contribution to growth in 2004. Conversely, demographics are projected to reduce the 0.8 percent growth in Medicare per beneficiary spending by 0.3 percentage point; in 2004 they added 0.1 percentage point to per beneficiary growth.

2015 In 2015 national health spending growth is projected to slow to 4.9 percent, despite an additional eight million uninsured Americans' gaining coverage through Medicaid or private plans and faster projected economic growth. This slowdown is projected to occur because of significant decelerations in Medicare and Medicaid spending.

Medicare expenditure growth is projected to slow by 1.5 percentage points, to 2.7 percent, mainly as a result of reduced payments to Medicare Advantage plans.[8,9] In addition, growth in Medicaid spending is projected to revert to a more historically consistent rate of 6.7 percent because the temporary increase in payments to primary care providers is scheduled to expire, and the surge in enrollment in 2014—the first year of coverage expansion—is projected to subside somewhat.

2016–23 During the remainder of the projection period, health care spending is expected to grow 6.1 percent per year, which is faster than the 4.7 percent average growth projected for 2013–15. One major factor is faster in-

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EXHIBIT 1

National Health Expenditures (NHE), Amounts And Annual Growth From Previous Year Shown, By Spending Category, Selected Calendar Years 2008–23

Spending category	2008[a]	2012	2013	2014	2015	2019	2023
EXPENDITURE, BILLIONS							
NHE	$2,411.7	$2,793.4	$2,894.7	$3,056.6	$3,207.3	$4,042.5	$5,158.8
Health consumption expenditures	2,257.3	2,633.4	2,735.1	2,893.3	3,040.8	3,834.0	4,891.3
Personal health care	2,017.1	2,360.4	2,448.3	2,579.3	2,706.0	3,413.1	4,359.7
Hospital care	729.0	882.3	918.8	959.9	1,008.5	1,276.1	1,637.7
Professional services	652.8	752.3	776.7	822.7	856.8	1,077.4	1,369.1
Physician and clinical services	486.5	565.0	583.9	618.5	641.9	805.2	1,023.8
Other professional services	64.0	76.4	79.8	87.6	92.3	119.3	153.4
Dental services	102.4	110.9	113.0	116.6	122.7	153.0	191.8
Other health, residential, and personal care	113.5	138.2	145.6	153.1	161.5	206.9	267.1
Home health care	62.3	77.8	81.5	86.2	91.7	121.5	162.3
Nursing care facilities and continuing care retirement communities	132.6	151.5	156.4	162.3	170.2	215.6	271.4
Retail outlet sales of medical products	326.9	358.3	369.2	395.2	417.3	515.6	652.3
Prescription drugs	242.6	263.3	272.1	290.7	309.3	381.8	482.8
Durable medical equipment	34.9	41.3	42.3	44.0	45.8	56.0	71.3
Other nondurable medical products	49.5	53.7	54.8	60.5	62.2	77.8	98.2
Government administration	29.4	33.6	35.1	36.3	37.8	50.1	66.7
Net cost of health insurance	139.2	164.3	174.5	196.7	212.5	268.7	341.0
Government public health activities	71.5	75.0	77.2	81.1	84.5	102.1	123.9
Investment	154.4	160.0	159.7	163.3	166.5	208.5	267.4
Noncommercial research	44.0	48.1	47.1	47.2	46.4	55.8	69.5
Structures and equipment	110.4	111.9	112.6	116.2	120.1	152.7	197.9
ANNUAL GROWTH							
NHE	7.1%	3.7%	3.6%	5.6%	4.9%	6.0%	6.3%
Health consumption expenditures	7.0	3.9	3.9	5.8	5.1	6.0	6.3
Personal health care	6.9	4.0	3.7	5.3	4.9	6.0	6.3
Hospital care	7.2	4.9	4.1	4.5	5.1	6.1	6.4
Professional services	6.4	3.6	3.2	5.9	4.2	5.9	6.2
Physician and clinical services	6.4	3.8	3.3	5.9	3.8	5.8	6.2
Other professional services	6.7	4.5	4.5	9.8	5.3	6.6	6.5
Dental services	6.1	2.0	1.9	3.1	5.3	5.7	5.8
Other health, residential, and personal care	7.0	5.0	5.3	5.1	5.5	6.4	6.6
Home health care	8.8	5.7	4.8	5.7	6.4	7.3	7.5
Nursing care facilities and continuing care retirement communities	5.6	3.4	3.2	3.7	4.9	6.1	5.9
Retail outlet sales of medical products	7.6	2.3	3.1	7.0	5.6	5.4	6.1
Prescription drugs	8.3	2.1	3.3	6.8	6.4	5.4	6.0
Durable medical equipment	4.8	4.3	2.5	4.0	4.1	5.2	6.2
Other nondurable medical products	6.3	2.1	2.1	10.4	2.7	5.8	6.0
Government administration	6.4	3.4	4.3	3.4	4.3	7.3	7.4
Net cost of health insurance	10.1	4.2	6.2	12.7	8.1	6.0	6.1
Government public health activities	6.2	1.2	2.9	5.1	4.2	4.8	5.0
Investment	7.8	0.9	−0.2	2.3	1.9	5.8	6.4
Noncommercial research	6.4	2.2	−2.1	0.1	−1.7	4.7	5.7
Structures and equipment	8.4	0.3	0.6	3.2	3.4	6.2	6.7

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Definitions, sources, and methods for NHE categories can be found at CMS.gov. National Health Expenditures Accounts: methodology paper, 2012: definitions, sources, and methods [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2014 [cited 2014 Jan 6]. Available from: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/dsm-12.pdf. Numbers may not sum to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 2002–08.

creases in both disposable personal income and private health insurance enrollment, which are projected to occur because of improved economic conditions: GDP growth is projected to be 5.3 percent in 2018. Consistent with the historical relationship between health spending and economic cycles, these projected changes in the economy are expected to influence health expenditure growth with a lag, which will contribute to a projected peak in the health spending growth rate of 6.6 percent in 2020.

Additionally, Medicare expenditure growth is

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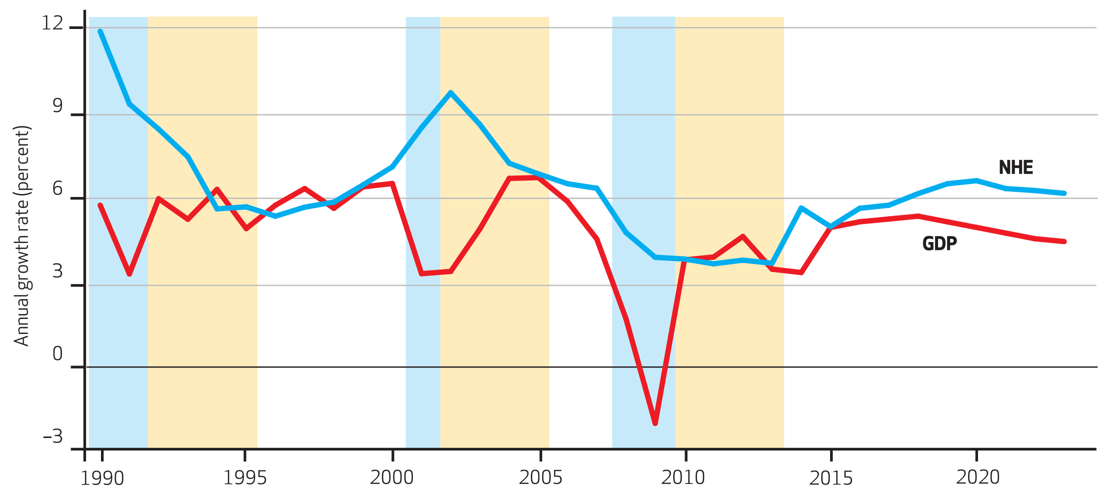
EXHIBIT 2

Annual Growth Rates, Gross Domestic Product (GDP) And National Health Expenditures (NHE), Calendar Years 1990–2023



SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and Department of Commerce, Bureau of Economic Analysis and National Bureau of Economic Research. **NOTES** Numbers for 2013–23 are projections. Blue areas represent US business cycle contractions (recessions in July 1990–March 1991, March 2001–November 2001, and December 2007–June 2009). Tan areas represent the four-year period after each contraction: 1992–95, when GDP was 5.6 percent and NHE 6.7 percent; 2002–05, when GDP was 5.4 percent and NHE 8.0 percent; and 2010–13, when GDP was 3.9 percent and NHE 3.7 percent.

projected to accelerate to a projection-period high of 7.9 percent in 2020. This is a result of continued enrollment in Medicare by the baby-boom generation and faster per beneficiary spending growth as this population ages.

Model And Assumptions

The national health expenditure projections employ actuarial and econometric modeling techniques, as well as judgments about future events and trends that influence health spending.[1] The projections use the economic and demographic assumptions from the 2014 *Medicare Trustees Report*, which were updated to reflect the latest macroeconomic data.[1,10] In addition, the CMS Office of the Actuary used its health reform model to determine the major impacts of the ACA's expansion-related provisions on national health spending and health insurance enrollment.[1]

The health expenditure projections presented here are consistent with the projected baseline scenario in the 2014 *Medicare Trustees Report*, which assumes that Medicare physician fee schedule rates will grow zero percent in 2015 and 0.6 percent per year for 2016–23,[10] as opposed to the scheduled growth under the Sustainable Growth Rate formula in current law, which includes a reduction of approximately 21 percent on April 1, 2015.

These projections remain subject to substantial uncertainty and reflect the variable nature of future economic trends, as exemplified by the prolonged and comparatively sluggish nature of the recovery from the 2007–09 recession.[11] In addition, the United States has experienced only the initial effects of the ACA's coverage expansions. The impacts of reform on the behavior of consumers, insurers, employers, and providers will continue to unfold throughout the projection period and beyond. In particular, the supply-side effects of the ACA remain highly speculative and are not included in these estimates.[12] However, methods by which to estimate such impacts are being investigated.[13]

Outlook For Medical Services And Goods

HOSPITAL SERVICES Total hospital spending growth is expected to have slowed from 4.9 percent in 2012 to 4.1 percent in 2013 and to have reached $918.8 billion (Exhibit 1). Because of the effects of sequestration and slower growth in utilization, Medicare hospital spending growth is expected to have slowed from 4.5 percent in 2012 to 2.5 percent in 2013. However, increased use of hospital services attributable to the ACA's coverage expansions are projected to result in accelerating growth in hospital spending of 4.5 percent in 2014 and 5.1 percent in 2015.

The projected rate of hospital spending growth generally increases after that point, reaching a peak of 6.7 percent in 2020 and then averaging

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6.4 percent per year through 2023. Continued rapid enrollment in Medicare by baby boomers and faster increases in per beneficiary spending because of the aging of the population are expected to result in robust Medicare hospital spending growth of 6.9 percent per year for 2016–23, despite the impact of slower Medicare hospital payment rate updates that have been in effect since 2012. Reflecting the impact of faster economic growth on health spending and insurance enrollment, private health insurance spending for hospital services is projected to increase by an average of 5.9 percent per year for 2016–23.

PHYSICIAN AND CLINICAL SERVICES Spending growth on physician and clinical services is projected to have been $583.9 billion in 2013 (Exhibit 1). This reflects a decrease in growth from 4.6 percent in 2012 to 3.3 percent in 2013.

Underlying the slowdown in spending growth is the lowest rate of price growth since 2002 (nearly zero percent). This is partly because of reductions in payments to Medicare providers resulting from the sequester and procedural payment changes.[14,15] Correspondingly, growth in Medicare expenditures for physician and clinical services is expected to have decelerated from 5.4 percent in 2012 to 2.6 percent in 2013. Medicaid spending for these services, in contrast, is anticipated to have grown 12.6 percent in 2013 (compared to 2.6 percent in 2012) as a result of temporary increases in payments to primary care physicians that continue through 2014.[16]

Expenditure growth for physician and clinical services is projected to accelerate to 5.9 percent in 2014 (Exhibit 1). This acceleration is influenced by expectations that the people who are newly insured—in particular, those newly covered by Medicaid—will be younger than the currently insured and thus will devote a higher share of their health care spending to these services relative to more acute hospital care.[17–19]

The effects of expanded coverage through Medicaid and private health insurance are expected to continue in 2015. However, expirations of temporary payment increases to Medicaid providers, combined with lower payments to Medicare Advantage plans,[8] are projected to result in slower overall growth in spending on physician and clinical services in that year (3.8 percent).

Growth in spending on these services is projected to climb steadily and to reach 6.5 percent by 2020, before slowing to 5.9 percent by 2023. With the continued aging of the baby-boom generation into Medicare, average annual growth in Medicare spending for physician and clinical services (7.1 percent) for 2016–23 is projected to outpace spending growth for these services paid for by private health insurance (5.4 percent). This occurs despite continuing coverage expansions under health reform and generally more favorable economic conditions, including higher levels of disposable personal income and higher enrollment in private health insurance.

PRESCRIPTION DRUGS In 2013 prescription drug spending is expected to have increased by 3.3 percent, up from 0.4 percent in 2012, and to have accounted for $272.1 billion in health expenditures (Exhibit 1). The projected acceleration is driven by a smaller effect of brand-name prescription drugs losing patent protection, compared to the previous year.[20] Use of prescription drugs (measured by dispensed prescriptions) was estimated to have increased by 1.6 percent in 2013, compared to 1.2 percent in 2012.[20]

In 2014 prescription drug spending growth is projected to accelerate to 6.8 percent. This is primarily a result of increases in the use of prescription drugs by the newly insured and by those who have switched to more generous insurance plans under the ACA's coverage expansions. Early analysis indicates that compared to other forms of private health insurance, Marketplace plans are experiencing greater use of drugs in several therapy classes, including higher use of specialty drugs.[21] In addition, expensive new hepatitis C treatments are expected to contribute to an acceleration of drug spending growth in 2014.[22]

For 2015, continued gains in insurance coverage through Medicaid and Marketplace plans are anticipated to lead to continued strong increases in the use of prescription drugs. As a result, the growth rate for drug expenditures is expected to be 6.4 percent.

For the periods 2016–19 and 2020–23, prescription drug spending growth is projected to average 5.4 percent and 6.0 percent, respectively. Growth in the first period is significantly faster than the 2.4 percent estimated for 2008–13. However, it is slower than the 6.6 percent projected for 2014–15. This is attributable to slower expected enrollment growth rates for Medicaid and Marketplace plans after the major coverage transitions occurring in 2014 and 2015.

In 2020–23 drug utilization is expected to increase slightly as a result of higher disposable personal income and changing guidelines that encourage physicians to introduce drug therapies at earlier stages of treatment. Also, the share of spending on expensive specialty drugs purchased through retail channels is expected to continue to increase steadily.[23]

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Payer Outlook

MEDICARE In 2013 Medicare expenditures are expected to have reached $591.2 billion (Exhibit 3). However, spending growth is expected to have slowed to 3.3 percent from 4.8 percent in 2012, largely driven by sequestration and lower utilization across Medicare services, including hospital services.

Medicare spending growth is projected to remain low in 2014 and 2015, as well. In 2014 an increase is expected in the use and intensity of most Medicare services. Nonetheless, Medicare spending growth is expected to reach only 4.2 percent as a result of continued slow payment rate increases and a decline in per beneficiary use of inpatient hospital services. In 2015 the growth rate is projected to be just 2.7 percent,[24] driven mainly by lower payments to Medicare Advan-

EXHIBIT 3

National Health Expenditures (NHE), Amounts, Share Of Gross Domestic Product (GDP), And Average Annual Growth From Previous Year Shown, By Source Of Funds, Selected Calendar Years 2008–23

Source of funds	2008[a]	2012	2013	2014	2015	2019	2023
EXPENDITURE, BILLIONS							
NHE	$2,411.7	$2,793.4	$2,894.7	$3,056.6	$3,207.3	$4,042.5	$5,158.8
Health consumption expenditures	2,257.3	2,633.4	2,735.1	2,893.3	3,040.8	3,834.0	4,891.3
Out of pocket	300.7	328.2	338.6	338.1	345.7	413.5	512.2
Health insurance	1,703.2	2,014.4	2,094.1	2,246.1	2,372.5	3,015.2	3,875.9
Private health insurance	807.8	917.0	947.5	1,012.2	1,082.4	1,330.4	1,653.2
Medicare	467.9	572.5	591.2	615.9	632.7	825.3	1,111.3
Medicaid	344.9	421.2	449.5	507.2	541.1	711.3	918.8
Federal	203.5	237.9	254.1	302.4	323.0	423.2	542.6
State and local	141.4	183.3	195.4	204.8	218.1	288.2	376.2
Other health insurance programs[b]	82.6	103.8	105.9	110.8	116.2	148.2	192.6
Other third-party payers and programs and public health activity	253.4	290.8	302.3	309.2	322.7	405.3	503.2
Investment	154.4	160.0	159.7	163.3	166.5	208.5	267.4
Population (millions)	303.9	313.3	315.9	318.5	321.3	333.2	345.2
GDP, billions	$14,720.3	$16,244.6	$16,799.7	$17,354.1	$18,204.4	$22,275.5	$26,691.1
NHE per capita	7,935.7	8,914.8	9,164.3	9,595.7	9,982.5	12,131.1	14,943.8
GDP per capita	48,437.1	51,842.7	53,185.6	54,479.7	56,660.1	66,847.0	77,318.0
NHE as percent of GDP	16.4%	17.2%	17.2%	17.6%	17.6%	18.1%	19.3%
ANNUAL GROWTH							
NHE	7.1%	3.7%	3.6%	5.6%	4.9%	6.0%	6.3%
Health consumption expenditures	7.0	3.9	3.9	5.8	5.1	6.0	6.3
Out of pocket	5.3	2.2	3.2	−0.2	2.3	4.6	5.5
Health insurance	7.7	4.3	4.0	7.3	5.6	6.2	6.5
Private health insurance	7.0	3.2	3.3	6.8	6.9	5.3	5.6
Medicare	9.5	5.2	3.3	4.2	2.7	6.9	7.7
Medicaid	6.3	5.1	6.7	12.8	6.7	7.1	6.6
Federal	6.3	4.0	6.8	19.0	6.8	7.0	6.4
State and local	6.3	6.7	6.6	4.8	6.5	7.2	6.9
Other health insurance programs[b]	10.6	5.9	2.1	4.7	4.9	6.3	6.8
Other third-party payers and programs and public health activity	5.2	3.5	4.0	2.3	4.4	5.9	5.6
Investment	7.8	0.9	−0.2	2.3	1.9	5.8	6.4
Population[c]	0.9	0.8	0.8	0.8	0.9	0.9	0.9
GDP	4.8	2.5	3.4	3.3	4.9	5.2	4.6
NHE per capita	6.1	3.0	2.8	4.7	4.0	5.0	5.4
GDP per capita	3.8	1.7	2.6	2.4	4.0	4.2	3.7

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and Department of Commerce, Bureau of Economic Analysis and Bureau of the Census. **NOTES** For definitions, sources, and methods for NHE categories, see CMS.gov. National Health Expenditures Accounts: methodology paper, 2012: definitions, sources, and methods (see Exhibit 1 Notes). Numbers may not sum to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 2002–08. [b]Includes health-related spending for Children's Health Insurance Program, Titles XIX and XXI; Department of Defense; and Department of Veterans Affairs. [c]Estimates reflect the Bureau of the Census's definition for *resident-based population*, which includes all people who usually reside in one of the fifty states or the District of Columbia but excludes residents living in Puerto Rico and areas under US sovereignty, and US Armed Forces overseas and US citizens whose usual place of residence is outside of the United States. Estimates also include a small (typically less than 0.2 percent of the population) adjustment to reflect census undercounts. Projected estimates reflect the area population growth assumptions found in the 2014 *Medicare Trustees Report* (see Note 9 in text).

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The share of GDP devoted to health care is projected to rise from 17.2 percent in 2012 to 19.3 percent by 2023.

tage plans.[8] On a per beneficiary basis, Medicare spending growth is projected to be just 0.8 percent in 2014 and −0.3 percent in 2015.

For 2016–23, growth in Medicare expenditures is projected to rebound, averaging 7.3 percent per year (and 4.3 percent per beneficiary). There are three primary factors underlying this faster projected growth. First, large numbers of baby boomers will continue to age into the program. Second, per beneficiary spending growth is expected to be faster, driven by increased utilization that comes closer to historical rates. Finally, improved economic conditions are expected to result in accelerated price increases for the goods and services required to treat Medicare patients—and those increases in input prices translate into higher Medicare payment rates. Provisions of the ACA that slow growth in payment updates to Medicare providers, as well as sequestration, serve to moderate this growth.

MEDICAID Following the slow growth experienced in 2011 and 2012, combined federal, state, and local Medicaid expenditures are expected to have increased by 6.7 percent in 2013 and to have totaled $449.5 billion (Exhibit 3). Several factors contributed to this return to average historical rates of growth, including temporary increases to primary care physician payment rates, which were mandated by the ACA. In addition, states increased provider reimbursement rates and expanded benefits.[7]

In 2014 Medicaid spending is projected to grow by 12.8 percent as a result of the expansion of Medicaid coverage in states that choose to cover childless adults with incomes of up to 138 percent of the federal poverty level. Medicaid enrollment is expected to increase by nearly eight million, and because these new enrollees are expected to be nondisabled adults and their children, who tend to use less health care than elderly and disabled beneficiaries, per enrollee spending is projected to decline by 0.6 percent in 2014.

Medicaid spending is projected to increase by 6.7 percent in 2015 and 8.6 percent in 2016, with the lower growth in 2015 partially influenced by the expiration of increased payments to primary care providers. An additional 8.5 million people are projected to enroll in the program during this two-year period, mainly because of the expansion. Additionally, some large employers of low-wage employees will elect to no longer offer health insurance to their employees by 2016. As a result, a portion of these affected employees will qualify for, and enroll in, Medicaid.

Medicaid enrollment growth is expected to decelerate and stabilize at roughly 1 percent per year after 2016. Medicaid spending growth is expected to slow less rapidly, to an average of about 6.6 percent in 2017–23. This is a result of the use of expensive long-term care services by elderly and disabled Medicaid beneficiaries.

PRIVATE HEALTH INSURANCE Enrollment in private health insurance is expected to have reached 188.5 million people in 2013. The projected increase is small (0.3 percent) because of the recent slow increase in the number of full-time jobs with health benefits.[4] Expenditures for total private health insurance premiums are anticipated to have grown 3.3 percent in 2013, compared to 3.2 percent in 2012, and to have accounted for $947.5 billion (Exhibit 3). The slightly faster increase in premiums in 2013 relative to the increase in benefits in 2013 (3.0 percent) reflects the impact of faster growth in the net cost of private health insurance, which is expected to have increased 6.0 percent in 2013 compared to 0.1 percent in 2012.[25]

In 2014 growth in private health insurance premiums is projected to accelerate to 6.8 percent (Exhibit 3). This is largely a result of higher per enrollee spending and increased insurance coverage through Marketplace plans or individually purchased insurance. On a per enrollee basis, growth in private health insurance premiums is expected to accelerate to 6.0 percent in 2014, up from 3.1 percent in 2013. The acceleration is attributable to increased utilization and spending among people with new or potentially more generous coverage through the coverage expansion.[26] Private health insurance premium growth is projected to remain elevated in 2015, at 6.9 percent, as new enrollment continues.

For 2016–23, average premium growth for private health insurance is projected to be 5.4 percent per year. This would be significantly faster than the 3.2 percent annual growth for 2009–13 and reflects faster projected economic growth that leads to increases in both private health insurance enrollment and the use of health care goods and services, relative to recent history.

The projected growth would have been higher,

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but it is dampened slightly by other factors. As mentioned above, some large employers of low-wage workers are expected to stop offering health insurance, resulting in employees' moving to Marketplace plans or Medicaid or becoming uninsured. Also, the excise tax on high-cost employer-based insurance plans starting in 2018 is expected to slightly constrain premium growth.

OUT-OF-POCKET SPENDING In 2013 out-of-pocket spending is expected to have increased by 3.2 percent—slightly slower than the rates of growth in 2011 and 2012—and to have reached $338.6 billion (Exhibit 3). This continued low growth has been primarily a result of low utilization growth, which was partially influenced by movement into high-deductible plans and generally higher cost-sharing requirements for the insured.[4] Higher deductibles by themselves would tend to increase out-of-pocket spending. However, the resulting reductions in the use of services have largely offset that effect.

In 2014 out-of-pocket expenditures are projected to decline by 0.2 percent, largely because of expanded insurance coverage through Medicaid and the Marketplaces. In addition, cost-sharing provisions will be subsidized for Marketplace plan enrollees whose family incomes are at or below 250 percent of poverty. The transitory impact of expanding insurance coverage is expected to result in relatively low out-of-pocket spending growth in 2015 also, at 2.3 percent.

Growth in out-of-pocket spending is projected to accelerate to a peak of 5.8 percent in 2020 and to remain above 5 percent through 2023. This acceleration is primarily due to projected faster growth in disposable personal income, which is subsequently associated with increased use of health care goods and services. Despite this faster growth, the expected share of total health expenditures paid out of pocket declines during the projection period to 9.9 percent, down from

EXHIBIT 4

National Health Expenditures (NHE) Amounts, Average Annual Growth From Previous Year Shown, And Percent Distribution, By Type Of Sponsor, Selected Calendar Years 2008–23

Type of sponsor	2008[a]	2012	2013	2014	2015	2019	2023
EXPENDITURE, BILLIONS							
NHE	$2,411.7	$2,793.4	$2,894.7	$3,056.6	$3,207.3	$4,042.5	$5,158.8
Businesses, households, and other private sources	1,414.4	1,564.6	1,626.1	1,653.5	1,729.1	2,142.9	2,664.9
Private businesses	528.1	578.5	600.1	623.8	657.3	790.2	975.6
Households	712.6	792.4	824.7	821.5	856.1	1,076.8	1,336.3
Other private revenues	173.7	193.7	201.4	208.2	215.8	276.0	352.9
Government	997.3	1,228.8	1,268.6	1,403.2	1,478.2	1,899.5	2,493.9
Federal government	584.9	731.6	749.3	859.1	903.9	1,173.8	1,574.8
State and local governments	412.4	497.2	519.3	544.1	574.3	725.7	919.1
ANNUAL GROWTH							
NHE	7.1%	3.7%	3.6%	5.6%	4.9%	6.0%	6.3%
Businesses, households, and other private revenues	6.1	2.6	3.9	1.7	4.6	5.5	5.6
Private businesses	5.1	2.3	3.7	4.0	5.4	4.7	5.4
Households	6.6	2.7	4.1	−0.4	4.2	5.9	5.5
Other private revenues	7.1	2.8	4.0	3.4	3.6	6.3	6.3
Government	8.7	5.4	3.2	10.6	5.3	6.5	7.0
Federal government	9.7	5.8	2.4	14.7	5.2	6.8	7.6
State and local governments	7.4	4.8	4.5	4.8	5.5	6.0	6.1
DISTRIBUTION							
NHE	100%	100%	100%	100%	100%	100%	100%
Businesses, households, and other private sources	59	56	56	54	54	53	52
Private businesses	22	21	21	20	20	20	19
Households	30	28	28	27	27	27	26
Other private sources	7	7	7	7	7	7	7
Government	41	44	44	46	46	47	48
Federal government	24	26	26	28	28	29	31
State and local governments	17	18	18	18	18	18	18

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** For definitions, sources, and methods for NHE categories, see CMS.gov. National Health Expenditures Accounts: methodology paper, 2012: definitions, sources, and methods (see Exhibit 1 Notes). Numbers may not sum to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 2002–08.

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11.7 percent in 2013, in part as a result of expanded coverage under the ACA.

Overview By Sponsor

For 2013, health care expenditures sponsored (or financed) by federal, state, and local governments are expected to have grown 3.2 percent and to have reached $1.3 trillion (Exhibit 4). In comparison, expenditures by businesses, households, and other private sources are projected to have risen by 3.9 percent and to have reached $1.6 trillion. This leaves the privately sponsored share of spending at 56 percent.

In 2014 certain features of the ACA coverage expansions are projected to shift health care financing from households toward the federal government. Because of a 100 percent initial federal matching rate for Medicaid spending incurred by newly eligible enrollees[16] and the availability of premium and cost-sharing subsidies for Marketplace coverage, health care spending sponsored by the federal government is projected to increase 14.7 percent in 2014. Its share of spending is expected to increase from 26 percent in 2013 to 28 percent (Exhibit 4). In comparison, expenditures by households are projected to decline slightly, largely stemming from net out-of-pocket and premium costs that are expected to be lower, on average, for people who gain coverage.

By 2023 federal, state, and local government financing is projected to account for 48 percent of national health expenditures, up from 44 percent in 2012, and to reach a total of $2.5 trillion (Exhibit 4). Increases in the federal government's share are mostly the result of expanded Medicaid eligibility, Marketplace premium and cost-sharing subsidies, and a growing gap between dedicated Medicare financing and program outlays.[27]

Conclusion

Since the end of the Great Recession in 2009, economic growth in the United States, as measured by GDP, has remained slow: just 3.9 percent per year, on average, which is well below the average rate experienced in the four years following the three previous recessions.[11] The fact that recent health spending increases have not returned to their prerecession rates is consistent with the long-standing relationship between overall economic growth and health spending growth.[1]

Growth rates for both the economy and health spending have been slow. However, the health share of GDP has remained relatively constant since 2009 and is expected to be 17.2 percent in 2013. Contributing to the stable share in 2013 are continued low use of medical care and provisions of both sequestration and health reform that constrain payments to Medicare providers.

The period in which health care has accounted for a stable share of economic output is projected to end in 2014, primarily because of the coverage expansions of the ACA. It is anticipated that by 2017, once the mostly one-time transition effects of expanded coverage have fully transpired, the health share of GDP will increase, albeit at a slower rate than its historical average, as an improving economy and the aging of the baby-boom generation lead to faster health spending growth. ■

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NOTES

1 Centers for Medicare and Medicaid Services. Projections of national health expenditures: methodology and model specification [Internet]. Baltimore (MD): CMS; 2014 Sep 3. Available from: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology.pdf

2 Martin AB, Hartman M, Whittle L, Catlin A, National Health Expenditure Accounts Team. National health spending in 2012: rate of health spending growth remained low for the fourth consecutive year. Health Aff (Millwood). 2014;33(1):67–77.

3 Mercer. US health benefit cost growth slowed again in 2013, but employers expect that will change in 2014 [Internet]. New York (NY): Mercer; 2013 Nov 20 [cited 2014 Jul 25]. Available from: http://m.mercer.com/press-releases/1565095?detail=D

4 Kaiser Family Foundation, Health Research and Educational Trust. Employer health benefits: 2013 survey [Internet]. Menlo Park (CA): KFF; 2013 Aug 20 [cited 2014 Jul 8]. Available from: http://kff.org/private-insurance/report/2013-employer-health-benefits

5 In July 2013 the Bureau of Economic Analysis revised the GDP upward for all historical years. For more information about this comprehensive revision, see Kornfeld R. Initial results of the 2013 comprehensive revision of the national income and product accounts. Survey of Current Business [serial on the Internet]. 2013 Aug [cited 2014 Jul 7]. Available from: http://www.bea.gov/scb/pdf/2013/08%20August/0813_nipa-revision%20text.pdf

6 Sequestration refers to budget or payment reductions mandated by the Budget Control Act of 2011. For Medicare, the following payment reductions are in effect: 2.0 percent, April 2013–March 2023; 2.9 percent, April 2023–September 2023; and

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1.11 percent, October 2023–March 2024. Spending reductions under the sequestration were also enacted in 2013 for other federal programs, including some that are health related.

7 Smith VK, Gifford K, Ellis E, Rudowitz R, Snyder L. Medicaid in a historic time of transformation: results from a 50-state Medicaid budget survey for state fiscal years 2013 and 2014 [Internet]. Menlo Park (CA): Kaiser Family Foundation; [updated 2013 Oct 24; cited 2014 Jul 25]. Available from: http://kff.org/medicaid/report/medicaid-in-a-historic-time-of-transformation-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2013-and-2014/

8 The reduction in Medicare Advantage payments for 2015 is largely associated with the expiration of the Quality Bonus Payment Demonstration, as well as the trend in fee-for service expenditures for 2010–15. For more information on the fee-for-service expenditure trends that we took into account, see Centers for Medicare and Medicaid Services, Office of the Actuary. 2015 payment notice: key components of USPCC trends: 2010–2015 [Internet]. Baltimore (MD): CMS; [cited 2014 Jul 25]. Available from: http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Narrative-2015-payment-notice.pdf

9 Under current law, a reduction of approximately 21 percent in Medicare physician payment rates is scheduled for April 1, 2015, based on the Sustainable Growth Rate formula. If these reductions were to go into effect, growth in total Medicare spending, in physician and clinical services, and in overall national health expenditures would be 1.2 percent, 2.4 percent, and 4.6 percent, respectively, in 2015.

10 Boards of Trustees. 2014 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2014 Jul 28 [cited 2014 Aug 14]. Available from: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2014.pdf

11 In the four years since the recession's conclusion, economic growth has averaged just 3.9 percent per year, while GDP in the four years following each of the 1981–82, 1990–91, and 2001 recessions averaged 8.2 percent, 5.6 percent, and 5.4 percent, respectively.

12 Foster RS. Estimated financial effects of the "Patient Protection and Affordable Care Act," as amended [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2010 Apr 22 [cited 2014 June 27]. Available from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PPACA_2010-04-22.pdf

13 Werling J, Keehan S, Nyhus D, Heffler S, Horst R, Meade D. The supply side of health care. Survey of Current Business [serial on the Internet]. 2014 Apr [cited 2014 Jun 27]. Available from: http://www.bea.gov/scb/pdf/2014/04%20April/0414_supply_side_of_health_care.pdf

14 Authors' analysis of Producer Price Index data for North American Industry Classification Codes 6211 and 6215 as of July 2014. See Bureau of Labor Statistics. Producer Price Indexes [Internet]. Washington (DC): BLS; [cited 2014 Jul 24]. Available for download from: http://www.bls.gov/ppi/

15 Evans M. PPI growth in March slower than average. Modern Healthcare [serial on the Internet]. 2013 Apr 12 [cited 2014 Jun 27]. Available from: http://www.modernhealthcare.com/article/20130412/NEWS/304129949

16 Centers for Medicare and Medicaid Services. 2013 actuarial report on the financial outlook for Medicaid [Internet]. Baltimore (MD): CMS; 2013 [cited 2014 Jul 7]. Available from: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2013.pdf

17 Kaiser Family Foundation. A profile of health insurance exchange enrollees [Internet]. Menlo Park (CA): KFF; 2011 Mar [cited 2014 June 27]. Available from: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8147.pdf

18 Freeman JD, Kadiyala S, Bell JF, Martin DP. The causal effect of health insurance on utilization and outcomes in adults: a systematic review of US studies. Med Care. 2008;46(10):1023–32.

19 Newport F. Newly insured in 2014 represent about 4% of U.S. adults. Gallup Well-Being [serial on the Internet]. 2014 Apr 16 [cited 2014 Jul 9]. Available from: http://www.gallup.com/poll/168548/newly-insured-2014-represent-adults.aspx

20 Aitken M. Medicine use and shifting costs of healthcare: a review of the use of medicines in the U.S. in 2013. Danbury (CT): IMS Institute for Healthcare Informatics; 2014 Apr.

21 Express Scripts. Exchange Pulse: public exchange report [Internet]. St. Louis (MO): Express Scripts; 2014 Apr [cited 2014 Jul 25]. Available from: http://lab.express-scripts.com/insights/government-programs/~/media/64dc7abc8a6145f19a9af0d5d40ed288.ashx

22 Westphal C. Hepatitis C cure may be costly—but also cost effective. Boston Globe. 2014 Apr 27.

23 CVS Caremark. Specialty trend management: where to go next [Internet]. Woonsocket (RI): CVS Caremark; 2013 [cited 2014 Jul 8]. Available from: http://info.cvscaremark.com/sites/default/files/Insights%202013.pdf

24 Note that the 2.7 percent growth rate for Medicare spending in 2015 is consistent with the projected baseline scenario in the 2014 *Medicare Trustees Report* (see Note 9). For more information, see the Model and Assumptions section of this article.

25 Adamopoulos H. Big 5 health insurers report Q4 profits. Becker's Hospital Review [serial on the Internet]. 2014 Feb 11 [cited 2014 Jul 8]. Available from: http://www.beckershospitalreview.com/payer-issues/big-5-health-insurers-report-q4-profits.html

26 Relative to plans in 2013, premium subsidies encourage the purchase of more generous plans, and cost-sharing subsidies lessen the impact of cost sharing at the point of service. Each type of subsidy is predicted to lead to greater use of health care goods and services.

27 For more information, see the 2014 *Medicare Trustees Report* (see Note 9), section II.D.

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Issue Brief

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The Commonwealth Fund

Arkansas: A Leading Laboratory for Health Care Payment and Delivery System Reform

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Abstract As states' Medicaid programs continue to evolve from traditional fee-for-service to value-based health care delivery, there is growing recognition that systemwide multipayer approaches provide the market power needed to address the triple aim of improved patient care, improved health of populations, and reduced costs. Federal initiatives, such as the State Innovation Model grant program, make significant funds available for states seeking to transform their health care systems. In crafting their reform strategies, states can learn from early innovators. This issue brief focuses on one such state: Arkansas. Insights and lessons from the Arkansas Health Care Payment Improvement Initiative (AHCPII) suggest that progress is best gained through an inclusive, deliberative process facilitated by committed leadership, a shared agreement on root problems and opportunities for improvement, and a strategy grounded in the state's particular health care landscape.

OVERVIEW

Increasingly, states are moving beyond their traditional Medicaid programs to embrace new roles as leaders of statewide payment and delivery system transformation. The search for statewide solutions is fueled by cost pressures, health system inefficiencies, and poor outcomes, and enabled by expansions in coverage and the availability of substantial federal funding.[1] In this issue brief, we examine the Arkansas Health Care Payment Improvement Initiative (AHCPII), which, while predating coverage expansion, both supported and was strengthened by the state's decision to expand Medicaid coverage through qualified health plans (QHPs). As such, AHCPII offers important lessons for policymakers.

In 2011, Arkansas began a process to address the challenges and opportunities presented by the state's existing health care delivery and payment environment. What emerged was a statewide payment reform initiative that spanned outpatient and inpatient care.[2] AHCPII consists of three components: 1) patient-centered medical homes (PCMHs), 2) Health Homes for chronically ill and other individuals with complex health care needs, and 3) payment and delivery models based on episodes of care. While these programmatic elements were developed in response to Arkansas's health

care landscape in particular, the process by which they were developed, funded, and implemented, as well as their most critical attributes, is probative beyond the state's borders.

This issue brief addresses AHCPII's origin, key components, evolution, and replication potential. It focuses on payment and delivery reform as well as the interrelationship between AHCPII and health insurance expansion. The brief is informed by published research, state documents, and interviews with the leadership and key stakeholders in Arkansas.

AHCPII Reforms Seek to Address Fiscal, Population, and Provider Challenges

In 2010, Arkansas officials faced a triple threat: a confluence of fiscal, population, and provider system challenges. A potential Medicaid Trust Fund shortfall loomed as enhanced federal matching dollars (FMAP) were coming to an end, with deficits projected as high as $400 million. Arkansas's population suffered from pervasive chronic disease: more than 50 percent of Arkansas's adults had at least one chronic disease.[3] In addition, Arkansas's provider community was fragmented, with 60 percent of physicians in practices of five or fewer physicians dispersed among a largely rural population with few formal structural connections between physicians and hospitals, other providers, or one another. An uninsured rate that exceeded the national average[4] and a Medicaid program with the lowest eligibility levels in the nation added to Arkansas's challenges.

While faced with fiscal and structural challenges, Arkansas benefited from government leaders who understood the Arkansas health care market, had the experience and expertise to diagnose the drivers of the existing challenges, and proved adept at designing a program that was responsive to stakeholders.[5]

In 2011, Arkansas Medicaid was almost entirely a fee-for-service system with low payment rates and substantial reliance on provider taxes and supplemental payments. The architects of Arkansas's statewide health system transformation determined that the traditional options for averting a Medicaid shortfall (e.g., rate cuts, reductions of benefits, introduction of Medicaid managed care) were unpalatable and that an alternative path was needed. In crafting a solution that could extend throughout the state and entire health system, the state benefited from a high degree of market concentration in two local payers—Arkansas Blue Cross Blue Shield (the largest in the state) and QualChoice—representing 80 percent of the commercial market.[6] With comparatively fewer payers, Arkansas could more easily achieve commonality across insurers' initiatives and more effectively influence delivery reform. Moreover, because the dominant plans were local, they had greater latitude to respond to state-specific payment models.

The state convened stakeholders to develop a common vision and framework for health system transformation. At the outset, providers and payers agreed on three foundational propositions:

1. the trajectory of health care costs was unsustainable;
2. there were inefficiencies in the system that, once corrected, could result in shared savings; and
3. the traditional fee-for-service model perpetuated misaligned incentives and had to be replaced with a value-based system.

Medicaid's fiscal crisis and similar pressures in the private sector presented an opportunity to integrate individual payer efforts into a collective framework for reform.

An especially important feature of the state's approach was its full commitment to a systemic, statewide transformation. In his February 11, 2011, letter to HHS Secretary Sebelius, Governor Beebe framed the proposed systemwide change as follows:

> Arkansas would like to try a different approach—a partnership between Medicaid, Medicare, and private insurers that would fundamentally transform the fee-for-service system. The plan is bold. It is not based on small-scale pilot projects, because such projects cannot yield broad-based cost and quality improvements in the near future.[7]

Emerging from the deliberative process was the Arkansas Health Care Payment Improvement Initiative, which placed providers at the helm of reform.[8] Rather than introducing additional layers of oversight and regulation, AHCPII incentivizes providers through greater accountability for costs and quality and concomitant opportunities to participate in generated savings that align interests across health care providers, purchasers, and payers.

With the stated goal of moving most public and private health care expenditures to a value-based system in four years, the state set an incremental course for implementing AHCPII. It first addressed pressing priorities in primary and acute care, leaving for a later phase long-term care and the integration of public health into its delivery and payment reforms. In a pragmatic approach to attaining what was feasible in the shorter term, the state postponed tackling Medicaid's antiquated per diem payment methodology and hospital supplemental payments.[9]

The state has worked to expand payer involvement to include self-insured plans. The self-insured Arkansas State Public Employee and Public School Health Insurance Plan now requires participation of its third party administrators, and Arkansas Blue Cross Blue Shield extended episodic payments to its self-insured accounts. In addition, the largest private sector employer in the state, Walmart, has committed to participate in AHCPII.[10]

> "Arkansas Blue Cross Blue Shield developed a medical home pilot program in 2010 with five practices. While initial results were promising, we needed involvement of other payers to fully support the practices. The Comprehensive Primary Care initiative and the state PCMH program offered solutions to get to scale more broadly and at a quicker pace."
>
> Alicia Berkemeyer, Director of Enterprise Networks Special Projects, Arkansas Blue Cross Blue Shield

AHCPII consists of three complementary components, which are summarized in Exhibit 1 and described in detail in Appendices B, C, and D.

Exhibit 1. Summary of Arkansas Health Care Payment Improvement Initiative Components

Patient-Centered Medical Home	Health Homes	Episode-Based Payments
Overview		
Patient-centered medical homes (PCMHs) are teams of providers who take responsibility for the overall health of assigned patients. A patient's team is led by a designated primary care doctor who communicates with other clinical and administrative professionals to better coordinate patients' care.	Health Homes extend the medical home care coordination approach to a subset of chronically ill patients who have the most complex or extensive needs. When implemented, Arkansas's Health Home program will serve patients with multiple chronic conditions, including those who need behavioral health care services or long-term services and support (LTSS).	The AHCPII outpatient payment component is a retrospective episode-based model that establishes a "principal accountable provider" (PAP) identified by the payer, who is responsible for the quality and costs of the health services to treat a particular diagnosis over a defined period of time.[11]
Key Features		
AHCPII includes two PCMH initiatives: 1) a federally funded Medicare Comprehensive Primary Care (CPC) 2012 initiative, which includes five payers (Medicare, Arkansas Medicaid, Arkansas Blue Cross and Blue Shield, Humana, and QualChoice of Arkansas) and 69 participating primary care practices;[12] and 2) a 2014 Medicaid-led PCMH initiative. Practices participating in PCMH initiatives receive payments to support care coordination by two mechanisms: 1) per member per month (PMPM) payments to providers for care coordination and practice transformation, and 2) shared savings.	Health Home payments will include a risk-adjusted, PMPM fee to be assessed by the state every two years based on costs, savings, and outcomes. A portion of the PMPM fee will depend on acceptable performance on process and outcome metrics for care management and coordination.[13]	Treating providers submit claims and are reimbursed on a fee-for-service basis; gain-sharing or penalties are determined by comparing performance to a predetermined target fee for each episode. The construction and implementation of episodes are largely the same across payers; slight variation occurs in the thresholds for shared savings and payment amounts.[14]
Implementation Status		
In October 2012, participating practices in the CPC initiative began receiving PMPM payments for care coordination. Voluntary enrollment of additional practices began in late 2013 and has continued through 2014. In January 2014, practices in the Medicaid initiative began receiving PMPM payments. In 2015, practices will begin receiving PMPM payments for Qualified Health Plan enrollees. CPC practices are also eligible for shared savings if they have a minimum of 5,000 patients enrolled in a PCMH.[15]	The Health Home rollout is expected to launch in 2014 and proceed in three waves through 2015. The first wave is for adults with developmental disabilities; the second covers individuals requiring LTSS; and the third covers individuals with serious mental illness.[16]	Payment changes for designated episodes of care have been rolled out incrementally among three payers–Medicaid, Arkansas Blue Cross Blue Shield, and QualChoice. From 2012 to 2013, participating payers launched changes for eight episodes of care on a statewide basis.[17]
Preliminary Results		
As of December 2013, more than 600 providers had signed up to participate in the Medicaid-led PCMH initiative, providing care to approximately 250,000 Medicaid members, or 72 percent of the Medicaid population eligible to participate in the program. In addition, the willingness of smaller practices to partner with other providers in virtual pools for shared savings eligibility has increased the ability of these providers to improve care coordination.[18]	The Health Home component is still in development, and results are not available.	Results from the first three episodes of care to be paid under the new payment method include increased adherence to evidence-based care protocols, reduction in unnecessary procedures, and reduction in costs.[19]

AHCPII Moving Forward

Within the next three years, Arkansas expects episode-based payments to account for 50 percent to 70 percent of the state's total health care spending for acute care and complex chronic conditions.[20] By 2017, Arkansas expects PCMHs to serve the majority of Arkansans.[21]

AHCPII expansion also will be boosted significantly by Arkansas's decision to expand Medicaid through QHPs in the state's federally facilitated insurance marketplace. Under a federal waiver, Arkansas uses funds authorized under the Affordable Care Act to expand adult Medicaid coverage through QHPs, referred to as the Private Option. The Arkansas Insurance Department requires QHP issuers to participate in the Private Option and, beginning in 2015, in AHCPII's PCMH program.[22]

> "AHCPII is appealing to employers because it introduces price signals into a market that typically does not have price signals."
>
> Randy Zook, President and Chief Executive Officer, Arkansas State Chamber of Commerce

These requirements will vastly increase the reach of the PCMH program; as of July 2014, over 170,000 individuals enrolled in QHPs through the Private Option,[23] and another 40,000 enrolled through the marketplace.[24] As the number of patients enrolled in a PCMH grows, practices will be eligible for additional per member per month (PMPM) payments, providing additional resources for practice transformation. In addition, AHCPII's success in addressing the underlying problems of the state's Medicaid program generated support for the coverage expansion. At this point, "the Private Option and AHCPII are now symbiotic: one accelerates and leverages the other," noted former state Medicaid director Andy Allison.[25]

AHCPII Has Lessons for Other States

While Arkansas's success is grounded in reforms that address its particular health care landscape, there are insights that can inform other states' health system delivery and payment reforms. These include:

- **Leadership.** There is no substitute for high-level leadership from the state's governor and his/her key advisors who can command the respect and attention of key stakeholders. In Arkansas, the governor identified payment and delivery system reform as a top priority, and achieved progress through focused leadership and dedicated resources across multiple state offices, including Medicaid, human services, insurance, the surgeon general, and the independent Arkansas Center for Health Improvement.
- **Inclusive and Ongoing Stakeholder Participation.** Comprehensive transformation of a state's health care system requires that providers, payers, and other key stakeholders are meaningfully engaged from inception through implementation. Rather than attempt to exercise its authority unilaterally, Arkansas engendered trust by creating and maintaining a transparent, collaborative process involving the health care system's multiple stakeholders.
- **Common Principles.** Stakeholder consensus on key principles is critical, providing a common lens for assessing progress and resolving problems. Arkansas galvanized participation and maintains ongoing engagement through broad-based agreement on the root causes of the health care quality and cost challenges.
- **Ambitious but Realistic Reforms.** While important for health reform to be bold to garner and maintain attention, it must take into consideration the health care system's capabilities and be paced pragmatically. AHCPII was designed to move the state's delivery system in dramatic ways; it was not, however, predicated on uprooting the current delivery system. Reforms were phased in over time, with a process in place to identify workable solutions and respond to unanticipated events.

- **Use of State Levers to Drive Multipayer Involvement.** To ensure the breadth and depth of payer and provider participation required for statewide health system reform, states must strategically deploy their purchasing and regulatory authorities across agencies (e.g., Medicaid, insurance, public health, and state employees), reinforced when needed by the state leadership's bully pulpit. Only a handful of states have a payer landscape like Arkansas's, dominated by relatively few local health plans; however, all states can draw upon Arkansas's use of state leadership to engage the commercial marketplace through large self-insured employers. And, through their certification requirements, state insurance agencies or state-based marketplaces can require QHPs to engage in value-based purchasing. Similarly, states using managed care in their Medicaid programs can accomplish reform through contractual requirements with their Medicaid managed care organizations,[26] much the same way that Arkansas has done with QHPs.
- **Payment Reform Coupled with Expanded Coverage.** Meaningful system reform will be far more difficult, if not impossible, to achieve for states in which a significant number of residents remain uninsured. Arkansas initiated AHCPII prior to implementation of the Affordable Care Act. However, by expanding coverage through Medicaid premium assistance (the Private Option) and requiring QHP participation, the state dramatically changed its health care landscape: it extended access to affordable coverage to 250,000 adults, cut uncompensated care costs, expanded the pool of patients included under payment reform, and ultimately accelerated the state's reform efforts.[27]
- **Funding.** Funding generates interest in and enables reform. The AHCPII planning and implementation process benefited from substantial private and public funding.[28] Going forward, other states can fund payment and delivery system reforms as a result of the availability of $730 million for the next round of State Innovation Model grants and Delivery System Reform Improvement Payment Program waivers, with the technical support of the Medicaid Innovation Accelerator Program (IAP).[29]

CONCLUSION

Whether driven by the triple aim of improved patient care, improved health of populations, and reduced costs; budget pressures; Medicaid expansion; or a combination of all three, states are advancing their health systems' evolution toward value-based care. Although their health care landscapes, reform starting points, and pace vary, states can draw valuable lessons from the AHCPII experience. Among the seven lessons learned, state leadership and funding are central. With fully committed and experienced state leaders and the increased availability of federal funding for multistakeholder strategies, states can work out the details of reform though a process of engaged, collaborative planning and implementation.

Appendix A. List of Interviewees

Mike Beebe, Governor of Arkansas

Andy Allison, Ph.D., former Director, Arkansas Division of Medical Services (Arkansas Medicaid)

Alicia Berkemeyer, Director of Enterprise Networks Special Projects, Arkansas Blue Cross Blue Shield

William Golden, M.D., Medical Director, Arkansas Division of Medical Services (Arkansas Medicaid)

Michael Motley, Prevention Specialist, Health Care Finance, Arkansas Center for Health Improvement

Lonnie Robinson, M.D., Arkansas Academy of Family Physicians Board of Directors

Bo Ryall, President and CEO, Arkansas Hospital Association, and Paul Cunningham, Executive Vice President, Arkansas Hospital Association

Stephen Sorsby, M.D., Medical Director, QualChoice, and Mark Johnson, Vice President of Network Services, QualChoice

Joseph Thompson, M.D., Arkansas Surgeon General and Director, Arkansas Center for Health Improvement

Craig Wilson, Director of Access to Quality Care, Arkansas Center for Health Improvement

David Wroten, Executive Vice President, Arkansas Medical Society

Randy Zook, President and Chief Executive Officer, Arkansas State Chamber of Commerce

Appendix B. AHCPII Patient-Centered Medical Homes

Patient-centered medical homes (PCMHs) are teams of providers who take responsibility for the overall health of assigned patients. A patient's team is led by a designated primary care physician (PCP) who communicates with other clinical and administrative professionals to better coordinate patients' care. Through improved care coordination and communication, PCMHs are intended to help patients stay healthy, improve the quality of care they receive, and reduce costs. AHCPII consists of two PCMH initiatives:

1. Medicare's Comprehensive Primary Care (CPC) initiative, which was launched in October 2012 and includes five payers (Medicare, Arkansas Medicaid, Arkansas Blue Cross Blue Shield, Humana, and QualChoice of Arkansas) and 69 participating primary care practices with 275 providers across the state.[30]

2. A Medicaid-led PCMH initiative which began its first performance period in January 2014. To participate in the PCMH program in 2014, a practice must serve at least 300 Medicaid patients. By 2015, all qualified health plan (QHP) issuers will be required to participate in the AHCPII, which includes "provid[ing] support for patient-centered medical home[s]."[31]

Though the CPC and Medicaid PCMH initiatives have different requirements, the overall objectives are consistent:

- include most of a provider's patient panel (e.g., 80 percent) in the medical home to ensure that the provider is well invested in PCMH principles;
- ensure that primary care providers have a deep understanding of current performance and drivers of value across their patient panel;
- create opportunities for a broad spectrum of PCMHs, with different starting points, to share in meaningful rewards; and
- provide guidance on practice transformation and care coordination without being overly prescriptive, allowing practices to focus on cost and quality of care.[32]

AHCPII is implementing PCMHs in three successive waves between 2012 and 2015, consistent with AHCPII's phased enrollment of physician practices. Once enrolled in AHCPII, participating practices begin receiving payments under the per member per month (PMPM) payment model.[33]

Reimbursement Under the PCMH Model

Practices participating in the PCMH program receive payments to support care coordination through two mechanisms: PMPM payments and shared savings. The payment amount per member varies by the type of PCMH initiative.

Under the CPC initiative, payers provide a PMPM payment to underwrite the costs of practice transformation and incentivize providers to practice effective population health management. Under the Medicaid initiative, the state pays a small portion of the total PMPM amount to a technical support vendor to promote practice transformation.[34]

As part of the AHCPII, all PCMH practices in either the Medicare or Medicaid initiative also can receive payments based on cost savings. AHCPII's shared savings model includes "upside payments" (i.e., providers share in expected savings, but are not penalized if payments exceed risk-adjusted baseline costs). To qualify for shared savings, practices must have at least 5,000 patients, either independently or by entering virtual risk pools with other practices,[35] and must meet the state's quality metrics.[36]

PCMH Results

As of December 2013, the Medicaid-led PCMH program included over 600 primary care physicians covering more than 250,000 Medicaid members (72 percent of all members eligible for a PCMH).[37] In February 2014, practices in the Medicaid initiative received their first quarterly PCMH reports showing quality and cost data.[38]

In addition to the brisk pace of enrollment, the public and private payers have been surprised and encouraged by providers' willingness to enter into virtual risk pools for shared savings. Not only do the risk pools generate revenue for providers, the virtual arrangements create partnerships that serve as a valuable foundation for care coordination in a market with a significant percentage of small, independent practices.[39]

Appendix C. AHCPII Health Homes

Authorized under Section 2703 of the Affordable Care Act, Health Homes extend the PCMH care coordination approach to a subset of chronically ill patients who have the most complex or extensive needs.

As a component of the Arkansas Health Care Payment Improvement Initiative (AHCPII), the Health Home program will serve patients with multiple chronic conditions, including those who may need behavioral health care services or long-term services and support (LTSS). Health Homes will be accountable for the range of services required by individuals with special needs—the frail elderly, those with developmental disabilities, those with severe and persistent mental illness, and other high-need behavioral health patients.[40]

For patients who have developmental disabilities (DD) or behavioral health (BH) needs or who require LTSS, the patient's primary provider of services over time, i.e., the "lead provider" will manage the Health Home.[41] The lead provider will be accountable for improving health outcomes, streamlining the care planning process, and developing and executing an integrated plan spanning medical care and DD, LTSS, or BH services.

AHCPII's Health Home rollout is expected to occur in three waves between 2014 and 2015.[42]

Health Home Reimbursement

Health Home payments will include a risk-adjusted, PMPM fee to be assessed by the state every two years based on costs, savings, and outcomes. A portion of the fee will depend upon on acceptable performance on process and outcome metrics for care management and coordination.[43]

Quality assurance for Health Homes will be achieved through multiple measures ranging from patient experience, care coordination, and preventive health for at-risk populations. Aggregate performance measures will be reported to providers and used to determine provider eligibility for incentive payments (shared savings, per member per month care coordination fees, or both). While DD, BH, and LTSS Health Homes will provide similar health home functions and activities, provider requirements, quality measures, and outcomes will reflect the unique needs of each population.[44]

Appendix D: AHCPII's Episode-Based Payments

Arkansas's payment strategy for acute care delivery is built on the episode-based payment, under which a single fee is paid for all the services a patient needs during an episode of care. Episodes—their duration and range of services included—are defined through an extensive stakeholder engagement process, a review of evidence-based guidelines, and an examination of claims data in consultation with both state staff and national experts. A provider most responsible for the quality and cost of care provided to a patient for a particular episode of care is designated as the "principal accountable provider," or PAP, and shares in an episode's savings or excess costs.

Arkansas designed its episodic payment system to target care conditions that exhibited clinical practice variation or treatment inefficiencies. For each episode, work groups analyzed Arkansas-specific data, created quality metrics and diagnosis exclusion criteria, determined risk adjustment, defined outliers, and identified potential adjustments based on severity, transfer cases, clinical factors, and facility per diem normalization.[45]

Currently, three payers—Medicaid, Arkansas Blue Cross Blue Shield, and QualChoice—are making episode-based payments for more than a dozen episodes of care the state designated for payment reform.[46]

The construction and implementation of episodes are largely the same across payers; slight variation occurs in the thresholds for shared savings and payment amounts.[47]

Reimbursement Under the Episode-Based Payment Model

To reward coordinated, team-based, high-quality care for all services related to an episode, payers identify a PAP, who is accountable for all prespecified services across the episode's duration. Physicians designated as PAPs vary depending on the episode and its treatment. For example, PAPs for hip and knee replacements are orthopedic surgeons;[48] PAPs for an ADHD episode can be a primary care physician, mental health professional, or an agency like the Rehabilitative Services for Persons with Mental Illness provider organization, depending on the treatment.[49]

The new payment model works under the existing fee-for-service system. For each episode, all treating providers continue to file claims and are reimbursed according to each payer's established fee schedule.[50] Gain-sharing or penalties are determined by comparing the PAP's performance to a predetermined target fee for each episode. For each episode, the payer determines "commendable" and "acceptable" cost thresholds. PAPs with average costs below the commendable threshold are eligible for gain-sharing only if they perform well enough on quality measures; alternatively, PAPs with average costs above the acceptable threshold are assessed penalties. PAPs with average costs between acceptable and commendable do not receive gain-sharing or penalties.[51]

Physician participation in episode-based payment implementation is not voluntary; a provider that bills for a triggering service—that is, a service specified in a given episode's definition—is included in the episode profiling process. Each PAP must meet a minimum caseload per episode (which varies by episode) to qualify for the opportunity to receive gain- or risk-sharing.[52] To aid in implementation, PAPs receive a baseline report showing how their quality and cost metrics compare with those of other providers in the state and with the gain-sharing thresholds established by each payer. PAPs also receive quarterly reports for each episode that show comparative performance for costs and quality.

Episode-Based Payment Model Results

Stakeholder feedback suggests that the episode-based payment component has introduced price signals—that is, sensitivity to cost—into the health system. Although Medicaid pays a fixed rate for services within an episode, commercial plans negotiate payment rates with providers; this creates cost variability and incentivizes PAPs to refer patients to facilities that have lower contracted rates.

From 2012 to 2013, participating payers launched eight episodes of care on a statewide basis. A review of Medicaid claims data and quality metrics showed the following results:

- Increased screening for diabetes, HIV, Hepatitis B, and other conditions in pregnant women.
- From October 2012 through December 2012, a 29 percent drop in ADHD episode costs.
- Improved coding and oversight of stimulant medication to ensure prescriptions match diagnoses.
- Stabilized costs for congestive heart failure and total joint replacements.
- From October 2012 through September 2013, a 19 percent decrease in unnecessary antibiotic prescriptions for unspecified upper respiratory infections.
- An 18 percent reduction in multiple courses of antibiotics prescribed for sinusitis and other upper respiratory infections.[53]

As of June 2014, Arkansas's Department of Human Services reported almost $400,000 in financial incentive payments to providers for meeting quality and efficiency goals and almost $600,000 that providers are required to reimburse Arkansas Medicaid because their costs were not comparable to their peers'.[54]

Notes

[1] Centers for Medicare and Medicaid Services, State Innovation Models Initiative: General Information, http://innovation.cms.gov/initiatives/state-innovations/; Centers for Medicare and Medicaid Services, Comprehensive Primary Care Initiative, http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/; Centers for Medicare and Medicaid Services, Health Homes, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html.

[2] While a number of states have developed or deployed various statewide either outpatient or inpatient payment reform efforts, only Arkansas has deployed both. Four other states (Colorado, Maryland, New Jersey, and Oregon) have launched statewide, multipayer PCMH initiatives, and 15 states (Alabama, Idaho, Iowa, Maine, Maryland, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, South Dakota, Vermont, Washington, and Wisconsin) have CMS-approved Health Home State Plan Amendments. Two states (Ohio and Tennessee) are developing plans to create a statewide, multipayer episode-based payment approach similar to that in Arkansas. Manatt Health Solutions analysis of Patient-Centered Primary Care Collaborative, "Primary Care Innovations and PCMH Map by State," http://www.pcpcc.org/initiatives/state, accessed July 8, 2014; Manatt Health Solutions analysis of Manatt Health Solutions analysis of Centers for Medicare and Medicaid Services, State Health Home CMS Proposal Status (effective June 2014), http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-MAP_v34.pdf, accessed July 8, 2014; Manatt Health Solutions analysis of publicly available CMMI State Innovation Model plans, http://innovation.cms.gov/initiatives/state-innovations/, accessed July 8, 2014.

[3] J. Thompson, "Building a Healthier Future for All Arkansans," Presentation at NASHP 25th Annual State Health Policy Conference, Oct. 16, 2012, http://www.nashpconference.org/wp-content/uploads/2012/presentations/Thompson.20.Builing.Healthier.Arkansas.pdf, accessed June 27, 2014.

[4] Henry J. Kaiser Family Foundation, Health Insurance Coverage of the Total Population, http://kff.org/other/State-indicator/total-population/, accessed June 27, 2014.

[5] Prior to his election in 2006, Governor Mike Beebe served on the board of a local hospital and was familiar with many of the challenges of health care delivery in the state. Arkansas also benefited from the legislatively created position of state surgeon general, an independent, cabinet-level advisor charged with identifying strategies and shaping policies to improve health in Arkansans. They were joined by experienced leadership at the Department of Human Services and its Medicaid agency (including two successive directors and the medical director), the Insurance Department, and the Arkansas Center for Health Improvement.

[6] J. Thompson, interview with Manatt, June 2014; W. Golden, interview with Manatt, June 2014.

[7] M. Beebe, Letter to Secretary Sebelius, Feb. 2011, http://www.paymentinitiative.org/referenceMaterials/Documents/Governor%20Mike%20Beebe%20AR%20Medicaid%20Transformation%20Proposal.pdf, accessed June 27, 2014.

[8] J. Thompson, interview with Manatt, June 2014.

[9] Supplemental payments serve as a critical source of revenue to hospitals, especially safety-net hospitals, but are disconnected from the specific services provided to patients and delinked from the efficiency or quality of the care provided. Because of this disconnect, supplemental payments potentially dilute the incentives built into AHCPII's market-based reforms.

[10] On January 10, 2013, Walmart agreed to serve on the AHCPII Employer Advisory Council and committed $670,000 to fund the development and distribution of information to the public and underwrite an annual statewide tracking report that evaluates the project; Walmart, "Walmart Joins Arkansas Health Care Payment Improvement Initiative," Jan. 2013, http://news.walmart.com/news-archive/2013/01/10/walmart-joins-arkansas-health-care-payment-improvement-initiative, accessed July 8, 2014.

[11] J. Thompson, W. Golden, R. Hill et al., "The Arkansas Payment Reform Laboratory," *Health Affairs Blog,* March 2014, http://healthaffairs.org/blog/2014/03/18/the-arkansas-payment-reform-laboratory/, accessed June 27, 2014.

[12] Centers for Medicare and Medicaid Services, Comprehensive Primary Care Initiative: Arkansas: Statewide, http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/Arkansas.html, accessed June 27, 2014.

[13] Arkansas Division of Medical Services, A*rkansas Behavioral Health Home State Plan Amendment; Preliminary Working Draft, March 2014,* http://www.paymentinitiative.org/referenceMaterials/Documents/DRAFT%20-%20AR%20Behavioral%20Health%20Home%20State%20Plan%20Amendment%20-%2003-11-14.pdf, accessed Aug. 11, 2014; Arkansas Department of Human Services, *Arkansas Health System Transformation State Innovation Plan* (Little Rock, Ark.: Arkansas DHS, Sept. 2012), http://www.paymentinitiative.org/referenceMaterials/Documents/SIM%20III.%20%20State%20Innovation%20Plan%202012%2009%2021%20%20FINAL%20-%20TO%20SUBMIT.pdf, accessed Aug. 11, 2014.

[14] Thompson, Golden, Hill et al., "The Arkansas Payment Reform Laboratory," 2014.

[15] W. Golden, J. Thompson, S. Olson et al., "Patient-Centered Medical Homes in Arkansas," *Health Affairs Blog,* May 2014, http://healthaffairs.org/blog/2014/05/20/patient-centered-medical-homes-in-arkansas/, accessed June 27, 2014.

[16] C. Wilson and M. Motley, interview with Manatt, July 2014.

[17] State of Arkansas, *Episode Spreadsheet with Notes: For Medicaid, Work Has Occurred on 24 Episodes, with 13 Having Gone Live,* http://www.paymentinitiative.org/referenceMaterials/Documents/Episode%20Spreadsheet%20-%2024%20with%20notes.pdf, accessed July 8, 2014.

[18] Golden, Thompson, Olson et al., "Patient-Centered Medical Homes in Arkansas," 2014; and Arkansas Hospital Association Medicaid Subcommittee Meeting, June 5, 2014.

[19] Arkansas Department of Human Services, *Review Shows Payment Improvement Initiative Advancing Patient Care, Decreasing Costs,* http://www.achi.net/Pages/News/Article.aspx?ID=35, accessed July 8, 2014.

[20] Arkansas Department of Human Services, *Arkansas Health System Transformation State Innovation Plan*, 2012.

[21] Ibid.

[22] Arkansas Insurance Department, Bulletin 3B-2013: Requirements for Qualified Health Plan Certification in the Arkansas Federally-Facilitated Partnership Exchange (Marketplace) (Little Rock, Ark.: Arkansas Insurance Department, June 2013), http://www.insurance.arkansas.gov/Legal/Bulletins/3B-2013.pdf, accessed June 27, 2014; Arkansas Insurance Department, Bulletin 9-2014: 2015 Plan Year Requirements for Qualified Health Plan Certification in the Arkansas Federally-Facilitated Partnership Marketplace (Little Rock, Ark.: Arkansas Insurance Department, April 2014), http://www.insurance.arkansas.gov/Legal/Bulletins/9-2014.pdf, accessed June 27, 2014.

[23] D. Ramsey, "Nearly 200,000 Arkansans Have Gained Health Insurance Coverage via the Private Option for Medicaid Expansion," *Arkansas Times,* Aug. 8, 2014, accessed Aug.10, 2014.

[24] D. Ramsey, "Enrollment in Arkansas Health Insurance Marketplace at 44,665," April 22, 2014, accessed Aug. 10, 2014.

[25] A. Allison, interview with Manatt, June 2014.

[26] See, e.g., D. Bachrach, W. Bernstein, and A. Karl, *High-Performance Health Care for Vulnerable Populations: A Policy Framework for Promoting Accountable Care in Medicaid* (New York: The Commonwealth Fund, Nov. 2012).

[27] In the first quarter of 2014, hospitals saw uncompensated care costs decrease by 30 percent with respect to hospital admissions and by 24 percent for emergency room use; M. Beebe, Governor Beebe's weekly column and radio address: Healthy Results, May 30, 2014, http://governor.arkansas.gov/newsroom/index.php?do:newsDetail=1&news_id=4480, accessed June 27, 2014.

[28] AHCPII was initially supported by a $1 million grant from Arkansas Blue Cross Blue Shield that was matched with Medicaid funds. Thereafter, the state received a $42 million grant from the Center for Medicare and Medicaid Innovation (CMMI) under the State Innovation Model (SIM) program. The state also benefited from its early participation in the CMMI's multipayer Comprehensive Primary Care initiative.

[29] Launched in July 2014, the IAP will develop strategies for advancing delivery system and associated payment reforms, aligned with transformation efforts under way in Medicare and the commercial market, Centers for Medicare and Medicaid Services, *CMS Fact Sheets: Medicaid Innovation Accelerator Program*, http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-07-14.html, accessed July 21, 2014.

[30] Centers for Medicare and Medicaid Services, Comprehensive Primary Care Initiative: Arkansas: Statewide, http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/Arkansas.html, accessed June 27, 2014.

[31] Arkansas Insurance Department, Bulletin 3B-2013: Requirements for Qualified Health Plan Certification in the Arkansas Federally-Facilitated Partnership Exchange (Marketplace) (Little Rock, Ark.: Arkansas Insurance Department, June 2013), http://www.insurance.arkansas.gov/Legal/Bulletins/3B-2013.pdf, accessed June 27, 2014.

[32] "Building a Healthier Future for All Arkansans: Arkansas SIM Site Visit," June 12, 2013.

[33] Golden, Thompson, Olson et al., "Patient-Centered Medical Homes in Arkansas," 2014.

[34] Ibid.

[35] Arkansas Department of Human Services, *Arkansas Health System Transformation State Innovation Plan,* 2012.

[36] Golden, Thompson, Olson et al., "Patient-Centered Medical Homes in Arkansas," 2014.

[37] Ibid.

[38] J. Selig, "Arkansas Health Care Payment Improvement Initiative," Presentation at the AcademyHealth National Health Policy Conference, Feb. 4, 2014, http://www.academyhealth.org/files/nhpc/2014/Pmt%20Improv%20for%202-4-14%20NHPC%20conference.pdf, accessed June 27, 2014.

[39] Arkansas Hospital Association Medicaid Subcommittee Meeting, June 5, 2014.

[40] *Arkansas Health Care Payment Improvement Initiative: Health Homes*, http://www.paymentinitiative.org/healthHome/Pages/Health-Homes.aspx, accessed July 21, 2014.

[41] Arkansas Department of Human Services, *Arkansas Health System Transformation State Innovation Plan,* 2012.

[42] C. Wilson and M. Motley, interview with Manatt, July 2014.

[43] Arkansas Division of Medical Services, Arkansas Behavioral Health Home State Plan Amendment; Preliminary Working Draft, March 2014.

[44] Arkansas Department of Human Services, Arkansas Health System Transformation State Innovation Plan, 2012.

[45] J. Thompson, "The Nuts and Bolts of Arkansas Health Care: Crafting a New System," Presentation at Children's Hospital Association Annual Leadership Conference, Oct. 14, 2013, http://www.childrenshospitals.net/Content/ContentFolders34/EducationMeetings2/AnnualMeeting/2013/SessionsMonday/The_Nuts_and_Bolts_of_Arkansas_Health_Care_Crafting_a_New_System_Presentation.pdf, accessed June 27, 2014.

[46] The designated episodes currently paid under the new payment model include upper respiratory infection (three types), attention deficit hyperactivity disorder (ADHD), perinatal care, congestive heart failure, total joint replacement (hip and knee), colonoscopy, gall bladder removal, tonsillectomy, oppositional defiance disorder (ODD), coronary artery bypass grafting (CABG), and asthma. Others designated for future episode-based payments include percutaneous coronary intervention (PCI), chronic obstructive pulmonary disease (COPD), neonatal care, and ADHD/ODD comorbidity. State of Arkansas, *Episode Spreadsheet with Notes: For Medicaid, Work Has Occurred on 24 Episodes, with 13 Having Gone Live*, http://www.paymentinitiative.org/referenceMaterials/Documents/Episode%20Spreadsheet%20-%2024%20with%20notes.pdf, accessed July 8, 2014.

[47] Thompson, Golden, Hill et al., "The Arkansas Payment Reform Laboratory," 2014.

[48] Arkansas Health Care Payment Improvement Initiative, *Episode Summary: Total Hip and Knee Replacement* (Little Rock, Ark.: AHCPII), http://www.paymentinitiative.org/referenceMaterials/Documents/hipKneeEpisode.pdf, accessed Aug. 11, 2014.

[49] Arkansas Health Care Payment Improvement Initiative, *Episodes of Care: Attention Deficit/Hyperactivity Disorder (ADHD): A Step by Step Guide* (Little Rock, Ark.: AHCPII, 2014), accessed Aug. 11, 2014.

[50] W. Golden, R. Griffin, J. Thompson et al., *Arkansas Health Care Payment Improvement Initiative: Overview and the Role of Quality Measures* (Little Rock, Ark.: Arkansas Foundation for Medical Care, July 2012), https://www.afmc.org/LinkClick.aspx?fileticket=7R-jyQ-Vh0E%3D&tabid=683&mid=1567, accessed June 27, 2014.

[51] Thompson, Golden, Hill et al., "The Arkansas Payment Reform Laboratory," 2014.

[52] Ibid.

[53] Arkansas Department of Human Services, *Review Shows Payment Improvement Initiative Advancing Patient Care, Decreasing Costs,* http://www.achi.net/Pages/News/Article.aspx?ID=35, accessed July 8, 2014.

[54] Ibid.

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Medicare At A Glance

Overview of Medicare

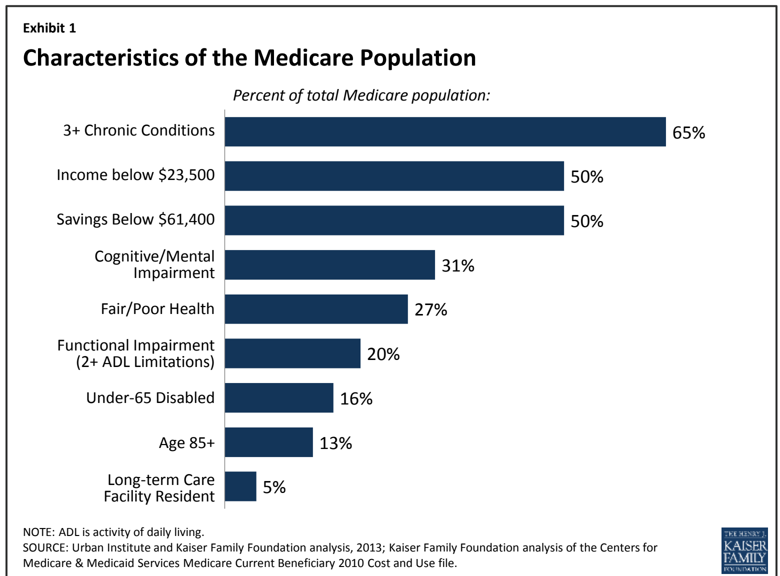
Medicare is the federal health insurance program created in 1965 for all people ages 65 and older, regardless of income or medical history, and expanded in 1972 to cover people under age 65 with permanent disabilities. Now covering 54 million Americans, Medicare plays a vital role in providing financial security to older people and those with disabilities. Medicare spending accounted for 14% of total federal spending in 2013 and 20% of national personal health spending in 2012.

Most people ages 65 and older are entitled to Medicare Part A if they or their spouse are eligible for Social Security payments and have made payroll tax contributions for 10 or more years. Nonelderly people who receive Social Security Disability Insurance (SSDI) payments generally become eligible for Medicare after a two-year waiting period, while those diagnosed with end-stage renal disease (ESRD) and amyotrophic lateral sclerosis (ALS) become eligible for Medicare with no waiting period.

Medicare has undergone numerous changes since its inception. Most recently, the Affordable Care Act of 2010 (ACA) contained a number of provisions affecting Medicare, including benefit improvements, spending reductions affecting providers and Medicare Advantage plans, delivery system reforms, premium increases for higher-income beneficiaries, and a payroll tax on earnings for higher-income people. These changes are being phased in over time.

Characteristics of People on Medicare

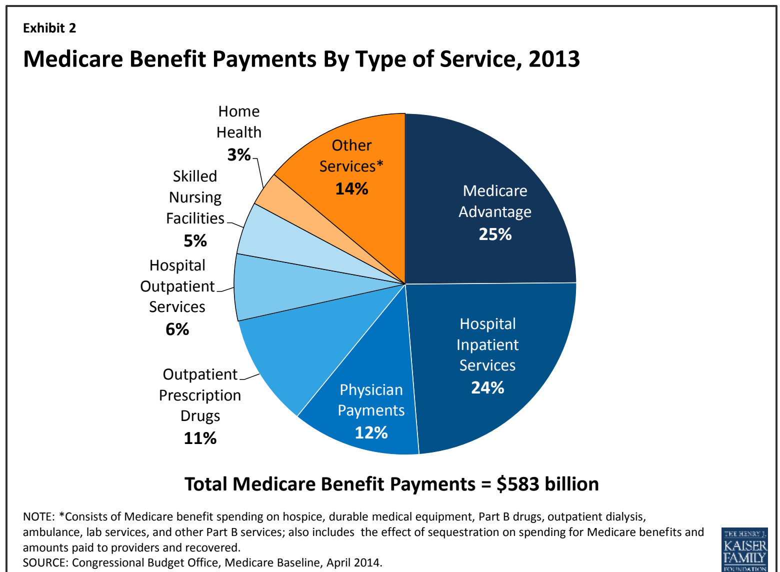
Medicare covers a diverse population (**Exhibit 1**). In 2013, half of all people on Medicare had incomes below $23,500 per person. In 2010 (the most recent year of data available), more than one quarter of all beneficiaries reported being in fair or poor health, and three in ten had a cognitive or mental impairment. Nearly 9 million beneficiaries (16%) are nonelderly people with disabilities and a growing share (13% in 2010) are age 85 or older. Two million beneficiaries (5%) lived in a long-term care facility in 2010.



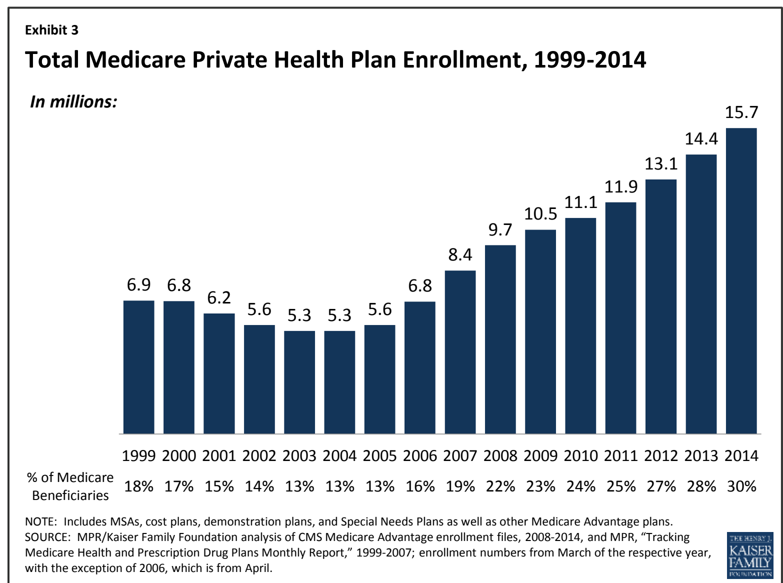
The Structure of Medicare

Medicare benefits are organized and paid for in different ways (**Exhibit 2**):

- **Part A** covers inpatient hospital stays, skilled nursing facility stays, some home health visits, and hospice care. Part A benefits are subject to a deductible ($1,216 per benefit period in 2014) and coinsurance.
- **Part B** covers physician visits, outpatient services, preventive services, and some home health visits.. Part B benefits are subject to a deductible ($147 in 2014), and cost sharing generally applies for most Part B benefits.
- **Part C** refers to the Medicare Advantage program through which beneficiaries can enroll in a private health plan, such as a health maintenance organization (HMO) or preferred provider organization (PPO), and receive all Medicare-covered Part A and Part B benefits and typically Part D



benefits. Enrollment in Medicare Advantage plans has grown over time, with nearly 16 million beneficiaries in a Medicare Advantage plan in 2014 (30% of all beneficiaries) (**Exhibit 3**).



- **Part D** covers outpatient prescription drugs through private plans that contract with Medicare, including both stand-alone prescription drug plans (PDPs) and Medicare Advantage drug plans (MA-PD plans); enrollment is voluntary. Enrollees pay monthly premiums and cost sharing for prescriptions (varying by plan), with additional financial assistance provided to beneficiaries with low incomes and modest assets. About 37 million receive Part D coverage under a PDP or Medicare Advantage drug plan in 2014.

Benefit Gaps and Supplemental Coverage

Medicare provides protection against the costs of many health care services, but traditional Medicare has relatively high deductibles and cost-sharing requirements and places no limit on beneficiaries' out-of-pocket spending. Moreover, Medicare does not pay for some services vital to older people and those with disabilities, including long-term services and supports, dental services, eyeglasses, or hearing aids. Beneficiaries enrolled in Part D plans also may be subject to higher drug costs in the drug benefit's coverage gap (also called the "doughnut hole"); in 2014, beneficiaries with prescription drug spending exceeding $2,850 are responsible for 47.5% of the cost for covered brand-name drugs and 72% of the cost of generics until they reach the catastrophic coverage limit ($4,550 in out-of-pocket costs in 2014). However, the coverage gap is gradually closing by 2020, when beneficiaries will pay no more than 25% of the cost of their drugs in the coverage gap.

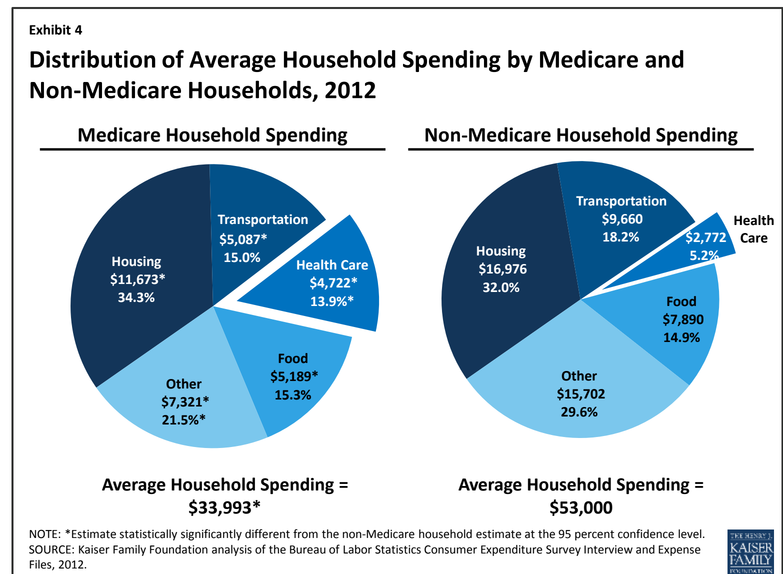
In light of Medicare's benefit gaps and cost-sharing requirements, most beneficiaries covered under traditional Medicare have some form of supplemental coverage to help cover cost-sharing expenses required for Medicare-covered services:

- Employer-sponsored retiree health plans are a primary source of supplemental coverage for people on Medicare today; over time, however, fewer seniors are expected to have this type of coverage, since the share of employers offering it to their employees has dropped from 66% in 1988 to 28% in 2013.[1]
- Medicare supplemental policies known as Medigap are another important source of supplemental coverage for people on Medicare. These policies fully or partially cover Medicare Part A and Part B cost-sharing requirements, including deductibles, copayments, and coinsurance. Premiums for Medigap can be costly, however, averaging $183 per month in 2010.[2]
- Medicaid helps pay for Medicare's premiums and cost sharing for Medicare beneficiaries with low incomes and modest assets (known as "dual eligibles"). Most of these beneficiaries also qualify for full Medicaid benefits, which include long-term care.

While most beneficiaries have some type of supplemental coverage, 18% of Medicare beneficiaries with traditional Medicare had no supplemental coverage in 2010, including a disproportionate share of beneficiaries under age 65 with disabilities, the near poor (those with incomes between $10,000 and $20,000), rural residents, and black beneficiaries.[3]

Out-of-Pocket Spending

Health expenses, including premiums, accounted for 14% of Medicare household budgets in 2012, nearly three times the share of spending on health care in non-Medicare households **(Exhibit 4)**. In 2010, Medicare beneficiaries spent $4,734 out of their own pockets for health care spending, on average, including premiums for Medicare and other types of supplemental insurance and costs incurred for medical and long-term care services. Beneficiaries in the top quartile of out-of-pocket costs spent, on average, $11,500 on premiums

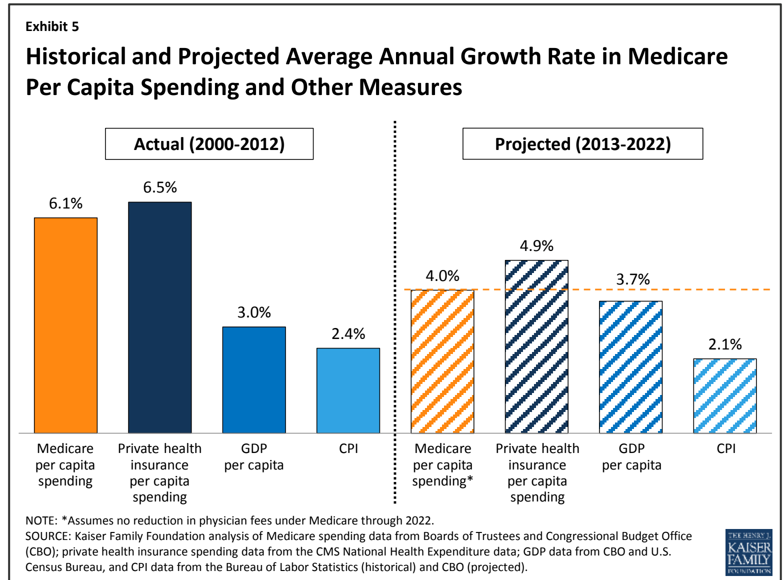


and services, more than twice as much as average out-of-pocket spending. As might be expected, beneficiaries in poorer health, who typically need and use more medical and long-term care services, tend to have higher out-of-pocket costs.

Medicare Spending Now and In the Future

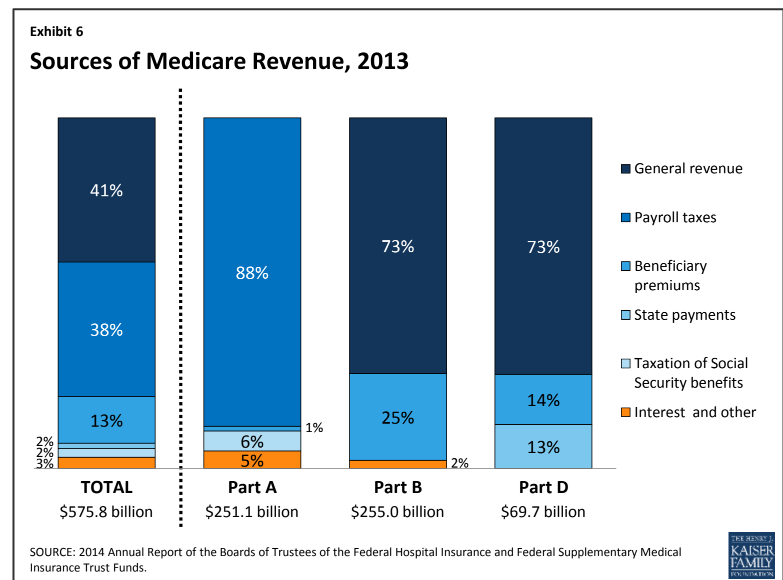
Medicare spending is affected by a number of factors, including the number of beneficiaries, how care is delivered, the use of services, and health care prices. Both in the aggregate and on a per capita basis, Medicare spending growth has slowed in recent years and is expected to grow at a slower rate in the future than in the past—and even slower than was projected just a few years ago. Based on a comparison of CBO's August 2010 and April 2014 baselines, Medicare spending in 2014 will be about $1,000 lower per person than was expected in 2010, soon after passage of the ACA.[4]

Looking ahead, Medicare spending (net of income from premiums and other offsetting receipts) is projected to grow from $512 billion in 2014 to $858 billion in 2024. These estimates do not take into account additional spending that is likely to occur to avoid reductions in physician fees scheduled under current law. On a per person basis, Medicare spending is projected to grow at 4.0% annually between 2013 and 2022 (factoring in the projected cost of physician payment updates). This growth rate is projected to be slower than private health insurance spending on a per person basis over the same time period, and somewhat faster than growth in the economy, as measured by GDP per capita **(Exhibit 5)**.



How Medicare is Financed

Medicare is financed by general revenues (41% in 2013), payroll tax contributions (38%), beneficiary premiums (13%), and other sources **(Exhibit 6)**.



- **Part A** is funded mainly by a 2.9% payroll tax on earnings paid by employers and employees (1.45% each) deposited into the Hospital Insurance Trust Fund. Higher-income taxpayers (>$200,000/ individual and $250,000/couple) pay a higher Medicare payroll tax on earnings (2.35%). The Part A Trust Fund is projected to be solvent through 2030.
- **Part B** is funded by general revenues and beneficiary premiums ($104.90 per month in 2014). Medicaid pays Part B premiums on behalf of beneficiaries who qualify for Medicaid based on low incomes and assets. Beneficiaries with higher incomes ($85,000 for individuals; $170,000 for couples) pay a higher, income-related monthly Part B premium, ranging from $146.90 to $335.70 per month in 2014. The income thresholds for the income-related premium will remain at 2010 levels through 2019.
- **Part C**, the Medicare Advantage program, is not separately financed; Medicare Advantage plans provide benefits covered under Part A, Part B, and (typically) Part D, and these benefits are financed primarily by payroll taxes, general revenues, and premiums, as described here. Beneficiaries enrolled in Medicare Advantage plans typically pay monthly premiums for additional benefits covered by their plan in addition to the Part B premium. The average premium for Medicare Advantage plans in 2014 is $35 per month (weighted by 2014 enrollment).
- **Part D** is funded by general revenues, beneficiary premiums, and state payments. The average premium for PDPs in 2014 is $38 (weighted by 2014 enrollment). Part D enrollees with higher incomes pay an income-related premium surcharge, with the same income thresholds used for Part B. In 2014, premium surcharges range from $12.10 to $69.30 per month for higher-income beneficiaries.

Medicare and Delivery System Reform

The Affordable Care Act directed the Centers for Medicare and Medicaid Services (CMS) to test and implement new approaches for Medicare to pay doctors, hospitals, and other providers and to bring about changes in how providers organize and deliver care. These new approaches typically include financial incentives that are designed to encourage collaboration and care coordination among different providers (such as hospitals and doctors), reduce spending on unnecessary services, and reward providers for providing higher quality patient care. Accountable Care Organizations (ACOs) are one example of a delivery system reform model currently being tested within Medicare. The ACO model allows groups of providers to accept responsibility for the overall care of Medicare beneficiaries and share in financial savings if spending and care quality targets are met. Other new models being tested include various payment approaches for so-called "medical homes" and initiatives aimed to reduce hospital readmissions. These models are being evaluated to determine their effect on Medicare spending and the quality of care provided to beneficiaries.

Looking to the Future

Medicare faces a number of critical issues and challenges, perhaps none greater than providing affordable, quality care to an aging population while keeping the program financially secure for future generations. The ACA included numerous changes designed to improve Medicare benefits, slow the growth in Medicare spending, and improve the quality and delivery of care. Further changes to Medicare could be considered as part of broader efforts to reduce the federal debt and to curtail reductions in Medicare's physician fee schedule which are called for in the coming years. And yet, in recent years Medicare spending has grown at a much slower rate compared to historical spending growth, which may ease the pressure for significant changes to the program in the near term and give policymakers an opportunity for thoughtful consideration of ways to bolster the program for an aging population over the longer term. As policymakers consider possible changes to Medicare, it will be important to monitor not only the effect of these changes on total health care expenditures, including Medicare spending, but also the impact on beneficiaries' access to quality care and their out-of-pocket costs.

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[1] Kaiser Family Foundation/Health Research & Educational Trust (HRET), *2013 Employer Health Benefits Survey*, Kaiser Family Foundation (August 2013); available at http://kff.org/private-insurance/report/2013-employer-health-benefits/.

[2] Gretchen Jacobson, Jennifer Huang, and Tricia Neuman, "Medigap Reform: Setting the Context for Understanding Recent Proposals," Kaiser Family Foundation (January 2014); available at http://kff.org/medicare/issue-brief/medigap-reform-setting-the-context/.

[3] Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2010 Cost and Use file.

[4] Tricia Neuman and Juliette Cubanski, "The Mystery of the Missing $1,000 Per Person: Can Medicare's Spending Slowdown Continue?" Kaiser Family Foundation (July 2014); available at http://kff.org/medicare/perspective/the-mystery-of-the-missing-1000-per-person-can-medicares-spending-slowdown-continue /.

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Affordable Care Act

Network Adequacy and Health Equity: Improving Private Health Insurance Provider Networks for Communities of Color

ISSUE BRIEF / AUGUST 2014

The Affordable Care Act's principal goal is to increase access to affordable, high-quality health care.

The law's main strategy for reaching this objective is through expanding health coverage to consumers who have been priced out of or otherwise excluded from the insurance market in the past. Expanding access to health insurance is particularly important for communities of color, who have much lower insurance rates than non-Hispanic whites.[1] Under the Affordable Care Act, uninsured rates for people of color, as well as for whites, have already decreased significantly.[2]

Unequal access to health coverage contributes to the many well-documented health disparities that affect racial and ethnic minorities.[3] But while having health insurance is vital to obtaining health care, evidence shows that communities of color confront additional obstacles to care even when they have health coverage.[4] Among these obstacles is the ability to get access to providers and facilities that can meet their needs.[5]

This brief describes the barriers that people of color face disproportionately in gaining access to necessary health care providers. It then describes the components of an adequate provider network for communities of color that can help alleviate some of these barriers, along with policies to help achieve such networks in private insurance plans. Finally, it outlines strategies to put these policies in place.

What are health disparities?

Variations in health outcomes, known as health disparities, have been documented for decades, particularly between racial and ethnic minorities and non-Hispanic whites. People of color are more likely to have serious chronic diseases like diabetes, certain cancers,[6] asthma,[7] and HIV/AIDS,[8] and are more likely to suffer complications from these conditions that lead to worse outcomes and even premature death.

Communities of Color Face Disproportionate Barriers to Accessing Health Care Providers

While having insurance is a critical first step to meeting people's health care needs, health coverage alone does not guarantee access to timely, affordable, high-quality care. Even when racial and ethnic minorities have insurance, they may continue to face barriers to accessing providers. These include, but are not limited to:

» **Insufficient distribution of providers**: In certain areas of the country, physical access to health care providers and facilities presents an obstacle to care. There are more than 3,500 areas in the country that have been designated by the federal government as medically underserved, meaning that access to health care is limited even for those with health coverage because there is an insufficient number of providers and/or facilities in the area.[9]

Even with health coverage, communities of color still face barriers to care. To help address these obstacles, health insurers' provider networks should be adequate—offering consumers the right care, at the right time, in a language they can understand, without having to travel unreasonably far. By working toward such "network adequacy," we may help reduce some of the health disparities that racial and ethnic minorities experience.

- **Transportation barriers**: Even in places that are not considered medically underserved, transportation challenges that are exacerbated by inadequate public transportation, the distance to medical facilities, and continued racial segregation can make it difficult for underserved populations to get the care they need.
- **Language barriers**: Some consumers may face challenges finding a provider who speaks their language, or a provider that at least has high-quality, certified professional translators available.
- **Lack of flexible hours**: Because many people of color work in low-paying jobs with limited benefits, including sick leave,[10] they may need providers that offer extended hours but struggle to find such providers in their communities.

Although insurance plans alone cannot eliminate all of these barriers, the size, composition, and quality of insurers' provider networks can have a significant impact on their enrollees' ability to obtain timely, high-quality, language-accessible, culturally-competent care.

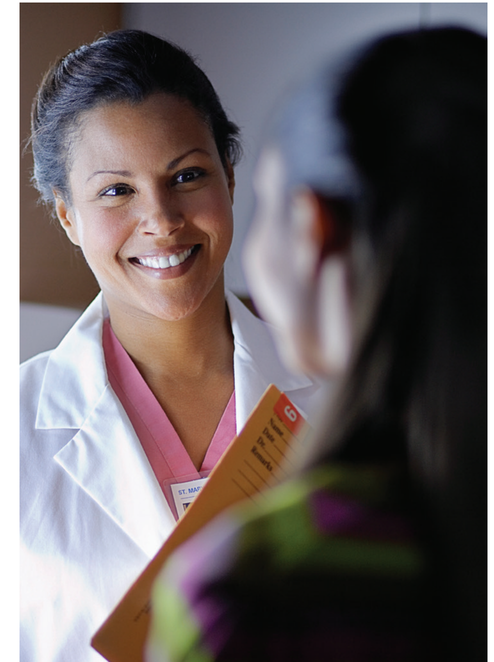
Health Plans Create Networks of Providers to Help Control Costs

Most types of health insurance plans, such as preferred provider organizations (PPOs) and health maintenance organizations (HMOs), create "networks" of providers (and hospitals and other facilities) as a way to control costs for the plan and its enrollees. Such insurance plans, often referred to as "managed care" plans, usually charge consumers extra if they receive care from out-of-network providers and facilities.

As part of their formal contracts, health plans and their network providers negotiate the reimbursement rates for the health care services that providers deliver to the health plan's enrollees. Through these contracts, a health plan can control the costs it will pay for its enrollees' medical care, and thereby control health insurance premiums for consumers.

If consumers receive care from health care providers who are not in their plan's network, they will most likely face costs beyond the deductible, copayments, or other cost-sharing they would have to pay if they received care from in-network providers. These extra costs could include a higher deductible, other additional cost-sharing, or the entire bill for the services that the out-of-network provider delivers.

PPOs and HMOs both charge more for out-of-network care, but HMO rules are stricter. If consumers go out of network for care in an HMO, they are likely to face higher costs than if they go out of network in a PPO plan. However, to avoid potentially unaffordable costs for care, it is important that consumers in all types of plans receive medical services from providers, hospitals, and other facilities that are considered "in-network."

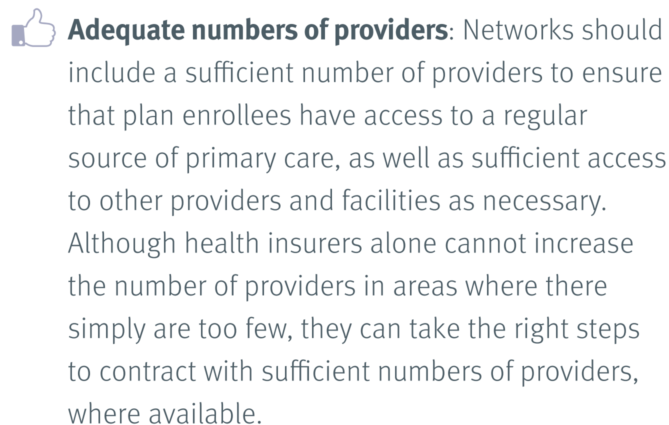


How Insurance Provider Networks Can Better Meet the Needs of Communities of Color

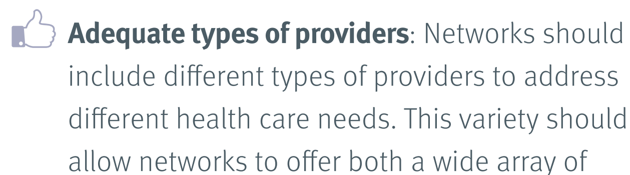
A health plan's network is adequate when it can provide meaningful access to care. This means that through the network, consumers are able to obtain:

- the right care
- at the right time
- in a language they understand
- without having to travel unreasonably far

For a network to be adequate for a diverse population, it must include the following components:



Adequate numbers of providers: Networks should include a sufficient number of providers to ensure that plan enrollees have access to a regular source of primary care, as well as sufficient access to other providers and facilities as necessary. Although health insurers alone cannot increase the number of providers in areas where there simply are too few, they can take the right steps to contract with sufficient numbers of providers, where available.



Adequate types of providers: Networks should include different types of providers to address different health care needs. This variety should allow networks to offer both a wide array of health care services and a variety of providers that fill different roles. Networks must include providers that can deliver all of the services covered under a health plan's benefits package, including primary care, mental health and substance use disorder care, and other specialty services. And not all providers who are needed are physicians: Networks should also include other types of providers who are critical for delivering necessary services or those who can deliver services instead of a physician provider.

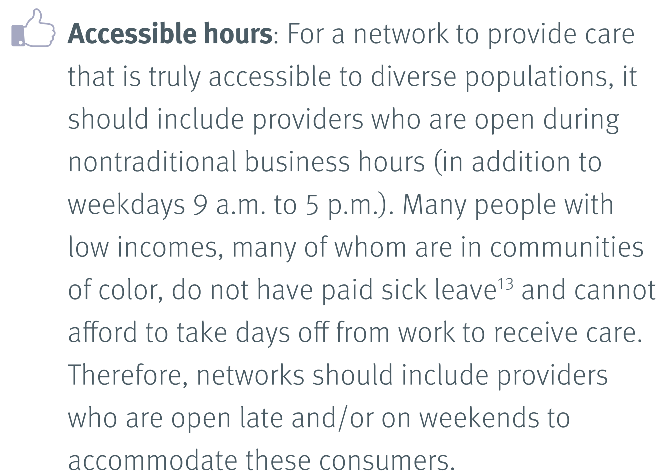
For communities of color, it is also particularly important that networks include essential community providers, or ECPs—providers who serve predominantly low-income, medically underserved individuals[11] that are specifically required by the Affordable Care Act[12]. See page 5.

What is "network adequacy"?

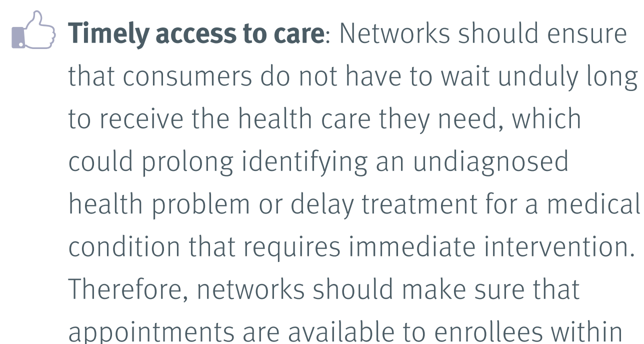
In most health plans, consumers must receive medical services from providers that are considered "in-network" to avoid extra costs for care. A health plan's network is adequate when it can provide meaningful access to care. This means that through the network, consumers are able to obtain the right care at the right time, in a language they understand, and without having to travel unreasonably far.

Networks should include different types of providers to address different health care needs.

Adequate geographic distribution of providers: Not only should a network have a sufficient number and array of providers, these providers should also be geographically distributed to allow individuals in diverse areas to reach them without having to travel unreasonably far from their homes or workplaces. This is particularly important for communities of color and other underserved groups, who may depend on public transportation, friends, or family members to travel to medical appointments and thus can only travel a limited distance to obtain care.

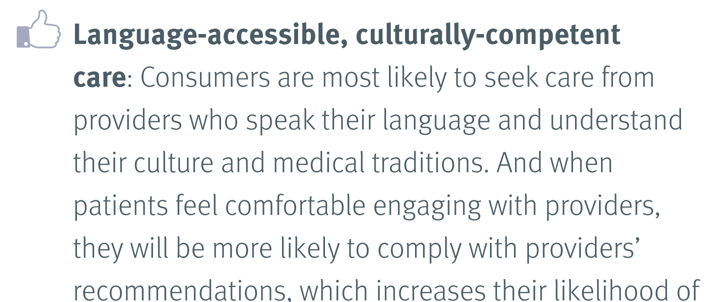


Accessible hours: For a network to provide care that is truly accessible to diverse populations, it should include providers who are open during nontraditional business hours (in addition to weekdays 9 a.m. to 5 p.m.). Many people with low incomes, many of whom are in communities of color, do not have paid sick leave[13] and cannot afford to take days off from work to receive care. Therefore, networks should include providers who are open late and/or on weekends to accommodate these consumers.



Timely access to care: Networks should ensure that consumers do not have to wait unduly long to receive the health care they need, which could prolong identifying an undiagnosed health problem or delay treatment for a medical condition that requires immediate intervention. Therefore, networks should make sure that appointments are available to enrollees within a reasonable amount of time. This is particularly important for communities of color, for whom there is already a greater likelihood of delayed diagnosis and treatment compared to whites.[15]

Essential community providers, who serve predominantly low-income, medically underserved individuals, have been invaluable to communities of color. Many ECPs have a long history of caring for underserved communities and have gained their trust. Many also have experience providing care that is culturally competent and language-accessible (for example, in languages other than English). In fact, some ECPs focus on specific minority or immigrant populations. Many ECPs also provide mental health, substance use disorder, and HIV/AIDS services, which may be difficult to obtain in health plan networks and often subject to stigma.[14] This makes culturally-competent treatment especially important. Therefore, contracting with ECPs is critical to creating health plan networks that meet the needs of communities of color.



Language-accessible, culturally-competent care: Consumers are most likely to seek care from providers who speak their language and understand their culture and medical traditions. And when patients feel comfortable engaging with providers, they will be more likely to comply with providers' recommendations, which increases their likelihood of

having better health outcomes.[16] Networks should therefore include providers who speak the same languages as their patients, or at least make high-quality language assistance services available.

Networks should also include providers who are culturally competent and understand the unique needs of their patient population. This need for culturally-competent providers applies not only to racial and ethnic minorities, but also to the lesbian, gay, bisexual, and transgender (LGBT) community, whose members may be less likely to seek care because they face or fear discrimination from providers.[17]

Accurate information about providers: Consumers need accurate, up-to-date information about which providers are in a plan's network. It is critical that health plans provide this information so that consumers can understand their options for care and avoid unintentionally visiting costly out-of-network providers. Access to accurate information is particularly important for underserved communities, who may have less experience using health insurance and navigating challenges related to determining whether or not providers are in a plan's network. To allow consumers from diverse backgrounds to identify health plans and providers that can best meet their needs, directories should indicate what languages other than English (if any) providers speak. Directory information should also be available in multiple languages.

The Affordable Care Act Gives Consumers Rights to Adequate Provider Access

Under the Affordable Care Act, private insurance consumers in the new health insurance marketplaces have new rights that are designed to ensure that once they are enrolled in coverage, they are able to get the care they need. These include rights to provider network adequacy in general, specific rights to see ECPs, and rights to information about which providers are in a plan's network.

Rights to an Adequate Network

Under the Affordable Care Act, health insurance marketplace plans are required to provide consumers with a "sufficient choice of providers."[18] Regulations to implement this section of the law further require that each marketplace plan "maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay."[19]

While consumers now have these important new rights, making these rights meaningful may require further action. Marketplaces or regulators may need to implement more specific standards to ensure that these new rights are carried out for plan enrollees.

Access to accurate information is particularly important for underserved communities, who may have less experience using health insurance and navigating challenges related to determining whether or not providers are in a plan's network.

State-based marketplaces: In states that operate their own marketplaces,[20] it is up to the state to define the additional specific standards, if any, that a health plan must meet to be considered compliant with the network adequacy requirements described above.

Federal marketplaces: In states with marketplaces that are operated by the federal government ("federally facilitated marketplaces"),[21] the U.S. Department of Health and Human Services (HHS) determines whether marketplace plans are meeting the standards described above, although marketplace plans must also comply with any state laws or rules regarding network adequacy.

For 2014, HHS took a passive approach to compliance for federally facilitated marketplaces. HHS relied mostly on network adequacy reviews conducted by the states or health insurance plan accreditors to verify compliance with the network adequacy requirements described above.

For 2015, HHS intends to more closely review network adequacy compliance for plans in the federally facilitated marketplaces, looking for plans that seem to be outliers based on their inability to provide "reasonable access" before certifying plans as qualified for the marketplace. HHS has also indicated that it is considering implementing more specific standards for network adequacy in the future,[22] which would likely better ensure that marketplace plans meet the requirements in the law and corresponding regulations.

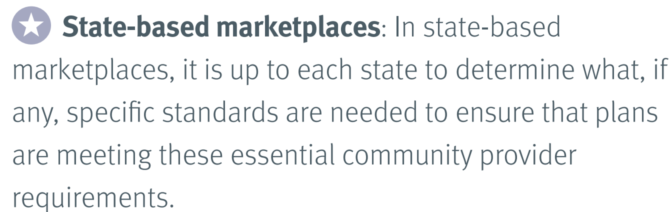
Rights to Essential Community Providers (ECPs)

The Affordable Care Act also requires health plans in the new marketplaces to include in their networks "essential community providers, where available, that serve predominately low-income, medically underserved individuals."[23] Regulations under the law further clarify that marketplace plans "must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals" in the area that the plan serves (the plan's "service area").[24]

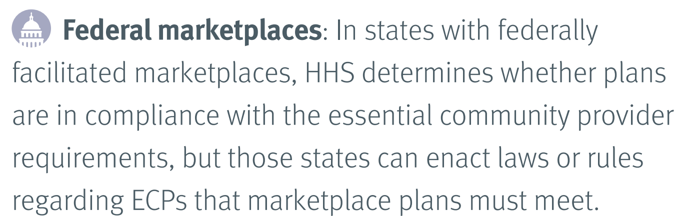
The law specifies that ECPs include (but are not limited to) those providers who are eligible for discounted prescription drugs under the federal 340B Drug Pricing Program. Examples of such providers include:

- Federally qualified health centers (FQHCs) and "look-alike" health centers
- Ryan White HIV/AIDS providers
- Hospitals such as Disproportionate Share Hospitals (which serve a significantly disproportionate number of low-income patients and receive payments from the Centers for Medicare and Medicaid Services to cover the costs of providing care to uninsured patients) and Sole Community Hospitals
- Title X family planning clinics
- Hemophilia treatment centers[25]

HHS created a "non-exhaustive database of essential community providers" to help health plans identify ECPs such as those listed above to include in their networks.[26]



State-based marketplaces: In state-based marketplaces, it is up to each state to determine what, if any, specific standards are needed to ensure that plans are meeting these essential community provider requirements.



Federal marketplaces: In states with federally facilitated marketplaces, HHS determines whether plans are in compliance with the essential community provider requirements, but those states can enact laws or rules regarding ECPs that marketplace plans must meet.

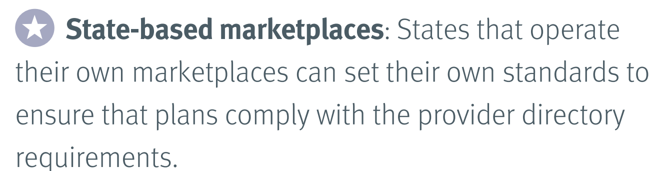
In 2014, HHS required plans in the federally facilitated marketplaces to include in their networks at least 20 percent of the ECPs in their service area. In addition, plans were required to offer contracts to all Indian health providers and at least one ECP in each ECP category (such as FQHCs, Ryan White providers, hospitals, etc.) in each county in the plan's service area where such providers are available. Plans that could not meet this standard could still receive certification to participate in the marketplace in certain circumstances that HHS approved.[27]

In 2015, plans must contract with at least 30 percent of the ECPs in their service area, in addition to offering contracts to the entities described above. As was the case for 2014, plans that cannot meet the 2015 standard may still be able to receive certification for the federally facilitated marketplace if they submit a sufficient justification and explanation of how they will serve low-income and medically underserved consumers.[28]

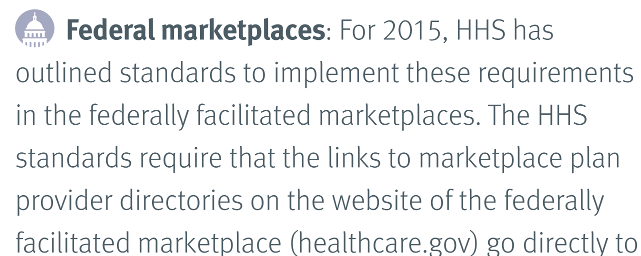
While the 2015 federally facilitated marketplace standards mark an improvement over the 2014 standards, they are still not as strong as what some states have implemented, as described on page 9.

Rights to Provider Network Information

Health plan provider directories are notoriously inaccurate.[29] The Affordable Care Act put in place first-ever federal protections regarding provider directories for private insurance consumers. The law requires marketplace plans to provide information to enrollees and prospective enrollees on which providers are in a plan's network.[30] Corresponding regulations further require plans to make provider directories available to the marketplaces for publication online and to potential enrollees in hard copy upon request. The regulations also require directories to list providers that are not accepting new patients.[31]



State-based marketplaces: States that operate their own marketplaces can set their own standards to ensure that plans comply with the provider directory requirements.



Federal marketplaces: For 2015, HHS has outlined standards to implement these requirements in the federally facilitated marketplaces. The HHS standards require that the links to marketplace plan provider directories on the website of the federally facilitated marketplace (healthcare.gov) go directly to

The Affordable Care Act put in place first-ever federal protections regarding provider directories for private insurance consumers.

a specific plan's up-to-date provider directory without requiring consumers to log in, enter a policy number, or otherwise navigate an insurance company's website before viewing the directory.

HHS guidance indicates that these directories should include "location, contact information, specialty, and medical group, any institutional affiliations for each provider, and whether the provider is accepting new patients." HHS is also encouraging plans to include in their directories the languages providers speak, provider credentials, and whether providers are Indian health providers. For Indian health providers, HHS further encourages directories to indicate whether providers limit their services to Indian beneficiaries or serve the general public.[32]

States with a federally facilitated marketplace can set additional standards beyond those set by HHS to help ensure accurate and accessible directories.

Making Provider Access Real for Communities of Color: Examples from the States

Taken together, the Affordable Care Act's provisions for access to providers, essential community providers, and provider network information create a new baseline for consumer protections to improve access to care. However, more specific standards in these areas can help ensure that the right to adequate networks as promised under the law is made a reality for private insurance consumers of color.

Below we provide examples of standards to help ensure that private insurance provider networks are adequate for diverse populations as described on page 4. These standards can serve as models for other states—or even the federal government—to implement as they work to ensure that provider networks meet the health care needs of all consumers.

Adequate numbers of providers

The following examples show standards that are designed to ensure that health plan networks have sufficient numbers of providers to meet all enrollees' medical needs:

California: Managed care plans must provide one full-time equivalent physician (generally) per every 1,200 enrollees and approximately one full-time equivalent primary care physician per every 2,000 enrollees.[33]

Delaware: In all plans sold in the marketplace, as well as managed care plans sold outside the marketplace, each primary care network must have at least one full-time equivalent primary care provider for every 2,000 patients. Insurers must receive approval from the insurance commissioner for capacity changes that exceed 2,500 patients.[34]

Adequate types of providers

The following examples show standards that are designed to ensure that health plan networks have a sufficient range of types of providers to meet enrollees' medical needs:

New Hampshire: Managed care plans must have sufficient numbers of specific providers and facilities in their networks that include, but are not limited to:[35]

- Primary care providers
- Obstetricians/gynecologists
- Psychiatrists
- Oncologists
- Allergists
- Neurologists
- Licensed renal dialysis providers
- Inpatient psychiatric providers
- Emergency mental health providers
- Short-term facilities for substance use disorder treatment
- Short-term care facilities for inpatient medical rehabilitation services

New Jersey: Managed care plans must have contracts or arrangements that allow enrollees to obtain covered services from certain types of facilities and providers at in-network costs. These providers and facilities include, but are not limited to:[36]

- Inpatient psychiatric facilities for adults, adolescents, and children
- Outpatient therapy providers for mental health and substance use conditions
- Emergency mental health service providers
- Residential substance abuse treatment centers
- Specialty outpatient centers for HIV/AIDS, sickle cell disease, and hemophilia
- Comprehensive rehabilitation service providers
- Licensed renal dialysis providers
- A hospital offering tertiary (highly specialized) pediatric services

New Jersey has additional standards that apply only to HMOs that require HMO provider networks to include sufficient numbers of specific types of providers including, but not limited to:[37]

- Primary care providers, which can include (among other providers): physician assistants, certified nurse midwives, and nurse practitioners/clinical nurse specialists certified in advanced practice categories comparable to family practice, internal medicine, general practice, obstetrics and gynecology, or pediatrics; and in hospitals or other facilities[38]
- Obstetricians/gynecologists
- Psychiatrists
- Cardiologists
- Neurologists
- Oncologists

Inclusion of essential community providers

The following examples show standards that are designed to ensure that health plan networks provide sufficient access to ECPs (those who serve predominantly low-income, medically underserved populations), as required by the Affordable Care Act:

Connecticut: By January 1, 2015, plans sold in the marketplace must include in their networks 90 percent of the federally qualified health centers (FQHCs) in the state and 75 percent of ECPs on the marketplace's non-FQHC essential community provider list.[39] The marketplace uses its own list of ECPs instead of HHS' database (mentioned on page 8) because it found that the HHS database does not include a sufficient number or sufficient geographic diversity of essential community providers in Connecticut. The marketplace also found that the database does not include sufficient ECPs to deliver all of the essential health benefits that consumers are entitled to receive through their health coverage under the Affordable Care Act.[40]

Washington: In addition to general quantitative standards for the inclusion of ECPs, regulations in Washington include more specific standards for the inclusion of essential community providers in networks that could be particularly important to communities of color:

> *"For essential community provider categories of which only one or two exist in the state, an issuer [insurer] must demonstrate a good faith effort to contract with that provider or providers for inclusion in its network."*
>
> *"The issuer's provider network must include access to one hundred percent of Indian health care providers in a service area... such that qualified enrollees obtain all covered services at no greater cost than if the service was obtained from network providers or facilities."*
>
> *"By 2016, at least seventy-five percent of all school-based health centers in the service area must be included in the issuer's network."*[41]

Adequate geographic distribution of providers

The following examples show standards that are designed to ensure that health plan networks provide consumers with access to care in locations that are geographically accessible to where they live or work:

New Jersey: There are geographic accessibility standards for the providers and facilities that all managed care plans must include in their networks, some of which are listed on page 10. For example:

- Outpatient therapy for mental health and substance use conditions, emergency mental health services, and licensed renal dialysis providers must be "available within 20 miles or 30 minutes average driving time, whichever is less, of 90 percent of covered persons within each county or service area."
- The other facilities and providers listed on page 10 that managed care plans must include in their networks (inpatient psychiatric services; residential substance abuse treatment; specialty

outpatient centers for HIV/AIDS, sickle cell disease, and hemophilia; comprehensive rehabilitation services; and a hospital with tertiary pediatric services) must be "available within 45 miles or 60 minutes average driving time, whichever is less, of 90 percent of covered persons within each county or service area."

What is important about these standards, particularly for communities of color, is that they are modified to meet the needs of enrollees who rely on public transportation. Specifically, "in any county or approved service area in which 20 percent or more of a carrier's [insurance plan's] projected or actual number of covered persons must rely upon public transportation to access health care services, as documented by U.S. Census Data, the driving times set forth in the specifications… above shall be based upon average transit time using public transportation, and the carrier shall demonstrate how it will meet the requirements in its application."[42]

In addition to these requirements for all managed care plans, there are geographic access standards that apply specifically to HMOs in New Jersey:

- Primary care providers must be available within "10 miles or 30 minutes average driving time or public transit (if available), whichever is less, of 90 percent of the enrolled population."
- For the specialists for which only HMOs have specific provider inclusion standards (including obstetricians/gynecologists, psychiatrists, cardiologists, neurologists, and oncologists, as listed on page 10), HMOs must have a policy that assures access to these specialists "within 45 miles or one hour driving time, whichever is less, of 90 percent of members within each county or approved sub-county service area."[43]

Vermont: Under state rules for marketplace plans and for managed care plans outside of the marketplace, travel times for enrollees to in-network providers "under normal conditions from their residence or place of business, generally should not exceed the following:

1. 30 minutes to a primary care provider;
2. 30 minutes to routine, office-based mental health and substance abuse services;
3. 60 minutes for outpatient physician specialty care; intensive outpatient, partial hospital, residential or inpatient mental health and substance abuse services; laboratory; pharmacy; general optometry; inpatient; imaging; and inpatient medical rehabilitation services;
4. Ninety (90) minutes for kidney transplantation; major trauma treatment; neonatal intensive care; and tertiary-level cardiac services, including procedures such as cardiac catheterization and cardiac surgery."[44]

Accessible hours

The following example illustrates a standard that is designed to ensure that health plan networks can provide care at times that are convenient to diverse populations who may be unable to obtain care during standard (9 a.m. to 5 p.m. weekday) business hours:

California: In addition to being available during standard business hours, basic health care services through a plan's network "shall be available until at least 10:00 p.m. at least one day per week or for at least four hours each Saturday" under California standards that apply to most PPO plans, as well as to some other managed care plans.[45]

Timely access to care

The following examples show standards that are designed to ensure that health plan networks can provide enrollees with access to care in a timely manner:

California: HMOs, as well as many PPOs,[46] must ensure that enrollees are offered appointments within the following timeframes:

- » Within 48 hours of a request for an urgent care appointment for services that *do not* require prior authorization from the HMO in order for the enrollee to have the appointment covered by the HMO
- » Within 96 hours of a request for an urgent appointment for services that *do* require prior authorization
- » Within 10 business days of a request for non-urgent primary care appointments
- » Within 15 business days of a request for an appointment with a specialist
- » Within 10 business days of a request for an appointment with a non-physician mental health care provider
- » Within 15 business days of a request for a non-urgent appointment for ancillary services for the diagnosis or treatment of an injury, illness, or other health condition

These waiting times may be shortened or extended as clinically appropriate based on the opinion of a qualified health care professional acting within the scope of his or her practice, consistent with professionally recognized standards of practice. If the waiting time is extended, it must be noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.[47]

Washington: Health plans must demonstrate that enrollees can get an appointment with a primary care provider for non-preventive services within 10 business days of requesting one. When an enrollee is referred to a specialist, health plans must establish that the enrollee can get an appointment with such a specialist within 15 business days for non-urgent services.[48]

Language-accessible, culturally-competent care

The following states provide examples of protections that are designed to ensure that health plan networks can provide language-accessible, culturally-competent care:

California: All health insurance plans must have language access programs (LAPs) that assess the language needs of their enrollees and provide free interpreter services at all points of contact in the health plan, including with providers in the health plan's network. Health plans must also provide enrollees with notice of their right to receive these language services.[49]

New York: HMOs must be assessed on their "ability to provide culturally- and linguistically-competent care to meet the needs of the enrollee population" during their initial licensure reviews and at least every three years thereafter.[50]

Accurate information about providers

The following states provide examples of protections that are designed to ensure that consumers with diverse needs have access to accurate, up-to-date information about which providers are in a health plan's network:

New York: This year, New York passed legislation with new consumer protections for health plans that use contracted provider networks (PPOs, HMOs, etc.). It includes a provision requiring that each plan's provider directory list providers' addresses, telephone numbers, languages spoken, specialties, and any hospital affiliations. Insurers must update these listings online within 15 days of a provider joining or leaving their network or a change in a provider's hospital affiliation.[51]

Washington: Health plans must update their provider directories monthly, and directories must be offered to accommodate individuals with limited English proficiency and disabilities. For the providers, the directories must list languages spoken, specialties, and institutional affiliations (such as hospital affiliations or provider groups of which they are a member), among other characteristics. Directories must also include information about any available interpreter services, communication and language assistance services, and accessibility of physical facilities, as well as the mechanism by which an enrollee may access such services. In addition, directories must include specific descriptions of any available telemedicine services.[52]

Other Standards to Consider

In addition to the standards mentioned above, there are other sources for model consumer protection language regarding provider networks. Individuals and governments seeking to strengthen provider network standards for private insurance consumers of color may also want to examine the following:

- network adequacy requirements from Medicaid managed care contracts
- network adequacy standards for private Medicare plans (Medicare Advantage)[53]
- the National Association of Insurance Commissioners' Managed Care Plan Network Adequacy Model Act[54]

HMOs must be assessed on their "ability to provide culturally and linguistically competent care to meet the needs of the enrollee population...

Rights to Go Out of Network

Protections to ensure that provider networks are adequate to serve all populations are critical. However, it is just as important that consumers have the right to go out of network in instances where health plans are unable to deliver in-network providers who can meet enrollees' medical needs in a timely manner.

In 2014, New York enacted such a right for consumers. Under New York's new "Surprise Medical Bills" law, "if a plan's network does not have a geographically accessible provider with appropriate expertise to treat a patient's medical problem, patients in all plans can seek services from an out-of-network provider without incurring the additional out-of-network expense—the patient's health plan will pay for all expenses other than the usual in-plan copayments and cost-sharing."[55]

Furthermore, if an enrollee and his or her health plan disagree on whether the plan has an appropriate in-network provider available to address the enrollee's medical needs, the enrollee has the right to take the disagreement to an independent arbitrator: the state's independent external review system. That system will order the plan to allow the enrollee to see the out-of-network provider (without facing extra costs) if it finds that:

- The health plan does not have an in-network provider with appropriate training and expertise
- There is an out-of-network provider who has the expertise needed and can treat the patient
- The out-of-network provider's services are likely to lead to a better clinical outcome[56]

It's critical that sufficient protections are in place everywhere to ensure that health plan provider networks are adequate to serve diverse communities. But even with these protections in place, there are times when a plan's network might not meet certain enrollees' medical needs. In these cases, it's important to have a stopgap protection in place that allows enrollees to go out of network without facing extra costs. This example from New York provides a model of such a stopgap that other states could replicate.

Advocating for Provider Network Standards to Protect Diverse Communities

There are many influencers at the state and federal level who have authority over which standards are in place to ensure that all communities have meaningful access to the providers and facilities necessary to meet their health care needs once they enroll in coverage.

Individuals concerned about health plan provider networks for communities of color should talk to the following officials about which standards should be in place to make timely, geographically accessible, culturally competent care more available to diverse populations:

- » state insurance regulators, usually called insurance commissioners
- » state legislators

- state marketplace board members, directors, and staff (in states that operate their own marketplaces)[57]
- federal officials who work for the U.S. Department of Health and Human Services (HHS), such as the HHS Regional Director for the relevant state, who can be found on the map at this website: http://www.hhs.gov/iea/regional/
- members of Congress

To be most effective in advocating for provider network standards, individuals should share concrete examples of the access problems that consumers in diverse communities face. Concerns from providers, including ECPs, are also powerful and should be shared not only with officials, but also with insurance companies, which may be able to develop better systems to contract with these providers.

Conclusion

The Affordable Care Act extended new health coverage options to millions of Americans in communities of color—a monumental step toward decreasing racial and ethnic disparities in health and health care. To build on this historic accomplishment, we must work to ensure that health plans can meet the needs of diverse populations.

Officials can help achieve this goal by enacting policies to ensure that health plan provider networks:

- include a sufficient breadth of providers and facilities
- include providers that are geographically accessible to communities of color
- offer timely care during convenient hours
- are language accessible and culturally competent
- have meaningful and accurate information available about the in-network providers and facilities

When health plan provider networks meet these criteria, they contribute to better health care, and, ultimately, better health outcomes, for people of color.

Health insurance plans alone certainly cannot eliminate all of the barriers consumers of color face when seeking health care. But the size, composition, and quality of insurers' provider networks can have a significant impact on their enrollees' ability to obtain timely, high-quality, language-accessible, culturally-competent care.

Endnotes

1 Carmen DeNavas-Walt, Bernadette Proctor and Jessica Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2012*, (Washington, D.C.: U.S. Census Bureau, September 2013), available online at: http://www.census.gov/prod/2013pubs/p60-245.pdf.

2 Jenna Levy, "U.S. Uninsured Rate Continues to Fall: Uninsured rate drops most among lower-income and black Americans," Gallup-Healthways Well-Being Index, March 10, 2014, available online at: http://www.gallup.com/poll/167798/uninsured-rate-continues-fall.aspx; Jenna Levy, "In U.S., Uninsured Rate Sinks to 13.4% in Second Quarter," *Gallup-Healthways Well-Being Index*, July 10, 2014, available online at: http://www.gallup.com/poll/172403/uninsured-rate-sinks-second-quarter.aspx.

3 Agency for Healthcare Research and Quality, *2013 National Healthcare Disparities Report*, (Washington, D.C.: U.S. Department of Health and Human Services, May 2014), available online at: http://www.ahrq.gov/research/findings/nhqrdr/nhdr13/2013nhdr.pdf.

4 National Association of Community Health Centers, *Access Is the Answer: Community Health Centers, Primary Care & the Future of American Health Care* (Washington, D.C.: NACHC, March 2014), available online at: http://www.nachc.com/client/PIBrief14.pdf.

5 Holly Mead, Lara Cartwright-Smith, Karen Jones, Christal Ramos, Kristy Woods, and Bruce Siegel, *"Racial and Ethnic Disparities in U.S. Health Care: A Chartbook"* (New York: The Commonwealth Fund, March 2008), available online at: http://www.commonwealthfund.org/usr_doc/Mead_racialethnicdisparities_chartbook_1111.pdf.

6 Debra Blackwell, Jacqueline Lucas, and Tainya Clarke, *Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2012*, (Atlanta: Centers for Disease Control and Prevention, February 2014), available online at: http://www.cdc.gov/nchs/data/series/sr_10/sr10_260.pdf.

7 Jeanne Moorman, Lara Akinbami, Cathy Bailey, et al., *National Surveillance of Asthma: United States, 2001–2010*, 2012, (Atlanta: Centers for Disease Control and Prevention, November 2012), available online at: http://www.cdc.gov/nchs/data/series/sr_03/sr03_035.pdf.

8 Centers for Disease Control and Prevention, *HIV Surveillance Report, 2011; vol. 23*, (Atlanta: CDC, February 2013) available online at: http://www.cdc.gov/hiv/surveillance/resources/reports/2011report/pdf/2011_HIV_Surveillance_Report_vol_23.pdf.

9 Health Resources and Services Administration Data Warehouse, *Preformatted Reports: Medically Underserved Areas/Populations (MUA/P)*, Accessed July 15, 2014, available online at: http://datawarehouse.hrsa.gov/HGDWReports/RT_App.aspx?rpt=MU.

10 U.S. Congress Joint Economic Committee, *Expanding Access to Paid Sick Leave: The Impact of the Healthy Families Act on America's Workers*, (Washington, D.C.: U.S. Congress, March 2010) available online at: http://www.jec.senate.gov/public/index.cfm?a=Files.Serve&File_id=abf8aca7-6b94-4152-b720-2d8d04b81ed6.

11 45 CFR § 156.235

12 42 U.S. Code § 18031

13 U.S. Congress Joint Economic Committee, *Expanding Access to Paid Sick Leave: The Impact of the Healthy Families Act on America's Workers*, op. cit.

14 Lois Bolden, *Stigma of Mental Illness Among Ethnic Minority Populations: African Americans* (Washington, D.C.: SAMHSA, June 27, 2004), available online at: http://www.emfp.org/MainMenuCategory/MFPFellows/Publications/LoisBoldenPublications.aspx; National Medical Association and HealthHIV, *African-American Physicians Believe Stigma Remains Significant Barrier To Routine HIV Testing: HealthHIV & National Medical Association Release Survey Findings in Recognition of National Black HIV/AIDS Awareness Day* (Washington, D.C.: National Medical Association and HealthHIV, February 6, 2012), available online at: http://www.healthhiv.org/modules/info/files/files_4f31915141746.pdf.

15 Holly Mead, Lara Cartwright-Smith, Karen Jones, Christal Ramos, Kristy Woods, and Bruce Siegel, op. cit.

16 Quyen Ngo-Metzger, Joseph Telfair, Dara H. Sorkin, Beverly Weidmer, Robert Weech-Maldonado, Margarita Hurtado, and Ron D. Hays, *Cultural Competency and Quality of Care: Obtaining the Patient's Perspective* (New York, NY: The Commonwealth Fund, October 2006), available online at: http://www.commonwealthfund.org/usr_doc/Ngo-Metzger_cultcompqualitycareobtainpatientperspect_963.pdf; Glenn Flores, "Language Barriers to Health Care in the United States," *The New England Journal of Medicine*, 355;3, July 20, 2006, available online at: http://mighealth.net/eu/images/b/bb/Flores3.pdf.

17 The Joint Commission, *Advancing Effective Communication, Cultural Competence, and Patient- and Family- Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide*, 2011, available online at http://www.jointcommission.org/assets/1/18/LGBTFieldGuide.pdf.

18 42 U.S. Code § 18031

19 45 CFR § 156.230

20 Richard Cauchi, *State Actions to Address Health Insurance Exchanges* (Washington, D.C.: National Conference of State Legislatures, May 9, 2014), available online at: www.ncsl.org/research/health/state-actions-to-implement-the-health-benefit.aspx (see interactive map).

21 Richard Cauchi, *State Actions to Address Health Insurance Exchanges* (Washington, D.C.: National Conference of State Legislatures, May 9, 2014), available online at: www.ncsl.org/research/health/state-actions-to-implement-the-health-benefit.aspx (see interactive map). HHS allows some states with federally facilitated marketplaces the option to perform "plan management" functions, and in such states the state will set network adequacy requirements for marketplace plans.

22 Center for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, *2015 Letter to Issuers in the Federally-facilitated Marketplaces,* (Washington, D.C.: U.S. Department of Health and Human Services, March 14, 2014), available online at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf.

23 42 U.S. Code § 18031

24 45 CFR § 156.235

25 42 U.S. Code § 18031; Health Resources and Services Administration, *340B Drug Pricing Program* (Washington, D.C.: U.S. Department of Health and Human Services, Accessed July 16, 2014), available online at: http://www.hrsa.gov/opa/.

26 Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, *Non-Exhaustive HHS List of Essential Community Providers* (Washington, D.C.: U.S. Department of Health and Human Services, 2014), available online at: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/non-exhaustive-list-essential-community-providers-2015.xlsx.

27 Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, *Affordable Exchanges Guidance: Letter to Issuers on Federally-facilitated and State Partnership Exchanges* (Washington, D.C.: U.S. Department of Health and Human Services, April 5, 2013), available online at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf.

28 Center for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, *2015 Letter to Issuers in the Federally-facilitated Marketplaces*, op. cit.

29 Linda Shelton, Laura Aiuppa, and Phyllis Torda, *Recommendations for Improving the Quality of Physician Directory Information on the Internet* (New York: The Commonwealth Fund and the National Committee for Quality Assurance, August 2004), available online at: http://www.commonwealthfund.org/usr_doc/731_shelton_physician_directory_information.pdf; New York State Office of the Attorney General, *Health Plan To Correct Inaccurate Physician Directories*, (Albany: New York State, December 19, 2006), available online at: http://www.ag.ny.gov/press-release/health-plan-correct-inaccurate-physician-directories.

30 42 U.S. Code § 18031

31 45 CFR § 156.230

32 Center for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, *2015 Letter to Issuers in the Federally-facilitated Marketplaces*. op. cit.

33 10 CCR § 2240.1; 28 CCR § 1300.67.2.

34 Delaware Department of Insurance, *Delaware State-Specific Qualified Health Plan (QHP) Standards for Plan Year 2015* (Dover: State of Delaware, 2014), available online at: http://www.delawareinsurance.gov/health-reform/DE-QHP-Standards-PY2015-May2014-v1.pdf; Sally McCarty and Max Farris, *ACA Implications for State Network Adequacy Standards* (Princeton: State Health Reform Assistance Network, August 2013), available online at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407486.

35 N.H. Code Admin. R. Ins 2701.06. Specific geographic access standards also apply to these types of providers and facilities.

36 N.J.A.C. 11:24A–4.10 Specific geographic access standards also apply to these types of providers and facilities, as listed on page 11.

37 N.J.A.C. 11:24–6.2 Specific geographic access standards also apply to these types of providers and facilities, as listed on page 11.

38 Non-HMO managed care plans have to meet similar primary care provider standards if they *require* enrollees to have or select a primary care provider.

39 Access Health CT, *Solicitation to Health Plan Issuers for Participation in the Individual and/or Small Business Health Options Program (SHOP) Marketplace* (Hartford: Access Health CT, March 18, 2014), available online at: http://www.ct.gov/hix/lib/hix/QHP_Solicitation_031814_Amended.pdf.

40 Connecticut Health Insurance Exchange Board of Directors, *Special Meeting Minutes* (Hartford: Access Health CT, June 26, 2013), available online at: http://www.ct.gov/hix/lib/hix/FinalMinutes62613.pdf.

41 Washington State Office of the Insurance Commissioner, Insurance Commissioner Matter No. R 2013-22, (Olympia: Washington State, April 26, 2014), available online at: http://www.insurance.wa.gov/laws-rules/legislation-rules/recently-adopted-rules/documents/2013-22103P.pdf.

42 N.J.A.C. 11:24A–4.10 In instances such as this in which geographic access standards must be met for no less than a minimum share of enrollees, it is important to ensure that this share does not leave out individuals who live in communities of color or other underserved areas.

43 N.J.A.C. 11:24–6.2 In instances such as this in which geographic access standards must be met for no less than a minimum share of enrollees, it is important to ensure that this share does not leave out individuals who live in communities of color or other underserved areas.

44 Vt. Admin. Code 4-5-3:10.500; Department of Vermont Health Access, *Vermont Health Connect Request for Proposals* (Montpelier: State of Vermont, amended December 21, 2012), available online at: https://www.statereform.org/system/files/vermont_qhp_rfp_amend_12_21_12.pdf.

45 10 CCR § 2240.1, 10 CA ADC § 2240.1 Health insurers in California may be regulated by one of two entities, either the Department of Managed Health Care or the California Department of Insurance. The rules for accessible hours referenced here apply to plans regulated by the California Department of Insurance, which include many PPOs, but no HMOs in the state. For more information, see: Department of Managed Health Care, *Agencies that Oversee Health Plans,* (Sacramento: DHMC, Accessed on July 31, 2014), available online at: http://www.dmhc.ca.gov/HealthPlansCoverage/ViewCompareHealthPlans/AgenciesthatOverseeHealthPlans.aspx#.U7GV37H5IfF .

46 Health insurers in California may be regulated by one of two entities, either the Department of Managed Health Care or the California Department of Insurance. The rules for timely access to care referenced here apply to plans regulated by the Department of Managed Health Care, which include all HMOs in California, as well as some PPOs. For more information, see: Department of Managed Health Care, *Agencies that Oversee Health Plans,* (Sacramento: DHMC, Accessed on July 31, 2014), available online at: http://www.dmhc.ca.gov/HealthPlansCoverage/ViewCompareHealthPlans/AgenciesthatOverseeHealthPlans.aspx#.U7GV37H5IfF.

47 California Department of Managed Health Care, *Timely Access* (Sacramento: DMHC, Accessed on July 31, 2014), available online at: http://www.dmhc.ca.gov/HealthCareLawsRights/HealthCareRights/TimelyAccess.aspx#.U7ClSqjc2zQ.

48 Washington State Office of the Insurance Commissioner. op. cit.

49 10 CCR § 2538.3, 10 CA ADC § 2538.3; Mara Youdelman, *The ACA and Language Access* (Washington: The National Health Law Program, January 2011), available online at: http://www.healthlaw.org/publications/aca-and-language-access#.U7McMLH5IfE.

50 N.Y. PBH. LAW § 4403 : NY Code - Section 4403: Health maintenance organizations; issuance of certificate of authority, available online at: http://codes.lp.findlaw.com/nycode/PBH/44/4403#sthash.FDgz4ut2.dpuf http://codes.lp.findlaw.com/nycode/PBH/44/4403.

51 NY Bill S6914-2013, Part H, available online at: http://stopsurprisemedicalbills.files.wordpress.com/2014/02/s-6914-a-2905-part-h.pdf.

52 Washington State Office of the Insurance Commissioner, op. sit.

53 Center for Medicare and Medicaid Services, *Calendar Year 2015 Medicare Advantage HSD Provider and Facility Specialties and Network Adequacy Criteria Guidance* (Washington: CMS, 2014), available online at: http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2015_MA_HSD_Network_Criteria_Guidance.pdf.

54 National Association of Insurance Commissioners, *Managed Care Plan Network Adequacy Model Act* (Washington: NAIC, October 1996), available online at: http://www.naic.org/store/free/MDL-74.pdf.

55 Mark Scherzer, *New York's New "Surprise Bill" Law Rolls out New Health Insurance Protections for Consumers* (Washington, D.C.: Families USA, April 10, 2014), available online at: http://familiesusa.org/blog/2014/04/new-york%E2%80%99s-new-surprise-bill-law-rolls-out-new-health-insurance-protections-consumers.

56 Ibid.

57 Richard Cauchi, *State Actions to Address Health Insurance Exchanges* (Washington, D.C.: National Conference of State Legislatures, May 9, 2014), available online at: www.ncsl.org/research/health/state-actions-to-implement-the-health-benefit.aspx (see interactive map).

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Implementing Consumer-Friendly Health Insurance Marketplaces (February 2013)

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ACA Implementation—Monitoring and Tracking

Physician Network Transparency: How Easy Is It for Consumers to Know What They Are Buying?

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act (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**.

INTRODUCTION

Transparency of insurance plan differences is important for consumers to make informed purchasing decisions, and it is important to developing effective competition across plans and insurance carriers. Among non-elderly adults who explored health insurance options under the Affordable Care Act (ACA), 78 percent used the websites developed by states and the federal government.[1] Roughly 60 percent of those using the websites were actively seeking to purchase health insurance or determine whether they were eligible for subsidized coverage, meaning many were using the information available there to identify their options and make plan decisions. About 48 percent of adults uninsured before reform and 68 percent of adults previously purchasing nongroup insurance reported that the choice of medical providers offered in a plan is very important in their choice.[2] Given the importance of provider network in making choices and the centrality of the websites for exploring options, how easy is it for consumers to find and use physician network information via the Marketplace websites?[3]

We studied 9 states' websites (California, Connecticut, Oregon, Colorado, Massachusetts, Minnesota, Rhode Island, Washington and the District of Columbia) and the federal healthcare.gov system. We are not able to assess network adequacy at this time, so this analysis focuses exclusively on the clarity, accessibility, and functionality of the directories. We assessed the websites on the following characteristics:

1. How clear is the plan type (e.g., health maintenance organization [HMOs], preferred provider organization [PPOs], point of service plans [POS plans], exclusive provider organizations [EPOs], narrow network, or tiered network) of each offering, given that these types are the first signal to the breadth of the providers reimbursed by the plan and the costs faced by enrollees using them?
   a. Though we found examples of Marketplaces that clearly labeled plans according to most of these categories and that defined the plan types in simple to understand ways with the definitions easily seen,
   b. Most states did not do so, and none clearly identified multitiered plans.

2. Are directories of participating physicians embedded in the Marketplace websites, or do they reside on carrier sites?
   a. Only three states in the study embedded their physician directories in the Marketplace websites.
   b. The others relied upon carrier websites, causing inconsistency both in format and information provided across carriers and often making directories associated with a particular plan difficult or impossible to find.

3. How effective and consumer-friendly is the functionality of the physician directories?
   a. Some of the directories had extremely effective functionalities, allowing consumers to identify the inclusion of specific physicians, search for physicians that meet many criteria simultaneously (such as accepting new patients), and visualize the number of physicians of a given type within a defined geographic area.
   b. Others had very limited functionality or were clearly not working as intended.

Methodological Notes: To enroll in coverage via Marketplace websites, individuals must provide sufficient information for the IT system to verify their identities as residents of a particular state. Marketplace websites often provide access to different information for those whose identities have been verified and those who would like to browse plan information anonymously. Given our inability to establish verifiable identities in each of these study states, we analyze the information accessible via the anonymous browsing portions of the sites. The two exceptions to this are California and the District of Columbia. The District of Columbia's Marketplace does not currently offer anonymous browsing; consequently, we established a local identity to review the site's capabilities. We were also able to establish a local identity in California and compared the anonymous and registered-shopper capabilities of that state.

Oregon has decided to use healthcare.gov for the coming year because of the substantial IT problems with their website, Cover Oregon.[4] However, we include Oregon in this analysis because it had interesting components that may be instructive for future Marketplace improvements.

It is also important to note that the Marketplaces studied here, as well as the individual insurers' websites, are changing rapidly. We have reported on the state of these websites at the time of our study. It is possible that websites have changed since that time.

HOW TRANSPARENT IS THE PLAN TYPE OF EACH OFFERING?

With health status and other forms of premium rating prohibited (except age and smoking status), many health insurance carriers report that network size and type are the primary tools available to them to cut costs and remain competitive in the changing individual insurance market in 2014 and beyond. The use of narrow networks (sometimes called "value networks") and tiered networks has enabled plans to keep costs low, but the consumer is often left unaware of these networks' natures. First and foremost, plan type is often an important factor in determining network size. HMOs and EPOs generally place stricter limits on which physicians will be included in their networks, while PPOs and POS plans are often more inclusive.[5] In most cases, HMOs and EPOs do not provide reimbursement for the use of physicians outside of their networks. PPOs and POS plans will reimburse for the use of non-network physicians, but the out-of-pocket cost for the enrollees who do so will generally be substantially higher than when they use in-network providers. The differences in these classifications, their implications for physician access and the costs associated with decisions to use particular physicians is new to many of the uninsured, particularly those obtaining private insurance coverage for the first time.

In several states, insurance carriers have introduced the use of tiered networks in recent years, as a mechanism to contain premiums while offering a nominally broader network of providers. In a tiered network arrangement, a carrier places different physicians and other types of providers into different tiers of consumer cost-sharing, with those contracting at lower rates or having a history of efficient medical practice associated with lower levels of cost-sharing, and others associated with higher levels of cost-sharing. All the providers in all of the tiers are considered to be part of the plan's network. Thus, a consumer can select an in-network provider, and without careful attention, select a provider in a higher cost-sharing tier, leaving them with substantially larger out-of-pocket cost responsibilities than anticipated. For this reason, transparency of both plan and network type are extremely important for consumers when selecting an insurance plan.

HMO, EPO, PPO, and POS Plan Distinctions

We used several criteria to assess how well Marketplaces identified plan types for their potential consumers. First, we identified whether the site clearly displayed plan type along with the basic plan details provided. Second, we determined how easy it was for a consumer to get an accurate definition for each plan type. Websites that provided "hover definitions"—definitions of plan types that appear when the cursor is positioned over the term HMO, EPO, PPO, POS plan, etc.—were given higher ratings. Finally, we assessed

how easily a consumer could determine whether a network, regardless of plan type, was broad, narrow, or tiered. During this process, we were looking for the system that provided the most network transparency with the least effort for the consumer. We grouped the study states into three categories based upon their effectiveness in displaying plan and network type. On the lower end of the effectiveness spectrum, we place Connecticut, the District of Columbia, and Rhode Island. We considered Colorado, Oregon, and Washington moderately effective. California, Healthcare.gov, Massachusetts, and Minnesota were most effective in this type of transparency.

We found that the availability of and ease in finding plan type information while browsing anonymously varied greatly among the studied Marketplaces. Some state Marketplaces labeled plan types; others relied on the plan names to indicate the type of network, but not all plans adopted the approach. Certain website designs make it difficult for the consumer to adequately understand the effect that their choice of plan type will have on their costs and their access to providers.

The Massachusetts Health Connector, the troubled website of the Massachusetts health Marketplace, provides perhaps the most transparency in terms of provider networks across the states studied. The Massachusetts website does not indicate the plan type unless the type is included in the plan name, but it does have a section entitled "provider network disclosure." This box, after selecting for more details, provides a user with one of several detailed descriptions of the network. These descriptions include the following:

- "This is a General Provider Network plan. If you purchase this plan, you will receive services through the broadest network of health care providers offered by this insurer," and
- "This is a limited provider network plan. If you purchase this plan, you will:
  - receive an ID card displaying the network name and the word limited
  - cannot cancel early or switch plans due to changes in the provider network.
  - will have access to fewer providers compared to this insurer's general provider network
  - know there is a doctor/provider acceptance tool (above) and understand that services are covered with listed providers only."

In addition to this disclosure, if a plan is deemed to have a narrow network (although the criteria are unclear for determining what is and is not narrow), it is indicated in large red lettering underneath the plan name.

Healthcare.gov has perhaps the best approach of the states studied for identifying plan type for consumers. The plan type is displayed directly underneath the plan name, and the plan name has a hover definition. The fact that the consumer does not have to leave the page is a substantial improvement over many of the state Marketplaces. California and Minnesota also provide hover definitions on their main plan browsing page.

Covered California's hover definitions, however, are only available after creating an account. Covered California has two distinct experiences when searching for plans. The anonymous browsing function does not have hover definitions and the glossary does not contain the definitions of plan type. The glossary does, however, indicate what each plan type is—an improvement over several states studied. Once logged in, a consumer has an entirely different browsing experience. There are clear hover definitions for plan type located underneath each plan description; the plan descriptions also include a brief explanation of the difference between an HMO and PPO (see image 1). Under the PPO definition, Covered California indicates that "unlike an HMO plan, under a PPO plan you do not need to pick a primary care doctor. You have the options to see any of the doctors or specialists inside the network." This approach helps consumers to compare and contrast the implications of different plan choices.

While not performing as well as those just described, Colorado, Oregon, and Washington all have commendable features, including reasonably clear definitions of plan types and ease in finding those definitions. Also, the Oregon glossary provides adequate definitions of the plan type options – HMO, EPO, PPO and POS. It does not, however, provide the plan definitions in this area. Connect for Health Colorado has a glossary with plan type definitions available after leaving the anonymous browsing page. This extra step to find plan definitions is a barrier for consumer understanding of the options available, particularly given that there is no glossary, and it is difficult to use the Connect for Health Colorado general search engine.

Oregon's site allows consumers to search for plans based upon type—HMO, EPO, PPO, and POS plan—a helpful feature found only in one other of our study states, Washington. Also, the Oregon glossary provides adequate definitions of the plan type options – HMO, EPO, PPO and POS. The Washington Health Benefit Exchange website notes the plan type under each listing, but the plan type definitions, though easy to find and clear, are not on the browsing page itself.

Image 1: Example of plan type "hover definition" in Covered California

Source: Screenshot taken from http://www.coveredca.com/

Connecticut, the District of Columbia, and Rhode Island all have similar approaches to the display of plan types, and none rate as well as the others studied. In all three cases, consumers are forced to leave the browsing page to find the relevant definitions, which are often in difficult-to-access locations. None of these states provide the plan type up-front unless it happens to be part of a plan's name.

Tiered Networks

None of the state websites or healthcare.gov sufficiently identify plans as "tiered," although many of the states are known to have such plans in their Marketplaces. Even the Marketplaces that clearly identify plans as HMOs, EPOs, PPOs, or POS plans do not include information about whether the plan is tiered. This omission is likely leading to considerable confusion for consumers once enrolled in these more complex network design options. Examples of tiered network plans include PreferredOne in Minnesota, Land of Lincoln in Illinois, and Medica in Minnesota.

Land of Lincoln is one example of the federal Marketplace relying upon the carriers themselves to identify the tiered nature of their networks on their own sites (rather than on healthcare.gov), but there is no standard for how that is done. For 2014, Land of Lincoln rented a provider network from Healthlink, a Wellpoint subsidiary, and therefore uses the Healthlink website. This site indicates there are tiers of providers, but does not indicate the cost-sharing differences associated with the different tiers. Thus, a consumer trying to choose a plan that includes his or her own doctor will not be able to see the cost to him or her of using that doctor under this plan as compared with another.

Recommendations

A number of preferred strategies emerge after examining the study states. First, the presence of clear and accurate hover definitions as seen with Healthcare.gov, California, and Minnesota is the ideal method for showcasing the plan type and initial indication of the size of the physician network, ideally while browsing anonymously as well as with a verified identity. Not requiring the shopper to look at multiple pages or follow links to understand the basic differences in plans' physician networks, a key characteristic of a plan, greatly simplifies and eases the comparison effort.

Another recommended approach is Massachusetts' obvious disclosure of limited versus broad networks. Massachusetts provides the consumer with clarity regarding network size, a particularly useful option for those who have not previously had coverage and are looking to connect with a doctor. As noted above, however, no system adequately displays when a network is tiered and this information should be added to the list of plan and network types shown.

IS THE PROVIDER DIRECTORY EMBEDDED IN THE MARKETPLACE WEBSITE OR ON EXTERNAL CARRIER SITES?

In addition to plan and network-type classifications, the accessibility and functionality of provider search directories varies across states. These directories are either embedded in the Marketplace website itself or located on external insurance-carrier websites. Provider directories located directly on the Marketplace website have many advantages over external directories. Embedded directories typically allow for fast and easy access, increasing the likelihood that consumers will use the directory and thus make plan choices that are more conducive to meeting their specific needs. Embedded directories also make it easier for consumers to compare directories across different carriers and plans, as well as eliminate the complexity of locating a desired Marketplace plan in an external directory.

Of the three state websites in this study that have embedded provider directories, Massachusetts' directory functions best, including all of the search functionality (discussed further in the next section) directly within the Marketplace website. Washington also has an encouraging Marketplace design with an embedded directory similar to Massachusetts's; but shoppers cannot filter by specialty directly on the Marketplace site. To see a plan's full provider network instead of searching for a particular physician by name, consumers must go to the external carrier's website, complicating the process; however, the Marketplace's website provides direct links to the pertinent directories. Colorado's embedded directory is similar to Washington's in that its embedded functionality allows consumers to search by the name of the physician and/or facility they would like included in their plan. However, unlike Washington's site, there are no direct links to insurers' websites to locate the broader information about the full network.

Despite the many advantages of embedded provider directories, a majority of the state websites in this study rely on each participating carrier to provide a link to their own external directory. Most Marketplace websites link to carrier pages where it is difficult to associate a directory with a particular Marketplace plan because network names do not always match Marketplace plan names, and a single insurer can have different networks that apply to different plans. With the exception of Blue Cross Blue Shield of Illinois and Aetna, for example, the majority of Illinois' carrier websites are poor in this respect. Coventry does not explicitly list the name of the marketplace plan networks, when directed from the link on healthcare.gov, potentially leading to confusion for the consumer. In Illinois, the links on healthcare.gov often lead to the general provider search page, which is not plan-specific. This can make it difficult to identify the appropriate network.

In both Connecticut and California, the Marketplaces link directly to insurers' websites. The links are inconsistent, however, in that some go to the carrier's homepage, but others link to either a general search page or a plan-specific search page. In the cases where the link does not go directly to the plan-specific search page, the user must navigate to the provider search page to find network information, and doing so can be difficult. Many of these external search engines do not have an option to search for a particular plan or, in some cases, do not even include Marketplace plans.

Recommendations

Based on this review, the recommended approach for provider directories is to include an embedded directory on the Marketplace website with full search functionality. Following the model of Massachusetts, this is an important step in alleviating the complexity and confusion around network-based plan choice.

HOW EFFECTIVE ARE THE PROVIDER DIRECTORIES' SEARCH FUNCTIONALITY?

Ideally, health insurance Marketplaces should provide consumers with accurate provider directories that present the information in an easily accessible manner to meet the different needs of consumers at different points in their lives, including:

- those who have an existing relationship with a physician and wish to choose a health plan that includes this provider in the network;
- those who do not have an existing relationship with a provider but have specific needs (e.g., needs related to a certain medical condition), and wish to know the in-network physicians and their locations who might meet these needs; and
- those who do not currently have specific health needs or an existing relationship with a provider, but wish to select a provider at a location that is convenient or otherwise desirable to them (e.g., is part of a certain medical group, has high quality ratings, speaks a certain language).

Findings from this study indicate that consumers' ability to effectively search for a physician within any of these scenarios is highly dependent on their state, with state and federal effectiveness in presenting provider directory information varying substantially.

As discussed in the previous section, at one end of the spectrum, some states provide links to consumers to redirect them to the selected insurer's webpage, where they can use the insurer's own search function. The quality and usability of these physician search tools vary widely between insurers. At the other end of the spectrum, several states (Massachusetts, Colorado and Washington)[6] have developed physician directories that are embedded in the Marketplace; thus, consumers can search for physicians in a uniform way across all carriers without leaving the website.

Search Functionality of Marketplace Embedded Physician Directories

Massachusetts's state Marketplace—The Massachusetts Health Connector—features a fully embedded provider search function. On the website, consumers can select up to five physicians at a time and then view which, if any, participate in a given plan. Results are clearly displayed: for each plan, the consumer will see a green checkmark for selected providers that are included in the network, and a red "X" for those that are not. The Massachusetts Health Connector also provides a useful feature for consumers who are not searching for a specific physician. Consumers can search for providers within a radius of up to 100 miles from a selected ZIP code. Results can be further refined by specialty type (including primary care for adults and children), language spoken, gender, hospital affiliation and whether or not the physician is accepting new patients. From these results, a consumer can select up to five physicians and view whether they are included in available Marketplace plans, as described. Although these search functions are effective and user-friendly in searching for a physician, there is no functionality that allows a consumer to view a full list of all physicians for a given plan, thus preventing a plan-by-plan comparison of provider volume.[7]

The Washington Health Plan Finder in Washington has similarly embedded its physician directory functionality. In Washington, a consumer can search for a provider within a 20-mile radius of their ZIP code. Once selected, the search results clearly display whether the selected provider is included in the network for each plan. One notable limitation of this system is that the consumer is unable to select multiple providers simultaneously, and instead must search for a single provider at a time. Additionally, there is no embedded functionality to search for a physician by specialty without knowing his or her name. It is possible to search for all physicians within a given area, but these results are displayed alphabetically, and there is no capability to filter by specialty, whether the physician is accepting new patients, or other criteria. These search results are unwieldy for consumers who do not have a usual source of care and wish to browse available options.

Finally, the Colorado Marketplace—Connect for Health Colorado—features an embedded provider search functionality where consumers can select physicians by name and then choose to see only plans that include them. Unfortunately, the usability of this function was limited and required the consumer to spell search terms exactly as they are contained in the website's database. This means that a misspelled provider name would not yield any results, and a successful facility search is contingent on the consumer knowing certain abbreviations (for example "Medical Center" must be entered as "Med Ctr" in some cases, although there is no obvious way for the consumer to know this convention). To prevent this complication, provider search functions should contain auto-fill technology that allows a consumer to confirm a match.

Search Functionality of External Physician Directories on Carrier Websites

The remaining states in the study (California, Connecticut, Minnesota,[7] Oregon, Rhode Island, the District of Columbia and the federally facilitated Marketplace) had not developed embedded provider directories at the time of our study; instead, they redirect consumers to the participating insurers' provider directories on external websites. The carrier directories vary in their usability, but some contain features that are especially useful for consumers investigating provider options in the Marketplaces, and could be adapted for embedded sites as well. Specifically, California's insurers offer clear and comprehensive provider directories that are multifunctional and easy to use.

For example, upon selecting a Blue Shield of California plan, Covered California automatically redirects the consumer to a page where the selected plan has been prepopulated in the search form. Then, the consumer can search for doctors, facilities, pharmacies, etc. Within the physician search, the consumer can filter results by location, specialty, provider gender, medical group affiliation and whether the physician is accepting new patients. HealthNet, another California insurer, links consumers to a page where they can either enter their membership information (to choose a primary care provider included in their chosen network) or browse anonymously. Anonymous browsers are prompted to select a network and notified that this is an important step, because some providers are included only in certain

Image 2: Example of multi-dimensional provider search on BlueCross BlueShield of Illinois's Website

BlueCross BlueShield of Illinois

Provider Finder®
Last Updated:07/24/2014
Search | Help | FAQs | Company Information | Disclaimer | en Español

You've Selected:
State
IL
Location
60017 (Remove)
Provider Type
Doctor Or Medical Professional (Remove)
Travel Distance
15 Miles (Remove)
Network Type
Blue Choice PPO℠ (Remove)
Accepting New Patients
Yes (Remove)

Narrow your results by:
Filter City
Filter County
Filter Specialty
Filter Essential Community Providers
Filter Language
Filter Gender
Filter Extended Hours

Start a New Search:
Return home and start a new search

Other Options:
Recommend a provider to your network.

Searched by: 60017 > Doctor Or Medical Professional > Blue Choice PPO℠ > New Patients > Radius: 15 Miles

Map Details

Print this page | View/Email PDF | Save this search

Results 1 - 50 (of 12,500)

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Name	Specialty	Blue Star	Distance
Kohn, Andrew E, OD Sam M Salituro Inc 1070 E Oakton St Des Plaines, IL 60018 (847)294-6722	Optometry		0.1
Patel, Paresh A, MD Oakton Medical Associates 1635 Oakton Pl Des Plaines, IL 60018 (847)635-5300	Internal Medicine		0.1

Source: Screenshot taken from https://public.hcsc.net/providerfinder/

networks. Marketplace plans are clearly labeled as options, making it easy for the consumer to select their intended plan. BlueCross BlueShield of Illinois is another example of a carrier with extensive multi-dimensional search functionality (see Image 2).

Many provider directories in other states are not as comprehensive. For example, Aetna in Illinois does not list Marketplace plans in its provider search function. Consequently, a consumer cannot effectively see which providers are included within the network he or she would actually be purchasing. Overall, few insurers allowed users to select the specific plan network they were investigating. For insurers that offer multiple networks—especially those that are offering narrow network plans on the Marketplace—viewing the insurer's entire list of participating providers can be exceptionally misleading. A consumer might purchase a plan after searching for a particular provider, only to learn that the provider is not included in the specific plan they purchased.

For consumers who do not have a usual source of care and are not searching for a specific physician but are instead interested in the breadth of a plan's network, there were several promising models in our study sample. For example, HealthPartners in Minnesota first allows a consumer to choose a plan's specific network (with the Marketplace plan offering clearly marked), and then displays search results as pinpoints on a Google map. The consumer can enter a search term (such as "oncology" or "primary care") and can filter by subspecialty, gender, language and whether the physician is accepting new patients. These filters can be applied simultaneously and the new results are displayed on the map, providing an excellent visual representation of the desired type of provider within a given area. The consumer can also zoom in and out of the map, sort by distance and view providers in different geographic areas.

Recommendations

There is significant room for improvement in physician search functionality both at the state-Marketplace level and at the individual-insurer level. To enable a seamless physician-search experience that is comparable across insurers, states should create embedded provider directories for each insurer, as noted in the previous section. Because individual plan directories available outside of an embedded Marketplace approach are not standardized, a consumer has to learn how to use each directory and record the results as they browse. Given these difficulties, a consumer faced with navigating individual-plan physician searches might abandon their plan search, or choose to make a decision without being aware of available providers, seriously compromising the effectiveness and comprehensiveness of the shopping process.

Ideally, a consumer would be able to click a button from the browsing page on the Marketplace site to view a plan's unique provider directory. These results should be able to be filtered by multiple dimensions including geography (e.g., physicians within a certain search radius), specialty (including primary care), language spoken, physician gender, patient-centered medical home recognition status, quality metrics and whether the doctor is accepting new patients. State Marketplaces should ensure consistency in terminology across physicians. For example, primary care practitioners should be clearly designated as such. In some cases, there was potential for confusion where physicians were searchable by their board certification, meaning that internal medicine, pediatricians, obstetricians/gynecologists and family practitioners were listed separately, and it was unclear which of these could be selected as a primary care provider.

Marketplaces should also perform several back-end maintenance tasks to ensure the reliability and usability of provider directories. For example, physician directories represent a convenient avenue for ensuring that plans meet state and federal standards in all regions where they are offered. For example, if a plan offers no physicians of a certain required specialty who are accepting new patients within a given service area, it can be assumed that either there is a mistake in the physician directory, a glitch in its functionality, or that a network adequacy standard is not being met. Ideally, Marketplace staff would coordinate with the state agency responsible for ensuring network adequacy standards to make sure that insurers are not offering plans without sufficiently meaningful network capacity, using online directories as one investigatory tool.

In addition, though this review does not address the accuracy of physician directories, Marketplace staff should implement systems to ensure accuracy on a periodic basis. Some obvious problems reveal themselves with random, simple use of online directories, including the west-coast carrier whose physician network within a 15-mile radius appeared to include physicians on the east coast. Additionally, consumers should be aware of when the directories were last updated. Currently, many Marketplaces note that consumers should check with their desired physician to confirm whether they are included in the selected network, but network information's date of last update should be clearly provided as well.

CONCLUSIONS

The first year of operation of the ACA's health insurance Marketplaces sees both some promising practices in physician network transparency and considerable room for improvement. Network transparency remains a high priority to ensure both well-functioning markets and consumers' ability to make well-informed choices, thus leading to their satisfaction with their decisions. With the first year of full reform implementation well underway, additional attention and resources can be used at the state and federal levels to improve this important component of the plan-selection process, generally the most time-consuming part of a consumer's enrollment process.

Our analysis of an array of Marketplace websites suggests the following:

- The anonymous browsing feature of Marketplace sites provides consumers with their first entry into the plan choice process, and they should include the same physician search functionality available to registered users. Otherwise, consumers browsing anonymously may (1) not be aware that additional functionality exists within the more restricted portion of the site, (2) find the information on participating physicians difficult to locate, and (3) become dissuaded from further shopping.
- Plan and network types should be clearly and prominently displayed with each plan listing, and user-friendly definitions of each should be visible when the cursor hovers over the label for that type. Not only should commonly used terms such as HMO, PPO, EPO, and POS plan be used for such categorization, but accepted definitions for narrow and multi-tiered networks should also be applied.
- Physician directories can be used most effectively when they are embedded directly into the Marketplace's own website. Allowing carriers to provide these directories externally on their own sites makes them less uniform and thus highly variable in quality and more difficult for consumers to find and use.
- Different types of consumers need physician directory information provided to them in different ways. Some want to search for particular doctors for their network participation, others want to search for physicians with particular types of medical practices or other characteristics, and others simply want an understanding of network breadth in their geographic area. A well designed web-based physician directory tool can and should accommodate all of these, including multidimensional searches by name, geography (e.g., physicians within a certain radius of a ZIP code), specialty (including primary care), languages spoken, physician gender, patient-centered medical home recognition status, quality metrics and whether the doctor is accepting new patients.

Finally, a highly functioning physician directory is only as effective as it is accurate. Reviewing and updating of network information provided by carriers should not be a once-per-year exercise. Back-office reviews of the networks for accuracy and compliance with adequacy standards, as well as the creation of simple avenues to receive feedback from consumers on web directory inaccuracies, are also high priority items.

Recommended Practices to Improve Marketplace Physician Network Transparency

- Clear and accurate "hover over" definitions of plan/network types and sizes, including HMO, EPO, PPO, POS, tiered networks, and narrow networks.
- Fully functional physician directory for the particular plan embedded in the Marketplace website as a component of each plan's general description in the anonymous browsing portion of the site.
- Physician search filter options that operate on multiple dimensions simultaneously, including: geography, specialty (including primary care), language spoken, physician gender, patient centered medical home recognition status, quality metrics, whether the doctor is accepting new patients, and, in the case of tiered networks, applicable cost-sharing tier.
- Labeling of when directory was last updated.
- Performance of a number of back-end maintenance tasks to ensure the reliability and user friendliness of provider directories.

ENDNOTES

1. Unpublished estimate from the Health Reform Monitoring Survey (HRMS), quarter 1 2014. The quarter 1 2014 sample includes an oversample of respondents who reported that they looked or planned to look for information on health plans in the Marketplace in quarter 4 2013. More information on the Health Reform Monitoring Survey can be found at http://hrms.urban.org/.
2. Blumberg LJ, S Long, GM Kenney, and D Goin, “Factors Influencing Health Plan Choice among the Marketplace Target Population on the Eve of Health Reform,” Urban Institute, 2013. http://hrms.urban.org/briefs/hrms_decision_factors.html.
3. Hospital network issues will be addressed in a forthcoming paper in this series. An analysis by the American Cancer Society’s Consumer Action Network provides important insights into Marketplace plan pharmaceutical formularies and areas in need of improvement. American Cancer Society Cancer Action Network. *Cancer Drug Coverage in Health Insurance Marketplace Plans.* Washington: American Cancer Society Cancer Action Network, 2014, http://www.acscan.org/content/wp-content/uploads/2014/03/Marketplace_formularies_whitepaper.pdf (accessed July 30, 2014).
4. Budnick N, “Cover Oregon officials hope to repair broken state health insurance exchange for 2016” The Oregonian, July 2014. http://www.oregonlive.com/health/index.ssf/2014/07/cover_oregon_officials_hope_to.html.
5. California introduced an embedded provider search function when the marketplace initially opened for open enrollment, but at the time of our study, this embedded feature was not functional. Instead, the Marketplace featured links that rerouted consumers to insurers’ provider directories.
6. Comparing the number of providers between two plans from the same insurer could help identify “narrow network” plans.
7. Minnesota’s marketplace—MNSure—features a button to search for providers, implying the presence of an embedded provider directory, but the functionality was not available at the time of our study.

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State Health Reform Assistance Network

Charting the Road to Coverage

ISSUE BRIEF

August 2014

Specialty Tier Pharmacy Benefit Designs in Commercial Insurance Policies: Issues and Considerations

*Prepared by **Sally McCarty** and **David Cusano,** Center on Health Insurance Reforms, Georgetown Health Policy Institute*

Overview

As health care costs increase, one of the chief determinants of the rate of increase has been the cost of prescription drugs. The role of prescription drugs in the overall medical Consumer Price Index (CPI) is clearly illustrated by the Bureau of Labor Statistics' CPI report for June 2014. The Bureau reported a 2.6 percent growth rate for the medical services CPI, and a 2.8 percent growth rate for the medical commodities CPI between June 2013 and June 2014.[1] Yet, prescription drugs, a component of the medical commodities index, increased by 4.1percent during the same period.[2] And that growth is expected to continue. In their 2013 Drug Trend Report, Express Scripts predicts that the cost of traditional (nonspecialty) drugs will increase at a rate of 2 percent each year for the next three years while, during the same period, the report predicts the cost of specialty drugs will increase at eight times that rate, or 16 percent per year. The report attributes the growth to expensive new therapies and "expanding indications for existing drugs."[3]

Over the past 20 years, health insurers have experimented with different approaches to moderating the costs of providing prescription drug coverage to their enrollees. The one design that has survived and emerged as the most common approach is the tiering of benefits, or benefit designs that assign covered prescription drugs to a "tier" based on cost-sharing and other requirements, like preauthorization. Early tiered pharmacy benefits were generally simple, two-tiered designs with generic drugs on the first tier and brand name drugs on the second tier. The next iteration included three tiers; with the brand name (second) tier becoming two tiers: brand name drugs with generic equivalents and brand name drugs with no generic equivalents. Those with generic equivalents were assigned to the third tier with more cost-sharing and restrictions. Another version of the three-tier design divided the second tier into a tier for preferred brand name drugs and a third tier for nonpreferred brand name drugs.

Over time, additional tiers have been added to pharmacy benefit designs and, as they were added, cost-sharing in the new, higher tiers has increased. With the enactment of the Affordable Care Act (ACA), which eliminated underwriting and imposed the federal minimum loss ratio, or MLR (a limit on administrative and

[1] Bureau of Labor Statistics, U.S. Department of Labor, Consumer Price Index, June 2014, pg. 9.

[2] Id. at 13.

[3] The Express Scripts 2013 Drug Trend Report, April 2014, pg. 5.

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other non-health care spending), health insurers have looked to pharmacy benefit designs as one of the few remaining mechanisms for controlling costs. As a result, tiered pharmacy benefit designs with as many as five or six tiers are emerging. Consequently, for those in need of drugs on the higher tiers with the most cost-sharing, three important issues have emerged for regulators to consider: 1) the affordability of prescription drug therapies for those who need them most; 2) the adherence challenges that result from loss of affordability; and 3) the potential for tiered pharmacy benefit designs to violate the anti-discrimination provisions of the ACA. This issue brief will explore those issues and offer potential regulatory approaches to address them.

Background

Individuals with chronic, rare, or other serious diseases and the advocacy groups that represent them became concerned when, in the early 2000s, simpler versions of two or three-tiered pharmaceutical benefit designs started sprouting fourth tiers accompanied by additional cost-sharing and authorization requirements (like step therapy[4] or preauthorization). "Specialty drugs," the drugs necessary to the health or even survival of those individuals, were commonly assigned to the fourth tier and, during that period, began to be referred to as "tier four drugs." A comprehensive definition of specialty drug used in some state statutes and legislation is a drug that:

1. Is prescribed for an individual with a:
   a. Complex or chronic medical condition, or
   b. Rare medical condition
2. Costs $600 or more for up to a 30-day supply
3. Is not typically stocked at retail pharmacies
4. Requires either:
   a. A difficult or unusual process of delivery to the patient in the preparation, handling, storage, inventory, or distribution of the drug; or
   b. Enhanced patient education, management, or support beyond those required for traditional dispensing before or after administration of the drug.[5]

Because the fourth or higher tiers were created to cull out specialty drugs and include the most burdensome requirements, they have become known as "specialty tiers."

Cost issues

Since the advent of tier four drugs, there has been a growing concern (which continues today) among chronically and seriously ill individuals and their advocates about the increasing patient share of the cost of vitally needed specialty tier drugs. As more tiers are added to prescription drug benefit designs, those individuals have seen their medications move up the tier structure (current plans may have as many as five or six tiers) and with each move up comes a concomitant increase in cost to the patient and, in many instances, additional requirements that must be met to secure authorization for coverage. These changes make affordability of drug therapies for the seriously and chronically ill increasingly elusive.

A reliable resource for tracing the development of specialty tiers in health insurance plans is the Kaiser Family Foundation's annual Employer Health Benefits Survey. The survey first began reporting information about a fourth tier in employer prescription drug benefit designs in 2004.[6] That survey report described designs with a fourth tier as "new types of cost-sharing arrangements that typically build additional layers of higher co-payments or co-insurance for specifically identified types of drugs, such as lifestyle or injectable drugs."[7] At that time, 3 percent of the covered employees of survey respondents were in plans that included a four-tier pharmacy benefit design. In 2008, the survey question was altered to ask if the benefit design included four *or more* tiers. That year's survey report showed that 7 percent of employees of responding employers were covered by plans with pharmacy benefits that included four or more tiers.[8]

In the 2013 survey report, the most recent year available, 23 percent of covered employees were in plans using pharmacy benefit designs with four or more tiers, nearly 800 percent more than in 2004 when the four-tier question was first asked. During that same

[4] Step therapy is a pharmacy benefit design that requires the trial use of a similar, less expensive drug to assess its effectiveness before a more expensive drug will be authorized.

[5] This definition appears in Maryland Insurance Article §15-847 and Virginia HB 304.

[6] Kaiser Family Foundation and Health Research & Educational Trust, Employer Health Benefits Survey, 2004, pg. 114.

[7] Id. at 115.

[8] Kaiser Family Foundation and Health Research & Educational Trust, Employer Health Benefits Survey, 2008, pg. 142.

period, the percentage of employees covered by a three-tier pharmaceutical benefit design dropped from 65 percent to 59 percent, and the percentage of employees in two-tiered plans was halved, dropping from 20 percent in 2004 to 10 percent in 2013.[9]

Additionally, the 2013 annual Kaiser Employer Survey report indicates that between 2004 and 2013, the average co-payment for generic drugs in plans with three or more tiers fluctuated between $10 and $11 and was $11 in 2013. During the same period, the average co-payment for tier four or higher drugs also fluctuated, with a low of $59 in 2004 and a high of $91 in 2011. The 2013 average co-payment for tier four drugs was $80, almost eight times the average co-payment for a generic drug.[10] The report also indicated that 48 percent of employees in plans with four or more tiers are paying co-insurance as opposed to 39 percent who are paying co-payments.[11]

Adherence issues

In addition to cost concerns, the indirect correlation between treatment cost and patient adherence to drug therapy regimens can present serious consequences for the health status of individuals dependent on specialty drugs. A group of University of North Carolina researchers studied more than 1,500 patients with chronic myeloid leukemia (CML) and their adherence to a tyrosine kinase inhibitor (TKI), a treatment that has greatly increased survival rates for CML patients. The report of their study was published in the December 2013 issue of the *Journal of Clinical Oncology*. It concluded that nonadherence to TKI therapy "undoubtedly results in disease progression and treatment resistance," and when the cost to the patient becomes too high, many will skip doses or stop the drug completely. More specifically, patients with higher co-payments were 70 percent more likely to stop their medication, and were 42 percent more likely to skip doses than patients with low co-payments.[12]

In the January 2012 edition of *P & T: A Peer Reviewed Journal for Formulary Management*, researchers reported on a literature review of 160 abstracts and articles using the following search terms: adherence, compliance, co-pay, cost-sharing, costs, noncompliance, outcomes, hospitalization, utilization, economics, income, and persistence. The articles reviewed covered a wide variety of interventions, measures, and populations, but, even with the variation, the researchers were able to identify "relatively clear relationships between cost-sharing, adherence, and outcomes." They found that 85 percent of the articles evaluating the relationship between changes in cost-sharing and adherence showed that an increasing patient share of medication costs was significantly associated with a decrease in adherence.[13]

Both studies present cause for concern because they point out the potential danger posed by specialty tier benefit designs to individuals reliant on specialty drugs. As the use of these designs increases, and affordability and access are reduced by additional cost-sharing and authorization requirements, the health of the most seriously ill can be placed in grave jeopardy.

Specialty tiers and ACA nondiscrimination

A third significant concern is that formulary designs with four or more tiers may implicate the new nondiscrimination protections under the ACA if an insurer is using these designs to intentionally shift the cost of expensive prescription drugs to individuals with specific diseases. Specifically, Section 1557 of the ACA extends existing federal civil rights protections to private health insurance and prohibits individuals from being subject to discrimination, excluded from participation, or denied the benefits of health programs or activities based on race, color, national origin, sex, age, or disability.[14]

The Office of Civil Rights (OCR) within the Department of Health and Human Services (HHS) has jurisdiction and enforcement authority over this provision. In fact, the AIDS Institute and National Health Law Program recently filed a complaint with OCR against four insurers (Coventry One, Cigna, Humana, and Preferred Medical) claiming discrimination under Section 1557 of the ACA.[15] The complaint alleges that the qualified health plans offered by these insurers on the Florida Marketplace impose overly restrictive utilization management requirements on HIV/AIDS medications and places all HIV/AIDS medications on the highest

[9] Kaiser Family Foundation and Health Research & Educational Trust, Employer Health Benefits Survey, 2013, pg. 150.

[10] Id. at 153.

[11] Id. at 148.

[12] Dusetzina SB, Winn AN, Abel GA, et al. Cost-sharing and adherence to tyrosine kinase inhibitors for patients with chronic myeloid leukemia. *Journal of Clinical Oncology*. 2014; 32:306–311.

[13] Eaddy MT, Cook CL, O'Day K, Burch SP, Cantrell CR. How patient cost-sharing trends affect adherence and outcomes: a literature review. *P & T: A Peer Reviewed Journal for Formulary Management*. 2012; 37(1):45–55.

[14] 42 U.S.C. § 18116 (2012).

[15] Administrative Complaint, AIDS Institute v. Coventry Health Care, Inc., Office of Civil Rights, U.S. Department of Health and Human Services, May 29, 2014.

cost-sharing tier, thus discouraging individuals diagnosed with HIV and AIDS from enrolling in these plans.[16] Advocates in Georgia are planning to file a similar complaint with the OCR.[17]

Additionally, insurers offering coverage in the individual and small group markets in a state both within or outside of the marketplace are required to offer the ten categories of essential health benefits (EHB) as set forth in that state's benchmark plan.[18] Insurers do not comply with this requirement if their benefit plan designs discriminate against an individual based on age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.[19] Insurers offering EHB in the individual and small group markets also are prohibited from implementing plan designs that discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or significant health needs.[20] The states and HHS have jurisdiction and enforcement authority over these provisions.

State legislative initiatives

Several states have introduced legislation that limits cost-sharing for specialty drugs (see Appendix A on page 6). The most common legislative initiatives include a cap of $150 for a 30-day supply of a single specialty tier drug. Delaware, Louisiana, and Maryland have enacted laws that include that provision. Delaware and Louisiana laws also include a requirement that issuers who utilize a specialty drug formulary establish an appeals process for enrollees whose health care providers attest that a nonformulary drug would be the most effective treatment for their disease or condition. Virginia and Hawaii have introduced legislation with the same two provisions. Additionally, each of those two states' initiatives, as well as Delaware's law, prohibits issuers from placing all drugs of a particular class on a specialty tier. Maryland's new law requires the $150 cap to be revisited each year and adjusted based on the medical care Consumer Price Index.

Illinois legislators introduced a House bill in February 2014 and a companion Senate bill three months later. Both bills seek to limit cost-sharing for specialty tier drugs to $100 for a single drug and $200 in the aggregate per 30-day period. Both also include the provision requiring issuers to establish an appeal process for nonformulary drugs. An additional provision in the House bill would limit annual out-of-pocket cost-sharing for prescription drugs to 50 percent of the federal out-of-pocket limits, both for self and for family.

Legislative initiatives introduced in California, Mississippi, and New York include different provisions than those in other states. California's bill limits cost-sharing for a 30-day supply of drugs that do not have a time-limited course of treatment, or have a course of treatment that lasts more than three months, to one-twelfth of the annual out-of-pocket limit applicable to self-only coverage. If a product has a course of treatment that lasts less than three months, the total cost-sharing cannot exceed half of the of the annual out-of-pocket limit.

New York's initiative instructs the Superintendent of Insurance to deny policies imposing drug tiers based on expense or disease category and that charge a cost-sharing percentage (co-insurance) for prescription medication. The bill also prohibits the issuance of policies that categorize prescription drugs based on a specific disease or specific cost and that charge based on a cost-sharing percentage.

Mississippi's initiative, which failed to progress out of committee in February 2014, also prohibited the creation of specialty tiers that utilize co-insurance as a cost-sharing measure and limited co-payments to 500 percent of the lowest co-payment for a drug on the policy formulary. The bill also capped out-of-pocket expenses for prescription drugs at $1,000 per contract year per insured individual, or $2,000 per contract year per insured family, adjusted for inflation. Additionally, the Mississippi initiative required any out-of-pocket limit for prescription drugs to be included in the out-of-pocket maximum amount for all services under the contract.

Federal legislation

The only federal legislative initiative to be introduced to date is the Patients' Access to Treatment Act of 2013 (H.R. 460), introduced by West Virginia Representative David B. McKinley on February 4, 2014. H.R. 460 seeks to establish cost-sharing limits for health plans that cover prescription drugs and use a formulary or other tiered cost-sharing structure; and prohibits cost-sharing in a specialty drug tier that exceeds the dollar amount of cost-sharing for the lowest cost, nonpreferred drug tier. The bill was referred to the House Subcommittee on Health on February 8, 2014 and has seen no action since that date.

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[16] Id.

[17] Associated Press, "AIDS Patients Fear Discrimination in ACA Exchange," *Washington Post*, August 6, 2014.

[18] 45 C.F.R. §§ 147.150 & 156.115.

[19] 45 C.F.R. § 156.125.

[20] See 45 C.F.R. §§ 147.104(e), 156.200(e) & 156.225.

Going forward

The challenges presented by the growing number of pharmacy benefit designs using specialty tiers are significant. As with so many health insurance issues, states have addressed the problems arising from specialty tier benefit designs in a variety of ways, creating a patchwork of activity ranging from strong statutory solutions that address affordability issues to no attention paid to the issue at all. Those states that have attempted to address or have succeeded in addressing the challenges have several approaches in common (see Appendix B on page 8).

To address cost concerns, the most effective solution would be the one that three states have adopted, and additional states are attempting to enact, namely, caps on out-of-pocket expenses for specialty tier drugs and a process for enrollees needing nonformulary drugs to seek an exception.

The proposed federal legislation, which ties cost-sharing for specialty tier drugs to the dollar amount of cost-sharing for the lowest nonpreferred drug tier, would provide a suitable federal floor for states to adhere to or build upon. And, some of the stronger provisions that have been introduced in state legislatures, like prohibiting co-insurance as cost-sharing for specialty tier drugs and prohibiting the placement of all drugs of the same class on a specialty tier, would go a long way in making specialty tier drugs more affordable for those who need them most.

The problems with adherence to potentially lifesaving drug therapies would most likely be substantially ameliorated if affordability of specialty tier drugs can be achieved. Still, health insurers should reconsider the cost versus value of requirements like prior authorization for specialty drug prescriptions. Apart from the risk to adherence posed by placing such obstacles between patient and treatment, the average primary care office spends roughly 15 hours per week interacting with health insurers about prescription drug issues, time that could be better spent devoted to patient care.[21] Promoting and supporting adherence is crucial not only (and primarily) for the health of the individuals whose conditions require the drug therapies, but also to preventing more serious illness and costs that may occur when adherence is not achieved.

Finally, potential for discrimination against groups of individuals with diseases and conditions that require costly prescription drugs may be quite real with pharmacy benefit designs that include specialty tiers. While state insurance regulators do not always have the staff or other resources to detect discriminatory designs during the form review process, advocates and other supportive groups may be able to offer assistance by promoting legislative efforts and developing new and creative resources to examine tiered formularies with specific groups or conditions in mind, much like the analysis conducted by the groups that filed the complaint against the Florida insurers.

The issues presented by specialty tier benefit designs in health insurance plans can best be addressed by the combined efforts of state and federal legislators, insurance regulators, advocates, and other interested groups. With the emergence of new and increasingly more expensive specialty drugs, those efforts should focus on ensuring the implementation of pharmacy benefit designs that make specialty tier drugs affordable, improve adherence, and eliminate discriminatory designs.

[21] Casalino LP, Nicolson S, Gans DN, et al. What does it cost physician practices to interact with health insurance plans? *Health Affairs*. July/August 2009: 28.4: 533-543.

Appendix A

SPECIALTY TIER LEGISLATION ENACTED, EFFECTIVE, OR OTHER ACTION IN 2014

STATE	BILL/LAW	INTRODUCED/ ENACTED	SUMMARY OF PROVISIONS	LAST ACTION
California	AB 1917	Introduced 2/19/2014	• For drugs used in a course of treatment with no time limit or that lasts longer than three months: Cost-sharing for a 30-day supply cannot exceed 1/12 of the annual out-of-pocket limit applicable to self-only coverage. • For drugs used in a course of treatment that lasts less than three months: Cost-sharing cannot exceed ½ of the annual out-of-pocket limit applicable for self-only coverage.	Passed Senate on 6/26/2014 and referred to Committee on Appropriations for Hearing scheduled for 8/4/2014
Delaware	18 Del. Laws, C. 33, §3364	Enacted 7/23/2013	• Limits co-payment or co-insurance for specialty tier drugs to $150 for a 30-day supply of any single specialty tier drug. • Requires issuers with a specialty drug formulary to implement a process for enrollees to seek exceptions. • Prohibits issuers from placing all drugs of a particular class on the specialty tier.	Effective 1/1/2014
Hawaii	SB 2173	Introduced 1/16/2014	• Limits co-payment or co-insurance for specialty tier drugs to $150 for a 30-day supply of any single specialty tier drug. • Requires issuers with a specialty drug formulary to implement a process for enrollees to seek exceptions. • Prohibits issuers from placing all drugs of a particular class on the specialty tier.	Deferred by the Senate Committee on Health 2/14/2014
Illinois	HB 6277	Introduced 5/27/2014 (companion to SB 3395)	• Limits co-payments or co-insurance for a specialty tier drug to $100 and $200 in the aggregate for a 30-day period before or after any applicable deductible is met. • Annual out-of-pocket limits for prescription drugs are limited to 50% of the federal out-of-pocket limits for self and family. • Requires issuers with a specialty drug formulary to implement a process for enrollees to seek exceptions.	Referred to Rules Committee 5/27/2014
	SB 3395	Introduced 2/14/2014	• Limits co-payments or co-insurance for a specialty tier drug to $100 and $200 in the aggregate for a 30-day period. • Requires issuers with a specialty drug formulary to implement a process for enrollees to seek exceptions.	Re-referred to Assignments 3/28/2014
Louisiana	HEA 453	Enacted 6/4/2014	• Limits co-payment or co-insurance for specialty tier drugs to $150 for a 30-day supply of any single specialty tier drug—*after* any deductible and *until* maximum out-of-pocket amount is reached. • Requires issuers with a specialty drug formulary to implement a process for enrollees to seek exception.	Adds R.S. 22:1060.5 to the insurance code. Effective 1/1/2015
Maryland	Insurance Article §15-847	Enacted 5/5/2014	• Limits co-payment or co-insurance for specialty tier drugs to $150 for a 30-day supply of any single specialty tier drug. • Any increase in limit will occur on July 1 of each year and will be indexed to the medical care component of the March CPI.	Effective 10/1/2014

STATE	BILL/LAW	INTRODUCED/ ENACTED	SUMMARY OF PROVISIONS	LAST ACTION
Mississippi	HB 1050	Introduced 1/20/2014	• Prohibits the creation of specialty tiers that require payment of a percentage of the cost of prescription drugs. • Co-payments limited to 500% of lowest co-payment for a drug on the policy's formulary. • Out-of-pocket expenses for prescription drugs must be included in the out-of-pocket maximum for all services under the contract. • Out-of-pocket expenses for prescription drugs may not exceed $1,000 per contract year per insured individual or $2,000 per contract year per insured family—adjusted for inflation. • An issuer must provide 60-days written notice to all affected enrollees before a formulary modification takes effect.	Died in Committee 2/4/2014
New York	A 2655	Introduced 1/17/2013	• Instructs the Superintendent of Insurance to deny policies imposing drug tiers based on expense or disease category. • Policies may not charge based on a cost-sharing percentage.	Referred to Insurance Committee 1/8/2014
Virginia	HB 304	Introduced 12/31/2013	• Limits co-payment and co-insurance for specialty tier drugs to $150 for a 30-day supply of any single specialty tier drug. • Requires issuers with a specialty drug formulary to implement a process for enrollees to seek exceptions. • Prohibits issuers from placing all drugs of a particular class on the specialty tier.	Left in Commerce and Labor Committee 2/12/2014
Federal Legislation	H.R. 460 Patients' Access to Treatments Act of 2013	Introduced 2/4/2014	• Establishes cost-sharing limits for health plans that use a formulary or other tiered pharmacy benefit cost-sharing structure. • Prohibits cost-sharing in a specialty drug tier that exceeds the cost-sharing dollar amount of in the lowest cost, nonpreferred tier.	Referred to House Subcommittee on Health 2/8/2014

Appendix B

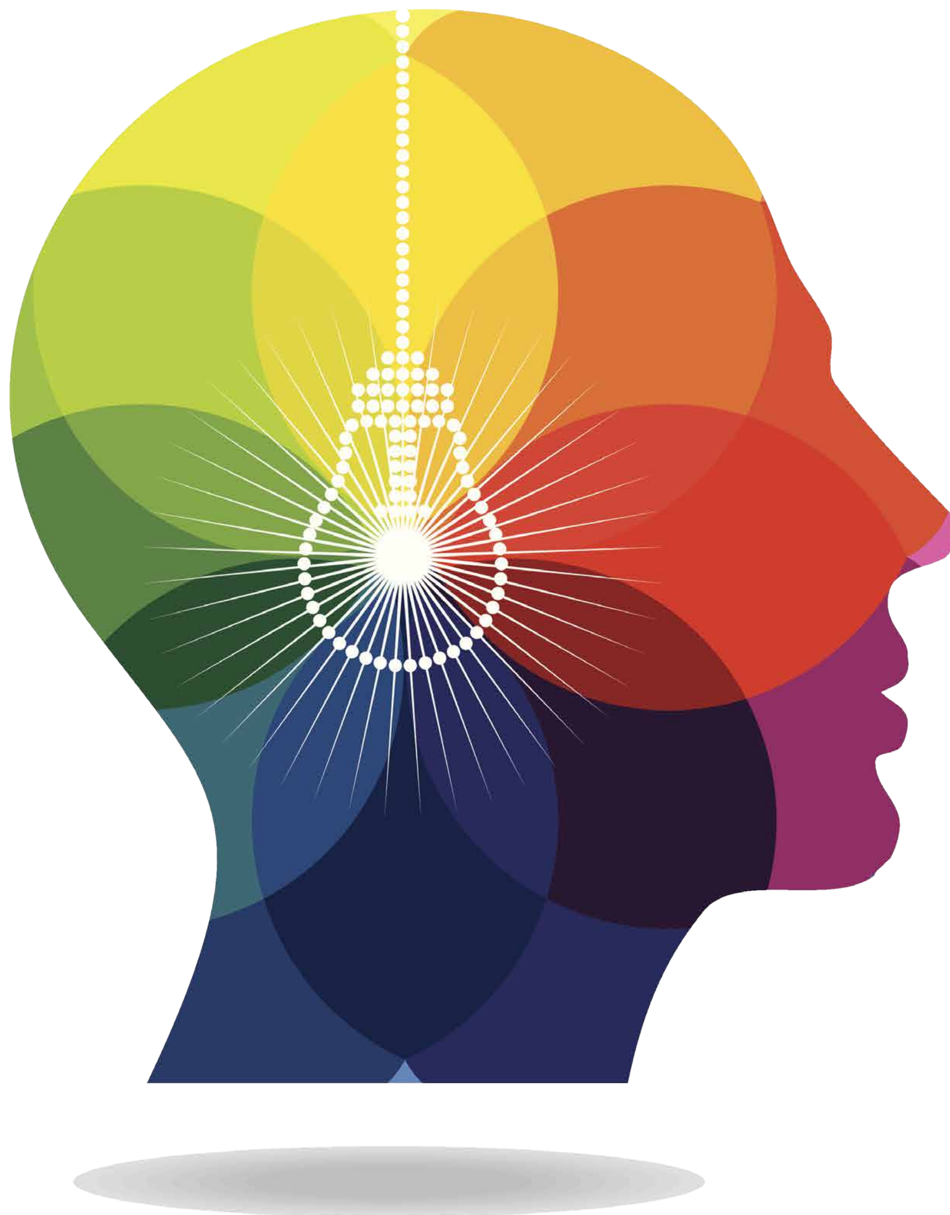
MOST COMMON PROVISIONS AMONG STATE AND FEDERAL LEGISLATIVE INITIATIVES

STATE	CAP OR LIMIT ON COST-SHARING	APPEAL PROCESS FOR NONFORMULARY DRUGS	PROHIBITIONS		
			ALL DRUGS OF SAME CLASS ON SPECIALTY TIERS	CO-INSURANCE FOR SPECIALTY TIER DRUGS	DRUG TIERS BASED ON EXPENSE OR DISEASE CATEGORY
California	X				
Delaware	X	X	X		
Hawaii	X	X	X		
Illinois	X	X			
Louisiana	X	X			
Maryland	X				
Mississippi	X			X	
New York	X			X	X
Federal	X				

STATE STRATEGIES FOR INTEGRATING PHYSICAL AND BEHAVIORAL HEALTH SERVICES IN A CHANGING MEDICAID ENVIRONMENT

Deborah Bachrach, Stephanie Anthony, and Andrew Detty
Manatt, Phelps & Phillips, LLP

AUGUST 2014



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AUGUST 2014

ABSTRACT
States across the country are embracing integrated care delivery models as part of their efforts to deliver high-quality, cost-effective care to Medicaid beneficiaries with comorbid physical and behavioral health needs. The Medicaid expansion authorized by the Affordable Care Act brings greater import to these efforts, as millions of previously uninsured low-income adults, many at increased risk for behavioral health conditions, gain coverage. State efforts to ensure that Medicaid beneficiaries have access to integrated care, however, are hindered by a fragmented behavioral health system that is administered and regulated by multiple state agencies and levels of government, and by purchasing models that segregate behavioral health services from other Medicaid-covered services. Drawing on a review of the literature and interviews with consumers, providers, payers, and policymakers, this report explores strategies states are deploying to address or eliminate system-level barriers to integrated care for this medically complex and high-cost Medicaid population.

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EXECUTIVE SUMMARY

States across the country are promoting integrated care delivery as part of their efforts to deliver high-quality, cost-effective care to Medicaid beneficiaries with comorbid physical and behavioral health conditions. The Medicaid expansion authorized by the Affordable Care Act (ACA) brings greater import to these efforts, as millions of uninsured low-income adults, many at increased risk for behavioral health conditions, gain coverage and states are required to provide behavioral health services and meet federal parity laws. State efforts to ensure that Medicaid beneficiaries have access to integrated care, however, are hindered by a fragmented behavioral health system that is administered and regulated by multiple state agencies and levels of government, and by purchasing models that segregate behavioral health services from other Medicaid-covered services.

Drawing on a review of the literature and interviews with diverse stakeholders, this report explores strategies states are deploying to address or eliminate system-level barriers to integrated care for this medically complex and high-cost Medicaid population.

Administrative Strategies

Most states vest responsibility for Medicaid physical health, mental health, and substance use disorder (SUD) services in two or more separate agencies, each with different missions, leadership, expertise, and constituencies. This fragmented administration often leads to misaligned purchasing strategies and conflicting and redundant regulation of physical and behavioral health providers.

Consolidating the various agencies responsible for physical and mental health and SUD services can help, though it can be politically and structurally difficult to implement given longstanding differences in agencies' mission and constituencies. Thus, it is more common for states to consolidate behavioral health purchasing, contracting, and rate-setting in their Medicaid agency and retain licensing and clinical policy in the behavioral health agencies. Where even that level of consolidation is not feasible states rely on informal collaborations to rationalize strategies across agencies. Informal collaborations are the most tenuous as they are dependent on personal relationships among agency leadership and staff.

Purchasing Strategies

Medicaid managed care is the preferred delivery model in most states. However, few states offer integrated benefits in managed care; most "carve out," or create separate reimbursement streams for at least some behavioral health services. Early decisions to carve out behavioral health services grew out of political, financial, and policy pressures ranging from stakeholder opposition to cost control to concerns about the ability of Medicaid managed care plans to manage behavioral health services. These carve-out arrangements continue despite mounting evidence that they create barriers to care coordination and information-sharing. Cognizant of these issues, states committed to the carve-out model are adopting various policies to create linkages across providers and systems.

At the same time, a growing number of states are implementing fully integrated managed care approaches, in some cases targeted to individuals with serious mental illness.

Regulatory Strategies

State regulations governing licensure and certification, billing, and health information exchange also can impede the delivery of integrated care. With authority over Medicaid physical and behavioral services vested in separate agencies or offices, state regulation of these sectors is rarely cohesive and frequently redundant or contradictory. Today, states are seeking to streamline their licensing rules and creating credentialing programs for nontraditional providers, such as community health workers and peer counselors, who increasingly play a role in integrated care models. States also are revising their Medicaid same-day visit policies and establishing billing codes for emerging treatments.

Finally, slower rates of adoption of information technology among behavioral health providers and state and federal constraints on sharing behavioral

health data also can impede integrated care delivery. State strategies to support greater information exchange include technical assistance funding for electronic health record implementation, policy guidance, streamlined privacy standards, and standardized, multiprovider consent forms.

Looking Ahead

While Medicaid has long been the dominant payer for behavioral health services and Medicaid beneficiaries with comorbid physical and behavioral health conditions are among the program's most medically complex and costly, state administrative, purchasing, and regulatory structures have not kept pace with best practices in the field. There is a large body of evidence showing that patients fare best when their physical and behavioral health needs are addressed in tandem. There is no single pathway through which all states will be able to achieve integrated behavioral and physical health care; the best strategy or combination of strategies will depend on a state's political and health care environment. However, regardless of the approach, states will succeed only if they put in place a cohesive framework that enables providers to deliver integrated care to Medicaid patients with comorbid physical and behavioral health needs.

STATE STRATEGIES FOR INTEGRATING PHYSICAL AND BEHAVIORAL HEALTH SERVICES IN A CHANGING MEDICAID ENVIRONMENT

INTRODUCTION

Medicaid plays a central role in financing mental health and substance use disorder (SUD) services, accounting for 26 percent of all spending on behavioral health services in this country.[1] Medicaid beneficiaries with behavioral health conditions are among the program's most medically complex, with health care costs for beneficiaries with comorbid chronic conditions and mental illness 60 percent to 75 percent higher than for those with chronic conditions but without mental illness. Costs for those who also have a substance use disorder are nearly three times higher.[2] Notwithstanding the level of spending, individuals with serious mental illness die on average 25 years earlier than those without, largely because of preventable chronic physical illness.[3]

Against this background, it is not surprising that nearly all states have embarked on efforts to improve health outcomes and better manage costs for beneficiaries with comorbid physical and behavioral health conditions. The imperative to rethink payment and delivery of behavioral health services is even more profound in states that have expanded Medicaid coverage as authorized by the Affordable Care Act (ACA).[4] The expansion population is a diverse group of low-income adults, including many at increased risk for behavioral health conditions.[5] Moreover, the ACA requires states to provide mental health and SUD services to adults covered under the Medicaid expansion, and to do so in parity with physical health services. By contrast, behavioral health services are optional for pre-ACA covered adults and the Mental Health Parity and Addiction Equity Act for the most part does not apply.[6]

Medicaid expansion brings greater urgency and import to states' efforts to purchase high-quality, cost-effective, integrated care for beneficiaries with comorbid physical and behavioral health conditions. However, these efforts often are hindered by a fragmented physical and behavioral health system that is administered, regulated, and financed by multiple state agencies and levels of government; by purchasing models that segregate behavioral health services from other Medicaid-covered services; and by the absence of a cohesive provider community sharing aligned incentives.

This report examines the features of successful integrated delivery models, the state policies and practices that create barriers to integrated care, and steps states are taking to break down those barriers and promote the delivery of integrated care.

CORE ATTRIBUTES OF INTEGRATED CARE DELIVERY

States across the country are embracing integrated care delivery as part of their efforts to deliver high-quality, cost-effective care to Medicaid beneficiaries with behavioral health needs. The prevalence and interacting effects of comorbid mental illness, substance use disorders, and physical health conditions are well documented, as is the high cost of care for Medicaid beneficiaries with comorbid physical and behavioral health conditions.[7] Additionally, a growing body of evidence indicates that integrated care delivery models can be cost-effective and improve health outcomes.[8]

A review of the literature[9] and interviews with consumers, providers, managed care entities, and policymakers identify the following features as key to the delivery of effective integrated care.

- **Accountability for the whole person.** A single provider, care team, or health care entity is responsible for coordinating or delivering the full spectrum of physical and behavioral health services and, to the extent applicable, long-term services and supports and social services, such as assistance with housing and employment.
- **Aligned financial incentives.** State purchasing models, payment policies, and contracting

requirements for Medicaid physical and behavioral health services are aligned.

- **Information-sharing.** Provider practices have the health information technology to communicate and exchange information in nearly real time on patient conditions, care, and outcomes with other providers, patients, and their families; managed care entities; and states. State privacy rules enable information-sharing to the maximum extent practicable.
- **"Up-to-date" state licensing, credentialing, and billing rules.** State licensing, credentialing, and billing rules support best practices on the ground, enabling providers to employ, deploy, and be reimbursed for the range of professionals and paraprofessionals and services required to meet the medical, behavioral health, and social needs of their Medicaid patients.
- **Cross-system understanding.** Behavioral health and physical health providers are trained in each other's fields to minimize mistrust, lack of understanding, or lack of communication resulting from cultural gaps between the two systems. Individuals with comorbid conditions are treated with respect and compassion, regardless of care setting.

In the next sections we examine state administrative, purchasing, and regulatory strategies and consider how they impede or advance the delivery of integrated care.

ADMINISTRATIVE STRUCTURES AND STRATEGIES

Administrative responsibility for physical and behavioral health services historically has been split among Medicaid and behavioral health agencies, with different leadership, missions, and staff expertise. Even today, most states vest responsibility for Medicaid, mental health, and SUD services in two or more separate agencies. For example, as of 2010, 48 states had separate Medicaid and mental health agencies, and in 20 of those states, mental health and SUD were in separate agencies.[10] It is not uncommon to find Medicaid payment and clinical policies and rules for behavioral health services outside the purview of the Medicaid director.[11]

The administrative bifurcation of physical health services and behavioral health services into separate agencies can lead to differences in vision and policy goals and misaligned program priorities, purchasing decisions, and provider regulations. Even where the respective agency leadership recognizes the value of integrated care, the success of such initiatives is highly dependent on personal relationships and a high level of commitment to agency coordination, reinforced by the governor's office.

In addition, separate agencies tend to institutionalize the cultural separation of physical and behavioral health at the provider level, creating different constituencies with competing interests and separate sources of guidance and support at the state level.[12] As discussed below, states are seeking to address the challenges of separate agency structure in both formal and informal ways.

> "I don't know that lawmakers think about integration."
>
> –Maryland provider

Agency Consolidation

In 2012 and 2013, California eliminated its existing mental health and SUD agencies, transitioning the majority of their responsibilities to the state's Medicaid agency, in order to integrate financing and improve patient outcomes.[13] The transitions occurred in the context of a state budget deficit and a broad restructuring of California state government, aimed in part at fixing a "haphazard structure that inhibit[ed] coordination and efficiency" because of a lack of cohesion and logical organization.[14]

Agency consolidation directly addresses the challenges that bifurcated administration creates for integrated care delivery, but it can be difficult to accomplish because of the level of upheaval required and longstanding differences in vision, mission, and constituencies among agencies. Consequently, states' use of this strategy is rare.

Consolidated Contract Oversight

Many states are addressing the challenges posed by a fragmented administrative structure by consolidating physical and behavioral health purchasing decisions, contracting, and rate-setting in a single agency, while maintaining separate agency structures for licensing and clinical policy.

In 2013, Kansas implemented a new Medicaid managed care program called KanCare, under which Medicaid managed care organizations (MCOs) cover both physical and behavioral health services. To support this shift, Kansas consolidated all Medicaid fiscal and contract management functions in the Kansas Department of Health and Environment (the Medicaid agency) and maintained responsibility for behavioral health policy direction, licensing, and waiver program management in a newly formed, separate Department for Aging and Disability Services.[15]

New York is following a similar approach within its existing agency structure, transitioning rate-setting responsibility for behavioral health services from its behavioral health agencies into its Department of Health (the Medicaid agency). In addition, when the state fully integrates (or "carves-in") behavioral health services into its Medicaid managed care program in 2015, the Department of Health will hold the contract with the managed care plans.

In April 2014, Arizona moved oversight of its physical health service contract for people with serious mental illness in Maricopa County (the state's most populous county, home to Phoenix) from the Arizona Health Care Cost Containment System (the Medicaid agency) to the Department of Health Services' Division of Behavioral Health Services. At this time, the Division began contracting with a regional behavioral health organization (or BHO, a managed care organization that specializes in behavioral health care) to cover physical and behavioral services for this population.

Consolidation of Medicaid purchasing decisions and contracting responsibility in a single agency centralizes administrative and financial accountability and allows clearer policy direction for plans and providers. Agency collaboration remains critical to ensuring that the responsible agency can tap into the expertise and relationships across the Medicaid and behavioral health agencies.[16]

> "A system of separate state agencies and constituencies prioritizes the institution over the patient."
>
> –New York State provider

Informal Collaboration

Where formal agency relationships do not exist, personalities and personal relationships are key to structuring integrated care models. We see this in Washington State, where the Health Care Authority (the Medicaid agency) and the Department of Social and Health Services (which administers Medicaid behavioral health services) jointly developed requirements for the state's Health Home program, under which MCOs, BHOs, and providers coordinate services across separate physical and behavioral health systems. While the Health Care Authority holds the contracts for Medicaid Health Homes, state officials report that the joint development and its role in stakeholder buy-in were critical to the successful launch of the program. An advantage of such informal arrangements is that they require the least administrative upheaval, compared with the strategies identified above. A disadvantage is that they are the most tenuous since they depend on relationships among agency leadership and staff.[17]

Regardless of the administrative structures by which a state delivers Medicaid physical and behavioral health services, interviewees emphasized the importance of having a clear and consistent strategic vision, goals, and direction across agencies.[18]

PURCHASING STRATEGIES

The historical bifurcation of Medicaid physical and behavioral health services across multiple agencies can result in different—and uncoordinated—purchasing strategies for physical and behavioral health services.

Of the 35 states that, along with the District of Columbia, provide physical health services through

Medicaid MCOs in 2014, only nine include all behavioral health services in an integrated benefit package. (One additional state has plans to do so.) The remaining 26 states (plus the District) carve out some or all behavioral health services from their MCO benefit package, providing them through fee-for-service Medicaid, a BHO, or an administrative services organization.

While a small number of states carve out all behavioral health services, most states' coverage varies by service type or Medicaid eligibility category. For example, psychotropic drugs may be included in the MCO benefit package, while treatment for addiction may be carved out. MCOs may cover behavioral health services provided by primary care providers, but not more specialized treatments provided by behavioral health professionals.

As Medicaid agencies gain more experience with managed care and integrated delivery models gain traction, a growing number of states are moving to consolidate their purchasing, so that a single managed care entity holds responsibility for both behavioral and physical health. As important as consolidation is, it does not guarantee integration at the provider level. Potential advantages of carve-in models include the ability to align incentives at the MCO level, availability of comprehensive claims data, and centralized accountability for cost, quality of care, and patient outcomes.[19] However, in the absence of clear and enforceable contract provisions that require or incentivize integrated care approaches, a carve-in payment approach ultimately may be no more supportive of integrated care than a carve-out approach.

Carve-Outs

The historical preference for behavioral health carve-outs grew from political, financial, and policy pressures ranging from stakeholder opposition to cost control to concerns about the ability of Medicaid managed care plans to manage behavioral health services. Some of these factors continue to have traction among consumers and behavioral health professionals who fear that behavioral health providers and the patients who rely on them will be shortchanged under a carve-in model.

> "When everyone is responsible [for coordinating care across separately funded systems], no one is responsible."
>
> –Washington State legislative staff person

On the other hand, the experience with carve-out payment arrangements strongly suggests that they impede the delivery of integrated care.[20] Strong contract provisions and carefully designed programs help, but rarely provide a completely satisfactory solution. When behavioral health benefits are carved out, accountability for a patient's health requires coordination across two (or even three) managed care or administrative entities that have separate budgets, financial responsibilities, and provider networks. MCOs and payers of carved-out services benefit financially from diverting members to services for which they do not have financial responsibility, potentially resulting in unnecessary or inappropriate referrals and fragmented care delivery. For providers, carve-out models can mean reimbursement models and incentives that do not align across payers (such as when physical health is paid on a capitated basis and behavioral health on a fee-for-service basis).

Carve-outs also complicate information-sharing and service coordination. With separate entities managing individuals' physical and behavioral health care, providers' access to comprehensive patient data often is limited. Responsibility for pharmaceuticals can be particularly confounding; limited access to prescription drug records across systems impedes medication reconciliation, which can lead to severe adverse clinical outcomes. While MCO, BHO, and administrative services organization contracts frequently include requirements to coordinate and share information across separate systems,[21] such requirements are challenging to enforce and more often than not ineffective. In addition, for consumers and their families, carve-outs create a complex system with multiple points of contact for accessing services and no single entity responsible for meeting the totality of an individual's needs. Despite

these drawbacks, carve-outs remain the predominant purchasing model for Medicaid behavioral health services. Cognizant of these shortcomings, states that maintain carve-out models are adopting strategies to address these concerns.

Financial alignment and shared accountability. Financial alignment—the use of financing mechanisms to create incentives for providers to integrate care—is a critical strategy in a carve-out environment. For example, starting in 2015, Maryland will contract with an administrative services organization to manage carved-out mental health and SUD services for Medicaid beneficiaries. A portion of the organization's payment will depend on its performance on physical health quality metrics, such as all-cause readmission rates and the percentage of patients with an annual primary care visit, thereby tying reimbursement to effective management of both physical and behavioral health services.[22]

Health Homes. The Medicaid Health Home option under Section 2703 of the ACA offers another mechanism for states with carve-out models to coordinate and manage care across delivery systems. Health Homes provide care management and coordination services to Medicaid beneficiaries with chronic conditions, including behavioral health conditions,[23] and can be deployed to connect services across managed care plans, BHOs, and fee-for-service Medicaid.

> "Without a dedicated funding stream for coordination, it is difficult to bridge [separate] systems."
>
> –Washington State county social services manager and chemical dependency coordinator

Carve-Ins

A number of states are moving to add behavioral health services to their managed care benefit package, having concluded that carve-ins provide the best opportunity to facilitate integrated care at the provider level. By centralizing accountability for patient outcomes, quality, and cost of care in a single entity, carve-in purchasing arrangements create an incentive for managed care entities to support, and for providers to deliver, integrated care.

New Mexico implemented a full carve-in arrangement in January 2014. As New Mexico's Medicaid waiver submission reads, "integration of behavioral health and physical health … is an opportunity for New Mexico to achieve better health outcomes as one entity will be responsible for managing care for the whole person."[24] New York, which currently carves out most behavioral health services, will implement its carve-in to MCOs in 2015. State officials note that under the current arrangement, beneficiaries "bounce" between care settings, receiving care that is inefficient and inattentive to patients' needs.[25] Washington State, which currently provides physical health, mental health, and SUD services through three separate systems, enacted legislation in April 2014 authorizing Medicaid to jointly procure all physical and behavioral health services through MCOs or BHOs, beginning in April 2016.[26]

As noted above, a carve-in purchasing model does not guarantee integrated delivery of care. The benefits can be diluted when an MCO subcontracts with a BHO, particularly in the absence of strong contract provisions and oversight.[27] Stakeholders raise two additional concerns: first, that BHOs' administrative costs divert funds from behavioral health services;[28] and, second, that MCOs lack the expertise to manage care for people with serious mental illness and SUDs. As discussed below, states have pursued a number of strategies to ensure that carve-in models advance integrated care delivery.

Contract requirements and financing provisions. New Mexico includes a provision in its MCO contracts prohibiting subcontracts with BHOs on an at-risk basis.[29] This arrangement allows MCOs to subcontract with such organizations to leverage their expertise in areas such as utilization management and coordination of care, while ensuring that MCOs remain financially responsible for behavioral health services. Tennessee, another carve-in state, allows MCOs to subcontract for management of behavioral health services, but requires

> "When MCOs entered into risk-based contracts with BHOs, funds were eaten up on the administrative side, and behavioral health services were either rationed or insufficiently delivered."
>
> –New Mexico Medicaid official

subcontractors to operate on site in MCO offices to facilitate coordinated management.[30]

To ensure that funding for behavioral health services is not diverted to physical health care or plan administration, states are considering including in plan contracts minimum medical loss ratios for behavioral health services. In addition to such a provision, New York is including a transitional provision requiring MCOs to pay ambulatory behavioral health providers at their current fee-for-service rates for two years after the carve-in is implemented.[31] This measure is intended to preserve funding to meet beneficiary needs and help small behavioral health providers making the transition to managed care contracting, with which they have little experience.

Special models for people with serious mental illness or SUDs. Stakeholders expressed the greatest concerns with respect to MCOs taking on responsibility for behavioral health services for individuals with serious mental illness or SUDs. At the same time, there was widespread recognition that these individuals need integrated care. Accordingly, states are beginning to develop capitated models specifically for high-need patients and requiring health plans to meet enhanced standards.

In April 2014, Arizona implemented an integrated physical and behavioral health benefit for Medicaid enrollees with serious mental illness in one county through a regional BHO.[32] Likewise, in July 2014, Florida implemented a fully integrated health plan through a BHO for residents with mental illness, starting in Miami-Dade and Broward counties and rolling out to other regions in September.[33] In 2015, New York will introduce Health and Recovery Plans (HARPs), an integrated managed care product for individuals with serious mental illness or SUDs, plus high-risk utilization patterns or functional deficits.[34] HARPs will be subject to more extensive behavioral health staffing and experience requirements than those for MCOs enrolling individuals with less serious behavioral health needs. HARPs also will be required to provide an enhanced benefit package that includes recovery-oriented home- and community-based services, such as employment and education supports, as well as all physical and behavioral health services.

By creating what are in effect special needs plans for individuals with serious behavioral health issues, states are able to vest in a single managed care entity responsibility for the full range of services that address the physical, behavioral health, and social needs of especially needy populations, and at the same time impose additional experiential requirements. These models are gaining interest among stakeholders who are anxious to see integrated models extended to populations with serious mental illness or SUDs, but are concerned that traditional MCOs are ill-equipped to manage these populations. One notable reservation with respect to this approach is a concern about the potentially stigmatizing effect of a separate delivery system for people with serious behavioral health conditions.

REGULATORY REQUIREMENTS

No matter how cohesive the administration and purchasing of Medicaid physical and behavioral health services, state regulatory policies with respect to licensing, certification, and reimbursement may stymie integration at the provider level.

Licensing and Certification

In states across the country, providers report that "licensing and administration have not kept pace with provider practices," often impeding integrated care.[35] It is not unusual for providers seeking to colocate physical, mental health, and SUD services to require licenses from multiple agencies, each of which has its own licensing policies and procedures.[36] This is at best an expensive burden for providers and at worst a deterrent to colocation of services.

In Massachusetts, state regulations require new or renovated facilities to provide separate waiting rooms for physical and behavioral health services, which not only stigmatizes behavioral health patients but also discourages integration among providers with limited space.[37] Recently, the state has granted waivers of these requirements to enable integration. Similarly, Arizona state officials noted that, until recently, colocation of physical and behavioral health services in the same space was not permitted.[38] Under new rules in Arizona, a wide range of facilities, including outpatient treatment centers, can provide both physical and behavioral health services under a single license.[39]

Professional credentialing rules similarly can impede integrated care. Integrated care models increasingly rely on "nontraditional" providers, including community health workers, patient navigators, and peer counselors. If such providers are not credentialed, their services may not be covered by Medicaid.[40] To facilitate the employment of nontraditional staff, New York, for example, is establishing a program that will enable certified peer advocates to deliver Medicaid-reimbursable services in outpatient clinic settings certified by the state's SUD agency.[41]

Billing Requirements

Medicaid billing rules also affect integrated care delivery. One policy relates to whether a provider may bill for both a behavioral health and physical health visit on the same day, something that might well be important in caring for patients with comorbid conditions. In 2010, 30 states and the District of Columbia allowed same-day billing for physical and behavioral health visits in federally qualified health centers. Fourteen states did not allow same-day billing by any providers, and three states allowed same-day billing in fee-for-service Medicaid outside of health centers.[42] States that decline to permit same-day billing at health centers point to federal rules that bar them from discounting payment for the second visit to account for efficiencies related to providing multiple services in the same day.[43]

Additionally, many state Medicaid agencies do not allow the use of billing codes for emerging treatments. For example, since at least 2011, the Substance Abuse and Mental Health Services Administration has recommended use of Screening, Brief Intervention, and Referral to Treatment, an evidence-based practice used to screen for, reduce, and prevent problematic substance use in physical health settings.[44] However, by 2012, just 16 state Medicaid agencies had developed a billing code for this practice.[45]

> "Existing licensing requirements are duplicative, necessitating separate licenses, redundant reporting, separate structures, separate hallways, and separate bathrooms for colocated services."
>
> –Arizona behavioral health official

Primary care providers face broader challenges related to billing for integrated care because of state rules limiting when and how they may bill for behavioral health services. For example, some states limit the types of practitioners who may bill for behavioral health services, or the procedures and diagnoses codes for which primary care practices may receive reimbursement.[46] Providers may work around billing limitations by recording patients' secondary, reimbursable physical health diagnosis rather than their primary nonreimbursable behavioral health diagnosis in claims and patient records. Among other things, this practice results in inaccurate treatment records and confusion among providers.

Data Exchange

Exchange of physical and behavioral health diagnosis and treatment information among providers is a pillar of integrated care. Two issues make this especially difficult with respect to behavioral health services: lack of information technology and constraints on sharing behavioral health data across practices and agencies.

Behavioral health providers lag physical health providers in adoption of electronic health records (EHRs). They have limited access to capital and are mostly ineligible to receive financial incentives under the Health Information Technology for Economic and

Clinical Health Act (only psychiatrists and nurse practitioners are eligible). Only about 2 percent of behavioral health providers were able to meet federal meaningful-use standards for EHRs in 2011, and only 5 percent anticipated being able to do so by the end of 2012.[47] By comparison, more than 50 percent of office-based physicians could meet 12 stage-one meaningful-use core objectives (out of a total of 15) in 2012.[48]

In 2012 and 2013, New York sought to address the lack of EHRs among behavioral health providers in its Health Home program by providing funding to Regional Extension Centers to offer technical assistance to those providers.[49]

Additionally, federal and state privacy laws place more stringent restrictions on behavioral health information exchange than on physical health information exchange. Particularly onerous is a federal regulation (42 CFR Part 2) that prohibits federally assisted alcohol and drug use programs from sharing SUD records for treatment, payment, or health care operations purposes without written patient consent, except in the event of medical emergencies. In May 2014, the federal government announced its intent to update these regulations, acknowledging the barriers they create to integrated care delivery, but also noting the continuing need to protect personal information from inappropriate disclosures.[50]

Regardless of federal action, strategies are available to states to support greater exchange of information among physical and behavioral health providers, while protecting patient privacy.[51] States can clarify privacy law through agency guidance, streamline privacy standards by offering a single set of requirements for all protected information, and develop standardized, multi-provider consent forms for the exchange of information. For example, the North Carolina Health Information Exchange Act supersedes other state privacy laws within the state health information exchange, allowing information sharing in accordance with federal standards. This law also provides immunity from liability for providers who, in good faith, rely upon information provided through the network. To streamline beneficiary consent to information-sharing in its Health Home program, New York has a standard consent form covering all information obtained by providers through the state's Regional Health Information Organizations.[52]

CONCLUSION

There is little dispute that Medicaid patients fare best when their physical and behavioral health needs are addressed in tandem, coordinated by a single professional or team of professionals. For states, the question is how best to support providers in achieving this goal. With Medicaid's increasingly important role in health care reform generally and in the payment and delivery of behavioral health services specifically, states are taking action to eliminate system-level impediments to the delivery of integrated care by revising their administrative, purchasing, financing, and regulatory structures. No single strategy will address every barrier to integrated care and different strategies will work in different states; however, all states have powerful levers through which to promote integrated care.

NOTES

[1] Truven Health Analytics, *National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986-2009*, No. SMA-13-4740 (Rockville, Md.: Substance Abuse and Mental Health Services Administration, April 2013), accessed March 26, 2014, http://store.samhsa.gov/shin/content//SMA13-4740/SMA13-4740.pdf.

[2] C. Boyd, B. Leff, C. Weiss et al., *Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations* (Hamilton, N.J.: Center for Health Care Strategies, Inc., Dec. 2010), accessed March 26, 2014, http://www.chcs.org/usr_doc/clarifying_multimorbidity_patterns.pdf.

[3] J. Parks, D. Svendsen, P. Singer et al., *Morbidity and Mortality in People with Serious Mental Illness*, Technical Report No. 13 (Alexandria, Va.: National Association of State Mental Health Program Directors, Oct. 2006), accessed March 26, 2014, http://www.nasmhpd.org/docs/publications/MDCdocs/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf.

[4] Healthcare.gov, "24 States Are Refusing to Expand Medicaid. Here's What That Means for Their Residents," accessed March 26, 2014, http://www.whitehouse.gov/share/medicaid-map.

[5] M. Regenstein and S. Rosenbaum, "What the Affordable Care Act Means for People with Jail Stays," *Health Affairs,* March 2014 33(3):448–54; S. A. Somers, E. Nicolella, A. Hamblin et al., "Medicaid Expansion: Considerations for States Regarding Newly Eligible Jail-Involved Individuals," *Health Affairs,* March 2014 33(3):455–61; J. Tsai, R. A. Rosenheck, D. P. Culhane et al., "Medicaid Expansion: Chronically Homeless Adults Will Need Targeted Enrollment and Access to a Broad Range of Services," *Health Affairs,* Sept. 2013 32(9):1552–59; and Substance Abuse and Mental Health Services Administration, *Enrollment Under the Medicaid Expansion and Health Insurance Exchanges: A Focus on Those with Behavioral Health Conditions in New York* (Rockville, Md.: SAMHSA, 2012), accessed March 26, 2014, http://store.samhsa.gov/shin/content//PEP13-BHPREV-ACA/NSDUH_state_profile_New_York_508_final_extra.pdf.

[6] State Medicaid Director Letter on the Application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP and Alternative Benefit Plans, Jan. 2013, at http://www.medicaid.gov/federal-policy-guidance/downloads/sho-13-001.pdf.

[7] Substance Abuse and Mental Health Services Administration, *Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings* (Rockville, Md.: SAMHSA, Jan. 2012), accessed March 26, 2014, http://www.samhsa.gov/data/NSDUH/2k10MH_Findings/2k10MHResults.htm; Parks, Svendsen, Singer et al., *Morbidity and Mortality*, 2006; M. Lindsey, W. Patterson, K. Ray et al., *Potentially Preventable Hospital Readmissions Among Medicaid Recipients with Mental Health and/or Substance Abuse Health Conditions Compared with All Others: New York State, 2007*, Statistical Brief No. 3 (Albany, N.Y.: New York State Department of Health, n.d.), accessed March 26, 2014, http://www.health.ny.gov/health_care/managed_care/reports/statistics_data/3hospital_readmissions_menta-health.pdf; and Kaiser Commission on Medicaid and the Uninsured, *The Role of Medicaid for People with Behavioral Health Conditions* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, Nov. 2012), accessed March 26, 2014, http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_bhc.pdf.

[8] J. Unützer, W. Katon, C. M. Callahan et al., "Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial," *Journal of the American Medical Association,* Dec. 11, 2002 288(22):2836–45, accessed March 26, 2014, http://jama.jamanetwork.com/data/Journals/JAMA/4859/JOC21093.pdf; J. Unützer, W. J. Katon, M. Y. Fan et al., "Long-Term Cost Effects of Collaborative Care for Late-Life Depression," *American Journal of Managed Care,* Feb. 2008 14(2):95–100, accessed March 26, 2014, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3810022/pdf/nihms-521130.pdf; and M. Butler, R. L. Kane, D. McAlpine et al., *Integration of Mental Health/Substance Abuse and Primary Care*, Evidence Report/Technology Assessment No. 173 (Rockville, Md.: Agency for Healthcare Research and Quality, Oct. 2008), accessed March 26, 2014, http://www.ahrq.gov/research/findings/evidence-based-reports/mhsapc-evidence-report.pdf.

[9] See, for example, A. Hamblin, J. Verdier, and M. Au, *State Options for Integrating Physical and Behavioral Health Care* (Baltimore: Integrated Care Resource Center, Oct. 2011), accessed March 26, 2014, http://www.integratedcareresourcecenter.com/pdfs/ICrC_bh_briefing_document_1006.pdf; C. J. Peek and The National Integration Academy Council, *Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus*, AHRQ Publication No. AHRQ 13-IP001-EF (Rockville, Md.: Agency for Healthcare Research and Quality, 2013), accessed May 1, 2014, http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf; and B. Heath, P. Wise Romero, and K. Reynolds, *A Standard Framework for Levels of Integrated Healthcare* (Washington, D.C.: SAMHSA-HRSA Center for Integrated Health Solutions), accessed May 1, 2014, http://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf.

[10] T. C. Lutterman, A. Berhane, R. Shaw et al., *Funding and Characteristics of State Mental Health Agencies, 2010* (Rockville, Md.: Substance Abuse and Mental Health Services Administration, 2011), accessed March 26, 2014, http://www.aahd.us/wp-content/uploads/2012/12/FundingStateMentalHealthAgencies2010.pdf.

[11] National Association of Medicaid Directors, *State Medicaid Operations Survey: Second Annual Survey of Medicaid Directors* (Washington, D.C.: NAMD, Feb. 2014), accessed March 26, 2014, http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/ops_survey.pdf.

[12] Manatt Health Solutions interview with New York State provider, Jan. 23, 2014.

[13] California Statutes of 2011, Chapter 32, Assembly Bill 106, accessed March 26, 2014, http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_0101-0150/ab_106_bill_20110629_chaptered.html; and California Senate Rules Committee, *Bill Analysis - Budget Act of 2011: Health* (Sacramento, Calif.: California Senate Rules Committee, June 2011), accessed March 26, 2014, http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_0101-0150/ab_102_cfa_20110609_094935_sen_floor.html.

[14] E. G. Brown, *Government Reorganization Plan* (Sacramento, Calif.: Office of Governor Edmund G. Brown, March 2012), accessed March 26, 2014, http://gov.ca.gov/docs/Cover_Letter_and_Summary.pdf.

[15] S. Sullivan, "ERO 41," Presentation before the Senate Ways and Means Committee, Feb. 15, 2012, accessed March 26, 2014, http://media.khi.org/news/documents/2012/02/15/KDoA_ERO_41.pdf; and Kansas Department for Aging and Disability Services, "KanCare Information Sessions: Focusing on KDADS Programs," Presentation at KanCare information sessions, Aug. 21–31, 2012, accessed April 8, 2014, http://www.kancare.ks.gov/download/KDADS_Specific_KanCare_Presentations_August_2012.pdf.

[16] Agencies assuming contracting and purchasing responsibility, however, may have limited experience with new service types and limited relationships with key stakeholders, making continuing interagency cooperation critical. For this reason, New York State envisions "team oversight" of Medicaid managed care contracts across the Department of Health and the state's behavioral health agencies, even as the Department of Health holds the MCO contracts (Manatt Health Solutions interview with New York State Medicaid and behavioral health officials, Jan. 21, 2014). Similarly, in Arizona, the Medicaid agency is assisting the Division of Behavioral Health Services with development of contract provisions and oversight with respect to physical health services (Manatt Health Solutions interview with Arizona provider, Jan. 21, 2014).

[17] Participant comments at Advisory Group meeting, Feb. 25, 2014.

[18] Ibid.

[19] Hamblin, Verdier, and Au, *State Options*, 2011.

[20] L. Summer and J. Hoadley, *The Role of Medicaid Managed Care in Health Delivery System Innovation* (New York: The Commonwealth Fund, April 2014), p. 13.

[21] See, e.g., Washington State Department of Social and Health Services, "Contract Amendment: PIHP Amendment [with North Sound Regional Support Network]," Contract No. 1169-36766, Amendment No. 3, Aug. 29, 2012, accessed March 26, 2014, http://www.nsmha.org/contracts/dshs/DSHS_Medicaid_and_SMHC/Amendments/DSHS-NSMHA-PIHP-11-13_1169-36766-03.pdf, and Washington State Health Care Authority, "Managed Care Contract: Basic Health and Healthy Options," 2012, accessed March 26, 2014, http://www.hca.wa.gov/Documents/managed_care/2012BH-HOFinal-Contract.pdf.

[22] Maryland Department of Health and Mental Hygiene, "Request for Proposals: Solicitation No. DHMH OPASS–14-13835. Administrative Services Organization for Maryland's Public Behavioral Health System," Feb. 4, 2014, accessed March 26, 2014, https://emaryland.buyspeed.com/bso/external/bidDetail.sdo?docId=MDM0031012802&external=true&parentUrl=bid.

[23] Patient Protection and Affordable Care Act § 2703.

[24] New Mexico Human Services Department, Centennial Care 1115 Waiver Amendment Request, April 25, 2012, accessed April 8, 2014, http://www.hsd.state.nm.us/uploads/FileLinks/f1a11ad705c94ea59ef5107bb672075a/Centennial_Care___Waiver_Submission_to_CMS.pdf.

[25] Manatt Health Solutions interview with New York State Medicaid official, Jan. 15, 2014.

[26] 63rd Washington State Legislature, 2014 Regular Session, Senate Bill 6312, accessed March 26, 2014, http://apps.leg.wa.gov/documents/billdocs/2013-14/Pdf/Bills/Senate%20Passed%20Legislature/6312-S2.PL.pdf.

[27] Participant comments at Advisory Group meeting, Feb. 25, 2014.

[28] W. Holt and R. Dougherty, *Increasing Access to Behavioral Healthcare: Managed Care Options and Requirements* (Washington, D.C.: National Council for Community Behavioral Health, July 2011), accessed March 26, 2014, http://www.thenationalcouncil.org/wp-content/uploads/2013/01/Increasing-Access-to-Managed-Care-Report.pdf.

[29] New Mexico Human Services Department. "Amended and Restated Medicaid Managed Care Services Agreement Among New Mexico Human Services Department, New Mexico Behavioral Health Purchasing Collaborative and HCSC Insurance Services Company, Operating as Blue Cross and Blue Shield of New Mexico," n.d., accessed March 26, 2014, http://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/General%20Information/Contracts/Medical%20Assistance%20Division/MCOs%20-%20Centennial%20Care/BCBSNM%20Contract%20Amendment%20%231.pdf.

[30] Hamblin, Verdier, and Au, *State Options,* 2011.

[31] State of New York, "New York Request for Qualifications for Behavioral Health Benefit Administration: Managed Care Organizations and Health and Recovery Plans," Dec. 5, 2013, accessed March 26, 2014, http://www.health.ny.gov/health_care/medicaid/redesign/docs/2013-12-5_draft_man_care_rfq_pub_review.pdf.

[32] Manatt Health Solutions interview with Arizona behavioral health official, Dec. 18, 2013.

[33] P. Galewitz, "Florida Shifts Medicaid Mental Health Strategy," *Kaiser Health News,* July 7, 2014.

[34] State of New York, "New York Request for Qualifications," 2013.

[35] Manatt Health Solutions interview with Arizona provider, Jan. 21, 2014.

[36] Hospital outpatient departments and diagnostic and treatment centers fall under Article 28 of the Public Health Law, mental health agencies fall under Article 31 of the Mental Hygiene Law, and SUD service agencies fall under Article 32 of the Mental Hygiene Law.

[37] Behavioral Health Integration Task Force, *Report to the Legislature and the Health Policy Commission* (Boston: Behavioral Health Integration Task Force, July 2013), accessed April 9, 2014, http://www.massneuropsych.org/wp-content/uploads/2013/06/Behavioral-Health-Integration-Task-Force-Final-Report-and-Recommendations_July-2013.pdf.

[38] B. Lang, "Breaking Down Barriers: Supporting Physical and Behavioral Health Through Licensing Rules," Presentation at Public Forum *Moving Forward: Implementing Integrated Models of Care in Arizona,* Aug. 24, 2012, accessed April 30, 2014, http://www.azdhs.gov/diro/documents/forums/2012/breaking-down-barriers.pdf; and 50th Arizona Legislature, First Regular Session, House Bill 2634: An Act Prescribing Adoption of Department Of Health Services Health Care Institution Rules, 2011, Chapter 96, accessed March 26, 2014, http://www.azleg.gov/FormatDocument.asp?inDoc=/legtext/50leg/1r/laws/0096.htm&Session_ID=102.

[39] Arizona Department of Health Services, "Public Health Services Licensing–Classification Structure & Licensing Process Crosswalk," n.d., accessed March 26, 2014, http://www.azdhs.gov/als/integrated/documents/classification-structure-crosswalk.pdf.

[40] Nardone, Snyder, and Paradise, *Integrating Physical and Behavioral Health Care*, 2014.

[41] New York State Office of Alcoholism and Substance Abuse Services, "Commissioner Arlene González-Sánchez Announces Peer Advocate Certificate in New York," June 19, 2013, accessed March 26, 2014, https://www.oasas.ny.gov/pio/press/20130619PeerAdCert.cfm.

[42] M. Brolin, A. Quinn, J. T. Sirkin et al., *Financing of Behavioral Health Services Within Federally Qualified Health Centers* (Washington, D.C.: Truven Health Analytics, July 2012), accessed March 26, 2014, http://www.integration.samhsa.gov/Financing_BH_Services_at_FQHCs_Final_7_23-12.pdf.

[43] Social Security Act 1902(bb). Notably, it is the federal rule barring states from discounting reimbursement to FQHCs (even to reflect efficiencies related to same-day visits) that states cite as one of the bases of the same-day billing rule. See T. M. Westmoreland, SMDL #01-014 (Baltimore: Centers for Medicare and Medicaid Services, Jan. 19, 2001), accessed April 9, 2014, http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd011901d.pdf.

[44] Substance Abuse and Mental Health Services Administration, *Screening, Brief Intervention and Referral to Treatment (SBIRT) in Behavioral Healthcare* (Rockville, Md.: SAMHSA, April 1, 2011), accessed April 9, 2014, http://www.samhsa.gov/prevention/sbirt/SBIRTwhitepaper.pdf.

[45] SAMHSA-HRSA Center for Integrated Health Solutions, *SBIRT: Screening, Brief Intervention, and Referral to Treatment–Opportunities for Implementation and Points for Consideration* (Washington, D.C.: SAMHSA-HRSA Center for Integrated Health Solutions, June 2012), accessed March 26, 2014, http://www.integration.samhsa.gov/SBIRT_Issue_Brief.pdf.

[46] C. Kautz, D. Mauch, and S. A. Smith, *Reimbursement of Mental Health Services in Primary Care Settings,* HHS Publication No. SMA-08-4324 (Rockville, Md.: Substance Abuse and Mental Health Services Administration, 2008), accessed May 7, 2014, http://www.integration.samhsa.gov/Reimbursement_of_Mental_Health_Services_in_Primary_Care_Settings.pdf.

[47] National Council for Community Behavioral Health, *HIT Adoption and Readiness for Meaningful Use in Community Behavioral Health: Report on the 2012 National Council Survey* (Washington, D.C.: National Council, June 2012), accessed March 26, 2014, http://www.thenationalcouncil.org/wp-content/uploads/2012/10/HIT-Survey-Full-Report.pdf.

[48] J. King, V. Patel, and M. F. Furukawa, *Physician Adoption of Electronic Health Record Technology to Meet Meaningful Use Objectives: 2009–2012*, ONC Data Brief No. 7 (Washington, D.C.: Office of the National Coordinator for Health Information Technology, Dec. 2012), accessed April 9, 2014, http://www.healthit.gov/sites/default/files/onc-data-brief-7-december-2012.pdf.

[49] New York eHealth Collaborative and NYC Regional Electronic Adoption Center for Health, "HEAL 22 Grant: Health Information Technology and Exchange for Behavioral Health," Webinar presentation, Nov. 19, 2012, accessed March 26, 2014, http://nyehealth.org/wp-content/uploads/2013/01/HEAL-22-Slides-11-19-Health-Home-EHR-Webinar.pdf.

[50] Substance Abuse and Mental Health Services Administration, Confidentiality of Alcohol and Drug Abuse Patient Records, Notice of Public Listening Session, May 12, 2014.

[51] W. Bernstein, R. Belfort, and S. Ingargiola, *Integrating Physical and Behavioral Health: Strategies for Overcoming Legal Barriers to Health Information Exchange* (Princeton, N.J.: Robert Wood Johnson Foundation, Jan. 2014), accessed March 26, 2014, http://www.manatt.com/uploadedFiles/Content/4_News_and_Events/Newsletters/IntegratingPhysicalandBehavioralHealth.pdf; and Colorado Regional Health Information Organization, *Supporting Integration of Behavioral Health Care Through Health Information Exchange: Recommendations for Integrating Colorado's Mental Health, Substance Use Treatment, and Medical Communities Through the Development of Statewide HIE* (Denver: CORHIO, April 2012), accessed April 30, 2014, http://www.corhio.org/media/40757/supporting_integration_of_behavioral_health_care_through_hie_april_2012-web.pdf.

[52] New York State Department of Health, "Health Home Patient Information Sharing Consent," No. DOH-5055, Nov. 2012, accessed March 26, 2014, https://www.health.ny.gov/forms/doh-5055.pdf.

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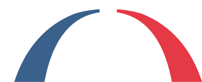
Transitioning from Volume to Value:

Opportunities and Challenges for Health Care Delivery System Reform

August 2014



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ABOUT BPC

Founded in 2007 by former Senate Majority Leaders Howard Baker, Tom Daschle, Bob Dole, and George Mitchell, the Bipartisan Policy Center (BPC) is a non-profit organization that drives principled solutions through rigorous analysis, reasoned negotiation, and respectful dialogue. With projects in multiple issue areas, BPC combines politically balanced policymaking with strong, proactive advocacy and outreach.

DISCLAIMER

This report is the product of the BPC Health Project with participants of diverse expertise and affiliations, addressing many complex and contentious topics. It is inevitable that arriving at a consensus document in these circumstances entailed compromises. Accordingly, it should not be assumed that every member is entirely satisfied with every formulation in this document, or even that all participants would agree with any given recommendation if it were taken in isolation. Rather, this group reached consensus on these recommendations as a package.

The findings and recommendations expressed herein are solely those of the commission and do not necessarily represent the views or opinions of the Bipartisan Policy Center, its founders, or its Board of Directors.

DELIVERY SYSTEM REFORM INITIATIVE

In April of 2013, BPC issued *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment,* a report which laid out a comprehensive set of policy recommendations for lowering costs, improving quality, and reducing inefficiency across the health care system. As a continuation of that work, the Delivery System Reform Initiative's four co-chairs – former Senate Majority Leaders Tom Daschle and Bill Frist, former White House and Congressional Budget Office Director Dr. Alice Rivlin, and former Ways and Means Health Subcommittee Chair Jim McCrery – are developing meaningful policy solutions to facilitate and accelerate the transition to a value-based health care system.

AUTHORS

This paper was produced by BPC staff in collaboration with a distinguished group of senior advisors for the Delivery System Reform Initiative. BPC would like to thank Sheila Burke, Stuart Butler, Paul Ginsburg, Chris Jennings, Steve Lieberman, and Tim Westmoreland for providing substantial direction and support, and acknowledge BPC staffers Katherine Hayes, Leah Ralph, Brian Collins, Katie Golden, Marisa Workman, and Katie Taylor for their role in researching and drafting the final paper.

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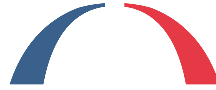


Introduction

In early 2014, the Bipartisan Policy Center's Health Project began discussions with a diverse set of health care experts and stakeholders on issues related to physician payment reform and transitioning to alternative systems of payment and delivery. In the coming months, the Bipartisan Policy Center (BPC) will issue a series of white papers, drawing from those discussions and other resources, to offer legislative and regulatory policy recommendations on the implementation and acceleration of delivery system and payment reforms. As the first in this series, this paper identifies opportunities and challenges in the transition to organized systems of care through the lens of the current legislative and regulatory environment. This includes pending Medicare physician payment legislation as well as a discussion of the primary alternative models of health care delivery.

Background

In April 2013, BPC's Health and Economic Policy Projects collaborated to produce a comprehensive solution to improve quality and value in the U.S. health care system. The report, *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*, was based on the growing consensus that the current fee-for-service (FFS) payment system inherently rewards volume and drives excessive utilization. Health care providers seeking to improve population health by coordinating care, providing appropriate services, and improving the overall quality of care are often penalized under the current FFS structure because many services used to improve care are inadequately rewarded, and accompanying decreases in volume result in lower revenues. BPC's 2013 recommendations centered around delivery system reforms designed to incentivize health care providers and patients to transition from the current volume-driven FFS system to organized systems of care, as well as reforms that would improve Medicare Advantage with competitive pricing, and modernize the Medicare benefit.

While BPC's leaders[1] continue to support and remain committed to the broad range of policies advanced in *A Bipartisan Rx*, the report was conceived in an environment of impending budget sequestration and the possibility of bipartisan compromise on deficit reduction, or a so-called "grand bargain." Since that time, the political environment has shifted, and prospects for comprehensive changes in the near-term are dim. Although there will be limited opportunities for legislative action in the coming year, it is still possible to advance the goals of improving quality and value in the health care system through the enactment and implementation of bipartisan physician payment reforms and regulatory changes in the structure of existing alternative systems of care.

Opportunities for Reform in the Near-term

Over the next year, opportunities to promote improved alternatives to the current FFS reimbursement system will likely be limited to two options. First, Congress will likely address Medicare physician payment reform, which is necessary to avoid a 20.9 percent payment cut in 2015. Second, there will be opportunities through regulatory action by the Centers for Medicare and Medicaid Services (CMS) related to transitioning to organized systems of care, which are the basis for the alternative payment models described in pending Medicare physician payment legislation and thus integral to implementation of the legislation.

Physician Payment Reform

Earlier this year, the three congressional committees of jurisdiction—the Senate Finance Committee, House Ways and Means Committee, and House Energy and Commerce Committee—reached agreement on the core elements of legislation to replace the Medicare sustainable growth rate (SGR) physician payment system (referred to here as the "tri-committee" bill).[2] The tri-committee bill links payment updates for physicians to participation in alternative payment models (APMs) that require physicians to assume some financial risk for the patients they serve, with the goal of improving quality and value of care. The legislation creates a two-track payment system, retaining a modified FFS system with a value-based incentive structure and providing incentives for providers to participate in APMs in the form of bonuses and higher payment updates. Several fundamental elements to physician payment reform employed in the tri-committee bill are consistent with BPC's approach and other major payment reform proposals. While there is agreement on the tri-committee bill, Congress has been unable to pass the legislation because of disputes over how to offset its cost.[3] We believe that costs associated with this approach should be fully offset in a thoughtful way that can garner bipartisan support. Currently, it is unclear whether the legislation will pass this year, will be delayed until next year, or if yet another temporary "patch" to prevent Medicare payment cuts must be enacted first. Nevertheless the bipartisan, bicameral consensus achieved in each of the committees—and ultimately across committees—points in the direction of payment reforms for physicians that might be politically feasible.

Regulatory Action on Alternative Systems of Care

Once the law is enacted, CMS faces a considerable task in implementing physician payment reform. A critical component of the success or failure of the law depends on the status of a number of alternative systems of care currently underway. The CMS Center for Medicare and Medicaid Innovation (CMMI) continues to develop and test innovative care models, some of which are critical to the success of physician payment reform. Many, if not most, of the opportunities and challenges outlined below are relevant to both physician payment reform and overall delivery system reform, which goes beyond physician-only models and includes the full range of providers and payers, including hospitals, post-acute care, non-physician practitioners, and private health insurers.

Alternative Systems of Care: Three Major Structures

In an effort to frame future discussions around physician payment reform and alternative systems of care, it is useful to define the key goals and characteristics of those models. Alternative systems of care, as we know them today, fall into three general structures: bundled payments, patient-centered medical homes (PCMHs), and accountable care organizations (ACOs). While differing in scope and design, all three of these models are designed to improve quality and value, leading to better care and lower health care costs.

Bundled Payments

Under bundled payments, providers are paid on the basis of a spending benchmark per episode of care. An important challenge with structuring bundles has been designing coherent, robust bundles that are meaningful while also avoiding inadvertently stimulating additional episodes. As we look ahead at how to expand the role of bundled payments in the movement toward alternative systems of care, BPC will explore how to best transition from independent arrangements toward episodes that most appropriately improve the efficiency and quality of our health care system.

Patient-Centered Medical Homes

The patient-centered medical home (PCMH) is another widely implemented alternative care model. PCMHs emphasize integrated care in which primary care physicians coordinate care, educate patients, and provide additional services not paid for under FFS. PCMH models are currently operating through private organizations, Medicaid waivers, and several CMMI models including the Federally Qualified Health Center's Advanced Primary Care Practice demonstration, and several Health Care Innovation Awards and State Innovation Models. PCMHs typically include an additional payment per beneficiary per month that supplements FFS payment. While the approach may be an appropriate first step toward alternative systems of care, there are opportunities for improvement within PCMH design and payment to allow it to continue to evolve toward a risk-bearing entity. In a future paper, BPC will examine PCMH model designs that promote increased provider participation while rewarding the uptake of one-sided risk, allowing the PCMH to share in the savings but not in the losses.

Accountable Care Organizations

Accountable care organizations (ACOs), which have received substantial attention from policymakers, payers, and providers, are health care provider organizations that agree to provide coordinated care to a defined patient population with shared incentives based on a benchmark of spending per attributed beneficiary. CMS is testing this model with the Medicare Shared Savings Program (MSSP) and two related CMMI models known as the Pioneer ACO and Advance Payment ACO models, in which Medicare providers are eligible for bonus payments on top of existing FFS payments if they can hit certain spending, quality, and patient-satisfaction targets. Currently, there are 338 MSSP participants, more than 200 ACO arrangements with private payers, and just over 70 ACOs with both government and commercial contracts across the country.[4]

While the Medicare ACO programs represent a start toward meaningful payment reform, many are not achieving early cost savings, and critical improvements to ACOs are needed for these models to be successful and sustainable, including stronger incentives for providers to participate, more accurate attribution of beneficiaries, revamped quality measures, and better tools to engage patients in their care. In a June 2014 letter to CMS, the Medicare Payment Advisory Commission (MedPAC) made a number of recommendations for suggested changes to the current Medicare ACO model and identified barriers to optimal operation, including the need for prospective beneficiary attribution and financial benchmarks, movement toward a small number of outcomes-based quality measures, provision of regulatory relief as an incentive for ACOs to move to two-sided risk, and stronger tools to encourage beneficiary engagement, including relaxed cost-sharing requirements and a streamlined process for CMS review of marketing materials.[5] Variations of many of these recommendations were also included in BPC's April 2013 *Bipartisan Rx* report. BPC will explore these and additional operational challenges with the ACO model in a subsequent white paper.

Key Challenges and Opportunities in Payment Reform: Alternative Systems of Care and Delivery System Reform

The success of these models, and a reformed delivery system that rewards quality and value, will principally rely on widespread participation among providers, strong engagement of beneficiaries, carefully constructed and appropriate measures—including quality measurements and financial benchmarks—and, in the long-term, providers taking two-sided risk (both bonuses and penalties). We also recognize that no single model is necessarily the best or most efficient for a geographically diverse, heterogeneous population.

Among the challenges that must be addressed by CMS to assure a successful transition to alternative systems of care:

- **Improving quality while also slowing the rate of health care cost growth.** Alternative systems of care must aim to improve quality while remaining less costly than the current FFS system.
- **Widespread provider participation.** Achieving new systems of care will require widespread provider participation in alternative systems of care, and shifting large numbers of physicians and other providers toward unfamiliar models with new cost and quality requirements will require strong incentives. As proposed in BPC's and similar delivery system reform proposals, differential updates are critical mechanisms to achieving this movement. The tri-committee bill took an important step in this direction by offering higher payment rates for physicians participating in APMs. Specifically, the legislation proposes that, starting in 2024 and after a transition period, providers participating in APMs receive annual updates of 1 percent, while other providers receive annual updates of 0.5 percent.[6] The legislation also provides for bonus payments, proposing that from 2018 through 2023, providers who receive a significant portion of their revenue from an APM are eligible to receive a 5 percent bonus. BPC's *A Bipartisan Rx* recommended a more aggressive differential,[7]

proposing that for ten years payment updates would only be available for providers, including hospitals and post-acute care providers, who belong to or contract with a "Medicare Network," BPC's version of an enhanced ACO model.[8]

- **Structuring incentives to incorporate the full range of providers, not just physicians**. Beyond differential updates, policymakers must ensure that alternative systems of care are structured to provide meaningful opportunities for a range of practitioners to participate, including physicians and advanced practice nurses, those in primary care and in specialties, and hospitals, ambulatory surgical centers, and post-acute care. Specialists in particular face significant barriers to participation in payment models currently being tested at CMS. The participation and investment of the medical community in these models are critical to their success and sustainability.
- **Facilitating the establishment of alternative systems of care in rural areas**. There is considerable difference of opinion among policymakers as to whether the ACO model is viable in rural and frontier areas. While some argue that current referral patterns can serve as a basis for risk-based relationships, others argue that the low volume of patients will not permit two-sided risk. Providers in rural areas, for example, may have far fewer resources, less access to data infrastructure and new technology, and limited ability to partner with larger organizations for assistance with clinical integration, claims processing, or other administrative support. Smaller, rural practices may be more likely to participate successfully if urban systems have the potential, and interest, to include rural physicians and other providers in their new models of care.
- **Structuring new models to best engage and pay specialists**. Policymakers continue to seek models that appropriately integrate specialty care. As currently structured, ACOs have not included physicians in many specialties as members of the organization, even if the primary care physician members are steering referrals to the higher-value specialists. Although CMMI is expected to pursue some additional models that are relevant to other specialties, to date, bundled payment initiatives have been limited to inpatient orthopedic and cardiac procedures.
- **Improved beneficiary engagement and attribution.** Policymakers continue to debate how to structure beneficiary information and incentives to encourage enrollment in enhanced ACOs, affiliation with primary care clinicians in a medical home, or the favoring of "in network" practitioners. Currently, Medicare beneficiaries have little incentive to seek care from providers in a specific ACO because they usually do not know they have been attributed to an ACO and have little to no understanding of the goals of ACOs or how belonging to one could improve their health or lower their spending. For a provider organization to effectively coordinate care and manage chronic diseases, beneficiaries must be aware that the organization exists, and incentives must be structured to encourage beneficiaries to favor the organization's network of providers.

- **Improved, streamlined quality measures.** Developing a limited and universal set of quality measures that is meaningful for the purposes of determining quality and payment has been a longstanding challenge for policymakers. A key criticism of public and private payers is the variety, complexity, and sheer number of quality measures. For the success of alternative systems of care, quality measures must be reviewed for consolidation and appropriateness.
- **Timely, useful performance and benchmark data to providers**. A frequent complaint of those participating in Medicare ACOs is the inability to get timely feedback on care being delivered to attributed beneficiaries by both ACO and non-ACO providers. We understand that CMS is working to address this issue in a forthcoming ACO rule.
- **Transparency in price and quality to assist beneficiaries in making meaningful choices about providers.** In an era of increasing out-of-pocket costs for insured individuals, consumers need to be able to obtain the appropriate information to allow them to make rational decisions about price and quality of care. Appropriate quality measures reflecting patient-reported outcomes and patient experience should be a means of providing the beneficiary with meaningful information to make decisions about their care.
- **Adequate technical assistance.** CMS needs to ensure the technical assistance currently available to providers through the learning collaboratives is sufficient to aid the creation and/or expansion of alternative systems of care, as well as improve their operations and performance.
- **Determining if and when health information technology can be fully interoperable.** Health care plans and providers continue to struggle with electronic health records that do not permit, much less facilitate, the flow of data necessary to quickly identify outliers and intervene to change provider behavior, as well as obtain patient information consistently.
- **Determining the impact of market consolidation.** To ensure that increasing market share does not result in driving up prices, it is necessary to investigate where the consolidation of providers improves quality and value.
- **Determining the appropriate role of telemedicine.** The appropriate use of telemedicine is key to evolving alternative systems of care that improve quality and value. Telemedicine coverage might be limited to risk-bearing organizations as an incentive to provider and beneficiary engagement, and/or services could be made more broadly available to improve care in medically underserved areas.
- **Assuring critical mass.** Models could be better structured to ensure parallel activities by private insurers and self-funded employers so that a sufficient percentage of beneficiaries are enrolled in alternative systems of care to make the models financially viable. Those who have successfully operated ACOs and other

alternative systems of care have noted the difficulty in making investments and changing medical practice based on a small percentage of patients. In many cases, providers who change the way they practice for all patients will not receive incentive payments for those who remain in FFS. Some experts have indicated that unless at least 60 to 70 percent of patients are paid on a value-based system, practices will operate at a loss and ultimately return to FFS.

- **Consistency across payers.** Many current models contract with multiple payers, including Medicare and commercial payers, who have different contract requirements that often do not align. Quality measures and contracting and reporting requirements should be broadly consistent across payers to best encourage providers to pursue alternative models of care.
- **Constrained budgets for innovation.** In the current budget environment, the longevity of CMS's ability to continue to test models should be assured. With available resources, CMS needs to be able to accurately evaluate models of care and participants' performance in those models in order to scale and spread successful models nationally.

Next Steps

While BPC does not intend to address all of the challenges outlined above, over the coming months we will begin to explore solutions to some of the major challenges to developing and implementing alternative systems of care. Acknowledging that FFS will remain the basis for other payment mechanisms and will continue to exist in some areas, BPC will examine possible innovations in the existing FFS program, as well as bundling, PCMHs, additional improvements to ACOs, and other issues related to delivery system reform.

Endnotes

[1] Former Senate Majority Leaders Tom Daschle and Bill Frist, former Senate Budget Committee Chairman Pete Domenici, and former Congressional Budget Office Director Dr. Alice Rivlin.

[2] SGR Repeal and Medicare Provider Payment Modernization Act of 2014 (S.2000/H.R. 4015), as introduced February 6, 2014, https://beta.congress.gov/bill/113th-congress/senate-bill/2000?q=%7B%22search%22%3A%5B%22s.2000%22%5D%7D.

[3] As introduced in February 2014, S. 2000/H.R. 4015 was scored at $138.4 billion over 2014-2024.

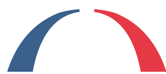
[4] See: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/PioneersMSSPCombinedFastFacts.pdf; *Growth and Dispersion of Accountable Care Organizations: June 2014 Update*, Leavitt Partners Accountable Care Cooperative.

[5] See: http://www.medpac.gov/documents/06162014_ACO_issue_letter_2014_COMMENT.pdf.

[6] Qualifying APMs must involve risk of financial losses and a quality-measurement component.

[7] In BPC's proposal, non-physician fee schedule providers are included in the differential.

[8] For more information, see *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*, Bipartisan Policy Center, April 2013.



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State Estimates of the Number of Uninsured Adults Eligible for a Special Enrollment Period in 2014

August 18, 2014

Background

In 2014, uninsured individuals who missed the March 31 enrollment deadline and are not eligible for Medicaid or the Children's Health Insurance Program (CHIP) still have an opportunity to enroll in health insurance if they experience one of several qualifying events that triggers a Special Enrollment Period (SEP).[i] Because of these additional special enrollment periods, millions of currently uninsured Americans could potentially gain coverage through their state or federal marketplace before the next open enrollment period begins. Examples of qualifying life events include permanently moving to an area where different plans are available on the marketplace, getting married, having or adopting a child, and becoming a citizen, national, or lawfully present individual.[ii] This memo provides national and state-level estimates of the percent of currently uninsured individuals who are likely to have experienced at least one of these qualifying events during the seven months between open enrollment periods and are therefore eligible for an SEP.

It is important to note that the currently uninsured constitute only part of the total population that could become eligible for an SEP. Individuals who lose coverage between open enrollment periods will also often be eligible to enroll in a marketplace plan through an SEP. However, due to data limitations it is not possible to estimate at the state level how many adults are likely to lose coverage over the course of the year.

Key Findings

- **Nationally, almost 7 million adults are likely to experience a qualifying event that could trigger a special enrollment period.** This includes about 2.7 million uninsured adults as well as 4 million currently insured adults who lose coverage during the course of the year. [iii]
- **Among the uninsured, approximately 6.5 percent will likely experience one or more qualifying events between open enrollment periods.** This corresponds to 2.7 million uninsured adults, or about one percent of the full U.S. adult population age 18-64, based on estimates from 2010-2012, the most recent time period for which reliable state-level estimates are available.

- **Moving constitutes the most common source of qualifying events among the currently uninsured**, with an estimated 1.8 million uninsured Americans likely to move to a new county between open enrollment periods.

Estimates are derived from Enroll America's analysis of the U.S. Census Bureau's 2010 – 2012 American Community Survey. A detailed explanation of each qualifying event and the share of uninsured individuals likely affected is provided in the following sections, with state-level estimates available in Table 1 in the attached appendix. In addition, some adults will become eligible for an SEP due to other qualifying events not listed here. In particular, gaining permanent resident status or being released from incarceration are both qualifying events. While some individuals who experience these events already have access to health insurance coverage from other sources, others will likely enroll through their marketplace. Estimates for the number of individuals who experience these qualifying events, regardless of current insurance status, are included in Table 2 in the appendix.

Qualifying Events for Special Enrollment Period Among Currently Uninsured

Moving

One of the most common ways that an uninsured individual will qualify for an SEP is by permanently moving to an area where new plans are available on the marketplace. Uninsured individuals are more likely to move than the general adult population, with 20 percent of all uninsured adults reporting that they have lived at their current residence for less than one year, compared to just 15 percent of the total population. However, moving alone does not trigger an SEP unless the person gains access to new marketplace insurance options. Moving to a new state satisfies this criteria, but only about 16 percent of all moves are between states. Using currently available data, it is not possible to estimate how many people moving within a state will qualify for an SEP. However, aggregate estimates for the percentage of moves that occur between counties can serve as a proxy for moving to a new marketplace area.[iv] Nationally, about 38 percent of all moves are between counties. Assuming that the uninsured move counties at similar rates and that moves are distributed evenly throughout the year, this suggests that on average **approximately 4.3 percent of the uninsured will move to a new county between open enrollment periods.**

Marriage

Nationally, approximately 2.2 percent of all uninsured adults reported that they had gotten married in the previous 12 months. While marriages do not occur at a uniform rate throughout the year, this suggests that on average **approximately 1.3 percent of the uninsured will get married between open enrollment periods**.

Having or adopting a child

Nationally, approximately 1.9 percent of all uninsured adults reported giving birth in the previous 12 months (figures on adoption rates among the uninsured are not available but adoption is unlikely to be a major source of SEPs given that only 2 percent of all children residing in a household are related through adoption[v]). In cases where the father can also claim the child as a dependent, the father will also be eligible for an SEP. Assuming that births are distributed uniformly throughout the year and that fathers generally will qualify for an SEP as well, **approximately 2.2 percent of all uninsured adults will have a child between open enrollment periods**.

Gaining citizenship

Using the ACS, it is possible to estimate the number of uninsured adults who have gained citizenship in the year that the survey was administered. While this will underestimate the number who have gained citizenship in the previous 12 months since interviews take place throughout each year, the estimates can be benchmarked against administrative data provided by the U.S. Department of Homeland Security. According to the ACS, approximately 411,177 citizens on average reported gaining citizenship each year between 2010 and 2012, while 690,513 adults were actually naturalized on average each year during this period, suggesting that the ACS estimates undercount the number of naturalizations by about 40 percent.[vi] Since 0.25 percent of all uninsured adults in the ACS survey had gained citizenship that year, and assuming naturalizations occur at a uniform rate throughout the year but are undercounted by 40 percent in the ACS, this means that on average **approximately 0.24 percent of the uninsured will become naturalized citizens between open enrollment periods.**[vii]

Any qualifying event due to moving, marriage, birth, or naturalization

Some individuals will experience multiple qualifying events—such as getting married and having a child or moving—so the total uninsured population eligible for an SEP is slightly smaller than the total number of qualifying events. Taking this into account, approximately 11 percent of all uninsured adults experienced at least one qualifying event in the previous year, suggesting that **approximately 6.5 percent of the uninsured population will become eligible for an SEP between open enrollment periods.**[viii]

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APPENDIX. STATE-LEVEL ESTIMATES OF SPECIAL ENROLLMENT POPULATION

Table 1. Percent of uninsured adults experiencing qualifying events for special enrollment periods.

Source: Enroll America analysis of U.S. Census Bureau, 2010-2012 American Community Survey

		Estimated Number and Percent of Uninsured Adults 18-64 Experiencing Qualifying Event between Open Enrollment Periods*				
State	Total Uninsured (2010-2012)	Uninsured Experiencing Any Qualifying Event[a]	Moved to new county[b]	Married	Gave birth[c]	Gained Citizenship[d]
Alabama	636,626	**47,435 (7.5%)**	29,871 (4.7%)	11,093 (1.7%)	9,936 (1.6%)	173 (0.0%)
Alaska	116,512	**6,634 (5.7%)**	4,433 (3.8%)	1,407 (1.2%)	1,020 (0.9%)	53 (0.0%)
Arizona	932,091	**59,472 (6.4%)**	39,864 (4.3%)	11,162 (1.2%)	10,219 (1.1%)	1,105 (0.1%)
Arkansas	464,409	**37,388 (8.1%)**	24,890 (5.4%)	9,537 (2.1%)	5,730 (1.2%)	227 (0.0%)
California	6,037,394	**299,706 (5.0%)**	176,946 (2.9%)	65,292 (1.1%)	57,800 (1.0%)	13,382 (0.2%)
Colorado	661,668	**63,789 (9.6%)**	48,572 (7.3%)	11,306 (1.7%)	7,305 (1.1%)	685 (0.1%)
Connecticut	292,954	**15,245 (5.2%)**	10,935 (3.7%)	2,988 (1.0%)	1,741 (0.6%)	319 (0.1%)
Delaware	77,260	**3,915 (5.1%)**	2,624 (3.4%)	781 (1.0%)	656 (0.8%)	58 (0.1%)
District of Columbia	40,031	**2,396 (6.0%)**	1,986 (5.0%)	239 (0.6%)	216 (0.5%)	22 (0.1%)
Florida	3,504,649	**222,719 (6.4%)**	146,909 (4.2%)	41,234 (1.2%)	34,574 (1.0%)	11,421 (0.3%)
Georgia	1,704,982	**147,870 (8.7%)**	108,377 (6.4%)	22,226 (1.3%)	23,972 (1.4%)	1,780 (0.1%)
Hawaii	85,710	**4,643 (5.4%)**	2,896 (3.4%)	1,236 (1.4%)	603 (0.7%)	81 (0.1%)
Idaho	227,490	**20,094 (8.8%)**	12,976 (5.7%)	4,705 (2.1%)	3,591 (1.6%)	122 (0.1%)
Illinois	1,588,884	**81,349 (5.1%)**	54,566 (3.4%)	16,309 (1.0%)	11,958 (0.8%)	1,686 (0.1%)
Indiana	839,359	**58,048 (6.9%)**	37,566 (4.5%)	13,387 (1.6%)	10,331 (1.2%)	415 (0.0%)
Iowa	242,348	**18,496 (7.6%)**	12,753 (5.3%)	3,140 (1.3%)	3,541 (1.5%)	220 (0.1%)

Kansas	329,628	**28,155 (8.5%)**	19,432 (5.9%)	5,623 (1.7%)	4,892 (1.5%)	225 (0.1%)
Kentucky	589,205	**42,581 (7.2%)**	28,270 (4.8%)	8,651 (1.5%)	8,118 (1.4%)	244 (0.0%)
Louisiana	759,792	**51,656 (6.8%)**	34,938 (4.6%)	9,681 (1.3%)	8,964 (1.2%)	402 (0.1%)
Maine	129,154	**7,059 (5.5%)**	5,676 (4.4%)	1,114 (0.9%)	415 (0.3%)	(0.0%)
Maryland	564,330	**35,828 (6.3%)**	23,966 (4.2%)	6,436 (1.1%)	6,367 (1.1%)	919 (0.2%)
Massachusetts	255,886	**16,209 (6.3%)**	11,670 (4.6%)	3,228 (1.3%)	1,574 (0.6%)	504 (0.2%)
Michigan	1,106,821	**62,464 (5.6%)**	42,939 (3.9%)	11,949 (1.1%)	9,645 (0.9%)	882 (0.1%)
Minnesota	386,855	**29,023 (7.5%)**	20,091 (5.2%)	6,120 (1.6%)	4,172 (1.1%)	347 (0.1%)
Mississippi	482,937	**31,385 (6.5%)**	21,111 (4.4%)	5,810 (1.2%)	6,222 (1.3%)	173 (0.0%)
Missouri	733,054	**58,634 (8.0%)**	43,140 (5.9%)	9,852 (1.3%)	8,755 (1.2%)	355 (0.0%)
Montana	151,080	**9,847 (6.5%)**	6,896 (4.6%)	1,886 (1.2%)	1,712 (1.1%)	(0.0%)
Nebraska	184,762	**15,209 (8.2%)**	10,294 (5.6%)	2,351 (1.3%)	3,289 (1.8%)	223 (0.1%)
Nevada	491,217	**33,460 (6.8%)**	21,333 (4.3%)	6,843 (1.4%)	6,599 (1.3%)	707 (0.1%)
New Hampshire	128,395	**8,579 (6.7%)**	6,417 (5.0%)	1,637 (1.3%)	1,201 (0.9%)	51 (0.0%)
New Jersey	1,034,561	**57,694 (5.6%)**	36,700 (3.5%)	10,946 (1.1%)	9,855 (1.0%)	3,339 (0.3%)
New Mexico	363,616	**22,453 (6.2%)**	13,967 (3.8%)	4,628 (1.3%)	4,708 (1.3%)	413 (0.1%)
New York	2,038,685	**103,379 (5.1%)**	62,439 (3.1%)	23,687 (1.2%)	16,886 (0.8%)	5,049 (0.2%)
North Carolina	1,417,687	**97,905 (6.9%)**	66,110 (4.7%)	17,996 (1.3%)	18,744 (1.3%)	1,236 (0.1%)
North Dakota	60,040	**5,458 (9.1%)**	4,393 (7.3%)	652 (1.1%)	576 (1.0%)	(0.0%)
Ohio	1,243,197	**65,955 (5.3%)**	45,605 (3.7%)	12,830 (1.0%)	9,631 (0.8%)	731 (0.1%)
Oklahoma	617,703	**49,308 (8.0%)**	33,511 (5.4%)	9,575 (1.6%)	9,169 (1.5%)	447 (0.1%)
Oregon	552,413	**41,080 (7.4%)**	30,081 (5.4%)	7,349 (1.3%)	5,301 (1.0%)	507 (0.1%)
Pennsylvania	1,163,229	**61,439 (5.3%)**	40,316 (3.5%)	12,215 (1.1%)	10,597 (0.9%)	1,304 (0.1%)
Rhode Island	111,450	**7,015 (6.3%)**	5,437 (4.9%)	1,070 (1.0%)	548 (0.5%)	122 (0.1%)
South Carolina	707,861	**47,850 (6.8%)**	33,507 (4.7%)	8,348 (1.2%)	8,601 (1.2%)	377 (0.1%)
South Dakota	83,798	**7,630 (9.1%)**	5,678 (6.8%)	1,336 (1.6%)	1,241 (1.5%)	28 (0.0%)

Tennessee	853,318	**57,242 (6.7%)**	38,301 (4.5%)	11,887 (1.4%)	10,162 (1.2%)	567 (0.1%)
Texas	5,016,782	**365,691 (7.3%)**	234,421 (4.7%)	71,233 (1.4%)	77,358 (1.5%)	6,170 (0.1%)
Utah	327,630	**27,032 (8.3%)**	16,412 (5.0%)	7,463 (2.3%)	5,047 (1.5%)	228 (0.1%)
Vermont	41,536	**2,501 (6.0%)**	1,951 (4.7%)	433 (1.0%)	148 (0.4%)	40 (0.1%)
Virginia	901,721	**71,972 (8.0%)**	53,007 (5.9%)	11,464 (1.3%)	10,946 (1.2%)	1,496 (0.2%)
Washington	855,709	**58,134 (6.8%)**	39,392 (4.6%)	11,242 (1.3%)	9,356 (1.1%)	1,044 (0.1%)
West Virginia	259,874	**15,152 (5.8%)**	10,071 (3.9%)	3,915 (1.5%)	2,357 (0.9%)	(0.0%)
Wisconsin	477,871	**28,880 (6.0%)**	20,541 (4.3%)	5,287 (1.1%)	3,950 (0.8%)	293 (0.1%)
Wyoming	75,365	**6,424 (8.5%)**	4,648 (6.2%)	1,571 (2.1%)	763 (1.0%)	100 (0.1%)
United States	41,949,529	**2,719,480 (6.5%)**	1,808,827 (4.3%)	532,349 (1.3%)	471,059 (1.1%)	60,274 (0.1%)

* Respondents were asked if they had experienced any of the qualifying events in the previous twelve months. Estimates reported here assume that events are distributed evenly throughout the year and therefore multiply the full year estimates by 7/12 to obtain estimates for the seven months between open enrollment periods.

[a] "Any qualifying event" estimates the number of uninsured who experienced at least one of the events listed—moving, getting married, having a child, , or becoming a citizen—in the previous 12 months and is therefore slightly smaller than the total of each individual event since some people experience multiple qualifying events in a year.

[b] Estimates of moves between counties are based on the inter-county migration rate for the full adult population in each state since figures for the uninsured population are not available. For a move to be a qualifying event an individual must gain access to new marketplace plans in the new area, meaning that not all moves between counties within a state will create an SEP. However this provides an approximate upper bound on the number of moves that are likely to create an SEP.

[c] Estimates for giving birth are limited to uninsured women and do not include adoptions or uninsured fathers of newborns who might also be eligible for an SEP.

[d] Due to differences in question wording, the uninsured naturalization estimates reported here undercount the number of individuals who have gained citizenship by approximately 40 percent compared to administrative reports. While all other figures reported here are for the previous twelve months, naturalized citizens were only asked the year in which they gained citizenship as opposed to whether they had become citizens in the previous twelve months. These estimates also do not account for the individual's previous immigration status, which could affect their eligibility for an SEP. Given the comparatively low rate of naturalizations among the uninsured, however, these factors are unlikely to substantially affect the overall estimate of the number of uninsured who experience a qualifying event.

Other qualifying events

While most uninsured who enroll in the marketplaces through an SEP are likely to qualify for one of the above reasons, two other major situations that can lead to qualifying events include immigrants who have gained permanent resident status and individuals who have recently been released from prison. While estimates are not available for the number of new immigrants or adults recently released from prison who are also uninsured, immigrants and former inmates are both disproportionately more likely to be uninsured and therefore, depending on their income, more likely to be eligible to enroll in their state marketplace.

In 2012, 1,031,631 individuals obtained legal permanent resident status and 637,411 were released from state or federal prison. New immigrants are generally barred from receiving insurance coverage through Medicaid for five years, and adults recently released from prison often will not be eligible for Medicaid in states that opted not to expand coverage to all adults with incomes up to 138 percent of the federal poverty level. However, uninsured individuals who gain permanent resident status or are released from incarceration will be eligible to enroll in the marketplaces through an SEP. Assuming that these events are distributed uniformly throughout the year, this suggests that on average at any given point in time, **as many as 973,608 additional individuals could be eligible for an SEP due to gaining a new immigration status or release from incarceration.**

Table 2. Number of additional individuals potentially eligible for a special enrollment period if currently uninsured.[a]

Sources: U.S. Bureau of Justice Statistics and U.S. Department of Homeland Security[ix]

	Other Qualifying Events	
State	Released from Prison[b]	New Permanent Residents[c]
Alabama	31,437	3,873
Alaska	2,974	1,612
Arizona	38,402	18,434
Arkansas	14,615	2,795
California	134,211	196,622
Colorado	20,462	13,327
Connecticut	11,961	12,237
Delaware	4,129	2,208
District of Columbia	0[d]	2,811
Florida	101,930	103,047
Georgia	53,990	26,134
Hawaii	3,819	6,764

Idaho	7,985	2,428
Illinois	49,348	38,373
Indiana	28,822	8,359
Iowa	8,686	4,679
Kansas	9,398	4,980
Kentucky	21,466	5,243
Louisiana	40,170	4,454
Maine	1,932	1,497
Maryland	21,281	24,971
Massachusetts	9,999	31,392
Michigan	43,594	17,494
Minnesota	9,938	12,999
Mississippi	21,426	1,583
Missouri	31,244	6,635
Montana	3,609	503
Nebraska	4,594	4,384
Nevada	12,744	10,343
New Hampshire	2,790	2,466
New Jersey	23,225	50,790
New Mexico	6,574	3,714
New York	54,073	149,505
North Carolina	34,983	17,487
North Dakota	1,512	1,144
Ohio	50,876	13,948
Oklahoma	24,830	4,646
Oregon	14,801	7,791
Pennsylvania	50,918	25,032
Rhode Island	1,999	3,798
South Carolina	21,725	3,924
South Dakota	3,644	1,521
Tennessee	28,411	8,573
Texas	157,900	95,557
Utah	6,960	5,932
Vermont	1,516	877
Virginia	37,044	28,227
Washington	17,254	23,060
West Virginia	7,027	779
Wisconsin	20,474	6,049
Wyoming	2,204	427
United States	**637,411**	**1,031,631**

[a] While not everyone who experiences these events will be uninsured, individuals recently released from prison and new permanent residents are disproportionately more likely to be uninsured, suggesting that a substantial share of this population will have an opportunity to enroll through a special enrollment period.

[b] Counts based on prisoners with a sentence of more than 1 year. Counts exclude transfers, escapes, and those absent without leave (AWOL). Totals include deaths, releases to appeal or bond, and other releases. State counts do not include inmates released from federal prison (approximately 9 percent of all releases), but these releases are included in the national total.

[c] Counts of new permanent residents include all individuals, including children. The United States total also includes new permanent residents residing in U.S. territories or other areas.

[d] As of December 31, 2001, sentenced felons from the District of Columbia are the responsibility of the Federal Bureau of Prisons and are therefore not included in the count for the District of Columbia.

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Endnotes

[i] Special enrollment periods, 45 C.F.R. §155.420. Available at http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=9045f9b1c870e10cb2133b1ee0e9315d&r=PART&n=45y1.0.1.2.70#45:1.0.1.2.70.5.27.5. Accessed August 14, 2014.

[ii] This list is not comprehensive, and some individuals in limited circumstances will also have the opportunity to enroll through an SEP if they were mistakenly directed to Medicaid during the initial open enrollment period or if they were denied coverage for Medicaid in a state that did not expand coverage to adults with incomes below 100 percent of the Federal Poverty Level but subsequently experience an increase in income that makes them eligible for tax credits through the marketplace. See http://marketplace.cms.gov/technical-assistance-resources/seps-for-limited-circumstances.pdf. Accessed August 14, 2014.

[iii] John Graves and Jonathan Gruber, "Obamacare Enrollment is Far from Over," *Talking Points Memo*, April 1, 2014. Available at http://talkingpointsmemo.com/cafe/obamacare-enrollment-is-far-from-over. Accessed August 14, 2014.

[iv] Moving to a new county is neither necessary nor sufficient for triggering an SEP, but counties typically offer different plans in large states. However in some states—including Alaska, Delaware, Montana, New Hampshire, South Dakota, West Virginia, and Wyoming—the same plans are available in all areas, so only moving to a new state would trigger an SEP. For this reason the estimates provided for smaller states likely overstate the share of the uninsured adults who qualify for an SEP due to moving. Plan availability by county for federally facilitated marketplaces and state-partnership marketplaces is provided by U.S. Department of Health and Human Services, Health Insurance Marketplace, "Health Plan Information for Individuals and Families." Available at https://www.healthcare.gov/health-plan-information/. Accessed August 14, 2014.

[v] Rose M. Kreider and Daphne A. Lofquist, "Adopted Children and Stepchildren: 2010, Population Characteristics," U.S. Census Bureau, April 2014.

[vi] James Lee, Department of Homeland Security Office of Immigration Statistics, U.S. Naturalizations: 2011. Available at http://www.dhs.gov/xlibrary/assets/statistics/publications/natz_fr_2011.pdf. Accessed August 14, 2014.

[vii] It is important to note that the ACS does not ask about previous immigration status, but the preamble to a final regulation issued by the Centers for Medicare and Medicaid Services clarified that the special enrollment period for gaining an immigration status "only applies to an individual who was not previously a citizen, national, or lawfully present, as opposed to an individual switching between one of these statuses." 78 FR 42263 (July 15, 2013). Available at http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf. Accessed August 14, 2014.

[viii] This estimate likely undercounts the total number of individuals who qualify for an SEP since it does not account for fathers who have recently had a child or the undercounting of naturalization in the ACS. However, this should not account for more than a 1 percent difference in the total estimate. The estimate also assumes that about 38 percent of all uninsured who have moved but did not report another qualifying event will be eligible for an SEP due to having new marketplace plans available.

[ix] U.S. Department of Homeland Security, *Yearbook of Immigration Statistics: 2012, Legal Permanent Residents,* Table 4. Available at https://www.dhs.gov/yearbook-immigration-statistics-2012-legal-permanent-residents. Accessed August 14, 2014. E. Ann Carson and Daniela Golinelli, U.S. Department of Justice, Bureau of Justice Statistics, *Prisoners in 2012: Trends in Admissions and Releases, 1991-2012*, December 2013. Available at http://www.bjs.gov/content/pub/pdf/p12tar9112.pdf. Accessed August 14, 2014.

THE FIELD POLL

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 2

Over One in Three Voters Under Age 65 Personally Visited the Covered California Website
Medi-Cal Viewed as Increasingly Important to Voters and Their Families
Support for Proposals Aimed at Improving State's Health Care System, Including Prop. 45

By Mark DiCamillo and Mervin Field

The major findings from Part 2 of the 2014 TCWF-Field Health Policy Survey conducted among 1,535 California registered voters about changes in the state's health care system following implementation of the Affordable Care Act (ACA) include the following:

- Over one in three voters under the age of 65 (36%) have personally visited the Covered California website and 9% say they obtained their health coverage there.
- While a majority (56%) of voters who visited the Covered California web site were satisfied with their experience there, 42% were dissatisfied. Voter evaluations of the web site are colored largely by a voter's party affiliation and overall opinion of the ACA. For example, 63% of registered Democrats and 71% of voters supportive of the ACA say they were satisfied with their experience at the web site. By contrast, 39% of Republicans and just 28% of voters opposed to the ACA who visited the site were satisfied. Interest in visiting the web site in the future is similarly partisan and is tied to a voter's party affiliation and overall opinion of the ACA.
- Nearly two in three voters (62%) say that the state's Medi-Cal program is important to themselves or their families. This is up from 58% who reported this in 2013 and 51% who said this in 2011. The proportion of voters who consider Medi-Cal to be "very important" has also increased from 29% in 2011 to 40% in the current survey. Two in three voters (65%) also believe Medi-Cal has been successful in meeting its program objectives, while just 16% feel it has not.
- Large majorities of voters support a number of proposals aimed at improving the state's health care system. These include: encouraging insurance companies to reward doctors and hospitals more for the quality of care they provide than the number of patients they serve (82%), encouraging insurance companies to reduce costs by allowing physician assistants and nurse practitioners to play a bigger role in providing care to patients (81%), and expanding state funding of not-for-profit health insurance co-ops (78%). Another 62% favor allowing insurance companies to offer a lower cost, high deductible plan option through Covered California.

- Opinions are more divided in regard to the proposal to expand Medi-Cal to provide preventive health services to undocumented immigrants. Slightly more than half (51%) support the idea, but 45% are opposed. Views about this are highly partisan and divide voters along racial/ethnic lines.
- There is strong early support for Proposition 45, the "Approval of Healthcare Insurance Rate Changes" initiative that will appear on the November 2014 statewide election ballot. Greater than two in three likely voters (69%) say they would vote YES after being read a summary of its official ballot description, while just 16% are initially opposed. Another 15% are undecided.
- Somewhat smaller majorities of likely voters say they're inclined to vote YES on Prop. 46, the "Drug and Alcohol Testing of Doctors; Medical Negligence Lawsuits" initiative (58%) and Prop. 47, the "Criminal Sentencing/Misdemeanor Penalties" initiative (57%).

"It is heartening to see that California voters increasingly observe the important role the Medi-Cal program plays in the health care safety net," said Judy Belk, president and CEO of The California Wellness Foundation. "Expanding access to Medi-Cal for hundreds of thousands of Californians has been a key element of the Affordable Care Act in our state and has helped them access health care that was out-of-reach for many before this important reform."

More than one in three voters under age 65 have personally visited the Covered California website and 9% obtained their health coverage there

Greater than one in three California voters under age 65 (36%) say they personally visited the Covered California web site to see what kinds of health insurance were being offered there. Of these, 9% say they obtained their health insurance coverage there.

Most likely to have visited the site were those currently uninsured (50%) or report having had a lapse in their insurance coverage during the past two years (47%).

The under age 65 segments least likely to have visited the site were non-English speakers (23%), those with no more than a high school education (24%), voters who have been continuously insured over the past two years (28%), and Asian Americans or Pacific Islanders (28%).

Evaluations of the Covered California web site and interest in visiting it in the future are colored by voters' political affiliations and their opinions of the ACA

When voters who visited the Covered California web site are asked to evaluate their experience at the site, 56% say they were satisfied, while 42% were dissatisfied. However, evaluations are directly related to voters' party affiliation and overall opinion of the ACA. Large majorities of registered Democrats (63%) and ACA supporters (71%) say they were satisfied with their experience at the site. On the other hand, just 39% of Republicans and only 28% of ACA opponents who visited the site say they were satisfied.

When voters are asked whether they are interested in visiting the web site in the future, 46% of voters under age 65 express some interest, while 51% do not. Interest is again highly partisan and tied to a voter's overall opinion of the ACA. More than twice as many Democrats (56%) as Republicans (25%) say they are interested in visiting the site in the future. Similarly, while 61% of

those who support the ACA express an interest in visiting the site in the future, just one in four (24%) of the law's opponents say this.

Increasing proportions consider the state's Medi-Cal program important to themselves and their families

The current survey finds that nearly two in three voters (62%) say that Medi-Cal, the state program that provides health insurance and long-term care to California's low-income adults and children, is important to themselves or their families. This is up from 58% who reported this last year and 51% who said this in 2011.

The proportion that consider Medi-Cal to be "very important" has also grown. In 2011 just 29% of voters reported Medi-Cal to be very important to themselves and their families. Last year this increased to 38%, while now it stands at 40%.

Most voters (65%) also believe the state's Medi-Cal program has been successful in meeting its goals. This compares to just 16% who feel the Medi-Cal program has not been successful in meeting its goals, down from 20% who felt this way last year and 24% in 2011.

Support for a number of proposals aimed at improving the state's health care system

Voters were asked their opinions of five proposals aimed at improving the state's health care system. Three proposals are favored overwhelmingly. They include:

- Encouraging insurance companies to reward doctors and hospitals more for the quality of care than the number of patients they serve. (82% favor vs. 12% oppose)
- Encouraging insurance companies to reduce health care costs by allowing physician assistants and nurse practitioners to play a bigger role in providing care to patients. (81% favor vs. 14% oppose)
- Expanding state funding of not-for-profit health insurance co-ops. (78% favor vs. 15% oppose)

A fourth proposal, to allow insurance companies to offer a new lower cost, high deductible coverage option through the Covered California insurance marketplace is also supported by a two-to-one margin (62% favor vs. 29% oppose).

On the other hand, a fifth proposal, expanding Medi-Cal to provide preventive health services to undocumented immigrants, divides the voting public. At present, 51% of voters favor the idea, but 45% are opposed. Views about this are highly partisan and divided along racial/ethnic lines. While Democrats support expanding Medi-Cal to include undocumented immigrants greater than two to one (68% to 28%), Republicans are opposed more than three to one (74% to 23%). In addition, larger proportions of Latinos (73%), African Americans (62%) and Asian Americans/Pacific Islanders (57%) are supportive, compared to white non-Hispanics (41%).

Strong early support for Proposition 45, the "Approval of Healthcare Insurance Rate Changes" initiative on the November statewide election ballot

There is strong early support for Proposition 45, the "Approval of Healthcare Insurance Rate Changes" initiative. After being read a summary of Prop. 45's official ballot description, 69% of likely voters say they would vote YES, while 16% say they would vote NO. Another 15% are undecided. Support crosses party lines, and currently includes about three in four Democrats (75%) and non-partisans (73%), and 58% of Republicans.

Somewhat smaller majorities of likely voters are also backing Propositions 46 and 47 on the general election ballot. Proposition 46, the "Drug and Alcohol Testing of Doctors; Medical Negligence Lawsuits" initiative, is currently supported by 58% and opposed by 30%, with 12% undecided. YES voters outnumber No voters on Proposition 47, the "Criminal Sentencing/Misdemeanor Penalties" initiative, 57% to 24%, with 19% undecided.

-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 completed 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 2

Voter Views of the Implementation of the Affordable Care Act in California and Recent Proposals Aimed at Improving the State's Health Care System

Conducted by

The Field Poll

for

The California Wellness Foundation

for release

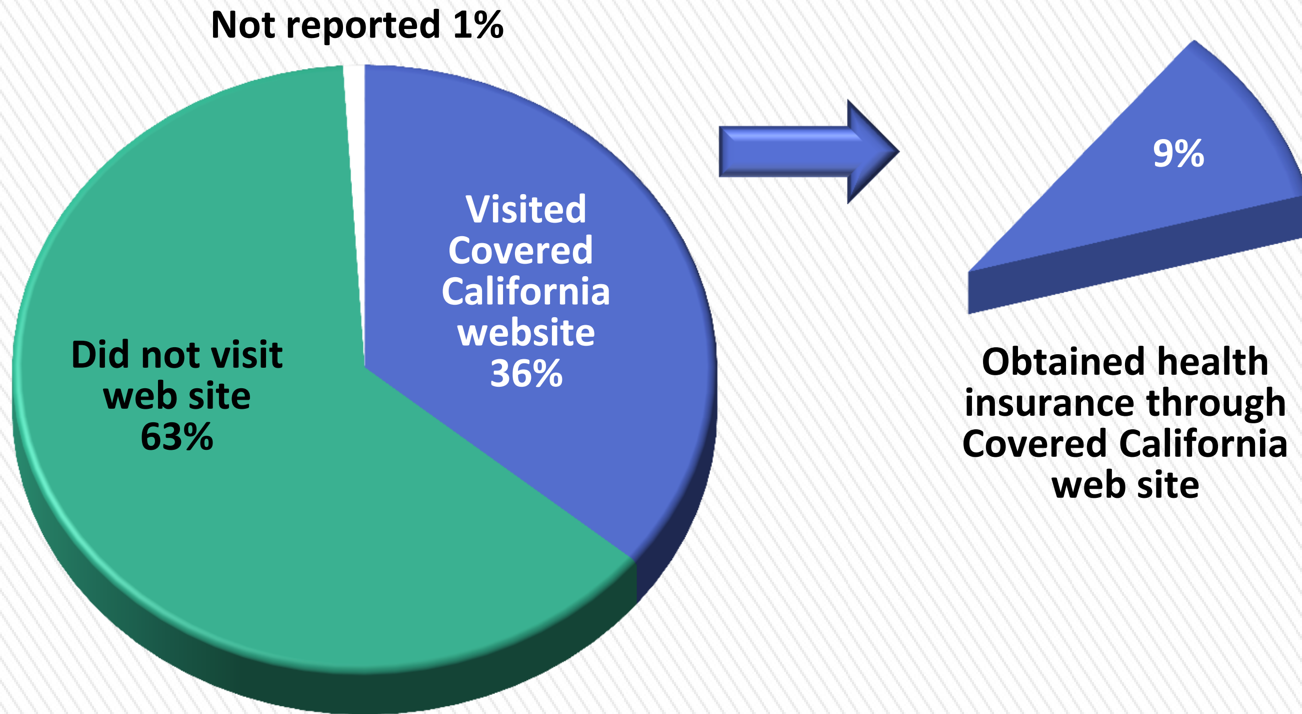
Wednesday, August 20, 2014

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.

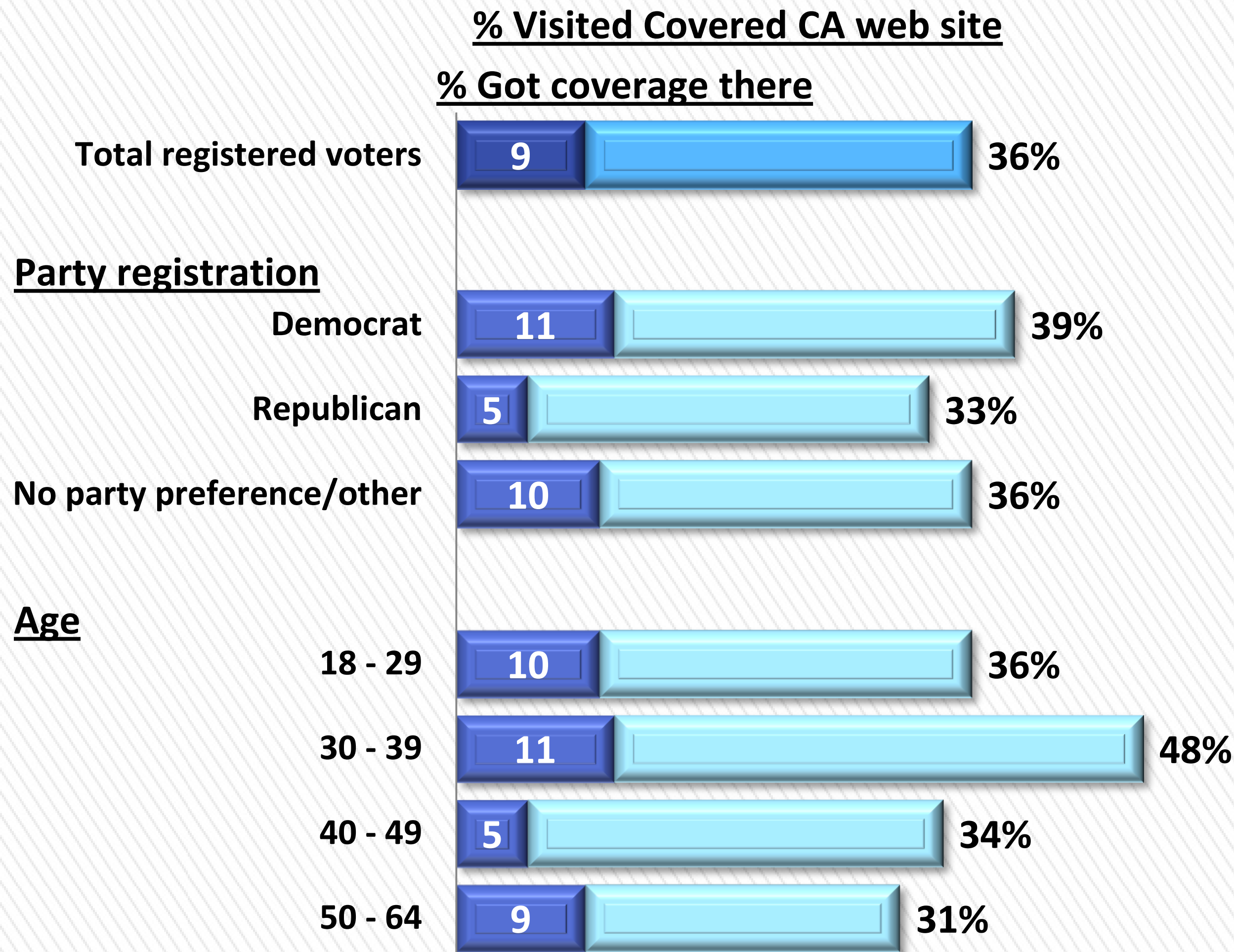
Graph 1

Voters reporting having visited the Covered California website and those who obtained their coverage there (among registered voters under age 65)



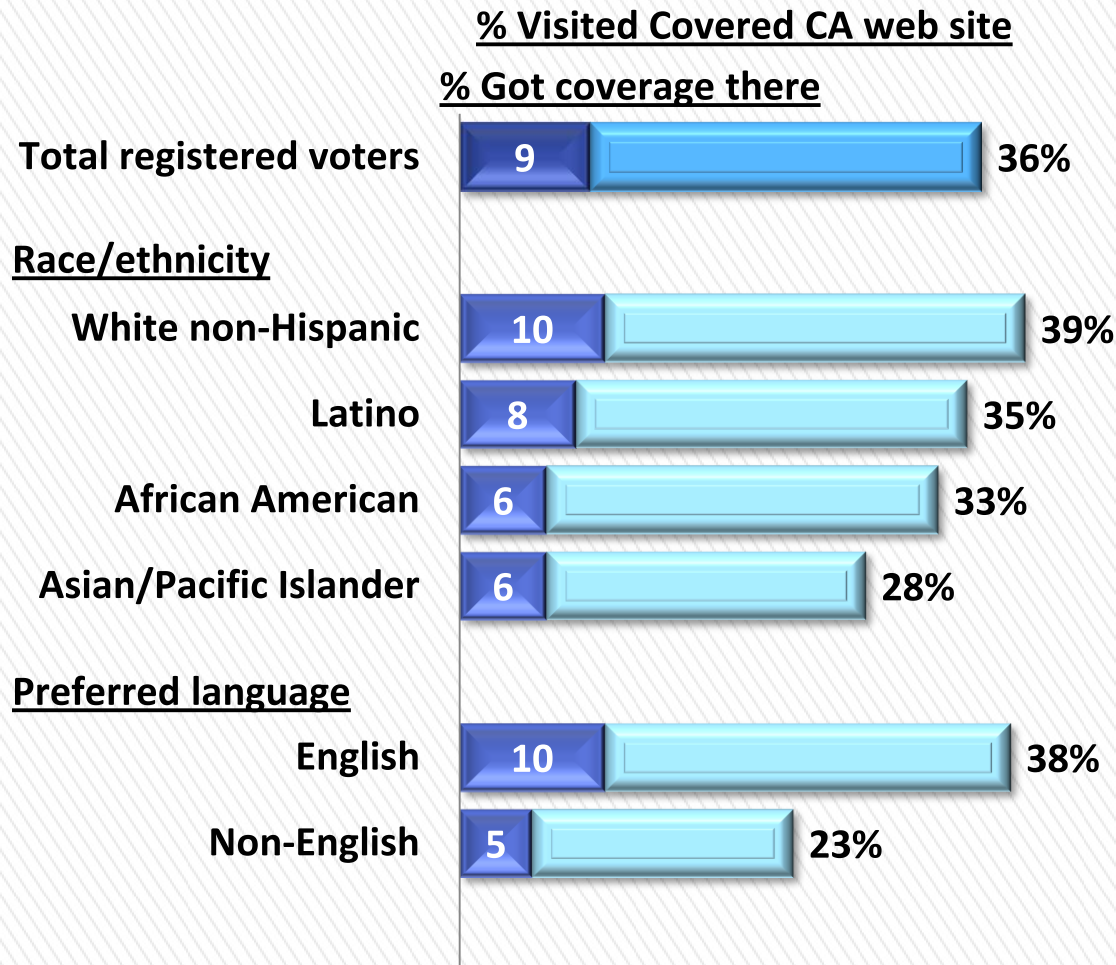
Graph 2a

Demographic characteristics of voters who visited the Covered California web site and the proportion who obtained insurance coverage there (among voters under age 65) *(1 of 3)*



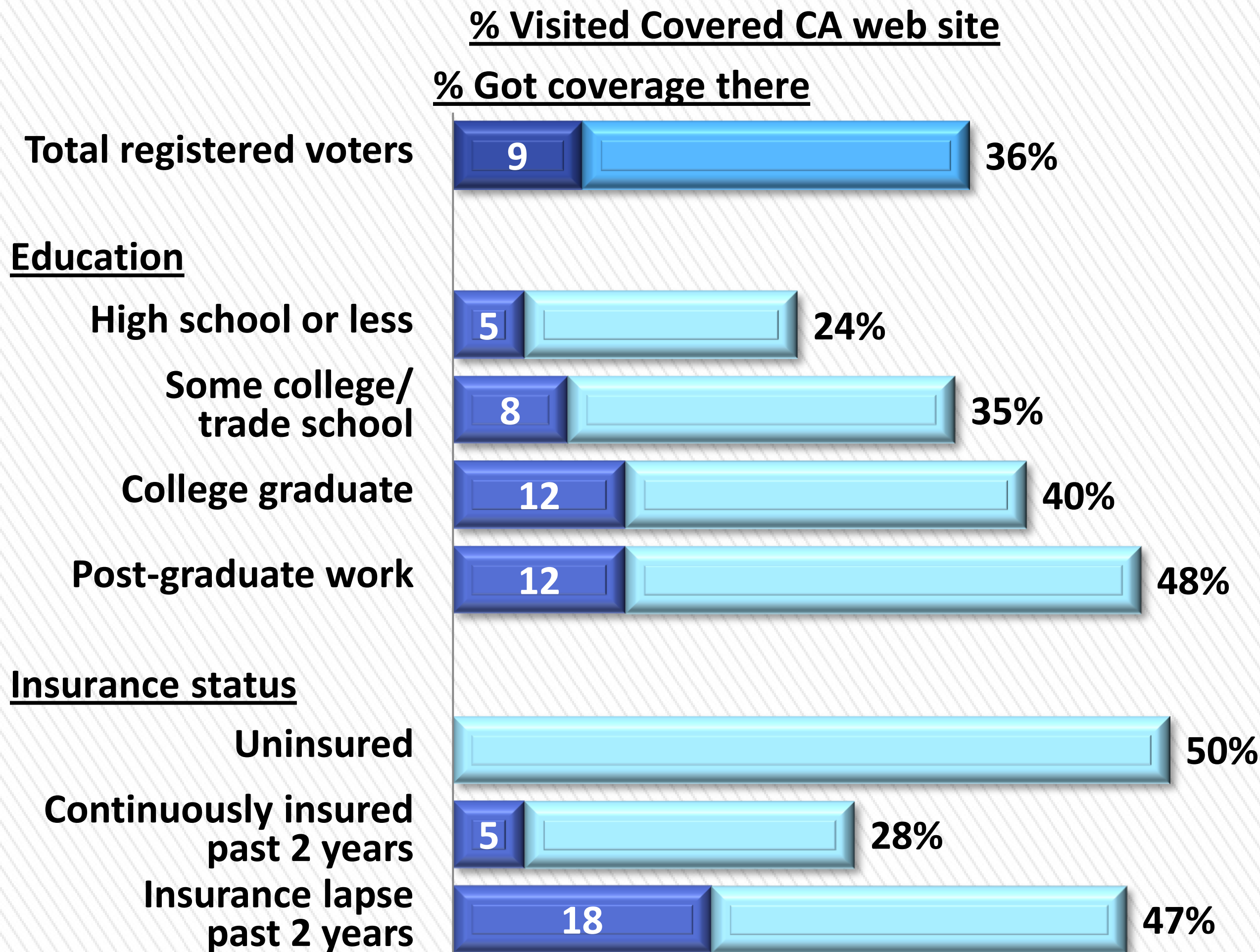
Graph 2b

Demographic characteristics of voters who visited the Covered California web site and the proportion who obtained insurance coverage there (among voters under age 65) *(2 of 3)*



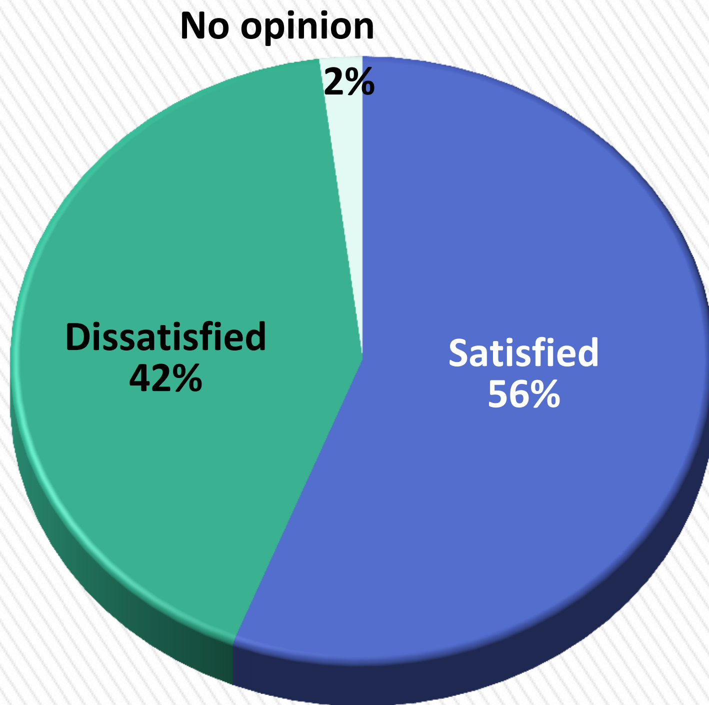
Graph 2c

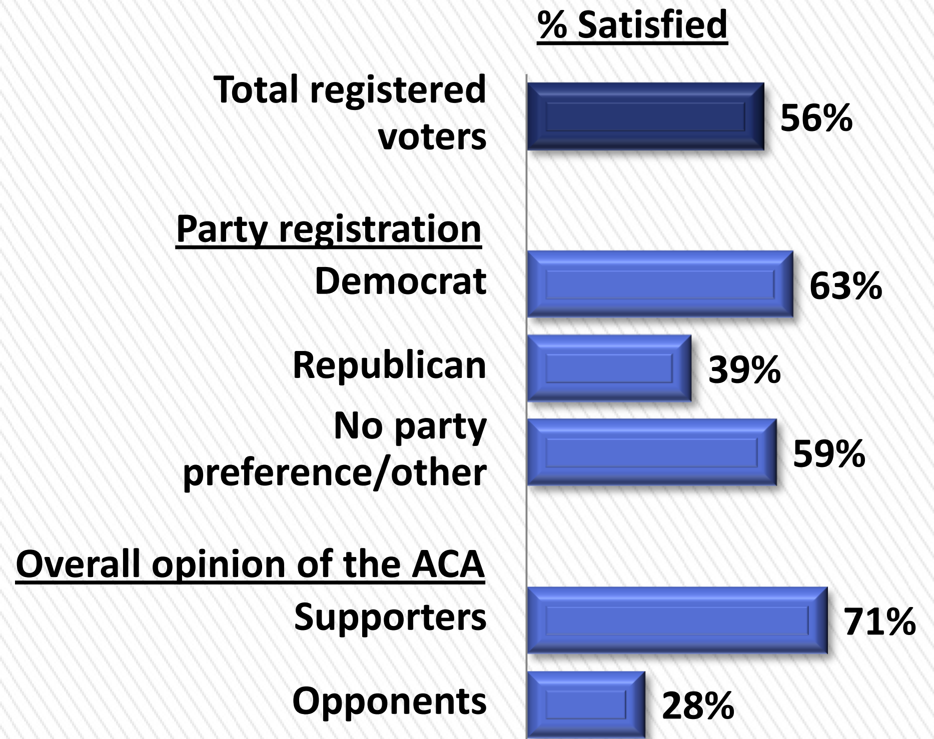
Demographic characteristics of voters who visited the Covered California web site and the proportion who obtained insurance coverage there (among voters under age 65) *(3 of 3)*



Graph 3

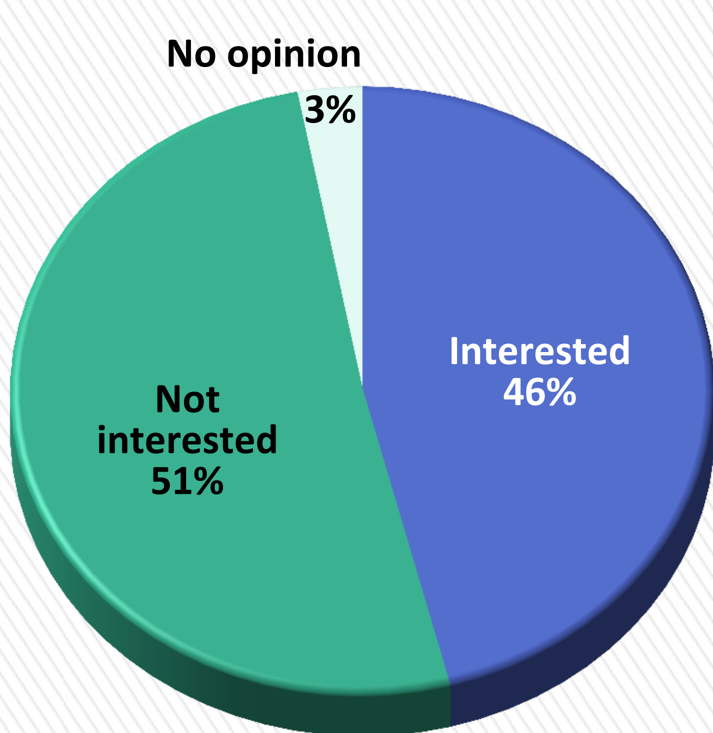
Satisfaction with the Covered California web site (among registered voters who visited the Covered California web site)

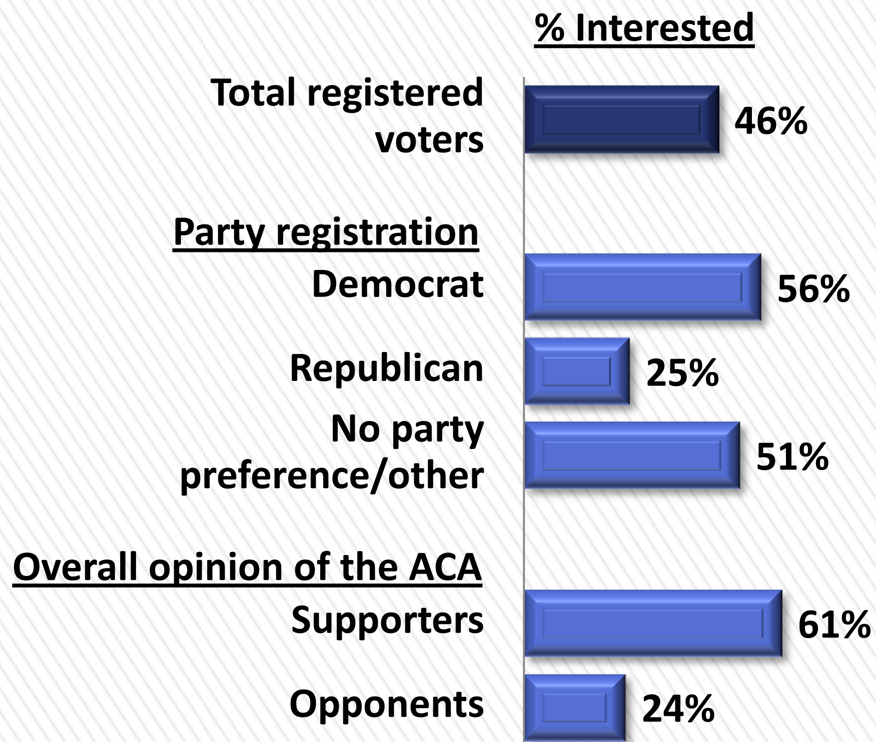




Graph 4

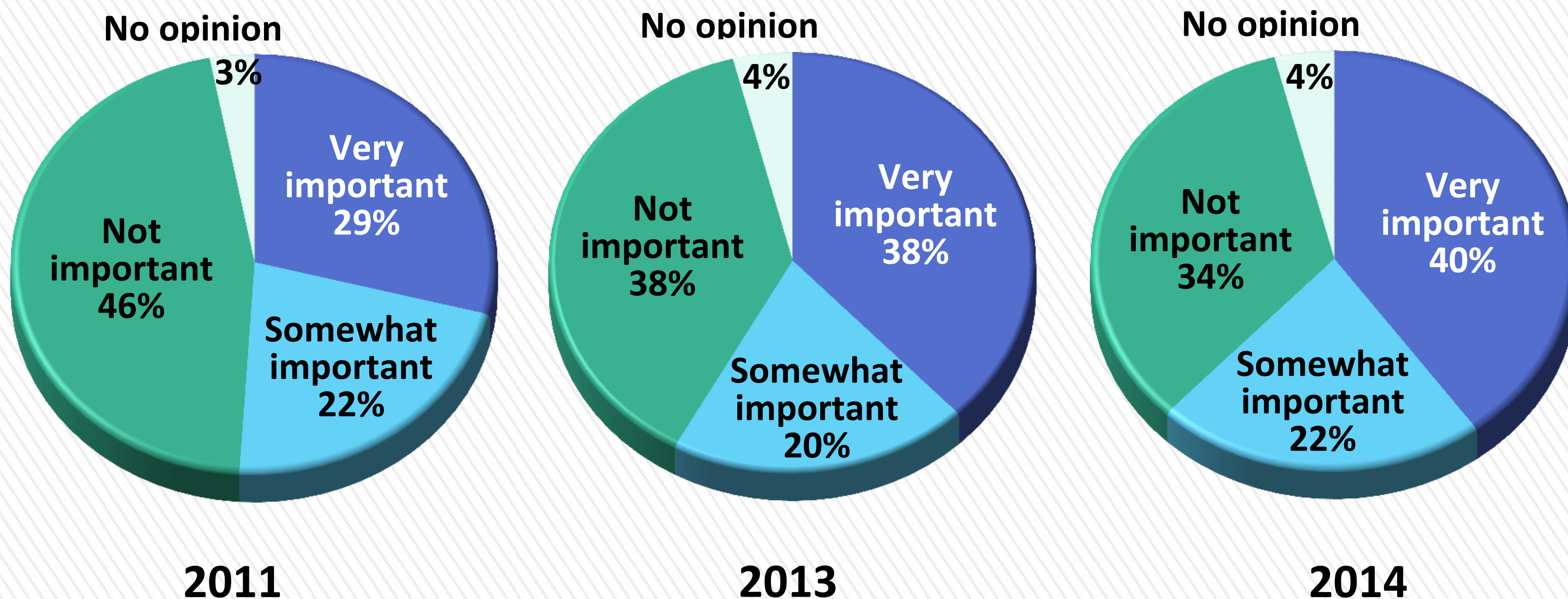
Voter interest in shopping for health insurance at the Covered California web site in the future (among registered voters under age 65)





Graph 5

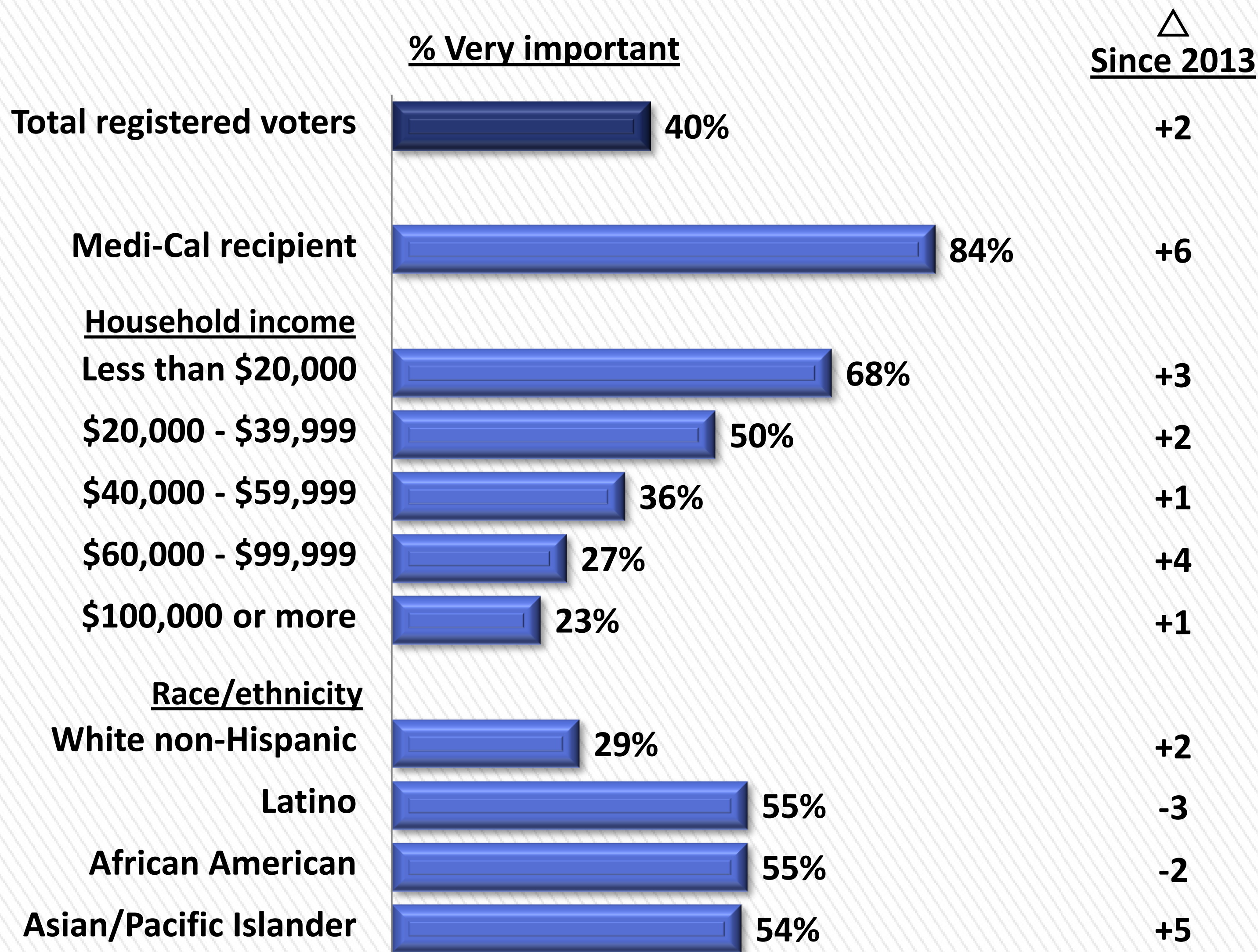
Importance of the state's Medi-Cal program to California voters and their families *(2011 – 2014)*



Note: Not asked in 2012 survey. In each survey Medi-Cal was described as California's health program that provides health insurance and long-term care to certain low-income adults and children.

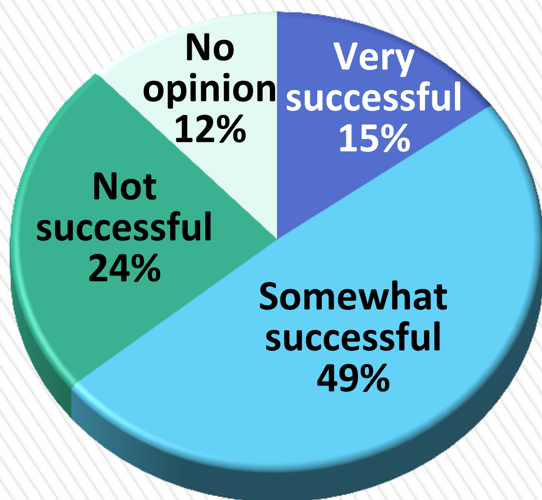
Graph 6

Importance of Medi-Cal among Medi-Cal recipients and by household income and race/ethnicity

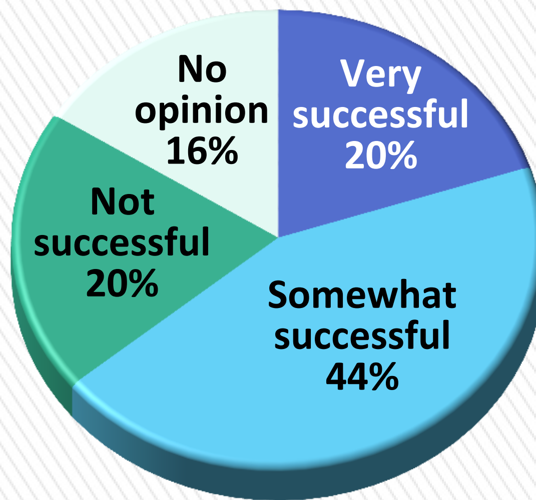


Graph 7

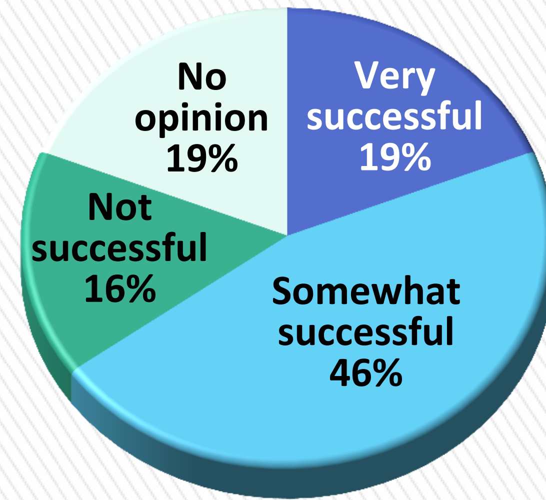
Perceived success of the Medi-Cal program in meeting its goals *(2011 – 2014)*



2011



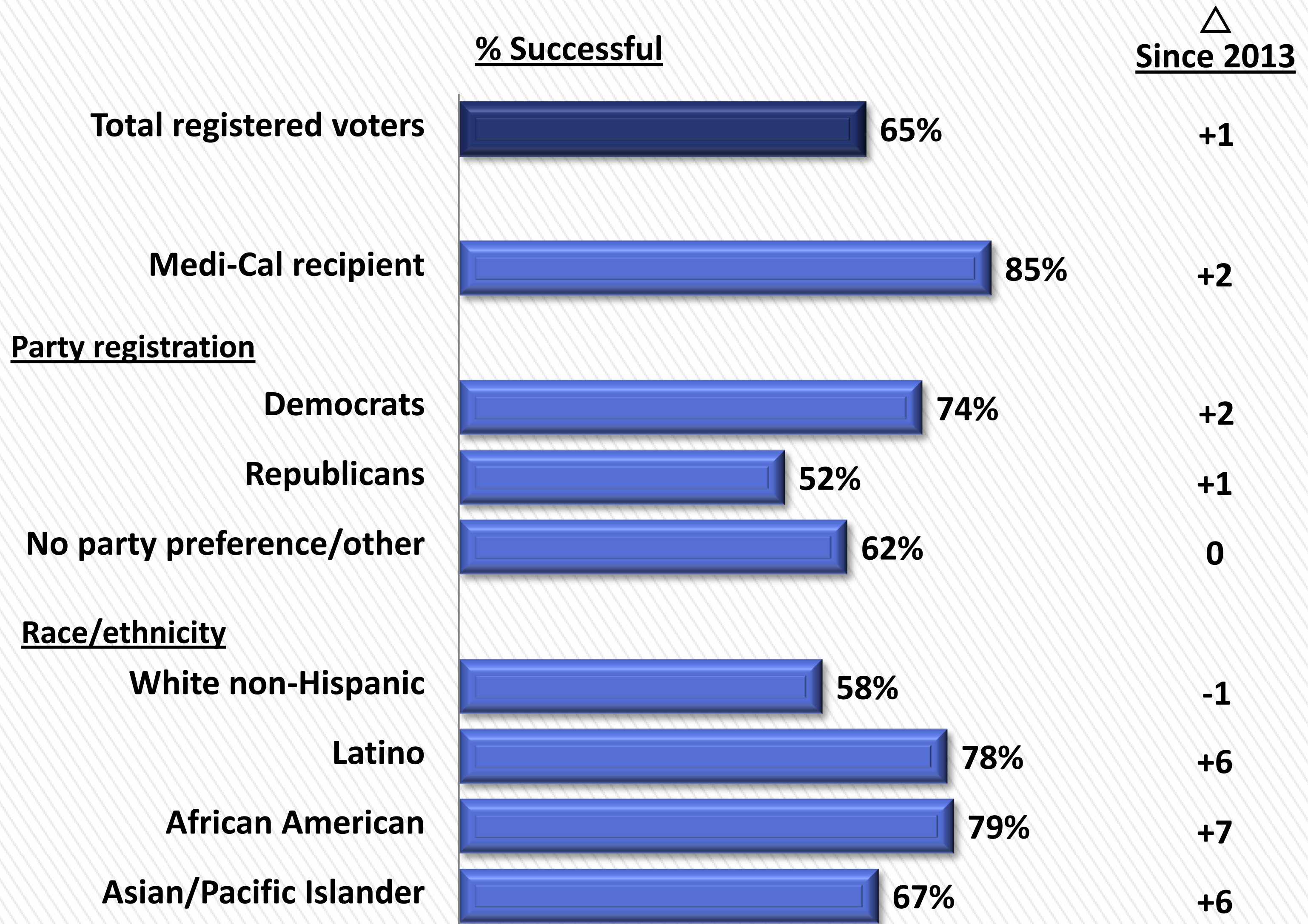
2013



2014

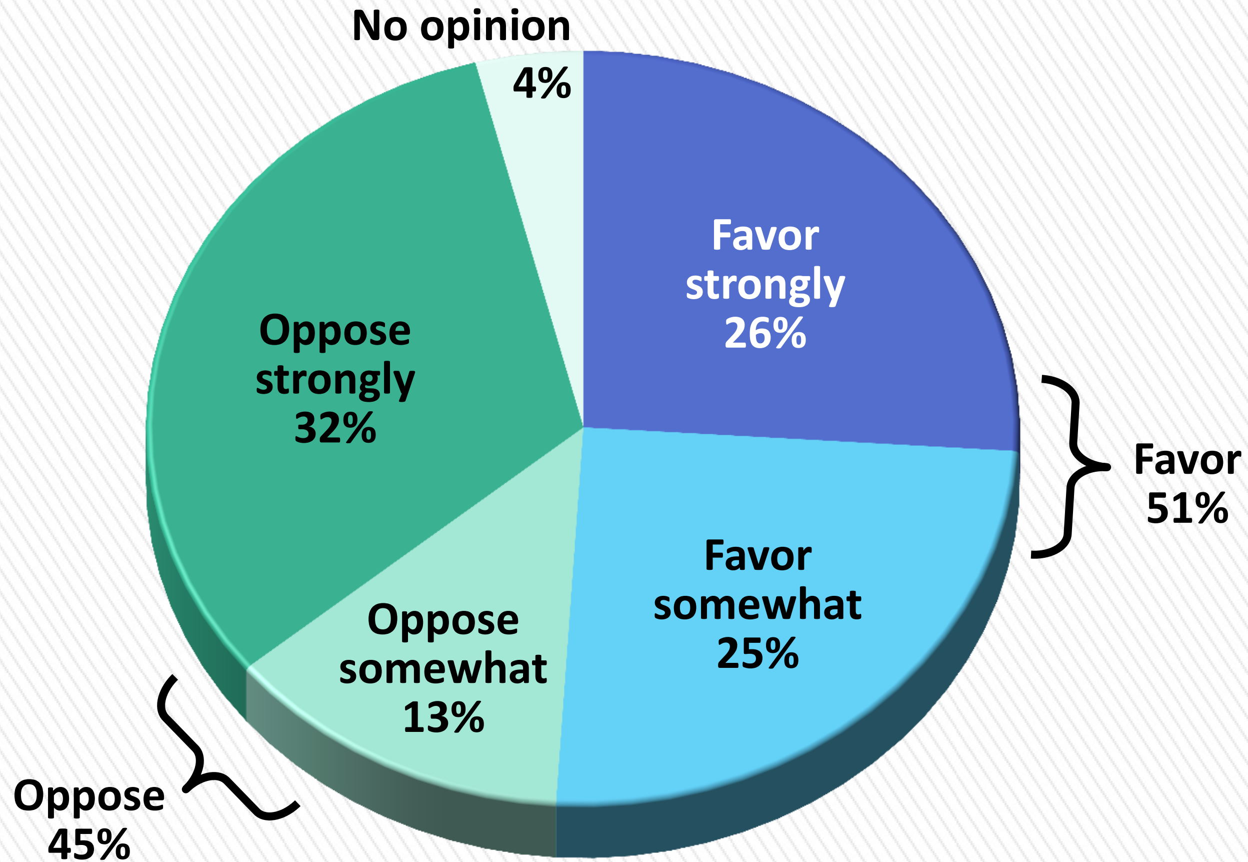
Graph 8

Perceived success of the Medi-Cal program among Medi-Cal recipients, by party registration and race/ethnicity



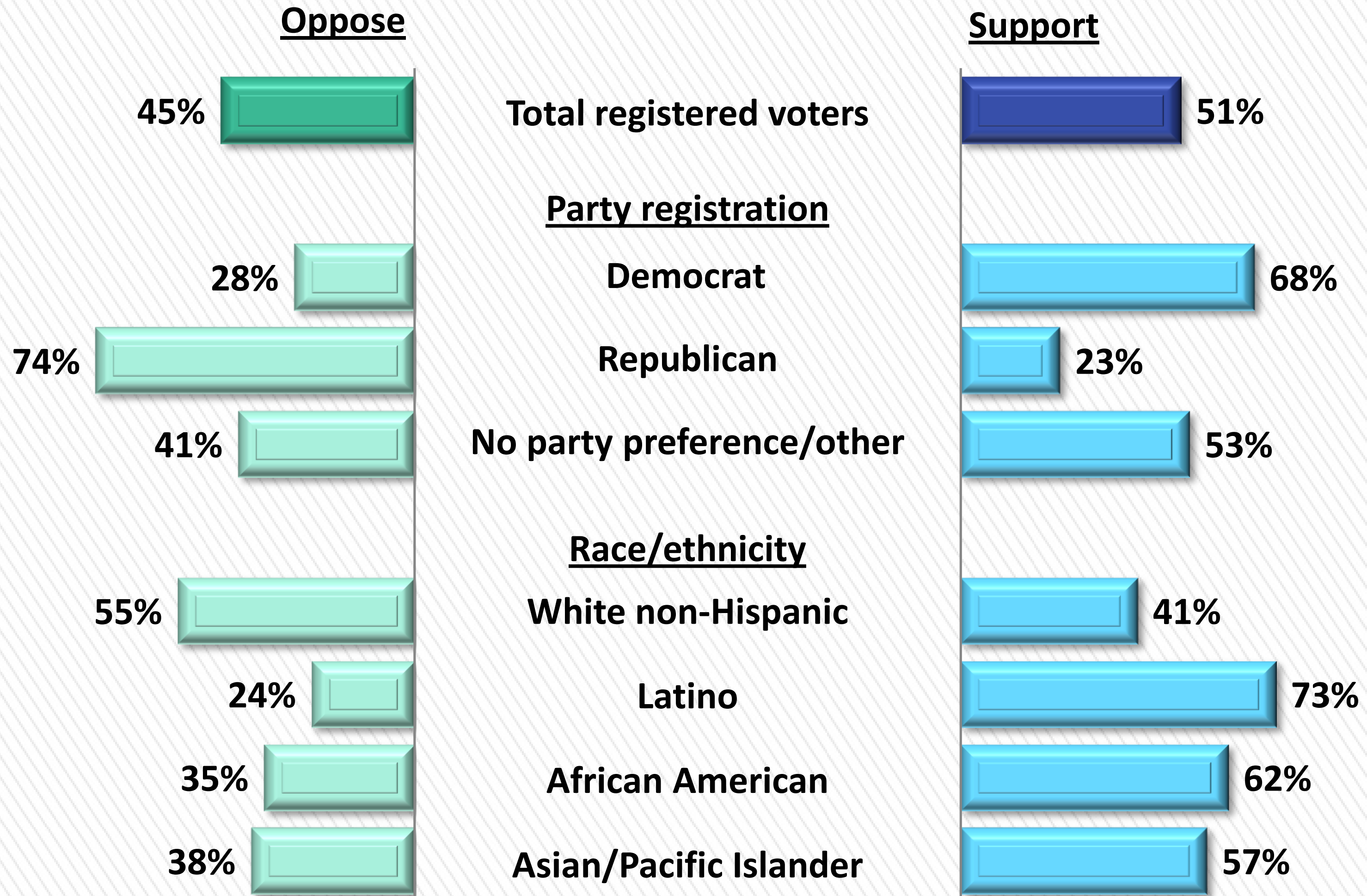
Graph 9

Voter opinion about expanding Medi-Cal preventive health services to the state's undocumented residents



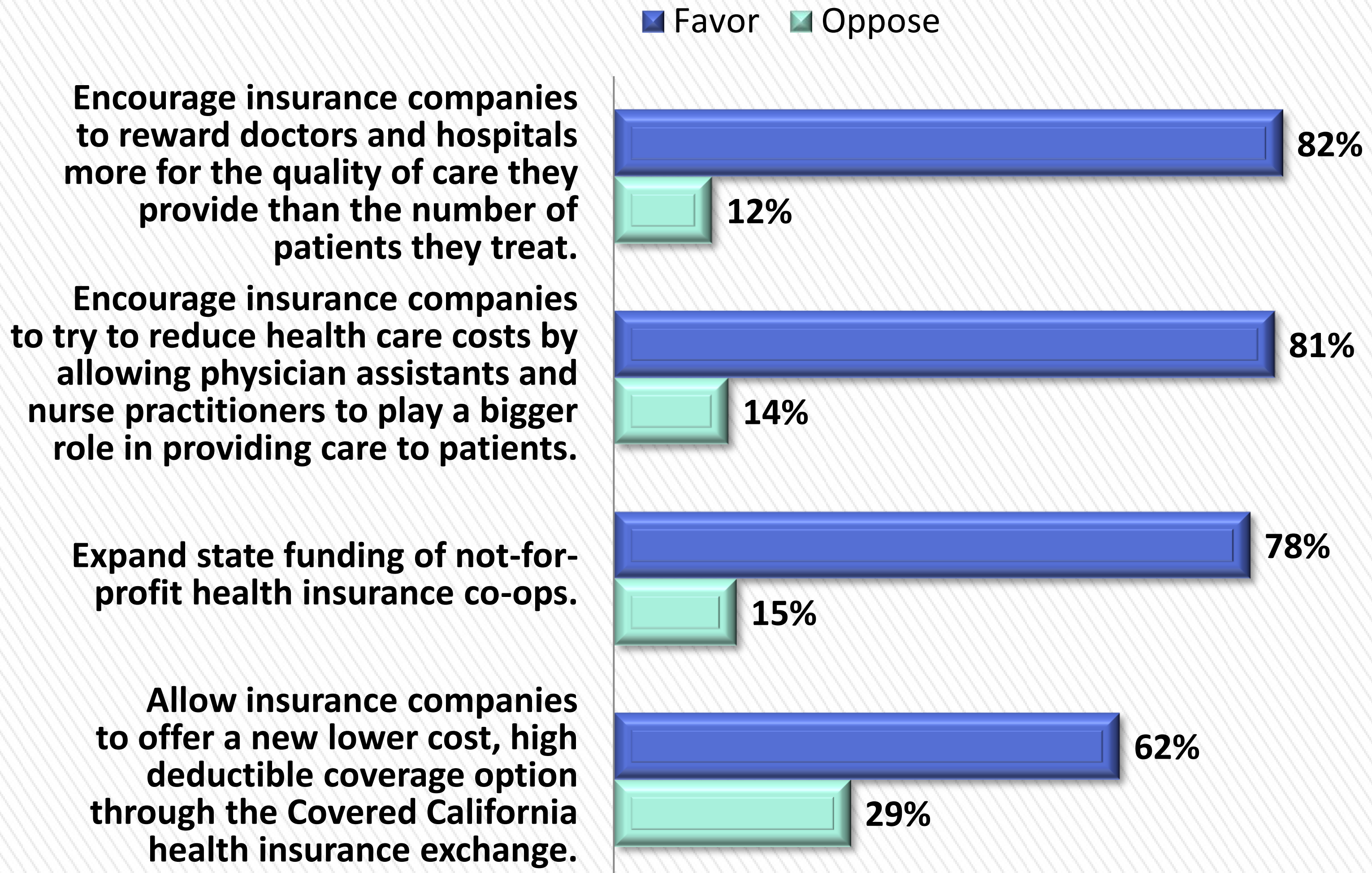
Graph 10

Opinions about expanding Medi-Cal to the state's undocumented residents by party registration and race/ethnicity



Graph 11

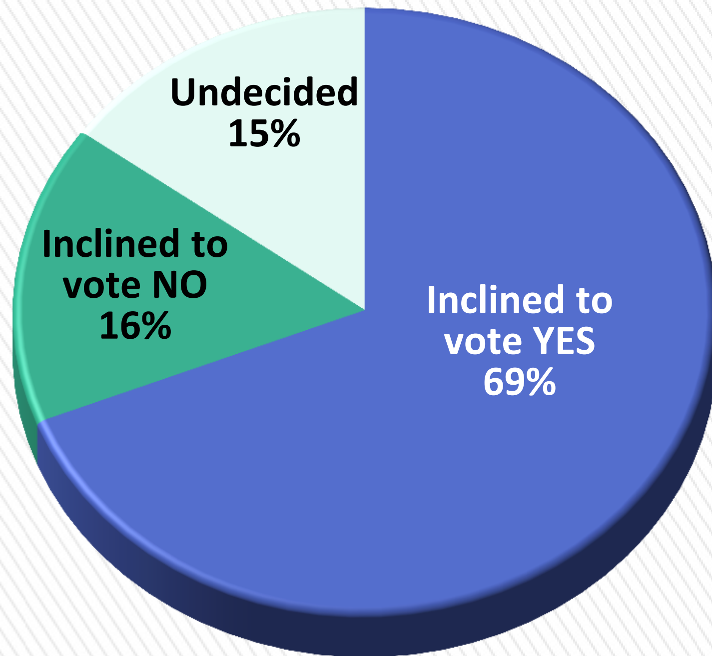
Voter views of proposals aimed at improving the state's health care system

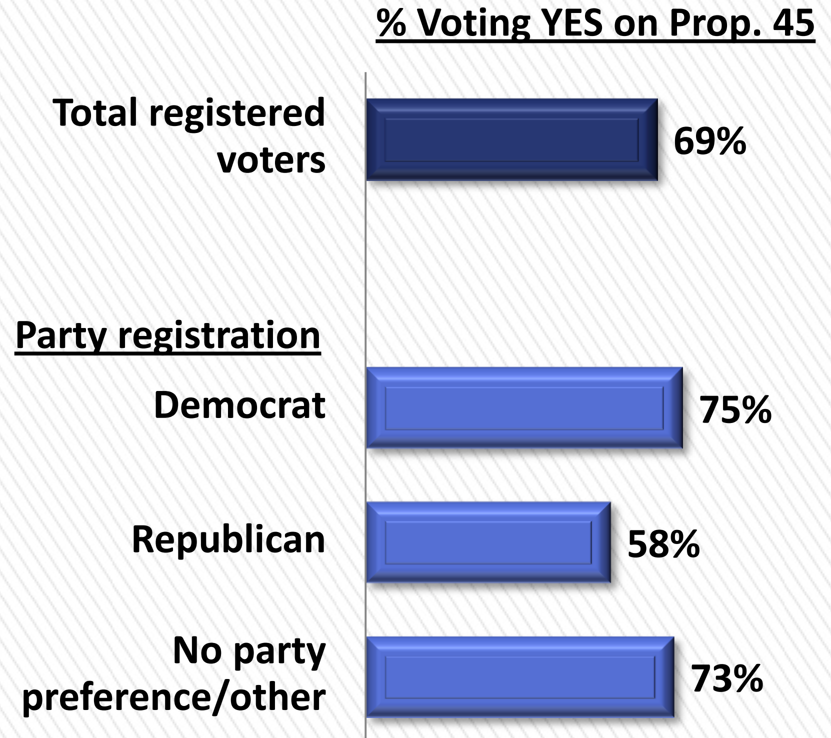


Note: Differences between 100% and the sum of each subgroup's percentages equal proportion with no opinion.

Graph 12

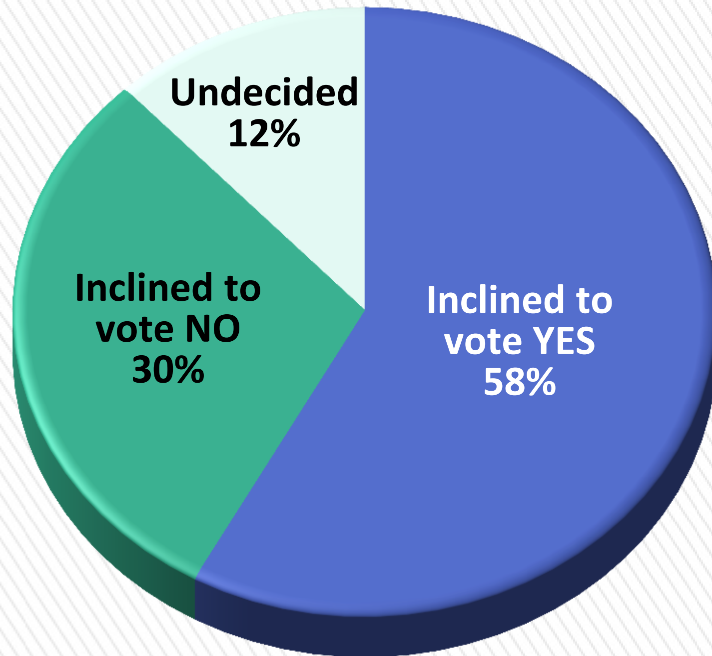
Early voter preferences regarding Proposition 45, the "Approval of Healthcare Insurance Rate Changes" statewide ballot initiative (among likely voters)

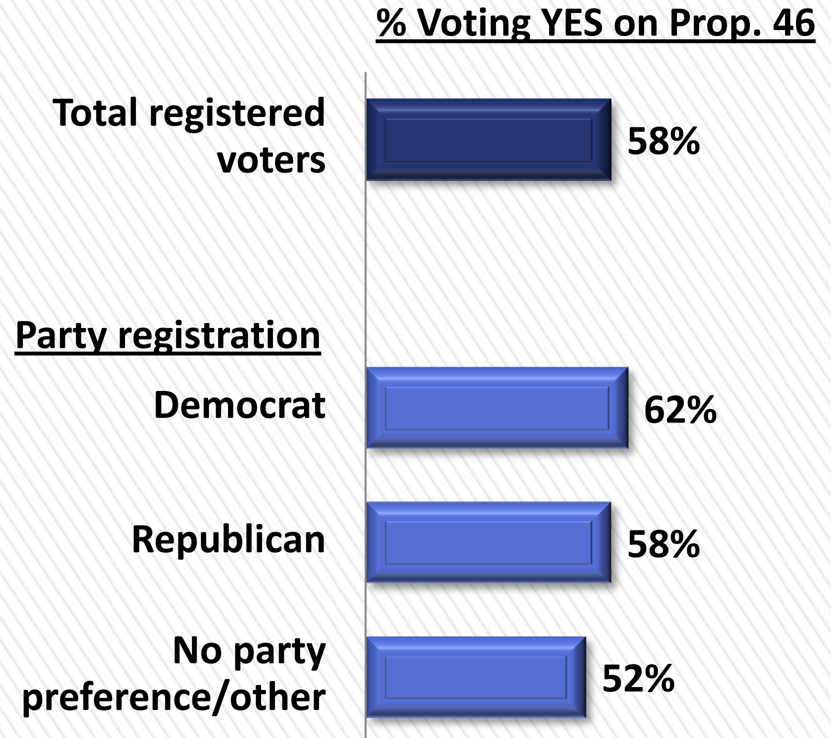




Graph 13

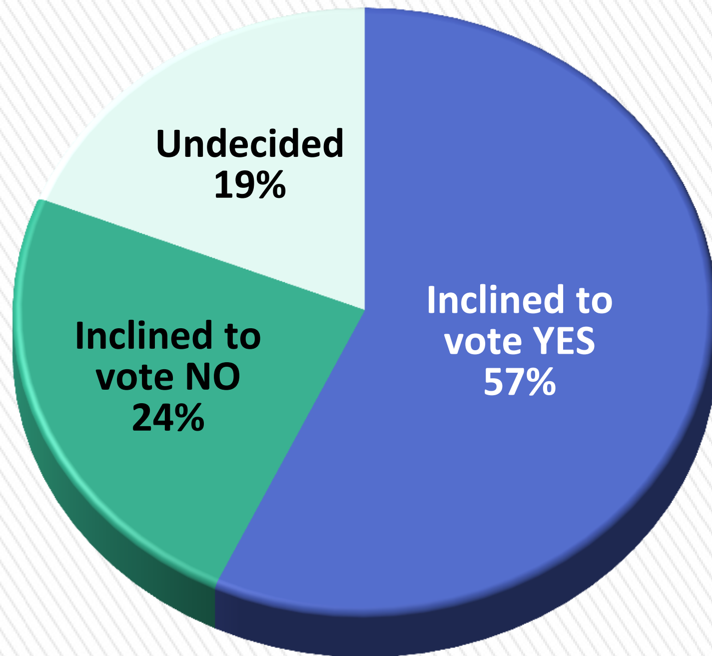
Early voter preferences regarding Proposition 46, the "Drug and Alcohol Testing of Doctors, Medical Negligence Lawsuits" statewide ballot initiative (among likely voters)

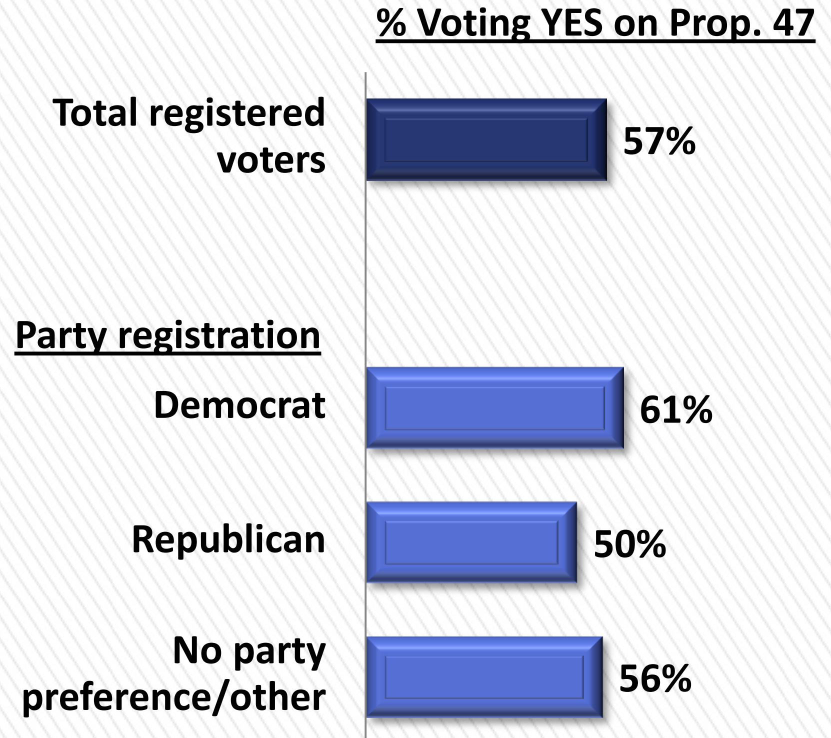




Graph 14

Early voter preferences regarding Proposition 47, the "Criminal Sentences/Misdemeanor Penalties" statewide ballot initiative (among likely voters)





Topline Findings
2014 TCWF-Field Health Policy Poll – Part 2
Voter Views of the Implementation of the Affordable Care Act in California and Recent Proposals Aimed at Improving the State's Health Care System

1. I am going to read some proposals that have been made to modify the health reform law in California, and please tell me whether you favor or oppose each one. (**ITEMS READ IN RANDOM ORDER, ASKING:**) Do you favor strongly, favor somewhat, oppose somewhat or oppose strongly this proposal?

	FAVOR STRONGLY	FAVOR SOMEWHAT	OPPOSE SOMEWHAT	OPPOSE STRONGLY	DON'T KNOW
( ) a. Expand the state's Medi-Cal health care program for low income residents to provide preventive health services to undocumented residents who are not eligible for coverage under the current health care law	26%	25	13	32	4
( ) b. Allow insurance companies to offer a new lower cost, high deductible coverage option through the Covered California health insurance exchange	27%	35	14	15	9
( ) c. Encourage insurance companies to change the way health plans are structured so they reward doctors and hospitals more for the quality of care they provide than the number of patients they treat or the number of services they prescribe	52%	30	6	6	6
( ) d. Expand state funding of not-for-profit health insurance co-ops, that can provide members with more health coverage choices often at lower prices than those offered by traditional insurance companies	44%	34	7	8	7
( ) e. Encourage insurance companies to try to reduce health care costs by allowing physician assistants and nurse practitioners to play a bigger role in providing care to patients	47%	34	6	8	5

2. How important for you and your family is Medi-Cal, California's health program that provides health insurance and long-term care to certain low-income adults and children? Is it very important for you and your family, somewhat important, not too important or not at all important?

VERY IMPORTANT	40%
SOMEWHAT IMPORTANT	22
NOT TOO IMPORTANT	12
NOT AT ALL IMPORTANT	22
NO OPINION	4

3. Overall, how successful do you think Medi-Cal has been in meeting its goals – very successful, somewhat successful, not too successful or not at all successful?

VERY SUCCESSFUL	19%
SOMEWHAT SUCCESSFUL	46
NOT TOO SUCCESSFUL	10
NOT AT ALL SUCCESSFUL	6
NO OPINION	19

(ASKED OF REGISTERED VOTERS UNDER AGE 65)

One part of the health reform law called for allowing each state to set up its own Health Insurance Exchange where individuals and small businesses could shop for health insurance from an online website. The health insurance web site that California set up for this purpose is called Covered California.

4. Since the Covered California web site became available to Californians in October of last year, have you personally visited the site to see what kinds of health insurance were being offered there?

Response	%
YES	36%
NO	63
NO OPINION	1

IF YES, ASK:

5. Overall, how would you rate your experience at the Covered California web site – very satisfied, somewhat satisfied, somewhat dissatisfied or very dissatisfied?

Response	%
VERY SATISFIED	18%
SOMEWHAT SATISFIED	38
SOMEWHAT DISSATISFIED	19
VERY DISSATISFIED	23
NO OPINION	2

6. Did you obtain your current health insurance coverage through the Covered California web site?

Response	%
VISITED COVERED CA (NET)	36%
YES	9
NO	25
NO OPINION	2

7. How interested would you be in shopping for health insurance at the Covered California web site (again) in the future – very interested, somewhat interested, not too interested or not at all interested?

Response	%
VERY INTERESTED	21%
SOMEWHAT INTERESTED	25
NOT TOO INTERESTED	15
NOT AT ALL INTERESTED	36
NO OPINION	2

(ASKED OF LIKELY VOTERS IN THE NOVEMBER 2014 STATEWIDE ELECTION)

8. Next, I am going to read some ballot propositions that are likely to appear on the statewide general election ballot in November. Please tell me if you would be inclined to vote YES or NO on each proposition if the election were being held today. (**READ ITEMS BELOW IN ORDER, ASKING:**) If the election were being held today, would you vote YES or NO on this initiative?

Item	YES	NO	DK
( ) a. Proposition 45 is called the “Approval of Healthcare Insurance Rate Changes’ initiative. It requires that health insurance rate changes be approved by the state Insurance Commissioner before taking effect and requires a sworn statement by health insurers to justify rate changes.	69%	16	15
( ) b. Proposition 46 is called the “Drug and Alcohol Testing of Doctors, Medical Negligence Lawsuits” initiative. It requires drug and alcohol testing of doctors and reporting of positive tests to the California Medical Board. It requires the Board to suspend a doctor pending investigation of positive tests and other possible disciplinary actions if the doctor was impaired while on duty. It requires health care practitioners to consult a state prescription drug history database before prescribing certain controlled substances and also increases the 250 thousand dollar cap on pain and suffering damages in medical negligence lawsuits to account for inflation.	58%	30	12
( ) c. Proposition 47 is called the “Criminal Sentences; Misdemeanor Penalties” initiative. It requires a misdemeanor sentence instead of a felony for petty theft, receiving stolen property, forging or writing bad checks of $950 or less, and for certain drug possession offenses. Allows felony sentences if offender has previous conviction of crimes such as rape, murder, child molestation or is a registered sex offender. It requires resentencing for persons serving felony sentences for these offenses unless a court finds unreasonable public safety risk and would apply cost savings to mental health, drug treatment, K-12 schools and crime victims.	57%	24	19

Improving the Road to Coverage: POLICY RECOMMENDATIONS FOR ENROLLMENT SUCCESS

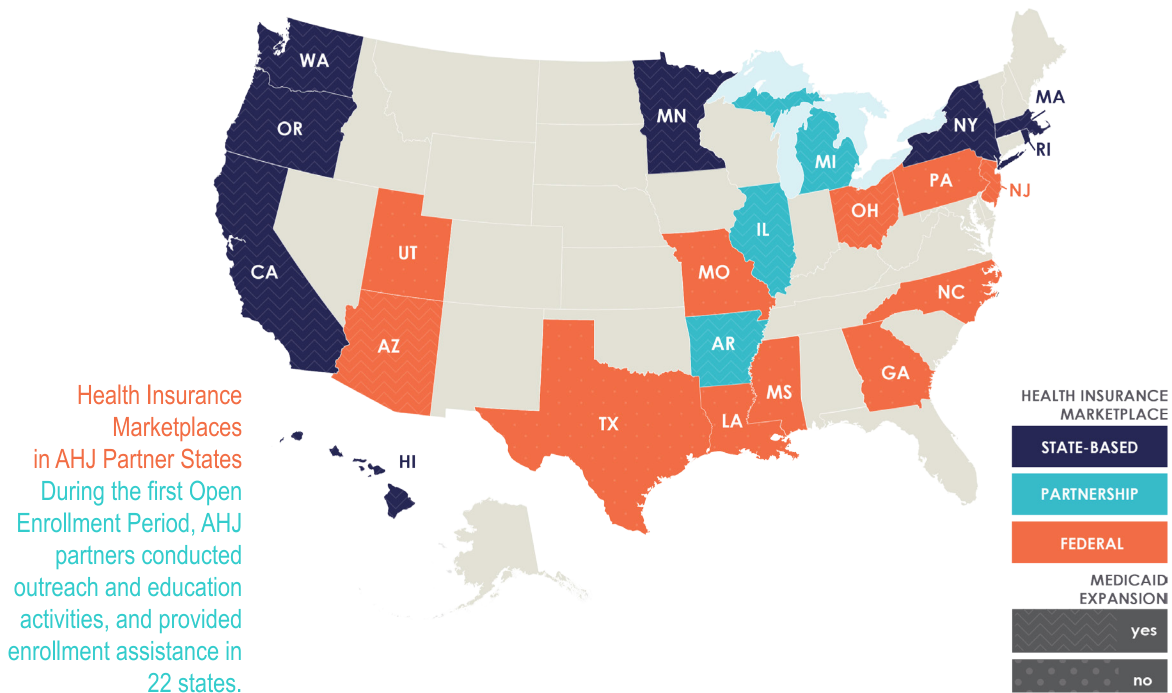
Asian & Pacific Islander American Health Forum
Association of Asian Pacific Community Health Organizations
Asian Americans Advancing Justice | AAJC
Asian Americans Advancing Justice | Los Angeles

Published: July 2014

Educate, Enroll, and Empower Asian Americans, Native Hawaiians, and Pacific Islanders

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) presents a historic opportunity to provide affordable, quality health insurance and coverage to millions of uninsured and underinsured Americans. Many organizations and collaboratives, including Action for Health Justice, have been actively involved in implementing the ACA across the country. This brief highlights some of the major barriers Asian American, Native Hawaiian, and Pacific Islander (AA and NHPI) communities faced during the first Open Enrollment Period, followed by recommendations to build upon and improve outreach, education, and enrollment efforts in the future.



Health Insurance Marketplaces in AHJ Partner States

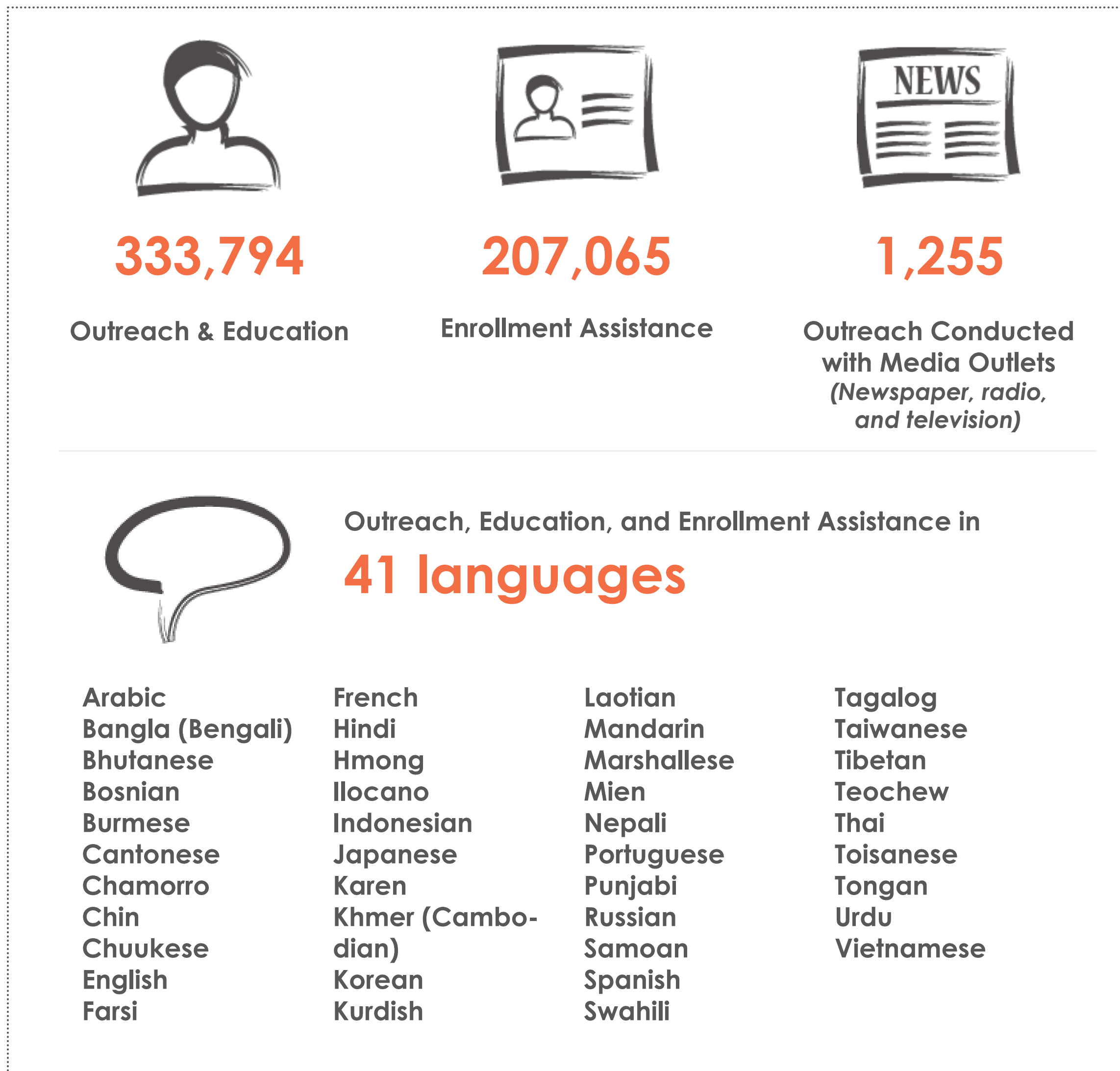
During the first Open Enrollment Period, AHJ partners conducted outreach and education activities, and provided enrollment assistance in 22 states.

ACTION FOR HEALTH JUSTICE

Action for Health Justice (AHJ) is a network of organizations established in July 2013 to reach and educate Asian Americans, Native Hawaiians, and Pacific Islanders (AAs and NHPIs) about their health insurance coverage options under the ACA, and to maximize enrollment in the Federally-facilitated Marketplace (FFM), state partnership marketplaces, state-based marketplaces, and Medicaid. AHJ focuses on hard-to-reach AA and NHPI communities, particularly individuals who are low-income, limited-English proficient (LEP), or in mixed immigration status families, as well as small business owners and employees and young adults. AHJ builds the capacity of local, state, and national organizations to serve, advocate for, and engage with AA and NHPI communities and improve their health.

AHJ consists of four national organizations (Asian & Pacific Islander American Health Forum, Association of Asian Pacific Community Health Organizations, Asian Americans Advancing Justice | AAJC, and Asian Americans Advancing Justice | Los Angeles), and more than 70 Asian American, Native Hawaiian and Pacific Islander national and local community-based organizations and Federally Qualified Health Centers dedicated to educating, empowering, and enrolling AAs and NHPIs in health coverage. ZeroDivide serves as the initiative’s technology counsel.

Impact of AHJ Partners in the First Open Enrollment Period



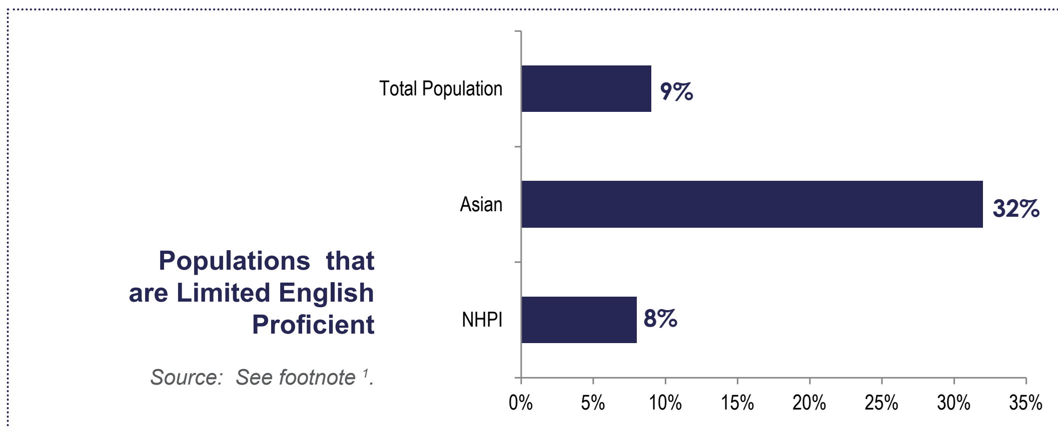
BARRIERS AND CHALLENGES TO ACCESSING AND PROVIDING INFORMATION AND ENROLLMENT SERVICES

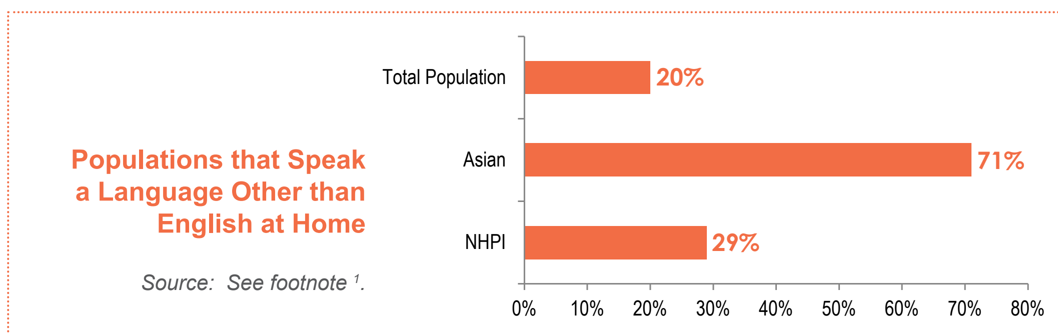
During the first Open Enrollment Period, AHJ identified major barriers that significantly hindered the enrollment of AA and NHPI consumers in the marketplaces. Systems put in place to assist and enroll consumers fell short of servicing consumers that had limited English language proficiency, low levels of health literacy, and immigration-related verification challenges. The demographic profile of AAs and NHPIs shows why providing language assistance services and culturally and linguistically appropriate materials should be a top priority for policymakers.

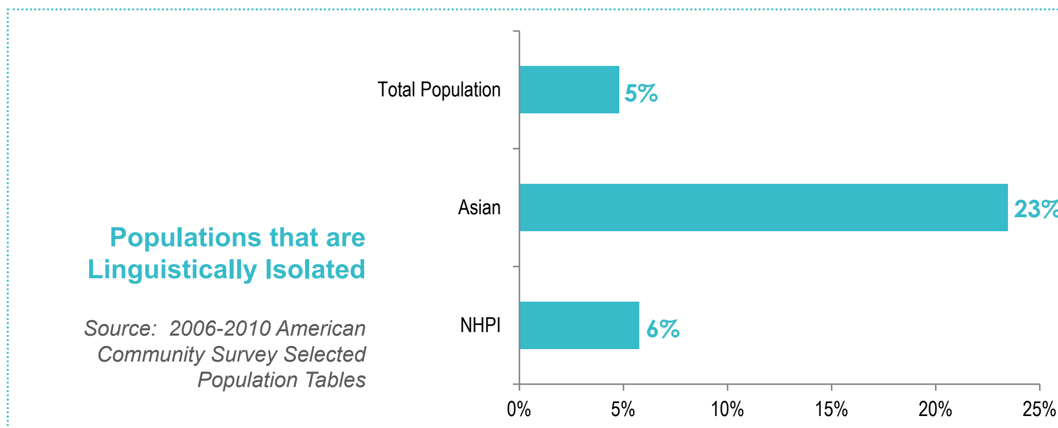
Sixty percent of Asian Americans and fourteen percent of Pacific Islanders are foreign-born, representing a range of immigration statuses.[1] Thirty-two percent of AAs are limited English

[1] Asian Americans Asian Americans Advancing Justice (formerly Asian American Center for Advancing Justice), A Community of Contrasts: Asian Americans in the United States: 2011, at 17, available at http://www.advancingjustice.org/sites/default/files/CoC%20National%202011.pdf.

proficient,[2] meaning they do not speak English as their primary language and have a limited ability to read, write, speak or understand English.[3] Twenty-nine percent of NHPIs speak a language other than English at home. Twenty-three percent of Asian American households are linguistically isolated, meaning all household members 14 years old and older speak English less than "very well."[4]







[2] Id. at 27. As used here in the context of Census data, "limited English proficient" describes a person who speaks English less than "very well." See U.S. Census Bureau, About Language Use (2013), https://www.census.gov/hhes/socdemo/language/about/index.html.

[3] U.S. Dep't of Health and Human Servs., Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47,311, at 47,313 (Aug. 8, 2003) [hereinafter HHS LEP Guidance].

[4] Asian Americans Advancing Justice, supra note 1, at 29.

Limited English Proficiency

State and federal agencies provided insufficient language assistance, including inadequate interpreting services by call centers and limited translated resources for LEP consumers. The lack of adequate language assistance led to increased consumer confusion and deterrence from enrolling in the marketplaces and/or Medicaid altogether. Translated materials were not easy to read, required a high level of literacy, and used literal and phonetic translations which made concepts more confusing for consumers. In most states, posters, fact sheets, websites, government presentations, and budgets for media engagement targeting English-speakers were not similarly provided for immigrant and LEP communities. Online application portals were not available in any Asian, Native Hawaiian, or Pacific Islander languages. This required community-based organizations and Federally Qualified Health Centers to fill in the gaps by translating and/or correcting existing marketplace materials and creating their own materials, often without financial support. In-person assisters also spent additional time helping LEP consumers because there were no translated applications, it was difficult to understand English applications, and consumers were discouraged from submitting paper applications (even in the handful of states where translated applications were available).

Low Health Literacy[5]

LEP consumers and immigrants needed tools to understand health insurance terminology. AHJ partners reported that LEP and immigrant consumers knew very little about key insurance concepts such as deductibles, premiums, and co-payments. They often returned to AHJ partners for additional assistance and expressed frustration at being unable to find culturally and linguistically accessible providers and the inability to access out-of-network specialty care services.

Immigration-Related Concerns

Concerns about the potential impact of enrollment on immigration status delayed and deterred enrollment for many immigrants. Lawfully present immigrants mistakenly believed that applying for coverage would have an adverse affect on their ability to adjust their immigration status in the future. This belief is understandable given the rise of the anti-immigration sentiment in some parts of the country and existing policies that make immigrant participation in some government-operated public programs (though not participation in the marketplaces or Medicaid) subject to a "public charge" determination. Mixed immigration status families, where at least one family member has a different immigration status from another family member, were particularly fearful and confused.[6] As a result,

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[5] The Institute of Medicine (IOM) defines health literacy as "the product of the interaction between individuals' capacities and the health literacy-related demands and complexities of the health care system. Specifically the ability to understand, evaluate, and use numbers is important to making informed health care choices." Inst. of Med., Health Literacy and Numeracy: Workshop Summary, at 1 (The Nat'l Academies Press 2014), available at http://www.nap.edu/openbook.php?record_id=18660&page=1.

[6] There are about 1 million undocumented immigrants from Asia residing in the United States. Asian Americans Advancing Justice, supra note 1, at 22.

undocumented head-of-households often did not apply for coverage for other eligible immigrant or U.S. citizen family members due to fear of deportation.[7]

When eligible immigrants applied for marketplace coverage, they encountered multiple hurdles throughout the enrollment process including difficulties with identity proofing, verification of immigration and citizenship status, and calculating income and household size. As a result, many immigrant consumers were not able to complete the enrollment process or have been stuck in limbo for months waiting for their cases to be resolved.

Lack of Disaggregated Data

Without adequate collection and reporting of disaggregated race, ethnicity, and primary oral and written language data for the extraordinarily diverse AA and NHPI population, it will be extremely difficult to develop targeted efforts to address gaps in outreach, education, and enrollment efforts. Clear data is needed to track the effectiveness of outreach, education, enrollment, and utilization activities of hard-to-reach groups. For example, preliminary disaggregated data from the Covered California marketplace confirmed that some sub-groups within AA and NHPI communities such as Cambodians, Hmong, and Pacific Islanders are underrepresented within the marketplace's enrollee population.

[7] A memo was issued by the U.S. Office of Immigration and Customs Enforcement clarifying that the information from the application would not be shared and no immigration proceedings would be triggered when applying for health coverage through the Marketplace. However, the clarification information did not reach many mixed status families due to lack of in-language outreach.   Even those who were aware of this memo continued to be fearful of deportation and many chose not to apply for coverage through the marketplaces. U.S. Immigration and Customs Enforcement, Clarification of Existing Practices Related to Certain Health Care Information (Oct. 25, 2013), available at http://www.ice.gov/doclib/ero-outreach/pdf/ice-aca-memo.pdf.

RECOMMENDATIONS

Based on the experiences of community partners across the country, AHJ proposes several recommendations to address the barriers and challenges that AAs and NHPIs faced and improve the enrollment process going forward.

Improve Training for Call Center Operators, Interpreters, Navigators, and Other Enrollment Assisters to Better Serve LEP Consumers and Immigrants

Individuals who provide outreach, education, or enrollment assistance services need additional training to understand the needs of LEP consumers and immigrants.

- Call center operators should undergo cultural and linguistic competency training. This includes training on the following: (1) identifying the language needs of LEP callers; (2) treating LEP callers with dignity and respect; and (3) connecting with and working with third party telephonic interpreters. Many LEP consumers and their assisters experienced problems and delays when trying to access interpreting services through the federal and state call centers.

- Call center operators should be trained to have a thorough understanding of the following topics: (1) immigrant eligibility rules for health plans in the marketplaces and Medicaid; (2) required immigrant documentation for enrollment; and (3) verification processes and workarounds to complete enrollment. Alternatively, call centers should hire technical assistance advisors who can help operators on these matters.

- Third party interpreters who provide their services through the call centers should receive training on basic information about the marketplaces, health insurance terminology, and other commonly encountered topics so they can accurately interpret the context and content of the information to consumers. Consumers often received incorrect interpretations and varying quality of service from interpreters.

- Trainings for Navigators, Certified Application Counselors, and other officially designated marketplace assisters for consumers (collectively, "Assisters") should include information on cultural and linguistic competency issues, including how to work with LEP consumers.[8] Assisters should be required to work together within a state or region to connect consumers with in-person assistance in their preferred language. The marketplaces should facilitate these collaborations and information sharing by creating in-language locator tools that list the language capacity of all Assister entities. Assisters should also receive training to help them understand the intricacies of verifying immigration status, identity, and income for immigrants.

IMPROVE TRAINING

- Train call center operators to better assist LEP consumers and immigrants.
- Train interpreters to better understand marketplace concepts.

[8] These recommendations supplement existing requirements for Navigators to "[r]eceive ongoing education and training in culturally and linguistically appropriate service delivery." 45 C.F.R. § 155.215(c)(5).

Create More Useful Translated Resources and In-Language Tools

Assisters working with LEP populations need adequate in-language educational and enrollment materials to help consumers learn about coverage options and enroll. Materials should explain concepts in plain language,[9] at the appropriate literacy level, be accurately translated, and avoid literal and phonetic translations.

- The Centers for Medicare & Medicaid Services (CMS) and state-based marketplace administrators should create readable and accurate in-language educational and enrollment materials for publication on federal and state marketplace websites, preferably at a fifth grade level of education, using visual aids such as videos and alternatives to written materials. CMS and state administrators should also work with community partners to review materials for accuracy and readability.

- CMS and state administrators should translate marketplace websites, online applications, and paper applications to allow LEP consumers to enroll either online or by mail.

- Consumers should be permitted to upload completed paper applications through the websites for submission instead of requiring applications to be mailed in.

TRANSLATE RESOURCES

- Make in-language materials more accurate and understandable for consumers.
- Translate websites, online applications, and paper applications into multiple languages.

Make Call Centers More Accessible to LEP Consumers and Assisters

Federal and state call center functions and features should be changed to improve effectiveness and efficiency for LEP consumers.

- Call centers should offer prompts in multiple languages and allow for automatic transfer to the appropriate language. For example, when a consumer contacts a call center, there could be in-language messages, such as "For Korean, press 1" which would directly connect callers to a Korean bilingual representative or signal an operator to connect with a Korean interpreter. This will save time and resources both for consumers and the call center. For the Federally-facilitated Marketplace, these prompts could be in the 12 most widely spoken languages of the uninsured across the country. For State-based marketplaces, the prompts can be offered in the Medicaid identified languages or at least the five most widely spoken languages of the uninsured in that state.

[9] Already, CMS requires the marketplaces to provide information to applicants and enrollees in plain language. 45 C.F.R. § 155.205(c) (2013) ("Information must be provided to applicants and enrollees in plain language and in a manner that is accessible and timely . . . ."); cf. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, § 1311(e)(3)(B) (2010) (requiring Qualified Health Plans to make information available in plain language to the public and defining plain language as "language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing").

- Call centers should hire and train more bilingual staff who can speak directly with callers and utilize dedicated language lines. Bilingual language ability should be made a priority for hiring purposes, especially for the most common languages in each marketplace.

- Call centers should implement a "tiered structure" where certain call center representatives receive additional, more complex training on certain issues. If representatives are unable to answer questions from consumers, they can refer them to these issue specialists, who will have more training on complex topics such as immigrant eligibility.

- CMS should also include a dedicated service line for Assisters to answer questions without requiring them to go through the regular federal call center. For example, California and New York created dedicated Assister lines which helped dissipate call center volume and wait times for Assisters and subsequently for consumers as well.

IMPROVE CALL CENTER SERVICES

- Offer prompts in multiple languages.
- Hire bilingual staff and issue specialists.

Create Additional Funding Opportunities to Support In-Person Assistance

Assisters who provide in-person education and enrollment services need adequate funding to account for the additional time needed to help LEP and immigrant consumers. During the first Open Enrollment Period, consumers needed several visits of one to two hours per visit (or sometimes longer) with Assisters to learn about insurance, explain the application process, explain required documentation and personal information requests, guide them through the enrollment process, and select a health plan. Moreover, many Assisters in both federal and state marketplaces (other than Navigators) did not receive any public funding during the first Open Enrollment Period despite conducting vigorous outreach, education, and enrollment services.

- State and federal governments should allocate and increase funding and resources for in-person assistance entities. Many immigrants and LEP consumers preferred using face-to-face services from trusted organizations to learn about their options.

IMPROVE FUNDING OPPORTUNITIES FOR IN-PERSON ASSISTANCE

- Prioritize funding for community organizations that have experience working with LEP, immigrant, and hard-to-reach populations.

- State and federal governments should prioritize funding opportunities for small community-based organizations that have experience working with hard-to-reach and underrepresented populations and can provide culturally and linguistically appropriate services. Assisters must be adequately compensated and need sufficient funding to help them in these efforts.[10]

Improve the Enrollment Experience for Immigrants

Many immigrants had difficulties enrolling in marketplace coverage or were unable to enroll because of complicated, inefficient, and unclear policies and procedures that uniquely affected eligible immigrants.

- CMS should continue to work with the U.S. Department of Homeland Security (DHS) to issue clarifying guidance to address enrollment fears and assure eligible immigrants and their families that it is safe to apply for marketplace coverage. U.S. Immigration and Customs Enforcement provided this type of assurance in a memo issued on October 25, 2013, reinforcing existing federal policy regarding the use of personal information.[11] DHS should provide similar assurances and public education campaigns to address public charge fears and other information to clarify uncertainties and confusion about the potential immigration consequences of receiving health coverage from the marketplaces or Medicaid.

- CMS and state agencies overseeing state-based marketplaces should engage trusted sources, such as immigrant-serving Assisters and community organizations, to conduct a review of marketplace websites and associated technical issues related to the enrollment process. Website fixes should be in place well before November 15, 2014 to ensure a smooth enrollment process for immigrants.

- CMS should relax the identity proofing requirements to allow persons without established credit histories to proceed with online applications. While we commend CMS for expanding the list of acceptable documents, the process for providing proof of identity is flawed and must be improved for immigrant consumers. If using a credit agency to verify identify, CMS and states should require the credit agency to provide adequate in-language assistance.

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[10] At the time of publication, the Office of Minority Health issued a grant opportunity of $2.7 million for community organizations to "assist and educate minority populations about [Marketplace] and coverage opportunities made possible by the Affordable Care Act." Office of Minority Health, U.S. Dep't of Health and Human Servs., 2014 Grants: Partnerships to Increase Coverage in Communities Initiative, http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=1#sthash.4RMBhV6L.dpuf (last accessed June 17, 2014). Additionally, on June 10, 2014, HHS announced a funding opportunity totaling $60 million for Navigators in the federally-facilitated and state partnership marketplace with an anticipated award date of September 8, 2014. Press Release, Centers for Medicare & Medicaid Servs., CMS Announces Opportunity to Apply for Navigator Grants in Federally-facilitated and State Partnership Marketplaces, (June 10, 2014), http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-06-10.html. In comparison to Navigator grants issued for the 2013 to 2014 period, HHS indicated this new grant will place a larger emphasis on community organizations that are connected to targeted populations..

[11] U.S. Immigration and Customs Enforcement, Clarification of Existing Practices Related to Certain Health Care Information (Oct. 25, 2013), available at http://www.ice.gov/doclib/ero-outreach/pdf/ice-aca-memo.pdf.

- CMS should create a tracking system that allows consumers and Assisters to easily track the status of pending applications and verification checks. This system should also allow consumers and Assisters to submit summaries of applicants' situations to ensure critical information and application histories are accurately conveyed to call center operators and CMS case workers.

IMPROVE THE ENROLLMENT EXPERIENCE FOR IMMIGRANTS

- Ensure identity and immigration status processes on marketplace websites are functional by November 15, 2014.
- Relax identity proofing requirements.
- Create accessible tracking system for pending applications.

Monitor and Enforce Nondiscrimination Laws

The marketplaces must comply with several nondiscrimination laws and standards including Title VI of the Civil Rights Act of 1964, Executive Order 13166, and Section 1557 of the ACA.[12] The Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) is charged with monitoring and enforcing these laws to ensure that LEP consumers are not excluded from participation in the benefits of the ACA and have meaningful access to the marketplaces and Medicaid.

- OCR, in conjunction with CMS, should monitor how federal and state marketplaces, Navigators and Assisters are providing public education, outreach activities, and enrollment services that are culturally and linguistically targeted at LEP groups.

- Based on the systemic issues identified in this brief and information HHS has gleaned from meetings with community advocates, OCR should initiate a compliance review of the marketplaces, particularly in states where there are suspected violations. For example, by examining uninsured and enrollment data, precipitous drops in enrollment or sustained uninsured rates of consumers from certain racial, ethnic, or langauge groups in a service area may indicate that there are barriers to enrollment that OCR should investigate. Where language access plans do not already exist, OCR should work with entities overseeing the marketplaces to develop them. If violations are identified, OCR should provide technical assistance to these entities on developing compliance measures to address cultural and linguistic barriers faced by consumers.[13]

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[12] Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin, which includes immigration status and language proficiency. Executive Order 13166 further clarifies that recipients of federal funding, which here includes the marketplaces and their affiliated services, to ensure meaningful access for LEP individuals to federally funded programs and activities. Section 1557 of the ACA applies Title VI and other nondiscrimination laws to the Marketplace and programs established by the ACA.

[13] See Office for Civil Rights, U.S. Dep't of Health & Human Servs., Case Resolution Manual for Civil Rights Investigations 80 (2009), http://www.hhs.gov/ocr/civilrights/complaints/crm2009.pdf (explaining OCR's authority to conduct compliance reviews and their objectives).

- HHS should clarify its standards for language assistance services related to consumer access to the marketplaces and Medicaid. Clarifying standards are needed to establish detail on literacy levels, thresholds for translation of written information, languages in which "taglines" (informing individuals how to access marketplace-related services) are provided on websites and other materials, and other access issues that have been identified by stakeholders in public comment responses to the agency's marketplace regulations.

- HHS should finalize the definition of "limited English proficient" used in marketplace guidance.[14] AHJ recommends adopting the definition used by the U.S. Census Bureau and HHS LEP Guidance, which describes "limited English proficient" individuals as those who speak English less than "very well"[15] and "individuals who do not speak or read English very well and who have a limited ability to read, write read, write, speak or understand English."[16]

- HHS should expeditiously promulgate regulations on the interpretation and enforcement mechanisms of Section 1557, the ACA's nondiscrimination provision which prohibits discrimination on the basis of race, color, national origin, and other protected categories.

MONITOR AND ENFORCE NONDISCRIMINATION LAWS

- Assess the provision of marketplace services for LEP consumers.
- Clarify standards and definitions for language assistance services in the marketplace and Medicaid.
- Promulgate regulations for Section 1557 of the ACA.

Implement Strategies to Address Health Literacy

LEP consumers need appropriate health literacy tools to navigate the complexities of the healthcare system and insurance plans.

- State and federal agencies should work with health plans participating in the marketplace to require that they develop culturally relevant and linguistically appropriate patient and consumer materials, including satisfaction surveys that account for different health literacy levels.

- The marketplace should be required to develop culturally relevant and linguistically appropriate health literacy tools, such as cost-benefit comparison charts of the most common plans.

[14] 77 Fed. Reg. 18,310, at 18,314 ("In the final rule, we do not adopt a definition for the phrase 'limited English proficient.' We anticipate issuing future guidance that will interpret this term and will provide best practices and advice related to meaningful access standards for limited English proficient individuals.").
[15] See U.S. Census Bureau, supra note 1.
[16] See HHS LEP Guidance, supra note 3.

- CMS should support and promote the development of health risks assessment tools designed to help consumers of varying health literacy levels understand their health risks, needed health services, and recommended health care utilization patterns.
- States should ensure that translated health literacy tools are available to help consumers select appropriate health insurance plans and obtain culturally and linguistically competent health care services.

INCREASE CONSUMER HEALTH LITERACY

- Issue consumer materials and satisfaction surveys at appropriate health literacy levels.
- Develop cost benefit comparison charts of health plans, health risk assessments, and other health literacy tools at appropriate literacy levels and in different languages.

CONCLUSION

Despite the challenges many AA and NHPI consumers faced during the initial Open Enrollment Period, including learning about the health insurance options provided through the ACA and enrolling in coverage, AHJ partners worked together to successfully assist the enrollment of AA and NHPI consumers. Through the creation of culturally and linguistically appropriate materials, direct in-person assistance to consumers, and shared strategies for enrolling AAs and NHPIs, AHJ partners were able to work in local and state-based collaboratives to overcome some language, immigration, and health literacy barriers. Full implementation of AHJ's recommendations will ensure that many more AAs and NHPIs can enroll in coverage to get the care they need, and achieve the true success of health care reform for all communities.

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Educate, Enroll, and Empower Asian Americans, Native Hawaiians, and Pacific Islanders