Reports and Research

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United States House of Representatives
Before the House of Representatives Committee on Energy and Commerce's
Subcommittee on Oversight and Investigations
September 29, 2015

Written Testimony Submitted by:
Peter V. Lee
Executive Director
Covered California

Good morning, Chairman Murphy, Vice Chairman McKinley, Ranking Member DeGette and distinguished members of the subcommittee. My name is Peter V. Lee, and I serve as the executive director of Covered California. It is an honor for me to be here in Washington, D.C., before this subcommittee, to speak with you about the successful implementation of the Affordable Care Act in California.

This landmark legislation has dramatically changed health care in California and America by expanding desperately needed coverage and putting in place new protections for all Americans. In California, we have moved beyond talking about "Obamacare" or the Affordable Care Act, we are now talking about the new era of health care in California that is woven into the fabric of our state and our country.

Today I am pleased to address how Covered California is working, what we consider to be the keys to our success and how we are actively improving the future of health care in California. Before I begin my testimony, I would like to give you the highlights of where Covered California stands now.

- ***California Embraced the Affordable Care Act:*** California formed the first state-based health exchange following the law's passage and began to effectively use all the tools available under the Affordable Care Act, including:
    - ***Active Purchaser:*** Covered California chooses which plans participate in the exchange and then negotiates the rates, networks and quality elements to get the best value for consumers.

  - ***Standard Benefit Design:*** Covered California sets which benefits must be offered to consumers, which requires carriers to compete with one another based on premium, network, quality, consumer tools and service.
  - ***Expanded Medicaid:*** California expanded Medi-Cal, opening the door to no-cost or low-cost health insurance for millions.
- ***Covered California is Working:*** A recent Field Poll survey shows 68 percent of registered voters believe California has been successful in implementing the new law.
- ***Strong Enrollment:*** Covered California is made up of 1.34 million active consumers as of March 2015, and the U.S. Census Bureau reports California has lowered its rate of uninsured from 17.2 percent to 12.4 percent, which is the fifth-largest drop in the nation.
- ***Rates Under Control:*** Covered California's weighted average change for 2016 is just 4 percent, which is lower than last year's change of 4.2 percent, and a fraction of the double-digit increases we saw before the Affordable Care Act. In addition, 20 percent of existing consumers will see their rates go down if they renew their existing health plan for next year.
- ***Good Risk Mix Saves Money:*** Covered California's enrollees are healthy, and we used our data to negotiate a total of more than $300 million in premium savings over the past two years.
- ***More Competition and More Choice:*** Covered California will add two new plans in 2016, Oscar Health Plan of California and UnitedHealthcare Benefits Plan of California. Several current plans will also be expanding the areas in which they offer coverage so all consumers will have at least two plans to choose from, and 99.6 percent of consumers will be able to choose from three plans.

Now I will go in depth to give you a comprehensive look at Covered California's achievements, challenges and its future.

Covered California Successfully Enrolls Diverse and Healthy Mix of Consumers

Covered California's success is firmly rooted in the hundreds of thousands of consumers we have helped obtain quality and affordable health care coverage. As of March 2015, Covered California had 1,342,956 consumers actively enrolled in a plan offered by one of the 10 health insurance companies currently participating in our health exchange.

Even more important than the number of people we have enrolled is the mix of those consumers. Our mix of enrollees is diverse and healthy, proving that our extensive outreach efforts are working. During our second open-enrollment period (OE2), from

Nov. 15, 2014 to Feb. 15, 2015, Covered California saw substantial gains in many key demographics, particularly among subsidy-eligible Latinos, subsidy-eligible African-Americans and millennial consumers. The breakdown below shows how Covered California hit nearly all of the marks estimated by the University of California's statistical model (CalSIM 1.91) of California's subsidy-eligible population. (See Attachment: Exhibit 1.)

	Open Enrollment 2	CalSIM 1.91
Latino	37%	38%
Caucasian	34%	34%
Asian/Pacific Islander	18%	21%
African-American	4%	5%

In addition, an independent study by the Kaiser Family Foundation confirmed that Covered California enrollees are more racially diverse than the group of Californians with private coverage. According to the study, 60 percent of enrollees identify themselves as belonging to a race other than white, with 37 percent being Latino. That compares to 50 percent of those with private coverage, with only 26 percent being Latino.

Covered California's enrollees also got younger during our second open-enrollment period. Thirty-four percent of enrollees during this time were between the ages of 18 and 34, compared to 29 percent during our first open-enrollment period.

When it comes to health status, Covered California's innovative data analysis on health care usage by its enrollees found that many were healthier and presented less risk to insurance companies than anticipated. Also, a recent report from the Centers for Medicare and Medicaid Services (CMS) showed that California had one of the lowest average risk liability scores in the country, which means Covered California's enrollees are among the nation's healthiest.

This data played a significant role in helping Covered California negotiate the best premium rates for its consumers, which we will address later in this testimony. In many ways the debate about the volume and mix of those who have enrolled should be over — the actuaries of the 12 plans we will contract with have spoken, and their proposed rate increase of only 4 percent is an affirmation of our enrollment success.

California Experiences a Massive Drop in its Uninsured Rate

There have been many significant changes to California's insurance market since Covered California opened its doors in January 2014. The most recent data on California's uninsured rate comes from the U.S. Census Bureau, which found that the state's rate dropped from 17.2 percent in 2013 to 12.4 percent in 2014, the fifth-largest drop in the nation. Since it has been more than a year since the Census data was collected, and other surveys show an even greater reduction in the nation's uninsured rate, we are confident that number is even lower at this point.

One key reason is that California, under the leadership of Gov. Jerry Brown and a new Legislature, adopted the Affordable Care Act's provisions to expand the state's Medicaid program. Covered California serves as a single entry point to apply for both Medi-Cal, which is California's version of Medicaid, and Advanced Premium Tax Credits that can be used to support the purchase of a private plan through our marketplace.

Since opening our doors, 3.7 million Californians have enrolled in Medi-Cal, with 2.3 million doing so after becoming newly eligible through the program's expansion. Even though this represents a small slice of California's overall population, a recent Field Poll found that nearly half of registered voters under the age of 65 had personally visited Covered California's website, which is up 12 points from last year. We are becoming part of the fabric of health care in California and improving the quality of life for millions.

We also saw California's individual market expand from 1.5 million to 2.2 million people, with more than 1.3 million of those people currently enrolled in a Covered California health plan. It is important to note that Covered California requires health insurance companies who offer their products on the exchange to offer the same plans, at the same prices, to consumers who purchase their coverage off exchange. Consumers also benefit from the changes in the Affordable Care Act if they are insured through their employer.

Covered California estimates that there are 2.8 million remaining uninsured in our state, so we still have work to do. However, 1.5 million are ineligible for subsidies because of their immigration status.

Covered California Has the Size and Scope to Shape the Future of Health Care

Covered California is now the second-largest purchaser of health care for those under 65 in California, and that is having a big impact on the future of health care in our state. Since we opened our doors, a total of 1.8 million consumers have been covered through the exchange for at least one month. (See Exhibit 2.) We estimate that $6.5 billion will be generated in health plan premiums through Covered California in 2015.

We have always known since day one that consumers would come in and out of Covered California as their needs change. Many of the consumers who left the exchange have gained coverage through their employer or Medi-Cal. Others are transitioning into Covered California if they are between jobs or moving out of Medi-Cal. No matter what their situation is, Covered California will be there for them, acting in many ways as the glue that holds together the employer, public sector and individual markets.

Together these elements give Covered California the clout to shape the health insurance market and enormous power to negotiate the best rates on behalf of our consumers.

Covered California Fights on the Consumer's Behalf as an Active Purchaser

The Covered California Board adopted the policy that we would be an "active purchaser" in this new era of health care. There are four key elements to being an active purchaser that allow Covered California to fight on the consumer's behalf.

First, Covered California puts every health insurance company that wants to be a part of the exchange through a rigorous review. Covered California health insurance carriers must meet high standards of quality, affordability and accountability as they compete in the marketplace. If they do not meet these standards, we will turn them away. Most other state exchanges and the federal marketplace have adopted the "clearinghouse" model, which means they sell any carrier that is compliant with the Affordable Care Act.

Currently we have 10 plans serving the state, including some of the biggest names in the health insurance industry, along with well-known regional entities and carriers that focus on California's Medi-Cal population. Covered California has 19 rating regions across the state and many of those regions are bigger than other states in the country. Currently each region has between three and six plans serving consumers.

We will be offering even more coverage options in 2016 when Oscar and UnitedHealthcare join the fold. In addition, several of our existing health plans will be expanding into new regions. As a result, every consumer in the state will have at least two carriers to choose from, and 99.6 percent of consumers will have three carriers to choose from. (See Exhibit 3.)

Second, after choosing which plans will participate in the exchange, Covered California vigorously negotiates the premiums they can charge. Prior to the Affordable Care Act, the California HealthCare Foundation found that the annual median increase for premiums in the individual health insurance market from 2011 to 2014 was 9.8 percent.

For the 2015 individual market, Covered California negotiated a weighted average change of 4.2 percent. This was achieved in part by having data that proved Covered California enrollees were healthier and presented less risk to insurance companies than anticipated, which helped drive down the cost of health premiums. Covered California enrollees saved an estimated $100 million in premiums because of this innovative use of information.

We did an even better job negotiating rates for the upcoming year. In 2016 the average weighted change will be even lower, at just 4 percent. Again, we used data which proved we had a good risk mix to negotiate a better deal with the health insurance companies and save consumers approximately $200 million in premiums. As a result, if they stay with their current plan, 56 percent of consumers will have a premium change of 5 percent or less, and 20 percent of consumers will see their rates go down. (See Exhibit 4.)

Consumers also have the ability to reduce the change in their plan by shopping around for a better deal within the same metal tier. For example, the average premium change in Los Angeles County is 1.8 percent. However, consumers can save an average of more than 10 percent if they switch to the lowest-cost plan within the same metal tier. (See Exhibit 5.)

All of this good news applies to the coverage our plans offer both inside Covered California and in the off-exchange individual market — benefiting the 900,000 Californians who are not in Covered California but get the benefit of our negotiating clout and work to expand the insurance pool.

These rates also help the tens of millions of Californians with employer-based coverage in two ways: First, by lowering the number of uninsured — we are reducing the cost shift to employers and their employees from hospitals and other providers needing to make up their uncompensated care in commercial premiums. Second, all Californians can know that if they lose employer-based coverage they will have affordable insurance available to them.

The third element of being an active purchaser is that Covered California developed standard benefit designs which detail which benefits must be offered to consumers. By requiring all carriers to have standard benefit designs for each metal tier, carriers are required to compete with one another based on premium, network, quality, and consumer tools and service. The result of this work has created a strong foundation of sound rates and stability in the ever-changing health insurance market. Even health

insurance plans that are not in Covered California's marketplace must offer a product that matches the standardized design in the individual market. (See Exhibit 6.)

Covered California also negotiated an increase in the number of services that are no longer subject to a deductible, which makes it easier for consumers to get the care they need. For example, none of the outpatient care available to anyone in a Silver, Gold or Platinum plan is subject to a deductible. Consumers will also have the cost of their specialty drugs capped at $250 per prescription per month. These are huge benefits to consumers that remove barriers to getting care.

This system also benefits anyone in California's health insurance market, because the benefits offered on the exchange must also be offered in the private market, even by plans that are not in Covered California.

By offering standardized products, Covered California is providing consumers better options, even if these options are fewer in number. We looked at Silver health plans in Colorado and Florida. While Covered California offers seven Silver plans in Los Angeles, both Denver and Miami offer 35 Silver plans each. Some of those products with the cheapest premiums mean you do not get any coverage unless you have satisfied a deductible of several thousand dollars.

For example, Covered California will increase the number of benefits that are no longer subject to a deductible in 2016. This improves access to care and helps consumers get the medical attention they need without having to first spend thousands of dollars to meet a deductible. This is contrary to what you will see in places like Denver, where 15 of the 35 Silver-level plans require the consumer to meet a deductible before the copay or coinsurance applies to a primary care physician or specialist visit. Standard benefit designs are the right thing to do for consumers.

Finally, Covered California uses its role as an active purchaser to improve the delivery of care. We recognize in the end that health care is delivered by doctors, by nurses and by hospitals, and we think it is our role to be an agent in partnership with these clinicians and their patients by working with other purchasers — like CMS, our Medicaid agency and with private purchasers — to improve how care is delivered.

The negotiations and contract requirements we have with our health plans are specifically designed to achieve the "triple aim" of better quality, healthier consumers and lower costs. As a result, Covered California requires its plans to:

- Participate in payment reform and quality collaboratives.

- Develop programs that chart progress in reducing health disparities in meaningful and measurable ways.
- Have a process that determines, monitors and records the health status of consumers over the age of 18 and use the information to promote better health among consumers.
- Encourage consumers to use their insurance and seek health and wellness services.
- Help consumers select a primary care physician, find a federally qualified clinic or team-based center (medical home) to coordinate all health and wellness needs.
- Actively help consumers with chronic conditions manage their illness through providers specializing in coordinated care for ailments such as hypertension, diabetes, asthma and heart disease.
- Provide and update information showing total costs and out-of-pocket costs for the most-used and highest-cost services.

Covered California's unique model helped it receive the highest overall grade from the National Health Council in its recent "State Progress Reports" which examined which exchanges were "beneficial for patients." The report stated Covered California "has led other states in its efforts to improve the comparability of exchange plans. Key protections in the state include the standardized benefit designs across all metal levels, including the cost-sharing reduction versions of Silver plans that are available to people with limited income. The state does not allow any non-standard plans in the exchange, which is unique among states with standardized plans. These requirements mean that all people enrolled in the same metal level plan in the state encounter the same cost sharing for the same benefits; in effect, it levels the playing field." (See Exhibit 7.)

Covered California Increases Access to Care While Maintaining Affordability

New studies provide some very early indicators that California's efforts to expand coverage are dramatically improving health care access for both Covered California's enrollees and those in Medi-Cal.

A Kaiser Family Foundation study found that 91 percent of Covered California enrollees found it was "very" or "somewhat easy" to travel to their usual source of care, which is identical in the private market. (See Exhibit 8.)

Fifty-nine percent of Covered California enrollees had a checkup or preventive visit by the fall of 2014, which is nearly twice the rate for preventive visits among the uninsured. This is not significantly different from other private markets, and if extrapolated over

time, this means more than 800,000 preventive visits have been provided through Covered California since January 2014.

A study by The Commonwealth Fund found that 86 percent of those newly covered were satisfied with their care. We are seeing people in California getting the care they need, when they need it, and that is only going to get better as time goes on.

We also have a requirement that every plan give every piece of their claims data to a third-party vendor, where it will be kept secure and analyzed to determine how plans are doing when it comes to treating specific illnesses. We will look at how the data changes for specific ages or incomes. We think this is a critical role for Covered California and something that every state-based exchange and the federal government should do to ensure that their consumers are getting the right care at the right time.

This is all being done while ensuring that Covered California enrollees can choose between health plans that offer both low premiums and low out-of-pocket costs. Our most recent data shows that (See Exhibit 9.):

- More than 69 percent of Covered California's subsidy eligible enrollees selected Silver plans, which have no deductibles for any outpatient services.
- 58 percent of all subsidy-eligible enrollees qualified for an "Enhanced Silver plan" which means even lower out-of-pocket costs when accessing care.
- More than 120,000 enrollees pay less than $10 per month, per individual.
- Twenty-five percent of enrollees in an Enhanced Silver 94 plan pay less than $25 per month, per individual, while more than half pay less than $50 per month, per individual. In addition, these enrollees pay only $3 for a doctor visit.
- Seventy-seven percent pay less than $150 per month, per individual. (See Exhibit 9.)

Fiscal Planning and Strong Enrollment Put Agency on Solid Financial Footing

Earlier this year Covered California's Board approved its budget for the upcoming fiscal year. Thanks to our prudent fiscal planning and strong enrollment, Covered California is on solid financial footing and well positioned to serve consumers for years to come.

From day one we used federal establishment funds to get Covered California up and running. At the same time, we began saving the fees collected from our health plans and banking that money to build our future. At the start of the upcoming fiscal year, Covered California will have approximately $200 million in unrestricted reserves. We will also have the ability to use $100 million in remaining federal establishment funds, as allowed by law, to complete our initial launch.

When our federal funding comes to an end this year, Covered California will be totally financially independent. We will be able to maintain our momentum, remain nimble and make adjustments from year to year if necessary. If enrollment is larger than anticipated, we will look to lower the assessment we charge health plans. If enrollment were to be lower, we would look at reducing costs, reducing our reserves, raising the assessment we charge health plans or a combination of all three options. The bottom line is Covered California's business model is one that guarantees ongoing support. (See Exhibit 10.)

Core Functions of a State-Based Marketplace

Finally, we are looking ahead to the future and how state-based exchanges can maintain their own marketplace. Covered California is responsible for all the core functions of running its exchange. However, some functions require more of a local focus, while others can be done on a regional or national level. There are four key functions of what an exchange does that need to be supported:

- Plan Selection, Contracting and Retention: Exchanges need to offer quality plans that offer a good value. They should leverage their purchasing power to help consumers and promote consumer-friendly benefit designs and delivery system reform. This is very specific to each state.
- Marketing, Outreach and Retention: Exchanges must effectively reach potential consumers and support the retention of those consumers. This includes conveying the value of subsides, supporting informed choice and support enrollment and education. These are specific to a state or locale, but there are opportunities for coordination among states that share media markets.
- Conduct Enrollment and Plan Selection: The website and information technology (IT) system for each exchange will conduct enrollment, determine subsidy eligibility and interface with health plans. This can be done regionally or nationally, but requires significant state-specific integration with Medicaid programs.
- Customer Service: Representatives who can provide clear and concise answers, over the phone or online, can be handled regionally or at the national level. However, they would require training relative to state law and plans.

As you can see, state-based exchanges have many options. They can share responsibilities with the federal exchange, or each other, to support the implementation of these functions.

Thank you for having me here this morning. California will continue to make fundamental changes to its health care system as we strive to improve the lives of millions of people. We are grateful for your support and I look forward to answering your questions and doing whatever we can at Covered California to help implement this new era of health care in our state and across the country.

United States House of Representatives

Before the House of Representatives Committee on Energy and Commerce's Subcommittee on Oversight and Investigations

Peter V. Lee
EXECUTIVE DIRECTOR
Covered California

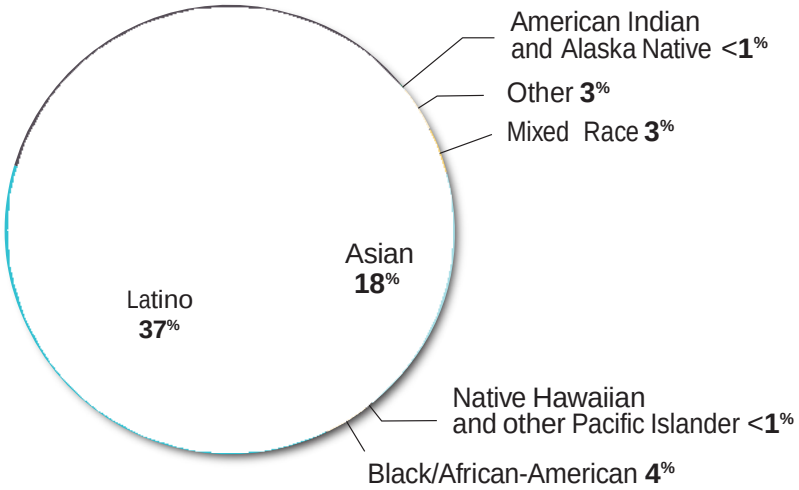
September 29, 2015

EXHIBIT 1

Covered California is Enrolling All Communities Across Our State

Enrollment data proves that our efforts to reach California's diverse population is working

Second Open Enrollment Nov. 1, 2014 - Feb. 15, 2015



Estimated subsidy-eligible population of the state developed by the University of California's statistical model[1]:

38%	34%	21%	5%
LATINO	WHITE	ASIAN/PACIFIC ISLANDER	AFRICAN-AMERICAN

An independent study conducted by the Kaiser Family Foundation[2] confirmed that:

- Covered California enrollees are more racially diverse than the group of Californians with private coverage. 60 percent identify as a race/ethnicity other than white. Latinos make up 37 percent of the total.

[1] CalSIM version 1.91 Statewide Data Book 2015-2019 http://bit.ly/1Que1NV

[2] Henry J. Kaiser Family Foundation. 2015. "Coverage Expansions and the Remaining Uninsured: A Look at California During Year One of ACA Implementation". Menlo Park, CA.

EXHIBIT 2

Covered California is Big and Having Big Impacts

It is now one of the largest purchasers of health insurance in California and the nation.

1.3 MILLION

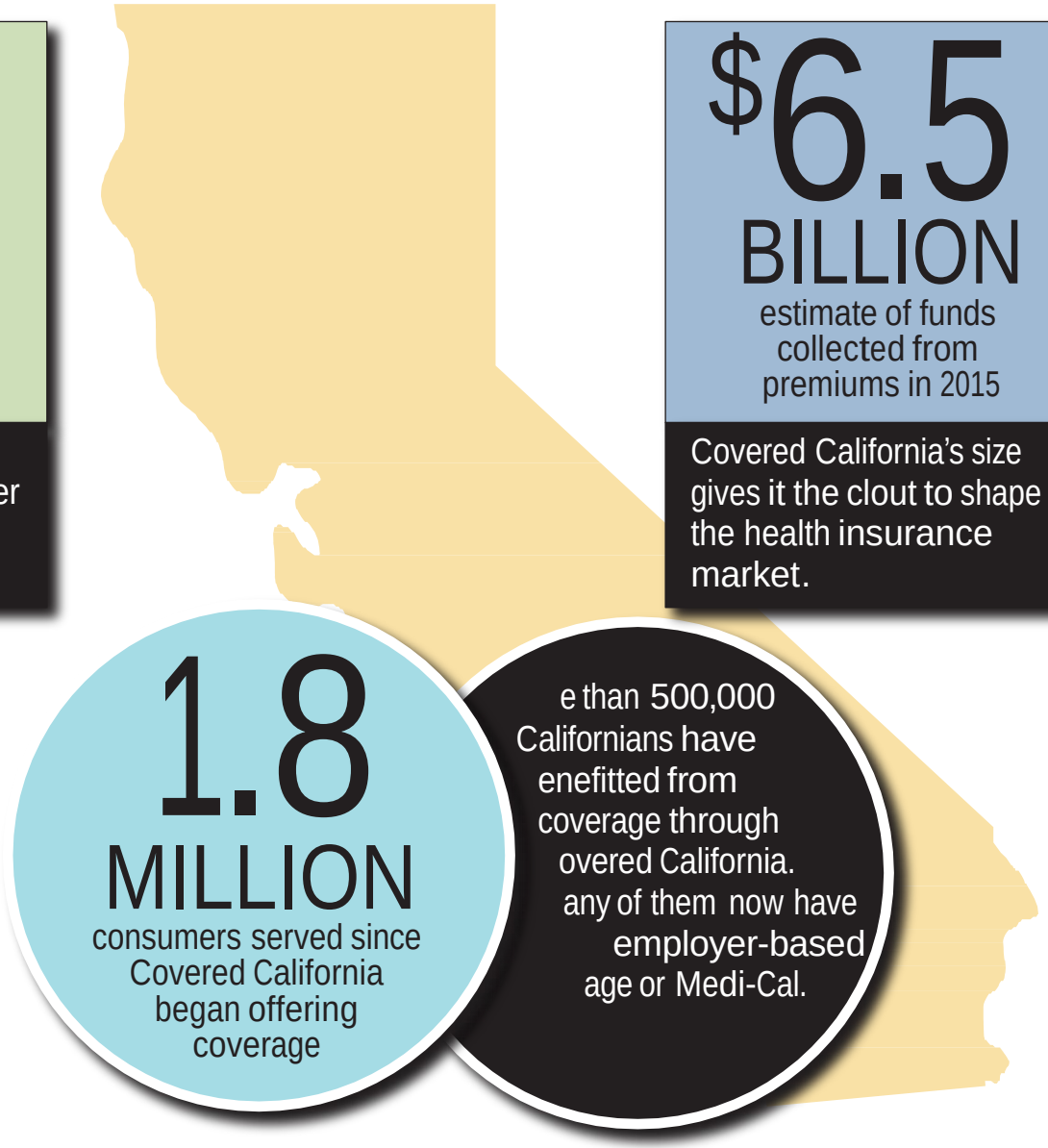
consumers have active health insurance as of March 2015

Covered California is now the second largest purchaser of health insurance in the state for those under 65.

$6.5 BILLION

estimate of funds collected from premiums in 2015

Covered California's size gives it the clout to shape the health insurance market.



1.8 MILLION

consumers served since Covered California began offering coverage

e than 500,000 Californians have enefitted from coverage through overed California. any of them now have employer-based age or Medi-Cal.

COVERED CALIFORNIA

EXHIBIT 3

Covered California Health Plan Offerings for 2016: Broad Choice, Local Options and Good Trend

PRICING REGION	ANTHEM	BLUE SHIELD	CHINESE COMMUNITY HEALTH PLAN	HEALTH NET	KAISER PERMANENTE	L.A. CARE HEALTH PLAN	MOLINA HEALTHCARE	OSCAR	SHARP HEALTH PLAN	UNITEDHEALTHCARE	VALLEY HEALTH PLAN	WESTERN HEALTH ADVANTAGE
1 Northern counties	●	●		◒	◒					●		
2 North Bay Area	●	●		●	◒							◒
3 Greater Sacramento	●	●		◒	◒							◒
4 San Francisco County	●	●	●	●	●							
5 Contra Costa County	●	●		●	●							
6 Alameda County	●	●			●							
7 Santa Clara County	●	●		◒	◒						●	
8 San Mateo County	●	●	◒	●	●							
9 Santa Cruz, San Benito, Monterey	●	●		◒						●		
10 Central Valley	●	●		◒	◒							
11 Fresno, Kings, Madera counties	●	●		◒	◒					●		
12 Central Coast	●	●			◒					●		
13 Eastern counties	●	●			◒		◒			●		
14 Kern County	●	●		◒	◒							
15 Los Angeles County, partial	●	●		●	◒	◒	◒					
16 Los Angeles County , partial	●	●		●	●	●	◒	◒				
17 Inland Empire	●	●		◒	◒		◒					
18 Orange County	●	●		●	●			●				
19 San Diego County	●	●		●	◒		◒		●			

● Full Region

◒ Partial Region

2016 AVERAGE RATE INCREASE OF 4.0

EXHIBIT 4

If Staying With Their Current Plan, 56% of Consumers Will Have A Premium Change of 5% Or Less

20% would have premiums that are less in 2016.

Changes To 2016 Premiums

If Consumers Stay with Current Plan

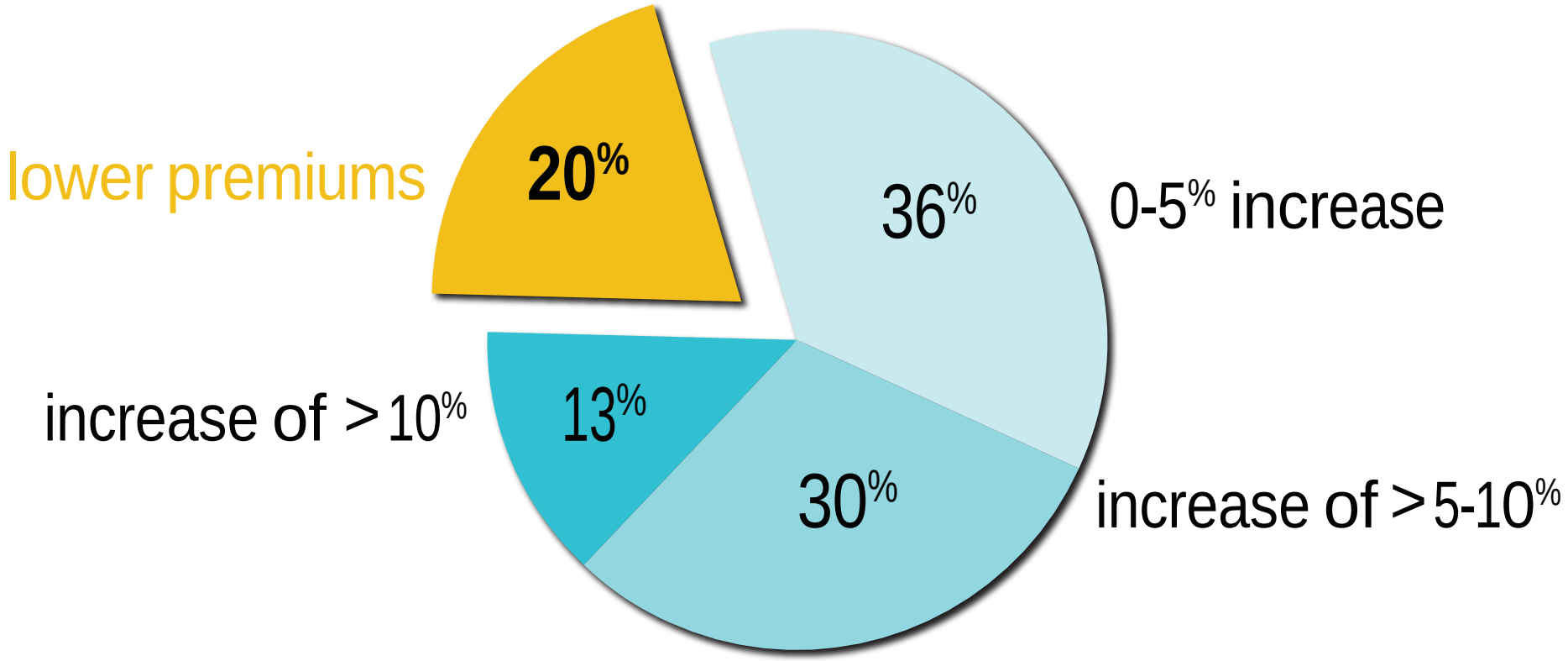


EXHIBIT 5

Example If A Consumer Were To Switch Carriers To The Lowest Priced Carrier In Their Same Metal Tier

With the addition of new carrier options, consumers should check to see if there is a more affordable option that works for them.

Covered California 2016 Rate Changes in Los Angeles

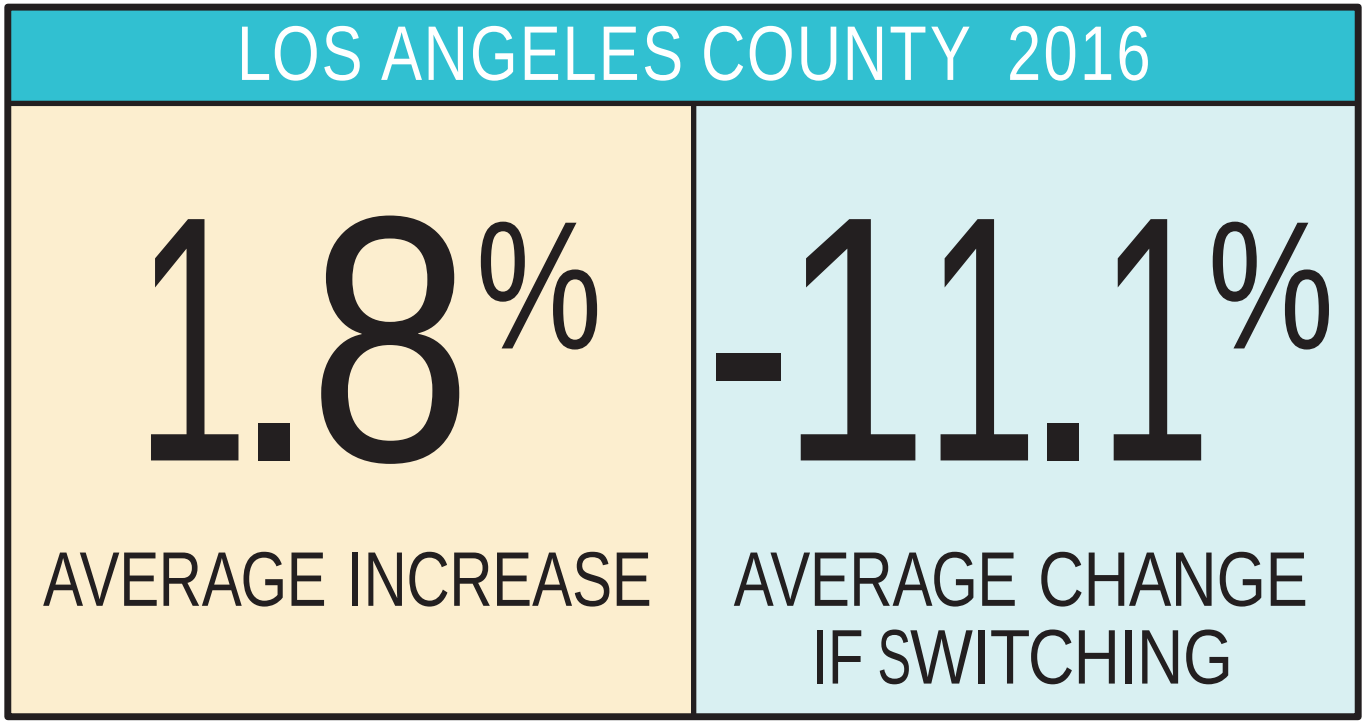


EXHIBIT 6

Covered California 2015 Standard Benefit Designs

In California, standard benefits allow apples-to-apples plan comparisons and seek to encourage utilization of the right care at the right time with many services that are not subject to a deductible.

Benefits below shown in blue are not subject to any deductible.

2015 STANDARD BENEFIT DESIGN BY METAL TIER								
Coverage Category	Minimum Coverage	Bronze	Enhanced Silver **94**	Enhanced Silver **87**	Enhanced Silver **73**	Silver	Gold	Platinum
Percent of cost coverage changes	Covers **0%** until out-of-pocket maximum is met	Covers **60%** average annual cost	Covers **94%** average annual cost	Covers **87%** average annual cost	Covers **73%** average annual cost	Covers **70%** average annual cost	Covers **80%** average annual cost	Covers **90%** average annual cost
Cost-sharing Reduction Single Income Range	N/A	N/A	**up to $17,235** (100% to ≤150% FPL)	**17,236 to $22,980** (>150% to ≤200% FPL	**$22,981 to $28,725** (>200% to ≤250% FPL)	N/A	N/A	N/A
Annual Wellness Exam	$0	$0	$0	$0	$0	$0	$0	$0
Primary Care Vist	after first 3 non-preventive visits, pay negotiated carrier rate per instance until out-of-pocket maximum is met	$60 for first 3 non-preventive visits	$3	$15	$40	$45	$30	$20
Specialist Visit	pay negotiated carrier rate per service until out-of-pocket maximum is met	$70 after deductible is met	$5	$20	$50	$65	$50	$40
Laboratory Tests		30% after deductible is met	$3	$15	$40	$45	$30	$20
X-Rays and Diagnostics		30% after deductible is met	$5	$20	$50	$65	$50	$40
Generic Drugs		$15 or less after deductible is met	$3	$5	$15 or less	$15 or less	$15 or less	$5 or less
Preferred Drugs		$50 after deductible is met	$5	$15	$35	$50	$50	$15
Emergency Room		$300 after deductible is met	$25	$75	$250	$250	$250	$150
Imaging		30% after deductible is met	10%	15%	20%	20%	20%	10%
Deductible	N/A	$5,000	$0	$500 medical $50 brand drugs	$1,600 medical $250 brand drugs	$2,000 medical $250 brand drugs	$0	$0
Annual Out-of-Pocket Maximum Individual and Family	$6,600 individual only	$6,250 individual $12,500 family	$2,250 individual $4,500 family	$2,250 individual $4,500 family	$5,200 individual $10,400 family	$6,250 individual $12,500 family	$6,250 individual $12,500 family	$4,000 individual $8,000 family

EXHIBIT 7

Enhancing the Patient Centeredness of State Health Insurance Markets State Progress Reports

National Health Council, July 2015

Link to full Report: http://www.nationalhealthcouncil.org/sites/default/files/Enhancing-State-Health-Insurance-Markets.pdf

EXHIBIT 8

Health Care Access is Improving Dramatically for both Covered California and Medi-Cal Enrollees

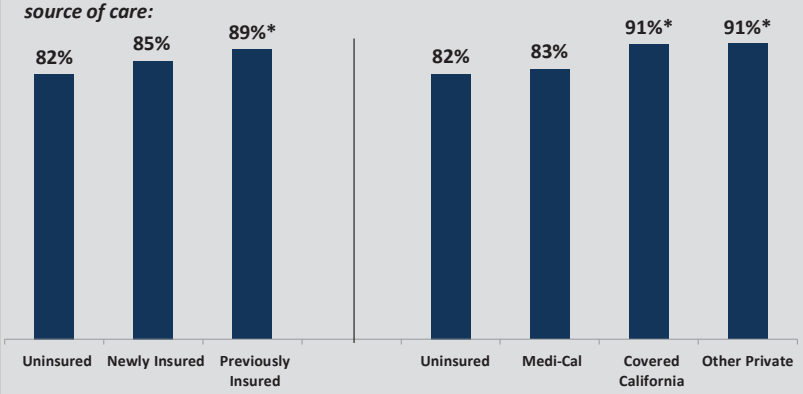
A Kaiser Family Foundation independent survey of consumer released in May 2015 reported on services through the Fall of 2014.

- 91 percent of Covered California enrollees reported it was "very" or "somewhat easy" to travel to their usual source of care, which matches the Other Private markets (Figure 19).
- 59 percent of Covered California enrollees had a check-up or preventive care visit by the Fall of 2014, which is nearly twice the rate for preventive visits amongst the uninsured (Figure 20). This is not significantly statistically different from other private market, and if extrapolated over time, this means more than 800,000 preventive visits have been provided through Covered California since Jan. 2014.

Figure 19

Ease of Travel to Usual Source of Care Among Nonelderly Adults in California, by Insurance Coverage and Type in Fall 2014

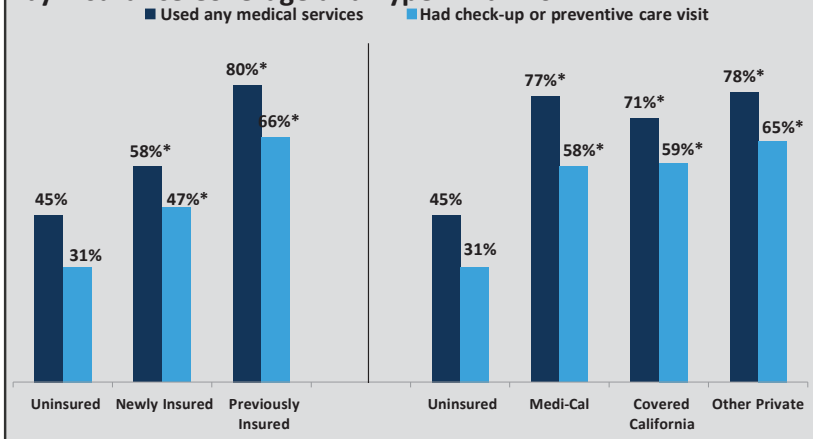
Share reporting it was "very" or "somewhat easy" to travel to their usual source of care:



NOTES: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014; some of these people may have switched coverage type. "Newly Insured" include people who were insured as of int erview date and gained coverage since January 2014. "Uninsured" includes people who lacked coverage as of the interview date. "Usual Source o f Care" does not include care received at an emergency department. *Significantly different from Uninsured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Figure 20

Use of Medical Services Among Nonelderly Adults in California, by Insurance Coverage and Type in Fall 2014



NOTES: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014; some of these people may have switched coverage type. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked coverage as of the interview date. *Significantly different from Uninsured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

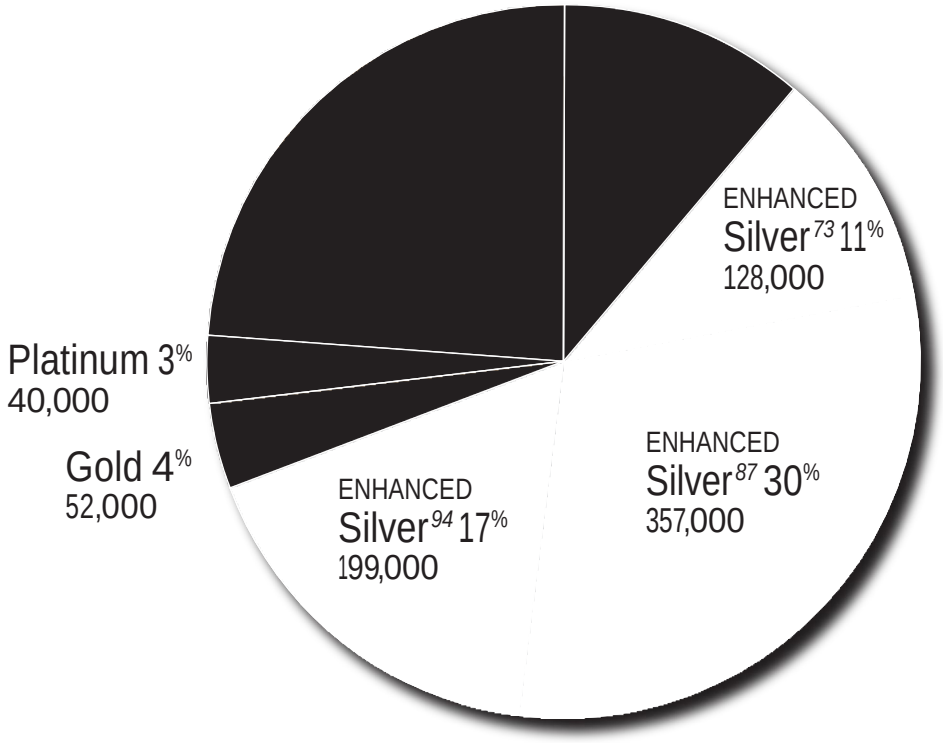
Source: Henry J. Kaiser Family Foundation. 2015. "Coverage Expansions and the Remaining Uninsured: A Look at California During Year One of ACA Implementation". Menlo Park, CA.

EXHIBIT 9

Covered California Enrollees Able to Choose BOTH Low Premium and Low Out-of-Pocket Designs

More than 69 percent of Covered California subsidy-eligible enrollees selected a Silver Plan — which have NO deductibles for any out-patient services; 58 percent of all subsidy eligible enrollees qualified for an "Enhanced Silver", which means even lower out-of-pocket costs when accessing services.

2015 Subsidized Enrollment by Metal Tier



Source: Covered California enrollment data as of April 2015, including only subsidized enrollees who have paid for coverage.

A few notes on monthly premium costs:

77 percent pay less than $150 per month per individual.

More than 120,000 enrollees pay less than $10 per month per individual.

25 percent of enrollees in an Enhanced Silver 94 plan pay less than $25 per month per individual, while more than half pay less than $50.

In addition, these individuals pay only $3 for doctor visits.

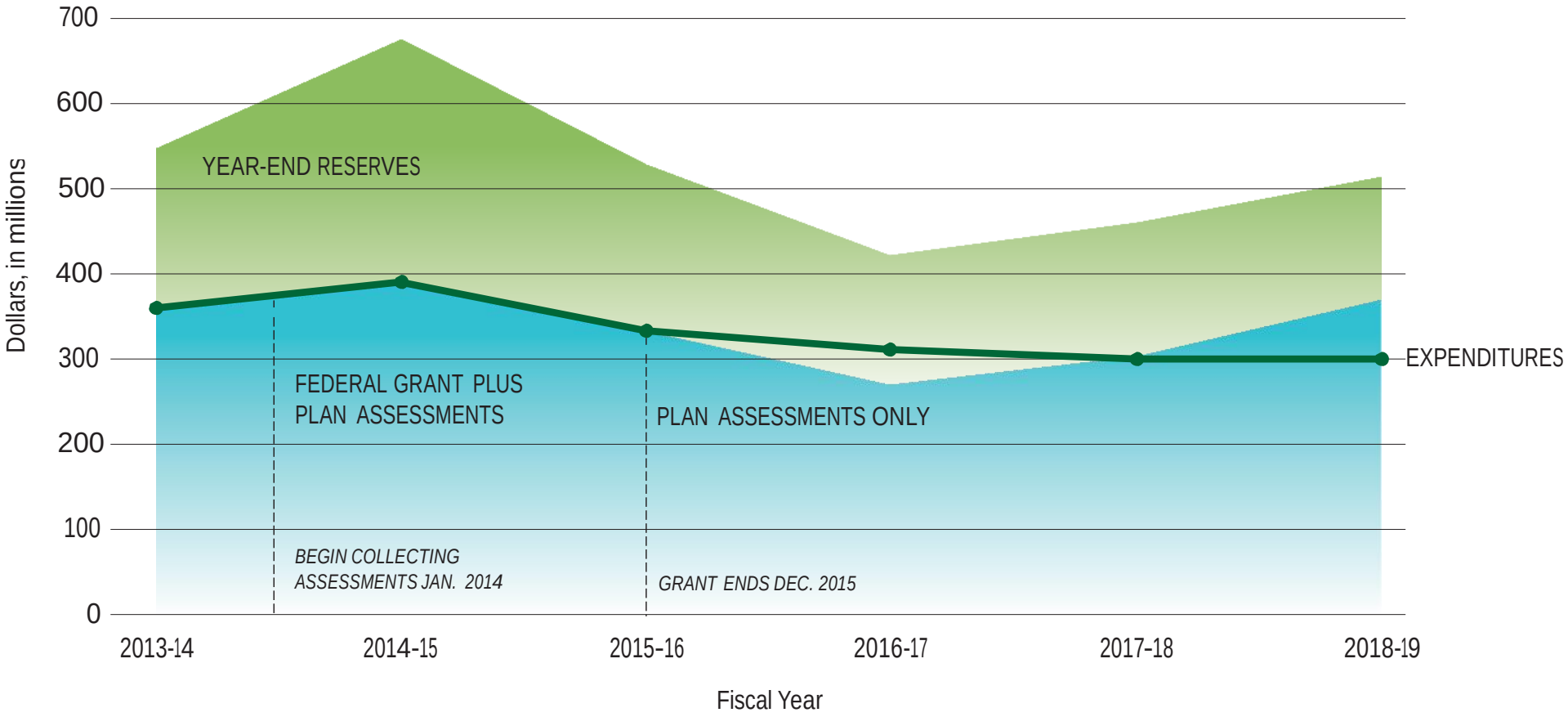
Covered California's Standard Benefit Design:

- Bronze — three office visits and lab work, not subject to deductible.
- Silver, Gold, Platinum — no deductibles on any outpatient services.

EXHIBIT 10

Covered California's Strong Balance Sheet and Financial Management Assures Long-Term Viability

With unrestricted reserves of more than $200 million in 2015 and the ability to adjust plan fees as appropriate, Covered California has a business model that guarantees ongoing support.



COVERED CALIFORNIA

REPORT BY THE

California Health Benefit Exchange

TO THE

Governor and Legislature

SEPTEMBER 2015

COVERED CALIFORNIA™

COVERED CALIFORNIA™

September 29, 2015

To the Governor of the state of California and the members of the Legislature,

On behalf of the governing board of Covered California, we are pleased to present this annual report on our progress in implementing the federal Patient Protection and Affordable Care Act of 2010. It includes financial information about state fiscal years 2013-14 and 2014-15 as well as observations from the state's second open-enrollment period, which ended in February 2015. It also includes the projected budget for state fiscal year 2015-16.

Since the fall of 2013, Covered California has offered health insurance to consumers through a competitive marketplace and the expansion of Medi-Cal enabled by the Affordable Care Act. Many Californians now have health insurance for the first time. We are happy to share the stories of some of those who got covered with photographs and video links in the pages of this report.

Our efforts to reach diverse communities in the languages and methods that resonate with them are unmatched in the nation. Through our successes, California has shown that the dream of health reform can become a reality, even in the largest and most diverse of states. There have been bumps along the way, but we are getting better every day and we are dedicated to a process of continuous improvement.

We are grateful for the support and close working relationships with insurance agents, county eligibility workers, labor unions, large and small businesses, community leaders, health providers and health plans who have supported Covered California in our historic mission. In addition, we thank the many philanthropic organizations that continue to provide invaluable support in their communities and inspire so many to enroll.

In the years ahead, Covered California will continue to focus on enrolling those never insured or chronically uninsured as well as expand our efforts to assure that consumers get the right care at the right time to stay healthy.

We look forward to continued collaboration and thank you for your ongoing support as we build on the successes of our early years and expand and improve our work in the years ahead.

Diana Dooley
Chair of the Board

Peter V. Lee
Executive Director

Table of Contents

Executive Summary

In the early spring of 2015, Covered California concluded its second-ever open-enrollment period, with more than 1.4 million people enrolled in health coverage from communities throughout the state.

Given the state's progress, it is difficult to imagine that only five years ago, the idea of a state-based marketplace was nothing more than words on paper.

Today, Covered California operates at a new headquarters as well as at service centers in Rancho Cordova and Fresno with more than 1,200 employees.

In the past year, Covered California has worked hard to make improvements based on lessons learned in the first open-enrollment period. Meaningful changes have been put in place, from adjusting our marketing and outreach efforts to expanding Service Center hours and improving our information technology systems to better handle demands.

Last fall, Covered California began the process of renewing Covered California enrollees for the first time while also launching its second open-enrollment period on Nov. 15. Ongoing efforts to reach California's diverse communities were expanded and improved this year, and enrollment numbers show better success enrolling key target communities for 2015.

The exchange also sent tax forms to hundreds of thousands of enrollees for the first time and worked to explain the new nexus between health coverage and taxes both to existing consumers and to those without coverage.

Enrollment figures show Covered California succeeded again, enrolling close to 500,000 new consumers.

Nearly 3.4 million previously uninsured Californians now have health care coverage through Covered California or Medi-Cal — one of the most historic expansions of health coverage in the history of our state and nation. Through Covered California alone, 800,000 households received more than $3 billion to help them afford health insurance premiums in 2014.

Those with coverage are now telling stories of the life-changing and sometimes life-saving care they are receiving because they have health coverage. Their stories are evidence that the promise of health care reform is becoming a reality in California.

Covered California looks to the future with optimism as it assumes a new role focusing on those who are uninsured during the year for occasional episodes versus those who have never had insurance before. Adjusting to this new role and assuring financial self-sufficiency will be part of our strategic planning in the months and years ahead.

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1 Progress Implementing the Affordable Care Act in California

It has been five years since the passage of the landmark Patient Protection and Affordable Care Act and four years since California became the first state in the nation to enact legislation establishing a state-based health insurance marketplace. Since that time, Covered California has worked with partners throughout the state to set in motion the dramatic expansion of health coverage that is continuing to this day. In addition, California made a critical decision to offer Medi-Cal to low-income childless adults, leading to a historic expansion of Medi-Cal coverage in the state.

In 2014, Covered California administered more than $3 billion in federal subsidies to make health care more affordable for Californians. Approximately 800,000 California households received federal subsidies to pay their monthly premiums, with the estimated average amount received being more than $5,200 per household per year, or about $436 per month.

Covered California took on the role of an active purchaser, selecting plans and offerings to give uninsured Californians the right mix of price and choice. The Exchange opened its doors for open enrollment the first time on Oct. 1, 2013, and continued its initial enrollment for consumers for six months until March 31, 2014. Covered California enrolled more than 3 million Californians during that time: 1.4 million in private health insurance through Covered California and more than 1.9 million in Medi-Cal. In that first open-enrollment period alone, California became a national example of the tremendous potential of the Affordable Care Act to dramatically expand coverage nationwide.

During the second open-enrollment period, Covered California enrolled nearly 500,000 new people. While Covered California celebrates the success of this enrollment period, we note that there is still work to do to get everyone insured. This number changes daily, monthly and yearly.

AFFORDABLE HEALTH PLANS

In the first year's open enrollment (October 2013 to March 2014), Covered California's selection criteria and standardization drove good product development and resulted in a competitive mix of more than 10 health insurance companies offering different coverage types. This resulted in an independent finding that the Exchange's efforts increased competition in the individual insurance market. Covered California went to market with products that offered choice and competitive pricing. Most consumers in the state had more than four health insurance companies to choose from. And although most Covered California consumers selected one of four carriers offered, the addition of regional plans meant the choices available varied in local communities and resulted in substantial enrollment in an array of plans at the local level. Almost 90 percent of Covered California enrollees benefited from receiving federal subsidies to lower their premium costs, and the majority selected Silver coverage, with Bronze coverage being the second-most-prevalent plan choice.

RATES AND CARRIERS FOR 2016

In July, Covered California announced its 2016 negotiated rates, which continued a downward trend of rate increases in the state. The statewide weighted average increase will be 4 percent, lower than last year's 4.2 percent increase. This represents a dramatic change from the trends that individuals faced in the years prior to the Patient Protection and Affordable Care Act.

The modest rate increases negotiated for 2016 represent the second year of Covered California's success as an active purchaser. In contrast to other state exchanges that allow any insurer to offer products, Covered California actively chooses which plans to allow into the Exchange based on the rates and value they provide to consumers.

Covered California Rate Changes

	2014-2015 Change	2015-2016 Change
Weighted Average Increase	4.2%	4.0%
Lowest-Priced Bronze (unweighted)	4.4%	3.3%
Lowest-Priced Silver (unweighted)	4.8%	1.5%
If a consumer shops and switches to the lowest-cost plan in the same tier		-4.5%

The majority of Covered California consumers will either see a decrease in their health insurance premiums or an increase of less than 5 percent if they choose to keep their current plan. In addition, consumers can reduce their premiums by an average of 4.5 percent, and more than 10 percent in some regions, if they shop around and change to a lower-cost plan within the same metal tier.

Covered California also announced two new health insurance companies: Oscar Health Plan of California and UnitedHealthcare Benefits Plan of California will be joining selected regions of the California market-place in 2016, bringing the total number of companies offering health plans through the marketplace to 12.

In 2016, more than 90 percent of hospitals ("general acute centers" as designated by the California Office of Statewide Health Planning and Development) in California will be available through at least one health insurance company, and now about three-quarters (74 percent) will be available through three or more companies. Also, since Covered California requires health insurance carriers to offer the same products at the same prices both inside and outside Covered California's marketplace, all individuals seeking to buy health insurance benefit from these rates.

Covered California selected the following health insurance companies to offer coverage to consumers in 2016:

- Anthem Blue Cross of California
- Blue Shield of California
- Chinese Community Health Plan
- Health Net
- Kaiser Permanente
- L.A. Care Health Plan
- Molina Healthcare
- Oscar Health Plan of California
- Sharp Health Plan
- UnitedHealthcare Benefits Plan of California
- Valley Health Plan
- Western Health Advantage

Dental and Vision Coverage

All Covered California health insurance plans for the individual and family market offered embedded pediatric dental plans for 2015. This means that dental insurance for children will be included in the price of all health plans purchased in the exchange. In addition, Covered California will offer supplemental dental coverage for adults in the 2016 plan year through optional family dental plans. Dental plans must follow Covered California's standard benefit designs.

Also new to Covered California for Small Business is the addition of embedded children's dental coverage. In the Sacramento, San Francisco and San Diego regions, small-business owners offer employees coverage that includes embedded dental plans for children. For a complete list of those carriers, visit www.CoveredCA.com/small-business/plan-providers.

Covered California is currently developing vision plan options for consumers and small businesses that conform to federal limitations on the provision of adult vision benefits by state health insurance exchanges. Vision benefits for children are already included with all Covered California health plans.

Covered California for Small Business

Covered California for Small Business is the health insurance marketplace for businesses with 50 or fewer eligible employees. The distinctive value it brings for small employers is the choice the employer has to select the metal tier of the health plans, and each employee is free to select from the various insurers available in their market. This brings a benefit of consumer choice to the small-employer market with a competitive pricing structure. In its role as an active purchaser, Covered California kept increases low for a majority of small-business consumers in 2015. Small-business consumers saw a statewide weighted average increase of just 5.2 percent for the 2015 plan year.

In 2015, Covered California for Small Business introduced some new additions that are advantageous to the small-business employer and employee. New is the dual-tier option, which allows the employer to offer plans at two metal tiers as long as they are contiguous (e.g., the Bronze and Silver levels, the Silver and Gold levels, or the Gold and Platinum levels). Also, additional plan designs were offered by Health Net, Western Health Advantage and Kaiser Permanente, which provide consumers with the essential health benefits required under the Affordable Care Act but also a little more flexibility with their premiums.

Businesses are not mandated to enroll in Covered California for Small Business, and there is no penalty for not participating. California businesses with 50 or fewer employees can choose from quality health insurance plans similar to those available to larger businesses. There were 2,607 employer groups and 17,308 members enrolled in the program as of May 31, 2015.

AN OVERVIEW OF MARKETING, OUTREACH, EDUCATION AND ENROLLMENT

Before the launch of the first marketing campaign in 2013, Covered California engaged in early research on target audiences; examined the experiences of other public and private health coverage providers; and worked in collaboration with insurance agents, community stakeholders, private foundations, health plans and policy experts. As a result, Covered California launched a multichannel, multicultural marketing, outreach, education and enrollment assistance effort anchored in local communities across the state.

The two primary program elements were:

- **Marketing and media** — The marketing and advertising program consisted of paid digital and traditional advertising and direct marketing, supportive collateral materials, media relations, coordinated events and social media outreach.

- **Community-based outreach and enrollment** — The consumer outreach program consisted of insurance agents; an outreach and education grant program that supported more than 250 local groups to do community-based outreach; a Community Outreach Network of uncompensated partners to bolster outreach efforts; partnerships with elected officials, counties and cities; partnerships with state agencies; community and grassroots organizations such as faith-based, labor, retail and health care organizations; and other in-person assistance programs aimed at directly assisting consumers in accessing and enrolling in coverage.

During the first open-enrollment period, Covered California conducted ongoing research and continued to make course corrections, including adding to community-level support and local coordination and reallocating media resources among different channels. As enrollment data identified potential enrollment opportunities, Covered California refocused resources and approaches to reach ethnic and target populations in regions that appeared to have relatively lower enrollment — such as the Central Valley, the Inland Empire and parts of Los Angeles. A broad array of local community organizations, grantees, counties, assisters and Certified Insurance Agents were effective and vital partners in outreach and education activities.

Following the first open-enrollment period, Covered California spent the summer months analyzing the outcomes of its marketing, outreach and enrollment efforts. In addition to making recommendations for improvements for the second open-enrollment period, Covered California was able to quantify some of its successes.

Covered California's 12,000 Certified Insurance Agents enrolled 40 percent of individuals in the first year and 43 percent of people in the second year. Their tremendous efforts have helped make us a success.

LESSONS LEARNED

Covered California learned many lessons in the first year and made adjustments along the way to improve marketing, sales efforts on the ground, and customer service. During the summer, a more thorough analysis of the first year was conducted and it culminated in a comprehensive report in October 2014 (www.CoveredCA.com/news/PDFs/10-14-2014-Lessons-Learned-final.pdf). Covered California heeded those lessons and adopted many improvements in time for the state's second open-enrollment period, which began on Nov. 15, 2014, and continued through Feb. 15, 2015.

One feature of the Affordable Care Act now getting more attention is the tax penalty, known as the shared responsibility payment. Those who could afford health insurance but refused to buy it in 2014 will pay a penalty when they file their taxes this year and could face higher penalties for tax years 2015 and 2016 (see pages 28 or 29 for more details). Because so many consumers are just learning about the tax implications of going without coverage, Covered California offered a special qualifying circumstance for enrollment, allowing Californians to purchase coverage through April 30, 2015, if they were unaware of the tax penalty for being uninsured.

2 Changes Adopted for the Second Open-Enrollment Period

Covered California's first open-enrollment period resulted in a dramatic expansion of health coverage for millions of Californians and set the bar high for the health benefit exchange in coming years. At the same time, there was room for improvement and significant amounts of learning along the way. Following the first open-enrollment period, Covered California conducted focus group testing, surveyed assisters and grantees, and engaged with state and local leaders throughout the year to prevent and identify problems and to implement needed strategies and course corrections.

Through these efforts, Covered California learned the following key lessons:

1. Many consumers were new to insurance and needed extensive education about health insurance terminology, how to enroll in coverage and how to use insurance.
2. Affordability meant different things to different people. Many consumers, even with financial assistance through federal subsidies, found cost to be a barrier to obtaining coverage.
3. Target enrollment groups had unique interests, experiences and perspectives and required tailored messaging and customizable materials.
4. Different ethnic groups used different service channels to enroll in the manner they felt was most comfortable.
5. Most consumers relied on multiple ways, including in-person assistance, to successfully complete enrollment. They wanted to ask questions, get answers, identify their options and then consider, often in consultation with friends and family, the coverage most suitable for them.
6. The multichannel marketing and media mix struck an effective balance between brand (awareness) and direct response (enrollment) and continues to be tailored to specific target audiences.
7. The volume of consumer interest and interactions online, on the phone and in person exceeded expectations and challenged all systems and service channels.
8. Educators, assisters and all service channels needed effective training, ongoing support and streamlined communications to support their outreach, education and enrollment activities.
9. Partnerships mattered and were transformative. At every stage of planning and implementation for the first open-enrollment period, Covered California relied on and collaborated with a multicultural and varied set of state and local partners who made the unprecedented effort possible.

IMPROVEMENTS BASED ON LESSONS LEARNED

Before the start of the second open-enrollment period, Covered California made significant operations and marketing adjustments in response to these lessons learned: Covered California re-tooled the Navigator grant program, more than doubled Service Center capacity, extended Service Center hours and redesigned its consumer website to include a full Spanish-language site and more information in more languages than it had in the first year.

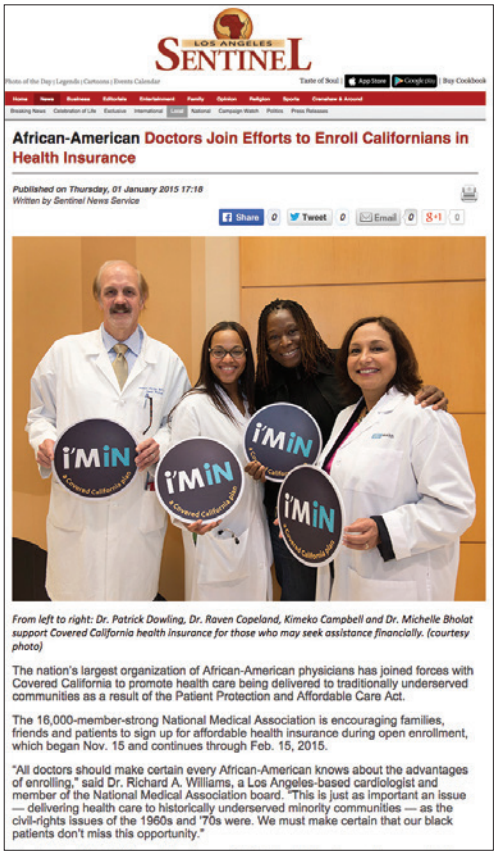
Covered California aired this Spanish-language ad to drive home to Latinos that it is safe to apply even if one of the members of their household is undocumented.

Covered California worked with community partners to encourage storefronts in retail locations, such as malls, to help assist consumers on a drop-in basis that meets their scheduling needs. During the second open-enrollment period, consumers were able to get help to enroll at more than 500 storefronts statewide.

Among the changes Covered California adopted for its marketing were stepped-up Spanish-language and English-language marketing focused on Latino consumers, as well as robust messaging designed to allay concerns about applying if a member of the family is undocumented.

In addition, Covered California hired experts to enhance marketing and outreach efforts in the Latino, Asian and Pacific Islander, and African-American communities to ensure these key target groups were reached in comprehensive, culturally relevant ways.

Covered California made special efforts in the second year of open enrollment to reach African-American consumers in publications tailored to their communities and interests.



LOS ANGELES SENTINEL

African-American Doctors Join Efforts to Enroll Californians in Health Insurance

Published on Thursday, 01 January 2015 17:18
Written by Sentinel News Service

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From left to right: Dr. Patrick Dowling, Dr. Raven Copeland, Kimeko Campbell and Dr. Michelle Bholat support Covered California health insurance for those who may seek assistance financially. (courtesy photo)

The nation's largest organization of African-American physicians has joined forces with Covered California to promote health care being delivered to traditionally underserved communities as a result of the Patient Protection and Affordable Care Act.

The 16,000-member-strong National Medical Association is encouraging families, friends and patients to sign up for affordable health insurance during open enrollment, which began Nov. 15 and continues through Feb. 15, 2015.

"All doctors should make certain every African-American knows about the advantages of enrolling," said Dr. Richard A. Williams, a Los Angeles-based cardiologist and member of the National Medical Association board. "This is just as important an issue — delivering health care to historically underserved minority communities — as the civil-rights issues of the 1960s and '70s were. We must make certain that our black patients don't miss this opportunity."

"I'M IN" STORIES

As Covered California continued its second historic year, people came forward to share how their lives were changed by getting health insurance. A series of videos aired on social media telling of enrollees who got access to care that saved their lives, improved care for their children and caught cancer through preventive screenings.

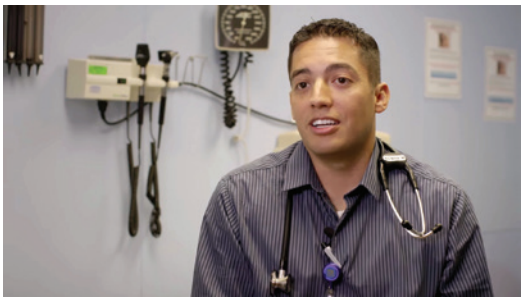
Gabriela Parra of San Diego is among the newly insured Californians now benefiting from private coverage for herself and her family. She is one of the recently covered enrollees appearing in Covered California videos to promote open enrollment. Before Covered California, Parra traveled to Tijuana for routine care for her daughter, who has asthma.

Gabriela Parra

"Since Covered California came into our lives, I don't have to worry about going to Tijuana. Now I can stay here. I can go to a doctor a couple of times a week. I have a $20 copay. I go to the pharmacy, and guess what? I pay $5 for medicine," Parra said. "Covered California is a blessing in our lives. That's a life-changer."

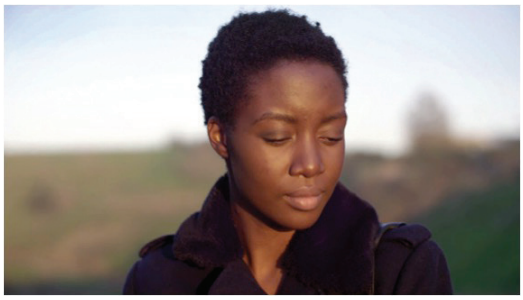
Diana Parret

Diana Parret says Covered California saved her life. Laid off from her job and unable to afford a doctor, Parret signed up through the health care marketplace in February 2014 for a health plan with a subsidy. Her first doctor's appointment revealed an aggressive cancer. Her April surgery was a success. Recovering well, Parret calls Covered California "a godsend."



Dr. Mario Martinez

Fresno-based family practice doctor Mario Martinez is seeing the benefits of Covered California firsthand on a daily basis. "If we get everyone covered, if we get everyone healthy, everyone who's been able to get covered with Covered California, our communities are going to be healthy," he said.



Sarah Kinsumba

One month after signing up for health coverage through Covered California, Sarah Kinsumba had a sudden health crisis. She ended up needing brain surgery, during which she had a stroke. After two months of rehabilitation, she was doing much better and was back home. The treatment cost $2.5 million, but with her Covered California subsidized insurance, she is only paying $7,000. "It's amazing," she said.

THE ENROLLMENT PROCESS

In communities across California, thousands of Certified Insurance Agents, Certified Enrollment Counselors and county eligibility workers continued their efforts to enroll the uninsured. To support them, Covered California created an online digital toolbox (at http://digitaltoolbox.CoveredCA.com) with dynamic and shareable digital content, including social links, campaign videos, English and Spanish tweets and Facebook posts, training and education videos, resources, reference guides and other communication materials.

Covered California upgraded its website that it oversees jointly with the Department of Health Care Services to make the consumer experience easier and more intuitive. CoveredCA.com and the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) application portal now have a unified look, with a common header and footer.

To meet high consumer demand, Covered California spent $22.6 million to upgrade CalHEERS, the online enrollment portal, to handle more simultaneous users and faster page loads so that consumers do not get stuck in the middle of the application process.

The Covered California website is available in both English and Spanish. Landing pages were added in 11 languages, including Arabic, Armenian, Chinese, Farsi, Hmong, Khmer, Korean, Lao, Russian, Tagalog and Vietnamese. These pages include fact sheets about enrollment and information about financial assistance and immigration.

Covered California continues to make significant improvements so that the notices consumers receive are clearer, the information on the website is better — in both English and Spanish — and the consumer experience is more seamless.

Finally, many consumers can now make their first premium payment online, increasing the convenience for consumers and diminishing the number of enrollees who sign up without going on to make their first month's premium payment.

NAVIGATOR GRANTS IN YEARS TWO AND THREE

On June 19, 2014, the California Health Benefit Exchange Board of Directors approved $16.9 million to distribute in grants to eligible entities through a competitive grant application process. The Navigator grant program agreements run from Oct. 1, 2014, through June 30, 2015. The purpose of the Navigator Program is to engage trusted organizations to conduct outreach, education, enrollment assistance and post-enrollment services on behalf of Covered California. A total of $14.65 million was allocated to provide grants to community organizations to reach new Covered California subsidy-eligible consumers.

An additional $2.25 million was allocated for a bonus pool that is estimated to reach an additional 30,000 Covered California subsidy-eligible consumers. Grantees who meet their enrollment goals would be eligible for a $7,500 bonus payment for each additional 100 effectuated enrollments. Covered California selected 66 organizations for funding, which includes an additional 161 subcontractors. Navigator grants total $17.1 million, which includes $14.65 million in new Navigator funding and $3 million in rollover funding from the Outreach and Education Program for the 18 outreach and education grantees that are receiving Navigator grants. The selected grantees will reach consumers in 13 languages: Arabic, Armenian, Chinese, English, Farsi, Hmong, Khmer, Korean, Lao, Russian, Spanish, Tagalog and Vietnamese. Seven grantees are targeting the LGBT community. Many of the selected grantees have proposed providing services to multiple populations.

For the upcoming third open-enrollment period, Covered California announced that it intends to award more than $10 million in grants to Navigators.

Approximately 68 organizations under the 2015-2016 Navigator Program will receive grants of between $50,000 and $500,000. Additionally, nearly 12,000 Certified Insurance Agents will be available across the state, there will be 400 storefronts where consumers can walk in and enroll, and thousands more Certified Enrollment Counselors will assist with applications through nonprofit organizations committed to improving the health of Californians.

A list of Navigator organizations and the amounts Covered California intends to award is available online at http://hbex.coveredca.com/navigator-program/PDFs/2015-16-Intent-to-Award-List.pdf.

During the last open-enrollment period, approximately 70 percent of eligible consumers enrolled or renewed with assistance from Certified Insurance Agents, Certified Enrollment Counselors or Navigators or with the help of Service Center representatives who delivered assistance over the phone.

3 Early Observations About the Second Year

RENEWAL

The fall of 2014 marked Covered California's first effort to renew consumers who enrolled in coverage in late 2013 and early 2014.

The first wave of renewal notices was sent to 1.12 million consumers in October 2014. Consumers were notified that they could take steps to change coverage or they could do nothing and be automatically renewed in their existing plan.

During December, Covered California forwarded to health plans the names of those consumers needing auto-renewal, and plans began sending billing statements that month.

Among those who did not renew, not everyone lost coverage. An estimated 85,000 consumers were determined eligible for Medi-Cal during the renewal process due to fluctuations in income or other life changes. Others gained job-based coverage and no longer needed health coverage through Covered California.

Consumers who completed the renewal process began hearing from their insurance plans in December 2014 and January 2015. Consumers who took no action were automatically renewed into their existing plan. Covered California will continue to analyze renewal patterns among existing enrollees in the months ahead, but a preliminary measure indicates that approximately 92 percent of those who were up for renewal went on to renew their coverage.

NEW ENROLLMENT EFFORTS FOR 2015

During the second open-enrollment period for 2015 coverage, Covered California recognized that the effort to enroll the uninsured would be harder, as many of those eager to sign up had already enrolled in the first year.

One month after the renewal process began, Covered California representatives hit the road on an 11-day bus tour to spread the word that the state's second-ever open-enrollment period would soon begin.

In November, the Covered California bus traveled throughout the state from Redding to San Diego, stopping at more than 30 locations in 23 cities to visit events and enrollment partners to encourage new enrollment. Nearly 100 media outlets — including print, online, radio and television journalists — attended press events during the bus tour, generating 34 million impressions of Covered California's name and brand. The bus, which was "wrapped" to reflect Covered California's "I'm In" campaign, became a magnet for social media selfies, with enrollers and consumers posing for photographs and passing along Covered California messaging via social media.

Crenshaw Health, Asian Americans Advancing Justice, 2-1-1 San Diego, local NAACP chapters, Sacramento Covered, California LGBT Health and Human Services Network, and the Fresno and Riverside Black Chambers of Commerce all stood with us on the tour. We also met with supporters at:

- Bakersfield Health Center/Clinica Sierra Vista
- Yerba Buena High School Library
- Natividad Medical Center in Salinas
- Altamed in Los Angeles
- Rogers Park & Recreation Center in Inglewood
- City of Refuge Church in Gardena

ENROLLMENT RESULTS FROM YEAR TWO

Before open enrollment began for 2015 coverage, Covered California projected a total enrollment of 1.7 million Californians, excluding Medi-Cal enrollees, by the end of the second open-enrollment period: 1.5 million in subsidized coverage and 230,000 in unsubsidized coverage. The forecast anticipated an increase of approximately 500,000 in total enrollment.

Numbers indicate that Covered California nearly met its target for new enrollees, by signing up 495,073 individuals for private coverage between Nov. 15, 2014 and Feb. 15, 2015. However, effectuation of those who had previously signed up turned out to be somewhat lower than expected — about 80 percent instead of 85 percent — leaving Covered California with about 1.34 million enrollees in March 2015. This is short of the 1.7 million projection, but the number of enrollees is expected to grow as individuals receiving Medi-Cal begin transitioning to private coverage offered through Covered California.

MEDI-CAL ENROLLMENT THROUGH COVEREDCA.COM

Increasingly clear is that the population of Covered California enrollees is not a single, static group, but rather an ever-changing population of enrollees. Some who sign up for coverage leave the exchange when they get a job with benefits. Others may age out of the marketplace and enroll in Medicare. Increasingly, Covered California will serve those who have episodes of being uninsured rather than mostly those who never had insurance before.

In total, more than 1.2 million Californians gained coverage through both private health insurance and Medi-Cal during Covered California's second open-enrollment period.

In addition to those who enrolled in private insurance during the second open-enrollment period, many consumers who came through the Covered California portal learned that their income level made them eligible for Medi-Cal. Between Nov. 15, 2014, and Jan. 31, 2015 (the latest date for which figures are available), an estimated 779,000 enrolled in Medi-Cal.

Official enrollment numbers — including Medi-Cal for the full duration of open enrollment, as well as those who signed up during the special-enrollment period ending April 30 — will be released by Covered California when they become available.

4 Connecting with California's Diverse Communities

COMMUNITY OUTREACH CAMPAIGN

As Covered California prepared for its second year, resources were allocated for successful retention, renewal and enrollment in 2015.

The more than 12,000 Covered California Certified Insurance Agents are a strong enrollment and renewal force. In the first two enrollment periods, they signed up at least 40 percent of the total number of those enrolled. Covered California's partners opened more than 400 storefronts in retail locations, such as malls, to help serve consumers on a drop-in basis that met their scheduling needs. Consumers got help at these sites to enroll, renew and learn more about health coverage options.

Covered California's new outreach and enrollment funding supported more than 227 organizations statewide to educate individuals about the Affordable Care Act and worked with them one on one to help them enroll consumers. The community outreach campaign began in October 2014 as Covered California reached out to those who enrolled last year to help them renew their coverage, and continued through the second open-enrollment period ending Feb. 15, 2015.

For the open-enrollment period for 2015 coverage, more than $14.6 million in new Navigator Program grants complemented $33.4 million in existing community resources and performance-based funds, bringing the total community investment for renewal and open enrollment for 2015 to $48 million.

In addition, Covered California supports efforts on the ground with a comprehensive $46 million advertising campaign, for a total community outreach campaign investment of $94 million. More than 1,402 organizations statewide use new and existing resources to reach the state's various

ethnic groups in both urban and rural areas, including schools, nonprofit community organizations, faith-based organizations, medical providers, unions and elected officials. Covered California had 6,365 Certified Enrollment Counselors, nearly 15,000 Certified Insurance Agents and thousands of county eligibility workers engaged in outreach and enrollment to help reach targeted communities in California.

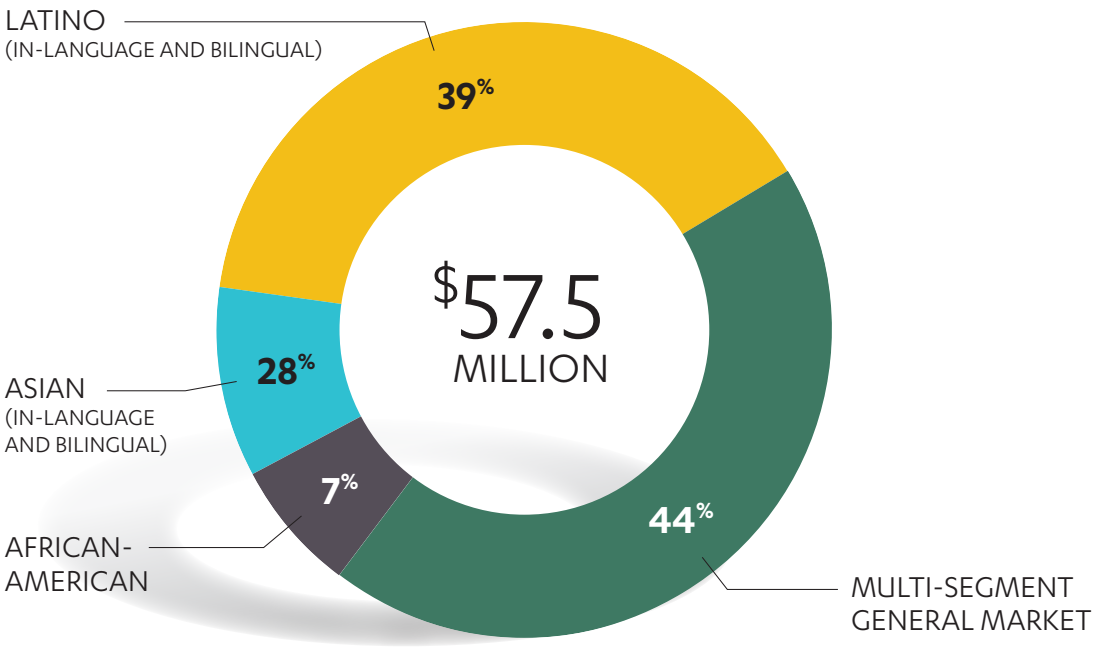
To support the ground effort, Covered California conducted a multifaceted television, radio, print, outdoor, digital, social media and paid search marketing campaign to reach the general market and ethnic groups in multiple languages.

In addition to analyzing the state's ethnic and cultural diversity and its media markets, the marketing planning process for 2015 benefited from 2013 research conducted for Covered California by NORC at the University of Chicago. NORC grouped potential enrollees into market segments based on other characteristics and behaviors that might affect their willingness and ability to seek health insurance coverage.

Covered California considered NORC market segments in the development of content, messaging, advertising targeting and training for community outreach and enrollment efforts.

Covered California continuously works to ensure its marketing campaign reaches the diverse cultures, languages and regional market segments in all 12 designated media markets of the state. For example, during the first open-enrollment period, the media strategy called for significant upfront and sustained investments of paid and earned media across virtually all available media channels, helping Covered California reinforce and amplify the community-based outreach efforts. As future lessons are learned and research is conducted about the state's second open-enrollment period, marketing efforts will be further refined and adjusted.

MEDIA SPENDING: CULTURAL SEGMENTS



MULTICULTURAL CAMPAIGNS

Covered California's media and marketing campaign was organized around four distinct cultural segments that specifically complemented the extensive community outreach campaigns happening in all parts of the state. The campaign segments are: general market (multi-segment), Latino, Asian and African American.

GENERAL MARKET (MULTI-SEGMENT) CAMPAIGN

The general market campaign was designed to cast the widest net, reaching English-speaking, subsidy-eligible Californians of multiple ethnic and cultural backgrounds from rural areas to urban areas. In addition to the multi-segment focus, the campaign was designed to reach the millennial population (ages 18-34) and emphasize digital media, including social media, digital and mobile advertising and paid search.

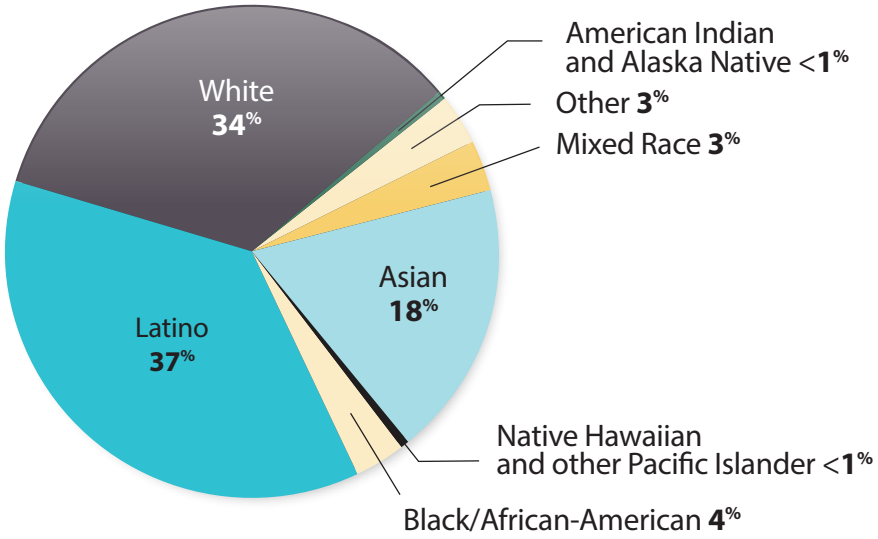
LATINO CAMPAIGN

Covered California is committed to a robust enrollment effort aimed at the Latino community. Some 42 percent of Latinos who enrolled through Covered California in the first year did so by self-enrolling in a health plan. Overall, 28 percent enrolled through Certified Insurance Agents, 20 percent enrolled through Certified Enrollment Counselors, 8 percent called the Service Center to enroll, and 2 percent enrolled through county human services offices or plan-based enrollers. The targeted enrollment effort helped Covered California exceed its enrollment goal for the Latino population.

For its second open-enrollment, Covered California continued its robust effort to reach both Spanish-speaking and English-speaking Latinos statewide. The Latino campaigned launched via television; radio; digital, paid search; print; social media; and direct response tactics such as direct mail and direct email. Covered California representatives were interviewed hundreds of times by the Spanish media in the last year. The increased effort paid off: new enrollments of subsidy-eligible Latinos surged six percentage points — from 31 percent in 2014 to 37 percent of the overall subsidy-eligible enrollment in 2015.

Covered California staff conducting Spanish-language media interviews.

Second Open Enrollment Nov. 1, 2014 - Feb. 15, 2015



Estimated subsidy-eligible population of the state developed by the University of California's statistical model[1]:

38%	34%	21%	5%
LATINO	WHITE	ASIAN/PACIFIC ISLANDER	AFRICAN-AMERICAN

[1] CalSIM version 1.91 Statewide Data Book 2015-2019 — http://bit.ly/1Que1NV

Covered California continues to provide bilingual materials highlighting in-person assistance in specific Latino communities. Covered California is doing outreach in targeted Latino communities through the use of community-based resources by actively coordinating and supporting local communities and partners. Covered California partners have a presence in storefronts, one-on-one meetings, community- and faith-based events, workshops, door-to-door canvasing, clinic-based outreach, mobile enrollment and home visits.

ASIAN/PACIFIC ISLANDER CAMPAIGN

Covered California is committed to ensuring Asians/Pacific Islanders have the tools they need to successfully sign up for health coverage through Covered California. Covered California's research shows that 54 percent of Asians/Pacific Islanders signed up for coverage through a Certified Insurance Agent and that 33 percent enrolled through self-service. Asians/Pacific Islanders preferred signing up through an agent compared with signing up through self-service.

In the first and second open-enrollment periods, Covered California continued its Asian/Pacific Islander campaign efforts in multiple media vehicles in major Asian languages, with additional emphasis on community-based and culturally focused media outlets. Covered California's outreach efforts target Asian/Pacific Islander communities through the use of community-based resources by actively coordinating and supporting local communities and partners. Covered California partners have a presence in storefronts, one-on-one meetings, community- and faith-based events, workshops, door-to-door canvasing, clinic-based outreach, mobile enrollment and home visits.

Community partners continue to work with Asian/Pacific Islander media, including radio, television, print and Internet media, and will leverage relationships with community and faith-based leaders in the Asian/Pacific Islander community to spread the word about the value of health insurance.

MARKETING EFFORTS

More than **$4** million in targeted advertising to the African-American community will be implemented statewide. Examples of planned advertising*:

Television	OWN, ABC, BET, The CW, USA
Radio	KJLH 102.3, KBLX 102.9, KSFM 1025
Print/Newspaper	LA Sentinel, Oakland Post, Sacramento Observer
Web Ads	AOL.com, BlackDoctor.org, Essence, YouTube
Social Media	Facebook, Twitter
Paid Search (SEM)	Google, Bing

"I'm In" television advertisement of a mother of two young boys who tells how having a Covered California health insurance plan allows her to save money while keeping her and her family healthy.

AFRICAN-AMERICAN CAMPAIGN

Covered California's marketing plan was enhanced in the second year of open enrollment to better reach African-American communities through specific media outlets and to deliver messages that better resonate with California's African-American audiences.

For its second open-enrollment, Covered California continued its African-American campaign efforts in multiple media vehicles with additional emphasis on community-based and culturally focused media outlets. Through existing and developing partnerships, Covered California has a presence in storefronts, one-on-one meetings, community- and faith-based events, workshops, door-to-door canvasing, clinic-based outreach, mobile enrollment and home visits. The percentage of African-American new enrollees who are subsidy-eligible increased from 3 percent in 2014 to 4 percent in 2015.

In addition, community partners continue to work with African-American media, including radio, television, print and digital platforms to spread the word about the value of health insurance.

COORDINATION WITH HEALTH PLAN MEDIA AND MARKETING

Covered California shares its marketing strategies, approaches, channels and creative messaging with its health plans. The ongoing communication allows Covered California to keep health plans informed about marketing plans and share information about early experiences, challenges and necessary program adjustments. In addition to Covered California's marketing investment, health plans invested approximately $46 million in marketing statewide.

5 Partnerships and New Messaging for 2015

In all phases of marketing planning and operations, Covered California built and relied on partnerships at the state and local levels to generate awareness, relay and reinforce key messages and convert consumer interest into action.

Covered California collaborated with state and federal agencies such as the California Department of Health Care Services and the California Employment Development Department to deliver educational and collateral materials to potential customers. For example, between November 2013 and March 2014, Covered California sent more than 6 million direct-mail pieces to unemployment benefit recipients and 300,000 pieces to Healthy Families Program households (California's Children's Health Insurance Program, now part of Medi-Cal) and child support program recipients.

Covered California also partnered with The California Endowment and Univision to drive awareness in local communities.

ELECTED OFFICIALS AND LOCAL GOVERNMENT

Covered California worked closely with elected officials at the federal, state and local levels to raise awareness of affordable, quality health insurance plans available through Covered California and opportunities for consumers to receive financial assistance to help them purchase a plan. Elected officials and their staff have become trusted sources for information about the Affordable Care Act and opportunities to enroll in coverage. Members of Congress and state legislators held more than 70 local events throughout the state to help educate their constituents and provide enrollment opportunities. More than two million informational pieces of mail were sent to inform constituents about the important changes that had been made in state and federal law. Hundreds of congressional and legislative staff members participated in regular briefings, trainings and webinars to stay up to date on the new laws and the enrollment process in order to provide effective assistance to constituents who had questions and needed help.

Local elected officials — mayors, city council members, county supervisors, community college district trustees and school board members — were also active in the outreach effort. Many cities, including Long Beach, Sacramento, Irvine, Seaside and West Hollywood, launched "Cover Your City" efforts to reinforce awareness about local opportunities to sign up for coverage. City and county libraries provided safe, trusted venues for enrollment counselors and agents to meet individuals who wanted to enroll.

ADDRESSING IMMIGRATION CONCERNS

Any U.S. citizen or person who is lawfully present in California is eligible for health insurance through Covered California, even if they have family members in their household who are undocumented. Non-citizens or undocumented family members who are listed on an application for insurance for other legal resident members of the household are not at risk. If a household includes both legal residents and non-legal residents, the legal residents can apply for coverage without fear.

Amid concern in local communities and market research suggesting that fear about immigration consequences were barriers to enrollment, Covered California joined with leaders of immigrant-rights groups to address the issue head on during the state's second open-enrollment period.

In December 2014, Covered California announced a joint campaign in partnership with the leaders of these major national immigrant-rights organizations to spread the word that immigration status should not discourage other family members eligible under the Affordable Care Act from applying for coverage.

The partnership included MALDEF (the Mexican American Legal Defense and Educational Fund), the National Immigration Law Center, Asian Americans Advancing Justice - Los Angeles, the National Association of Latino Elected and Appointed Officials (NALEO) Educational Fund, the Coalition for Humane Immigrant Rights of Los Angeles and the California Immigrant Policy Center.

In January 2015, Asian Americans Advancing Justice - Los Angeles and the state treasurer joined Covered California to encourage members of the Asian-American, native Hawaiian and Pacific Islander (AANHPI) communities to enroll for health coverage before the second open-enrollment deadline of Feb. 15. Leaders of Covered California reminded consumers that all information submitted is used strictly to determine eligibility for health insurance programs available under the Affordable Care Act and that the immigration status of family members is strictly confidential.

More information for immigrants can be found on our website here — http://www.coveredca.com/individuals-and-families/special-circumstances/immigrants/

PHYSICIANS AND OTHER HEALTH CARE PROVIDERS

In December 2014, Covered California, the California Medical Association and leaders of 13 physician, pharmacist, hospital and health care provider groups joined forces to highlight the delivery of health care as a result of the Affordable Care Act and to announce a new partnership promoting health coverage offered during open enrollment.

The California Medical Association is one of 14 statewide health provider organizations that began sending letters (see www.CoveredCA.com/news/PDFs/Joint-Letter.pdf) to their members, along with resource materials encouraging them to promote open enrollment and to display an "I'm In" placard so that patients, prospective patients and family members would know that the providers accept insurance plans offered through Covered California.

Kimeko (left) is thankful that she got enrolled in Covered California. She is getting the care she needs by the caring doctors and nurses at UCLA Medical Center at a cost she can afford.

MARKETING, OUTREACH AND ENROLLMENT ASSISTANCE ADVISORY COMMITTEE

At every step of the way, Covered California has worked with its Marketing, Outreach and Enrollment Assistance Advisory Committee. Guidance offered by the committee led Covered California into its partnerships with Latino and Asian immigrant-rights organizations to help spread the word that information on health care applications is secure and confidential. In addition, feedback from the committee helped shape and inform Covered California's effort to step up messaging around tax penalties for those who can afford to buy insurance but choose not to despite the new requirement in federal law.

HEALTH CARE AND TAXES

In 2015, Covered California began implementing features of the Affordable Care Act related to taxes for the very first time. A significant new operational and communication challenge for Covered California in 2015 was the issuance of new Health Insurance Marketplace Statements, or Internal Revenue Service (IRS) Form 1095-A documents, to an estimated 900,000 households.

1095-A FORMS

Covered California spent many months working with federal health officials, the IRS and our service channels to plan for and issue Health Insurance Marketplace Statements for all Covered California consumers. The forms detail for consumers the amount of subsidy, or Advanced Premium Tax Credit, consumers received in 2014. Similar to a W-2 or 1099, a 1095-A is used by consumers when they prepare their tax return for 2014. Covered California prepared a fact sheet and an extensive list of frequently asked questions to assist consumers. Not all forms were correct, and some consumers have been frustrated while seeking corrected forms. However, the vast majority of Covered California consumers received an appropriate form and filed the information with their taxes so that appropriate adjustments can be made to ensure the subsidy they received is just right. Basic information about Form 1095-A, as well as the latest updates for consumers, can be found at www.CoveredCA.com/youre-in/form-1095-a/.

In the years ahead, Covered California will make improvements based on lessons learned regarding the issuance of Form 1095-A, and consumers will have more familiarity with the importance of estimating and updating their income regularly, as well as the reconciliation process that occurs when they file taxes.

TAX PENALTIES FOR REMAINING UNINSURED

In addition to the new tax form for individuals who received a subsidy to help them purchase health insurance through Covered California, many Americans without health coverage are learning this year about the tax consequences of being uninsured.

Under the Affordable Care Act, all Americans who can afford health insurance are required to have it or pay a tax penalty known as a "shared responsibility payment." The payment was calculated as Americans prepared their taxes for 2014.

In January 2015, Covered California began emphasizing in news conferences, advertising and collateral materials that the new penalty for being uninsured in tax year 2015 will be even higher than it was in 2014. Uninsured consumers are advised to enroll for 2015 to avoid steeper penalties when they prepare their taxes next spring.

The following is a sample of Covered California's tax penalty messaging:

> It's never smart to avoid having health insurance — one accident can lead to an emergency room visit and tens of thousands of dollars in bills, or learning you have cancer when it's too late to treat it. Now there's another reason to get insured: taxes.
>
> The "shared responsibility payment" is a new tax penalty that Americans have to pay this year if they can afford health insurance but choose not to buy it. It's called a shared responsibility payment because everyone in the United States is now required to be part of our health insurance system — buying health coverage for themselves and their families rather than relying on others to pay for their care. Those who don't buy health insurance in 2015 may be subject to the penalty, which is $325 per person in a household or two percent of their income, whichever is greater.

It's Getting More Expensive to Go Without Insurance

PENALTIES* BY TAX YEAR	2014	2015	2016
Jim earns $40K/yr	$299	**$594**	$736
Eduardo & Julia earn $70K/yr	$497	**$988**	$2,085

* **2014 amounts** based on IRS estimations, www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Calculating-the-Payment. **2015 and 2016 amounts** estimated using ACA calculator – http://taxpolicycenter.org/taxfacts/acacalculator.cfm.

6 Leadership and Funding

LEADERSHIP

Covered California is led by a five-member board appointed by the governor and the state Legislature. Two board members are appointed by the governor, one is appointed by the Senate Rules Committee, and one is appointed by the speaker of the Assembly. The secretary of the Health and Human Services Agency or another designee serves as an ex officio voting member of the board. Appointed members serve four-year terms. The board is responsible for making major policy decisions and for hiring senior staff. Peter V. Lee continues to serve as Covered California's first executive director since he was hired in October 2011, and Yolanda Richardson continues as Covered California's chief deputy director since she began her tenure in April 2012.

The Covered California Board met for the first time on April 20, 2011, and has held more than 49 meetings at locations in Sacramento and throughout the state. The Covered California Board now meets regularly in the boardroom of its new Sacramento headquarters.

Board members make important strategic decisions related to eligibility and enrollment, affordability, benefit design, education and outreach, and marketing, as well as how best to operate the Service Center and how to hire, train and support individuals who will help people enroll in coverage.

Covered California's first board included board chair Diana Dooley, Dr. Bob Ross, Susan Kennedy, Kimberly Belshé and Paul Fearer. We thank them for being such a dedicated, engaged and hard-

Covered California Board Members

Diana S. Dooley, Chair

Paul Fearer

Genoveva Islas

Marty Morgenstern

Art Torres

working board. Their thoughtful decision-making helped shape Covered California into the organization it is now.

In March, Gov. Edmund G. Brown Jr. appointed Genoveva Islas and Marty Morgenstern to the Covered California board to replace Susan Kennedy and Kimberly Belshé.

Covered California Board Members	Appointing Authority	Term
DIANA S. DOOLEY Secretary, Health and Human Services Agency; Chair of the Board (elected by the board), Covered California Secretary Dooley began her professional career in public service as an analyst with the State Personnel Board. In 1975, she was appointed to the staff of then Gov. Edmund G. Brown Jr., where she served as legislative secretary and special advisor until the end of his term in 1982. Prior to returning to public service in 2011, Ms. Dooley was president and chief executive officer of the California Children's Hospital Association. She was appointed by Gov. Brown to serve as secretary of the Health and Human Services Agency in 2011.	Ex Officio Voting Member as Secretary of the Health and Human Services Agency	Ex Officio
PAUL E. FEARER Board Member Mr. Fearer recently retired as a senior executive vice president and director of human resources of UnionBanCal Corp. and its primary subsidiary, Union Bank N.A. He served as the chair of the Pacific Business Group on Health and has provided strategic leadership on both small-group and large-employer purchasing for many years.	Assembly	January 2017
GENOVEVA ISLAS Board Member Ms. Islas has been the program director at the Public Health Institute's Cultiva La Salud, formerly the Central California Regional Obesity Prevention Program, since 2006. She was an area field representative at the California Department of Public Health, California Diabetes Program from 2004 to 2005. Islas was an adjunct faculty member at Bakersfield College from 1997 to 2005 and health education-cultural linguistics supervisor at Kern Health Systems from 1993 to 1999.	Governor	January 2019
MARTY MORGENSTERN Board Member Mr. Morgenstern has served as a senior adviser in the Office of the Governor since 2013. He served as secretary of the California Labor and Workforce Development Agency from 2011 to 2013 and was a consultant for the University of California labor relations matters from 2004 to 2006 and from 2009 to 2011. Morgenstern was director of the California Department of Personnel Administration from 1999 to 2003 and from 1981 to 1982 and was a consultant in private practice from 1994 to 1999.	Governor	January 2019
ART TORRES Board Member Art Torres is vice chair of the governing board of the California Institute for Regenerative Medicine. As vice chair, he helps oversee the allocation of $3 billion in stem cell research to California universities and research institutions. He served in the California State Senate from 1982 to 1994 and in the California State Assembly from 1974 to 1982. Prior to being elected to the California Legislature, Torres served as the national legislative director for the United Farm Workers Union, working closely with Cesar Chavez and Dolores Huerta.	Senate	January 2016

Covered California informs its policy development through four stakeholder advisory groups that provide feedback on the development of programs: Plan Management; Marketing, Outreach and Enrollment Assistance; Covered California for Small Business; and Tribal Consultation. At meetings held each quarter, Covered California receives comment and feedback from these groups on a

variety of topics. In addition, Covered California regularly holds webinars and other public forums to gather input from stakeholders on a wide range of issues.

The board, senior and specialized staff and contractors are subject to appropriate provisions of the California Political Reform Act and Conflict of Interest Code provisions adopted by the California Fair Political Practices Commission. In addition, Covered California adopted an administrative policy in February 2013 related to Public Records Act requests. Requests for documents are submitted to the Covered California Office of Legal Affairs. These policies were codified under Senate Bill 332, which was signed by the governor earlier this fall. It amended Government Code Section 100508 and took effect immediately upon signature.

In 2011, the board established a vision, mission and set of values that have served to guide staff on an ongoing basis.

The vision of Covered California is to improve the health of all Californians by ensuring their access to affordable, high-quality care.

The mission is to increase the number of insured Californians, improve health care quality, lower costs and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

Covered California is guided by six primary values:

Consumer-focused: At the center of the Covered California's efforts are the people it serves, including patients and their families, and small business owners and their employees. The Exchange will offer a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of those we serve.

Affordability: Covered California will provide affordable health insurance while assuring quality and access.

Catalyst: Covered California will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities.

Integrity: Covered California will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability and cooperation.

Partnership: Covered California welcomes partnerships, and its efforts will be guided by working with consumers, providers, health plans, employers and other purchasers, government partners and other stakeholders.

Results: The impact of Covered California will be measured by its contributions to expanding coverage and access, improving health care quality, promoting better health and health equity and lowering costs for all Californians.

FUNDING

The Exchange continues to implement the historic provisions of the Affordable Care Act and make sure that consumers are aware of the health insurance options available to them under the law. Since 2011, when the state Legislature and governor enacted a state law creating the exchange, Covered California transformed itself from a fledgling organization to a well-recognized brand.

To support this undertaking, Covered California has received more than $1 billion in federal grant funding in the last three years to launch the Exchange; build the information technology infrastructure; hire staff; undertake multicultural marketing, outreach and education efforts statewide; and work with community partners to educate target communities. Covered California has received federal permission to use federal grant resources for the purposes of establishing the Exchange through Dec. 31, 2015.

Fiscal Year 2013-14

In fiscal year (FY) 2013-2014, Covered California's expenditures totaled $361.4 million. This included developing and enhancing information technology and infrastructure; promoting Covered California through marketing, public relations and communications activities; establishing and staffing three Service Centers; and providing grants to community-based organizations to educate and enroll consumers. Resources were also used to support staff recruitment and training, to gather stakeholder input and creating Covered California for Small Business.

Actual expenditures for FY 2013-2014 were 19 percent less than the budget authority due to a slower pace of contractual spending, hiring at a slower pace and the timing of Service Center development and other activities.

Fiscal Year 2014-15 — Projected

Covered California ended FY 2014-15 under budget, with expenditures estimated at $374.3 million, approximately 9 percent less than the budget of $411.7 million, adopted in June 2014. Expenditures in FY 2014-15 have been focused on promoting new enrollment through community outreach and paid marketing, expanding Service Center and system capacity, administering the first renewal effort for existing Covered California members and issuing Health Insurance Marketplace Statements (IRS Form 1095-A) to consumers.

Fiscal Year 2014-15: Projected Expenditures Versus Budget

	2014-2015			
	BOARD APPROVED	ACTUAL	DIFFERENCE	CHANGE
Service Center	$ 97,022,224	$ 96,836,382	$ (185,842)	0%
CalHEERS	$ 88,177,616	$ 93,607,718	$ 5,430,102	6%
Outreach and Sales, Marketing	$ 189,831,459	$ 153,558,948	$ (36,272,511)	-19%
Plan Management & Evaluation	$ 17,334,578	$ 11,286,694	$ (6,047,884)	-35%
Administration	$ 37,796,386	$ 36,460,965	$ (1,355,421)	-4%
Enterprise Shared Costs	$ 12,589,363	$ 1,543,057	$ (11,046,306)	-88%
TOTAL EXPENSES	**$ 442,751,626**	**$ 393,293,764**	**$ (49,457,862)**	**-11%**
CalHEERS Cost Sharing	$ (3,058,183)	$ (8,849,420)	$ (5,791,237)	189%
Reimbursements	$ (28,000,000)	$ (10,165,633)	$ 17,834,367	-64%
TOTAL OPERATING COSTS	**$ 411,693,443**	**$ 374,278,711**	**$ (37,414,732)**	**-9%**

The current multiyear plan is designed to fund FY 2015-16 with federal establishment funds and plan assessments and to balance revenues and expenditures by FY 2017-18. The plan will provide a six-month operating reserve throughout FY 2015-16 with a fiscal year-end position of approximately $197 million. It reflects that a series of strategic reductions to operating expenses are made for FY 2015-16 and in the next two fiscal years while still allowing programs to meet necessary service levels to maintain and expand membership.

Fiscal Year 2015-16 and Beyond

On June 18, the Covered California Board adopted the budget for FY 2015-16. This budget provides $335 million and 1,399 positions to ensure that the organization has the right tools, processes, and resources to deliver on its mission. The FY 2015-16 budget is balanced with the last year for federal establishment funds and the use of plan assessment fees. Covered California will end the fiscal year with approximately $194 million in reserve funding to address any unforeseen economic uncertainties and to facilitate the transition to supporting our operations solely on plan assessments. This budget meets the guidance provided by the board and the legislative intent behind the establishment of Covered California. The budget reflects the organization's multiyear financial strategy of providing continuous fiscal integrity, transparency and accountability.

The following table shows five-year budget scenarios based on medium enrollment in Covered California health plans.

Multiyear Financial Outlook — Based Upon Medium Scenario

(dollar amounts are in millions)

	FISCAL YEAR				
	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019
Effectuated Enrollment *(at fiscal year end)*	1,299,521	1,476,342	1,666,617	1,809,095	1,977,792
Plan Assessments — Cash Basis	$ 197.4	$ 234.4	$ 269.2	$ 303.6	$ 329.2
Expenditures	$ 384.7	$ 335.0	$ 310.0	$ 300.0	$ 300.0
Funds Available at Year-End	$ 297.9	$ 197.2	$ 156.4	$ 160.0	$ 189.2
Minimum time that expenditures are covered by reserve	9.3 months	7.1 months	5.6 months	5.4 months	6.1 months

The multiyear outlook reflects the approved budget of $335 million in FY 2015-16, projected budgets of $310 million in FY 2016-17, and $300 million in FY 2017-18 and beyond. This outlook is based on the medium-enrollment scenario and would change if actual enrollment figures different from the medium projection. Starting Jan. 1, 2016, the sole source of Covered California's funding for ongoing operations will be per-member-per-month fees assessed on qualified health plans. Covered California will enter fiscal year 2016-17 with approximately $197 million in reserve to support ongoing operations. Fiscal year 2016-17 is the first year that Exchange operations will rely entirely on fees rather than federal grant funding.

Link to budget: http://board.coveredca.com/meetings/2015/6-18/2015-16-CoveredCA-June-Budget-Revision.pdf

7 Looking to the Future — Delivering on the Promise

Following the second open-enrollment period, Covered California did a thorough analysis of what worked well and where the organization can improve, sharing our latest lessons learned with elected officials, stakeholders and the public at large.

These first two open-enrollment periods in many ways mark "the end of the beginning." Strategies and tactics were refined based on the first renewal experience and the second year of open enrollment. These lessons learned are informing efforts for 2016, when Covered California will spend more on retention but significantly less on community outreach, marketing and new enrollment.

Covered California will continue to focus its planning on how to transition from an entity focused primarily on open enrollment "seasons" to one that establishes a year-round presence.

A Kaiser Family Foundation survey released in July 2015 titled "California's Previously Uninsured After The ACA's Second Open Enrollment Period" provides further proof that the Patient Protection and Affordable Care Act is working in California. The survey found that more than two-thirds of California's uninsured population (68 percent) gained health coverage since the Affordable Care Act went into effect in 2014. That share is up from 58 percent of Californians who became insured after Covered California's first open-enrollment period in 2014.

The survey also found that 86 percent of recently insured consumers say their health needs are being met, which is up from 51 percent in the first survey conducted in 2013 before Covered California's first open-enrollment period. Additionally, 70 percent of recently insured Covered California consumers say the cost of the health insurance coverage was about what they expected or even less than they expected.

Covered California estimates based on data from the California Department of Public Health, the federal Department of Health and Human Services and the U.S. Centers for Disease Control and Prevention (www.CoveredCA.com/news/PDFs/impact-of-health-coverage-fact-sheet.pdf) indicate that insurance coverage is helping improve care for a number of prominent health conditions, including asthma and diabetes.

Specifically, an estimated 8,700 more Californians will have access to care to better control their asthma, 45,064 Californians will be diagnosed with diabetes and could begin treatment, 63,922 Californians with diabetes will be able to increase their medication to control the disease and an estimated 36,527 Californians will avoid catastrophic medical expenses.

These estimates show promise but data from actual health care usage by Covered California enrollees will offer a more precise picture in the years ahead.

New rates were negotiated for plan offerings for 2016, and Covered California will continue to work to ensure that health care providers are available to consumers as needed in underserved parts of the state by encouraging new offerings in some regions in the year ahead.

Through statewide partnerships and strong political support, a very strong foundation has been laid. As Covered California moves into the future, it will increasingly rely on a budget funded entirely from the assessment on health plans that is built into consumers' premiums. Covered California will be challenged by the need to "right-size" the organization and achieve the proper balance of operational, outreach and marketing spending in the years ahead, given more limited resources.

Today, Covered California is helping people get the health coverage they need to get access to the care that can improve their lives. The stories they are sharing about their access to care are historic and powerful. In the years ahead, these anecdotes will be complemented by data Covered California will soon collect, telling how consumers are using their coverage to get the care they need.

As Covered California moves into the future, the promise of health reform will move beyond just expanding coverage, to achieve the broader "triple aim" of health reform: improving the experience of care, improving the health of populations and reducing per-capita costs. Covered California is ready to meet the challenge and continue making history.

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The ACA's §1332 State Innovation Waivers: A Primer

ITUP
Insure the Uninsured Project

ITUP's mission is to increase coverage of California's uninsured by building consensus on targeted issues among the state's health leaders.

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ITUP is a non-partisan, non-profit health policy "think tank" based in Santa Monica, CA.

We are funded by generous grants from Blue Shield of California Foundation, The California Endowment, California Community Foundation, Kaiser Foundation Hospitals, California HealthCare Foundation, and L.A. Care Health Plan.

What is a §1332 Waiver?

§1332 of the Affordable Care Act (ACA) permits states to waive four of the law's requirements with aim of allowing new, broad innovative state-based models for expanding health coverage. Elements that states may waive:

1. **Individual Mandate**
2. **Employer Mandate**
3. **Essential Health Benefits**
4. **Health Benefit Exchanges and Subsidies for Coverage**

What does a §1332 require?

State §1332 waivers must still satisfy the four following criteria:

1. **Must extend health coverage to as many people as the ACA**
2. **Must provide coverage that is as comprehensive as the ACA**
3. **Must provide coverage that is as affordable to consumers as the ACA**
4. **Must not add to the federal deficit**

Other Requirements and Restrictions

- States must pass legislation authorizing a §1332
- States may not implement a waiver before January 1, 2017, but may begin planning a waiver application at any time, and may submit before 2017
- States must hold a pre-application public hearing, and hold annual public forums on waiver after approval

What does a §1332 NOT do?

While §1332 waivers are quite flexible and broad, there are clear limits to their reach. A §1332 may not:

- **Waive other ACA insurance market reforms**
  - **Prohibitions related to rating based on preexisting conditions,**
  - **Annual and lifetime coverage limits,**
  - **Required coverage of preventive care,**
  - **Coverage for dependents up to age 26**
- **Modify requirements of Medicaid or Medicare**
  - **Broad modifications to a state's Medicaid program would still require a §1115 waiver**
  - **Modifications to Medicare would require a Medicare waiver**

Financial Flexibility with Subsidies

States may use funds that residents would have received through premium and cost-sharing subsidies to support different approaches to coverage.

Some options for state innovation:

- **Restructure sliding scale for subsidies to smooth abrupt increases in consumer cost (particularly at 250% and 400% FPL in California)**
- **Combine federal and state resources to increase consumer affordability by expanding range or size of subsidies**
- **Expand size, length, structure, or eligibility of small business tax credits**
    - **Currently available for two years to firms with fewer than 25 employees, that cover at least 50% of premiums, with average wages less than $50,000—credits can cover as much as 50% of premium costs**

Financial Flexibility with Subsidies

Additional options for state innovation

- "Enhanced Bronze" plan that would parallel Enhanced Silver (10% lower actuarial value) with increased cost-sharing subsidies
- Fix "Family Glitch" and create definition for affordable family coverage, allowing more family members to access subsidized Covered California plans

Financing expanded assistance

- Could establish a California "Cadillac tax" in addition to the ACA tax on highest cost plans to fund increased consumer assistance with premiums and cost-sharing

Waiving Employer Mandates

States may waive or modify the employer requirements to offer coverage by 2016 if they have 50 or more full-time employees (and 100 or more in 2015), with a penalty assessed for employees without coverage.

Modifying the strictness and scope of requirements affects the number of people with health coverage, and may also have budgetary implications

- **Relaxing employer requirements may require increased financing for premium and cost-sharing assistance for exchange plans if employees choose that option**
- **Additional or more generous assistance would be more costly, requiring a budgetary offset**

Waiving Employer Mandates

Some options to keep enrollment and §1332 spending at ACA levels:

- **If fewer employers affected by requirements, could concurrently increase penalty amount for employers and/or individuals AND consumer assistance to allow employees to enroll in exchange**
- **Create alternatives like a required employer "fair share" contribution for health—could be a defined percentage of payroll, similar to Healthy San Francisco's required contribution per hour of work**
- **Facilitate employer contributions to employees' premiums for Covered California plans**

Waiving Individual Mandate

States may waive or modify the individual requirement to purchase coverage, along with its exemptions and tax penalties.

- Again, modifying the strictness and scope of requirement affects the number of people with health coverage and has budgetary implications
- Relaxing the individual requirement would reduce enrollment

Some options if requirement is modified:

- With broader exemptions, could concurrently increase size of individual and employer penalties to prevent addition to deficit and increase consumer assistance to maintain enrollment
- Create auto-enrollment policy in place of individual requirement to maintain enrollment levels

Broad Multi-Waiver Innovations

States may submit §1332 waiver coordinated with §1115 Medicaid and Medicare waivers to make programs more aligned, consumer friendly, and high-value.

Some options for California:

- **Create uniform eligibility threshold for all groups between Medi-Cal and Covered California**
- **Place certain Medi-Cal eligibility groups in Covered California plans**
- **Align or merge certain administrative functions (rules/policies, plan contracting, etc.) of Covered California and Medi-Cal**
  - **Facilitate more seamless consumer transitions between programs**
  - **Facilitate plan and provider continuity between Covered California and Medi-Cal**

Broad Multi-Waiver Innovations

Some options for California (continued):

- **Bring Medicare Advantage plans into Covered California**
- **Bring all individual, small-group, and large group markets (except self-insured) into Covered California**
- **Allow for undocumented residents to purchase Covered California plans**

Using a §1332 for Payment and Delivery System Reform

States can act to increase value-based purchasing to improve service quality and health outcomes, and to contain costs across payers.

Some examples:

- **Modify subsidy amounts according to plan quality performance metrics**
- **Align contracting strategies to emphasize value, and to facilitate plan and participation across payers (commercial, Medi-Cal, Medicare Advantage)**
- **Align provider incentives and delivery system designs to facilitate participation across payers and reduce administrative burden for providers**

What can states do without a §1332?

States can also take a variety of actions to innovate and improve health coverage without a §1332.

Some examples:

- **Modify the benchmark plan for a state's Essential Health Benefits package**
- **Merge individual and SHOP marketplaces in exchanges, or allow large employers to purchase through the Exchange**
- **Attach quality and cost performance requirements to Covered California contracts with health plans**

Awaiting Further Federal Guidance

Further federal guidance is needed to answer many questions about the specific requirements of §1332.

- **How will CMS determine whether or not §1332 coverage is comparable to ACA coverage?**
- **What formula will Treasury use to calculate impact on the federal deficit?**
- **The number of people covered under the ACA vs. a §1332?**
- **Consumer affordability of coverage under ACA vs. a §1332?**

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The COMMONWEALTH FUND

Comparing Individual Health Coverage On and Off the Affordable Care Act's Insurance Exchanges

Toplines

- (#)Insurers aren't seeking lower-risk customers outside the ACA exchanges as some feared
- (#)The ACA's insurance reforms are working in the individual market

Abstract

The new health insurance exchanges are the core of the Affordable Care Act's (ACA) reforms, but how the law improves the nonsubsidized portion of the individual market is also important. This issue brief compares products sold on and off the exchanges to gain insight into how the ACA's market reforms are functioning. Initial concerns that insurers might seek to enroll lower-risk customers outside the exchanges have not been realized. Instead, more-generous benefit plans, which appeal to people with health problems, constitute a greater portion of plans sold off-exchange than those sold on-exchange. Although insurers that sell mostly on the exchanges incur an additional fee, they still devote a greater portion of their premium dollars to medical care. Their projected administrative costs and profit margins are lower than are those of insurers selling only off the exchanges.

Background

The Affordable Care Act's health insurance market reforms are designed to encourage insurers to compete on the value of their products rather than on their ability to identify and segment people based on their risk of incurring medical costs. The ACA does this by: requiring insurers to accept all applicants; requiring them to charge consumers within a geographic area the same age-banded premiums, regardless of health status; and

prohibiting other forms of so-called medical underwriting, like excluding preexisting conditions. In addition, the ACA's state and federal health insurance exchanges (also called marketplaces) help consumers shop for insurance by standardizing covered benefits and presenting information about costs in an accessible way.

Health insurers, however, are not required to sell policies through the new exchanges.[1] In the individual market, subsidized coverage—which is offered to people earning up to 400 percent of the federal poverty level (about $47,000 for an individual or $97,000 for a family of four)—is available only on the exchanges.[2] But insurers that sell subsidized coverage may also sell outside the exchanges. Moreover, some insurers in the individual market opt to stay out of the exchanges entirely, instead selling to people who do not qualify for or claim the premium subsidies.

Accordingly, two distinct segments have emerged in the individual market: coverage sold on the exchanges, mostly to people who qualify for a subsidy; and coverage sold off the exchanges, through traditional channels to people who pay full price. This division of the individual market provides an opportunity to explore how effective the ACA has been at promoting good coverage at lower prices.

Comparing these two segments allows us the opportunity to observe whether insurers use this market division to engage in the types of risk segmentation that the ACA is meant to eliminate. Before the exchanges launched, analysts speculated that insurers might attempt to segregate higher-risk from lower-risk subscribers by encouraging those at higher risk to purchase on the exchanges and those with lower risks to remain off the exchanges.[3] If successful, that adverse selection strategy could increase the cost of government subsidies.

The ACA has several provisions that keep any potential for risk segregation in check. First, to keep insurers from segregating their risk pools, the ACA requires each insurer in the individual or small-group market to maintain a "single risk pool" for ACA-compliant plans.[4] This means that insurers must use the same premium rating factors for all subscribers and plans within the relevant market, rather than using different rates for separate risk pools. If an insurer sells coverage both on and off the exchanges, rates must be identical for identical coverage. If coverage differs, rates may be adjusted only for actuarial value and not for differences in health status or overhead costs. Second, to counter insurers' incentives to avoid greater risks across the market, the ACA has a risk-adjustment mechanism in the individual and small-group markets that requires insurers with lower-risk subscribers to subsidize insurers that enroll people expected to incur more medical claims.

To assess how well these rules are working, we examine insurers' federal filings for premium rates that took effect in 2015 for ACA-compliant products sold on and off of the insurance exchanges.[5] These filings, which demonstrate carriers' compliance with the ACA's rating rules, allow us to observe how different market segments are performing.

Findings

Market Shares and Risk Selection

Because the ACA's premium subsidies are available only through the federal and state exchanges, it is no surprise that the majority of coverage in the individual market is sold there. For 2015, insurers projected that only 21 percent of their anticipated 14 million ACA-compliant subscribers will be in plans sold only off the exchanges. The others will be in plans sold predominantly through the exchanges.[6]

We see little evidence of insurers actively pursuing risk segmentation in their offerings on and off the exchanges. One way risk segmentation might occur is for insurers to offer leaner plans off the exchanges because these appeal more to healthier people. But this does not appear to be occurring (Exhibit 1). Bronze-level plans, which cover only an average 60 percent of medical expenses, have a similar share on and off the exchanges—about one-quarter of projected enrollment. Notably, the most generous (and most expensive) plans—i.e., the gold- and platinum-level plans—are much more prevalent off-exchange than on, constituting one-third of projected enrollment off compared with less than one-fifth on. There is a much greater proportion of people in silver-level plans on the exchanges, compared with off (58% vs. 37%). One likely reason is that lower-income people who are eligible for reduced out-of-pocket cost-sharing must choose a silver plan to receive the full benefit of that subsidy.

Another factor that dampens potential adverse selection is the different provider networks that insurers offer on and off the exchanges. The exchanges allow for shopping based on head-to-head price comparisons. Therefore, to be competitive, insurers formed narrower provider networks based on doctors and hospitals willing to give deeper discounts.[7] Narrow networks are less appealing, however, to people with more complex health problems who tend to prefer a wider choice of specialists. Therefore, people with preexisting conditions could be more likely to shop for plans off the exchanges.

Two different sources suggest this is happening. A health insurance website that aggregates insurance prices reported in 2014 that the least expensive ACA-compliant plans offered by the major insurers that sold only off the exchanges cost 40 percent more than the cheapest equivalent coverage sold on the exchanges (disregarding subsidies).[8] It is unlikely that this large difference was simply the result of price competition. It more likely occurred because insurers offered more expensive plans with broader networks off the exchanges. These broader networks have not attracted sicker subscribers, however. Surveys by the Kaiser Family Foundation found similar age distributions in subscribers on and off the exchanges in their first two years of operation.[9] Moreover, based on self-reported health status, enrollees off the exchanges have a similar health profile. Thus, it does not appear that, at least initially, the leaner networks on the exchanges are pushing sicker people off the exchanges.

Targeted Medical Loss Ratios

The ACA's insurance exchanges were intended to improve consumer value in two ways: by making insurers more price competitive and by reducing overhead sales costs. One way to measure this is through insurers' medical loss ratios (MLRs). The MLR is the percentage of total premium cost that an insurer spends on medical claims, with the remainder earmarked for overhead costs and profits.

To isolate the separate market dynamics, we compared the projected MLRs in 2015 for insurers that sell only off-exchange with those that sell all products on-exchange.[10] To minimize the effect of outliers, we report median rather than mean values. As shown in Exhibit 2, insurers competing off the exchanges project a median MLR that is 3.3 percentage points lower—meaning they spend this much more on overhead and profit—than those that sell all of their individual plans on the exchanges. This difference is largely accounted for by greater administrative costs. The median for administrative costs is 3.2 percentage points higher off the exchanges.

Exhibit 2. Projected Median Financial Performance Ratios, 2015

	All insurers	Insurers selling all products on the exchanges	Insurers selling all products off the exchanges
N=	571*	194	222
Medical loss ratio	78.1%	79.3%	76.0%
Administrative ratio	14.0%	12.0%	15.2%
Tax and fee ratio	5.9%	6.2%	5.2%
Profit ratio	2.5%	2.0%	2.7%

Note: Median values are not additive across the four performance measures.
* The total for "All insurers" exceeds the sum of issuers "ALL ON" and "ALL OFF" because some issuers offer plans both on and off exchanges.
Source: Authors' analysis of Uniform Rate Review data from the Centers for Medicare and Medicaid Services.

While their administrative costs may be lower, insurers selling products on the exchanges are also projected to have higher taxes and fees because the exchanges charge fees for plans purchased there.[11] These fees are built into each insurer's marketwide rates, including rates for plans sold off-exchange that do not incur the fee, which somewhat reduces the rate impact of these fees.[12]

Summing together all three overhead components—administrative costs, profits, and taxes and fees—the lower total overhead by insurers on the exchanges suggests that the fees charged by exchanges cover services that help reduce insurers' sales and administrative costs. That is only one possible interpretation, however. Because the insurers that sell exclusively off-exchange are different from those that sell on-exchange, we cannot draw firm conclusions about whether the exchanges themselves cause insurers to devote a lower proportion of their premiums to overhead and profits. It is possible that carriers with historically higher

overhead or profits chose not to participate in the exchanges. However, it is also possible that the exchange structure promotes greater efficiency by reducing sales and administrative costs and by increasing price competition.

Components of Premium Increases

We next look at changes in premiums between 2014 and 2015. Exhibit 3 shows the components of insurers' 2015 premium increases, overall and on and off the exchanges. Overall, the member-weighted average premium paid in the individual market increased $30 per person per month in 2015, with a somewhat higher increase off the exchanges ($34) compared with on ($29).[13]

Exhibit 3. Components of Premium Increases in the Individual Market for 2015, On vs. Off the Health Insurance Exchanges

	All individual products (PMPM)	Percent increase	Products on exchange (PMPM)	Percent increase	Products off exchange (PMPM)	Percent increase
N=	1,060		578		482	
Inpatient	$3.6	12.1%	$3.31	11.3%	$4.93	14.7%
Outpatient	$5.5	18.3%	$5.04	17.3%	$7.31	21.8%
Professional	$6.1	20.3%	$5.68	19.5%	$7.77	23.2%
Drugs	$4.2	14.0%	$4.22	14.5%	$4.14	12.3%
Other	$1.5	4.8%	$1.15	3.9%	$2.62	7.8%
Medical subtotal		**69.5%**		**66.5%**		**79.8%**
Administration	–$0.1	–0.2%	–$0.39	–1.3%	$1.20	3.6%
Taxes and fees	$9.0	29.9%	$9.93	34.1%	$5.45	16.2%
Profit	$0.2	0.7%	$0.22	0.8%	$0.12	0.4%
Nonmedical subtotal		**30.4%**		**33.6%**		**20.2%**
Total premium increase, PMPM	**$30.1**		**$29.16**		**$33.54**	

Note: PMPM = per member per month.
Source: Authors' analysis of Uniform Rate Review data from the Centers for Medicare and Medicaid Services.

Seventy percent of the premium increase overall resulted from growth in medical costs; 30 percent was from overhead and profits (Exhibit 3). Less than half of the medical cost increase is attributable to hospitals; the remainder is attributable to physicians, drugs, and other expenses. These percentage components are roughly

the same on and off the exchanges, with any differences being difficult to interpret based on available information.

The nonmedical component of the 2015 premium increase was driven almost entirely by government fees and taxes, rather than by profits or administrative costs. About half of this increase in taxes is attributable to the fees that exchanges began to charge in 2015, and the other half appears to be taxes that affect all products. These new fees should affect premium increases for only one year, after which they will become part of insurers' base rates.

Conclusion

The Affordable Care Act's market reforms appear to be working well in the individual market, both on and off the exchanges. On a national level, we see little indication that risk segmentation is causing adverse effects in either market segment. All the major plan types (bronze, silver, gold) are being actively sold in both market segments, and general patterns of medical cost increase are similar in each segment. Of note, nonmedical overhead appears to differ. Insurers that sell only off the exchanges project that a higher percentage of total premium dollars will go to overhead and profits than do insurers that sell only on the exchanges—a testament to the exchanges' ability to sell coverage efficiently.

How This Study Was Conducted

Data for this analysis come from the "unified rate review template" (URRT) spreadsheets for 2015; insurers must file these with the Center for Medicare and Medicaid Services' Center for Consumer Information & Insurance Oversight to document how they develop premium rates for Affordable Care Act–compliant plans. The URRT includes two sections: the market-level analysis section, which develops the projected single risk pool rate from prior experience data, and the product/plan section, which reports the projected premiums and enrollment for the coming year in each health plan. This database provides the change in premium per member for plans offered on and off the exchanges, as well as the types of medical claims (e.g., inpatient or outpatient) and administrative costs driving premium changes.

There were 570 unique insurers in different states. For measuring the components of premium increases, we analyzed 1,060 product lines that existed in both 2014 and 2015, weighted by insurers' projected 2015 membership in each product. We also used projected membership to classify insurers and products as selling predominantly on the government exchanges versus off the exchanges. For plans sold on exchanges, insurers must also offer these plans off the exchanges. Therefore, some on-exchange plans also have off-exchange enrollment. However, because the majority of enrollees receive subsidies that are available only through the exchanges, enrollment in these plans is predominantly on-exchange; therefore, the exchange dynamics determine the pricing of these plans even when sold off-exchange.

Notes

[1] States could, if they chose to, require insurers to sell through the exchanges, but so far only Washington D.C. has done so.

[2] Some small employers may also claim a tax credit for coverage purchased through the SHOP (Small Business Health Options

Program) exchanges, but limitations on this tax credit have resulted in only a small fraction of employers doing so. U.S. Government Accountability Office, "Small Business Health Insurance Exchanges: Low Initial Enrollment Likely Due to Multiple, Evolving Factors (http://www.gao.gov/products/GAO-15-58)" (Washington, D.C.: GAO, Nov. 2014).

[3] T. S. Jost, *Health Insurance Exchanges in Health Care Reform: Legal and Policy Issues (http://www.commonwealthfund.org/publications/fund-reports/2009/dec/health-insurance-exchanges-in-health-care-reform-legal-and-policy-issues)* (New York: The Commonwealth Fund, Dec. 2009).

[4] However, insurers still may maintain separate risk pools in different states, between the individual and small-group markets, and between ACA-compliant versus grandfathered coverage.

[5] These data do not include grandfathered or other noncompliant plans that people have renewed from prior to 2014. In 2014, such plans accounted for roughly a third of individual market enrollment. L. Hamel, M. Norton, L. Levitt et al., *Survey of Non-Group Health Insurance Enrollees (http://kff.org/health-reform/report/survey-of-non-group-health-insurance-enrollees/)* (Menlo Park, Calif.: Kaiser Family Foundation, June 2014). That proportion is expected to diminish substantially each year, however. J. Appleby, "Canceled Health Plans: Round Two (http://khn.org/news/canceled-health-plans-round-two/)," *Kaiser Health News,* Oct. 2, 2014.

[6] As explained in the "How This Study Was Conducted" box, however, ACA-compliant plans sold predominantly on-exchange also can have some off-exchange enrollment. Therefore, our projected percentages are not precise market shares. Nevertheless, the 21% we measure is similar to the off-exchange enrollment of 24% reported for 2014, and 26% for 2015, based on a representative survey (rather than on comprehensive enrollment data). Hamel, Norton, Levitt et al., *Survey of Non-Group (http://kff.org/health-reform/report/survey-of-non-group-health-insurance-enrollees/)*, 2014; L. Hamel, M. Norton, L. Levitt et al., *Survey of Non-Group Health Insurance Enrollees, Wave 2 (http://kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-2/)* (Menlo Park, Calif.: Kaiser Family Foundation, May 2015). These estimates are smaller than estimates by others that also include "grandfathered" plans that are non-ACA-compliant sold off-exchange.

[7] McKinsey Center for U.S. Health System Reform, *Hospital Networks: Evolution of the Configurations on the 2015 Exchanges (http://healthcare.mckinsey.com/2015-hospital-networks)* (Washington, D.C.: McKinsey and Company, April 2015).

[8] J. Geneson and K. Coleman, "Cheapest Plans from Major Off-Exchange Companies Over 40% More Expensive Than Cheapest Exchange Plans" (June 2014), http://www.healthpocket.com/healthcare-research/infostat/off-exchange-vs-on-exchange-premium-comparison (http://www.healthpocket.com/healthcare-research/infostat/off-exchange-vs-on-exchange-premium-comparison).

[9] Hamel, Norton, Levitt et al., *Survey of Non-Group (http://kff.org/health-reform/report/survey-of-non-group-health-insurance-enrollees/)*, 2014; Hamel, Norton, Levitt et al., *Survey of Non-Group, Wave 2 (http://kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-2/)*, 2015.

[10] These are simple, unadjusted loss ratios, that do not take account of several factors allowed by the ACA's minimum loss ratio regulation.

[11] S. J. Dash, J. Giovannelli, K. Lucia et al., "State Marketplace Approaches to Financing and Sustainability (http://www.commonwealthfund.org/publications/blog/2014/nov/state-marketplace-approaches-to-financing-and-sustainability)," *The Commonwealth Fund Blog,* Nov. 6, 2014.

[12] J. T. O'Connor, *Comprehensive Assessment of ACA Factors That Will Affect Individual Market Premiums in 2014 (http://ahip.org/MillimanReportACA2013/)* (Milliman, April 2013). Moreover, states that operate their own exchange often use broader-based fee structures that reduce fees paid on the exchange by imposing fees also off-exchange. Finally, because both this fee

structure and the reporting template are new, it is also possible that the exchange fees are not being fully or accurately reported. Therefore, it will be important to repeat this analysis in subsequent years, when data integrity is better established.

[13] These are not actual premium "rates," however, because they do not account for any changes projected in the age of subscribers. Actual premium rate changes have been reported previously, for exchange products. J. R. Gabel, H. Whitmore, S. Stromberg et al., "Analysis Finds No Nationwide Increase in Health Insurance Marketplace Premiums (http://www.commonwealthfund.org/publications/blog/2014/dec/zero-inflation-nationwide-for-marketplace-premiums)," *The Commonwealth Fund Blog,* Dec. 22, 2014.

THE KAISER FAMILY FOUNDATION -AND- HEALTH RESEARCH & EDUCATIONAL TRUST

Employer Health Benefits

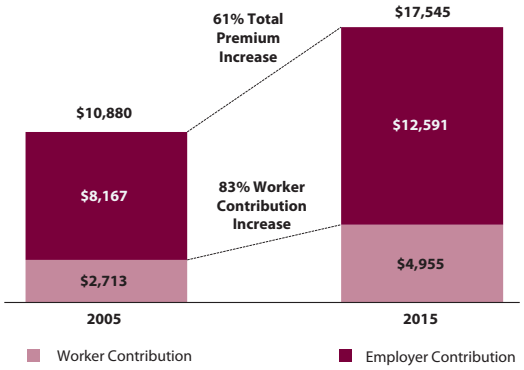
2015 Summary of Findings

Employer-sponsored insurance covers over half of the non-elderly population, 147 million people in total.[1] To provide current information about employer-sponsored health benefits, the Kaiser Family Foundation (Kaiser) and the Health Research & Educational Trust (HRET) conduct an annual survey of private and nonfederal public employers with three or more workers. This is the seventeenth Kaiser/HRET survey and reflects employer-sponsored health benefits in 2015.

The key findings from the survey, conducted from January through June 2015, include a modest increase (4%) in the average premiums for both single and family coverage in the past year. The average annual single coverage premium is $6,251 and the average family coverage premium is $17,545. The percentage of firms that offer health benefits to at least some of their employees (57%) and the percentage of workers covered at those firms (63%) are statistically unchanged from 2014. Relatively small percentages of employers with 50 or more full-time equivalent employees reported switching full-time employees to part time status (4%), changing part-time workers to full-time workers (10%), reducing the number of full-time employees they intended to hire (5%) or increasing waiting periods (2%) in response to the employer shared responsibility provision which took effect for some firms this year. Employers continue to be interested in programs addressing the health and behaviors of their employees, such as health risk assessments, biometric screenings, and health promotion and wellness programs. Meaningful numbers of employers which offer one of these screening programs now offer incentives to employees who complete them; 31% of large firms offering health benefits provide an incentive to complete a health risk assessment and 28% provide an incentive to complete a biometric screening. A majority of large employers (200 or more workers) (53%) have analyzed their health benefits to see if they would be subject to the high-cost plan tax when it takes effect in 2018, with some already making changes to their benefit plans in response to the tax.

EXHIBIT A

Exhibit A: Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2005–2015



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005–2015.

HEALTH INSURANCE PREMIUMS AND WORKER CONTRIBUTIONS

In 2015, the average annual premiums for employer-sponsored health insurance are $6,251 for single coverage and $17,545 for family coverage (Exhibit A). Each rose 4% over the 2014 average premiums. During the same period, workers' wages increased 1.9% and inflation declined by 0.2%.[2] Premiums for family coverage increased 27% during the last five years, the same rate they grew between 2005 and 2010 but significantly less than they did between 2000 to 2005 (69%) (Exhibit B).

Average premiums for high-deductible health plans with a savings option (HDHP/SOs) are lower than the overall average for all plan types for both single and family coverage (Exhibit C), at $5,567 and $15,970, respectively. The average premium for family coverage is lower for covered workers in small firms (3-199 workers) than for workers in large firms (200 or more workers) ($16,625 vs. $17,938).

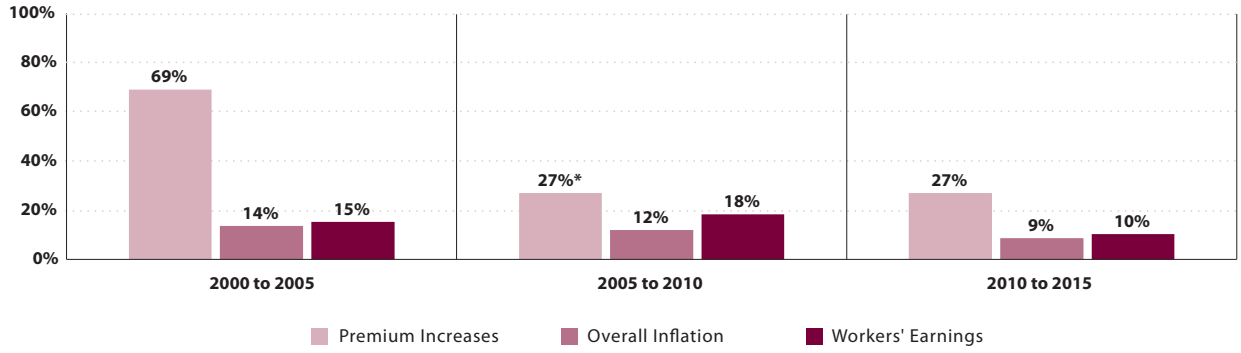
As a result of differences in benefits, cost sharing, covered populations, and geographical location, premiums vary significantly around the averages for both single and family coverage. Eighteen percent of covered workers are in plans with an annual total premium for family coverage of at least $21,054 (120% or more of the average family premium), and 22% of covered workers are in plans where the family premium is less than $14,036 (less than 80% of the average family premium). The distribution is similar around the average for single coverage premiums (Exhibit D).

Employers generally require that workers make a contribution towards the cost of the premium. Covered workers contribute on average 18% of the premium for single coverage and 29% of the premium for family coverage, the same percentages as 2014 and statistically similar to those reported in 2010. Workers in small firms contribute a lower average percentage for single coverage compared to workers in large firms (15% vs. 19%), but they contribute a higher average percentage for family coverage (36% vs. 26%). Workers in firms with a higher percentage of lower-wage workers (at least 35% of workers earn $23,000 a year or less) contribute higher percentages of the premium for family coverage (41% vs. 28%) than workers in firms with a smaller share of lower-wage workers.

As with total premiums, the share of the premium contributed by workers varies considerably. For single coverage, 61% of

EXHIBIT B

Average Premium Increases for Covered Workers with Family Coverage, 2000-2015



* Premium change is statistically different from previous period shown (p<.05).

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2015. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2000-2015; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2000-2015 (April to April).

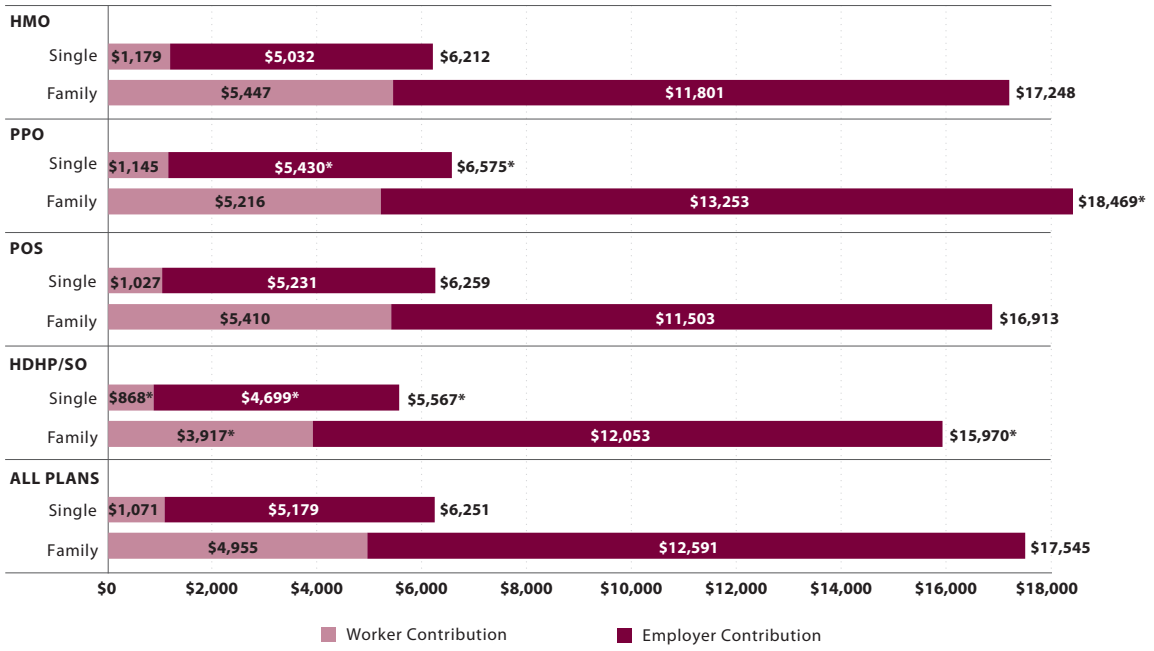
covered workers are in plans that require them to make a contribution of less than or equal to a quarter of the total premium, 2% are in plans that require more than half of the premium, and 16% are in plans that require no contribution at all. For family coverage, 44% of covered workers are in plans that require them to make a contribution of less than or equal to a quarter of the total premium and 15% are in plans that require more than half of the premium, while only 6% are in plans that require no contribution at all (Exhibit E).

Employers use different strategies to structure their employer contributions; 45% of small employers offering health benefits indicated that they contribute the same dollar amount for family coverage as single coverage, 34% contributed a larger dollar amount for family than single coverage, and 18% used some other approach.

Looking at the dollar amounts that workers contribute, the average annual premium contributions in 2015 are $1,071 for single coverage and $4,955 for family coverage. Covered workers' average dollar contribution to family coverage has increased 83% since 2005 and 24% since 2010 (Exhibit A). Workers in small firms have lower average contributions for single coverage than workers in large firms ($899 vs. $1,146), but higher average contributions for family coverage ($5,904 vs. $4,549). Workers in firms with a higher percentage of lower-wage workers have higher average contributions for family coverage ($6,382 vs. $4,829) than workers

EXHIBIT C

Average Annual Firm and Worker Premium Contributions and Total Premiums for Covered Workers for Single and Family Coverage, by Plan Type, 2015

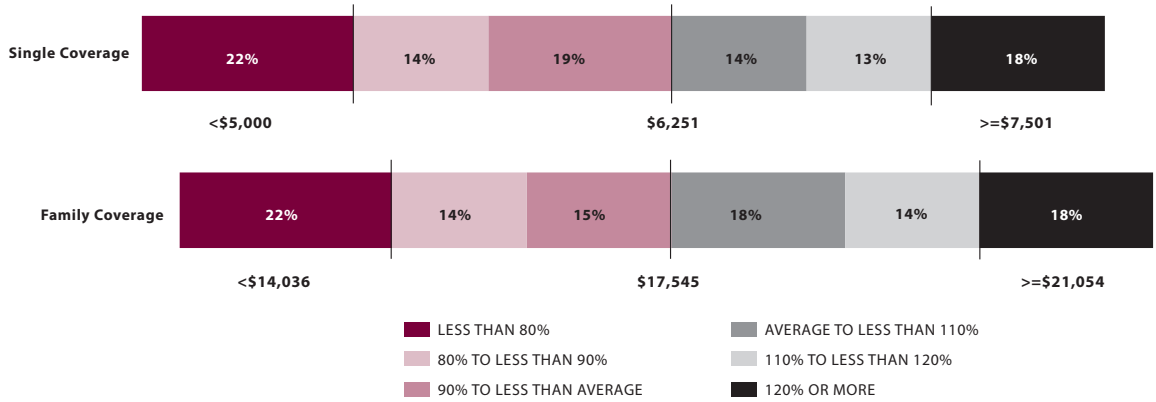


* Estimate is statistically different from All Plans estimate by coverage type (p<.05).

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015.

EXHIBIT D

Distribution of Annual Premiums for Single and Family Coverage Relative to the Average Annual Single or Family Premium, 2015



NOTE: The average annual premium is $6,251 for single coverage and $17,545 for family coverage. The premium distribution is relative to the average single or family premium. For example, $5,000 is 80% of the average single premium, $5,625 is 90% of the average single premium, $6,876 is 110% of the average single premium, and $7,501 is 120% of the average single premium. The same break points relative to the average are used for the distribution for family coverage.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015.

in firms with lower percentages of lower-wage workers.

PLAN ENROLLMENT

PPO plans remain the most common plan type, enrolling 52% of covered workers in 2015, although a smaller percentage than 2014. Twenty-four percent of covered workers are enrolled in a high-deductible plan with a savings options (HDHP/SO), 14% in an HMO, 10% in a POS plan, and 1% in a conventional (also known as an indemnity) plan (Exhibit F). Enrollment distribution varies by firm size; for example, PPOs are relatively more popular for covered workers at large firms than small firms (56% vs. 41%) and POS plans are relatively more popular among small firms than large firms (19% vs. 6%).

Almost a quarter (24%) of covered workers are enrolled in HDHP/SOs in 2015; enrollment in these plans has increased over time from 13% of covered workers in 2010. In 2015, 7% of firms offering health benefits offered a high-deductible health plan with a health reimbursement arrangement (HDHP/HRA), and 20% offered a health savings (HSA) qualified HDHP.

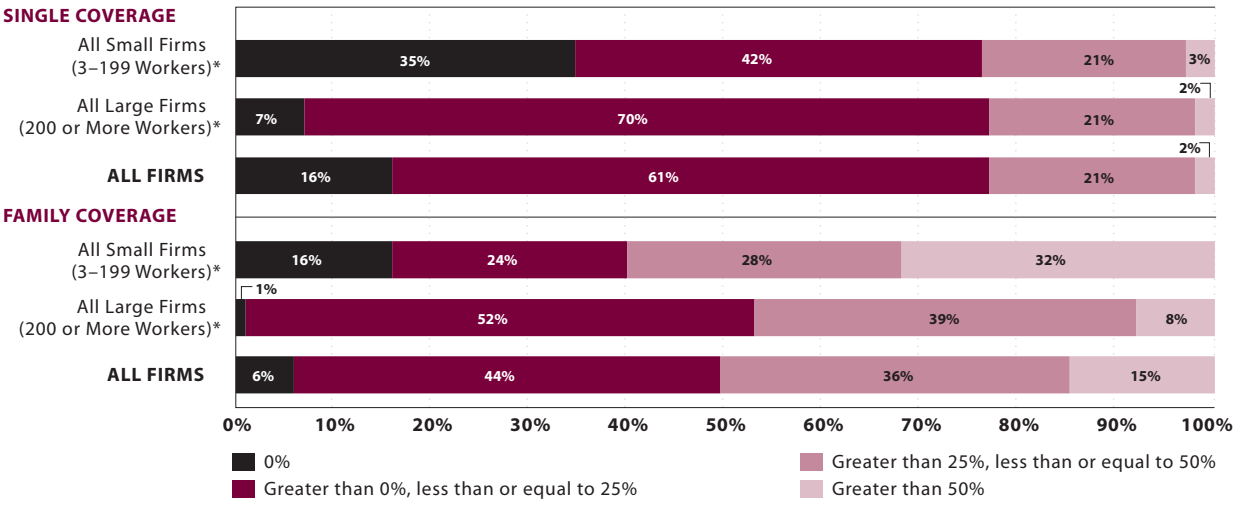
EMPLOYEE COST SHARING

Most covered workers face additional out-of-pocket costs when they use health care services. Eighty-one percent of covered workers have a general annual deductible for single coverage that must be met before most services are paid for by the plan. Even workers without a general annual deductible often face other types of cost sharing when they use services, such as copayments or coinsurance for office visits and hospitalizations.

Among covered workers with a general annual deductible, the average deductible

EXHIBIT E

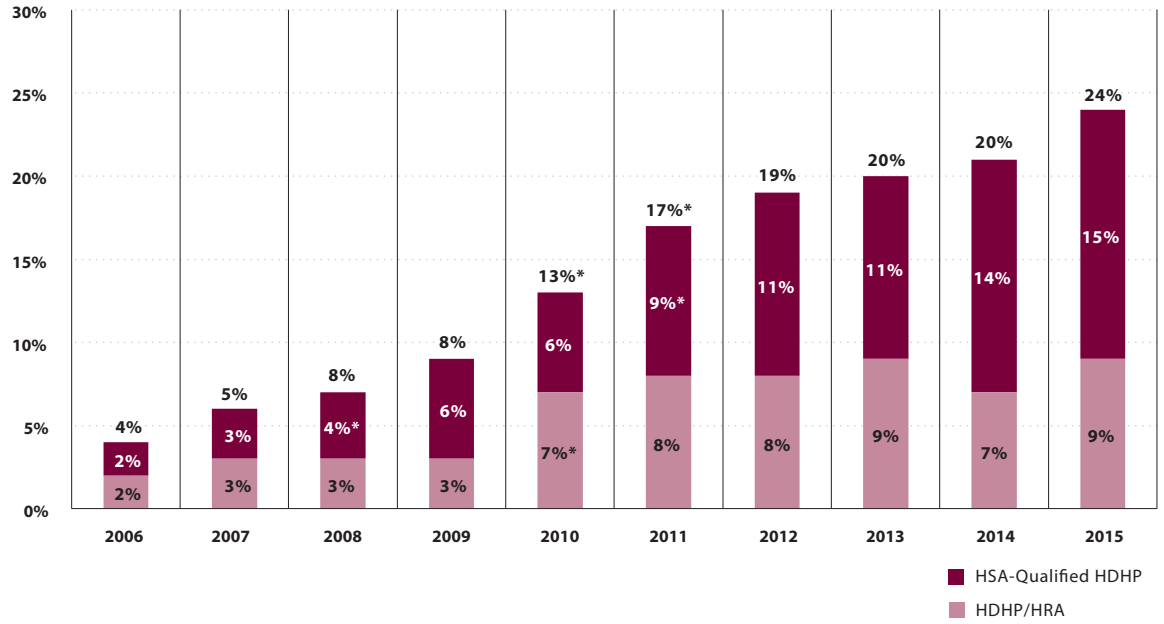
Distribution of Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Firm Size, 2015



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015.

EXHIBIT F

Percentage of Covered Workers Enrolled in an HDHP/HRA or HSA-Qualified HDHP, 2006-2015



*Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTE: Covered Workers enrolled in an HDHP/SO are enrolled in either an HDHP/HRA or a HSA-Qualified HDHP. For more information see the Survey Methodology Section. The percentages of covered workers enrolled in an HDHP/SO may not equal the sum of HDHP/HRA and HSA-Qualified HDHP enrollment estimates due to rounding.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2015.

amount for single coverage is $1,318. The average annual deductible is similar to last year ($1,217), but has increased from $917 in 2010. Deductibles differ by firm size; for workers in plans with a deductible, the average deductible for single coverage is $1,836 in small firms, compared to $1,105 for workers in large firms. Sixty-three percent of covered workers in small firms are in a plan with a deductible of at least $1,000 for single coverage compared to 39% in large firms; a similar pattern exists for those in plans with a deductible of at least $2,000 (36% for small firms vs. 12% for large firms) (Exhibit G).

Looking at the increase in deductible amounts over time does not capture the full impact for workers because the share of covered workers in plans with a general annual deductible also has increased significantly, from 55% in 2006 to 70% in 2010 to 81% in 2015. If we look at the change in deductible amounts for all covered workers (assigning a zero value to workers in plans with no deductible), we can look at the impact of both trends together. Using this approach, the average deductible for all covered workers in 2015 is $1,077, up 67% from $646 in 2010 and 255% from $303 in 2006.

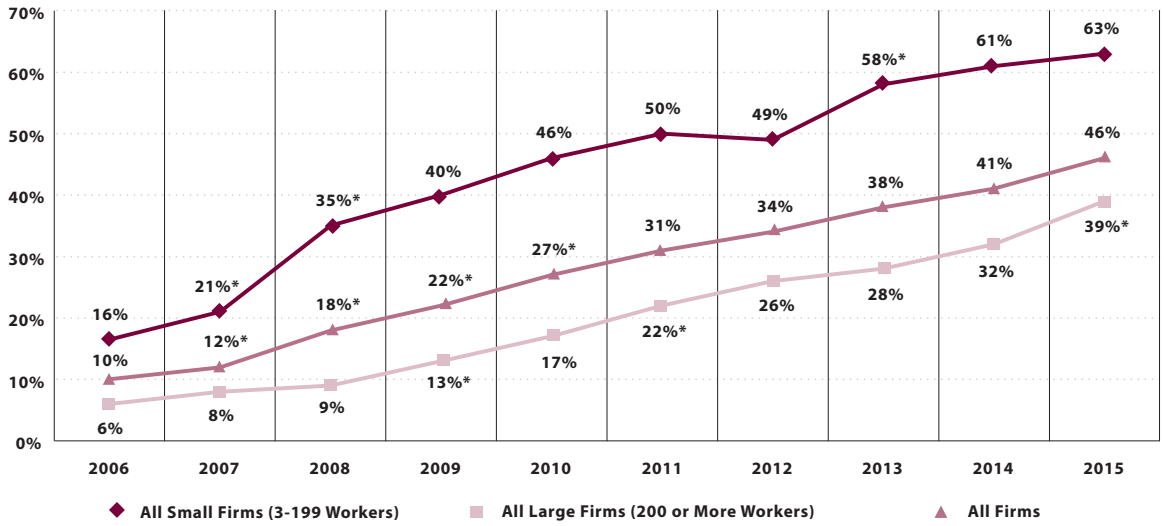
A large majority of workers also have to pay a portion of the cost of physician office visits. Almost 68% of covered workers pay a copayment (a fixed dollar amount) for office visits with a primary care or specialist physician, in addition to any general annual deductible their plan may have. Smaller shares of workers pay coinsurance (a percentage of the covered amount) for primary care office visits (23%) or specialty care visits (24%). For in-network office visits, covered workers with a copayment pay an average of $24 for primary care and $37 for specialty care. For covered workers with coinsurance, the average coinsurance for office visits is 18% for primary and 19% for specialty care. While the survey collects information only on in-network cost sharing, it is generally understood that out-of-network cost sharing is higher.

Virtually all (99%) of covered workers are enrolled in a plan that covers some prescription drugs. Cost sharing for filling a prescription usually varies with the type of drug – for example, whether it is a generic, brand-name, or specialty drug – and whether the drug is considered preferred or not on the plan's formulary. These factors result in each drug being assigned to a tier that represents a different level, or type, of cost sharing. Eighty-one percent of covered workers are in plans with three or more tiers of cost sharing. Twenty-three percent of covered workers are enrolled in a plan with four or more cost sharing tiers compared to 13% in 2010. Copayments are the most common form of cost sharing for tiers one through three. Among workers with plans with three or more tiers, the average copayments in these plans are $11 for first tier drugs, $31 for second tier drugs, $54 for third tier drugs, and $93 for fourth tier drugs. HDHP/SOs have a somewhat different cost sharing pattern for prescription drugs than other plan types; just 61% of covered workers are enrolled in a plan with three or more tiers of cost sharing, 12% are in plans that pay the full cost of prescriptions once the plan deductible is met, and 22% are in a plan with the same cost sharing for all prescription drugs.

Most covered workers with drug coverage are enrolled in a plan which covers specialty drugs such as biologics (94%). Large employers have used a variety of strategies for containing the cost of specialty drugs including utilization management programs (31%), step therapies where enrollees must first try

EXHIBIT G

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, By Firm Size, 2006-2015



* Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTE: These estimates include workers enrolled in HDHP/SO and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2015.

alternatives (30%) and tight limits on the number of units administered at a single time (25%).

Twelve percent of covered workers enrolled in a plan with prescription drug coverage are enrolled in a plan with a separate annual drug deductible that applies only to prescription drugs. Among these workers, the average separate annual deductible for prescription drug coverage is $231. Five percent of covered workers are enrolled in a plan with an annual deductible for prescription drug coverage of $500 or more.

Most workers also face additional cost sharing for a hospital admission or an outpatient surgery episode. After any general annual deductible is met, 65% of covered workers have a coinsurance and 14% have a copayment for hospital admissions. Lower percentages have per day (per diem) payments (4%), a separate hospital deductible (2%), or both copayments and coinsurance (11%). The average coinsurance rate for hospital admissions is 19%. The average copayment is $308 per hospital admission, the average per diem charge is $281, and the average separate annual hospital deductible is $1,006. The cost sharing provisions for outpatient surgery are similar to those for hospital admissions, as most covered workers have either coinsurance (67%) or copayments (15%). For covered workers with cost sharing, for each outpatient surgery episode, the average coinsurance is 19% and the average copayment is $181.

Almost all (98%) of covered workers are in plans with an out-of-pocket maximum for single coverage, significantly more than the 88% in 2013. While almost all workers have an out-of-pocket limit, the actual dollar limits differ considerably. For example, among covered workers in plans that have an out-of-pocket maximum for single coverage, 13% are in plans with an annual out-of-pocket maximum of $6,000 or more, and 9% are in plans with an out-of-pocket maximum of less than $1,500.

AVAILABILITY OF EMPLOYER-SPONSORED COVERAGE

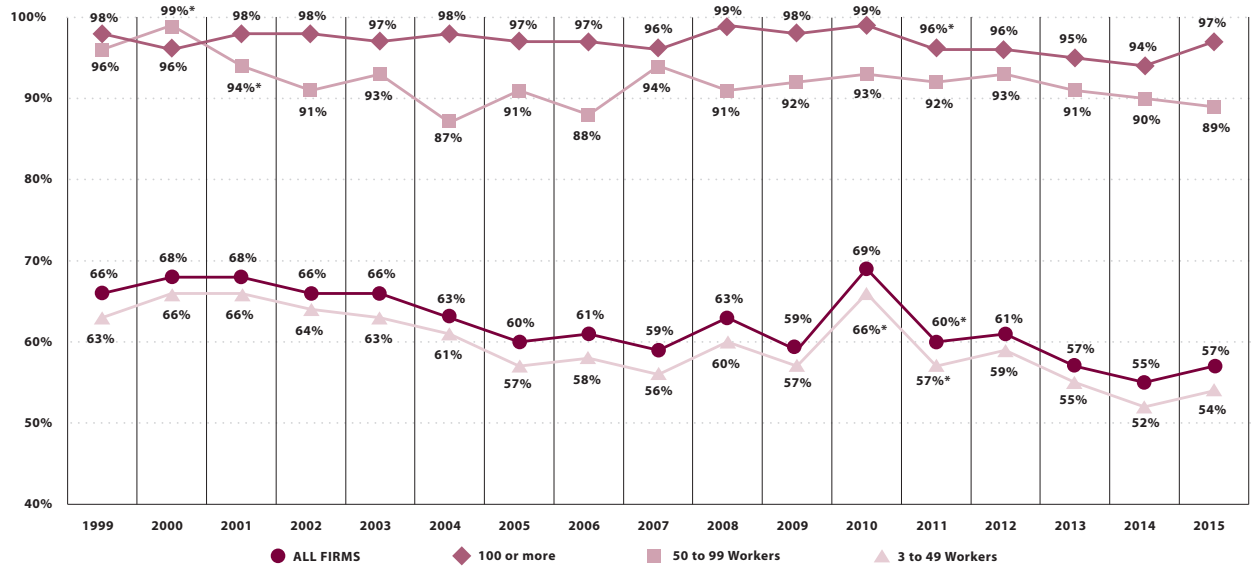
Fifty-seven percent of firms offer health benefits to their workers, statistically unchanged from 55% last year and 60% in 2005 (Exhibit H). The likelihood of offering health benefits differs significantly by size of firm, with only 47% of employers with 3 to 9 workers offering coverage, but virtually all employers with 1,000 or more workers offering coverage to at least some of their employees. Ninety percent of workers are in a firm that offers health benefits to at least some of its employees, similar to 2014 (90%).

Even in firms that offer health benefits, not all workers are covered. Some workers are not eligible to enroll as a result of waiting periods or minimum work-hour rules. Other workers do not enroll in coverage offered to them because of the cost of coverage or because they are covered through a spouse. Among firms that offer coverage, an average of 79% of workers are eligible for the health benefits offered by their employer. Of those eligible, 79% take up their employer's coverage, resulting in 63% of workers in offering firms having coverage through their employer. Among both firms that offer and those that do not offer health benefits, 56% of workers are covered by health plans offered by their employer, similar to 2014 (55%).

Beginning in 2015, employers with at least 100 full-time equivalent employees (FTEs) must offer health benefits to their full-time workers that meet minimum standards for value and affordability or pay a penalty. The requirement applies to employers with 50 or more FTEs beginning in 2016. Of firms reporting at least 100 FTEs (or, if they did not know FTEs, of firms with at least 100 employees), 96% report that they offer one health plan that would meet these

EXHIBIT H

Percentage of Firms Offering Health Benefits, by Firm Size, 1999-2015



*Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTE: Estimates presented in this exhibit are based on the sample of both firms that completed the entire survey and those that answered just one question. For more information see the Survey Methods Section

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2015.

requirements, two percent did not and three percent reported "don't know." Five percent of these firms reported that this year they offered more comprehensive benefits to some workers who previously were only offered a limited benefit plan. Twenty-one percent reported that they extended eligibility to groups of workers not previously eligible because of the employer shared responsibility provision.

We asked firms reporting 50 or more FTEs (or, if they did not know how many FTEs, firms with at least 50 employees) about changes to their workforce in response to the employer requirement. Four percent reported that they changed some job classifications from full-time to part-time so employees would not be eligible for health benefits while 10% reported changing some job classifications from part-time to full-time so that they would become eligible. Four percent also reported reducing the number of full-time employees that they intended to hire because of the cost of health benefits.

RETIREE COVERAGE

Twenty-three percent of large firms that offer health benefits in 2015 also offer retiree health benefits, similar to the percentage in 2014 (25%). Among large firms that offer retiree health benefits, 92% offer health benefits to early retirees (workers retiring before age 65), 73% offer health benefits to Medicare-age retirees, and 2% offer a plan that covers only prescription drugs. Employers offering retiree benefits report interest in new ways of delivering them. Among large firms offering retiree benefits, seven percent offer them through a private exchange and 26% are considering changing the way they offer retiree coverage because of the new health insurance exchanges established by the ACA.

WELLNESS, HEALTH RISK ASSESSMENTS AND BIOMETRIC SCREENINGS

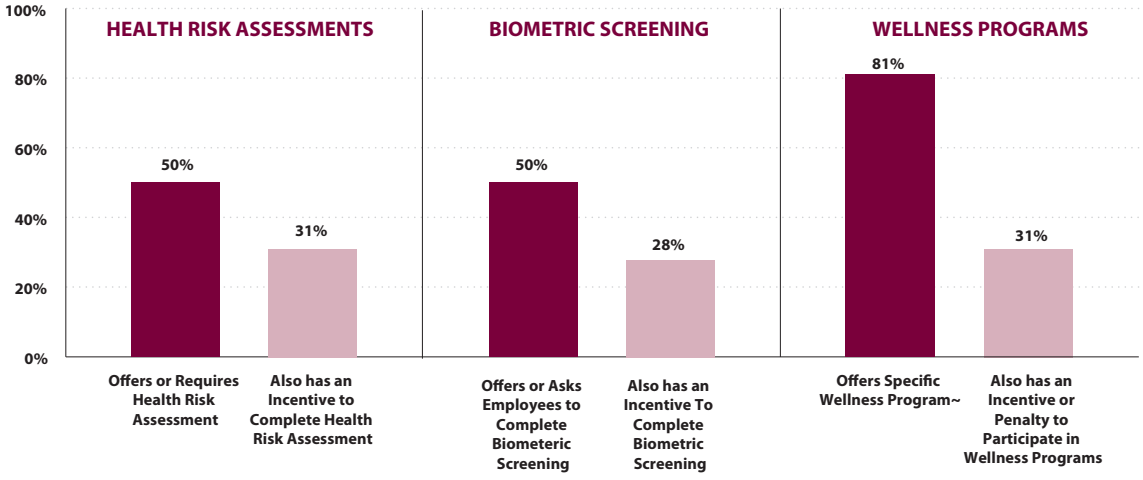
Health Risk Assessment. Employers continue to offer programs that encourage employees to identify health issues and to manage chronic conditions. A majority of larger employers now offer health screening programs including health risk assessments, which are questionnaires asking employees about lifestyle, stress or physical health, and in-person examinations such as biometric screenings. Some employers have incentive programs that reward or penalize employees for a range of activities including participating in wellness programs or meeting biometric outcomes.

Fifty percent of large employers offering health benefits provide employees with an opportunity or require employees to complete a health risk assessment. A health risk assessment includes questions about medical history, health status, and lifestyle, and is designed to identify the health risks of the person being assessed. Large firms are more likely than small firms to offer an opportunity or require employees to complete a health risk assessment (50% vs. 18%). Among firms with a health risk assessment, 62% of large firms report that they provide incentives to employees that complete the assessment. There is significant variation in the percentage of employees that complete a health risk assessment among firms; 27% of large firms with a health risk assessment report that more than three-quarters of employees complete the screening while 41% report that a quarter or less complete it.

Biometric Screening. Fifty percent of large firms and 13% of small firms offering health benefits ask or offer employee the opportunity to complete a biometric screening. Biometric screening is a health examination that measures an employee's risk factors such as body weight, cholesterol, blood pressure, stress, and nutrition. Among large firms

EXHIBIT I

Among Large Firms (200 or more workers) Offering Health Benefits, Percentage of Firms Offering Incentives for Various Wellness and Health Promotion Activities, 2015



~ Firms which offer either "Programs to Help Employees Stop Smoking", "Programs to Help Employees Lose Weight", or "Other Lifestyle or Behavioral Coaching "

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015.

with biometric screening programs, 56% offer employees incentives to complete a biometric screening. Among firms with a biometric screening program and an incentive to complete it, 20% have a reward or penalty for meeting specified biometric outcomes such as achieving a target body mass index (BMI) or cholesterol level. The maximum financial value for meeting biometric outcomes ranges considerably across these firms: 16% have a maximum annual incentive of $150 or less and 28% have a maximum annual incentive of more than $1,000.

Wellness Programs. Many employers offer wellness or health promotion programs to improve their employees' health. Eighty-one percent of large employers and 49% of small employers offer employees programs to help them stop smoking, lose weight, or make other lifestyle or behavioral changes. Of firms offering health benefits and a wellness program, 38% of large firms and 15% of small firms offer employees a financial incentive to participate in or complete a wellness program. Among large firms with an incentive to participate in or complete a wellness program, 27% believe that incentives are "very effective" at encouraging employees to participate (Exhibit I).

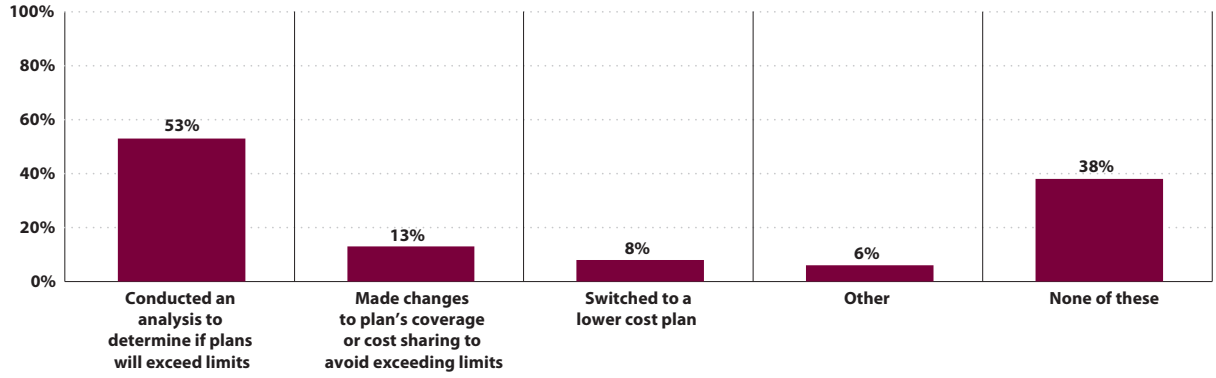
Disease management programs. Disease management programs try to improve the health and reduce the costs for enrollees with chronic conditions. Thirty-two percent of small employers and 68% of large employers offer disease management programs. Among firms with disease management programs, eight percent of large firms and 24% of firms with 5,000 or more workers offer a financial incentive to employees who participate.

PROVIDER NETWORKS

High Performance or Tiered Networks. Seventeen percent of employers offering health benefits have high performance or tiered networks in their largest health plan. These programs identify providers that are more efficient or have higher quality care, and may provide financial or other

EXHIBIT J

Among Large Firms (200 or more Workers) Offering Health Benefits, Percentage of Firms Who Have Taken Various Actions in Anticipation of the Excise Tax on High Cost Plans, by Firm Size, 2015



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015.

incentives for enrollees to use the selected providers. Firms with 1,000-4,999 workers employees are more likely to have a largest plan that includes a high performance or tiered network (33%) than firms in other size categories.

Narrow Networks. Some employers limit their provider networks to reduce the cost of the plan. Nine percent of employers reported that their plan eliminated hospitals or a health system to reduce cost and seven percent offer a plan considered a narrow network plan. These plans typically have a provider network more limited than the standard HMO network.

Telemedicine. Telemedicine includes exchanging heath information electronically, including through smart phones or webcasts in order to improve a patient's health. The largest health plan at 27% of large firms (200 or more workers) offering health benefits covers telemedicine.

OTHER TOPICS

Pre-Tax Premium Contributions. Thirty-seven percent of small firms and 90% of large firms have a plan under section 125 of the Internal Revenue Service Code (sometimes called a premium-only plan) to allow employees to use pre-tax dollars to pay for a share of health insurance premiums.

Flexible Spending Accounts. Seventeen percent of small firms and 74% of large firms offer employees the option of contributing to a flexible spending account (FSA). FSAs permit employees to make pre-tax contributions that may be used during the year to pay for eligible medical expenses. The Affordable Care Act put some additional limits on FSAs, including capping the amount that could be contributed in a year ($2,550 in 2015) and limits on the use of FSA dollars for non-prescribed over the counter medications and premiums.[3] Three percent of firms not offering health benefits offered an FSA in 2015.

Waiting Periods and Enrollment. With exceptions for orientation periods and variable hour employees, the ACA limits waiting periods to no more than 90 days for all group health plans.[4] The average waiting period for covered workers who face a waiting period decreased from 2.1 months in 2014 to 2 months in 2015. The provision of the Affordable Care Act requiring employers with 200 or more full-time employees to automatically enroll eligible new full-time employees in one of the firm's health plans after any waiting period has not yet taken effect. In 2015, 13% of large employers (200 or more workers) and 42% of small employers automatically enroll eligible employees.

Self-Funding. Seventeen percent of covered workers at small firms and 83% of covered workers at large firms are enrolled in plans that are either partially or completely self-funded. Overall, 63% of covered workers are enrolled in a plan that is either partially or completely self-funded, 60 percent of whom are covered by additional insurance against high claims, sometimes known as stop loss coverage. The percentage of covered workers at both small and large firms in self-funded plans is similar to the percentage reported in 2010.

Private Exchanges. Private exchanges are arrangements created by consultants, brokers or insurers that allow employers to offer their employees a choice of different benefit options, often from different insurers. While these arrangements are fairly new, 17% of firms with more than 50 employees offering health benefits say they are considering offering benefits through a private exchange. Twenty-two percent of employers with 5,000 or more employees are considering this option. Enrollment to this point has been modest: 2% of covered workers in firms with more than 50 employees are enrolled in a private exchange.

Professional Employment Organization. Some firms provide for health and other benefits by entering into a co-employment relationship with a Professional Employer Organization (PEO). Under this arrangement, the firm manages the day-to-day responsibilities of employees but the PEO hires the employees and acts as the employer for insurance, benefits, and other administrative purposes. Five percent of employers offering health benefits with between three and 499 workers offer coverage through a PEO.

Grandfathered Health Plans. The ACA exempts "grandfathered" health plans from a number of its provisions, such as the requirements to cover preventive benefits without cost sharing or the new rules for small employers' premiums ratings and benefits. An employer-sponsored health plan can be grandfathered if it covered a worker when the ACA became law (March 23, 2010) and if the plan has not made significant changes that reduce benefits or increase employee costs.[5] Thirty-five percent of firms offering health benefits offer at least one grandfathered health plan in 2015. Twenty-five percent of covered workers are enrolled in a grandfathered health plan in 2015.

EXCISE TAX ON HIGH-COST HEALTH PLANS

Beginning in 2018, employer health plans will be will be subject to an excise tax of 40% on the amount by which their cost exceeds specified thresholds ($10,200 for single coverage and $27,000 for family coverage in 2018).[6] The tax is calculated with respect to each employee based on the combinations of health benefits received by that employee, including the employer and employee share of health plan premiums (or premium equivalents for self-funded plans), FSA contributions, and employer contributions to health savings accounts and health reimbursement arrangement contributions. Fifty-three percent of large firms (200 or more workers) offering health benefits have conducted an analysis to determine if they will exceed the 2018 thresholds, with 19% of these firms saying that their largest health plan would exceed the 2018 threshold. A small percentage of large employers offering health benefits report that they already have made changes to their plans' coverage or cost-sharing requirements (13%) or switched to a lower cost plan (8%) in response to the anticipated tax (Exhibit J).

CONCLUSION

The continuing implementation of the ACA has brought about a number of changes for employer-based coverage, ranging from benefits changes (such as the requirement to cover certain preventive care without cost sharing or have an out-of-pocket limit) to the requirement for larger employers to offer coverage to their full-time workers or face financial penalties. Even with these new requirements, most market fundamentals have stayed consistent with prior trends, suggesting that the implementation has not caused significant disruption for most market participants. Premiums for single and family coverage increased by 4% in 2015, continuing a fairly long period (2005 to 2015) where annual premium

growth has averaged about 5%. The percentage of employers offering coverage (57%) is similar to recent years,[7] as is the percentage of workers in offering firms covered by their own employer (63%). The offer and coverage rates have been declining very gradually since we have been doing the survey, with the current values generally below those we saw prior to 2005.

The stability we have seen over the last several years does not mean that no changes are occurring. Employers continue to focus on wellness and health promotion and extend their programs to assess health risk; here programs that collect personal health information and provide financial incentives for employees to undertake health programs or meet biometric targets have the potential to significantly alter how people with employer-based coverage interact with their health plan. Employers, particularly large employers, continue to show interest in private exchanges, although enrollment to date is not very large. If these exchanges succeed, they have the potential to move some of the decision-making about benefits away from employers, which could transform how employees and employers interact over benefits.

While the ACA has not transformed the market, changes are occurring and more are likely to come. Some employers report that they have modified job classifications in reaction to the employer requirement to offer benefits, with more reporting that they increased the number of jobs with full-time status than decreasing it. Additionally, five percent of large firms (200 or more workers) employers reported that they intend to reduce the number of full-time employees that they intend to hire because of the cost of providing health care benefits. Employers also are considering the potential impacts that the high-cost plan tax may have on their health benefits, with small percentages already taking action to lower plan costs. Over a longer period, the high-cost plan tax has the potential to cause significant changes in employer-sponsored coverage as employers and workers look for ways to keep cost increases to inflation far below the even moderate premium increases we have seen in recent years.

Whether the period of moderate premium growth will continue as the economy improves is one the biggest questions facing the employer market. Higher costs tend to follow improvements in economic growth,[8] and recent increases in spending for health services will put upward pressure on premiums.[9] At the same time, concerns about the high-cost plan tax will have employers and insurers looking for savings. These competing pressures may well lead to plan changes such as tighter networks, stricter management and higher cost sharing as employers and insurers struggle to contain these higher costs.

METHODOLOGY

The Kaiser Family Foundation/Health Research & Educational Trust 2015 Annual Employer Health Benefits Survey (Kaiser/HRET) reports findings from a telephone survey of 1,997 randomly selected public and private employers with three or more workers. Researchers at the Health Research & Educational Trust, NORC at the University of Chicago, and the Kaiser Family Foundation designed and analyzed the survey. National Research, LLC conducted the fieldwork between January and June 2015. In 2015, the overall response rate is 42%, which includes firms that offer and do not offer health benefits. Among firms that offer health benefits, the survey's response rate is also 41%.

We asked all firms with which we made phone contact, even if the firm declined to participate in the survey: "Does your company offer a health insurance program as a benefit to any of your employees?" A total of 3,191 firms responded to this question (including the 1,997 who responded to the full survey and 1,194 who responded to this one question). Their responses are included in our estimates of the percentage of firms offering health coverage. The response rate for this question is 67%.

Since firms are selected randomly, it is possible to extrapolate from the sample to national, regional, industry, and firm size estimates using statistical weights. In calculating weights, we first determine the basic weight, then apply a nonresponse adjustment, and finally apply a post-stratification adjustment. We use the U.S. Census Bureau's Statistics of U.S. Businesses as the basis for the stratification and the post-stratification adjustment for firms in the private sector, and we use the Census of Governments as the basis for post-stratification for firms in the public sector. Some numbers in the report's exhibits do not sum up to totals because of rounding effects, and, in a few cases, numbers from distribution exhibits referenced in the text may not add due to rounding effects. Unless otherwise noted, differences referred to in the text and exhibits use the 0.05 confidence level as the threshold for significance.

For more information on the survey methodology, please visit the Methodology section at http://ehbs.kff.org/.

The Kaiser Family Foundation, a leader in health policy analysis, health journalism and communication, is dedicated to filling the need for trusted, independent information on the major health issues facing our nation and its people. The Foundation is a non-profit private operating foundation based in Menlo Park, California.

The Health Research & Educational Trust (HRET) is a private, not-for-profit organization involved in research, education, and demonstration programs addressing health management and policy issues. Founded in 1944, HRET, an affiliate of the American Hospital Association, collaborates with health care, government, academic, business, and community organizations across the United States to conduct research and disseminate findings that help shape the future of health care.

[1] Majerol, Melissa, Newkirk, Vann and Garfield, Rachel. "The uninsured: A primer—key facts about health insurance on the eve of coverage expansions." Kaiser Commission on Medicaid and the Uninsured. Dec 2014. http://kff.org/uninsured/report/the-uninsured-a-primer/ See supplemental tables - Table 1: 268.9 million non-elderly people, 54.6% of whom are covered by ESI.

[2] Kaiser/HRET surveys use the April-to-April time period, as do the sources in this and the following note. The inflation numbers are not seasonally adjusted. Bureau of Labor Statistics. Consumer Price Index - All Urban Consumers: Department of Labor; 2015. [cited 2015 September 2] http://data.bls.gov/timeseries/CUUR0000SA0?output_view=pct_1mth. Wage data are from the Bureau of Labor Statistics and based on the change in total average hourly earnings of production and nonsupervisory employees. Employment, hours, and earnings from the Current Employment Statistics survey: Department of Labor; 2015 [cited 2015 September 2]. http://data.bls.gov/timeseries/CES0500000008

[3] "Application of Market Reform and other Provisions of the Affordable Care Act to HRAs, Health FSAs, and Certain other Employer Healthcare Arrangements." Notice 2013-54. Internal Revenue Service. http://www.irs.gov/pub/irs-drop/n-13-54.pdf

[4] Federal Register. Volume 79, No 36, February 24, 2014. http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=27369&Month=2&Year=2014

[5] Federal Register. Vol. 75, No 221, November 17, 2010, http://www.gpo.gov/fdsys/pkg/FR-2010-11-17/pdf/2010-28861.pdf.

[6] Claxton, Gary & Levitt, Larry. "How Many Employers Could be Affected by the Cadillac Plan Tax?" Kaiser Family Foundation. Apr 2015. http://kff.org/health-reform/issue-brief/how-many-employers-could-be-affected-by-the-cadillac-plan-tax/

[7] The 2015 offer rate is significantly lower than the 69% of firms which indicated that they offered benefits in 2010. The increase in the 2010 estimate was primarily driven by a 12 percentage point increase in firms with between 3 and 9 employees offering coverage. Given the number of small firms in the country, statistics weighted by the number of employers tend to be volatile - for more information see the survey design section.

[8] "Assessing the Effects of the Economy on the Recent Slowdown in Health Spending." Kaiser Family Foundation. Apr 2013. http://kff.org/health-costs/issue-brief/assessing-the-effects-of-the-economy-on-the-recent-slowdown-in-health-spending-2/

[9] "How has health spending changed over time?" Peterson-Kaiser Health System Tracker. June 2015. http://www.healthsystemtracker.org/chart-collection/how-has-health-spending-changed-over-time/?slide=1

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The full report of survey findings (#8775) is available on the Kaiser Family Foundation's website at www.kff.org.
This summary (#8776) is also available at www.kff.org.

New ACA Marketplace Findings: Premium Costs For Lower-Income Enrollees Similar To Those With Employer Coverage; Many Who Say They Can't Find An Affordable ACA Plan Could Qualify For Subsidies

Large Shares of Marketplace Enrollees and Those with Employer Coverage Have High Deductibles

New York, N.Y., September 25, 2015—Six in 10 marketplace enrollees and 55 percent of those with employer plans reported they pay either nothing or less than $125 a month for individual coverage, according to a new report from The Commonwealth Fund.

According to *Are Marketplace Plans Affordable? (/publications/issue-briefs/2015/sep/are-marketplace-plans-affordable)*, one of two new briefs based on the Commonwealth Fund Affordable Care Act (ACA) Tracking Survey, there are similarities between premium costs for marketplace enrollees and those for people with employer plans. That's because most marketplace enrollees are eligible for a premium subsidy and do not pay the full premium amount out of their own pockets, similar to how most employers pay part of their employees' premiums. The effect of subsidies is seen most clearly among people earning less than 250 percent of the federal poverty level ($29,175 for a single person), 72 percent of whom paid nothing or less than $125 a month in premiums.

However, people with employer coverage perceived their health insurance as more affordable, with 76 percent reporting it was very or somewhat easy to afford their premiums, compared to 53 percent of those with marketplace coverage. The difference narrows for those with lower incomes: 65 percent with employer coverage said it was easy to afford, compared to 54 percent with marketplace coverage.

Overall, larger shares of adults with marketplace plans had per-person deductibles of $1,000 or more than did those with employer plans (43% vs. 34%). The differences were widest among those with higher incomes: in this group, over half (53%) with marketplace plans had high deductibles, compared to about one-third (35%) with employer plans. In the survey, people with high deductibles were less confident than those with lower deductibles that they could afford needed care.

"The survey findings suggest that the Affordable Care Act's premium subsidies have been effective in making the cost of marketplace coverage similar to that of employer plans for people who have been most at risk of being uninsured," said Sara Collins, lead author of the report and vice president for Health Care Coverage and Access at The Commonwealth Fund. "But many marketplace enrollees report high deductibles."

The second study, *To Enroll or Not to Enroll? Why Many Americans Have Gained Insurance Under the Affordable Care Act While Others Have Not (/publications/issue-briefs/2015/sep/to-enroll-or-not-to-enroll)*, focused on people's experience shopping for and enrolling in marketplace and Medicaid coverage. Two-thirds (66%) of people who bought new marketplace coverage or switched plans during the 2015 open enrollment period said costs (premiums, deductibles, and copayments) were the most important factor in selecting a plan.

Affordability was also a primary reason why some who shopped for coverage ultimately didn't enroll—57 percent of those who visited the marketplaces and didn't select a plan said they could not find a plan they could afford. Excluding people who got coverage through another source, 54 percent of people who said they couldn't find an affordable plan had incomes that would have qualified them for subsidies. One-quarter (26%) of those who said they couldn't find an affordable plan lived in a state that had not expanded Medicaid and had incomes below the range that made them eligible for marketplace subsidies.

Personal Assistance Improves Enrollment Experience

The report found that personal enrollment assistance was helpful to potential enrollees in both marketplace plans and Medicaid. After controlling for demographic differences like income and education, 78 percent of marketplace visitors who received personal assistance eventually enrolled, while only 56 percent of those who did not get assistance did.

People who enrolled also had an easier time comparing premiums, out-of-pocket costs, and benefits compared to those who didn't sign up for coverage.

"The Affordable Care Act was designed to assure all Americans have access to affordable and comprehensive health insurance so they can get the health care they need," said Commonwealth Fund President David Blumenthal, M.D. "But this survey shows that problems understanding insurance offerings are keeping many

people from getting insured."

Having their preferred provider in their plan's network was of less concern than were costs to survey respondents when they were selecting a plan in the marketplace—22 percent of those who chose a plan in 2015 said having their preferred doctor, health clinic, or hospital in their plan was the most important factor in their decision. Many consumers were not averse to selecting a plan with a "narrow network" of providers—54 percent who had the option to pay less for a plan with fewer participating doctors or hospitals did so.

The authors conclude that the cost of insurance was a significant reason why millions of people were uninsured prior to the passage of the ACA and it continues to be a top factor in consumers' decisions about whether to sign up for coverage and about which plans they choose. Many people who ultimately did not enroll expressed concerns about affordability, even those in the range for subsidies. Others selected lower-cost plans that may leave them exposed to high deductibles. The authors suggest that "getting assistance during the enrollment process may help people better understand the trade-offs between health plans they were considering. …Whether someone received personal assistance or not during the enrollment process made a significant difference in whether they signed up for coverage."

Deloitte.

Public health insurance exchanges
Opening the door for a new generation of engaged health care consumers

Insights from the Deloitte Center for Health Solutions 2015 Survey of US Health Care Consumers

Executive summary

Public health insurance exchanges (HIX) are beginning to deliver on the promise of transforming the individual insurance market. HIX customers are actively engaging in the buying process, using both "high-tech" and "high-touch" purchasing channels, and putting health plans on notice that they will switch if they are dissatisfied. The exchanges already rank among consumers' most trusted sources for information, suggesting that they are quickly becoming an accepted way to purchase health insurance.

Through this new buying experience, the exchanges are opening the door for a new generation of actively engaged consumers. Findings from the Deloitte Center for Health Solutions *2015 Survey of US Health Care Consumers* suggest that HIX customers differ from those with other sources of insurance coverage. They are more cost-conscious, price-sensitive, and focused on finding a plan that offers good value and fit. By the time they enroll, HIX customers have a better understanding of plan benefits and costs than individuals with coverage through employers, Medicaid, or Medicare. They are inclined to compare plans, providers, and services on price but show interest in quality measures, too. These early signs suggest that HIX enrollees are becoming savvy, informed consumers who are geared to shop around not just for health insurance, but also for health care services and products.

The exchanges have improved access to care, but affordability remains a problem. Enrollees report getting care they may not have been able to afford without their HIX coverage and are connecting with primary care providers at twice the rate of the uninsured. However, one in three enrollees with coverage for the entire year had trouble paying their out-of-pocket (OOP) health care expenses. Compared to other insured cohorts, HIX enrollees are less confident that they can get affordable care and feel less prepared financially to handle their future health care costs. Potential buyers may need better guidance in selecting affordable coverage and might be open to plans that offer value-based incentives or that swap coverage limits for lower premiums and copayments. Consumers' willingness to accept limited provider networks for lower prices is on the rise, especially among younger enrollees, signaling that tradeoffs like these may be part of the solution.

Eight in ten renewing enrollees stayed with the same insurance carrier, but plan satisfaction is an issue. Nearly half of renewing enrollees report they switched insurance products, and only 30 percent of all surveyed HIX enrollees say they are satisfied with their current plan, which is significantly lower than other insured cohorts. Switching plans with a carrier is not necessarily a problem. If the consumer is learning about value and switching plans because of a poor initial fit, making a change could lead to better satisfaction and signal to a health plan which product consumers prefer. Price is the most commonly reported driver of dissatisfaction and switching, but switchers also indicate wanting broader coverage or better alignment with personal needs. Responding to the diverse expectations HIX consumers bring to the marketplace is part of the challenge. Satisfaction varies by age, subsidy eligibility, and prior insurance status, reflecting differences in expectations, needs, and preferences. Exchanges and health plans will likely need to give thoughtful consideration to strategies for accommodating these differences as they strive to retain HIX customers and prepare for subsequent waves of enrollees.

What is needed to equip this new generation of health care consumers? Survey findings point to multiple purchasing channels, more reliable information sources, better decision support, and further development of online resources and digital technologies. Improvements in these areas may help HIX enrollees become well-informed health insurance purchasers and more fully engaged health care consumers. Advancements, especially those related to communication and plan design, may also go a long way towards reaching individuals who remain uninsured. Most of them want coverage, but say they need lower-cost options, better information, security assurances, and an easier enrollment process. By developing effective strategies to improve these aspects of the consumer experience, public health exchanges and health plans can further widen the engagement door they have opened.

What are public health insurance exchanges?
Public health insurance exchanges (HIX), as established by the Affordable Care Act (ACA), are marketplaces that individuals can use to compare and buy coverage offered by competing private health insurance companies. Depending on one's state of residence, individuals use either the federally facilitated exchange (commonly known as HealthCare.gov) or their state's exchange. Currently, 13 states and the District of Columbia operate their own exchanges, while 37 states rely on the federal government to operate their exchange to varying degrees (27 use the federally facilitated exchange, seven operate a state-federal partnership exchange, and three have state-based exchanges that use the federal IT platform).[1]

These public exchanges provide consumers with a new way to buy health insurance in the individual insurance market. Potential buyers can log onto an exchange website or contact a call center to learn about their coverage options and see if they qualify for a subsidy or government program such as Medicaid or the Children's Health Insurance Program (CHIP). Consumers cannot be denied coverage based on their health status or any pre-existing conditions, and new limits have been imposed on the factors insurance companies can use to vary health insurance premiums. Multiple plans with various coverage levels are available through the exchanges. Once a consumer has selected a plan, the website enables them to purchase the coverage and complete the enrollment process. Trained "navigators," insurance company representatives, and insurance brokers are available to provide assistance in person or over the phone. As with other sources of coverage, consumers can sign up or switch plans only during specific open enrollment periods, unless they experience a qualifying life event that allows them to enroll at other times.

Purchasing a complex health insurance product in this novel way – through a transaction that takes place directly with an insurance company without an intermediary (e.g., employer or government program) and preselected offerings – could be daunting for many individuals. Yet, armed with new protections and assistance afforded to them by the ACA, 10.2 million consumers enrolled in a health plan through the public exchanges as of March 2015.[2]

Results from the Deloitte Center for Health Solutions 2015 Survey of US Health Care Consumers, presented in this report, suggest that consumers are not only embracing this new buying opportunity, they are also on their way to becoming actively engaged consumers of health care services and products.

HIX enrollees versus those with different types of coverage:

Compared to people with coverage through employers, Medicaid, or Medicare, HIX enrollees are more cost-conscious, price-sensitive, and focused on finding a plan that offers good value and fit.

76% of HIX enrollees say the overall amount they have to pay in terms of premiums, deductibles, and copays was an important factor when they chose their current plan

VS

65% in employer plans
62% in Medicaid plans*
69% in Medicare plans

64% of HIX enrollees indicate that finding good value was important to them when they chose their current plan

VS

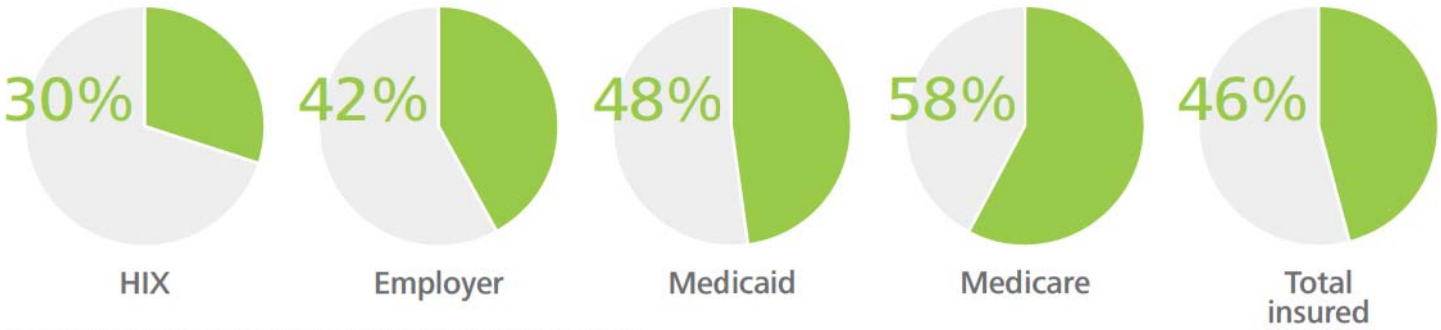
57% in employer plans
54% in Medicaid plans
59% in Medicare plans

41% of HIX enrollees say the availability of a tool to help them find the best plan based on their personal health, finances, and preferences was an important factor when they chose their current plan

VS

32% in employer plans
37% in Medicaid plans
36% in Medicare plans

Only 30% of all surveyed HIX enrollees say they are satisfied with their current plan, which is significantly lower than other insured cohorts.



*Note that Medicaid is included as a comparison group in this study. For most Medicaid enrollees, plans are available that do not charge premiums and cost-sharing is de minimis.

HIX enrollees are less confident that they can get affordable care and feel less financially prepared to handle their future health care costs.

24% of HIX enrollees are confident they can get affordable care when they need it

VS

27% in employer plans
36% in Medicaid plans
38% in Medicare plans

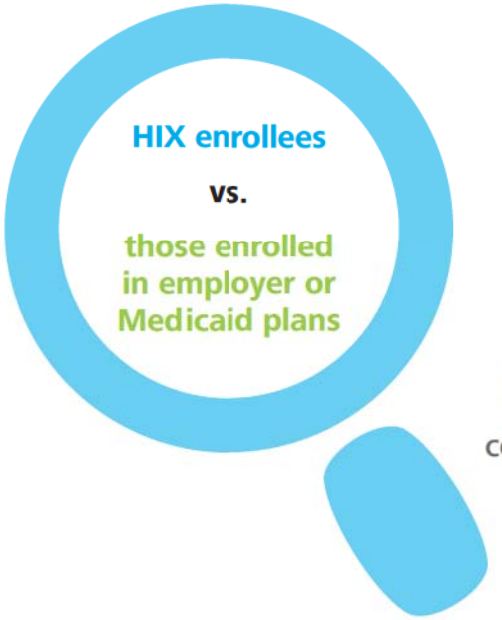
16% of HIX enrollees feel financially prepared to handle their future health care costs

VS

24% in employer plans
17% in Medicaid plans
27% in Medicare plans

By the time they enroll, HIX customers have a better understanding of plan benefits and costs than individuals with coverage through employers or Medicaid.

51%
of HIX enrollees
vs.
47%
of employer-plan enrollees and **45%** of Medicaid enrollees felt they had a good understanding of the benefits of their plan at the time they enrolled (Medicare is highest at **59%**)



55%
of HIX enrollees
vs.
47%
of those enrolled in employer or Medicaid plans felt they had a good understanding of the total costs of their plan at the time they enrolled (Medicare is highest at **60%**)

Experience with the exchanges:

The trust that consumers place in the marketplaces rivals other trusted sources. This suggests that the marketplaces are realizing the vision for being an honest broker for health plan shopping.

35% of HIX enrollees trust exchanges to provide reliable information about health plans, placing them among the most highly-rated sources of information:

38%
family and friends

36%
health care providers

36%
independent consumer-oriented organizations

Enrollees report getting care they may not have been able to afford without their HIX coverage and are connecting with primary care providers at twice the rate of the uninsured.

65% of current HIX enrollees have used their plans to access care or purchase medication

72% of those who used their benefits to get care say they may not have been able to get that care without their HIX coverage

However, **one in three** enrollees with coverage for the entire year had trouble paying their OOP health care expenses

Price is the most commonly reported driver of dissatisfaction and switching, but switchers also indicate wanting broader coverage or better alignment with personal needs.

35% of dissatisfied HIX enrollees feel they are paying too much for their plan

40% of HIX enrollees who switched plans between 2014 and 2015 switched to get a lower price

Trends across all coverage groups:

More than two-thirds of HIX enrollees are **INTERESTED** in using digital technologies to...

Less than one-third, however, has **USED** websites, mobile apps, and personal devices in the last year to...

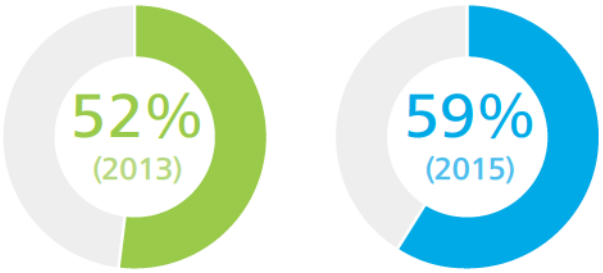
Consumers' use of digital health technologies is growing, but gaps between use and interest indicate there is unmet demand for technologies that can support engagement in personal health monitoring, communication with providers, and administrative transactions like paying medical bills online.

72%	Pay medical bills	32%
72%	Communicate with providers	17%
68%	Access their records	19%
67%	Track changes in their health	21%

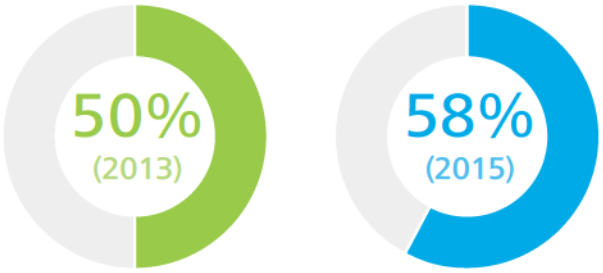
Consumers' willingness to accept limited provider networks for lower prices is on the rise, especially among younger enrollees, signaling that tradeoffs like these may be part of the solution.

The percentage of insured enrollees who say they would be willing to accept a smaller network of hospitals or doctors in exchange for lower payments rose from 2013 to 2015

Smaller network of hospitals



Smaller network of doctors



Survey findings

HIX consumers appear to be moving faster towards becoming fully engaged health care consumers than other insured cohorts – they are more focused on price and value, informed about plan benefits and costs, inclined to use online resources, and interested in using health technologies

Price remains consumers' top consideration when choosing a health plan, but HIX enrollees also point to the importance of value, fit, and online systems

Insured consumers, especially HIX enrollees, rank price at or very near the top of the factors that are important to them when choosing a plan (Figure 1). Scope of coverage (benefits and network) and value follow closely behind. Brand/reputation, customer service, and assistance from navigators* appear to be second-tier choice factors, and quality ranks even lower, not yet emerging as a major factor.

More than other insured cohorts, HIX enrollees cite criteria that focus on determining whether coverage is worth the cost (value) and finding a plan that meets one's personal needs, preferences, and financial circumstances (fit). Demand for capabilities that can strengthen consumer engagement is sizeable: nearly half of the HIX cohort (less in other cohorts) says online systems facilitating interactions between consumers and plans are important; more than one in three (in every cohort) indicates that health management programs and resources factor into their choice.

* Navigators are federally trained individuals who provide in-person assistance to consumers to help them apply and enroll in a HIX plan. They also provide outreach and education to raise awareness about the exchanges.

Figure 1. Factors important to plan choice by insurance source*

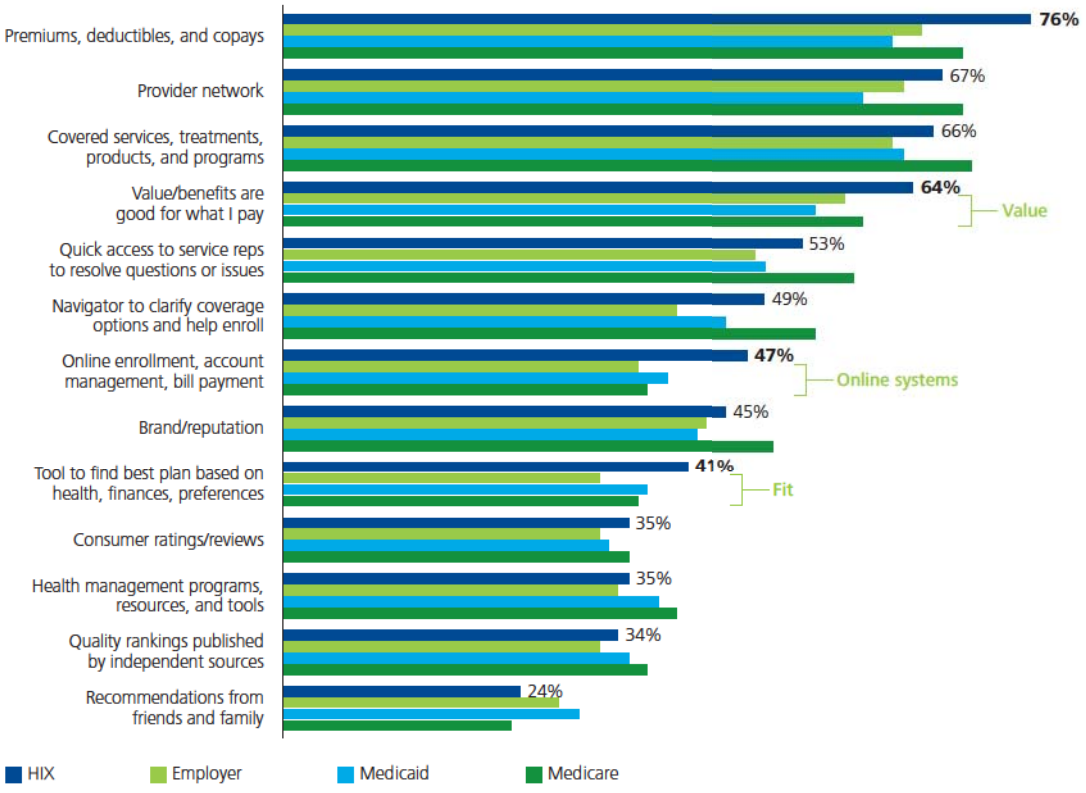


Chart shows percentage of respondents who rated importance of factor as 8, 9, or 10 on a 10-point scale, where 1 is "not at all important" and 10 is "extremely important."

Source: Deloitte Center for Health Solutions: 2015 Survey of US Health Care Consumers

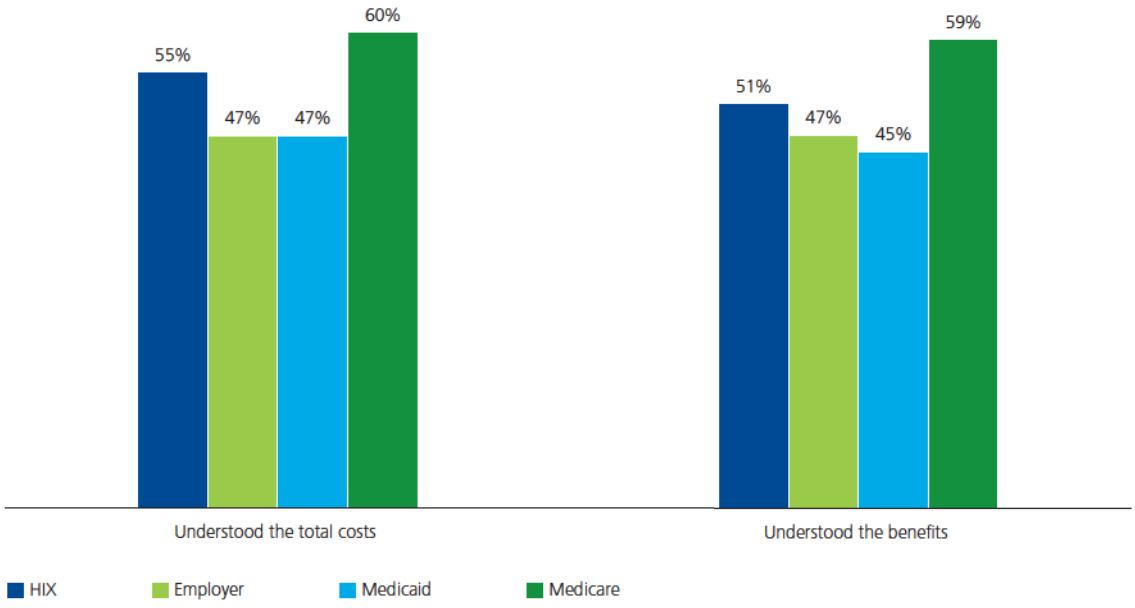
*Note that Medicaid is included as a comparison group in this study. For most Medicaid enrollees, plans are available that do not charge premiums and cost-sharing is de minimis.

HIX enrollees express greater understanding of plan costs and benefits than individuals in employer plans and Medicaid (but understanding is not strong)

HIX enrollees are more likely to say they understood the costs and benefits of their plan at the time of purchase than those with coverage through employers or Medicaid (Figure 2). Just around half of HIX enrollees say they felt they had a good understanding.

Enrollees who renewed or switched plans between 2014 and 2015 are considerably more likely to say they understood their plan's costs and benefits than those who obtained new coverage. However, levels of understanding do not exceed 60 percent among even the experienced subgroups, reflecting a potential need for better information, communication, and education on coverage details. Individuals who received a subsidy express better understanding than respondents who paid the full price.

Figure 2. Understanding of plan costs and benefits at time of purchase by insurance source



Charts shows percentage of respondents who gave a rating of 8, 9, or 10 on a scale of 1 through 10, where 1 is "did not understand" and 10 is "fully understood."

Source: Deloitte Center for Health Solutions: 2015 Survey of US Health Care Consumers

HIX enrollees show signs of using online resources and paying greater attention to health care costs and quality than individuals with other sources of coverage

HIX enrollees rely on online resources and health plan websites to a greater extent than enrollees with other forms of coverage (Figure 3). They also report greater use of and interest in cost and quality information and generally express more cost-sensitive attitudes. On quality, respondents across all surveyed insurance cohorts more commonly say they are *likely* to use information about quality than have actually looked for this type of information.

Figure 3. Use of online resources and attitudes related to cost and quality information by insurance source

	HIX	Employer	Medicare	Medicaid
Sample	**406**	**1,611**	**703**	**397**
Using online resources				
Looked online for health- or care-related information of any kind*	**58%**	55%	51%	49%
Used a health plan website to look up general information†	**50%**	34%	26%	28%
Used a health plan website to review personal information§	**39%**	32%	20%	17%
Focused on price				
Believe doctors should provide and explain total treatment costs	**64%**	58%	60%	57%
Likely to use an online tool that would tell you how much your health plan would pay for certain services	**63%**	53%	51%	44%
Likely to use an online tool that could help you compare and negotiate prices with doctors and hospitals	**51%**	45%	36%	40%
Asked about pricing before agreeing to treatment	**20%**	15%	12%	11%
Looked online for costs/prices of services	**19%**	16%	8%	12%
Moving toward quality				
Likely to use an online quality rankings, satisfaction ratings, and patient reviews for doctors and hospitals	**52%**	47%	49%	46%
Looked online for information about the quality of care provided by a specific doctor or hospital	**18%**	15%	13%	15%
Looked at health plan scorecard or report card	**14%**	10%	8%	12%

Note: reported behaviors that occurred during the last 12 months

* Includes looking for information related to any of the following: wellness, prevention, or healthy living; an illness, injury, or health problem (symptoms, tests, treatment, or follow-up); quality of care provided by a doctor or hospital; costs or prices of services; choosing a hospital)

† Includes information related to plan choices and costs, health care providers, health problems, treatment choices, special programs

§ Includes information related to coverage details, bills/claims, health assessments, care management plans

Source: Deloitte Center for Health Solutions: 2015 Survey of US Health Care Consumers

Gaps between use and interest point to consumer demand for digital technologies that can further enhance their engagement

More than two-thirds of HIX enrollees are interested in using digital technologies to pay medical bills, communicate with providers, access their records, and track changes in their health (Figure 4). Less than one-third, however, has used websites, mobile apps, and personal devices for those health-related purposes in the last year. The untapped interest suggests HIX enrollees are inclined to become more digitally engaged as technologies supporting health improvement, care management, and administrative transactions are further developed and enrollees become familiar with what is available.

Figure 4. Use of and interest in digital technologies for health-related purposes

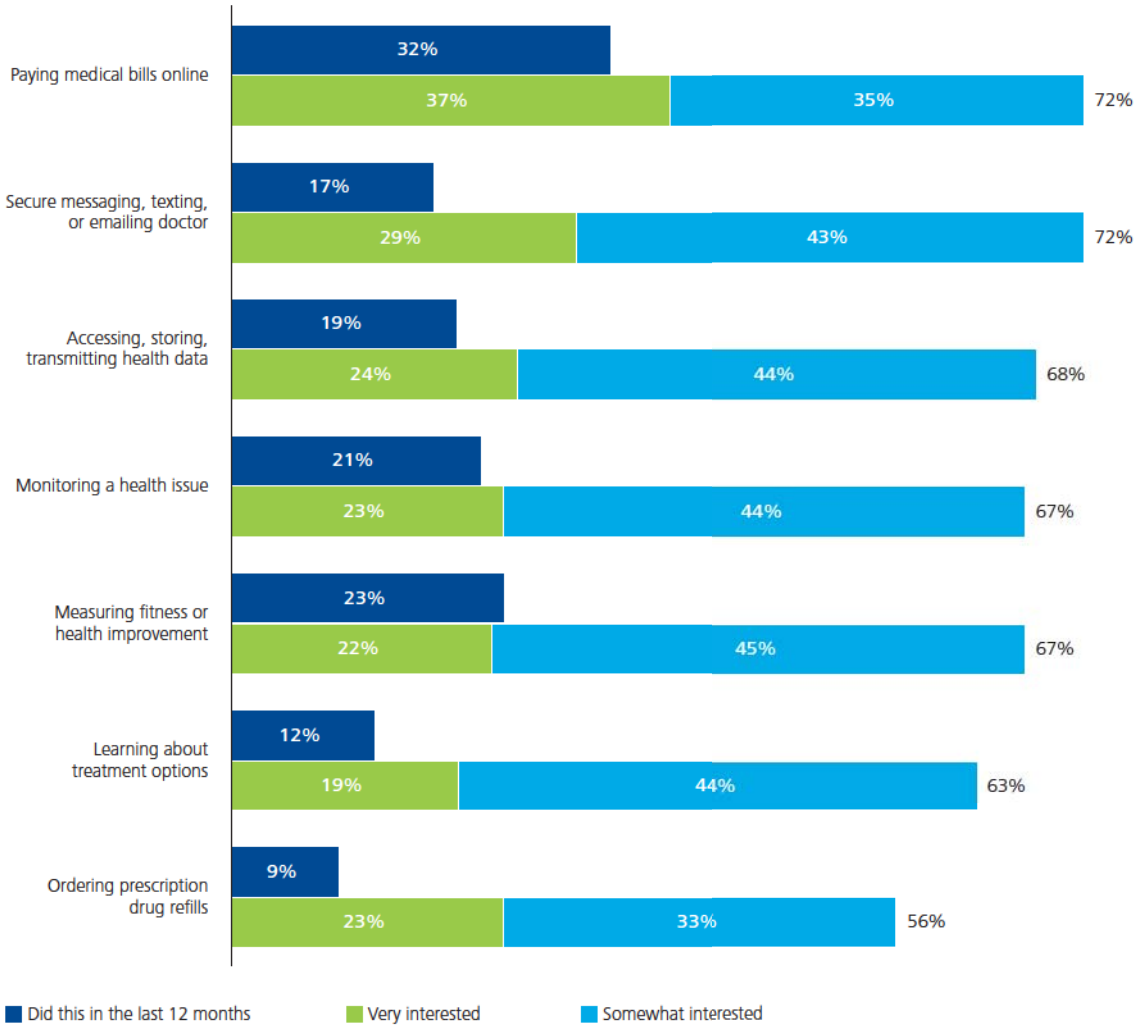


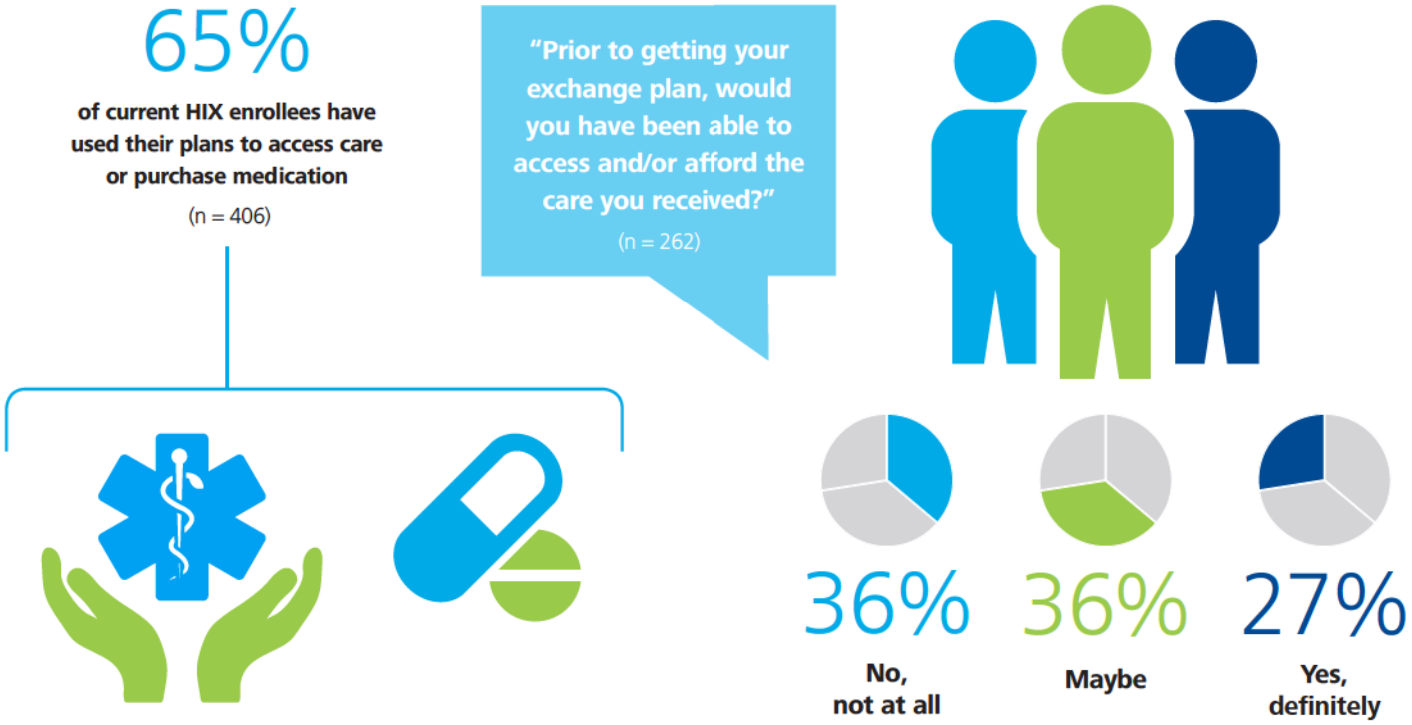
Chart shows percentage of HIX enrollees (n = 406) who used a website, mobile application, or personal device in the last 12 months and percentage who are interested in using in the future

Source: Deloitte Center for Health Solutions: 2015 Survey of US Health Care Consumers

Public health insurance exchanges have had success in improving access to care, but affordability issues remain

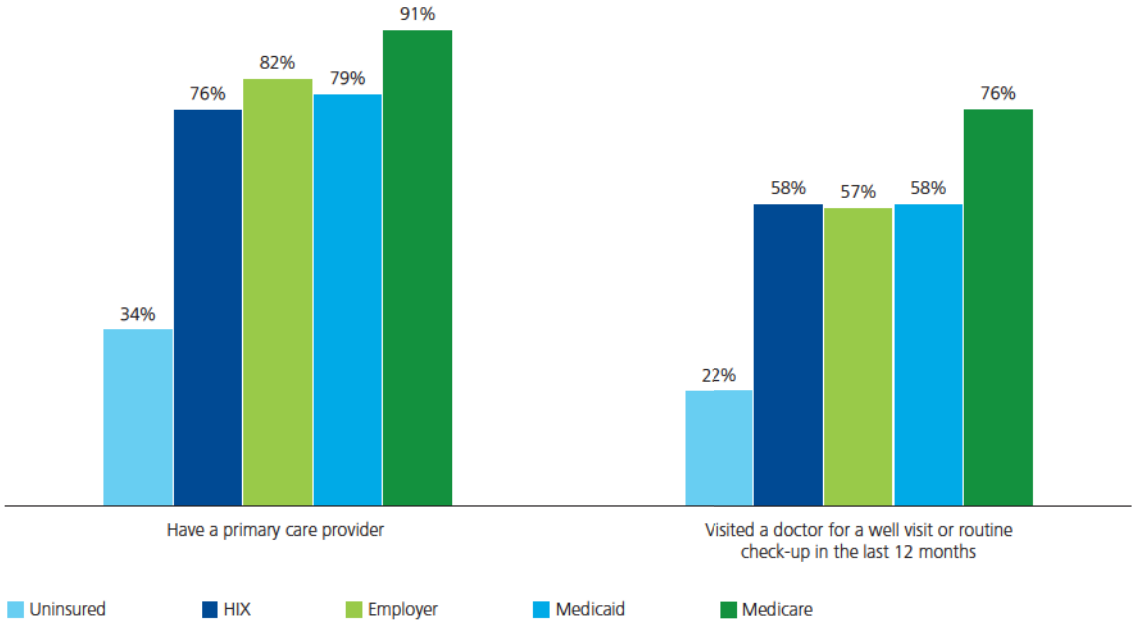
HIX enrollees are getting care they may not have been able to afford before and are more than twice as likely as the uninsured to have a primary care provider

Nearly two-thirds of HIX enrollees say they have used their plan benefits, and nearly three-fourths of benefit users believe that they may not have been able to afford those services without their HIX coverage.



Seventy-six percent of HIX enrollees currently have a doctor, nurse practitioner, physician assistant, or other health care professional they consider to be their primary care provider, compared to only 34 percent of those who have remained uninsured (Figure 5). Nearly 60 percent of HIX enrollees report visiting a doctor for a well visit in the last year, which is similar to individuals covered by employer plans or Medicaid.

Figure 5. Access to primary care



Source: Deloitte Center for Health Solutions: 2015 Survey of US Health Care Consumers

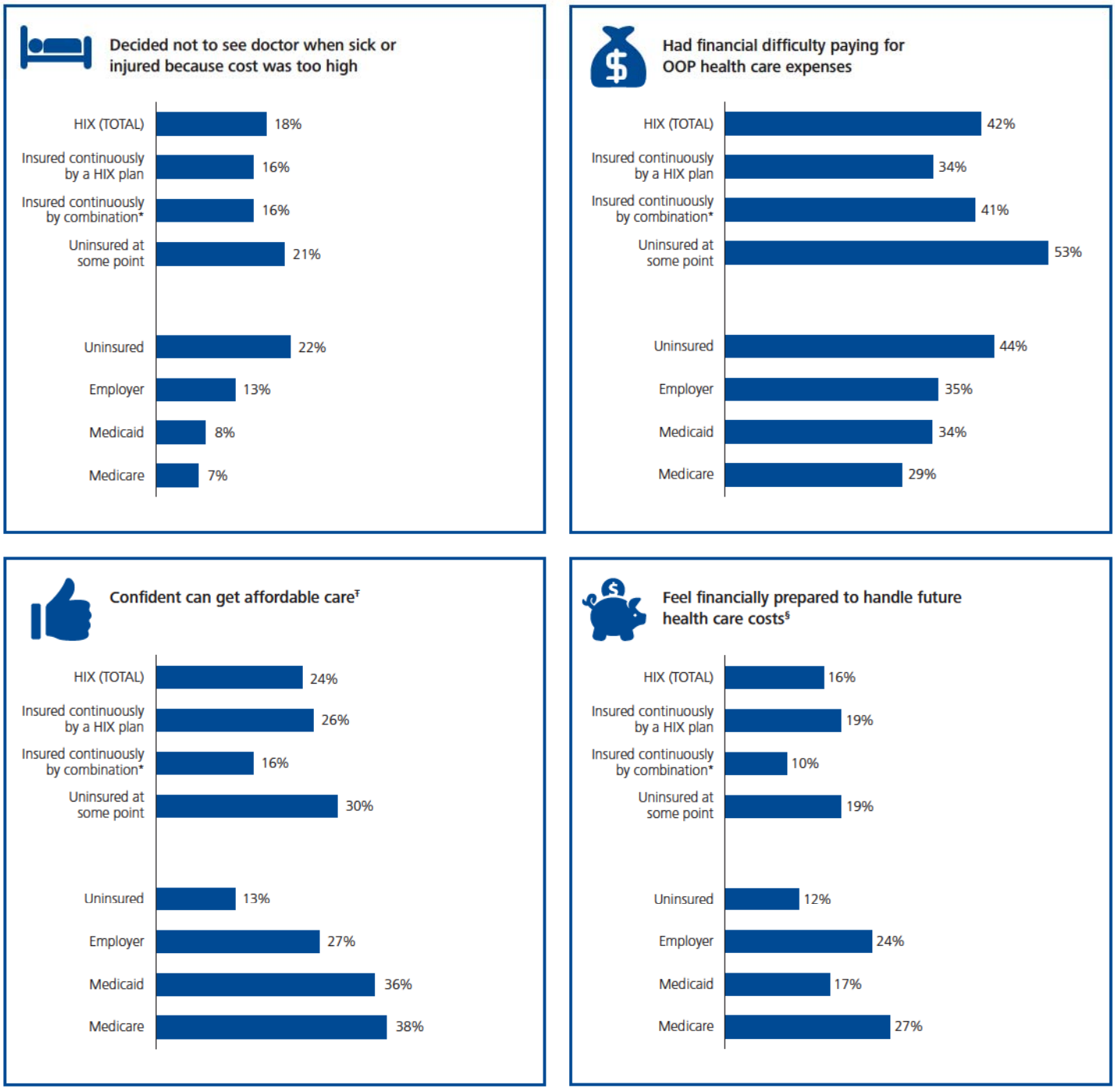
Substantial numbers of HIX enrollees are having trouble paying OOP expenses and are skipping care because of cost. HIX enrollees also are less confident about getting affordable care and paying for future health care expenses than other insured consumers

One in three enrollees who were continuously covered by a HIX plan through 2014 reports financial difficulty paying OOP health care expenses. While this is far lower than the rate reported by those who were uninsured at some point during the year, the sizeable share of HIX enrollees experiencing financial difficulty signals that consumers may need assistance in budgeting for anticipated costs and better information and guidance to help them select a plan with lower OOP exposure.

Cost concerns led 16 percent of continuously covered HIX enrollees to skip seeing a doctor when they were sick or injured (Figure 6). This is slightly higher than rates reported by employer plan enrollees and double the rates reported by Medicare and Medicaid enrollees, suggesting that the comparatively higher cost-sharing associated with HIX plans may be influencing consumers' decisions to seek care.

Only 24 percent of HIX enrollees believe that they can get affordable care when they need it. Like individuals in employer plans, HIX enrollees are twice as likely as the uninsured to express confidence, but these insured groups are significantly less confident than the Medicaid and Medicare cohorts. Only 16 percent feel financially ready to handle their future health care costs, which is significantly lower than those with coverage through employers and Medicare.

Figure 6. Financial challenges and attitudes by insurance status and source during the last 12 months



* These respondents were covered by some other source of insurance and then enrolled in a HIX plan within the last 12 months.
† Percentage who rated confidence as an 8, 9, or 10 on a 10-point scale, where 1 = "not at all confident" and 10 = "completely confident."
§ Percentage who rated preparedness as an 8, 9, or 10 on a 10-point scale, where 1 = "not at all prepared" and 10 = "completely prepared."

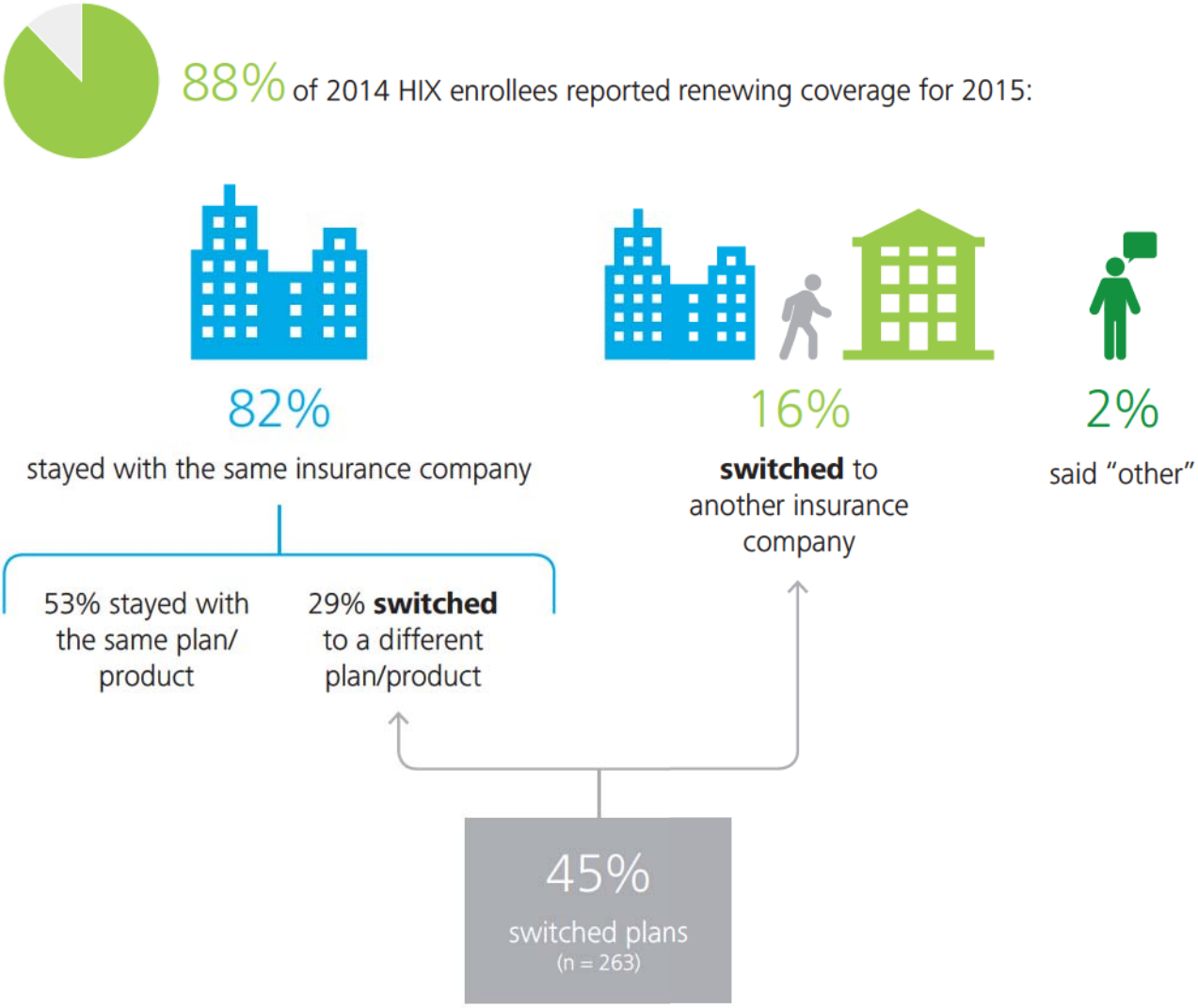
Source: Deloitte Center for Health Solutions: 2015 Survey of US Health Care Consumers

HIX consumers will switch plans if they are dissatisfied and many are unhappy with their current plan, mostly due to price but coverage is a concern for some

Nearly half of renewing enrollees made a change to their coverage

Among those who had HIX coverage in 2014 and renewed for 2015, 82 percent say they stayed with the same insurance company, while 16 percent switched to a new carrier (Figure 7). However, not all of those who stayed with the same insurance company kept the same insurance product – 29 percent report they switched to a different product offering. Combining these people who stayed with the same company but chose a different insurance product and people who switched insurance companies, we found that 45 percent of renewing enrollees switched to a new plan.

Figure 7. Switch rates among enrollees who had HIX coverage in 2014 and renewed for 2015



Source: Deloitte Center for Health Solutions: 2015 Survey of US Health Care Consumers

HIX enrollees are less satisfied with their current health plan than individuals with other sources of coverage

When asked to rate how satisfied they are with their current health plan, only 30 percent of HIX enrollees report being satisfied. The HIX rate is lower than rates reported by the other surveyed insurance cohorts, which range from 42 percent of enrollees in employer plans to 58 percent of enrollees in Medicare (Figure 8).

Figure 8. Ratings of overall satisfaction with current health plan

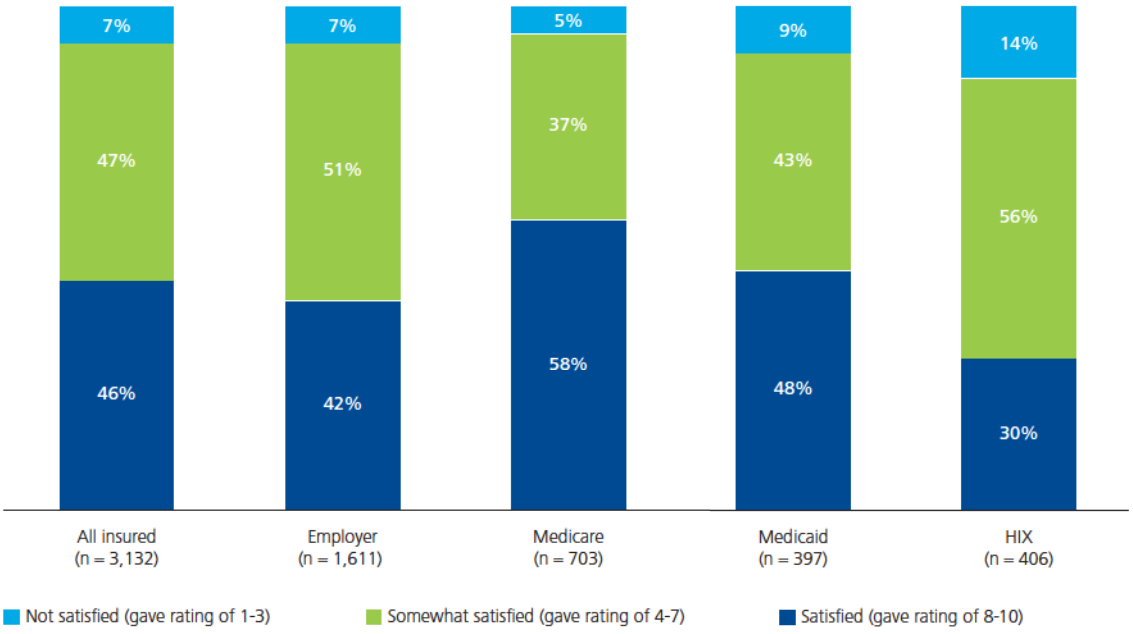


Chart shows percentage of respondents who rated their satisfaction on a 10-point scale, where 1 = "not at all satisfied" and 10 = "completely satisfied."

Source: Deloitte Center for Health Solutions: 2015 Survey of US Health Care Consumers

Satisfaction varies – younger enrollees are the most satisfied, as are enrollees with a year of HIX experience, the opportunity to switch to a more suitable plan, and financial assistance

Only around two in five HIX enrollees say they are satisfied with the total costs of their plan, the benefits their plan includes, and the experience of buying a plan through an exchange (Figure 9).

Looking within the HIX cohort, enrollees in the first wave report higher satisfaction with their current plan (32 percent) than enrollees in the second wave (24 percent). First-wave enrollees have had HIX coverage for a longer period of time: those who renewed the same plan have likely become familiar and experienced with what their plan offers, and those who switched plans may prefer their current plan more than their original one. Benefits – more than costs – appear to be a key factor contributing to lower satisfaction among second-wave enrollees; only 34 percent of them rated benefits highly compared to 46 percent of first-wave enrollees.

Renewing enrollees and those switching from one HIX plan to another give the highest satisfaction ratings for benefits and the buying experience. Individuals who switched into a HIX plan from a non-HIX plan are least satisfied.

Enrollees who received a subsidy express greater satisfaction than those who didn't, likely reflecting a tendency for consumers to feel more satisfied by something that costs less. Younger enrollees express higher satisfaction with all facets of their plan compared to older enrollees.

Figure 9. Ratings of satisfaction with current plan overall, total costs, plan benefits, and buying experience

	Satisfied with current plan overall	Satisfied with total costs	Satisfied with benefits	Satisfied with buying experience
HIX enrollees (Total)	**30%**	**37%**	**43%**	**43%**
First wave (enrolled in HIX for 2014 coverage)	32%	38%	46%	45%
Second wave (enrolled in HIX for 2015 coverage	24%	35%	34%	37%
Newly insured in 2015 (previously uninsured)	20%	42%	34%	42%
Renewals (stayed in same HIX plan)	34%	37%	46%	44%
Switchers from one HIX plan to another HIX plan	33%	36%	50%	48%
Switchers from a non-HIX plan into a HIX plan	27%	29%	34%	32%
Received subsidy	33%	43%	47%	48%
Did not receive subsidy	19%	21%	32%	32%
18 to 34 years old	43%	49%	53%	47%
35 to 54 years old	27%	35%	41%	41%
55 + years old	28%	35%	40%	43%

For overall plan satisfaction, table shows percentage of respondents who rated their satisfaction on a 10-point scale, where 1 = "not at all satisfied" and 10 = "completely satisfied."

For total costs, benefits, and buying experience, table shows respondents who gave a rating of 8, 9, or 10 on a 10-point scale, where 1 = "very dissatisfied" and 10 = "very satisfied."

* These respondents were covered by some other source of insurance and then enrolled in a HIX plan within the last 12 months.

Source: Deloitte Center for Health Solutions: 2015 Survey of US Health Care Consumers

Price is the most commonly reported driver of plan switching and dissatisfaction, but some consumers want broader coverage or better alignment with personal needs

Price-related factors top the list of reasons why HIX enrollees switched plans last year: 40 percent say they moved for a lower price, and 25 percent say eligibility for a subsidy motivated them. Just over 20 percent report they had to switch because their former plan was canceled or discontinued; just under 20 percent say they were seeking better coverage for certain providers or services. Less than 10 percent cite customer service problems, quality concerns, job-related changes, or recommendations from others.

Price is also the primary reason why HIX enrollees are dissatisfied with their current plan (Figure 10). When asked to identify the key reason, 35 percent of unhappy enrollees say they feel that they pay too much. Price is followed by concerns about insufficient financial protection (24 percent) and network limits (19 percent). HIX enrollees are more dissatisfied with their provider network than individuals with employer or Medicare coverage, but less dissatisfied with various aspects of customer support, including information received about benefits and costs, the claims process, customer service, and online tools and programs that can help individuals improve their health.

Figure 10. Most important reason insured consumers are dissatisfied with their current health plan

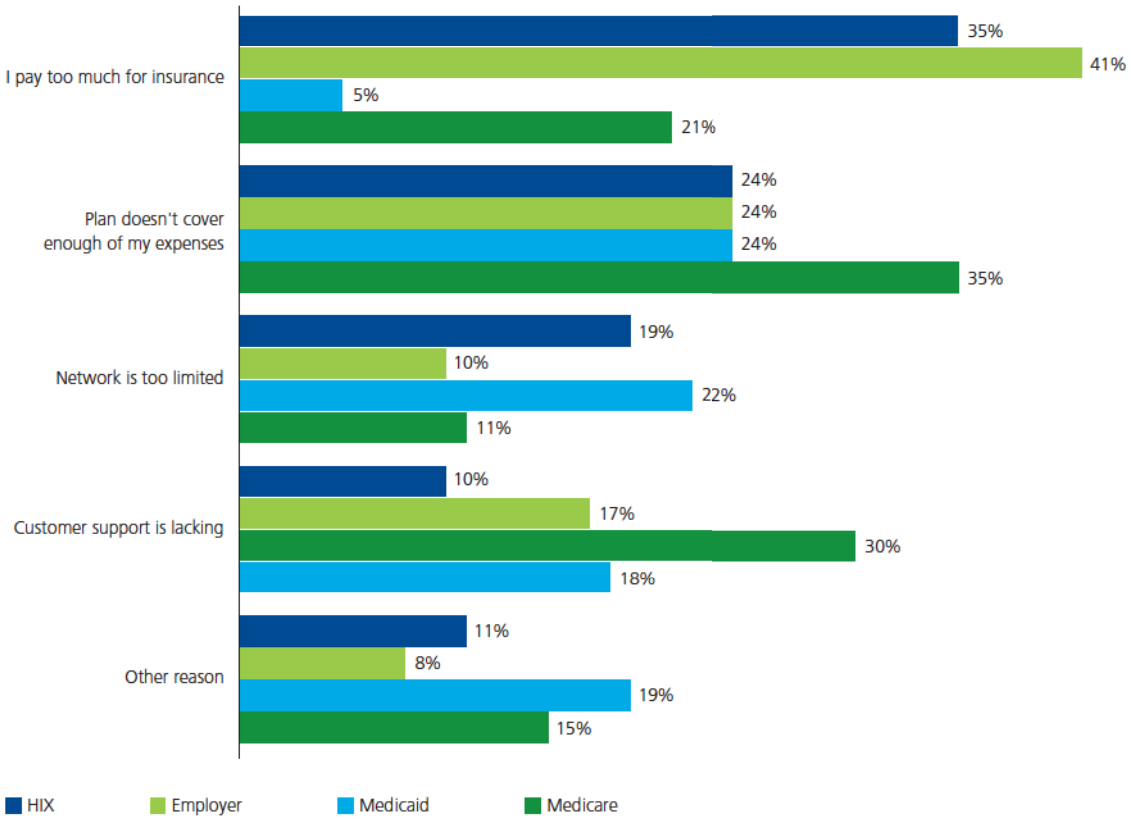


Chart shows percentage of dissatisfied enrollees who selected each factor as the most important reason (respondents could select only one).

Source: Deloitte Center for Health Solutions: 2015 Survey of US Health Care Consumers

Addressing affordability is a core challenge – plans that restrict networks in exchange for lower prices may be part of the solution for a growing number of consumers

Willingness to accept limited networks in exchange for lower premiums and copays has reached a new high – younger people are significantly more willing than older people, especially within the HIX cohort

Up to 60 percent of insured consumers are now "willing" or "somewhat willing" to accept a smaller network of hospitals or a smaller network of doctors for a lower price, and just over half (52 percent) express some willingness to accept a network that does not include their current primary care provider. These levels are higher than levels reported in recent years (Figure 11), suggesting that the average consumer is becoming more open to accepting network-price tradeoffs.

Figure 11. Increase in willingness to accept network-price tradeoffs among insured consumers

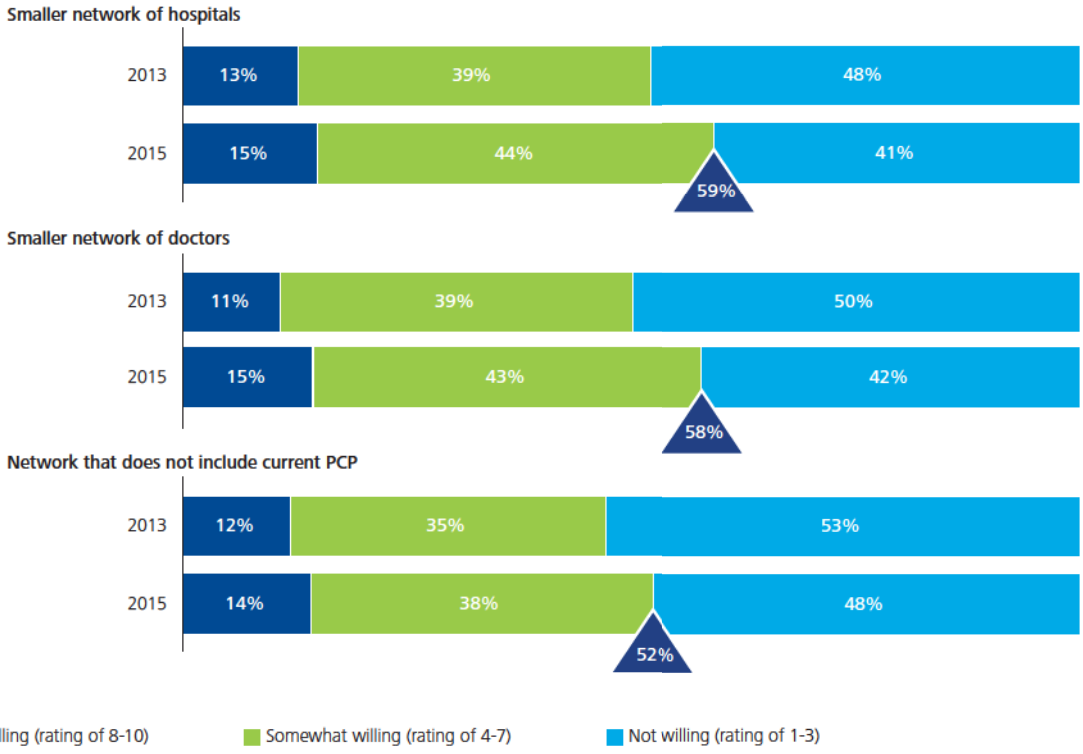


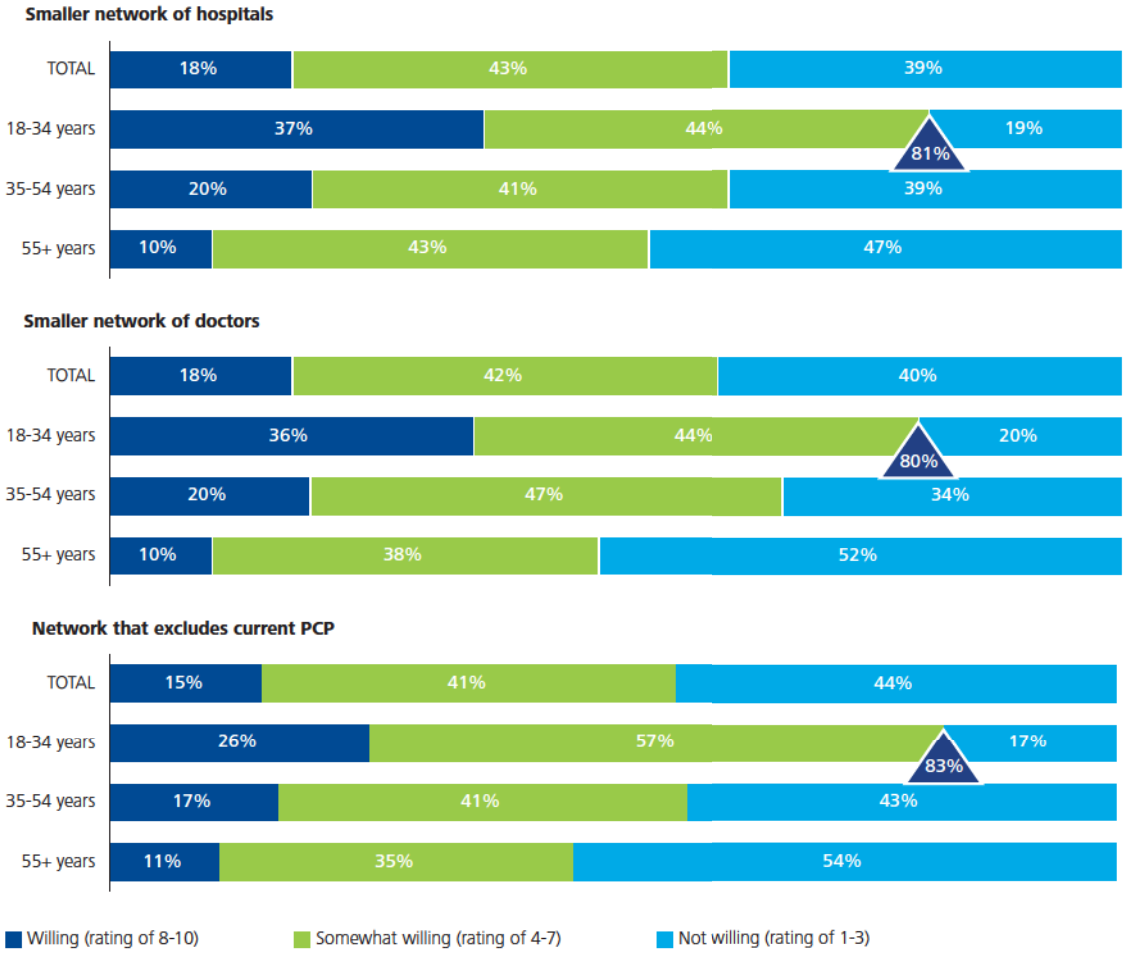
Chart shows responses for survey participants who reported being insured through HIX, direct purchase, an employer, Medicare, Medicaid, or some other source (n = 3,339 in 2013 and n = 3,132 in 2015).

Source: Deloitte Center for Health Solutions: 2015 Survey of US Health Care Consumers

Willingness does not vary significantly by income (as might be expected with price considerations) but it does vary by age. Younger buyers are significantly more willing to accept coverage-price tradeoffs than older buyers, and this age difference is especially pronounced in the HIX cohort (Figure 12). Up to 83 percent of 18-to-34 year olds are at least somewhat willing to accept a network that does not include their current primary care provider, and nearly that many are open to smaller provider networks in exchange for lower premiums and copays. Younger individuals may find these tradeoffs easier if they have not yet established relationships with specific providers, as many older individuals have.

Within the HIX cohort, recently uninsured individuals express the greatest openness to network-price tradeoffs. HIX enrollees who renewed their coverage or switched from one HIX plan to another HIX plan between 2014 and 2015 appear more willing than those who were covered by some other source before enrolling in a HIX plan for coverage in 2015.

Figure 12. Willingness to accept network-price tradeoffs among HIX enrollees by age



Source: Deloitte Center for Health Solutions: 2015 Survey of US Health Care Consumers

Familiarizing consumers with affordable coverage options could be essential for reaching the uninsured, who also say they need an easier enrollment process, better information, and assurances that personal information will be protected

Most individuals who have remained uninsured would like to be covered

Seventy-six percent of the uninsured express attitudes that suggest they would like to be covered but they face hurdles related to affordability, eligibility, information, coverage adequacy, process complexity, and privacy and security concerns (Figure 13). Only 24 percent indicate they do not want health insurance, either because they feel they don't need it and/or they would rather pay for care when the need arises.

Many of the 57 percent who think health insurance is unaffordable may not be aware of subsidies. In a February 2013 Deloitte survey conducted prior to the start of the exchanges, 44 percent of all uninsured respondents were aware that the ACA would offer tax credits to help eligible individuals afford health insurance.[3] Younger adults (18 to 34 years) were less aware than older adults (40 percent versus 48 percent). Just over a year later, in April 2014, 53 percent of uninsured young adults (19 to 34 years) reported knowing about government subsidies.[4] Awareness has likely continued to rise with the exchanges now in their second year, but the low baselines suggest a gap probably still exists.

Figure 13. Reasons for not having coverage cited by those who are currently uninsured

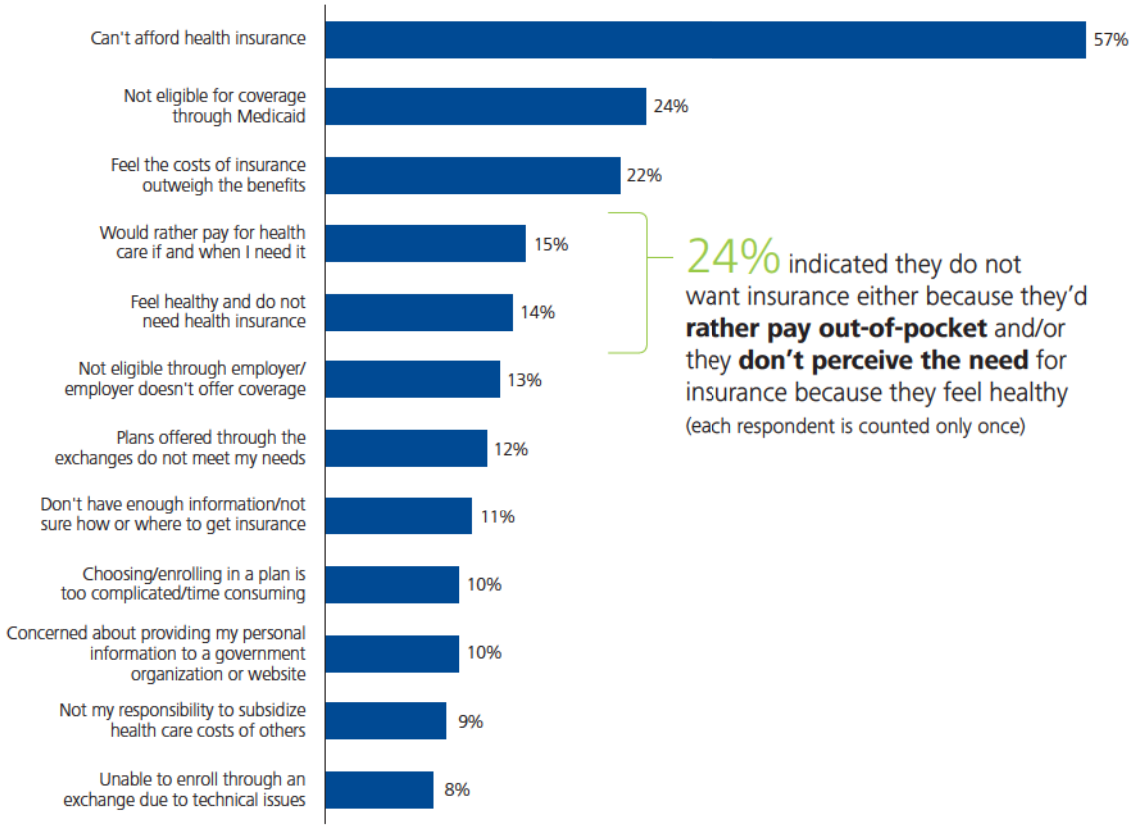


Chart shows percentage of currently uninsured respondents (n = 484) who reported each of these reasons for not having health insurance (respondents could select more than one).
Source: Deloitte Center for Health Solutions: 2015 Survey of US Health Care Consumers

Reasons differ between those who had been uninsured for more than a year versus less than a year. The longer-term uninsured more commonly say they cannot afford health insurance (64 percent versus 43 percent) or selecting a plan is too complicated and time-consuming (12 percent versus seven percent). The newly uninsured are more likely to say they do not have access to insurance through an employer (17 percent versus 11 percent) or that exchange plans do not meet their needs (16 percent versus 10 percent).

Potential buyers report facing substantial technical and usability barriers, and need better decision-making support. Half of the uninsured say they visited an exchange website, but three in four failed to find all the information they needed and two in five had technical difficulties that contributed to their decision not to enroll (Figure 14).

Fourteen percent of the uninsured website visitors say they learned they were eligible for a subsidy, and nine percent discovered they were eligible for Medicaid. They ultimately decided not to enroll, suggesting a substantial portion of individuals are not signing up even as other reports indicate a sizeable share is "coming out of the woodwork" to sign up for Medicaid.[5]

Figure 14. Experiences reported by currently uninsured respondents who visited an exchange website

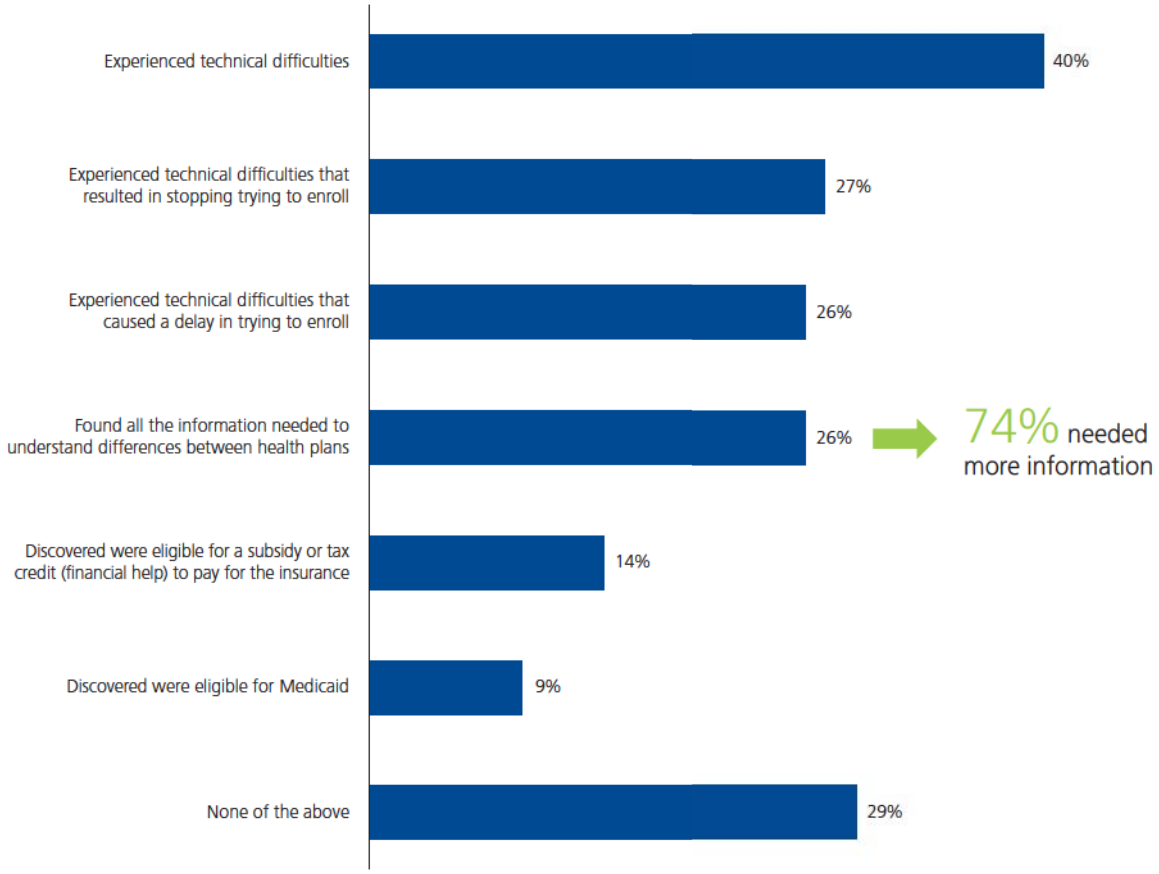


Chart shows percentage of currently uninsured respondents who visited an exchange (n = 239) who reported these experiences (respondents could select more than one).
Source: Deloitte Center for Health Solutions: 2015 Survey of US Health Care Consumers

Among the half who did not visit an exchange, only one in 10 says they are likely to buy insurance through an exchange in the future. Top reasons these uninsured are reluctant to use an exchange include cost (25 percent) and lack of information about how exchanges work (17 percent). One in seven is concerned about the privacy and security of their personal information if they were to buy health insurance online. Other reasons include challenges related to figuring out what to buy (14 percent), understanding plan differences (11 percent), and finding a plan that meets their personal needs (10 percent). Less than 10 percent state they would prefer to get insurance through another source, are waiting until technical issues are resolved, or feel current options do not provide enough value for what they would have to pay.

Supporting multiple purchasing channels and strengthening trust in information sources might be critical for advancing individual insurance market transformation

Consumers shopped for HIX plans in both "high-tech" and "high-touch" ways – counter to stereotypes, younger enrollees relied on navigators more than older enrollees, and older enrollees were just as comfortable with website shopping as the younger, "online generation"

Nearly three in five consumers report they shopped online through federal, state, or insurance company websites, while one in four used phone channels, one in seven relied on a navigator, and one in eight used an insurance agent (Figure 15). Most enrollees (84 percent) report using only one channel, but seven percent tapped two channels, and five percent tapped three or more in the course of shopping for a plan (four percent could not recall or were not sure).

Age breakouts reveal the unexpected finding that a substantial portion of the young, "high-tech" generation may prefer a "high-touch" buying experience, while many in the older generations are comfortable using online purchasing channels. Younger enrollees (18 to 34 years) say they were more likely to use navigators than older enrollees; 35-to-54 years olds were more likely than other age groups to use websites; and older enrollees (55 years or older) were more likely than younger enrollees to use phone channels.

Figure 15. Shopping channels

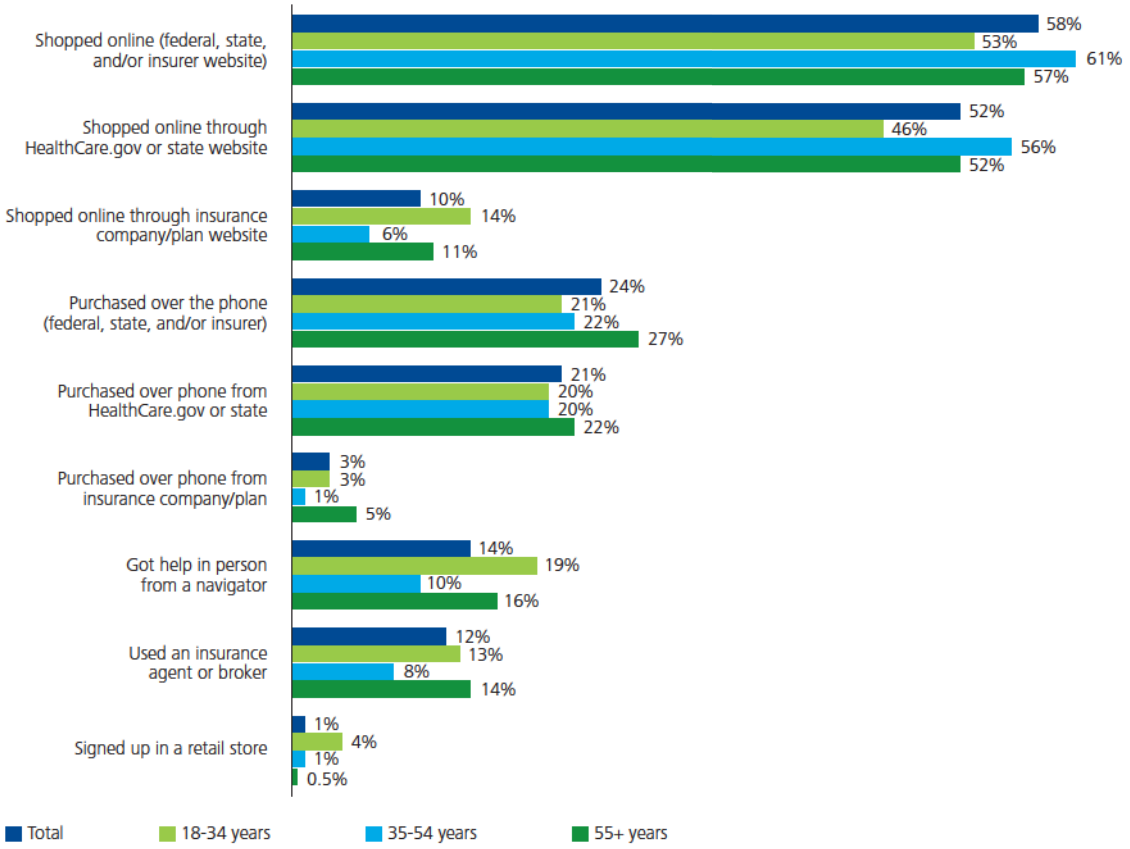


Chart shows percentage of respondents (n = 406) who reported using these channels in the course of buying insurance through an exchange (respondents could select more than one)
Source: Deloitte Center for Health Solutions: 2015 Survey of US Health Care Consumers

Exchanges have emerged as trusted sources for reliable information that can help consumers choose a plan – but trust remains low across the board, suggesting consumers may feel that the quality and usefulness of available information could be improved

Consumer trust in sources of information about health plans is generally low, with less than 40 percent giving any source a favorable rating (Figure 16). However, consumers' trust in exchanges is just as strong as their trust in other top-rated sources, including friends and family, providers, and independent consumer-oriented organizations. Fewer say they trust navigators, insurance companies, and employers, but that may be due, in part, to a lack of opportunity or experience in using those sources.

Encouraging older individuals to share information and advice with their younger relatives and associates may be an effective outreach strategy, as younger enrollees are more trusting of friends and family (47 percent) than other sources. Additionally, younger enrollees express higher-than-average levels of trust in Internet search engines (30 percent versus 20 percent), employers (30 percent versus 21 percent), and social networking sites (21 percent versus 11 percent), suggesting these communication channels may be effective in reaching and educating younger individuals about health plan options. Nearly three in ten in the younger group have a higher level of trust in insurance companies than the average consumer (29 percent versus 23 percent), indicating that direct-to-consumer strategies may potentially be well-received by younger enrollees.

Figure 16. Trust in sources to provide reliable information and advice about health plans

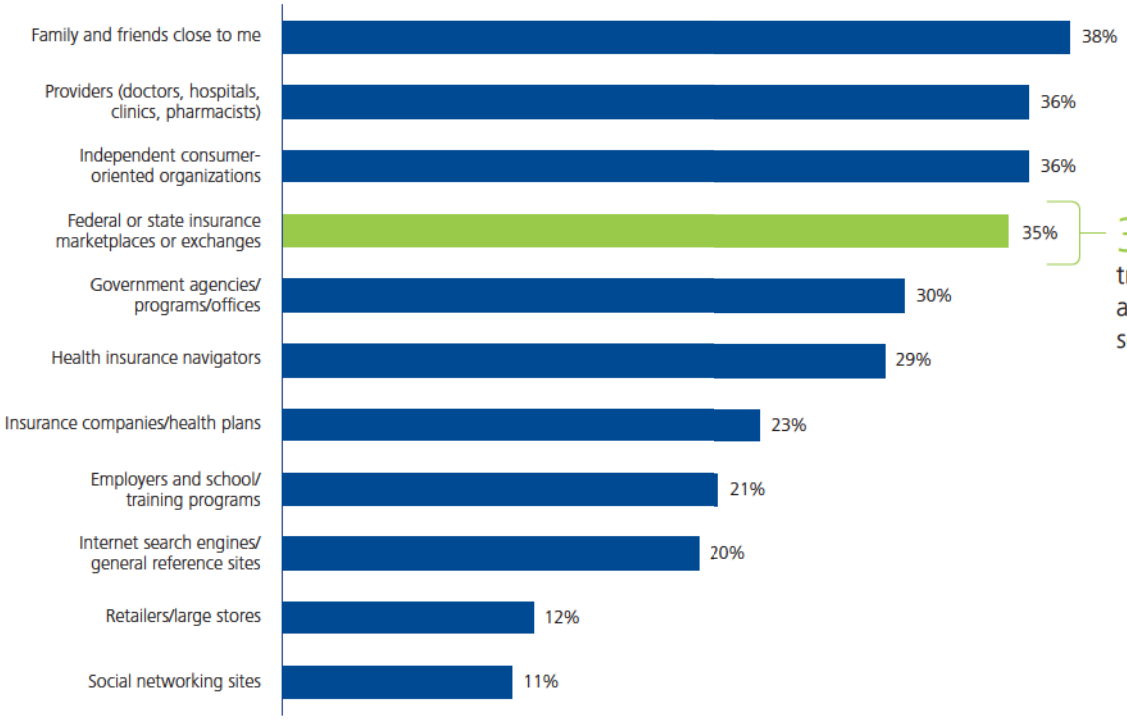


Chart shows percentage of respondents (n = 406) who gave a rating of 8, 9, or 10 on a 10-point scale, where 1 is "no trust" and 10 is "complete trust" in each source to provide "reliable information and advice regarding the best health plans for you and your family."

Source: Deloitte Center for Health Solutions: 2015 Survey of US Health Care Consumers

Implications

To support the continued transformation of individual insurance markets into thriving online marketplaces and customers into engaged consumers of both health insurance and health care services, public health exchanges and the health plans offered through them should consider taking these steps:

- **Focus plan design on affordability and value:** Plan designs that optimize coverage-price tradeoffs and align closely with consumers' personal coverage preferences may help to attract new enrollees and reduce churn within insurers' books of business. Given their focus on price and interest in digital resources, HIX enrollees may be especially receptive to value-based benefit structures that incorporate incentives, programs, and tools supporting consumer engagement in health improvement and chronic care management.
- **Maintain multiple purchasing channels:** Many HIX buyers are comfortable using online purchasing channels but substantial numbers still rely on phone and face-to-face interactions and a meaningful share tapped more than one channel while making a purchasing decision. To reach consumers with different shopping preferences and those who remain uninsured, exchanges and health plans likely will need to continue supporting both online and in-person processes for potential buyers to learn about their options, select a plan, and enroll.
- **Provide better information and decision support:** For potential buyers to find the plan that suits them best, they need to become more familiar with coverage options, possible subsidies, and plan differences. Improving the quality of comparative information, resolving lingering website technical issues, and reducing enrollment process complexity may help consumers make better decisions and increase trust in exchanges and health plans. Some consumers may also need additional guidance and assistance to select a plan that matches their needs, preferences, and financial circumstances.
- **Close the digital gap:** HIX enrollees seem generally more inclined than other insured cohorts to rely on online resources. Directing them to digital technologies that can help them understand how to use their benefits, compare and select providers and services, and take steps to improve their health may enable them become more active consumers. Addressing existing gaps between interest and use likely will increase consumer engagement and help to establish and strengthen long-term relationships between insurers and HIX enrollees. Even with improved access to online resources and health technologies, however, a substantial share of consumers (young and old alike) may still prefer to interact personally with plan representatives as they make decisions that affect their coverage, care, and health.

Survey methodology and sample

Since 2008, the Deloitte Center for Health Solutions has annually polled a nationally representative sample of US adults about their experiences and attitudes related to their health, health insurance, and health care and their views about the health care system. The general aim of the survey is to track changes in consumer engagement over time and investigate key questions of interest to the health plan, provider, life sciences, and government sectors. The 2015 survey included 3,887 adults (18 years and older). The national sample is representative of the US Census with respect to age, gender, race/ethnicity, income, geography, insurance status, and insurance source. A subsample of 406 respondents reported getting coverage through HealthCare.gov or a state health insurance marketplace, exchange, or connector. Respondents in the HIX subsample varied with respect to demographic characteristics, prior insurance status, subsidy status, and type of exchange used (see the table).

Characteristics of the HIX sample	Number of respondents	Percentage of the HIX sample (n = 406)
Geographic region		
Midwest	97	24%
Northeast	87	21%
South	139	34%
West	83	20%
Age		
18 to 34 years	70	17%
35 to 54 years	143	35%
55 years or older	193	48%
Race/ethnicity		
Non-Hispanic White	307	76%
Hispanic	37	9%
Non-Hispanic Black	31	8%
Non-Hispanic Asian	21	5%
Non-Hispanic Other	10	2%
Employment status		
Employed with paid work 30 or more hours/week	137	34%
Employed with paid work < 30 hours/week	104	26%
Not employed, not looking for work	114	28%
Not employed, looking for work	51	13%

Characteristics of the HIX sample	Number of respondents	Percentage of the HIX sample (n = 406)
Income		
Less than $25,000	109	27%
$25,000 to $49,999	151	37%
$50,000 to $74,999	76	19%
$75,000 to $99,999	27	7%
$100,000 or more	25	6%
Prefer not to say	18	4%
Insurance status at time of enrollment		
Uninsured	213	52%
Insured	193	48%
Subsidy		
Received a subsidy	277	68%
Did not receive a subsidy	89	22%
Don't know/not sure	40	10%
Type of exchange		
Federally-facilitated model	275	68%
State-based model	118	29%
State switched type between 2014 and 2015	13	3%

Endnotes

1. Kaiser Family Foundation. "State health insurance marketplace types, 2015." http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/ Accessed on 6/3/1015.
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Acknowledgements

We wish to extend special thanks to Laura Eselius, PhD, MPH, for her work on the concept, analysis, and writing of this report without which, this report would not have been possible.

We wish to thank Bill Copeland, Jason Girzadas, Claire Boozer Cruse, Leslie Korenda, Kathryn Robinson, Sheryl Coughlin, Liz Stanley, and the many others who contributed their ideas and insights to this project.

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Robert Wood Johnson Foundation

AUGUST 2015

Big Data: A New Paradigm for Health Plan Oversight and Consumer Protection?

By Sabrina Corlette, Sandy Ahn, and JoAnn Volk

Support for this report was provided by a grant from the Robert Wood Johnson Foundation

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The Center on Health Insurance Reforms (CHIR), based at Georgetown University's McCourt School of Public Policy, is composed of a team of nationally recognized experts on private health insurance and health reform. We work regularly with a multidisciplinary group of faculty and staff dedicated to conducting research on issues related to health policy and health services.

CHIR faculty and staff study health insurance underwriting, marketing and products, as well as the complex and developing relationship between state and federal rules governing the health insurance marketplace. CHIR provides policy expertise and technical assistance to federal and state policy-makers, regulators and stakeholders seeking a reformed and sustainable insurance marketplace in which all consumers have access to affordable and adequate coverage.

Introduction

Large data sets that can be analyzed to determine patterns of behavior – popularly called "big data" – are being used in ever-expanding ways. For example, big data is used to track consumer shopping patterns, understand environmental trends and prevent crime. In health care, physicians and scientists are using big data to help devise personalized treatments for diseases and track epidemics, and some major health systems are starting to use it to improve the quality of care.[1] More than a dozen states are using big data – through All-Payer Claims Databases (APCDs) – to better understand the pricing and use of health care services. Insurance companies were early adopters of big data, collecting and analyzing large volumes of information about the risks posed by prospective and current policyholders.

State insurance regulators have adopted the use of big data to conduct oversight of certain kinds of insurance, such as workers' compensation and life insurance. And state and federal regulators regularly collect detailed data from health insurers to assess their financial solvency, as well as summary-level data to evaluate the reasonableness of premium rates and compliance with benefit standards. But those agencies providing oversight of health insurers have undertaken only modest efforts to collect, analyze and use large sets of claims, enrollment or sales data to understand market trends and how consumers are using their health insurance to access and pay for care.

Big Data: *noun.*

Extremely large data sets that may be analyzed computationally to reveal patterns, trends, and associations, especially relating to human behavior and interactions.

That could change, however, thanks to two yet-to-be-implemented provisions within the Patient Protection and Affordable Care Act (ACA) that contemplate a new regime of comprehensive data reporting by insurers and employer-based plans to both insurance regulators and the public. The ACA ushered in sweeping reforms of the health insurance industry, prohibiting previously widespread practices such as the use of health status underwriting, gender rating, and the use of benefit design to discourage the enrollment of higher risk individuals. Policymakers recognized that with these practices prohibited, insurers might use other mechanisms to keep costs low that could undermine the ACA's goal of ending health status discrimination. They also recognized that the reforms envisioned under the law are dependent on effective enforcement and greater transparency. Further, for the first time, federal taxpayers are subsidizing private health insurance companies through premium tax credits to defray the cost of coverage for millions of people. Such an outlay of tax dollars requires a high level of oversight. As a result, the ACA includes enhanced tools to monitor insurers' compliance with the new standards.

Among these enhanced tools are expanded data collection authority and transparency requirements. Under the law, health insurers that market individual and group policies as well as employer-sponsored plans are required to report to the U.S. Department of Health and Human Services (HHS), states' departments of insurance (DOIs) and the public a comprehensive range of information and data about their policies, practices and enrollee experiences.[2] Insurers that sell qualified health plans (QHPs) in the health insurance marketplaces must additionally report the information and data to the marketplaces.[3]

The U.S. Departments of Labor (responsible for the regulation of group health plans) and HHS (responsible for non-group plans and QHPs) have just begun a process to determine what data they will collect and how. But the agencies will require some very limited data reporting for some QHPs beginning in 2016 and sometime thereafter for off-marketplace individual and group plans.[4] While the long-term regulatory approach is uncertain, the Secretary of HHS has called more generally for the use of big data to "transform our healthcare system in unprecedented ways… our commitment…is to liberate data in every way we can."[5]

A few states have adopted the data reporting provisions as part of their own implementation of the ACA, but most have not attempted to get ahead of federal regulators to operationalize the required data collection. There are likely three primary reasons for the delay. First, since enactment

of the ACA, federal and state officials have had to grapple with numerous pressing issues, such as the establishment and operation of health insurance marketplaces and the oversight of an insurance market undergoing dramatic changes in benefit design, marketing and pricing. Second, embarking on a comprehensive effort to collect, store, analyze and use large amounts of health plan data poses some policy, technical and resource challenges. Third, employer and insurance company interests are strongly opposed to implementation of these provisions, arguing they are too administratively burdensome.[6]

In this issue brief, we discuss how insurance regulators (primarily state DOIs and the federal Center for Consumer Information and Insurance Oversight, or CCIIO) and third parties are currently using data collection and how it could change under the ACA to improve health plan oversight and compliance. In particular, we discuss how the new ACA requirements could prompt a sea change in regulatory oversight – and counterintuitively – reduce the regulatory burden on health plans. Not included in this brief, however, is a discussion of how data can be used by the general public, i.e., for purposes of comparing and shopping for health plans. We hope to revisit this topic in a future brief.

To prepare this paper, we analyzed state and federal requirements related to the collection and transparency of insurance company data, as well as guidance and reports from independent organizations that collect or receive health plan data, such as national accrediting bodies and state APCDs. We also conducted 15 interviews with consumer advocates, state and federal regulators, insurance company executives, and executives with organizations involved in the collection and analysis of health plan data.

Current and Potential Uses of Health Plan Data

The ACA contemplates the reporting and collection of a broad range of health information, from enrollment to claims and underwriting practices to financial information. (See Figure 1).

Figure 1. Data Categories Insurers and Plans Must Report under the ACA

- Claims payment policies and practices;
- Periodic financial disclosures;
- Data on enrollment;
- Data on disenrollment;
- Data on the number of claims that are denied;
- Data on rating practices;
- Information on cost-sharing and payments with respect to any out-of-network coverage;
- Information on enrollee rights; and
- Other information as determined appropriate by HHS.[7]

Some of this information, in summary form, is already reported to state or federal regulatory entities, and in some cases to the public. In addition, the health insurance marketplaces, both state- and federally run, have access to data about enrollments, disenrollments and premium payments for QHPs. California's marketplace has embarked on a first-of-its kind initiative to mine health claims data beginning in the fall of 2015 in order to better assess insurers' benefit designs and whether consumers are receiving appropriate and timely health care services.[8]

With the exception of a small number of DOIs that have begun to use APCDs to support regulatory oversight, state DOIs and federal oversight officials are generally not collecting or using consumer-level data from health insurers, such as sales, enrollment, and claims data, as an oversight tool. As a result, much of what health plans do remains, as one consumer advocate put it, "a black box." What the ACA envisions via data collection is "fundamentally different [from what regulators do currently]." Depending on how ACA data reporting requirements are implemented, the new data disclosures hold the potential for regulators and the public to see in an in-depth way how insurance is really working for people.

In most states, the DOI is responsible for the oversight of insurers, ensuring their ability to pay claims and enforcing compliance with the ACA's market reforms. DOIs have broad authority to require insurers to submit data to help them perform their oversight and enforcement duties. However, a federal statute, the Employee Retirement Income Security Act (ERISA), regulates employer-based health plans. As a result, state DOIs do not collect data about self-funded employer plans (i.e., those where the employer shoulders the responsibility for paying claims). The interplay of state insurance regulation and ERISA is

complex and has been the subject of frequent litigation, including a case before the Supreme Court regarding Vermont's ability to compel employer plans to submit claims data to its APCD.[9]

Further, most health insurer data reported to DOIs are summary-level data reports about financials, plan design, rates, marketing and claims processing practices. Insurers of some products and services, such as life insurance, long-term care, and homeowner policies must file a market conduct annual statement (called the MCAS) with state insurance regulators. These annual statements are used to support more in-depth assessments of insurers' compliance with state laws. However, a similar statement is not currently required of those selling health insurance. The National Association of Insurance Commissioners (NAIC) is developing a MCAS for health plans, but progress has been slow. In the meantime, the NAIC has developed a survey and standardized data request form that DOIs can use to better assess insurance company compliance with the ACA's market reforms. However, this effort relies on summary reports that insurers submit and is not designed to provide access to consumer-level sales, enrollment, claims or other health plan data.[10]

The federal agencies responsible for health plan oversight – the U.S. Department of Labor (DOL) and CCIIO – are also primarily receiving summary-level data about plans. However, big data is not new to federal health regulators. The Centers for Medicare and Medicaid Services (CMS) – CCIIO's parent agency – uses the sophisticated analysis of millions of health claims to detect and combat fraud in the Medicare program.[11] CMS has also recently released a massive data bank of provider charges to the Medicare program, allowing researchers and others to mine the data to better understand the pricing and use of health care services.[12]

Table 1. Examples of "Big Data" vs. Summary-Level Data

Big Data	Summary-level
Sales transactions	Total number of policies sold
Enrollment and disenrollment (i.e. 834 and 820 transaction forms)*	Total number of disenrollments
Medical, pharmacy, dental claims	Total number of claims paid Total number of claims paid to out-of-pocket network providers

*An 834 form is a HIPAA-standardized transaction used by employers, government agencies and insurers to enroll and disenroll members in a health benefit plan. It includes information about the subscriber, the plan, and, if the member is disenrolling from the plan, the reason for disenrollment. Another standard transaction is the 820 transaction, which is used to provide premium payment information to insurers.

Third party data reporting

Health insurers don't just report data to state and federal regulators. Those that sell QHPs on federal and state marketplaces share data about enrollment and disenrollment and premium payments and, as noted above, those selling QHPs in California will soon begin sharing claims data with the marketplace.

Insurers in many states are also reporting data to third parties such as APCDs, either voluntarily or as required by state law. APCDs provide a kind of "big data" – state-based databanks of paid medical, pharmaceutical and sometimes dental claims, submitted by both private and public payers. APCDs are currently operating or being implemented in 18 states.[13] APCDs have considerable experience working with health plans to improve the accuracy and usability of data reporting. While the information that APCDs collect does not perfectly overlap with the ACA's contemplated data collection (for example, APCDs do not collect denied claims), states could leverage their experience and data to help implement the ACA's requirements.[14]

Some state DOIs are already beginning to use APCDs as an independent data source to buttress their regulatory oversight role. For example, DOIs in states such as Arkansas and Rhode Island intend to analyze APCD data to corroborate insurers' claims about price and utilization trends included in their proposed rate filings.

Many insurers also report important data elements to health plan accrediting organizations, such as the National Committee for Quality Assurance (NCQA) and URAC. The ACA's marketplaces require insurers to be accredited, as do many large employers. State and federal officials also often use accreditation as a proxy for an insurer's compliance with Medicare, Medicaid and commercial

plan standards. The accrediting bodies require plans to report clinical quality data, but also collect reports on plan policies and procedures. However, they do not generally collect claims, sales or enrollment data.

A few states also have government agencies or independent entities that collect health plan quality or complaint data and publish consumer-facing analyses or report cards. For example, Massachusetts' Health Policy Commission provides on its website annual reports noting the numbers of grievances and appeals filed against insurers in the state.[15] A new state law requires California's Office of the Patient Advocate (OPA) to collect, analyze and report on consumer complaint data drawn from state consumer assistance centers.[16] The state also publishes health plan report cards based on clinical quality and patient experience data.

The ACA's Data Categories

The ACA doesn't prescribe what specific data should be collected within the outlined data categories, nor does it articulate the method of data collection. However, the comprehensive nature of the data categories listed in the law – financial, claims, enrollment, rating, benefit design and enrollee rights – gives state and federal regulators a powerful new ability to answer important questions about health insurers' behavior in the market and how consumers are accessing and paying for health care. To best answer these questions, regulators will need a data collection framework that captures a maximum amount of information in the most efficient and cost-effective way possible. This suggests a need to rely not just on traditional summary reports that must be individually read and analyzed over hundreds of staff hours but also to take advantage of the revolution in big data – those exceptionally large data sets that can be mined with a computer and sophisticated algorithms. Regulators need both in order to fully implement the ACA's vision for data collection. The following section discusses key data collection categories listed in the ACA and how a reporting scheme could be implemented to improve the efficiency and effectiveness of oversight.

Financial information

One data category required by the law – periodic financial disclosures – appears to be fairly consistently collected from insurers and analyzed across state DOIs. A common refrain among insurance regulators is that the "number one consumer protection is insurer solvency," and state DOIs take their solvency oversight duties seriously. Insurers selling health policies to individuals and employer groups are required to report quarterly financial information to support their ability to cover the current and future claims costs of policyholders.

Within the federal government, CCIIO collects both rate filings and disclosures about insurers' expenses, premium revenue and claims in order to implement key provisions of the ACA. For example, CCIIO uses revenue and expense data to assess each plan's medical loss ratio (MLR), or the percentage of total premium revenue spent on paying for health care services. Under the ACA, insurers who don't meet a minimum MLR threshold must pay a rebate to policyholders. Insurers must also submit claims data to participate in the ACA's risk mitigation programs, which help compensate insurers who enroll people with high health care costs.[17] In both cases, CCIIO receives these data in summary reports. The agency has not engaged in any efforts to date to access large sets of claims, sales or enrollment data from insurers.

In addition to requiring financial reporting from insurers, the ACA also requires it from employer health plans, including those that are self-funded. Currently, state DOIs do not collect any data from employers that self-fund their employees' health benefits. Large employer-based plans (those with over 100 employees) must file a form with the U.S. Department of Labor (DOL) that contains financial disclosures. However, small employer-based plans (those with fewer than 100 employees) are largely exempt from the DOL requirement.[18] Yet small firms employ approximately 40 million people.[19] To fully implement the ACA requirement, the DOL will need to require some sort of financial filing from employers that are currently exempt.

Both DOL and HHS will also need to assess whether insurers need to submit new or different financial information in order to fulfill the ACA's data transparency objective. In general, both consumer advocate and insurance company stakeholders commented that, for most insurers, the current regime of financial reporting works reasonably well to protect consumers. It is less clear whether it is working for self-funded employer plans.

Enrollment information

The ACA requires insurers to report data on enrollment and disenrollment. While enrollees cycle in and out of coverage on a regular basis, particularly in the non-group insurance market, regulators can use enrollment and disenrollment data to help identify outliers or potential

trends. A consumer advocate noted, "disenrollment is a good proxy for satisfaction with a plan…it could be an early warning signal that something is going on."

To fully implement this requirement, regulators would benefit from both big data and summary-level data, which could help them gain a full picture of who is enrolling in or disenrolling from health coverage and why. To an extent, some insurers (i.e., those selling policies to individuals and small employers) already report limited summary-level enrollment data to state and federal regulators through rate and other filings, usually provided as the total number of members or policyholders. State DOIs can at any time ask for disenrollment data from insurers. Such a request might garner, for example, the number of policy terminations or cancellations initiated by the consumer and the number that occur because the consumer didn't pay the premium.[20]

However, this category is one in which summary-level reports from insurers have limited analytical potential by themselves. To effectively implement this provision and gain useful information about insurance company practices and consumer behavior, regulators should be allowed to access raw enrollment and disenrollment data – such as the 834 forms – at the transaction level. States that operate their own marketplaces already have this data for QHPs.

Regulators and the marketplaces could mine this enrollment data along with other data sources such as health claims, by characteristics such as zip code, subsidy eligibility, type of plan and diagnosis code, all of which they could use to flag whether a plan's marketing, utilization management, or other policies are worth a closer look. For example, if an unexpectedly high proportion of people with mental health diagnoses are disenrolling from a plan, regulators may decide the plan's mental health benefits, provider network or management of mental health claims require additional review. Or, if a plan is only enrolling individuals from zip codes in its service area known to have young, healthy residents, regulators may wish to investigate the company's marketing practices. "The nice thing about [big data mining]," noted one consumer advocate, "is that you don't have to know the answer ahead of time. You'll see trends you maybe hadn't even thought about."

Rating practices

Neither the statute nor federal rules define "rating practices," another required reporting category. However, former congressional staff interviewed for this paper suggest that Congress was interested in capturing information about the factors insurers use to set premium rates, such as age, industry, claims experience, and gender. DOIs can generally obtain information about a plan's rating practices from annual rate filings. The ACA bans many of the most egregious rating practices, such as health status and gender rating, but only for plans sold to individuals and small employers (currently defined 2-50 employees). Insurers selling policies to large employers, however, may still use these rating practices to set premiums. Yet many states do not require rate filings for plans sold to these larger employer groups, and states do not have authority to regulate the plans that employers self-fund.

Employer-based health wellness programs are permitted under federal rules to impose premium surcharges on employees for tobacco use, failure to participate in a wellness program, or failure to meet specified health goals, such as a target body mass index (BMI) or blood sugar level. The ACA's data collection provision could give state and federal regulators the authority to collect the information needed to better assess who is being charged these higher premium rates and on what basis.

Claims practices and denied claims

The ACA requires insurers to report information about their claims policies and practices and the number of denied claims. Such disclosures could help federal and state officials discern whether discriminatory practices exist, particularly if stratified by diagnosis, zip code or type of service. Here again, state and federal regulators would benefit from capturing claims data – submitted, paid, and denied – at the transaction level. For example, access to claims data through an APCD in one state allowed officials to conduct a "targeted review" of how consumers were accessing substance use treatment. The APCD data enabled them to gain a comprehensive picture of how health plans were covering these services. In a similar vein, regulators may want to query denied claims to check whether insurers are denying coverage of certain types of services such as behavioral health or oncology more than other services.

The collection and use of information about insurers' claims and claims practices currently vary widely state-to-state. Most states do not collect data on how many claims are denied and for what reason. While all states record, categorize and store consumer complaints made to the DOI, and have the authority to ask insurers for data on the number of grievances and appeals filed by

policyholders, not all will ask for this information on a regular basis; some may only do so in preparation for a targeted audit. Yet regular access to data – even if provided in summary-level reports – regarding internal and external appeals and their disposition would give regulators the ability to compare how insurers handle enrollee grievances.

Cost-sharing and provider network information

The ACA requires insurers to report data on "cost-sharing." This information could help policymakers and regulators better understand consumers' experiences with deductibles, co-payments, coinsurance and out-of-pocket maximums. For example, if regulators were collecting claims data from health plans, they could query how many enrollees are hitting their out-of-pocket maximum in a given year. They could further refine such a query by diagnosis code or service category. Such data could also help answer questions such as: Are deductibles affecting the use of primary care services? Is a plan's cost-sharing structure, such as the use of tiered formularies or provider networks, consistent with ACA rules prohibiting discrimination in benefit design? How is the use of cost-sharing affecting the use of brand-name vs. generic drugs? Are providers and plans appropriately handling claims for preventive services to ensure that enrollees don't face cost-sharing, as required under the ACA?

The ACA also requires plans to report data on "payments with respect to any out-of-network coverage." Data on enrollees' use of out-of-network services could help regulators assess whether a plan's network has a sufficient number and range of providers to deliver on promised benefits. For example, regulators could analyze claims data to determine how many enrollees receive services from an out-of-network provider, and whether there are meaningful differences by type of plan (i.e., open vs. closed network), zip code, type of service, or other enrollee or provider characteristic. Analysis could also provide information about the extent of balance billing associated with out-of-network claims. Such analyses could not only help regulators assess plans' compliance with state and federal law, but also other broader policy challenges such as provider workforce supply, provider market power and appropriate use of service settings.

Further, some states require plans to ensure that enrollees can access services within a maximum distance from their home or workplace or within a specified time frame in order to demonstrate an adequate network.[21] But it is difficult to know whether these "time/distance" standards ensure that a plan network is fully meeting enrollees' needs. Understanding patterns of out-of-network use could be "the guts of a new and different network adequacy standard," observed one consumer advocate. Instead of guessing at an appropriate network size, regulators could review data to give them an accurate picture of enrollees' actual experiences using in- and out-of-network care.

Some states have unique data reporting requirements that are similar to the ACA that could be leveraged to answer some of these questions. For example, Massachusetts requires sellers of limited and tiered network plans to annually report summary-level data on use of services by provider tier and the use of out-of-network services.[22] However, state officials noted that reporting differences among insurers and problems with data integrity have led to delays in publishing reports. Five years after the requirement became effective, officials reported that they are still "refining" the data collection tool to make it more consistent across insurance companies. They noted that it has taken "lots of communication" between the state and insurers to get to a point "where the data is reliable."

"Other information as determined appropriate by the Secretary"

The ACA includes a catch-all data category, providing the HHS with broad authority to determine what other information would be useful to collect from insurers. This could include, for example, information on marketing practices and broker commission structures, which can help assess compliance with the ACA's prohibitions against discrimination based on health status. It could also include requests for information about market trends or problems that emerge over time but are not apparent today.[23]

Regulation the Big Data Way: Implementation Issues to Consider

While health insurers were early adopters of big data in order to understand their current and prospective policyholders, for health insurance regulators it is new territory (state regulators do use big data for oversight of other lines of insurance, however). Instead of an oversight system that relies on insurers compiling summary data reports on finances, benefit design, rates and complaints, regulating via big data instead means using algorithms and sophisticated analytics to mine massive amounts of claims, sales and enrollment data to capture insurers' behavior in the market and policyholders' experiences with their plans. This approach would be largely new for state regulators, but advantages include improved data integrity, improved oversight, and greater efficiency.

Improved data integrity

Currently regulators rely largely on summary reports from individual insurers. Insurers have different IT systems, methods of compiling the reports, and interpretations of key terms and data categories. Relying on insurers to compile these summary reports increases the risk of differences in interpreting data definitions among insurers as well as the submission of incorrect data. Such data integrity problems require regulators to spend considerable time and effort communicating with insurers to shore up the accuracy of the data. That time and effort would not be eliminated for regulators able to access standardized sales, claims and enrollment data, because all data collection efforts require a quality assurance program. But big data could mitigate some of the significant data integrity problems currently hindering effective regulation.

Improved oversight

As noted above, big data allows regulators to conduct refined queries of large data sets and run analytics that allow for a more granular understanding of marketing trends and how policyholders with specific characteristics (i.e., diagnosis or geographic location) are faring under their plan. The data allows regulators to see details and trends that could be lost in summary-level reports. In addition, because regulators are not solely relying on summary-level reports that can vary from insurer to insurer, a big data approach can enable more apples-to-apples comparisons among insurance companies. "Insurers won't like [regulation through] big data because it means they're more accountable," predicted one consumer advocate.

Greater efficiency and reduced regulatory burden

Instead of requiring insurers to spend hundreds of employee hours compiling summary-level reports, this approach can be automated. Regulators can learn from and build on the experience of APCDs. Although APCD officials noted that a big data reporting system is resource-intensive to establish, once it is in place and the scope and frequency of reporting decided, insurers can provide data to regulators (or, more likely, to a data consolidator acting on the regulator's behalf) via a pre-programmed feed. "Someone is really just pushing a button [to submit the data]," an APCD official told us.

However, the use of big data for regulatory oversight is not without challenges. These include the need to address privacy and security concerns and resource constraints, and to monitor and correct definitional problems.

Privacy and security concerns

Any collection or transfer of data raises concerns about privacy and security. Regulators and the insurance marketplaces must balance these risks with the benefits of using big data as an oversight tool. No system can be completely invulnerable to those determined to break in, but regulators and insurers can take steps to protect sensitive information. Big data is, by its very nature, information about individual consumer transactions – it is only through this individual transaction data that data mining and predictive analytics are possible. Where data includes personally identifiable information, including highly sensitive health information, it should not be available to the public, and access must be highly controlled. There are federal (through the Health Insurance Portability and Accountability Act, or HIPAA) and state safeguards to protect personal information, but because they may not always apply to all data collection efforts, officials will likely want to ensure these and perhaps even stronger standards are enforced.

APCDs have implemented best practice safeguards to mitigate the possibility of breaches. These include encryption during data transmissions and data storage and the use of software programs to de-identify personal information either before or upon transmission. Regulators can also ensure that any publicly available reports derived from big data use non-specific information to reduce the risk of information being traced back to a particular

individual. Those who store and transfer data also must be prepared to adapt their protective measures as technological capabilities evolve.

Addressing resource constraints

States and federal officials are unlikely to replace their current reliance on summary-level reports from insurers as an oversight tool. Such reports provide useful information and have long been the mainstay of insurance regulation. Rather, the use of large data sets can supplement that summary-level data, allowing regulators to stay on top of market trends in closer-to-real-time. Capturing, storing and analyzing millions – if not billions – of raw data requires resources, including sophisticated IT systems and experienced personnel. For DOIs already strapped for funding, these costs, especially if on top of the costs associated with reviews of summary-level data – could be perceived as a significant barrier. Regulators can gain significant economies of scale, however, by relying on a regional or national data consolidator, an entity that can store the data feeds from insurers and maintain a staff with the expertise to run the algorithms and analytics requested by state and federal regulators. States may also choose to make the data available to authorized third parties, such as researchers, who can use the data to identify market trends or emerging consumer protection concerns. CMS has successfully done this with its Medicare provider utilization and payment data set.

In addition, officials can conserve resources by avoiding duplication of data collection efforts already underway. For example, most individuals interviewed pointed to the regular financial disclosures that insurers are required to make to federal and state officials, and few could identify any additional value in requiring additional disclosures. As one insurer put it, "if federal regulators come out with something different [than what is already required], it won't be fun."

The new data collection requirements in the ACA include a number of data elements that are not being collected anywhere, or are being collected and used only in limited circumstances or for specific purposes, such as for an audit or market conduct exam. For example, we could find no entity regularly collecting data on numbers or percentages of denied claims, and while some states require insurers to report data on the use of out-of-network services, most are not. These are data elements for which a big data approach would not only be less burdensome on plans and regulators than summary reports, but would also generate far more useful information about policyholders' experiences. In addition, once built, the experience of APCDs suggests that the uses of the data will expand. Said one APCD official, "…there are uses for the [APCD] data now that we had never anticipated."

Definitional challenges

Those experienced with health plan data collection – whether via big data or through summary-level reports – universally remarked upon how challenging it can be to settle upon common definitions of data elements that all insurers can use. An APCD official told us that they had to do "lots of back and forth [with insurers] to define terms." Similarly, a state official engaged in a data collection effort noted that a failure to clearly define terms early on in the project rendered the first couple of annual reports meaningless, because different insurers interpreted the information requested in different ways. "Definitions have to be tight and well understood," he said.

Consumer advocates also support a "gradual" approach, with regular communications with insurers on data categories and definitions in order to set a solid foundation. Multiple parties noted that running a data collection and analysis enterprise is not a "once-and-done" proposition – it requires continual monitoring and assessment of data integrity. You have to "watch the shop very well," one official observed. State officials further expressed concerns that federal implementation would incorporate different definitions than the ones used in the state, potentially complicating their own data collection and analysis efforts.

Conclusion

The data reporting requirements included in the ACA are currently slated to begin for some marketplace plans in 2016 and sometime thereafter for other group and individual market plans. The broad sweep of the data categories laid out in the statute provides an opportunity for government officials to re-think how they use data for oversight purposes. As more and more industries seize on the advantages of big data to understand consumers, so too should those with the responsibility of protecting consumers consider a move in this direction.

Health insurance regulators don't often use big data, and doing so requires a real shift in the ways data is collected and used. But the advantages are considerable, including a reduced regulatory burden on insurers and a richer understanding of insurer behavior and consumer experience. In particular, it can allow regulators to monitor and address market trends in real time and at a granular level that is unachievable via a summary-level report. The ACA requires the development of a new data collection infrastructure. As one expert on insurance regulation framed it, when implementing the ACA provisions "let's not institutionalize a 19th century view… when it should be a 21st century view."

Acknowledgements

The authors thank the state and federal insurance regulators, insurance company executives, consumer advocates and health data experts that generously shared their time and expertise. We also gratefully acknowledge the editorial contributions of Kevin Lucia, Karen Pollitz, Timothy Jost, Christopher Koller, Peter Lee, Andrea Routh, Birny Birnbaum, Deven McGraw, Amy Costello and Josephine Porter.

Endnotes

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August 2015 | Fact Sheet

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The California Health Care Landscape

The Affordable Care Act (ACA) went into full effect on January 1, 2014, ushering in health insurance reforms and new health coverage options in California and elsewhere across the country. Prior to 2014, under a waiver, California undertook an early expansion of Medi-Cal, the state's Medicaid program, and enacted innovative strategies to redesign the health care delivery system within its safety net. In 2014 and 2015, millions more gained coverage through Covered California, the state's health insurance Marketplace, and through further expansions in Medi-Cal. Building on these reforms, the state is continuing to expand eligibility and redesign delivery systems with the goal of providing efficient, high-quality care to state residents. This fact sheet provides an overview of population health, health coverage, and the health care delivery system in California in the era of health reform.

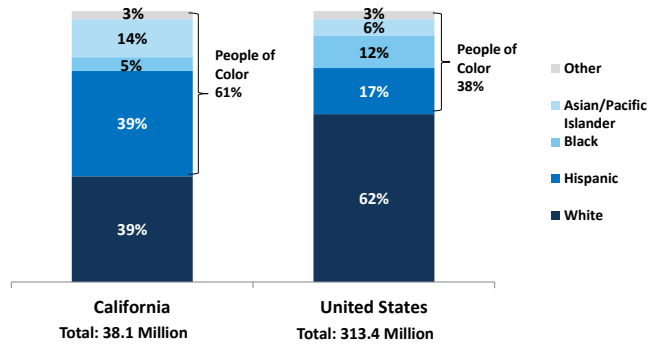
DEMOGRAPHICS

California is home to over 38 million people, making it the most populous state in the U.S. With nearly 156,000 square miles, California is the 3rd largest state in terms of geography.[1] While about a third of the state's total surface area is made up of forest,[2] the vast majority of state residents (95%) live in urban areas, and half are concentrated in Southern California in just 5 of the state's 58 counties. Los Angeles and San Diego counties alone account for a third of the state's population.[3]

California's population is highly diverse (Table 1). Unlike most states in the U.S., California's population is majority minority, with 39% of residents identifying as White, another 39% as Hispanic, 14% as Asian, 5% as Black, and 3% as another race/ethnicity (Figure 1).[4] Over a quarter (27%) of the population is foreign born[5] and 12% are non-citizens, representing approximately 22% of non-citizens nationally.[6] Over four in ten (44%) residents speak a language other than English in the home, a rate more than double that of the national average (21%),[7] and nearly one in five (19%) speak English less than "very well."[8] By contrast, the age distribution in the state resembles national averages, with nonelderly adults representing the majority of the population (62%) followed by children (25%) and the elderly (12%).

Figure 1

Racial and Ethnic Distribution of Residents, 2013

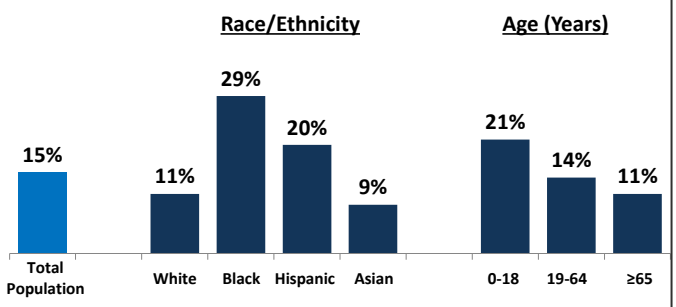


NOTE: Data may not total to 100% due to rounding. Data for Whites and Blacks exclude Hispanics.
SOURCE: Kaiser Family Foundation estimates based on the Census Bureau's March 2014 Current Population Survey (CPS:Annual Social and Economic Supplement).

Poverty rates in California reflect national averages and vary by race/ethnicity and age (Table 1). In 2013, over 5.7 million Californians, or 15% of the state's population, were living in poverty, a decrease since 2011 when the poverty rate reached 17%.[9] Blacks (29%) and Hispanics (20%) in California are significantly more likely to be poor than Whites (11%) and Asians (9%).[10] The overall poverty rate and rates by race/ethnicity are consistent with national averages. However, the cost of living in California is among the top four highest in the country, so low-income people in California may have a harder time making ends meet than in other places; a family of four in California would need to earn $137,643 in a middle cost urban area to have purchasing power equal to 400% of the federal poverty level ($97,000).[11] As in most other states, children in California are more likely than adults to live in a poor household and as of 2013, over one in five (21%) children in the state were living in poverty, compared to 14% of nonelderly adults and 11% of seniors (Figure 2).[12]

Figure 2

Poverty Rates by Race/Ethnicity and Age in California, 2013



NOTE: Data for Whites and Blacks exclude Hispanics.
SOURCE: Kaiser Family Foundation estimates based on the Census Bureau's March 2014 Current Population Survey (CPS:Annual Social and Economic Supplement).

Table 1: Selected Demographic Characteristics of the Californian Population, Compared to the United States Overall, 2013

	California	United States
Race/Ethnicity		
White	39%	62%
Black	5%	12%
Hispanic	39%	17%
Asian	14%	6%
Other Race/Ethnicity	3%	3%
Age		
0-18	25%	25%
19-64	62%	61%
65+	12%	14%
Citizenship Status		
Citizen	88%	93%
Non-Citizen	12%	7%
Distribution of Population by Federal Poverty Level		
Under 100%	15%	15%
100-199%	21%	19%
200-399%	28%	30%
400% +	36%	36%

NOTE: Data may not sum to 100% due to rounding and data restrictions.
SOURCES: Kaiser Family Foundation estimates based on the Census Bureau's March 2014 Current Population Survey (CPS: Annual Social and Economic Supplement).

State Economy

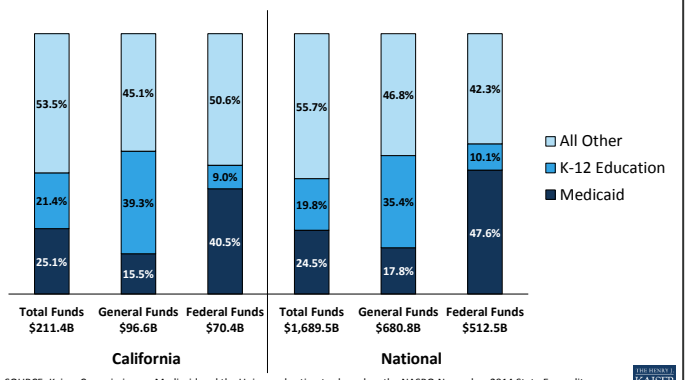
California's economy continues to recover after the recession, but unemployment remains high. California, like most states, experienced a decline in GDP during the Great Recession, but the economy has experienced marked improvements since then. In 2014, California's per capita real GDP was $54,462 compared with the national average of $49,469.[13] While the national real GDP grew by 2.2% from 2013 to 2014, California's grew by 2.8%, placing it among the top nine highest GDP growth rates in the US.[14] The largest industry sector in the state is finance, insurance, real estate, rental and leasing, which accounted for 21% of total GDP in 2014. Education, health care and social assistance contributed to 7% of total GDP, a share slightly less than the national average (8%).[15] The unemployment rate has also significantly improved since the recession, declining from a height of 12.2% in October 2010 to 6.3% in June 2015.[16] However, California's unemployment rate remains well above the national rate of 5.3% with nearly 1.2 million people in California remaining unemployed as of June 2015.[17]

Budget actions, tax increases and a strengthening economy have helped to improve California's fiscal outlook since 2012. In addition to state actions to control costs and raise revenues, the state's economy also improved. Economic recovery resulted in sharp increases in personal income tax collection and soaring stock prices in 2013, which led to higher than projected revenues.[18] After nearly a decade of recurring budget deficits, the peak of which was $45.5 billion in FY2010,[19] California experienced a budget surplus in FY 2015 and projected a surplus for FY 2016.[20]

Medi-Cal acts as both a source of state budget expenditures as well as a source of federal revenue. In FY2013, California spent just over a quarter (25.1%) of its total funds on Medi-Cal, compared to the national average of 24.5%. However, because Medicaid is jointly funded by states and the federal government, California gets at least $1 in federal funds for every $1 it spends from its own resources on the program. Due to this funding structure as well as state constitutional requirements related to K-12 funding in California, Medi-Cal represents only 15.5% of total general fund spending, a far second to K-12 education. Meanwhile, Medi-Cal represents the largest share of federal funds flowing into the state (40.5%) Provider taxes and local funds, among other funding sources, contributed to Medi-Cal funding in FY2013.

Figure 3

Budget Expenditures by Funding Source, California Compared to National, FY 2013



SOURCE: Kaiser Commission on Medicaid and the Uninsured estimates based on the NASBO November 2014 State Expenditure Report (data for Actual FY 2013.)

Population Health

California ranks above the national average on many measures of population health but faces substantial environmental health challenges. On overall health measures, California ranks 17th among the 50 states in the United Health Foundation's report, *America's Health Rankings 2014*.[21] Compared to other states, California has among the five lowest rates of smoking, obesity, and physical inactivity, and violent crime has decreased by 54% since 1990.[22] However, high levels of air pollution as well as an extended period of severe and unprecedented droughts[23] present continuous public health challenges to the state.

Disparities in health access and outcomes exist in California (Table 2). As in other states across the country, measures of health status and access vary by race/ethnicity in California (Table 2). Whites (14%) are more likely to smoke than Hispanics (10%) and nearly as likely as Blacks (15%) to do so, but a smaller share of Whites report being in fair or poor health, poor mental health, having diabetes, or being overweight or obese compared to Blacks and Hispanics. In addition, Hispanics (57%) and Asians (74%) in California are less likely than Whites (81%) to report having a usual source of care. Disparities in health factors and outcomes also exist across California's 58 counties, with poor rural counties, especially those in the north and Central Valley, faring worse than urban ones on measures such as life expectancy, health behaviors, clinical care and environmental factors.[24]

Table 2: Selected Measures of Health Status and Health Access for Adults by Race/Ethnicity in California Compared to the United States, 2013

Health Indicators	California				United States			
	White	Black	Hispanic	Asian	White	Black	Hispanic	Asian
Fair or poor health	13%	20%	29%	12%	16%	23%	26%	10%
Mental Distress	36%	39%	38%	35%	33%	36%	34%	30%
Smoke	14%	15%	10%	10%	19%	20%	14%	11%
Diabetes	8%	20%	12%	10%	9%	14%	11%	8%
Are overweight or obese	57%	74%	69%	40%	63%	73%	68%	41%
Have a usual source of care	81%	82%	57%	74%	82%	74%	59%	72%

Data may not sum to 100% due to rounding and data restrictions. Data for Whites and Blacks exclude Hispanics.

SOURCES: Center for Disease Control and Prevention (CDC)'s Behavioral Risk Factor Surveillance System (BRFSS) 2013 Survey Results.

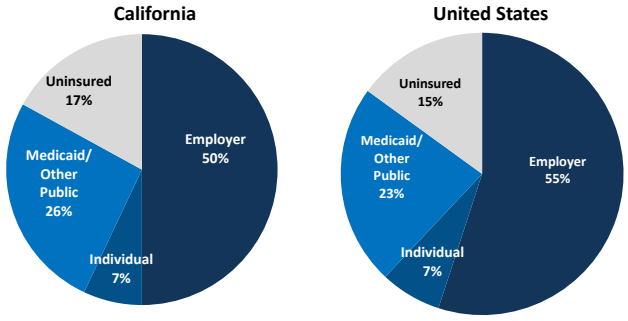
State and local efforts are underway to address health disparities in California. California's Office of Health Equity (OHE) was integrated into the California Department of Health in 2012 to provide a leadership role in reducing health and mental health disparities among vulnerable communities, including racial minorities, the LGBT community, persons with disabilities, and undocumented immigrants. Among its major initiatives, the OHE has launched the California Reducing Health Disparities Project (CRDP), an initiative to reduce mental health disparities in the state. The Office also has a Climate Change and Public Health Team which has issued two reports on how to reduce the impact of climate change with an emphasis on vulnerable communities.[25] In addition, through the leadership of OHE, the state is encouraging Health in All Policies (HiAP), a collaborative approach to improving the health of all people by incorporating health, equity, and sustainability considerations into decision-making across sectors and policy areas.[26]

Health Coverage in California Before the ACA

Prior to ACA implementation, California had the largest number of uninsured of any state in the country. In 2013, just before the major coverage expansions of the ACA went into effect, 5.8 million nonelderly Californians (15%) were uninsured, and California alone accounted for 14% of all nonelderly uninsured people nationwide.[27] In 2013, half of nonelderly Californians were covered under an employer plan, while over a quarter (26%) were enrolled in Medi-Cal, or other public coverage (Figure 4).[28] Private coverage rates in the state were low due to a combination of high unemployment (which limited access to employer coverage) and high premium costs for non-group coverage[29] (which made such coverage unaffordable for many). Pre-ACA public coverage through Medi-Cal was limited to only some groups of low-income adults, leaving many without an affordable coverage option.

Figure 4

Health Insurance Coverage of the Nonelderly Population, 2013

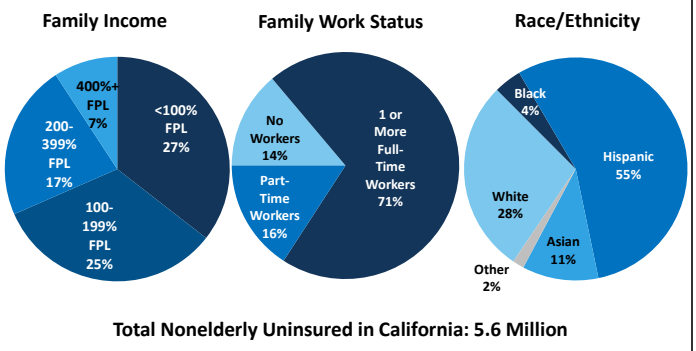


NOTES: Data may not total to 100% due to rounding. Medicaid includes the Children's Health Insurance Program (CHIP) and Other Public includes non-elderly Medicare and military-related insurance.
SOURCE: Kaiser Family Foundation estimates based on the Census Bureau's March 2014 Current Population Survey (CPS:Annual Social and Economic Supplement).

As in other states across the U.S., the majority of nonelderly uninsured people in California had at least one full-time worker in their household (71%), and more than half (52%) had incomes below 200% FPL. Over half (55%) of nonelderly uninsured Californians identify as Hispanic, over a quarter (28%) identify as White, 4% as Black, 11% as Asian, and 2% as another race/ethnicity (Figure 5).[30] As shown in Figure 10 (Appendix), the nonelderly uninsured in California are not equally distributed across the state, with the San Francisco Bay Area and surrounding counties generally having lower rates of uninsured than other areas of the state.

Figure 5

Characteristics of the Nonelderly Uninsured in California, 2013



Total Nonelderly Uninsured in California: 5.6 Million

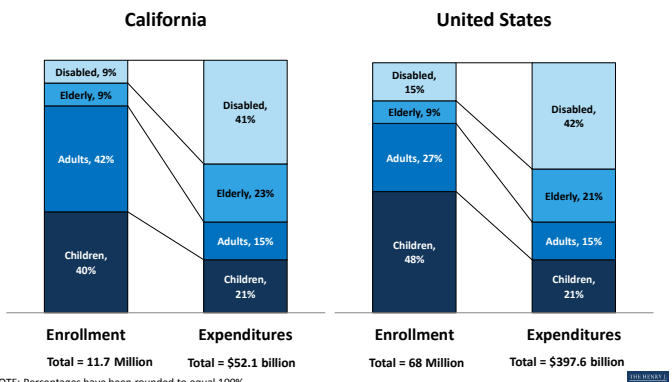
NOTE: Data may not total to 100% due to rounding. Data for Whites and Blacks exclude Hispanics.
SOURCE: Kaiser Family Foundation estimates based on the Census Bureau's March 2014 Current Population Survey (CPS:Annual Social and Economic Supplement).

Before the ACA, Medi-Cal helped fill gaps in the availability of private coverage but was limited to certain groups. As of 2013, 41% of children were enrolled in Medi-Cal compared to 15% of nonelderly adults, reflecting differences in eligibility levels, as well as poverty levels, between these two groups.[31] Historically, Medi-Cal eligibility for adults has been limited to parents with very low income. In 2013 children up to 250% FPL and pregnant women up to 300% FPL (under the CHIP unborn child option) were eligible for Medi-Cal or CHIP, while eligibility for working parents was 106% FPL (100% for non-working parents).[32] Adults without dependent children were not eligible for Medi-Cal. However, since 2010, parents and other adults living in a county participating in the Low-Income Health Program (LIHP) were eligible for coverage under a waiver that provided more limited benefits than Medi-Cal (discussed in more detail below). Medi-Cal also covered individuals with disabilities and provided wrap-around coverage for many elderly in the state.

In 2011, the majority of Medi-Cal beneficiaries were children and non-elderly adults, but the elderly and people with disabilities accounted for most of the program's expenditures. While most Medi-Cal enrollees in 2011 were children and adults (82%),[33] they accounted for slightly over a third (36%) of total Medi-Cal expenditures.[34] Conversely, the elderly and people with disabilities accounted for less than one-fifth (18%) of enrollees[35] but nearly two-thirds (64%) of total program costs (Figure 6).[36] Average spending per beneficiary in California in 2011 was $4,468, the fifth lowest in the country and below the national average of $5,790.[37] Medicaid costs are shared by states and the federal government; for most services and groups before the ACA, the federal government paid 50% of Medi-Cal costs in California.[38]

Figure 6

Medicaid Enrollment and Expenditures, FY 2011



NOTE: Percentages have been rounded to equal 100%.
SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2011 MSIS and CMS-64 reports.

In January 2013, children enrolled in California's separate CHIP program began transitioning to Medi-Cal. Prior to 2013, California had a separate Children's Health Insurance Program (CHIP) called the Healthy Families Program (HFP). Beginning in January 2013, the state phased out this program and transitioned over 750,000 children from HFP into Medi-Cal. The state continues to receive enhanced CHIP matching funds for children in the income group previously covered through Healthy Families.[39] While some access issues resulting from the transition were reported, the majority of children maintained access to the same primary care provider that they had while enrolled in HFP and still receive comprehensive health, dental, mental health and substance abuse services under Medi-Cal, according to a comprehensive report issued by the California Department of Health Care Services.[40]

Health Coverage Under The Affordable Care Act in California

A main goal of the Affordable Care Act (ACA) was to extend health coverage to many of the 42 million nonelderly uninsured individuals across the country, including many of the 5.8 million who lived in California.[41] The ACA accomplishes this through insurance market reforms and by establishing new coverage pathways, including expanding Medicaid and providing premium subsidies to most individuals with incomes from 100 to 400% FPL to purchase coverage on the Health Insurance Marketplace. California expanded Medi-Cal to cover nearly all nonelderly adults with incomes at or below 138% FPL ($16,242 per year for an individual and $27,724 for a family of three in 2015) and established its own marketplace, called Covered California.

Leading up to and throughout ACA implementation, the state invested heavily in outreach and enrollment efforts for both Medi-Cal and Covered California. These efforts included statewide marketing campaigns, community mobilization, provider training, and targeted efforts to reach vulnerable populations who may be newly eligible for coverage. Covered California also established an Assisters Program and worked with community organizations to provide direct assistance to consumers to help them enroll in coverage. In addition, the state received extensive federal and private funds, most of which were distributed to localities, for local outreach efforts. These local outreach efforts included support for Medi-Cal Certified

Enrollment Counselors, outreach to hard-to-reach populations, and marketing to increase awareness and understanding of new coverage options.[42, 43, 44] In addition, 125 health centers operating over 1,000 sites throughout the state received federal grants to help with outreach and enrollment assistance.[45] Supported by federal funding under the ACA, new grants in 2015 provided funding for the existing Covered California Outreach and Education Program, in-person enrollment assistance programs, and community outreach campaigns.[46]

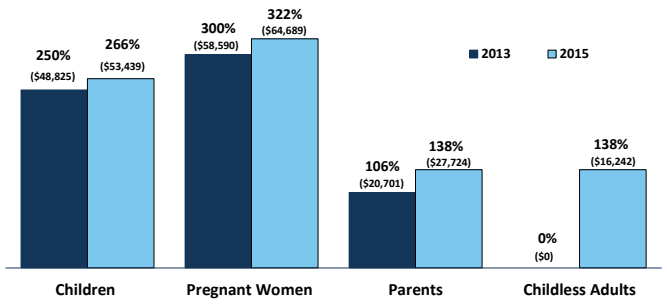
Medi-Cal Expansion

California was one of a handful of states to undertake an early expansion of its Medicaid program in anticipation of full expansion in 2014. The state did so under its five-year "Bridge to Reform" §1115 Medicaid Demonstration Waiver, which was approved by the federal government in 2010. In addition to other provisions, the waiver allowed for federal matching funds for the creation of a county-based coverage expansion program, known as the Low-Income Health Program (LIHP), which covered low-income adults who were not otherwise eligible for Medi-Cal. The majority of counties participated in LIHP, and by the end of 2013, over 650,000 adults were enrolled in the program.[47] The benefits provided under the waiver were more limited than Medi-Cal. These individuals were either auto-enrolled in Medi-Cal or transferred to Covered California when ACA coverage expansions became available in January 2014.[48]

The ACA Medicaid expansion resulted in increased Medi-Cal income eligibility levels for parents and other adults. Under the ACA expansion, nearly all citizens and legal immigrants who have been in the country for over five years with income at or below 138% FPL ($16,242 per year for an individual or $27,724 for a family of three in 2015) are eligible for Medicaid, and states receive substantially enhanced federal matching funds for this expansion population. As a result, eligibility levels for parents and childless adults increased after full ACA implementation.[49,50] The ACA also changed the method for determining financial eligibility for Medicaid for children, pregnant women, parents, and adults and CHIP to a standard based on modified adjusted gross income (MAGI). As a result, existing Medicaid income limits for these groups were converted to MAGI-equivalent limits (Figure 7). While the converted 2014 standards appear higher than 2013 levels, they are intended to approximate the existing eligibility levels using different methodology for determining income. Enrollment in the Medi-Cal program grew by 37%, or 3.4 million people, between October 2013 and May 2015.[51] While some enrollees may have been eligible for Medi-Cal before the ACA, many were likely newly-eligible under the adult expansion.[52]

Figure 7

Medicaid/CHIP Income Eligibility Thresholds Pre- and Post-ACA Implementation In California



NOTES: Eligibility levels are based on their respective year's federal poverty levels (FPLs) for a family of three for children, pregnant women, and parents, and for an individual for childless adults. In 2015,the FPL was $20,090 for a family of three and $11,770 for an individual. In 2013, the FPL was $19,530 for a family of three and $11,490 for an individual. As of 2013, childless adults in California were not eligible for Medicaid coverage. However, 50 of 58 counties covered parents and other adults up to 200% FPL under a waiver that provided more limited benefits than Medicaid. Income eligibility limits for children and pregnant women both reflect upper limits under Title XXI.
SOURCE: Based on results from two national surveys conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012-2013 and 2015.

Undocumented immigrants and some lawfully-residing immigrants remain ineligible to enroll in Medi-Cal. Under federal law, undocumented immigrants remain ineligible to enroll in federally-funded full Medi-Cal coverage. In addition, many lawfully present immigrants are subject to a five-year waiting period before they may enroll in Medi-Cal, and some groups of lawfully present immigrants remain ineligible

regardless of their length of time in the country. However, the state has taken several actions to expand eligibility for immigrants. For example, it has taken up the options available to states to eliminate the five-year waiting period for lawfully-residing immigrant children and pregnant women. In addition, it extends coverage to pregnant women with incomes up to 322% FPL regardless of immigration status through the CHIP unborn child option.[53] Recent state legislation would further expand coverage for undocumented immigrants. Senate Bill 4, known as the Health Care for All Act, passed the State Senate in June 2015. This bill would provide fully state-funded Medi-Cal coverage for children age 19 and under, regardless of immigration status.[54] Some local programs in the state also cover immigrant children regardless of immigration status.

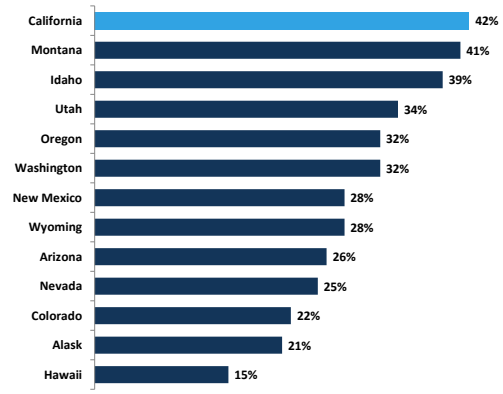
Under the ACA, all states are required to implement new simplified eligibility and enrollment processes. To implement these new processes, the state received federal funding to create a single online portal, available in Spanish and English, where users can apply and receive eligibility determinations for Medi-Cal or Marketplace insurance. The application can also be completed in-person, by phone, fax or mail, and paper applications are available in thirteen languages. In addition, the state adopted the Express Lane Enrollment Project to target adults and children enrolled in California's Supplemental Nutrition Assistance Program (SNAP), known as CalFresh. Covered California's online application system, also known as the California Health Care Eligibility, Enrollment and Retention System (CalHEERS), coordinates with county social services departments through an online system called Statewide Automated Welfare Systems (SAWS).[55] However, like many states, California experienced outreach and enrollment challenges in 2014, including a shortage of in-person assisters,[56] problems with cultural and linguistic resources,[57] technological issues with the Covered California website,[58] and a Medi-Cal backlog,[59] which led to delayed or abandoned applications. Through late 2014 and 2015, the state took action to address many of the challenges it faced during the first open enrollment period, though some challenges remain.

Covered California

California operates its own state-based insurance marketplace, known as Covered California. Through Covered California, individuals who do not have access to another source of affordable coverage are eligible to purchase individual coverage directly from insurers. People with incomes above Medi-Cal eligibility but below 400% of poverty are eligible for premium tax credits, and people with incomes up to 250% of poverty are additionally eligible for cost-sharing subsidies. Legal, permanent residents who have been living in the country for less than five years may purchase health insurance through Covered California and may receive subsidies, but undocumented immigrants are currently prohibited from purchasing insurance in the Marketplace. If SB4, the "Health Care for All" Act is passed in its current form, undocumented Californians would be able to purchase unsubsidized insurance through Covered California.[60] In addition, small businesses (up to 50 workers) can offer coverage to their workers via Covered California's Small Business Health Options Program (SHOP). Beginning on October 1, 2013, individuals and small businesses could begin shopping for health insurance plans, and coverage began in January 2014. Ten health insurance companies offered plans in the Marketplace in both 2014 and 2015. Statewide in 2014, the average premium rate for the lowest cost Bronze plan was $219 per month and $304 per month for the lowest cost silver plan.[61] The statewide average rate increased by 4.2% between 2014 and 2015 across plans and benefit designs: 16% of consumers saw their premium remain constant or decrease while the majority (71%) saw increases of up to 8%. In response to consumer feedback, some health plans expanded their provider networks in 2015.[62]

As of March 2015, nearly 1.4 million people were enrolled in a Covered California health plan, representing 42% of the potential Marketplace population (Figure 8).[63] Two-thirds (65%) of those enrolling during the second open enrollment period (2014-2015 period) were reenrolling, and over half were between the ages of 45 and 64 (51%).[64] Almost nine out of ten (88%) enrollees are receiving premium tax subsides, while half (51%) are additionally receiving cost-sharing subsidies.[65]

Figure 8
Number of Individuals Selecting a Marketplace Plan, as a Share of the Potential Marketplace Population in Western States, March 2015



SOURCE: CMS, March 31, 2015 Effectuated Enrollment Snapshot, accessed June 2, 2015. http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html.

Delivery System and the Safety Net

California's counties play an important role in the structure and delivery of the state's health care safety net. Counties in California are required by state law to be the health care providers of last resort for people who are medically indigent. However, significant variation exists with respect to the services provided, the method of delivery and the populations served. Twelve counties are "provider" counties, meaning they own and operate inpatient hospitals and clinics and generally provide coverage to broader groups of people than other counties.[66] Five "payer" counties contract with private hospitals and/or clinics for care delivery, and six "hybrid" counties deliver outpatient care in their own clinics but contract with private hospitals for inpatient care. County Medical Service Program (CMSP) counties are part of an association of 35 primarily rural counties that collectively pay private providers for care. County programs are funded by a complicated mix of local, state, and federal funds, including Medi-Cal funds, and are also primary providers of public health services and behavioral health services for low-income, underserved, and uninsured populations.[67] In addition, California is home to 129 federally-funded health center organizations, together running 1,225 delivery sites throughout the state. In 2015, the state's health centers served nearly 3.5 million patients, 38.5% of whom were uninsured.[68]

California is in the process of reforming its payment and delivery system for safety-net programs with funding from a Medicaid Delivery System Reform Incentive Pool (DSRIP). In 2010, California was the first state to secure a DSRIP waiver designed in large part to continue supplemental payments to public hospitals while also ensuring a level of accountability for the funds. The DSRIP initiative was included in the Bridge to Reform §1115 waiver. California's $6.67 billion dollar DSRIP initiative ties funding for the public hospitals to projects and milestones in one or more of five priority areas: infrastructure development; innovation and redesign; population-focused improvement; urgent improvement in care; and HIV transition projects.[69,70] On average, each public hospital system is carrying out 15 simultaneous projects with an average of 217 milestones per year.[71]

On March 27, 2015, California submitted a renewal application for its Medicaid §1115 waiver, which is being renamed "Medi-Cal 2020." The renewal requests authority for a series of delivery system transformation and alignment programs, including a continuation of DSRIP funding for public hospital systems. However, the proposed waiver expands the scope of DSRIP-eligible institutions to 42 safety net institutions run by health care districts (referred to as "non-designated public hospitals"). These institutions

are predominantly located in rural areas and are often the only hospitals serving their communities. The delivery system transformation and alignment programs also seek to transform and improve the managed care system; improve the fee-for-service system used to pay for dental and maternity care; spur workforce development; increase access to supportive services and housing; and promote regionally-based "whole-person" integrated care pilot projects.[72]

Medi-Cal Managed Care

The majority of Medi-Cal beneficiaries receive their health care through a managed care plan. In May 2015, over 9.5 million people,[73] or a little over three-quarters of the Medi-Cal population, were enrolled in a managed care plan. The state uses six different models of managed care, which vary with respect to how many plans operate in a county, whether the plans are private or county-operated, and whether there is a fee-for-service option. Each county is served by a single managed care model. In 35 counties, individuals may choose from between two and five plans, with at least one commercial plan option. In 22 counties, everyone is in the same managed care plan that is operated by the county, and one county (San Benito) offers a choice between one commercial plan and traditional fee-for-service.[74]

California has recently expanded mandatory enrollment in managed care to certain seniors and persons with disabilities (SPDs). Under California's "Bridge to Reform" waiver, mandatory enrollment of Medi-Cal-only SPDs in California began in June 2011 in some non-rural counties.[75] Goals of the transition included care coordination, better management of chronic conditions, improved health outcomes and cost savings. Dual eligible beneficiaries, those receiving long term care services, as well as certain other groups were excluded from this requirement. Since June 2011, approximately 340,000 SPDs in 16 counties were transitioned from fee-for-service (FFS) to managed care.[76] Findings from a beneficiary survey of over 1,500 SPDs found that approximately two-thirds of SPD beneficiaries reported satisfactory experiences with the transition, while one third did not. Some key issues were identified in the notification and distribution of materials to beneficiaries as well as beneficiaries' knowledge of plan navigation and consumer protections.[77] The state and advocates are looking at the experiences from this transition to inform similar transitions in an additional 19 (rural) counties[78] and the transition of dually eligible beneficiaries into managed care, both of which began in 2014.

The Coordinated Care Initiative (CCI) is changing the way seniors and persons with disabilities receive health care and long term services and supports (LTSS) in California. The goal of CCI is to enhance health outcomes and beneficiary satisfaction for SPDs and those dually eligible for both Medicare and Medi-Cal. CCI, which is being implemented in seven counties,[79] contains two major components: Cal MediConnect and Managed Medi-Cal Long-Term Supports and Services (MLTSS).

Cal MediConnect is a three-year demonstration to integrate care and align financing for beneficiaries eligible for both Medicare and Medi-Cal. California is one of twelve states carrying out such a demonstration, which began in the state in April 2014.[80] Cal MediConnect plans are responsible for the delivery and coordination of all Medicare and Medi-Cal medical, behavioral health, and long-term services and supports (LTSS) for their enrollees. Participation in the demonstration is voluntary for purposes of Medicare managed care enrollment, while all beneficiaries must enroll in managed care for purposes of their Medi-Cal benefits. Cal MediConnect enrollment is passive, and individuals must actively notify the state if they choose not to enroll. As of July 2015, the opt-out rate, excluding Los Angeles County, was 33%, consistent with most other states participating in the demonstration. Los Angeles had an unusually high opt-out rate of 51%.[81]

Under the Managed Medi-Cal MLTSS initiative, all Medi-Cal beneficiaries, including dual eligible beneficiaries, are required to join a Medi-Cal managed care plan to receive LTSS and other Medi-Cal-covered benefits. Managed care plans are required to provide care coordination for MLTSS beneficiaries. Some stakeholders have been concerned about the transition of SPDs to managed care because of the complicated nature of their health care needs and their use of multiple providers and medications.

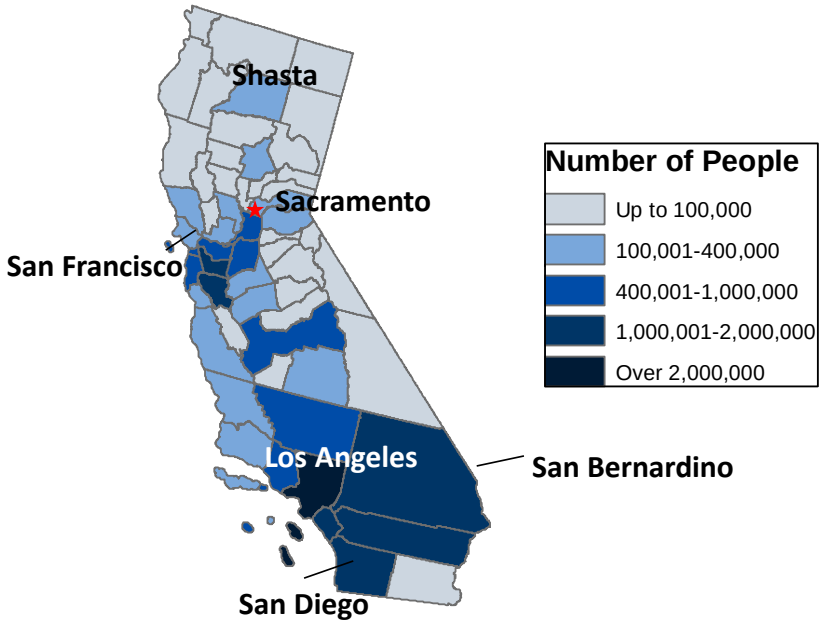
Looking Ahead

With over 38 million residents, California is the most populous state in the U.S, and the health and health care of its residents have important implications for the nation at large. Through ACA implementation and changes to its Medi-Cal program over the past five years, the state expanded coverage to millions of the previously uninsured and developed the foundation for the state's managed care infrastructure. Moving forward, the state continues to invest in its health care delivery system and infrastructure and to address the health care needs of the remaining uninsured and medically indigent populations. The state's proposed "Medi-Cal 2020" waiver focuses on programs aimed at delivery system transformation and alignment, including an extension with some changes to the DSRIP program.[82]

Despite all of California's efforts and successes, many challenges lie ahead. While substantial coverage gains were achieved under the ACA, millions of people are still uninsured and will likely rely on California's public clinics and health centers when they need care, which will require ongoing support.[83] Individuals who have newly gained coverage through Medi-Cal or the Marketplace are beginning to use their new health plans and seek care, but some are reporting access barriers and health literacy issues.[84] These challenges notwithstanding, California has made substantial progress in reducing the number of uninsured in the state. From 2013 to 2014, the uninsured rate among the nonelderly in California dropped from 19.1 percent to 13.4 percent, with an even bigger drop among nonelderly adults targeted by ACA expansions.[85] These coverage gains, combined with delivery system transformation, payment reform and continued support to the health care safety net will likely impact the health, health care access, and health care utilization of Californians in the long term.

Figure 9

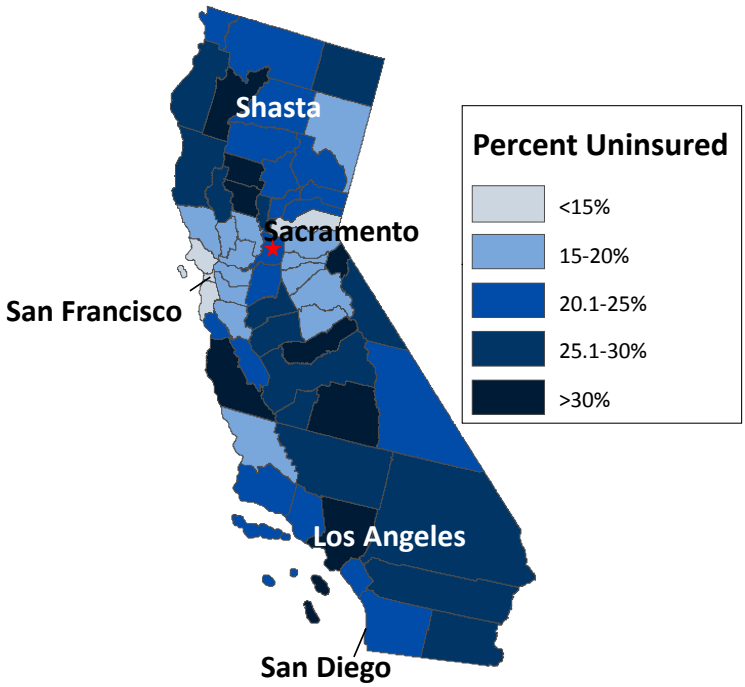
California, Nonelderly Population Density by County, 2009-2013



SOURCE: U.S. Census Bureau, 2009-2013 American Community Survey.

Figure 10

California Nonelderly Uninsured Rate by County, 2009-2013



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CALIFORNIA HEALTHCARE FOUNDATION

Hidden from View:
How Consumers Find Information About Prescription Coverage

AUGUST 2015

Contents

About the Authors

The HSM Group (HSM) is a health care market research and consulting firm based in Scottsdale, Arizona. Through qualitative and quantitative research, HSM gathers perspective and insight from a variety of stakeholders in the health care arena. HSM's team of researchers has extensive knowledge of the changing landscape of health care. Katy Wilson, MPH, of Wilson Analytics, led the secondary research and served as an advisor and partner to HSM throughout the study.

Acknowledgments

The authors would like to thank members of the advisory group for their contribution to this study: Beth Capell and Tam Ma, Health Access; Athena Chapman, California Association of Health Plans; Anne Donnelly and Emalie Huriaux, Project Inform; Betsy Imholz, Consumers Union; and Dana Malick, American Cancer Society Cancer Action Network. HSM would also like to express our gratitude to Caroline Pearson and her team at Avalere for their earlier work on existing online formulary examples that supplemented the secondary research phase of this project.

About the Foundation

The California HealthCare Foundation (CHCF) is leading the way to better health care for all Californians, particularly those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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Introduction

When shopping for health plans, consumers face many challenges in finding accurate information on prescription drug benefits. Publicly posted formularies are often incomplete, inaccurate, or difficult to navigate due to lack of standardization and confusing or inaccessible consumer cost information.[1]

This paper seeks to provide insight into the consumer experience of accessing prescription drug coverage information, pinpoint consumer priorities and preferences for display of prescription drug benefit information, and identify opportunities for improving transparency of prescription drug benefit information.

Background

In the past two years, millions of Californians have gained coverage following the passage of the Affordable Care Act (ACA), which led to the establishment of the state-based marketplace, Covered California, and to the expansion of Medi-Cal coverage. Many of these individuals are new to shopping for health insurance, with little or no prior knowledge of health care benefits. While California went further than other states in standardizing plan designs to improve and simplify consumer shopping, significant variation persists among each plan's prescription drug benefits.

In an effort to improve consumer access to accurate prescription drug coverage information in California, SB 1052 was signed into law August 2014. The legislation requires:[2]

- Health plans and insurers that provide prescription drug benefits and maintain drug formularies to post the formulary or formularies for each product offered on the plan's website in a manner that is accessible and searchable by potential enrollees and providers.
- The Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) to develop a standard formulary template that contains specified information by January 1, 2017.[3]
- Health plans and insurers to use the standard formulary template within six months of the date the template is developed by DMHC and CDI.
- Health plans and insurers to update their posted formularies as needed on a monthly basis.

In light of this legislation, the goal of this research project is to share insights into consumers' drug benefit shopping experiences and preferences with health plans, insurers, and their regulators so they can improve consumer access to this information.

Methods

The research was designed to solicit first-hand experiences from state residents who shopped for their own health insurance in the past year. The information was gathered through focus groups, in-person interviews, telephone interviews, and an online bulletin board.

Participants included those purchasing insurance in the individual market (either through Covered California or elsewhere), as well as those choosing among employer-sponsored coverage options. A small number of participants found they were eligible for government subsidies or Medi-Cal because of Medicaid expansion under the ACA. Participants had shopped for health coverage in a variety of ways, including online, with assistance from insurance agents and enrollment counselors, and by calling insurance companies. Consumers were asked to complete a short written survey on drug benefits following the in-person discussions.

In preparation for this research, the authors examined the range of information and tools available to shoppers who prioritize drug coverage in choosing health insurance plans. Resources were evaluated in terms of how they could help shoppers understand their drug coverage and costs, using a selection of health plans and drugs as examples. This included review of existing plans on Covered California and formulary resources of plans sold on Covered California, as well as several best-in-class examples from outside the state. A subset of examples considered among the best available was selected for use as stimuli for feedback during the research, including formulary excerpts from two health plans sold through Covered California. For more on these resources, see Appendices B, C, and D.

The research covered the following topics:

- The experience of shopping for health insurance and steps taken by consumers
- Factors considered when choosing health plans
- Knowledge of specific terms related to prescription benefits and cost-sharing elements
- Information wanted about specific medications and drug coverage in general
- Preferences on display of formularies and select sections on www.coveredca.com
- Feedback on several best-in-class resources from outside of California

A wide range of consumers with different health care needs was included in this research, with focus groups and interviews segmented by target population:

- Generally **healthy** individuals who take one to four prescription medications voiced their opinions on an online bulletin board. Half took only generic drugs.
- People with a variety of **chronic conditions** such as asthma, diabetes, hypertension, multiple sclerosis, depression, or migraines participated in focus groups. The majority had at least two chronic conditions requiring prescription medication.
- Individuals requiring high-cost or **specialty medications** for their conditions (e.g., HIV/AIDS, hepatitis C, cancer) participated in individual, in-person interviews.

Defining Speciality Medications

While there is no standard definition of specialty drug, the term generally includes medicines that are complex to manufacture and that may require special handling or administration instructions. Increasingly the term is used to more broadly describe high-cost prescription drugs, which are sometimes placed on a health plan's highest cost-sharing tier. The term is used in this report to refer broadly to high-cost prescription medications used to treat complex, chronic conditions. Not all plans will place the same drugs in the specialty tier.

Research also included agents and enrollment counselors:

- Small group discussions were held with **insurance agents (Agents)** certified by Covered California.
- Telephone interviews were conducted with **Covered California-certified enrollment counselors (Counselors)** including those who assist clients speaking Mandarin, Cantonese, or Spanish.

A total of 95 individuals participated in the research. Telephone interviews and the bulletin board included people from around the state while in-person research was conducted in Los Angeles, San Francisco, and Fremont in April 2015. The bulletin board was live in late March 2015. The focus groups and interviews with people with chronic diseases and specialty medication needs were conducted in Spanish as well as English. The study population was diverse in terms of gender, race, education, and income. Appendix A provides further detail on research participants.

There are limitations to the findings produced from this research. Qualitative research such as this study is designed to provide an in-depth exploration into critical perceptions and experiences and does not constitute a statistically valid representative sample. Findings should be considered directional in nature.

The Shopping Experience

What Is Most Important to Shoppers?

Participants reported that the affordability of monthly premiums and other out-of-pocket costs is the foremost consideration in purchasing a health plan.

As important as prescription drugs are to people with medical conditions, when shopping for health insurance, drug benefits take a backseat in the decision process, according to participants in the study. Consumers described basing their health plan choices on affordability of monthly premiums, physician access, and out-of-pocket costs such as deductibles and copays for physician office visits. This proved true for those with greater medical needs as well as for healthier

participants. Agents and counselors confirmed that their clients express similar priorities.

Physician selection ranked high as a factor in choosing health insurance for all consumers, whether healthy or living with medical problems. Participants felt it was important to stay with physicians who know them and any medical issues they might have. Staying with institutions — hospitals and clinics — also played a role, albeit lesser than staying with physicians.

"As long as my primary care physician is covered in it [the plan]. I also look at what medical group and network for my plan is associated with that PCP. I have to go to a lot of specialists."

— Consumer with chronic conditions

Although all respondents in the focus groups and interviews had several chronic conditions or took specialty medications, drug benefits were rarely the primary focus when shopping for coverage. Many times, participants said they assumed their drug(s) would be covered and did not think about the need to double-check their availability or potential cost. Some consumers have had to switch drugs in the past and assumed if a new plan does not cover what they currently take, there will be other options to consider or their doctor will advocate for an exception with the insurance company.

"I assumed drug benefits are the same — [that] all PPO plans will cover the drug I take. At the time, I didn't have cancer. Now that you bring it up, I should have looked at the drug benefits."

— Cancer patient

Consumers with HIV exhibited limited concern about the cost of their medications, primarily citing the safety net offered by the AIDS Drug Assistance Program, which helps provide medication to people living with HIV and AIDS who meet income requirements. There was also an assumption that doctors and staff specializing in HIV treatment would make certain that necessary drugs were covered.

Shopping for Drug Benefits Has Challenges

Although many consumers had not thought about checking whether their medications would be covered prior to selecting a health plan, those who did look for the information had difficulty locating it. Participants noted that prescription benefit information is not prominent on plan websites or on the Covered California website. For many participants, it took multiple clicks to locate a company's formulary — if it was found at all.

"I looked and looked and looked for drug information but I never found it."

— Spanish-speaking consumer

Regardless of health status or prescriptions needed, consumers reported that the task of finding information on drug coverage is frustrating and time-consuming. Most were unable to find all the information they wanted and resorted to calling each plan under consideration to check whether their own drugs were covered and details on their financial responsibility. For a few participants, the process lasted several weeks before they could gather sufficient information to make a comparison.

"I feel like there was information, but it lacked details. It needed to include easy and concise information about brand name medication copays."

— Consumer with few prescription drug needs

Consumers also cited frustration with incomplete or vague information that could lead them to making less-than-optimal decisions on health plans.

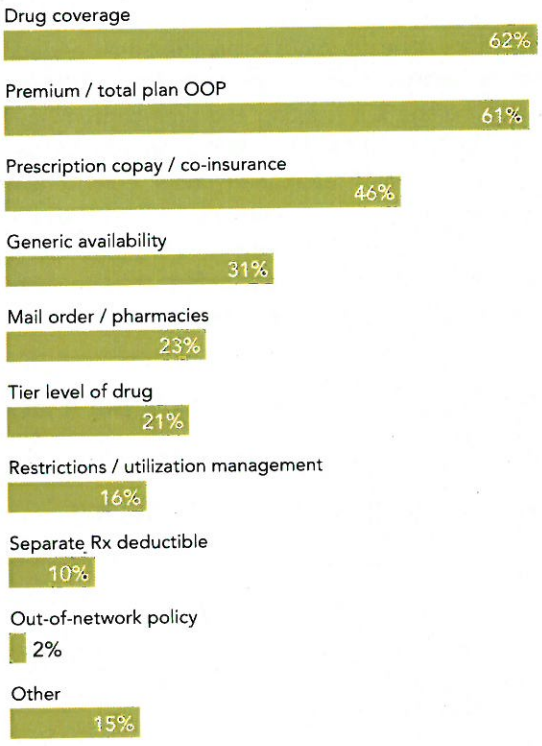
Neither agents nor counselors reported routinely helping clients conduct such drug benefit searches. Agents in the

"It's not difficult, it's tedious. When you sit down and start doing the cost analysis on what this client is costing me, as opposed to what I'm making on it."

— Insurance agent

Choosing a Plan: What Prescription Drug Information Is Important to Consumers with Chronic Conditions?

After the conclusion of the focus groups and in-person interviews, a brief, written survey about prescription benefits was completed by 61 consumers with chronic conditions and those taking specialty drugs. Consumers were asked through an open-ended question to specify the three most important things to know about prescription medications before deciding on a health plan. Coverage of drugs they take and the overall premium amount were mentioned by three in five consumers. Specific out-of-pocket drug costs — copay and co-insurance amounts — were listed by nearly half.



study said they feel it is too time-consuming to be profitable, while counselors reported that they themselves have limited familiarity with the process.

Understanding Terms and Benefit Design

Participants were asked to review and discuss two excerpts from health plan formularies sold through Covered California and identified by researchers as best-in-class examples. (For more on the criteria for formulary selection, see Appendix D.) Both formularies are available in PDF format with each having several pages of introduction, including background on how formularies are developed, instructions on how to read the formulary, definitions of tiers, and coverage limits or restrictions, as well as available drugs, their tier placement, and any restrictions or utilization management requirements.

In general, respondents were not familiar with many of the terms used routinely in prescription benefit information.

Key examples include:

- A majority did not know the term **formulary**, and those who recognized the term were not certain of its definition. Not only were consumers unfamiliar with the concept of a drug formulary, some counselors also confessed to not knowing the term.
- **Co-insurance** was often mistaken as being secondary insurance that pays after primary insurance reimbursement. Few taking specialty drugs reported encountering the term.
- **Prescription drug tiers** were sometimes confused with ACA metal tiers for plans offered through Covered California.
- **Preferred** versus **nonpreferred**, in reference to medications, confused people. Many participants asked if preferred indicated a better drug, rather than a lower tier and lower copay brand medication.

"From my experience, formulary information would not be relevant. To me, this [sample PDFs] is not helping. It is confusing. Even if I was to know the definition of all of these terms, there's no way I would tell this to the client. They would look at me like, 'what are you talking about?' It would make it more difficult."

— Enrollment counselor serving Spanish-speaking consumers

- There was a lack of familiarity with the **exception or appeals process**, and many were not able to find this information easily when they needed it.

"It's not really reader friendly. They use terminology and language that I'm like, 'Okay, I don't know what that means.' Then you just say, 'Forget it, I'm not going to sit here and read all this.'"

— Consumer with hepatitis C

Need for Information in Languages Other than English

Although more than half of the Spanish-speaking respondents in this study reported being comfortable reading English, they (as well as participants who do not read English) said drug information such as formularies should be available in Spanish.[4]

Counselors stressed the need for a wider array of language translations of both formularies and other health plan information. They also noted that the type of language used, when information in languages other than English is available, is either too technical or translations are not standardized across terms and definitions.

Preferences for Information Display

Study participants were presented with examples of three online formulary search tools assessed by the authors and found to be among the best tools publicly available. In addition, several areas with prescription information on the Covered California website were reviewed with respondents. Screenshots of the examples are provided in Appendix B.

Participants were asked to react to the following tools:

- Medicare Plan Finder on www.medicare.gov
- Connect for Health Colorado Health Plan Finder (planfinder.connectforhealthco.com)
- Managed Markets Insight & Technology (MMIT) Mobile App and MMIT-powered California Choice
- Select pages on www.coveredca.com:
  - **Prescription drugs.** Links to each Covered California health insurance plan formulary
  - **Preview plans.** Qualified benefits based on household information
  - **Shop and compare tool.** Available plans based on household information
- Table developed for this research consolidating drug benefit information from plans offered through Covered California

Not surprisingly, for the majority with chronic conditions or specialty drug needs, the Medicare Plan Finder was described as a "perfect" interactive tool. Some participants had used the tool with family members and raved about it, while others had favorable first impressions. Agents and counselors also cited this website as a model. Numerous features were considered valuable, including the drug search tool, dosage options, cost estimates for a consumer's own list of drugs for every plan under consideration, and ability to save and edit drug lists and compare across plans. The ability to recognize misspellings and suggest possible substitutes was seen as an added bonus since many participants find some drugs difficult to spell and pronounce. (Healthier consumers were not asked to review the Medicare tool.)

"[My mother] has to go through like 20, 30 different prescription plans. She gets to select all of her medicines [on Medicare Plan Finder] and it pops out and tells us exactly which one's the cheapest and everything. It's perfect."

— Consumer with chronic conditions

The Colorado Health Plan Finder tool was well-received by all consumers and agents (counselors were not presented this example). This online search tool offers a variety of filters that can be applied to refine plan options. A feature that was important to consumers and agents alike was the medication look-up filter where shoppers enter their prescription information and filter to see only plans that cover those specific drugs. The tool also displays the copays. Participants said it was important because it allowed them to figure out what they would be spending monthly on prescriptions.

"This [Connect for Health Colorado Health Plan Finder] appears to be quite useful and helpful in terms of being able to narrow down your choices faster especially with the drug look up tool. . . . I do appreciate that feature. I like how it listed the various prices of drugs and even had dosage amounts listed. This site seems to be designed with the customer in mind who wants to do their research."

— Consumer with few prescription drug needs

Consumers were split on the MMIT mobile app, a formulary search tool that can be used to check the coverage level of a drug on multiple plans simultaneously. Many were concerned about security on mobile devices. Others rely heavily on their mobile Internet access through smartphones and liked the tool. Because formulary tier definitions are not standardized, MMIT's initial search results categorize drug placement as "restricted," "covered," and "preferred" along with red, yellow, or green dots to indicate the coverage status of a drug. Some participants noted that the wording was counter-intuitive as "covered" seemed to imply a higher level of benefits than "preferred" which, in actuality, was not the case. A positive feature of MMIT mobile app is the ability to see what medications are possible substitutes for a noncovered drug.

During in-person research, a screenshot of a page from the Covered California website was shared that includes links to the formularies of all companies with plans sold through the Exchange (see Appendix B).[5] Many participants who researched prescription coverage did not recall finding that information on the site.

As part of this research, information throughout the Covered California website was consolidated into a table to clarify relationships between prescription coverage and various metal tier options. Agents and consumers were asked to review and discuss the usefulness of the table. All of the agents reported that they would find information presented in this way useful when explaining drug cost details to clients. Consumers were split on whether they could understand all elements of the table without additional explanation or definition of terms. Appendix C includes the table with suggestions for improvement.

Considerations

Respondents offered a range of ideas — from relatively straightforward fixes to ambitious undertakings to improve consumer access to and understanding of prescription drug information. Suggestions included actions that could be taken by regulators as they develop California's standardized template, improvements to individual plans, and changes that purchasers and marketplaces, such Covered California, could implement.

Make It Easier for Consumers to Find Drug Information

Create an interactive Internet formulary search tool. This would streamline the process of finding out whether specific medications are covered by various health plans. All consumer groups, counselors, and agents agreed that such a tool would improve the insurance shopping process. Ideally, the tool would allow input of drug names, and results would include details such as cost and tier placement for each plan offered by a carrier. (Examples of interactive tools are included in Appendix E.)

Simplify path to formulary information. In lieu of an interactive search tool, locating plan formularies should be simplified. Once aware a link exists, most say they would want it to take them directly to the formulary PDF rather than to a company home page. Additionally, respondents said that it would be helpful if drug benefit information was consolidated on the plan's site and made accessible through a clearly labeled tab using a minimum number of clicks.

"I want to see the name of the drug, the carrier, and breakdown to the plan, breakdown to the tier level, one-two-three-four, then breakdown to the actual cost of the copay. These can all be programmed. The data is there. That's just extracting and putting it into the active model."

— Insurance agent

Improve Formularies for Consumers

Six out of ten consumers with chronic conditions or who take specialty drugs preferred the term "Prescription Drug List" to "formulary." This term was also preferred and considered less confusing for consumers by all agents and all but one counselor.

Other suggestions from research participants for making formularies easier to access and interpret included:

- Use consumer-friendly medical terms. Participants agreed that drug categories should use understandable terms like "high blood pressure" instead of "hypertension."
- Standardize formulary terminology and abbreviations to make comparisons less confusing.
  - Replace word names and abbreviations (such as GP for generic drugs) with common tier definitions, or create standardized tier numbers that correspond to copay amounts (e.g., Tier 1 is least).
- Display copay information with tier placement to highlight monthly cost of prescriptions.
- Publish formularies in Spanish and other languages, and ensure translations are accurate, understandable, and standardized.
- Use graphic layout of the formulary (e.g., font size, tables, and white space) to improve ease of comprehension.
- Add key to abbreviations (i.e., drug tiers and utilization management notes) to every page of the formulary.
- Clearly differentiate between branded drugs and generics (e.g., capitalize all letters in brand name drugs and lowercase all letters for generic drugs).
- Specify information on step therapy (i.e., what drug[s] must be taken prior to approval of a certain brand-name medication).
- Provide information on the exception process within the introduction so consumers know what to do next if a drug is not on formulary.
- Include a list of pharmacies where prescriptions can be obtained.
- Indicate on the formulary cover page what type of plan corresponds with the formulary; three-quarters of respondents taking the written survey said it is very important for a formulary to specify whether it is for individual or group plans, or those included or excluded from Covered California.

Increase Consumer Education Efforts

Consumer education initiatives should address the substantial gap in knowledge about prescription drug benefits (e.g., meaning of terms and significance of differences among formulary designs). Particular attention should be paid to educating consumers on the exception and appeals process, including how and where consumers can appeal medication denials and seek redress of other prescription drug coverage issues. Enrollment counselors also admit to having insufficient knowledge about prescription coverage and would also benefit from additional education to bridge the gaps in client understanding of prescription benefits.

There are many opportunities for consumer education on formulary information, as well as the exceptions and appeals process. As Covered California, health plans, and regulators educate consumers on changes in a range of areas, these outreach efforts can serve as a vehicle for formulary education as well. Examples of these opportunities include communication of new requirements regarding specialty medications and prescription coverage, the transition to a uniform formulary template for health plans, and outreach about open enrollment periods.

Endnotes

1. "Digging for drugs and docs in Covered California is no easy task," HealthLeaders-InterStudy, hl-isy.com. *Better Shop Around: Out-of-Pocket Prescription Drug Costs in Covered California Plans* (May 2015), California HealthCare Foundation, www.chcf.org.
2. "California Legislative Information, SB-1052 Health care coverage," accessed February 9, 2015, Legislative Counsel of California, leginfo.legislature.ca.gov.
3. This includes information on cost-sharing tiers and utilization controls, drugs that are preferred over other drugs on the formulary, information to educate enrollees about the differences between a medical benefit and prescription benefit, how to obtain coverage information regarding drugs that are not covered under the plan's prescription drug benefit, and information to educate enrollees on methods to obtain prescription drugs not listed on their health plan if they are deemed medically necessary by a clinician.
4. Researchers reviewed formularies of the 10 carriers participating California's State Based Marketplace during February to March 2015 and found one plan offering a complete formulary in Spanish, one with introductory pages in Spanish, and one that included instructions in Spanish to call the plan for assistance in Spanish.
5. "Covered California, Prescription Drugs, Resources for Individuals and Families," accessed April 2, 2015, Covered California, www.coveredca.com.

Appendix A. Participant Details

Eligible consumer participants consisted of a mix of males and females, ages 18 to 63, who met the following criteria:

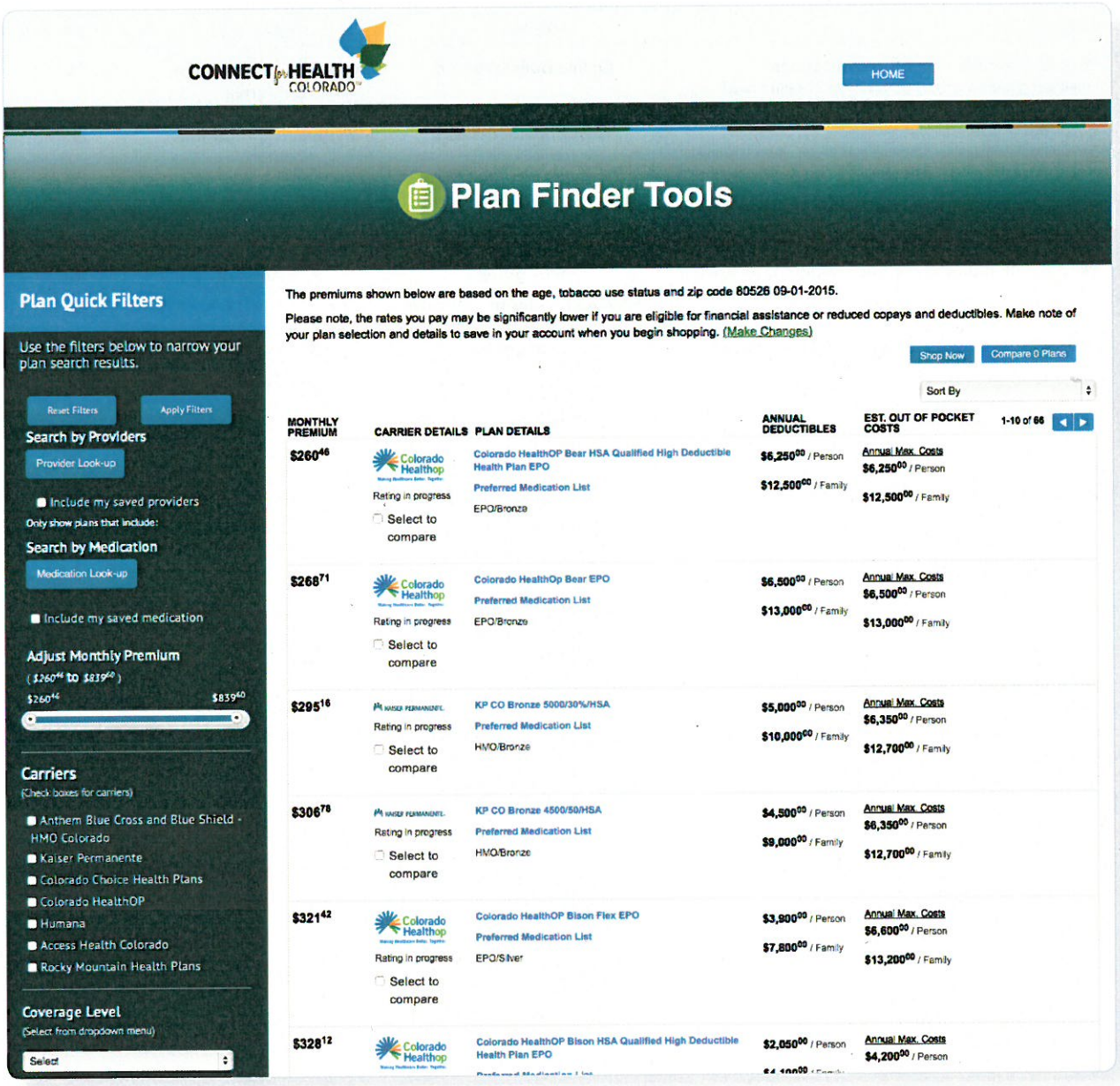
POPULATION	METHOD	LOCATION(S)	NUMBER OF PARTICIPANTS
People who take 1 to 4 Rx medications (~half get generics only, ~half take 1 to 2 brand drugs)	Online bulletin board	dispersed throughout California	18
Enrollment counselors* (including 1 who speaks Chinese and 1 who speaks Spanish)	Telephone interviews	dispersed throughout California	4
Insurance agents*	Small group discussion	SF Bay Area†	3
		Los Angeles	4
People with multiple chronic conditions (in Spanish)	Focus groups	Los Angeles	6
	Individual in-depth interviews		2
People with multiple chronic conditions (in English)	Focus groups	SF Bay Area†	17
		Los Angeles	14
People using specialty drugs	Focus groups	SF Bay Area†	6
		Los Angeles	10
Individuals with HIV/AIDS	Individual in-depth interviews	SF Bay Area†	5
		Los Angeles	1
Individuals with Hep C	Individual in-depth interviews	Los Angeles	2
Individuals with cancer	Individual in-depth interviews	SF Bay Area†	1
		Los Angeles	2
Total Number of Participants			**95**

*Certified insurance agents help small-business employers, their employees, and indivduals select insurance plans while earning a commission for each plan they sell.

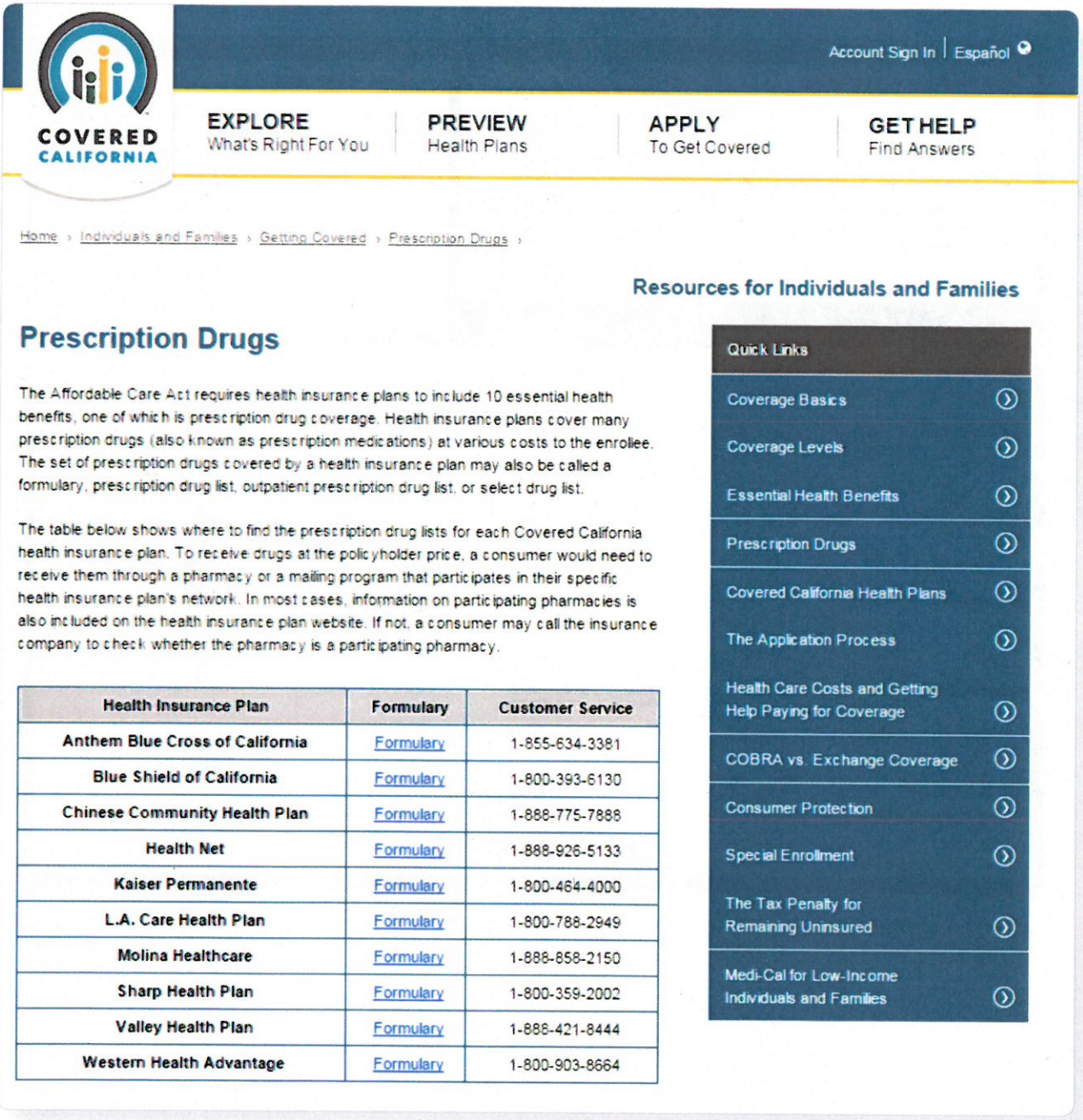
†SF Bay Area research conducted at research facilities located in San Francisco and Fremont.

Appendix B. Consumer Stimuli: Examples of Online Formulary Search Tools

Colorado Plan Finder (planfinder.connectforhealthco.com)



Covered California (www.coveredca.com)



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Home › Individuals and Families › Getting Covered › Prescription Drugs ›

Resources for Individuals and Families

Prescription Drugs

The Affordable Care Act requires health insurance plans to include 10 essential health benefits, one of which is prescription drug coverage. Health insurance plans cover many prescription drugs (also known as prescription medications) at various costs to the enrollee. The set of prescription drugs covered by a health insurance plan may also be called a formulary, prescription drug list, outpatient prescription drug list, or select drug list.

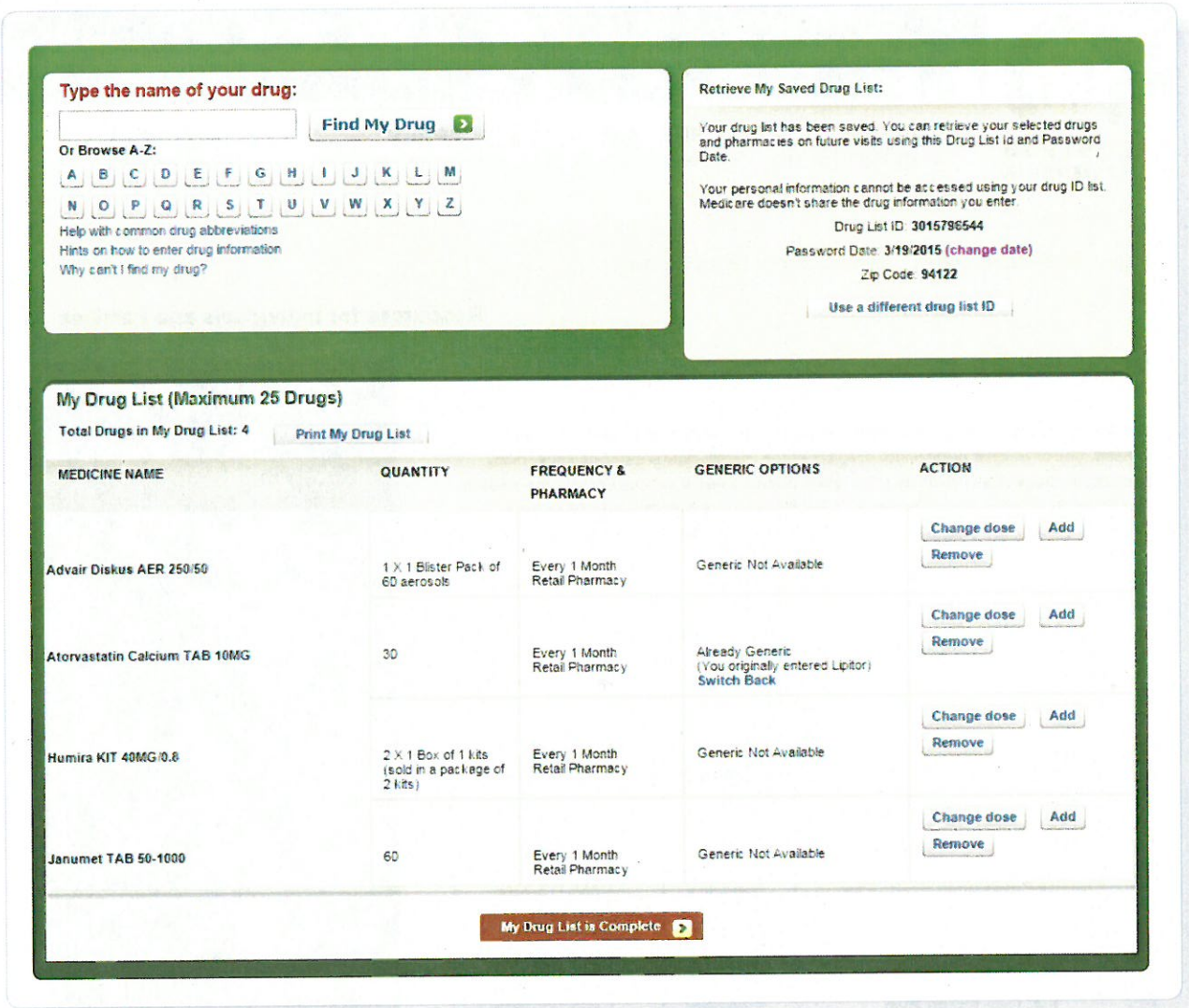
The table below shows where to find the prescription drug lists for each Covered California health insurance plan. To receive drugs at the policyholder price, a consumer would need to receive them through a pharmacy or a mailing program that participates in their specific health insurance plan's network. In most cases, information on participating pharmacies is also included on the health insurance plan website. If not, a consumer may call the insurance company to check whether the pharmacy is a participating pharmacy.

Health Insurance Plan	Formulary	Customer Service
Anthem Blue Cross of California	Formulary	1-855-634-3381
Blue Shield of California	Formulary	1-800-393-6130
Chinese Community Health Plan	Formulary	1-888-775-7888
Health Net	Formulary	1-888-926-5133
Kaiser Permanente	Formulary	1-800-464-4000
L.A. Care Health Plan	Formulary	1-800-788-2949
Molina Healthcare	Formulary	1-888-858-2150
Sharp Health Plan	Formulary	1-800-359-2002
Valley Health Plan	Formulary	1-888-421-8444
Western Health Advantage	Formulary	1-800-903-8664

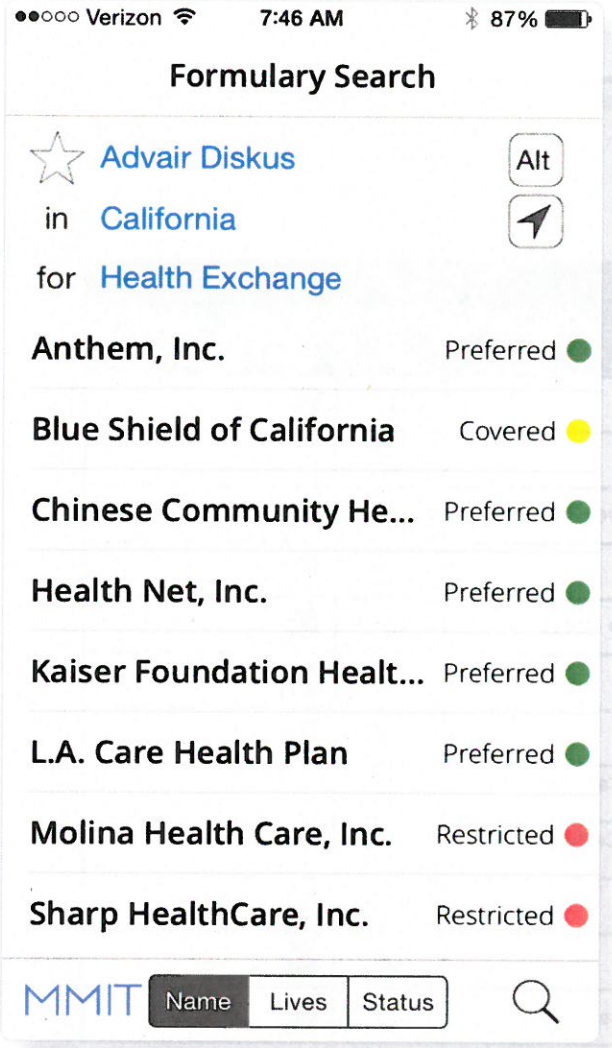
Quick Links

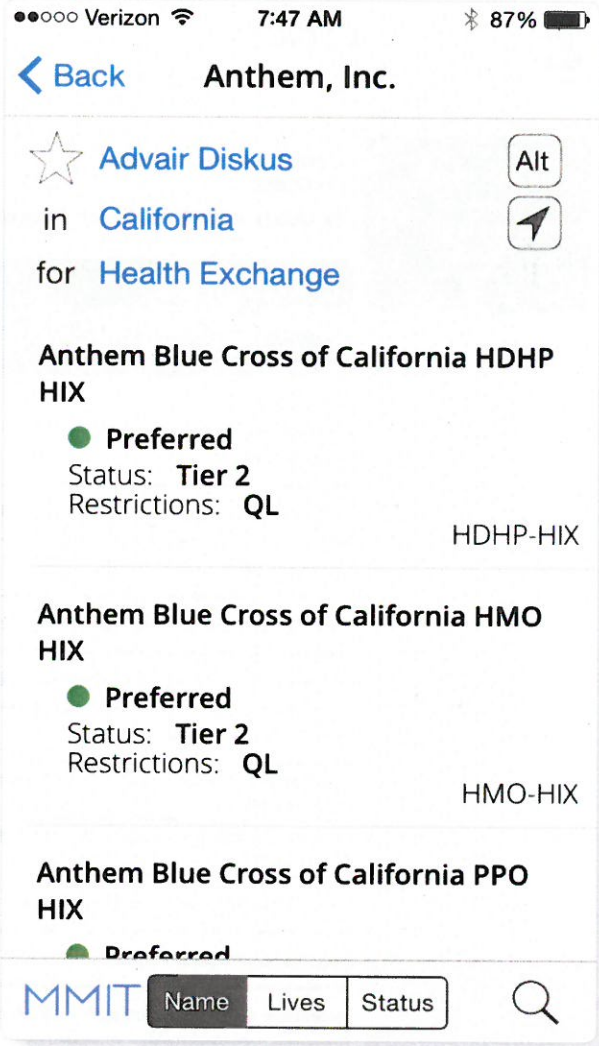
- Coverage Basics
- Coverage Levels
- Essential Health Benefits
- Prescription Drugs
- Covered California Health Plans
- The Application Process
- Health Care Costs and Getting Help Paying for Coverage
- COBRA vs. Exchange Coverage
- Consumer Protection
- Special Enrollment
- The Tax Penalty for Remaining Uninsured
- Medi-Cal for Low-Income Individuals and Families

Medicare Plan Finder (www.medicare.gov)

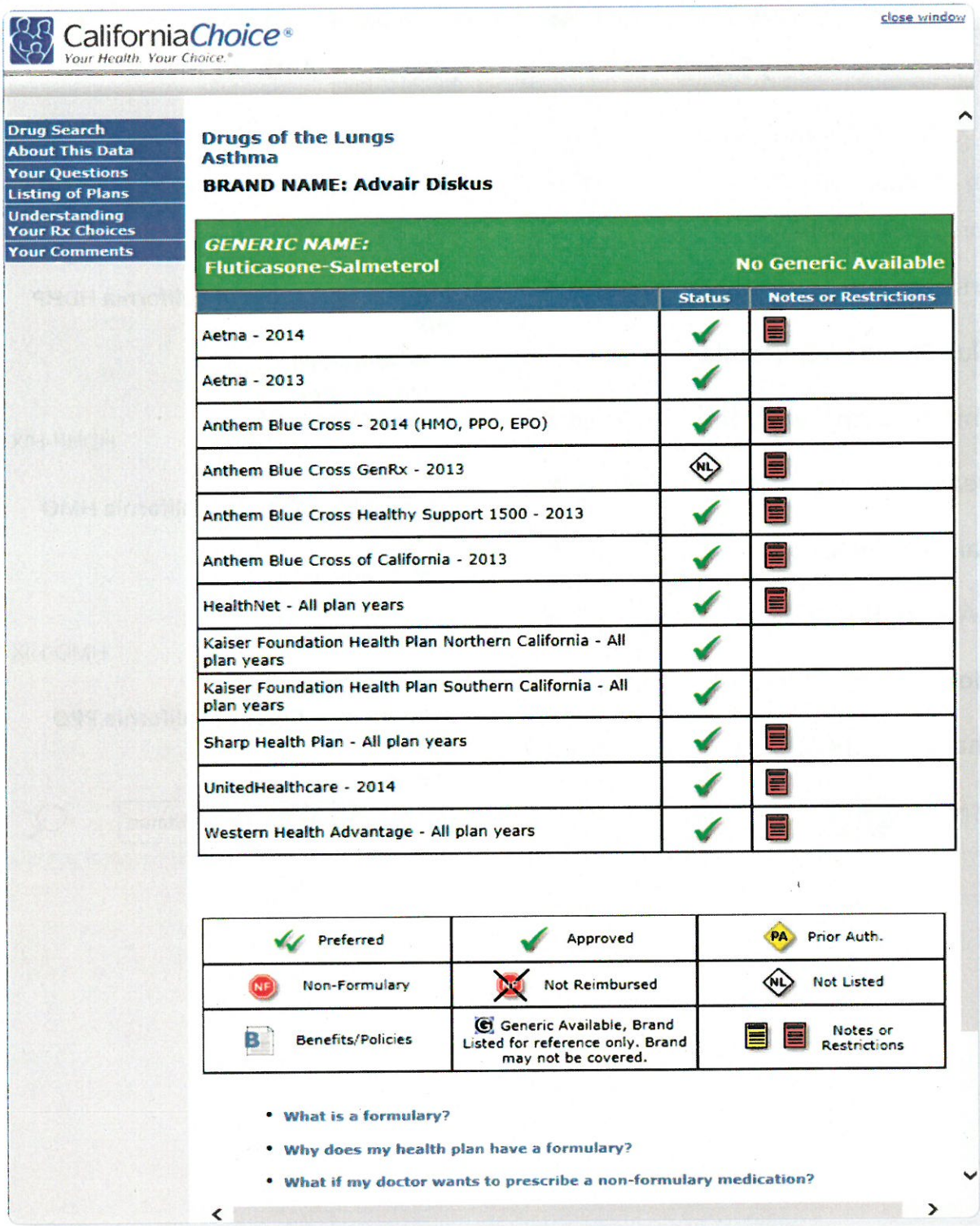


Mobile App: MMIT





California Choice Online Tool – Powered by MMIT (www.calchoice.com)



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close window

Drug Search
About This Data
Your Questions
Listing of Plans
Understanding Your Rx Choices
Your Comments

Drugs of the Lungs
Asthma
BRAND NAME: Advair Diskus

GENERIC NAME: Fluticasone-Salmeterol	No Generic Available	
	Status	Notes or Restrictions
Aetna - 2014	✓	
Aetna - 2013	✓	
Anthem Blue Cross - 2014 (HMO, PPO, EPO)	✓	
Anthem Blue Cross GenRx - 2013	NL	
Anthem Blue Cross Healthy Support 1500 - 2013	✓	
Anthem Blue Cross of California - 2013	✓	
HealthNet - All plan years	✓	
Kaiser Foundation Health Plan Northern California - All plan years	✓	
Kaiser Foundation Health Plan Southern California - All plan years	✓	
Sharp Health Plan - All plan years	✓	
UnitedHealthcare - 2014	✓	
Western Health Advantage - All plan years	✓	

✓✓ Preferred	✓ Approved	PA Prior Auth.
NF Non-Formulary	NR Not Reimbursed	NL Not Listed
B Benefits/Policies	G Generic Available, Brand Listed for reference only. Brand may not be covered.	Notes or Restrictions

- What is a formulary?
- Why does my health plan have a formulary?
- What if my doctor wants to prescribe a non-formulary medication?

Appendix C. Consolidated Prescription Drug Costs Table

Table 3. Standard Cost Sharing Levels for Individual Coverage Products, Covered California, 2015

	① Prescription Drug Cost Sharing					Plan Features Which May Apply		
Metal/Product	**Generic**	**Preferred Brand**	**Non-Preferred Brand**	**Specialty Drugs**	**Brand Name Drug Deductible**	**Overall Deductible (Integrated Med/Rx)**	**Medical Deductible** ②	**OOP Max**
Platinum	$5	$15	$25	10%	$0	$0	$0	$4,000
Gold	$15	$50	$70	20%	$0	$0	$0	$6,250
Silver	$15	$50	$70	20%	$250	n/a	$2,000	$6,250
Enhanced Silver 94	$3	$5	$10	10%	$0	0	$0	$2,250
Enhanced Silver 87	$5	$15	$25	15%	$50	n/a	$500	$2,250
Enhanced Silver 73	$15	$35	$60	20%	$250	n/a	$1,600	$5,200
Bronze	$15	$50	$75	30%	n/a	$5,000	n/a	$6,250
Bronze H.S.A.	③ 40%	40%	40%	40%	n/a	$4,500	n/a	$6,250
Catastrophic	0%	0%	0%	0%	n/a	$6,600	n/a	$6,600

④ Deductible Must Be Met First
Deductible Amount Applicable to Drugs

Note: Eligibility for the enhanced silver plans is by income level (100-150% of FPL; 150-200% FPL; 200-250% FPL). Standard "copay" and "coinsurance" products available in each metal tier have identical cost sharing for the coverage items shown here (deductibles and drug cost sharing); therefore separate lines for each are not shown.

Sources: Office of Administrative Law, Approval of 2015 Standard Benefit Plan Designs, California Health Benefit Exchange. Covered California, Prescription Drugs http://www.coveredca.com/individuals-and-families/getting-covered/prescription-drugs/

① Avoid using "cost sharing"; find better term for title.

② Add a "mouse-over" feature to explain confusing terms or abbreviations.

③ Additional information needed (e.g., a cost range or estimate).

④ The shading is well-liked. Possibly use more intuitive colors, such as "stoplight" green, yellow, and red.

Appendix D. Criteria for Selection of Formularies as Best-in-Class Examples

Researchers identified two best-in-class formularies based on a set of criteria that was developed with the help of consulting firm Avalere Health, which has conducted extensive work on online formulary design. Researchers asked consumers to look at each formulary and provide feedback on this same set of criteria:

- Layout and use of space on the formulary page
- Tier explanations
- Presence of information on options when a drug is not listed on the formulary (exception procedures)
- Presence of utilization management detail (for example, when quantity limits exist, does the formulary say two tablets/day; or when step therapy is required, does the formulary specify which drug[s] must be tried first?)
- Placement of the legend (e.g., bottom of every page or at the beginning)
- Methods for distinguishing "at a glance" between generic and brand name drugs
- Comprehensiveness of the list
- Organizing principles (e.g., by class of drug or alphabetically)
- Availability of the document in other languages
- Ability to use the list to determine the tier placement of six "sample" drugs*

*Criterion used by researchers only, not study participants, to identify best-in-class formularies.

Appendix E. Selected Tools and Resources

The following online tools were identified by researchers between January and April 2015 as resources offering consumers information on prescription drug coverage, cost, or both.

Table 1. Formulary Search Tools

Formulary search tools provide the tier placement of a drug on an insurer's formulary; they are not (currently) integrated with cost-sharing information (such as copays) or sample prices (e.g., for a user that might need to compute coinsurance). These tools are useful because tier placement determines the cost sharing amount for the consumer. Selected tools are third-party, standalone.

	Formulary Search	Limited to Participating Plans	See Results for Multiple Health Insurers or Benefit Plans at Once	Tier Detail Available	Mobile App Available	Individual	Commercial	Medi-Cal	Medicare	Source or Sponsor	Limitations
CaliforniaChoice (CalChoice) – Rx Search	✔	✔	✔				✔			*CHOICE* Administrators program, part of The Word & Brown Companies (Rx formulary data powered by MMIT)	No tier information
Fingertip Formulary	✔			✔	✔	✔	✔	✔	✔	A Decision Resources Group Company	Long plan selection list
MMIT Formulary Lookup	✔		✔	✔	✔ (main public-facing tool)	✔	✔	✔	✔	Managed Markets Insight & Technology, LLC	Initial comparisons limited to preferred, covered, restricted categories; tier detail on drill-down

Table 2. Cost Estimators and Plan Selectors

Researchers examined cost estimator and plan selector tools that take the user's prescription drugs into account. These tools can help consumers factor in drug coverage and costs when shopping for health insurance.

	User Can Specify Drugs	Provides Rx Drug OOP $	Rx OOP Reflects Plan's Formulary	Provides Total Estimated OOP $ (Premium + OOP $)	Option to Filter Plan Results by Whether Drugs Are Covered	See Results for Different Local Pharmacies	Integrates Drug Cost with Insurance Coverage	Source or Sponsor	Limitations
Colorado Plan Finder	✔	Copays and coinsurance levels; not OOP $ for the year	✔		✔		✔	State of Colorado Health Exchange	Shows cost-sharing levels; not $ estimates for user-specified drugs
Medicare Plan Finder	✔	✔	✔	✔	✔	✔	✔	CMS	Medicare only
Putting Patients First	✔	✔		✔			✔ (but same formulary assumed for all coverage)	National Health Council	Cost estimator for Exchanges, not a plan selector
Stride Health (not fully tested by researchers)	✔	✔	✔	✔			✔	Startup	Emerging; evaluation in progress

Table 3. Price Checking Tools

Price checking tools provide drug store prices, including with discount coupons, for prescription drugs purchased without insurance. These sites can help users understand their up-front costs before deductibles are reached, and estimate coinsurance, for example, for specialty drugs.

	Retail Price	Discount Price	Discount Coupons Included	Prices Specific to Geographic Area and Store	Look Up Prices for a Class of Drugs	Check for Multiple Drugs at Once	Source or Sponsor	Limitations
Good Rx	✔	✔	✔	✔	✔ "Compare Similar Drugs" feature	✔ "My Best Pharmacy" feature	2011 Startup (founded by early Facebook employees, Scott Marlette and Doug Hirsch)	
WeRx		✔	✔	✔	✔		2011 Startup (Ali Khoshnevis; Amir Khoshnevis)	Line between crowdsourced and other-sourced data unclear
Health Care BlueBook	"Fair Price"	✔	✔	✔	✔		Founded 2007; owned by CareOperative, LLC; Rx Data from GoodRx	Available only for medications for 20 specific illnesses

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August 2015 | Issue Brief

How Many Employers Could be Affected by the Cadillac Plan Tax?

Gary Claxton, Larry Levitt

As fall approaches, we can expect to hear more about how employers are adapting their health plans for 2016 open enrollments. One topic likely to garner a good deal of attention is how the Affordable Care Act's high-cost plan tax (HCPT), sometimes called the "Cadillac plan" tax, is affecting employer decisions about their health benefits. The tax takes effect in 2018.

The potential of facing an HCPT assessment as soon as 2018 is encouraging employers to assess their current health benefits and consider cost reductions to avoid triggering the tax. Some employers announced that they made changes in 2014 in anticipation of the HCPT, and more are likely to do so as the implementation date gets closer. By making modifications now, employers can phase-in changes to avoid a bigger disruption later on. Some of the things that employers can do to reduce costs under the tax include:

- Increasing deductibles and other cost sharing;
- Eliminating covered services;
- Capping or eliminating tax-preferred savings accounts like Flexible Spending Accounts (FSAs), Health Savings Accounts (HSAs), or Health Reimbursement Arrangements (HRAs);
- Eliminating higher-cost health insurance options;
- Using less expensive (often narrower) provider networks; or
- Offering benefits through a private exchange (which can use all of these tools to cap the value of plan choices to stay under the thresholds).

For the most part these changes will result in employees paying for a greater share of their health care out-of-pocket.

In addition to raising revenue to fund the cost of coverage expansion under the ACA, the HCPT was intended to discourage employers from offering overly-generous benefit plans and help to contain health care spending. Health benefits offered through work are not taxed like other compensation, with the result that employees may receive tax benefits worth thousands of dollars if they get their health insurance at work. Economists have long argued that providing such tax benefits without a limit encourages employers to offer more generous benefit plans than they otherwise would because employees prefer to receive additional benefits (which are not taxed) in lieu of wages (which are). Employees with generous plans use more health care because they face fewer out-of-pocket costs, and that contributes to the growth in health care costs.

The HCPT taxes plans that exceed certain cost thresholds beginning in 2018. The 2018 thresholds are $10,200 for self-only (single) coverage and $27,500 for other than self-only coverage, and after that they generally increase annually with inflation. The amount of the tax is 40 percent of the difference between the total cost of health benefits for an employee in a year and the threshold amount for that year.

While the HCPT is often described as a tax on generous health insurance plans, it actually is calculated with respect to each employee based on the combination of health benefits received by that employee, and can be different for different employees at the same employer and even for different employees enrolled in the same health insurance plan. While final regulations have not yet been issued, the cost for each employee generally will include:

- The average cost for the health insurance plan (whether insured or self-funded);
- Employer contributions to an (HSA), Archer medical spending account or HRA;
- Contributions (including employee-elected payroll deductions and non-elective employer contributions) to an FSA;
- The value of coverage in certain on-site medical clinics; and
- The cost for certain limited-benefit plans if they are provided on a tax-preferred basis.

The inclusion of FSAs here is important. FSAs generally are structured to allow employees the opportunity to divert some of their pay to pretax health benefits, which means that they can avoid payroll and income taxes on money they expect to use for health care. Employees often are permitted to elect any amount of contribution up to a cap (which is $2,550 in 2015), which means that the amount of benefits for an employee subject to the HCPT in a year could vary depending on their FSA election.

The amount and structure of the HCPT provide a strong incentive for employers to avoid hitting the thresholds. The tax rate of 40 percent is high relative to the tax that many employees would pay if the benefits were merely taxed like other compensation, and the ACA does not allow the taxpayers (e.g., the employer) to deduct the tax as a cost of doing business, which can significantly increase the tax incidence for for-profit companies. Further, to avoid the perception that this was a new tax on employees, the HCPT was structured as a tax on the service providers of the health benefit plans providing benefits an employee: insurers in the case of insured health benefit plans; employers in the case of HSAs and Archer MSAs; and the person that administers the benefits, such as third party administrators, in the case of other health benefits. While it is generally expected that insurers and service providers will pass the cost of the tax back to the employer, doing so may not always be straightforward. Because there can be numerous service providers with respect to an employee, the excess amount must be allocated across providers. In some cases, it may not be possible to know whether or not the benefits provided to an employee will exceed the threshold amount until after the end of a year (for example, in the case of an experience-rated health insurance plan), which means that service providers may need to bill the employer retroactively for the cost of the tax they must pay. Amounts that employers provide to reimburse service providers for the HCPT create taxable income for the service provider, which the parties will want to account for in the transaction. The IRS has requested comments on potential methods for determining tax liability among benefit administrators, including a way that could assign the responsibility to the employer in cases other that insured benefit plans. The proposed approach could simplify administration of the tax.

How the High-Cost Plan Tax Works

Let's take an employer that, in 2018, offers employees an HSA-qualified health plan with a total annual premium of $7,800 ($650 monthly) for single coverage. The employer makes an annual contribution of $780 to HSAs established by its employees, and offers a FSA plan where employees can elect to contribute up to $2,700 (the estimated legal maximum) for the year through payroll deduction. Employee A enrolls in single coverage under the plan for all 12 months but does not elect to contribute to an FSA while employee B enrolls in single coverage under the plan for all 12 months and elects to make the maximum FSA contribution. For employee A, the monthly health benefit cost would be the sum of $650 for the health plan premium and $65 (one-twelfth of the annual HSA contribution by the employer), or $715. Because this is less than the monthly threshold amount for single coverage of $850 (one-twelfth of $10,200), no HCPT would be owed for employee A. For employee B, the monthly health benefit cost would be the sum of $650 for the health plan premium, $65 (one-twelfth of the annual HSA contribution by the employer) and $225 (one-twelfth of the annual FSA contribution), or $940. Because this is more than the monthly threshold amount for single coverage of $850, there would be a HCPT for employee B for the month equal to 40 percent of the health benefit cost in excess of the threshold. The excess amount in this case is $90 ($940 - $850), and 40 percent of the excess is $36. The annual HCPT owed for employee B would be $432.

To illustrate the impact of the HCPT, we created a simple model of future plan costs, based on the distribution of employer-sponsored plans from the 2015 Kaiser/HRET Employer Health Benefits Survey (EHBS), and estimated the share of employers with plans that could be expected to hit the HCPT threshold in 2018, 2023 and 2028 if plan premiums grew at a range of reasonable rates. The EHBS has information about plan premiums, and employer contributions to HSAs and HRAs, but generally does not ask about the details of other health benefits offered to employees. While we can identify which employers make an FSA option available to employees, we do not have information about permitted or actual contribution levels.

Our estimates focus on the self-only plan threshold because the EHBS asks about premiums for a family of four while the HCPT threshold for family coverage applies to any family enrollment (such as couple or single plus one) other than self-only. We assume that premiums and employer contributions to HSAs and HRAs would rise five percent annually, which is consistent with estimates of future health care cost increases. We also present tables showing how the results would change if premiums, HSA and HRA contributions were to grow annually at four and six percent. Employers in the EHBS provide information about their largest plan for up to four plan types (health maintenance organization, preferred provider organization, point of service plan, high deductible health plan combined with a savings option) and we assess the cost each plan option separately to determine if the cost would exceed the HCPT threshold. We do not have information that would allow us to make adjustments permitted by the ACA for plans with older workers, plans in certain industries, or multiemployer plans, which means we may be somewhat over-counting the percent of these firms reaching the threshold. Other limitations are discussed in the methods (see below).

Two sets of estimates are presented. The first is based on the premiums for health coverage plus employer contributions for HSAs and HRAs, while the second includes the effects of FSA plans as well to illustrate how

FSA elections impact the number of plans affected. We assume that employees offered an FSA option are permitted to elect contributions up to the maximum allowed by law, and that some employees do so.

The purpose here is to look at the share of current plans that might meet the definition of "high cost" over time, assuming modest premium growth and no changes to the plan. We do not attempt to estimate the share of employer plans that will actually be assessed under the HCPT, as we believe its high tax rate and potentially complicated structure will encourage most employers to make plan adjustments to avoid the tax for as long as they can. These estimates can be understood as the share of employers who have plans where the cost for some employees will exceed the thresholds for the HCPT, presenting employers with a choice of whether to pay the tax or (more likely) restructure their benefits to avoid it.

Estimates

Looking first at the expected costs for just plan premiums plus employer contribution to HSAs and HRAs, we estimate that about 16 percent of employers offering health benefits would have at least one health plan that would exceed the $10,200 HCPT self-only threshold in 2018, the first year that plans are subject to the tax (Table 1). The percentage would increase to 22 percent in 2023 and to 36 percent in 2028.

Table 1: Share of Employers with At Least One Plan Hitting Threshold

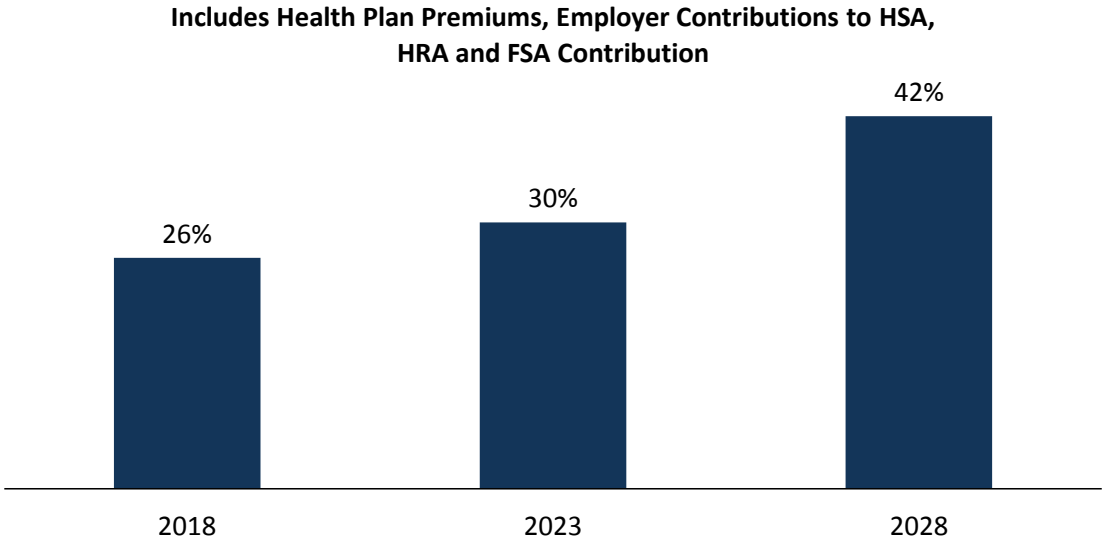
Year	HCPT Self-Only Threshold	Premium, HSA, HRA	Premium, HSA, HRA & FSA
2018	$10,200	16%	26%
2023	$11,800	22%	30%
2028	$13,500	36%	42%

Source: Kaiser Family Foundation analysis

These percentages rise significantly when we consider the impact that FSA options can have: up to 26 percent in 2018, 30 percent in 2023 and 42 percent in 2028 (Figure 1).

Figure 1

Percent of Employers Offering Health Benefits with Plans that Would Exceed HCPT Threshold With 5% Premium Growth



SOURCE: Kaiser Family Foundation analysis

This should not be surprising since the maximum FSA contribution levels (estimated to be $2,700 in 2018, $3,100 in 2023 and $3,600 in 2028) are quite large and generally are additive to other benefit costs for employees that elect to contributions. As we noted above, not all employees offered an FSA option will make the maximum contribution, and some will make no contribution, which means that the threshold will be reached for some employees and not for others with the same plan choices. For example, consider two employees offered a PPO with a premium of $9,000 in 2018 and an FSA option that permits a payroll deduction of up to $2,700. If one employee elects not to contribute to the FSA, the threshold is not met for that employee and no tax is owed. If the other employee contributes the full amount, the threshold is hit and a 40 percent tax is assessed on the excess ($1,500) allocated between the administrators or the PPO and the FSA (if they are different). For the percentages above, we count a plan as exceeding the threshold if an employee who elected the maximum FSA contribution would cause the plan to exceed the threshold for that employee. Because large firms (200 or more workers) are much more likely than smaller firms to offer an FSA, large firms are much more likely to have a plan that exceeds the HCPT threshold when FSA contributions are considered (Table 2).

Table 2: Share of Employers with At Least One Plan Hitting Threshold By Firm Size

Year	HCPT Self-Only Threshold	Premium, HSA, HRA & FSA	
		Small Firms (3-199 workers)	Large Firms (200 or more workers)
2018	$10,200	25%	46%
2023	$11,800	29%	56%
2028	$13,500	41%	68%

Source: Kaiser Family Foundation analysis

The assumed rate of premium growth also has a large impact on these estimates, particularly in the later years (Table 3). The HCPT thresholds increase with inflation, so what matters over the longer run is the difference between the growth in benefit costs and inflation. With our inflation assumption of 2.7 percent annually between 2018 and 2028, a four percent annual growth in health plan costs would reduce the 2028 percentage to 29 percent when FSA offers are considered, while a six percent annual growth in premiums would increase the percentage to 54 percent. This wide range shows how sensitive the effects of the tax are to premium growth in excess of inflation, and how those effects compound over time.

Table 3: Share of Employers with At Least One Plan Hitting Threshold, Different Premium Growth Assumption

Year	HCPT Self-Only Threshold	Premium, HSA, HRA & FSA		
		4% Premium Growth	5% Premium Growth	6% Premium Growth
2018	$10,200	24%	26%	27%
2023	$11,800	26%	30%	38%
2028	$13,500	29%	42%	54%

Source: Kaiser Family Foundation analysis

Discussion

Our estimates suggest that a meaningful percentage of employers would need to make changes in their health benefits to avoid the HCPT in 2018, and that this percentage grows significantly over time unless employers are able to keep heath plan cost increases at low levels. In fact, 19 percent of employers already in 2015 have a plan that would exceed the HCPT threshold when FSA offers are considered; these firms would need to reduce their current plan costs over the next several years to avoid the tax. We estimate that by 2028, 42% of employers would have plans where costs would exceed the threshold for some or all employees. To the extent that health plan premiums continue to grow faster than inflation – a likely scenario – the share of employers affected by the HCPT will grow and eventually reach 100 percent. To avoid the tax, an employer would have to keep plan costs below the threshold and contain growth in costs over time to no more than inflation.

In addition to raising revenue to fund the expansion of coverage under the ACA, the HCPT provides powerful incentives to control health plans costs over time, whether through efficiency gains or shifts in costs to workers in the form of higher deductibles and other patient cost-sharing.

The design of the HCPT also has several implications for how employers structure and administer their health benefits, including:

The potential complexity of the tax may cause employers to simplify their health benefit offerings. The tax is calculated on total costs for an employee across health benefit programs but assessed separately against coverage providers. For employers that use multiple providers for health benefits, the employer and service providers may not know until the end of the year whether or not they owe a tax or how much it may be. The potential complications associated with allocating the tax burden and managing reimbursements to insurers (and potentially other services providers) may encourage employers to simplify their benefit arrangements and reduce the number of options that employees have and the number of coverage

providers involved. The IRS is considering an option where the employer could be considered the benefit provider (and therefore the party that owes the tax) for most benefit arrangements, including self-funded health plans, although this would not be possible where there is an insured health plan (where the tax is assessed against the health insurer).

The HCPT threshold may be passed for some employees of an employer but not for others if employees are able to choose different amounts of benefits. This may make employers reluctant to give employees the ability to select benefit options that have the potential to trigger the tax. One current benefit that may be at particular risk is the option to contribute to an FSA because, as currently structured, it allows employees to add up to several thousand dollars to their benefit costs. These plans are separate from the core health insurance options provided by employers, so limiting or eliminating them provides a way for employers to lower costs without affecting the plans that most employees rely upon and value the most. Employers also may consider reducing other ancillary health benefit options (e.g., critical disease or hospital indemnity plans) offered on a pre-tax basis if the cost of the core health insurance plans approach the HCPT thresholds.

The significant tax rate, which would likely be borne by the employer (either directly or through reimbursing tax paid by coverage providers), may cause employers to limit employee choice generally and even among core health insurance offerings. Discussions about employee health benefits often focus on giving employees choices and sometimes focus on making employees aware of costs by having them pay all of the additional costs if they select more expensive plans. Under the HCPT, a significant additional cost for plans that exceed the threshold is borne in the first instance by the employer, who may be reluctant to permit employees to elect these plans if it can be avoided. Employers could structure the employee contributions for plans above the threshold so that they include a surcharge, which would pass the tax incidence on to the employees who selected the plans. Doing so would require knowing before the beginning of the year if, and (perhaps roughly) by how much, the options selected by an employee would exceed the threshold. This approach would be possible for an employer sponsoring multiple plan options on its own or offering insured health benefits through a private exchange (where the insurers could collect the additional contribution).

Employers considering this design would need to assess whether, and which, employees would be willing to pay a high surcharge to elect these more expensive benefit options. Plan choice generally results in employees that are less healthy selecting more comprehensive benefit options, and putting a surcharge on these options would increase the adverse selection against these plans, increasing their costs. If the additional contribution for an employee was small (for instance, the excess cost above the threshold is modest), enrollment may not fall too much, but if the additional contribution was large, or grew larger over time, enrollment in the more expensive options would likely shrink and skew less and less healthy. This could affect the viability of these plan options.

We expect employers to make modifications to their health benefit plans over the next several years to avoid or delay hitting the threshold for the HCPT. While some will need to move more quickly than others, the tax will be an important contrast for a large share of employers within the next decade.

METHODS

We used information about the premiums for employer-sponsored health insurance from the 2015 Kaiser/HRET Employer Health Benefits Survey (EHBS) to estimate the percentage of employers that would have at least one health plan that would be subject to the High Cost Plan Tax (HCPT) assuming certain future rates of premium growth. The EHBS is an annual survey that collects information about health benefits offered by about 2,000 employers with three or more employees.

The EHBS collects information from responding employers about their largest plan for up to four plan types -- health maintenance organization (HMO), preferred provider organization (PPO), point of service plan (POS), and high deductible health plan offered with a savings account (HDHP/SO). An HDHP/SO is a plan with a single deductible of $1,000 or more offered with a health reimbursement arrangement (HRA), or a health plan that qualifies the employee to make contributions to a Health Saving Account (HSA). The EHBS asks respondents for the premium for single coverage and for a family of four for their largest plan in each plan type. For HDHP/SOs, the amounts that employers contribute to employees' HSAs or make available to employees through HRAs are also collected. Periodically, including in 2015, the EHBS asks about whether or not the employer sponsors a flexible spending account (FSA) but does not obtain information about participation or the amounts contributed.

For the estimates, we took the single premium for each health plan offered by responding employers and increased them by five percent annually. We also looked at alternate scenarios with a four percent and a six percent increase. For HSA qualified plans we added the amount that employers contribute to employees' HSAs to the premium. For high deductible health plans offer with an HRA, the survey collects information about the amounts employers make available to employees but not the amounts that are actually contributed. To be conservative, we added one-half of the amount that employers make available through the HRA to the plan premium. The HSA and HRA amounts were also increased by the percentages above. A five percent annual growth rate is roughly consistent with the historic trend for these contributions. For employers that reported offering an FSA, we added the maximum contribution amount permitted for an FSA to the estimated premium for each plan type except HSA qualified plans for each of the three years. We did not add the FSA amount to the premium for HSA qualified plans because generally a person cannot establish an HSA if they have an FSA that could reimburse expenses before the plan deductible is met. We used the maximum contribution amount because we were looking to see if the cost for the plan could exceed the threshold for an employee. The total costs for each plan for 2018, 2023 and 2028 were compared to the estimated HCPT thresholds to determine if any plan offered by an employer would hit the threshold.

To calculate the HCPT thresholds, we assumed that inflation increase annually by 2.7 percent between 2018 and 2028. This is consistent with the assumptions used in the 2015 Medicare Trustees Report. We also used the Trustee's assumed annual inflation from 2015 to 2028 to calculate the maximum FSA contribution amounts.

THE HENRY J. KAISER FAMILY FOUNDATION

Topline

Kaiser Health Tracking Poll: August 2015

August 2015

METHODOLOGY

This *Kaiser Health Tracking Poll* was designed and analyzed by public opinion researchers at the Kaiser Family Foundation (KFF). The survey was conducted August 6-11, 2015, among a nationally representative random digit dial telephone sample of 1,200 adults ages 18 and older, living in the United States, including Alaska and Hawaii (note: persons without a telephone could not be included in the random selection process). Computer-assisted telephone interviews conducted by landline (480) and cell phone (720, including 419 who had no landline telephone) were carried out in English and Spanish by Princeton Data Source under the direction of Princeton Survey Research Associates International (PSRAI). Both the random digit dial landline and cell phone samples were provided by Survey Sampling International, LLC. For the landline sample, respondents were selected by asking for the youngest adult male or female currently at home based on a random rotation. If no one of that gender was available, interviewers asked to speak with the youngest adult of the opposite gender. For the cell phone sample, interviews were conducted with the adult who answered the phone. KFF paid for all costs associated with the survey.

The combined landline and cell phone sample was weighted to balance the sample demographics to match estimates for the national population using data from the Census Bureau's 2013 American Community Survey (ACS) on sex, age, education, race, Hispanic origin, nativity (for Hispanics only), and region along with data from the 2010 Census on population density. The sample was also weighted to match current patterns of telephone use using data from the July-December 2014 National Health Interview Survey. The weight takes into account the fact that respondents with both a landline and cell phone have a higher probability of selection in the combined sample and also adjusts for the household size for the landline sample. All statistical tests of significance account for the effect of weighting.

The margin of sampling error including the design effect for the full sample is plus or minus 3 percentage points. Numbers of respondents and margins of sampling error for key subgroups are shown in the table below. For results based on other subgroups, the margin of sampling error may be higher. Sample sizes and margins of sampling error for other subgroups are available by request. Note that sampling error is only one of many potential sources of error in this or any other public opinion poll. Kaiser Family Foundation public opinion and survey research is a charter member of the Transparency Initiative of the American Association for Public Opinion Research.

Group	N (unweighted)	M.O.S.E.
Total	1,200	±3 percentage points
Party Identification		
Democrats	362	±6 percentage points
Republicans	326	±6 percentage points
Independents	359	±6 percentage points
Opinion of ACA		
Favorable	525	±5 percentage points
Unfavorable	525	±5 percentage points
Prescription Drug Use		
Currently taking prescription medicine	743	±4 percentage points
Not currently taking prescription medicine	453	±5 percentage points
Half Samples		
Half Sample A	576	±5 percentage points
Half Sample B	624	±5 percentage points

All trends shown in this document come from Kaiser Health Tracking Polls except:

01/11: Kaiser Family Foundation/Harvard School of Public Health *The Public's Health Care Agenda for the 112th Congress* (January 4-14, 2011)

03/08: Kaiser Family Foundation/USA Today/Harvard School of Public Health *The Public on Prescription Drugs and Pharmaceutical Companies* (January 3-23, 2008)

1. As you may know, a health reform bill was signed into law in 2010. Given what you know about the health reform law, do you have a generally (favorable) or generally (unfavorable) opinion of it? [GET ANSWER THEN ASK: Is that a very (favorable/unfavorable) or somewhat (favorable/unfavorable) opinion?] [INTERVIEWER NOTE: If respondent asks if the health reform law refers to the Affordable Care Act or Obamacare, please answer "yes"] (ROTATE OPTIONS IN PARENTHESES)

	Very favorable	Somewhat favorable	Somewhat unfavorable	Very unfavorable	Don't know/ Refused
08/15	23	21	16	25	14
06/29/15	23	20	13	27	17
06/09/15	19	20	16	26	19
04/15	22	21	15	27	14
03/15	22	19	15	28	16
01/15	19	21	16	30	15
12/14	18	23	16	30	14
11/14	18	19	16	30	18
10/14	16	20	16	27	20
09/14	15	20	15	32	19
07/14	15	22	18	35	11
06/14	19	20	15	30	16
05/14	19	19	12	33	17
04/14	19	19	16	30	16
03/14	18	20	14	32	15
02/14	16	19	14	33	18
01/14	17	17	15	35	16
12/13	17	17	12	36	18
11/13	15	18	13	36	18
10/13	21	17	13	31	18
09/13	20	19	13	30	17
08/13	17	20	14	28	20
06/13	15	20	13	30	23
04/13	16	19	12	28	24
03/13	17	20	13	27	23
02/13	18	18	13	29	23
11/12	19	24	12	27	19
10/12	20	18	14	29	19
09/12	25	20	12	28	14
08/12	21	17	13	30	19
07/12	20	18	13	31	17
06/12	25	16	11	30	18
05/12	17	20	12	32	19
04/12	20	22	9	34	15
03/12	18	23	11	29	19
02/12	17	25	16	27	15
01/12	18	19	14	30	19
12/11[1]	19	22	15	28	17
11/11	17	20	15	29	19
10/11	12	22	20	31	15
09/11	18	23	14	29	16
08/11	16	23	17	27	17
07/11	20	22	12	31	15
06/11	15	27	16	30	12
05/11	19	23	15	29	14
04/11	20	21	14	27	18
03/11	21	21	15	31	13
02/11	16	27	19	29	8
01/11	19	22	16	34	9
12/10	22	20	14	27	18
11/10	19	23	12	28	18
10/10	18	24	15	29	15
09/10	19	30	15	25	11

[1] May 2010 through December 2011 trend wording was "As you may know, a health reform bill was signed into law early last year…"

Q.1 continued

	Very favorable	Somewhat favorable	Somewhat unfavorable	Very unfavorable	Don't know/ Refused
08/10	19	24	13	32	12
07/10	21	29	10	25	14
06/10	20	28	16	25	10
05/10	14	27	12	32	14
04/10[2]	23	23	10	30	14

2. Do you think the news media covers the health care law (too much), (too little) or about the right amount? (ROTATE VERBIAGE IN PARENS)

	08/15
Too much	16
Too little	37
About the right amount	37
Don't know/Refused	9

3. What would you like to see Congress do when it comes to the health care law? (READ AND ROTATE 1-4; 4-1)

	08/15	06/29/15	06/09/15	04/15	03/15	01/15	12/14	11/14
Expand what the law does	28	25	24	24	23	23	24	22
Move forward with implementing the law as it is	22	22	19	22	23	19	21	20
Scale back what the law does	12	12	12	12	10	14	12	17
Repeal the entire law	28	27	29	29	30	32	31	29
None of these/Something else (VOL.)	4	5	7	5	7	5	4	5
Don't know/Refused (VOL.)	5	7	10	8	7	7	7	8

4. Do you think Congress should (repeal the law and replace it with a Republican-sponsored alternative) or should they (repeal the law and not replace it)?

Based on those who say Congress should repeal the health care law (n=364)

	08/15
Repeal the law and replace it with a Republican-sponsored alternative	44
Repeal the law and not replace it	40
None of these/Something else (VOL.)	12
Don't know/Refused	4

Summary Q3 and Q4 based on total

	08/15
Repeal the entire law	28
Repeal and replace with a Republican-sponsored alternative	12
Repeal and not replace	11
None/Something else (VOL.)	3
Don't know/Refused	1
Expand what the law does	28
Move forward with implementing the law as it is	22
Scale back what the law does	12
None/Something else (VOL.)	4
Don't know/Refused (VOL.)	5

[2] April 2010 trend wording was "[President Obama did sign a health reform bill into law last month…] Given what you know about the new health reform law, do you have a generally (favorable) or generally (unfavorable) opinion of it? (Is that a very favorable/unfavorable or somewhat favorable/unfavorable opinion?)"

5. What if you heard that about 19 million people would become uninsured if the health care law is repealed? Would you still favor repealing the health care law, or not?

Based on those who say Congress should repeal the health care law (n=364)

	08/15
Still favor repealing	80
No longer favor repealing	12
Don't know/Refused	8

Summary of Q3 and Q5 based on total

	08/15
Repeal the entire law	28
Still favor repealing	23
No longer favor repealing	3
Don't know/Refused	2
Expand what the law does	28
Move forward with implementing the law as it is	22
Scale back what the law does	12
None/Something else (VOL.)	4
Don't know/Refused	5

6. As far as you know, do the Republicans in Congress have an agreed-upon alternative to the health care law, or not?

	08/15	01/15	05/14	03/11[3]
Yes, Republicans have an agreed-upon alternative	12	14	13	13
No, they don't	70	63	61	60
Don't know/Refused	18	23	26	26

7. Thinking about how the issue of the 2010 health care law might affect your vote for president: (READ LIST. ROTATE 1-3, 3-1. ENTER ONE ONLY)

	08/15	02/12
Would you only vote for a candidate who shares your views on the health care law	22	25
Would you consider a candidate's position on the health care law as just one of many important factors	58	58
Do you not see the health care law as a major factor in your vote	15	14
Don't know/Refused	5	4

[3] Trend wording was "As far as you know, do the Republicans in Congress have an agreed-upon alternative to the health care reform law that was passed last year, or not?"

READ TO ALL: On another topic…

8. I am going to read you a list of companies and groups. For each one please tell me if you have a favorable or an unfavorable opinion of each. How about (INSERT AND RANDOMIZE)? Do you have a favorable or an unfavorable opinion? (GET ANSWER THEN ASK: Is that very or somewhat?)

Items a, b, f based on Form A half sample
Items c, d, e based on Form B half sample
Item g based on total

		Very favorable	Somewhat favorable	Somewhat unfavorable	Very unfavorable	Don't know/ refused
a. Oil companies						
	08/15 (n=576)	13	27	25	27	8
	03/08 (n=846)	9	20	17	46	8
b. Food manufacturers						
	08/15 (n=576)	18	40	22	12	8
	03/08 (n=846)	24	47	12	8	8
c. Airlines						
	08/15 (n=624)	18	37	21	13	11
	03/08 (n=849)	21	40	15	8	15
d. Banks						
	08/15 (n=624)	17	41	20	18	3
	03/08 (n=849)	27	42	16	7	7
e. Health insurance companies						
	08/15 (n=624)	14	30	25	26	5
	03/08 (n=849)	13	27	25	29	6
f. Doctors						
	08/15 (n=576)	43	35	11	7	5
	03/08 (n=846)	44	37	8	7	4
g. Pharmaceutical or drug companies						
	08/15 (n=1200)	12	30	23	30	5
	03/08 (n=1695)	15	32	21	23	8

9. In general, do you think the cost of prescription drugs is reasonable or unreasonable?

	08/15	06/09/15	03/08
Reasonable	24	22	18
Unreasonable	72	73	79
Don't Know/ Refused	4	5	2

10. Which of the following do you think would do a better job at keeping prescription drug costs down... (READ AND ROTATE)?

	08/15	06/03[4]
Regulation by the federal government (or)	40	46
Competition in the marketplace	51	44
Both (VOL.)	4	4
Neither (VOL.)	2	1
Don't know/Refused	3	5

[4] Trend wording was "Which of the following do you think would do a better job at keeping health care costs down?"

11. I'm going to read actions some say would help keep prescription drug costs down. Please tell me whether you would favor or oppose each one. (First/Next), would you favor or oppose (INSERT AND RANDOMIZE)? GET ANSWER THEN ASK: Is that strongly or just somewhat? (ENTER ONE ONLY)

Based on Form A half sample (n=576)

	Strongly favor	Somewhat favor	Somewhat oppose	Strongly oppose	Don't know/ Refused
a. Allowing the federal government to negotiate with drug companies to get a lower price on medications for people on Medicare	55	28	7	8	2
b. Allowing Americans to buy prescription drugs imported from Canada	44	28	11	12	6
c. Requiring drug companies to release information to the public on how they set their drug prices	69	17	7	6	2
d. Limiting the amount drug companies can charge for high-cost drugs for illnesses like hepatitis or cancer	55	21	8	13	3
e. Encouraging people to buy lower cost drugs by requiring them to pay a higher share if they choose a similar, higher cost drug	18	30	19	20	13

12. I'm going to read actions some say would help keep prescription drug costs down. Please tell me how effective you think each one would be in keeping prescription drug costs down. (First/Next), do you think (INSERT AND RANDOMIZE) would be very effective, somewhat effective, not too effective or not at all effective? [IF NECESSARY: in keeping prescription drug costs down] (ENTER ONLY ONE)

Based on Form B half sample (n=624)

	Very effective	Somewhat effective	Not too effective	Not at all effective	Don't know/ Refused
a. Allowing the federal government to negotiate with drug companies to get a lower price on medications for people on Medicare	37	35	12	15	2
b. Allowing Americans to buy prescription drugs imported from Canada	33	41	10	12	3
c. Requiring drug companies to release information to the public on how they set their drug prices	46	35	7	10	2
d. Limiting the amount drug companies can charge for high-cost drugs for illnesses like hepatitis or cancer	47	30	9	11	2
e. Encouraging people to buy lower cost drugs by requiring them to pay a higher share if they choose a similar, higher cost drug	16	41	20	19	5

13. Do you think prescription drugs developed over the past 20 years have generally made the lives of people in the US (better), (worse), or haven't they made much difference? (ROTATE VERBIAGE IN PARENS)

14. Would you say a lot (better/worse), or only a little (better/worse)?

Summary of Q13 and Q14 based on total

	08/15	03/08
Better	62	73
A lot better	42	52
A little better	19	19
Worse	15	10
A lot worse	11	7
A little worse	5	3
Haven't made much difference	19	14
Don't know/Refused	4	3

15. By researching and developing new drugs, do you think pharmaceutical companies are making more of a contribution to society than most other companies, less of a contribution, or about the same contribution?

	08/15	03/08
More of a contribution	22	26
Less of a contribution	17	14
About the same	57	56
Don't know/ Refused	4	4

16. In general, do you think people in this country pay higher or lower prices than people in Canada, Mexico, and Western Europe pay for the same prescription drug, or do you think they pay about the same amount?

	08/15	03/08
Pay higher prices	74	76
Pay lower prices	6	6
Pay about the same amount	12	10
Don't know/ Refused	7	8

17. In general, do you think pharmaceutical or drug companies make too much profit, not enough profit, or about the right amount of profit?

	08/15	03/08
Too much profit	73	74
Not enough profit	1	2
About the right amount of profit	21	22
Don't know/ Refused	5	2

18. Which statement comes closer to your own view? (READ AND ROTATE 1-2. ENTER ONE ONLY)

	08/15	03/08
Pharmaceutical companies are too concerned about making profits, and not concerned enough about helping people (or)	74	70
The balance of concern at pharmaceutical companies between making profits and helping people is about right	23	28
Don't know/ Refused	3	2

19. Have you heard of any programs by pharmaceutical companies that allow people who can't afford needed medications to apply for free or discounted drugs, or not?

	08/15	03/08
Yes, have heard	54	58
No, have not heard	45	42
Don't know/ Refused	1	1

20. Do you think these programs go far enough or not far enough to help people who can't afford medications they need?

Based on those who have heard of programs

	08/15	03/08
Far enough	27	23
Not far enough	61	65
Don't know/ Refused	12	12
	(n=720)	(n=1069)

Summary of Q19 and Q20 based on total

	08/15	03/08
Yes, have heard	54	58
Think programs go far enough	15	13
Programs don't go far enough	33	37
Don't know/Refused	6	7
No, have not heard	45	42
Don't know/ Refused	1	1

READ TO ALL: On another topic…

21. Next, please tell me how closely you have followed these stories that have been in the news recently. (First/Next,) (INSERT--READ AND RANDOMIZE). READ FOR FIRST ITEM THEN AS NECESSARY: Did you follow this story very closely, fairly closely, not too closely, or not at all closely?

		Very closely	Fairly closely	Not too closely	Not at all closely	Don't know/ Refused
a. Controversy about Planned Parenthood	08/15	27	30	19	24	1
b. The merger between health insurance companies Anthem and Cigna	08/15	7	15	22	55	*
c. FDA approval of an expensive new cholesterol-lowering drug	08/15	6	12	21	62	*
d. Profits made by insurance companies	08/15	9	21	27	43	*
e. The 2016 presidential campaigns	08/15	33	36	17	13	1
	06/29/15	22	32	22	22	1
	06/09/15	25	31	18	26	1
f. Release of Medicare's annual financial report	08/15	6	14	26	55	*
g. The recent agreement on Iran's nuclear program between Iran, the United States and other nations	08/15	28	35	19	18	1
h. Four Marines killed in a shooting in Chattanooga, Tennessee	08/15	31	35	18	15	1
i. The death of an African American woman, Sandra Bland, in a Texas jail	08/15	23	31	19	26	1

READ TO ALL: Now I'm going to ask you a few questions about the neighborhood you live in…

22. Would you say your neighborhood does or does not have enough (INSERT AND RANDOMIZE)? How about (NEXT ITEM)? [IF NECESSARY: Would you say your neighborhood does or does not have enough (ITEM)?]

	Enough	Not Enough	Too much/ too many (VOL.)	Don't know/ Refused
a. Places where you can buy groceries including fresh produce	80	19	*	1
b. Restaurants	73	23	2	1
c. Places where children can play outside	67	31	--	1
d. Public transportation	51	46	*	3
e. Police presence	77	19	3	2

23. These days, how safe from crime do you feel in your neighborhood? Would you say you feel very safe from crime, somewhat safe, not too safe, or not safe at all? (ENTER ONE ONLY)

	08/15
Very safe from crime	54
Somewhat safe	36
Not too safe	7
Not safe at all	3
Don't know/ Refused	1

24. How much of the time do you think you can trust the police to do what is right for you or your community? Almost always, most of the time, only some of the time, OR almost never? (ENTER ONE ONLY)

	08/15
Almost always	40
Most of the time	34
Only some of the time	19
Almost never	7
Don't know/ Refused	1

READ: Finally, I have just a few questions we will use to describe the people who took part in our survey…

D5. What is your age? (RECORD EXACT AGE AS TWO-DIGIT CODE.)
D6. (ASK IF DON'T KNOW OR REFUSED AGE) Could you please tell me if you are between the ages of... (READ LIST)

	08/15
18-29	23
30-49	31
50-64	27
65 and older	19
Don't know/Refused	*

D4. Are you, yourself, now covered by any form of health insurance or health plan or do you not have health insurance at this time? (READ IF NECESSARY: A health plan would include any private insurance plan through your employer or a plan that you purchased yourself, as well as a government program like Medicare or [Medicaid/Medi-CAL])?

	08/15
Covered by health insurance	87
Not covered by health insurance	13
Don't know/Refused	*

D4a. Which of the following is your MAIN source of health insurance coverage? Is it a plan through your employer, a plan through your spouse's employer, a plan you purchased yourself either from an insurance company or a state or federal marketplace, are you covered by Medicare or (Medicaid/[INSERT STATE-SPECIFIC MEDICAID NAME]), or do you get your health insurance from somewhere else?

Based on those who are insured (n=1,078)

	08/15
Plan through your employer	35
Plan through your spouse's employer	12
Plan you purchased yourself	11
Medicare	21
Medicaid/[STATE-SPECIFIC MEDICAID NAME]	11
Somewhere else	2
Plan through your parents/mother/father (VOL.)	7
Don't know/Refused	1

25. Did you purchase your plan directly from an insurance company, from the marketplace known as healthcare.gov (or [INSERT STATE-SPECIFIC MARKETPLACE NAME]), or through an insurance agent or broker?

Based on those ages 18-64 who purchased own insurance plan (sample size insufficient to report)

Summary D4, D4a, Q25 based on those ages 18-64 (n=842)

	08/15
Covered by health insurance	85
Employer	35
Spouse's employer	12
Self-purchased plan	10
Directly from an insurance company	3
From healthcare.gov or [STATE MARKETPLACE NAME]	3
Through an insurance agent or broker	4
Somewhere else (VOL.)	*
Don't know/Refused	*
Medicare	6
Medicaid/State-specific Medicaid name	10
Somewhere else	2
Plan through parents/mother/father (VOL.)	7
Don't know/Refused	1
Not covered by health insurance	15
Don't know/Refused	*

26. Regardless of how you purchased your plan, do you know if it is a marketplace or [healthcare.gov/INSERT STATE SPECIFIC MARKETPLACE NAME] plan, is it NOT a marketplace or [healthcare.gov/INSERT STATE SPECIFIC MARKETPLACE NAME] plan, or are you not sure? (ENTER ONE ONLY)

Based on purchased own insurance plan except those who bought plan through marketplace (sample size insufficient to report)

Summary D4, D4a, Q25, and Q26 based on those ages 18-64 (n=842)

	07/15
Covered by health insurance	85
Employer	35
Spouse's employer	12
Self-purchased plan	10
Directly from insurance company/agent or broker/Other	7
Marketplace plan	1
Non-marketplace plan	2
Not sure/Refused	3
From healthcare.gov or [STATE MARKETPLACE NAME]	3
Medicare	6
Medicaid/State-specific Medicaid name	10
Somewhere else	2
Plan through parents/mother/father (VOL.)	7
Don't know/Refused	1
Not covered by health insurance	15
Don't know/Refused	*

27. Thinking about your own health care costs, which of the following do you find to be the greatest financial burden? Is it paying for: (READ LIST, ROTATE 1-4. THEN 5, READ 6 LAST.)

Based on those who are insured

	08/15	05/12	07/11
The deductible you pay before insurance kicks in	17	14	16
Your health insurance premiums	14	17	21
Your prescription drugs	11	--	--
Your doctor visits	7	--	--
Some other health care cost	3	5	4
Or is paying for health care and health insurance not a financial burden for you?	44	42	32
Co-pays for doctor visits and prescription drugs[5]	--	16	19
All equally (VOL.)	3	3	6
Don't know/Refused	1	3	2
	(n=1,078)	(n=1,013)	(n=1,025)

28. Do you currently take any prescription medicine or not?

	08/15	06/09/15	03/08
Yes, take	54	50	54
No, do not take	46	49	45
Don't Know/ Refused	*	*	*

[5] Trend results included an option for "Co-pays for doctor visits and prescription drugs".

29. How many different prescription drugs do you take?

Based on those who take Rx medicine

	08/15	03/08
1	23	28
2	22	20
3	16	16
4 or more	37	35
Don't Know/ Refused	2	1
	(n=743)	(n=1,029)

Summary of Q28 and Q29 based on total

	08/15	03/08
Take Rx medicine	54	54
1	13	15
2	12	11
3	8	9
4 or more	20	19
Don't take Rx medicine	46	45
Don't know/Refused	*	*

30. In general, how easy or difficult is it for you to afford to pay the cost of your prescription medicine? Very easy, somewhat easy, somewhat difficult, or very difficult?

Based on those who take Rx medicine

	08/15	06/09/15
Very easy	45	48
Somewhat easy	27	28
Somewhat difficult	16	12
Very difficult	8	9
Don't have to pay (VOL.)	3	3
Don't Know/ Refused	1	1
	(n=743)	(n=686)

Summary of Q28 and Q30 based on total

	08/15	06/09/15
Take Rx medicine	54	50
Very easy to afford cost	24	24
Somewhat easy to afford cost	15	14
Somewhat difficult to afford cost	9	6
Very difficult to afford cost	4	5
Don't have to pay (VOL.)	2	1
Don't know/Refused	*	*
Don't take Rx medicine	46	49
Don't know/Refused	*	*

31. In the past 12 months, have you or another family member living in your household… (READ AND RANDOMIZE) because of the COST, or not? INTERVIEWER NOTE: PLEASE READ "BECAUSE OF THE COST" AFTER EACH ITEM.

		Yes	No	Don't know/ Refused
a. Not filled a prescription for a medicine				
	08/15	21	79	1
	06/09/15	18	81	1
	05/12	24	75	1
	08/11	25	74	1
	03/11	21	78	*
	12/10	26	73	*
	06/10	20	79	1
	03/10	26	74	*
	12/09	24	76	*
	11/09	26	74	*
	09/09	26	73	*
	07/09	20	80	*
	06/09	26	74	1
	04/09	29	71	1
	02/09	21	78	*
	10/08	27	72	*
	04/08	22	78	*
	04/05	20	79	*
	01/00	13	87	*
b. Cut pills in half or skipped doses of medicine				
	08/15	14	86	1
	06/09/15	12	88	*
	05/12	16	83	*
	08/11	17	82	1
	03/11	15	85	*
	12/10	20	80	*
	06/10	16	84	1
	03/10	21	79	-
	12/09	18	81	1
	11/09	17	83	*
	09/09	21	78	1
	07/09	15	84	*
	06/09	19	80	1
	04/09	18	81	1
	02/09	15	85	*
	10/08	22	78	*
	04/08	18	81	*
	04/05	16	84	*

32. In most cases, do you think brand name prescription drugs are better, worse, or about the same in quality as generic prescription drugs?

	08/15	03/08
Better	15	13
Worse	2	2
About the same	79	81
Don't know/ Refused	4	3

33. In the last two years, have you asked for a generic drug when you were prescribed a brand-name, or not?

	08/15	03/08
Yes, have	44	54
No, have not	55	46
Don't know/ Refused	1	*

D1. Record respondent's sex

Male	50
Female	50

D2. In general, would you say your health is excellent, very good, good, only fair, or poor?

Excellent	23
Very good	33
Good	27
Only fair	13
Poor	4
Don't know/Refused	*

D2b. Are you currently married, living with a partner, widowed, divorced, separated, or have you never been married?

Married	48
Living with a partner	7
Widowed	8
Divorced	10
Separated	3
Never been married	24
Don't know/Refused	1

D3. What best describes your employment situation today? (READ IN ORDER)

Employed full-time	45
Employed part-time	11
Unemployed and currently seeking employment	5
Unemployed and not seeking employment	3
A student	6
Retired	17
On disability and can't work	7
Or, a homemaker or stay at home parent	5
Don't know/Refused (VOL.)	1

D8. In politics today, do you consider yourself a [ROTATE: Republican, Democrat/Democrat, Republican], an Independent, or what?

Republican	25
Democrat	30
Independent	30
Or what/Other/None/No preference/Other party	10
Don't know/Refused	4

D8a. Do you LEAN more towards the [ROTATE: Republican Party or the Democratic Party/Democratic Party or the Republican Party]? (ROTATE OPTIONS IN SAME ORDER AS D8)

Summary D8 and D8a based on total

Republican/Lean Republican	39
Democrat/Lean Democratic	46
Other/Don't lean/Don't know	15

Five-Point Party ID

Democrat	30
Independent Lean Democratic	15
Independent/Don't lean	14
Independent Lean Republican	14
Republican	25
Undesignated	1

D8b. Would you say your views in most political matters are liberal, moderate or conservative?

Liberal	25
Moderate	33
Conservative	37
Don't know/Refused	5

D9. Are you registered to vote at your present address, or not?

Yes	77
No	23
Don't know/Refused	*

D11. What is the highest level of school you have completed or the highest degree you have received? (DO NOT READ)

Less than high school (Grades 1-8 or no formal schooling)	3
High school incomplete (Grades 9-11 or Grade 12 with NO diploma)	4
High school graduate (Grade 12 with diploma or GED certificate)	32
Some college, no degree (includes some community college)	19
Two year associate degree from a college/university	11
Four year college or university degree/Bachelor's degree	16
Some postgraduate or professional schooling, no postgraduate degree	2
Postgraduate or professional degree, including master's, doctorate, medical or law degree	12
Don't know/Refused	*

D12. Are you, yourself, of Hispanic or Latino background, such as Mexican, Puerto Rican, Cuban, or some other Spanish background?

D13. What is your race? Are you white, black, Asian or some other race? (IF RESPONDENT SAYS HISPANIC ASK: Do you consider yourself a white Hispanic or a black Hispanic?)

White, non-Hispanic	65	
Total non-White	33	
Black or African-American, non-Hispanic		12
Hispanic		15
Asian, non-Hispanic		5
Other/Mixed race, non-Hispanic		2
Undesignated	2	

D12a. Were you born in the United States, on the island of Puerto Rico, or in another country?

Based on Hispanics (n=147)

U.S.	47
Puerto Rico	3
Another country	49
Don't know/Refused	2

D14. Last year—that is, in 2014—what was your total family income from all sources, before taxes? Just stop me when I get to the right category. (READ)

Less than $20,000	18
$20,000 to less than $30,000	14
$30,000 to less than $40,000	10
$40,000 to less than $50,000	9
$50,000 to less than $75,000	12
$75,000 to less than $90,000	8
$90,000 to less than $100,000	4
$100,000 or more	15
Don't know/Refused (VOL.)	10

END OF INTERVIEW: That's all the questions I have. Thanks for your time.

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This publication (#8768-T) is available on the
Kaiser Family Foundation website at www.kff.org.

Lessons from the Small Business Health Options Program

The SHOP Experience in California and Colorado

Leif Wellington Haase, David Chase, and Tim Gaudette

AUGUST 2015

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The COMMONWEALTH FUND

Lessons from the Small Business Health Options Program: The SHOP Experience in California and Colorado

Leif Wellington Haase, David Chase, and Tim Gaudette

AUGUST 2015

ABSTRACT

The Small Business Health Options Program (SHOP) got off to a slow start, with lower-than-expected enrollment and a public perception problem. This report examines California and Colorado's small-business marketplaces, which opened on schedule in October 2013. For business owners, employee choice was the most important reason cited for considering SHOP, with ease of administration a distant second. Several owners see SHOP as a viable alternative to the private exchanges now taking root among large and midsize employers. Interviews also revealed that business owners consider insurance brokers to be an important source of enrollment assistance. Those in the insurance and policy communities perceived small-business owners to be poorly informed about available tax credits; business owners disagreed, saying the credits were simply not key to their decision to elect SHOP. Potential growth areas for SHOP include developing alternative benefit designs, contracting with Medicaid plans, and offering ancillary products, such as wellness programs.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. To learn more about new publications when they become available, visit the Fund's website and register to receive email alerts. Commonwealth Fund pub. 1833.

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Tim Gaudette directs Small Business Majority's outreach and development efforts in Colorado, Nevada, and other western states. He works to build and maintain relationships with small-business owners, organizations, and foundations. Before joining Small Business Majority, Gaudette worked at a small firm in Denver, and his background includes significant finance and investment-related work in the regulatory, research, and sales areas in Denver, Washington, D.C., and Baltimore. He also served as chairman and board member for the all-volunteer board of the Denver Gay and Lesbian Chamber of Commerce. Gaudette is a member of the Denver Metro Chamber of Commerce Foundation's Leadership Denver Class of 2009. He has degrees from the College of William and Mary and the University of Exeter.

Editorial support was provided by Deborah Lorber and Chris Hollander.

EXECUTIVE SUMMARY

The Small Business Health Options Program (SHOP) was established by the Affordable Care Act to provide small firms in each state with greater access to a range of affordable health plans through new insurance exchanges, or marketplaces, and tax credits. The program is designed to allow businesses to pool their buying power and shed burdensome administrative tasks, while enabling owners and workers alike to easily compare coverage options. The program, however, got off to a slow start, and it has been plagued by lower-than-expected enrollment and a public perception problem.

Based on findings from interviews and surveys with business owners, policymakers, and other industry insiders, this report takes a close look at California and Colorado's SHOP exchanges, which both opened on schedule in October 2013.

Key Findings

In both states, the SHOP exchange took a back seat to the individual insurance marketplace in terms of staff time and resources. Colorado devoted more time and money than California did to outreach activities, both through its SHOP website and through community meetings, and for the most part its website for enrolling small groups functioned adequately from day one. California's SHOP portal, on the other hand, proved difficult to use and, in February 2014, was shut down after numerous agents and businesses complained they were unable to complete their applications. Responsibility for the SHOP enrollment process in California was ultimately turned over to a third-party administrator that was already handling sales operations.

Virtually everyone we interviewed agreed that SHOP's operational problems must be addressed to make the enrollment process more comparable to that for purchasing health plans outside the SHOP exchange. For their part, brokers and agents are wary that customers will use the SHOP websites to bypass their services, or that business will be driven through counselors and navigators. Despite these misgivings, however, brokers have signed up in droves to become certified to sell through the individual and SHOP exchanges.

Colorado paid more attention to the broker distribution channel from the start, setting up a call center with lines dedicated specifically to brokers. California chose instead to publicize the possibility that businesses could self-enroll in SHOP and, at least at the outset, kept brokers and agents at arm's length. In California and Colorado, agents are now prominently featured as trusted sources both on the SHOP websites and in statewide radio and television advertisements.

For business owners, employee choice was by far the most important reason for electing SHOP or considering doing so. Ease of administration was a distant second. Several owners interviewed saw SHOP as a viable alternative to the private exchanges that are now taking root among large and midsize employers.

According to those in the insurer and policy communities, small-business owners were not well informed about available tax credits, although our surveys of owners show nearly all were aware of the credits. Nevertheless, most business owners reported the tax credits were not key to their decision to elect SHOP.

Our research indicates that a future growth area for SHOP may be experimentation with alternative benefit designs and the inclusion of ancillary products with coverage. For instance, wellness programs and explicit human-resources assistance could conceivably be bundled with SHOP plans. In addition, SHOP could provide greater value for lower-income workers by contracting with Medicaid health plans, which otherwise are not available in the commercial market.

In the end, most insurers and agents are willing to take a wait-and-see approach toward SHOP's potential. Carriers, meanwhile, appear to be in it for the long haul: most of the same insurers renewed for the second year in both California and Colorado.

LESSONS FROM THE SMALL BUSINESS HEALTH OPTIONS PROGRAM: THE SHOP EXPERIENCE IN CALIFORNIA AND COLORADO

BACKGROUND

The Small Business Health Options Program (SHOP) got off to a slow and problem-filled start. SHOP marketplaces, which every state was required to establish under the Affordable Care Act (ACA), promised a wider choice of health insurance plans for employees than offered in existing small-group markets, as well as fewer administrative hassles and more competitive premiums. But even before the rocky launch of the HealthCare.gov website, several decisions took the wind out of SHOP's sails. In summer 2013, the Obama administration announced that small businesses could keep their non-ACA-compliant plans for an additional year. In spring 2014, the administration offered states the option to continue this transitional policy through October 2016.

Most health insurance brokers urged firms to take early renewal—that is, they encouraged them to renew coverage on existing terms before the typical 12-month expiration period—to avoid ACA-related changes, like modified community rating, which denies insurers the ability to use health status to set premiums, and new standardized health plan benefits. Industry sources suggest that some 70 percent to 80 percent of small businesses retained these so-called "grandmothered" plans. As a result, most small employers in a majority of states will not be purchasing plans that meet ACA standards until 2017. In California and Colorado—the two states that are the focus of this report—this will happen in late 2015.[1]

To the sharp disappointment of SHOP's proponents, the administration also suspended the employee-choice feature of SHOP, which would have allowed workers to choose among multiple insurers and insurance policies.[2] It allowed 18 states to suspend this requirement again for the 2014–15 plan year.

These decisions depressed enrollment and contributed to the public perception that SHOP was on life support. Both the trade and popular press ran stories with headlines such as "SHOP Flop" and "Are Obamacare's SHOP Exchanges Doomed?"[3] One senior staff member with Colorado's marketplace, Connect for Health Colorado, remarked that "negative national stories set the context for the exchange rollout and especially for SHOP."

While falling far short of the initially optimistic projections for enrollment, the SHOP marketplaces in California and Colorado have enrolled thousands of small businesses and workers.[4] As of February 2015, SHOP in California had 2,311 participating businesses and 15,671 employees enrolled. In Colorado, 1,860 employees from 220 small firms signed up by March 2014; by October 2014, 2,521 employees were enrolled.

In this report, we examine these two states to gain an early view of the implementation of the SHOP program. We interviewed more than 50 SHOP small-business owners, insurance executives, insurance brokers, consumer advocates, and policymakers and surveyed dozens of business owners in both states.

WHY SHOP IS PART OF THE AFFORDABLE CARE ACT

Small businesses are less likely to offer health care coverage than larger firms. Those that do offer coverage typically do not offer a choice of plans, nor do they typically offer the same kind of benefits as do larger employers. Before the passage of the Affordable Care Act, owners of small businesses had comparatively low rates of offering insurance coverage and, consequently, their employees had higher rates of being uninsured. Ninety-seven percent of all large companies with over 100 employees in the U.S. offered health insurance benefits to employees in 2011, while just 57 percent of small businesses with 50 or fewer workers did the same.[5] In 2012, just over 20 percent of firms with fewer than 50 employees offered two or more health insurance plans, compared with more than two-thirds of companies with 50 or more employees.[6]

Proponents of SHOP believed that these marketplaces would widen access to a range of affordable plans, allow small businesses to pool their buying power, and let owners and workers easily compare options and shed burdensome administrative tasks–features they believe are widely lacking in many existing small-group insurance markets.

HEALTH CARE REFORM AND THE SHOP MARKETPLACE IN CALIFORNIA AND COLORADO

Prior to the passage of the Affordable Care Act, California and Colorado had embarked on comprehensive health care reform efforts; both were among the earliest state adopters of federal health care reform.[7] Each state set up SHOP-specific advisory boards that met several times a year and made recommendations to the marketplace staff and trustees. After years of formal planning and informal dialogue among exchange and agency staff and insurers, hospitals, and business groups, California and Colorado's small-business exchanges both opened on schedule in October 2013.

Despite showing interest in SHOP, most small businesses in California and Colorado stayed on the sidelines. Employers were affected by the negative media stories about the ACA and were unsure SHOP would offer superior benefits. As a result, most small businesses that already purchase insurance coverage stayed with the status quo.

The CEO of one Northern California employer, which has been paying 100 percent of employee coverage for more than 25 years, summed up the reasons most companies decided on early renewal:

> There were too many unknowns going into SHOP. Our renewal came up at a time when I was aware of SHOP but it was still in flux. It was so much easier to renew and to wait for the dust to settle and then make a decision in a more stable environment.…What we have now is about the same as what was offered in SHOP, so why would I change?

Peter Lee, executive director of Covered California, the state's marketplace, strongly endorsed keeping employee choice even when the federally facilitated SHOP marketplaces dropped it.

Originally, Covered California required all insurers participating in the individual marketplace to submit bids to participate in SHOP. In July 2013, Anthem Blue Cross, which held the second-largest share of the California group market as of 2011, dropped out of SHOP after this requirement was relaxed.[8] Six insurers participated in the California SHOP marketplace, compared with 11 on the individual exchange. Six insurers participated in Colorado, compared with 10 in the individual market.[9]

Limited Outreach

Even for the strongest backers of small-business marketplaces, it was clear that the daunting task of establishing an individual marketplace would make launching SHOP a secondary priority.[10] Most respondents in both states told us this decision regarding priority-setting was made for understandable though regrettable operational and political reasons.

As the November 2014 individual marketplace deadline neared, there was diminished staff time and resources available for SHOP. It was hard for exchange and state agency staff in either state to focus on the individual marketplace and other high priorities, such as integrating Medicaid enrollment with marketplace operations.[11] A Colorado nonprofit insurance executive said SHOP "grew a reasonable amount given the reality of the enrollment process"—a reality that included early renewals, the balky rollout, and real and imagined concerns about the ACA.

"SHOP was the ignored little brother of the individual exchange," said one business representative to California's SHOP advisory board, echoing the sentiments of many other stakeholders. "Little money was available for marketing and outreach, compared to tens of millions of dollars for the individual exchange. When we complained, we were told that Covered California didn't have the bandwidth to do these things right now."

> "SHOP was the ignored little brother of the individual exchange."

Colorado appears to have devoted more time and money to direct outreach on behalf of SHOP, both through its online portal and in face-to-face meetings with stakeholders. The Colorado exchange put together a small business development center and reached out

to the ethnic Chambers of Commerce, particularly the Hispanic and Asian ones.

Colorado prominently featured SHOP on its marketplace website from the outset. Covered California was much slower to promote SHOP on its site. There was no prominent link to SHOP or to brokers on the site's front page until early 2014, months after the beginning of the individual marketplace's open enrollment period. California did not develop a SHOP marketing plan until mid-2014, and it was quite bare-bones.[12]

Website Woes

Colorado's website for enrolling small groups into SHOP functioned adequately from the beginning of open enrollment. As explained by Colorado's marketplace outreach director, "We relied on a small team actively managing its own vendors. Many difficult decisions were made to simplify functionality. We knew exactly what our system could do and could not do. We knew we wouldn't bring out the Cadillac on October 1." This approach embodied the no-frills approach used in most states that had relatively smooth website launches.[13]

Praise for the Colorado SHOP website, despite its basic functionality, was far from universal. A trustee at Connect for Health Colorado—the state's health insurance marketplace—felt that despite the best efforts of marketplace staff, CGI (the vendor that built the Colorado website) tended to drive the policies and to raise fees without providing appropriate value in return. Some brokers and insurers felt considerable dissatisfaction with the website and believed it was less than fully functional. One insurer representative said CGI greatly underestimated the problem of producing "834s"—the notifications sent to insurers to indicate a customer is enrolled—and was poor at doing manual workarounds. He also felt frustrated in his efforts to have useful dialogues about technology problems either with CGI or with the exchange.

California's SHOP portal proved extremely difficult to use and was eventually shut down in February 2014 after numerous complaints from agents and businesses who were unable to use it to complete applications.[14] Accenture, which did a workmanlike job constructing the web portal for the individual marketplace and federal data link known as the California Healthcare Eligibility, Enrollment, and Retention System, or CalHEERS, had little incentive to focus on building a dedicated online portal devoted to SHOP. Its personnel lacked knowledge of the small-group market and its particular needs. Far from being easy to navigate and allowing direct enrollment by employers, as some agents had feared, the process was time-consuming and practically impossible to complete even by the most dedicated and tech-savvy small businesses. Agents and employers alike unanimously described California's online SHOP enrollment system as "horrible" and "a total mess."

One general agent described his firm's experience trying to enroll businesses:

> The portal relied on CalHEERS, which is a system aimed at the individual market. Tweaks were based on the coding for individuals and there was apparently no testing ahead of time. You couldn't input a group into the system cleanly without hours of work with CalHEERS directly. As the system came to market there was a wholesale failure of online applications, which were scrapped by the end of the first quarter. For example, if I added a new employee the carrier didn't recognize me. The system was built on the assumption that everyone shows up on day one.

In the wake of the website's failure, Covered California turned over responsibility for the entire SHOP enrollment process to Pinnacle Claims Management, a Southern California–based third-party administrator that already handled sales operations for SHOP. Pinnacle began enrolling groups in its system in March 2014 and by September had shifted all groups originally hosted in CalHEERS to the Pinnacle system.

> "This is a whole sales team that is not doing sales."

Shifting administrative functions to Pinnacle has improved relations between most brokers and SHOP. However, this change has not yet brought about the fully streamlined enrollment process that was envisioned during the initial rollout. Pinnacle, for instance, still relies on paper forms. No specific date has been set for rebuilding a fully operational web portal within CalHEERS. Additionally, the sales team at Pinnacle has spent its first year scrambling to keep abreast with these operational hitches rather than promoting new business. As one agent commented, "This is a whole sales team that is not doing sales."

The spokesman for one small firm in California listed dozens of problems he and his employees encountered while trying to enroll—even while armed with considerable knowledge and a broker's help. For instance, his company found consistent discrepancies between the agent's quote and the actual amount billed by Covered California. Adding new employees and those from another rating area was an ordeal, even though the ease of such features was supposed to be among SHOP's selling points. "The hassles we were trying to avoid ended up being multiplied," he said. While he and others cautioned that these problems went along with being first adopters and would be ironed out in time, he felt that they contributed greatly to negative impressions of the small-business exchange.

Virtually everyone with whom we spoke felt strongly that the operational problems must be solved. Employers surveyed in Colorado were unanimous in picking ease of enrollment and better access to information as the most important thing to improve as SHOP entered its second season. Most small-business owners are much more receptive toward SHOP when they are able easily to compare specific premium costs and benefits with those of off-exchange plans. Enrolling in SHOP needs to be straightforward, comparable in difficulty to seeking products outside the exchange.

Policymakers, insurers, and agents generally feel that SHOP has a small margin for error, and that it must recover from the loss in reputation stemming from the operational foul-ups in the early days. But most experts in insurance markets told us these kind of mistakes tend to be forgiven.

HOW BROKERS AND AGENTS HAVE RESPONDED

Brokers and general agents are a vital part of the small-group insurance market.[15] As much as 80 percent of small businesses in California, Colorado, and other states use brokers to purchase group coverage.[16]

In both states, brokers were wary of the ACA. Attitudes in the broker community ranged from mild interest to outright antagonism.[17] Despite the fact that former insurance agents with decades of experience were being tapped to head up the SHOP marketplaces, brokers felt their expertise was given short shrift. Early assertions that customers could use websites to bypass agents—like travelers using Expedia—stung in particular. "Brokers are paranoid, but they have a right to be," said one Connect for Health Colorado trustee.

A general agent put it this way: "SHOP seemed like a total afterthought. There was a predisposition against the broker community: all business was supposed to be driven through the counselors and navigators and there was little sense of the role that brokers play or resources devoted initially to getting brokers up to speed." The most neglected part of their role, brokers frequently told us, was following up on questions about how policies worked once they were sold—a service that the navigators and certified enrollment counselors created under the ACA usually do not provide.

Despite their misgivings, brokers signed up in large numbers to become certified to sell through the individual and SHOP exchanges. California marketplace staff had expected perhaps 6,000 brokers to sign up. In reality, more than 14,000 have sought certification to date. Nearly 700 brokers actively sold SHOP policies during roughly the first year of operations.[18] In Colorado, the SHOP director estimated that 1,200 brokers had qualified to participate in SHOP, of which some 300 were active producers. Many of these were property and casualty agents seeking an occasional line of work as well as health care–focused brokers acting defensively.

> We want SHOP to succeed–we really do. But we need a functioning product for us to sell.

Colorado paid more attention to the broker distribution channel from the start. The marketplace set up a dedicated call center with lines specifically for brokers and enlisted an internal broker team that targeted small-business owners. California, on the other hand, publicized the possibility that businesses could self-enroll in SHOP and at the outset kept brokers and agents at arm's length.[19] However, once it soon became apparent that brokers were a vital distribution channel in both the individual and small-group markets, there was a belated rapprochement between California brokers and Covered California. Brokers proved to be one of the most reliable sources for attracting enrollees to the individual marketplace—some 40 percent of enrollees used a broker—as well as the principal channel for selling through SHOP.[20] Both in California and Colorado, agents are now mentioned prominently as a trusted source on the websites and in statewide radio and television advertisements.

"We want SHOP to succeed, we really do," one Colorado agent said. "But we need a functioning product for us to sell." He cited difficulties across the board, including hurdles to adding new employees, adopted dependents, or domestic partners to existing plans.

In California the challenges were greater. Brokers reported, for instance, not being paid for their work more than nine months after they had enrolled groups. Brokers generally agreed it is considerably more work for a broker to write a SHOP policy and for the employer to elect it than for a product from outside the marketplace.

Insurers and general agents questioned whether SHOP helped solve a genuine access-to-coverage problem. In Colorado, one agent noted that even prior to SHOP there were four insurers offering small-group policies in the least competitive areas of the state. Likewise in California, several agents and brokers felt the presence of California Choice, a private exchange, diminished the necessity of SHOP.

One owner of a California footwear company testified to the importance of brokers and wished for a better direct online experience as well: "Going through a broker was tough because they're all swamped. The website was not user-friendly and it was very vague. You really had to use a broker. I wanted more information as a small-business owner than I could get online."

It appears that obtaining buy-in from brokers and agents is a high priority, as is timely payment. Brokers can heavily influence existing small-business owners' choice of coverage. Although direct enrollment by small firms through the marketplace website could conceivably be the norm in the future, that is not the current reality. It might be helpful to increase the number of brokers who sell SHOP products. Alternatively, state officials may wish to focus limited resources on the best-selling brokers—for instance, offering preferential leads to the brokers with the best track record—rather than shoring up the marginal ones.[21]

SHOP'S VALUE PROPOSITION

Most respondents to our Colorado survey of small employers said employee choice was their principal reason for considering SHOP. Ease of administration was a distant second. Owners of firms of all sizes want to choose from among various options from multiple carriers. Some policymakers we spoke with in both states felt that such options are more practical for businesses that are near the 50-employee threshold. (In plan years starting in 2016, this threshold will be 100, because the ACA expands the definition of small employers to include businesses with up to 100 employees.)

One insurance executive commented that the principal value proposition of SHOP is that it allows multiple carriers to be offered alongside one another in a stable environment in which insurers are willing to quote: "We know there is a market for employers who have trouble with multiple carriers playing together." In his opinion, the most promising business opportunity

exists for small groups that approach the 50-person threshold, while "micro" groups would be better served by letting employees sign up for insurance coverage in the individual marketplace. Others interviewed disagreed, feeling that when factors such as household income and tax deductions only available to those with job-based coverage are considered, employees of very small companies are not always better off in the individual marketplace.

Unlike California, Colorado allowed employers to offer plans at two adjacent metal tiers (coverage levels) in its first year.[22] This kind of choice has always proven popular on employer surveys.[23] For instance, it permits management to select more comprehensive coverage and employees to choose less expensive products, all under the same umbrella. As of late 2014, the multitier approach was also being offered through Covered California.[24] One concern about this approach is splitting the risk pool and creating adverse selection, but the existing numbers in SHOP are currently too small to do that.[25]

The option of choosing multiple carriers on adjacent tiers is available through California Choice, a Southern California–based private exchange operated by general agent Word & Brown. It was also part of the Health Insurance Plan of California/PacAdvantage small-business exchange, which operated from 1992 to 2006. California Choice also features Anthem Blue Cross plans, among the most recognized and widely sought plan offerings in California, which are not available through SHOP.[26]

Even if it does not enroll large numbers of businesses from the outset, SHOP can be a catalyst in changing the small-business insurance markets. In California, the rollout of SHOP galvanized California Choice to compete more aggressively and to tout its multitier and paired choice offerings with considerable success. Few states have a situation comparable to California, in which a well-entrenched private exchange caters to the small-group market. In Colorado, which does not have a similar competitor to SHOP, more businesses were attracted to SHOP and its unique features.

Several business owners interviewed saw SHOP as a viable alternative to the private exchanges that are now taking root among large and midsize employers. They believe SHOP could offer greater choice than most private exchanges while helping to ensure year-to-year cost certainty for businesses.[27]

Tax Credits

Firms with fewer than 25 full-time employees earning an average wage of $50,000 a year or less are eligible for a tax credit of up to 50 percent, available only through SHOP, for a maximum of two years. A smaller tax credit of up to 35 percent was available between the launch of the ACA in 2010 and 2013.

> "Tax credits are a talking point, not a selling point."

Multiple respondents and interviewees in the insurer and policy communities felt small-business owners were not well informed about tax credits. However, nearly all owners whom we surveyed said they were aware of the credits. Most, however, did not feel the credits were the key element in their decision to elect SHOP. One director of an insurance co-op in Colorado said, "Tax credits are a talking point, not a selling point." Others agreed. A trustee of the Colorado exchange felt it was more viable for individuals in small firms to seek subsidies on the individual exchanges, if they were eligible. Some felt the paperwork demands were too great, while others who used their accountants or went through the process themselves found either that the savings were minimal or that they did not qualify.

One company, however, said the tax credit was its sole reason for signing up and considering SHOP. And several agents felt the credit was the principal, if not the sole advantage, that SHOP possessed in the small-group marketplace.[28]

One experienced California insurance executive found that even those companies that might have

qualified for the credit chose not to elect it. In 2010, when the tax credit was first offered, his insurance company expected a bump in so-called "virgin groups"—businesses that had never offered insurance to employees before—but that rise never materialized. Even after the maximum size of the tax credit rose from 35 percent to 50 percent, he doubted it would have a significant impact, given that companies may not know about it, the credit might prove too much trouble to apply for, or the savings might be too low to be useful. Such pessimism is not unwarranted: previous programs using tax credits to raise health insurance coverage rates have had low take-up rates.[29]

Growth Opportunities

One potential avenue for expanding SHOP's appeal is experimenting with alternative benefit designs and including ancillary products with coverage. For instance, wellness programs and explicit human resources assistance could conceivably be bundled along with SHOP if regulations allowed. Merging SHOP coverage with worker's compensation coverage in California could greatly reduce administrative demands on firms at the high end of SHOP eligibility, especially when the requirement to expand SHOP to firms with up to 100 employees takes effect in 2016. SHOP could provide greater value for lower-income workers by contracting with Medicaid health plans, which otherwise are not available in the commercial market.

LOOKING TOWARD THE FUTURE

A full test of SHOP's appeal will not really take place until the cycle of "grandmothered" early renewal plans ends. Most insurers and agents are willing to take a wait-and-see approach toward SHOP's potential. Carriers are in it for the long haul, if not indefinitely: most of the same insurers renewed for the second year in both California and Colorado. As one Colorado policymaker put it, "We need enough momentum to overcome the period of inertia and misinformation and to have a viable program once the early renewal period is over."

NOTES

[1] For explanation as to why California and Colorado will make plans ACA-compliant sooner, see K. Lucia, S. Corlette, and A. Williams, "The Extended 'Fix' for Canceled Health Insurance Policies: Latest State Action," *The Commonwealth Fund Blog,* Nov. 21, 2014.

[2] To read a summary of the main problems with the federally facilitated SHOP rollout and efforts to solve them, see K. Lucia, J. Giovannelli, and S. Miskell, "After a Slow Start, Federal Business Health Insurance Marketplace Offers New and Improved Functions," *The Commonwealth Fund Blog*, Feb. 19, 2015. For a summary of employee choice, see S. Dash and K. Lucia, "Employee Choice," *Health Affairs*, published online Sept. 18, 2014.

[3] A. Goldstein, "HealthCare.gov's Insurance Marketplace for Small Businesses Gets Off to a Slow Start," *Washington Post* online, Nov. 30, 2014.

[4] Government Accountability Office, Report to the Chairman, Committee on Small Business, U.S. House of Representatives, "Small Business Health Insurance Exchanges: Low Initial Enrollment Likely Due to Multiple, Evolving Factors" (Washington, D.C.: GAO, Nov. 2014). Originally, California SHOP executives expected as many as 90,000 employees to enroll. Despite the small numbers in absolute terms, these enrollments in SHOP were the second- and third-highest among U.S. states following New York. This omits Vermont and the District of Columbia, which combined their individual and small-business marketplaces as allowed under the ACA.

[5] T. Gardiner and I. Perera, "SHOPping Around: Setting Up State Health Care Exchange for Small Businesses: A Roadmap" (Washington, D.C.: Center for American Progress and Small Business Majority, July 2011). This is a good guide to the issues around the creation of SHOP and the problems small employers face in purchasing coverage.

[6] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2012 Medical Expenditure Panel Survey (MEPS)–Insurance Component, Table I.A.2.d (2012).

[7] See M. Weinberg and L. W. Haase, *State-Based Coverage Solutions: The California Health Benefit Exchange* (New York: The Commonwealth Fund, May 2011). In California, Governor Arnold Schwarzenegger presided over three years of debates about universal statewide insurance coverage. This debate resulted in a bill that passed the State Assembly but foundered in the State Senate. In 2006, Colorado Gov. Bill Owens created the so-called "208 Commission." This commission laid out five blueprints for enacting comprehensive state health insurance reform in Colorado; its findings were reviewed extensively in the state legislature. California was the first state to establish an exchange board after the ACA's passage, and Colorado followed suit several months later. Both states chose to set up their marketplaces as stand-alone, independent government agencies whose trustees were appointed both by the governor and by the legislature. Existing laws and state regulations were easily modified to conform to the ACA. Both California and Colorado have mature and stable small-group markets with a relatively high degree of insurer participation and competition. In California the existing small-group marketplace is regulated by comprehensive legislation passed in 1992 and referred to as AB 1672. As part of AB 1672, there is a requirement of 50 percent contribution by an employer to the employee-only premium, and minimum participation requirements, namely that 75 percent of the eligible employees are enrolled in the plan offered by the employer. Guaranteed issue was already in place. Colorado has similar rules in place regarding guaranteed issue and employer participation requirements.

[8] C. Terhune, "WellPoint Anthem Blue Cross Spurns California Small-Business Exchange," *Los Angeles Times,* July 19, 2013. In 2011, Kaiser held 42 percent of the group market, Anthem Blue Cross 17 percent, and Blue Shield 14 percent. In the same year, Anthem accounted for 47 percent of the individual market, Blue Shield 21 percent, and Kaiser 19 percent. California HealthCare Foundation, *California Health Care Almanac: California Health Plans and Insurers: A Shifting Landscape* (Oakland, Calif.: March 2013), p. 21.

[9] In 2015, SeeChange, one of the six SHOP carriers in Colorado, will leave the marketplace and the state altogether.

[10] Nationally, New Mexico and Utah, which decided to build their own SHOP exchanges while defaulting to the federal government for the individual exchanges, are the only potential exceptions.

[11] The decision in both states not to integrate Medicaid with the exchange helped improve the functionality of the web portals but led in part to long delays in processing Medicaid applications; these persisted for many months in both states after the end of open enrollment. On the other hand, trying to implement "no wrong door" fully in the application process helped to trip up more ambitious exchanges in Oregon, Massachusetts, and Maryland.

[12] Personnel turnover exacerbated California's problem with SHOP outreach, and to a lesser extent Colorado's as well. The SHOP director in California, a former insurance executive and agent, left his position in fall 2013 and was never replaced on a permanent basis. A series of consultants took over the day-to-day management of SHOP. After a year remaining vacant, the position was superseded by a new post of sales director for both individual and small-business insurance products.

[13] CGI Federal, the Colorado vendor, was an independent subsidiary of the company that won the contract for federally run exchanges and botched the rollout.

[14] J. D. Harrison, "California Takes Down Online Health Insurance Exchange for Small Businesses," *Washington Post,* Feb. 14, 2014; E. Bazar, "Small-Business Exchange is Offline, Off Target," *Sacramento Bee,* Feb. 25, 2015.

[15] General Agents (GAs) are insurance agents that partner with various insurance carriers to market and distribute their products to brokers. They are paid directly by the carrier in a separate payment from the broker commission. Certain GAs work principally with certain carriers.

[16] Well-established small businesses are most likely to use brokers. According to a study by Pacific Community Ventures, those firms that offer health insurance coverage already are most comfortable with brokers, while those that don't are the most skeptical. Insight at Pacific Community Ventures, *Health Care + Small Business: Understanding Health Care Decision Making in California* (San Francisco: PCV, Oct. 2011.

[17] Some of this antagonism was political. Many employers in both states said politics hadn't affected their own decision but they were certain that it played a role in choices other business owners made. One Central Valley agent told us: "In Bakersfield, where my business is, we are a very conservative town. A lot of people probably are not proponents of the ACA and don't want anything to do with Covered California. Eighty-five to 90 percent of Kern County is that way. Many people just don't want to hear about SHOP. Hard to say where they first hear it but it's likely connected to the Affordable Care Act and so it has a negative connotation." Several other businesses, by contrast, elected SHOP specifically to underscore their support of the ACA.

[18] C. Coleman, "What's Ahead for Covered California? Medium-Term Policy Considerations," Insure the Uninsured Project, Sept. 2014.

[19] S. Kleffman, "California's Subsidized Health Insurance 'Marketplace' Takes Shape," *Contra Costa Times*, July 31, 2012.

[20] About 13 percent of Q1 2015 SHOP sales in California were "employer-direct" or conducted without using an agent.

[21] In the past several months in California, Pinnacle has instituted promotional programs that provide incentives such as direct mail and lead generation services for agents who meet specific sales and promotion targets.

[22] Under the Affordable Care Act, plans are classified on different tiers, referred to as bronze, silver, gold, and platinum. The tiers are distinguished by their actuarial value–namely, the total expected medical costs paid by the plan. For instance, bronze plans, on average, cover 60 percent of the cost of medical care, while the consumer is responsible for 40 percent.

[23] See J. R. Gabel, J. Pickreign, H. Whitmore et al., "Small Employer Perspectives on the Affordable Care Act's Premiums, SHOP Exchanges, and Self-Insurance," *Health Affairs* Web First, published online Oct. 16, 2013.

[24] "New at SHOP: Dual Tier Choice," Covered California, Oct. 2014.

[25] State Health Reform Assistance Network (Wakely Consulting Group), *Design Considerations in Structuring Employee Choice for SHOP Exchange* (Princeton, N.J.: Robert Wood Johnson Foundation, Dec. 2012).

[26] PacAdvantage captured as much as 10 percent of the small-group market, peaking at around 150,000 enrollees in 1998, but foundered principally as a result of adverse selection against it both from outside the market and by plans inside it. California Exchange Executive Director Peter Lee headed up PacAdvantage and many of the current senior staff at Covered California worked for this purchasing group for small business. See M. Weinberg and B. Kramer, *Building Successful SHOP Exchanges: Lessons from the California Experience* (San Francisco: Pacific Business Group on Health, 2012).

[27] On private exchanges and SHOP, see "Competition from Private Exchanges, Teeny Tax Credit Keep Businesses from SHOP-ing" *Inside Health Insurance Exchanges*, April 2015 5(4); and J. Millman, "The Coming Revolution in How Employers Provide Health Insurance," *Washington Post,* April 7, 2015.

[28] Because the average group size of early enrollees in both California and Colorado was very low–75 percent of the groups enrolling in California had fewer than six employees, while the average size of Colorado's group was fewer than five–the opportunity for tax credits that are aimed at the smaller end of the small-business-spectrum businesses remains. California SHOP Advisory Group Meeting, August 2014, cited in Coleman, "What's Ahead for Covered California?" 2014.

[29] S. Dorn, J. Varon, and F. Pervez, *Limited Take-Up of Health Coverage Tax Credits: A Challenge to Future Tax Credit Design* (New York: The Commonwealth Fund, Oct. 2005).

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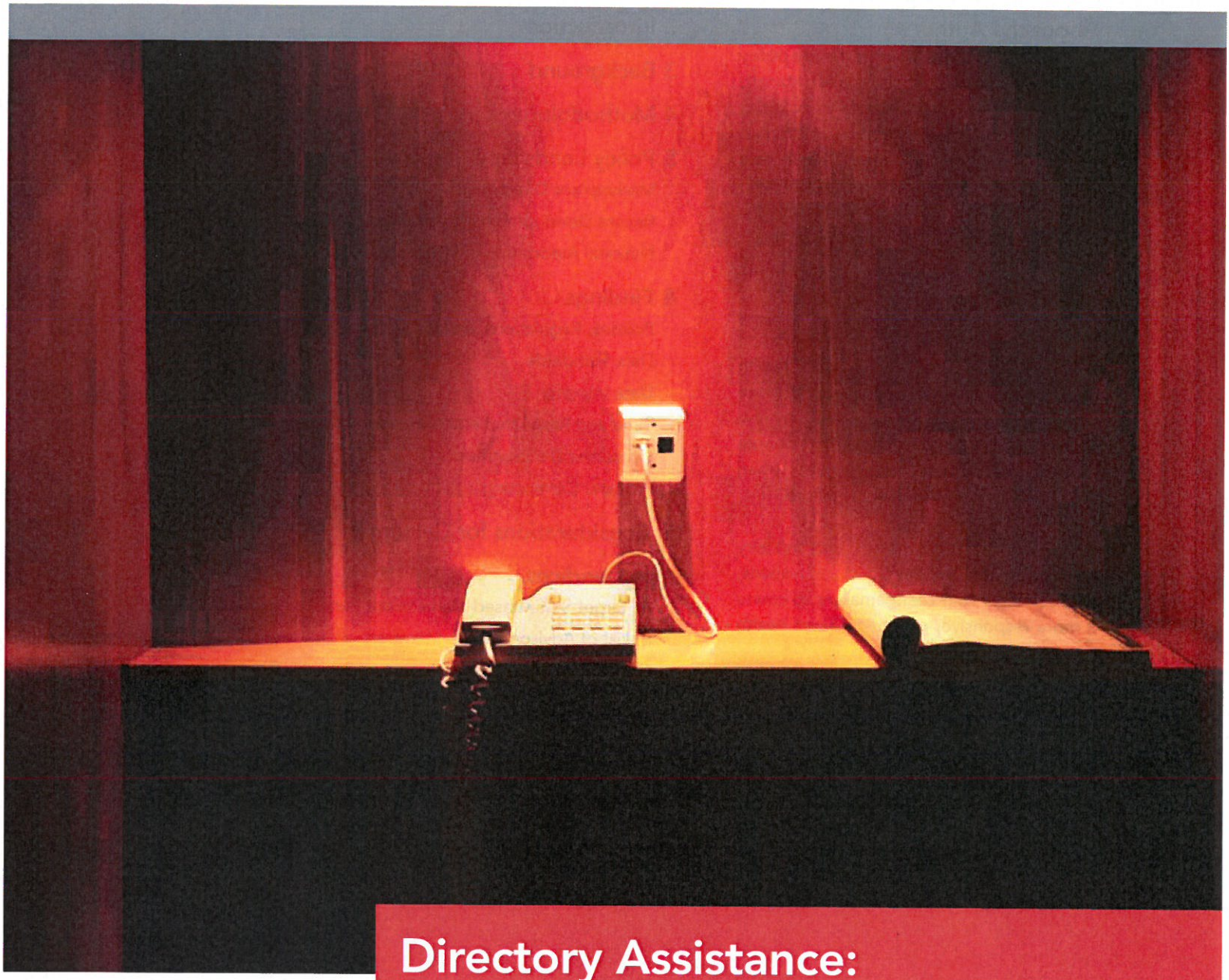

Directory Assistance:
Maintaining Reliable Provider Directories for Health Plan Shoppers

SEPTEMBER 2015

Contents

About the Author

Manatt Health is the interdisciplinary policy and business advisory division of Manatt, Phelps & Phillips. Manatt Health provides expertise in health care coverage and access, health information technology, health care financing and reimbursement, and health care restructuring. For more information, visit www.manatt.com.

About the Foundation

The California HealthCare Foundation (CHCF) is leading the way to better health care for all Californians, particularly those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

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Introduction

In this post-Affordable Care Act (ACA) era, many consumers are making health coverage decisions for the first time and in new ways; some are struggling to choose between health insurance products with varying provider network configurations and cost structures. To understand their choices and inform their decisions, many consumers turn to provider directories — electronic or printed lists of physicians, hospitals, and other health care providers in each health insurance carrier's products.

Inaccurate provider directories can lead to consumer frustration and confusion, and result in substantial out-of-pocket costs for consumers who may unintentionally seek and receive out-of-network care. Yet it has proven challenging for organizations to maintain accurate and up-to-date provider directories given the lack of data and communication standards used to transmit changes between providers and carriers, the frequency with which networks change (e.g., opening of new practices and locations; providers entering, leaving, and closing practices; changes to contracts), and the dearth of strong incentives and enforcement mechanisms requiring regular updates.

This report examines policy, operational, business, and technical challenges and solutions for maintaining well-functioning, integrated provider directories in four states: Colorado, Maryland, New York, and Washington. It details the perspectives and experiences of consumer advocates, carriers, providers, state-based marketplaces (SBMs), and state Medicaid agencies in these four states, as well as in California, with the goal of informing California policymakers and stakeholders as they seek to improve access to provider network information.

The considerations in this report are generally applicable to stakeholders across all sectors of the market — including, but not limited to, commercial carriers, Medicaid, and Medicare. And while the information on provider networks that is contained in provider directories may be used for many purposes, including review of carriers' compliance with network adequacy requirements, this report's focus is on provider directories as tools to help consumers make informed decisions when selecting and using health coverage. The findings shed light on opportunities to make directories more accessible to California's diverse population of consumers and more accurate through better regulation and standards.

Background

Since implementation of the ACA, more Californians are shopping for health insurance through the individual commercial market. Many of these consumers are obtaining insurance for the first time. While California has taken steps to simplify and standardize health plan benefit designs, these consumers and the millions of Californians who get health benefits through their employers must navigate a complex coverage market and make important decisions for themselves and for their families based on available information. Simultaneously, as carriers seek to control costs and keep premiums from skyrocketing, some provider networks are becoming increasingly selective, making consumer access to accurate information about provider network participation even more important.

In 2013, consumers who were likely to purchase marketplace-based coverage were surveyed. More than half of survey participants identified choice of providers as a very important factor influencing their selection of a product.[1] In addition, with the creation of marketplaces in response to the ACA's focus on simplifying health plan shopping and enrollment, as well as the continued proliferation of web-based shopping and comparison tools for health care and other products, it is safe to assume that consumers will have high expectations when it comes to the accuracy and availability of provider network information.

Some carriers, state Medicaid agencies, and SBMs publish provider directories to inform consumers as they select, enroll in, and use carriers' products. Organizations that offer multiple products across multiple carriers, such as SBMs, may publish integrated provider directories — online databases of carrier and product data, which consumers may search or filter based on a set of criteria, such as provider name, address, and location. Some state Medicaid agencies and SBMs do not publish provider directories, and instead point consumers to online provider directories published and maintained by carriers.

Definitions

Application programming interface (API). A software-to-software interface that contains a set of computer programming instructions and standards for a software application or tool.[2] APIs allow software developers to design other products to interact with the original company's product. For example, Amazon.com releases an API so that a third-party website can directly post links to Amazon products with updated prices and allow customers to purchase the items.[3]

Delegated model. A health care delivery model in which health plans contract with and delegate to medical groups some health plan functions, such as claims payment, utilization review, and care management, in return for a fixed, per-person monthly fee (capitation payment) for the subset of the health plan's enrollees assigned to the group. This model has been in wide use among California HMOs since the mid-1980s.

Federally Facilitated Marketplace (FFM). A health insurance exchange model under the ACA in which the US Department of Health and Human Services (HHS) performs all or most of the exchange functions. Consumers in states with a FFM apply for and enroll in coverage through www.healthcare.gov.

Health insurance product ("product"). A health coverage plan or insurance policy that specifies the enrollees' covered benefits, the provider network and coverage model, and the consumer share of the costs. Product types include, but are not limited to, HMOs, PPOs, EPOs, and high-deductible health plans.

Integrated provider directory. A searchable database bringing together provider network data from multiple carriers' health insurance products. An integrated provider directory may include contracted physicians, clinics, and medical groups by carrier, or product, or both, and may also provide information about participating hospitals or other contracted facilities, such as pharmacies. Integrated directories may include advanced search functionality allowing consumers to search by location, specialty, open or closed panel, languages, or other characteristics.

Leased networks. A provider network organized and contracted with a third party that carriers may lease from the third party. Carriers may opt to lease provider networks in areas where they do not have a sufficient number of contracted providers to meet regulatory requirements (such as network adequacy) or to support ancillary or supplemental products, such as behavioral health or dental products. Carriers may also lease their networks to other payers, such as self-insured plans.

Machine-readable. Data formatted to be understood and consumed automatically by a computer system or web browser without human intervention. Machine-readable data allows third parties to access data and potentially reuse it to create new search solutions, tools, and services for other purposes.

Marketplace. The umbrella term used by the Centers for Medicare & Medicaid Services (CMS) for ACA health insurance exchanges through which eligible individuals, families, and small businesses can purchase coverage. An ACA marketplace is the only venue where consumers can apply for and receive federal assistance in the form of premium tax credits to help pay for coverage. It also offers a website where consumers can shop for and compare available health insurance products.

Network adequacy. A carrier's ability to deliver necessary health benefits and services contractually or legally required by providing access to a sufficient number of in-network (contracted) providers, including primary care physicians, specialists, hospitals, and other facilities.

Provider directory. A list of participating providers such as physicians, hospitals, and other facilities included in the network of a carrier's insurance product.

Provider network. The providers (physicians, hospitals, and other health care providers) available to consumers enrolled in a specific health insurance product. Network providers agree by contract to accept negotiated rates from the carrier for services. Depending on the health insurance product type, consumers may be limited to the contracted (network) providers for nonemergency care and will generally pay lower out-of-pocket costs for network providers compared to those out-of-network.

State-based marketplace (SBM). A health insurance exchange under the ACA where the state assumes responsibility for performing most marketplace functions. Consumers in these states apply for and enroll in coverage through marketplaces established and maintained by the states.

Qualified health plan (QHP). A health insurance plan certified by ACA state-based or federal marketplaces as meeting specific federal and state requirements, including that the plan's product covers required ACA benefits (essential health benefits). Only certified QHPs may be offered in ACA marketplaces, but carriers may also offer QHPs outside of the marketplaces subject to relevant federal and state laws. (California requires carriers to offer products that mirror their QHPs outside the marketplace.)

Consumers use provider directories to:

- Evaluate coverage options to determine whether a primary care physician, specialist, hospital, clinic, or other health care provider they would like to use is considered in-network and covered under a product
- Select products based on cost, network size, and care options
- Identify and locate providers and services when seeking care

A March 2015 survey by Consumer Reports National Research Center found that 78% of privately insured Americans used their carrier's online provider directory in the past two years to find doctors, facilities, or both.[4]

Despite the availability of provider directories, it is widely acknowledged throughout the industry that directories often contain inaccuracies. Directory errors may lead a consumer to seek care at the wrong address, or worse, a consumer may learn that the health insurance product they purchased does not cover a specific provider they want to see or are already seeing, despite being listed in the directory. This is troublesome because consumers may be required to pay significant fees to cover their visits to out-of-network providers. In fact, more than half of consumers surveyed were unsure if they would be responsible for extra costs associated with seeing an out-of-network provider if it was due to an error in the carrier's provider directory.[5]

Methodology

To identify target states, Manatt conducted research in February 2015 to identify SBMs with functioning, integrated provider directories that were accessible from the marketplace's website and that returned search results. Researchers assessed and documented the capabilities of each marketplace's provider directory, eliminating those that did not return search results. Manatt could not confirm the accuracy of the data returned by directory searches and, at the time of the research, there was very limited public information available on the accuracy of SBM provider directories.[6]

This review yielded functioning, integrated provider directories operated by Connect for Health Colorado (connectforhealthco.com), Maryland Health Connection (www.marylandhealthconnection.gov), New York State of Health (www.nystateofhealth.ny.gov), and Washington Healthplanfinder (www.wahealthplanfinder.org). The search capabilities of each SBM's provider directory are documented in Appendix A. While California's SBM, Covered California, does not have an operational provider directory at time of publication, California served to provide context for the findings from other states.

Manatt conducted additional research on carriers and state Medicaid agencies in the target states, as well as a literature review and stakeholder interviews. This research focused on relevant state laws and regulations; carrier, SBM, and provider business policies, practices, and requirements; and technical considerations related to creating and maintaining integrated provider directories. Manatt conducted 32 interviews with stakeholders representing consumer advocates, SBMs, state Medicaid agencies and regulators, carriers, and providers.

Finally, Manatt and the California HealthCare Foundation convened a small advisory group of California stakeholders and subject matter experts to guide the project's approach and to review and provide feedback on key findings. A list of advisory group members can be found in Appendix B.

Policy Landscape

Marketplace Directories

The passage of the ACA, which sought not only to broadly expand health coverage but also to modernize the enrollment process for consumers receiving public financial assistance for health care, shed light on many of the longstanding challenges associated with providing timely, accurate provider network information.

Federal regulators began to address provider directories in the early stages of marketplace planning and implementation, seeking to resolve challenges while at the same time allowing states flexibility. (Please refer to Appendix C for additional detail on the national policy landscape.) In March 2012, the Department of Health and Human Services (HHS) issued the final rule for the establishment of marketplaces and qualified health plans (QHPs), and included expectations for marketplace

and QHP provider directories.[7] The rule states that HHS expects Federally Facilitated Marketplace (FFM) and SBM QHP issuers' provider directories to be "consistent with current industry practice" and to include provider licensure, specialty, and contact information at a minimum, allowing individual SBMs to establish additional data requirements. The rule also requires QHP issuers to identify providers that are not accepting new patients but does not specify frequency of updates to provider directories, suggesting that timelines should strike a balance between supporting consumer choice and carriers' administrative burdens.[8]

States preparing to go live with SBMs in time for the first open enrollment period in 2013 were not required to produce or host provider directories. A few states, including California, went beyond SBM requirements in an effort to support consumer decisionmaking and enrollment, and published integrated provider directories as part of their initial implementation on October 1, 2013.

In 2014, reports of inaccuracies in SBM provider directories began to surface and gain national attention. California's provider directory was removed indefinitely in February 2014 after consumers and providers grew frustrated with its errors. Covered California did not reinstate the provider directory for the 2015 open enrollment period and instead directed consumers to each carrier's website and provider directory. The marketplace's 2016 QHP application removed former references to a centralized provider directory.[9] In the summer of 2014, the Mental Health Association of Maryland performed a secret shopper study to verify the accuracy of the Maryland Health Connection's provider directory and found only 14% of psychiatrists listed in the directory were accepting new patients, and 57% were unreachable.[10] Finally, in advance of the 2015 open enrollment period, the New York Attorney General advised consumers not to rely only on carriers' provider directories, encouraging consumers to call carriers and providers directly to confirm network participation.[11]

"I . . . strongly urge New York consumers not to rely solely on provider lists offered by insurance companies. Call the insurance company you are considering, as well as your providers, to confirm that they are in the plan's network. Do this before you sign up. It's a quick and easy way to protect your family's health and your wallet."

— New York State Attorney General
Eric T. Schneiderman

A recent report by the Commonwealth Fund found that several SBMs, including those in California, New York, and Washington, increased their provider directory requirements for participating QHPs between the first and second years of coverage, demonstrating an increasingly active role for marketplaces with respect to provider directories.[12]

Figure 1. Required Data Updates, by SBM

SBM	FREQUENCY OF UPDATES
California*	Quarterly
Colorado	Every other week
Maryland	Every other week
New York	Quarterly
Washington	Monthly

*California's SBM does not currently maintain an integrated directory but contractually requires that carriers submit provider information to Covered California on a quarterly basis.

Recent HHS guidance for the FFM is more specific than its previous guidance. HHS guidance released in February 2015 requires FFM QHPs to provide a hyperlink to their provider directory and to include the following information for each provider: location, contact information, specialty, medical group, any institutional affiliations, and whether the provider is accepting new patients.[13] QHPs must update this information at least monthly and make their provider directories publicly available in a machine-readable file format specified by HHS to allow third parties to create aggregated provider directories.[14]

According to the HHS final rule: "The general public should be able to easily discern which providers participate in which plan(s) and provider network(s) if the health plan issuer maintains multiple provider networks, and the plan(s) and provider network(s) associated with each providers…" The Center for Consumer Information and Insurance Oversight and CMS indicated in 2016

guidance that HHS may impose civil monetary penalties up to $25,000 should a QHP provide incorrect information to a marketplace, or $100 per day for each person adversely affected by a QHP's noncompliance.[15] Notably, this guidance did not address SBMs, which continue to set their own requirements for participating QHPs, nor did it mandate the use of standards or a common data template for QHPs participating in the Federally Facilitated Marketplace.

Recent Developments for Medicare and Medicaid Directories

Federal regulations regarding Medicare, Medicaid, and Children's Health Insurance Program (CHIP) provider directories have also become increasingly prescriptive in response to concerns and reports of pervasive errors. In December 2014, HHS's Office of the Inspector General found that over half of the providers in Medicaid managed care products could not offer timely appointments to enrollees because the providers could not be reached at their listed location, were not accepting new Medicaid patients, or were not participating in the Medicaid managed care product.[16]

In February 2015, CMS released guidance for Medicare Advantage Organizations (MAOs) establishing new and more detailed expectations for MAO provider directories.[17] The new guidance requires MAOs to create structured processes to assess provider availability and to update online directories in real-time, and notes than an effective process will include at least quarterly communication between the MAO and providers to ensure that provider information is up-to-date and to confirm whether providers are accepting new patients.

CMS plans to monitor MAO provider directory compliance by engaging a contractor to verify directory accuracy, audit directories, and take action against MAOs that fail to comply. MAOs that "fail to maintain complete and accurate directories may be subject to compliance and/or enforcement actions, including civil money penalties or enrollment sanctions."[18] CMS is also considering requiring MAOs to report network information in a standardized electronic format beginning in or after 2017 for eventual inclusion in a nationwide provider database.

In May 2015, CMS released new proposed regulations for Medicaid and CHIP managed care carriers requiring that their directories include information on physicians, hospitals, pharmacies, behavioral health providers, and long-term supports and services (LTSS) providers.[19] The regulations propose that electronic directories should be updated within three business days of receipt of information and be posted in a machine-readable file format. In addition, the proposed regulations state that CMS believes provider directories would be more accurate and useful in a standardized format and exposed through open and standardized application programming interfaces (APIs); as such, CMS is considering requiring carriers to use the "best available provider directory standard" as defined by the Office of the National Coordinator for Health Information Technology (ONC) in the 2015 Interoperability Standards Advisory.[20]

National Association of Insurance Commissioners

In November 2014, the National Association of Insurance Commissioners (NAIC), an association of the chief insurance regulators from the 50 states, released revised draft model legislation on health plan network access and adequacy.[21] NAIC model legislation can be highly influential, as it is a reflection of best practices and often leads to the passage of legislation or creation of administrative rules in states. Carriers also look to the NAIC as a guidepost and may adopt recommended practices independent of state regulations.

The model legislation would require carriers to update provider directories at least monthly and include information for physicians, hospitals, and other health care providers. The NAIC also suggested that states consider requiring carriers to contact providers who have not submitted claims in the past six months, conduct internal audits, and initiate more robust monitoring of consumer complaints. The NAIC updated a draft of the model legislation in September 2015.[22]

Findings

Policies, Regulations, and Enforcement

Lack of enforcement of regulatory and contractual requirements creates an environment that does not foster shared accountability.

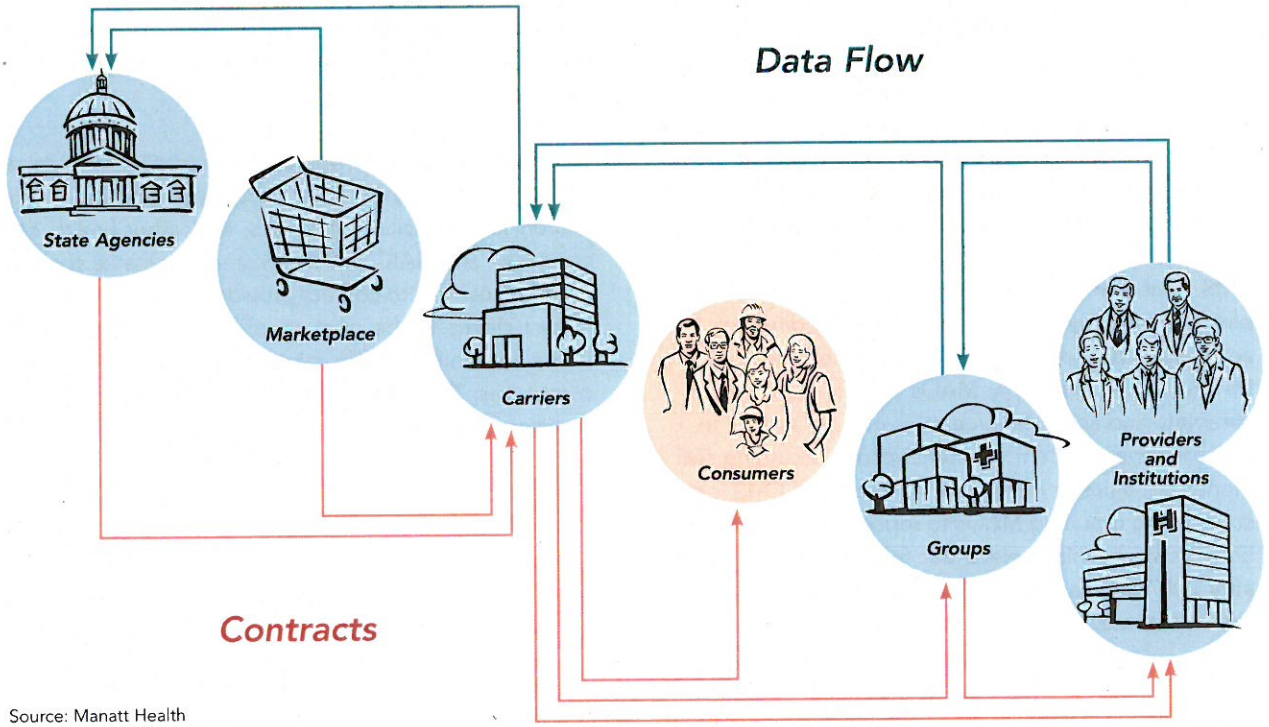
Shared Accountability

The development and maintenance of a provider directory involves many actors, including carriers and marketplaces, physician practices and clinics, IPAs, hospitals, and other facilities and institutions. Each actor is dependent on the others for specifying and meeting directory requirements, delivering and receiving directory information, and publishing and making information available to consumers. Over time, these individual actors have developed their own processes, systems, and requirements to create and update information used to populate and maintain directories.

The authors found that all carriers, marketplaces, and state Medicaid agencies have contractual language requiring accurate and timely provision of provider directory data. These contracts and their requirements for provider directory data are passed through carriers to medical groups, individual providers, and institutions.

In addition to specifying data requirements, contracts between state Medicaid agencies, SBMs, carriers, physicians and other health care providers, such as hospitals, also describe penalties or remediation measures should a party fall out of compliance. According to interviewed stakeholders, carriers and SBMs may impose such penalties as de-delegation or suspension of assignment or enrollment of new enrollees to providers and carriers. SBMs and state Medicaid agencies also use corrective action plans to work with carriers to amend and improve their practices rather than imposing more severe penalties. While these contractual provisions appear prevalent, stakeholders reported that penalties are generally not enforced, primarily out of concern for compromising robust provider networks and the mutual interests of state Medicaid agencies, SBMs, and carriers to minimize disruption of member services.

Figure 2. Who Is Accountable for Provider Directory Information? A Cascade of Contracts and Data.



Source: Manatt Health

"Insurers are placed in a difficult position when establishing requirements for providers to update their information. When providers don't update their information in accordance with contractual requirements, it is difficult for insurers to simply end the contractual relationship, as they must maintain an adequate network."

— Vice president, government affairs, carrier

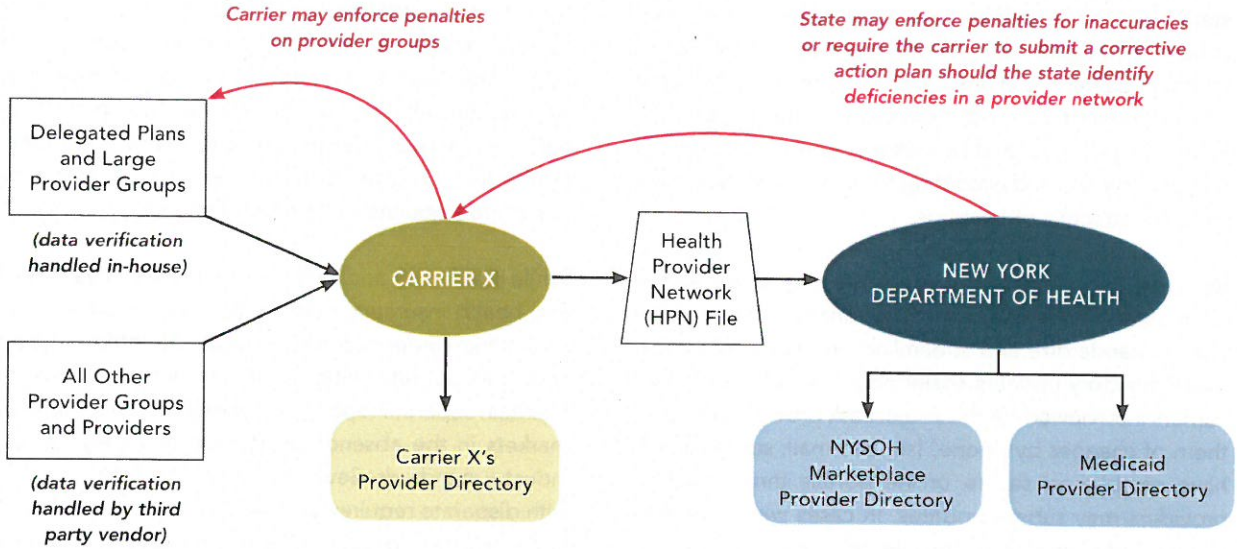
Many states have taken actions to set baseline requirements and expectations for provider directories, and all of the target states examined for this project and California have passed laws or regulations requiring carriers to maintain accurate provider directories. In most states, however, there has been limited to no regulatory enforcement or penalties issued to carriers for failure to maintain accurate directories. As a result, there are few incentives for institutions to invest significant resources to maintain directories or to penalize contracted network entities for failing to meet contractual obligations to provide them with necessary information.

New York's Aggressive Regulatory Action

New York stakeholders were the only interviewees to report enforcement of penalties by the state for failure to maintain accurate directories. The New York State Attorney General has reached settlements with more than a dozen carriers related to their provider directories since 2010. In a 2012 settlement, the attorney general required eight carriers to "ensure the accuracy of provider directories . . . implement new business practices for updating their online provider directories in a timely manner . . . and to pay restitution to consumers who paid more than they should have because they saw providers erroneously listed as in-network."[23] A similar settlement in 2010 required five carriers to correct issues with their online provider directories and improve their business practices.[24]

The New York State Attorney General's actions created an environment that motivated carriers to take steps to ensure that their provider directories are up-to-date and accurate. In response to the attorney general's actions, carriers reformed their business practices and made investments in infrastructure and processes to support the collection, audit, and review of provider directory data. Following the settlements and recognizing the

Figure 3. New York Carrier Contracting and Accountability



Source: Manatt Health

potential for the state's Department of Health to enforce additional penalties, one carrier overhauled its processes relative to review and audits of provider data. The carrier's revamped processes initially reduced the carrier's unique record count by approximately 25% as it deleted inaccurate and duplicative records; the carrier continues to eliminate 10% to 12% of records annually due to provider turnover.

In other states where policies have not been coupled with aggressive regulatory action, research and interviews found that carriers have not been as motivated to improve their provider directories.

Data Standards

"Garbage in, garbage out" — A lack of uniform data standards and accompanying guidance results in unusable data, especially when data come from disparate sources.

Lack of Standards and Standardized Processes

Provider directories that exist at the state Medicaid agency, SBM, and carrier levels have largely been homegrown — built by the organization — rather than developed according to industry standards. As a result, provider directories, and the standards and processes used to maintain them, are largely unique to each organization. This poses significant challenges for marketplaces, state Medicaid agencies, and other organizations that collect, aggregate, and reconcile provider data across multiple carriers and insurance products to create a single, integrated provider directory. It also poses challenges for providers and carriers that must submit data in multiple formats and according to disparate standards to satisfy contractual obligations.

Research and stakeholder interviews suggested that in most states, there is minimal coordination or collaboration to standardize and streamline processes that could make directory updates easier and more efficient. Most carriers interviewed for this project ask providers to notify them of changes by phone, fax, and mail; some carriers have established secure online portals through which providers may submit updates. In cases where medical groups, IPAs, and third-party leased networks contract directly with carriers on behalf of a provider or group of providers, these groups serve as an intermediary and assume responsibility for transmitting updated provider information to carriers, adding an additional layer to the cascade of contracts and data flows (Figure 2, page 8).

Provider Directory Data Submission Templates

Some state Medicaid agencies and SBMs require the use of standards or a common template for carrier submission of provider data. For example, in California, the Department of Managed Health Care (DMHC), which enforces network adequacy and timely access standards, requires plans to use a standard template when submitting data. Plans submit an annual timely access report to confirm the status of their network and enrollment on a county-by-county basis.[25] DMHC and Covered California have partnered to enable health plans to use the DMHC template for both the required DMHC timely access filing and their Covered California quarterly network report.[26] Covered California may also use carriers' submissions to populate a provider directory in the future. This approach minimizes the burden on carriers and streamlines reporting of provider information.

In New York, carriers submit quarterly provider data to the Department of Health for all state-sponsored plans (Medicaid and CHIP) and the marketplace, and submit data annually for commercial managed care products via the Provider Network Database System (PNDS).[27] The state provides carriers with over 370 pages of data submission guidelines, underscoring the complexity of the data submission process, the resources the state has devoted to standardizing the process, and the resources carriers devote to submitting the necessary information.[28] The New York State Department of Health uses information submitted via the PNDS to complete regular network adequacy reviews, and the New York State of Health (NYSOH), the SBM for New York, uses the information to populate its provider directory.

While California and New York are examples of states and health insurance marketplaces working together to streamline carrier reporting of provider information, carriers that operate nationally or in multiple states must maintain separate reporting processes for their respective markets in the absence of national or widely accepted industry standards. Several carriers noted that complying with disparate requirements and submission guidelines is burdensome and requires significant resources. To minimize the burden, some carriers look for common data elements across requesting parties to develop baseline data submission forms and processes.

Data Integrity

Efforts to audit, perform quality assurance, and verify the accuracy of provider directory data vary widely, with many organizations performing little to no quality review.

Lack of Robust Quality Assurance Processes

Ensuring the integrity of provider directories via quality assurance processes is a critical function when aggregating disparate carrier and provider data or passing data between parties. Data integrity is especially relevant in the context of SBMs and state Medicaid agencies that consume data from multiple sources to create a single integrated provider directory. Despite the significant need for deliberate and ongoing efforts to ensure data integrity, few carriers, marketplaces, or state Medicaid agencies reported conducting robust data review or quality assurance activities.

Each step in the cascade of contracts and data (see Figure 2, page 8) introduces opportunities for errors and a breakdown in the flow of information. Errors can occur anywhere in the cascade as data are received in a variety of formats and standards, and issues can persist as compromised data are passed up the chain from providers and carriers to marketplaces and state Medicaid agencies.

The cascade also has implications for the timeliness of data updates; one vendor that operates a marketplace's provider directory reported a two-week lag between when an error is identified and when it is corrected in the provider directory. Other organizations reported similar lags of 15 business days to a few weeks between error notification and correction. These lags were attributed to data processing and the need for data to often pass through multiple departments and personnel before they can be published. Finally, marketplaces and provider representatives noted that even when providers submit updated information to a carrier, the information is not always carried through and reflected in the latest version of the carrier's or marketplace's provider directory.

Almost all marketplaces and some carriers report provider information as they receive it and perform little to no quality assurance or data reconciliation. (Some seek to verify data using existing databases, but typically do not change data found to be incorrect.) This approach may result in multiple entries for the same provider due to differences in carrier naming conventions (e.g., Dr. John Smith, Dr. J. Smith, and Dr. John H. Smith). A few SBMs and carriers attempt to clean the data, using identifying information such as the provider's national provider identifier (NPI), address, date of birth, or a state licensing number to reconcile the disparate information submitted by carriers and to create a single record for each provider. Even when data are cleaned or reconciled, however, significant limitations remain because organizations do not have access to a single source of provider information and may not be able to successfully resolve all provider records. Unique data elements such as an NPI may assist organizations attempting to create a master provider or institution index against which to match information submitted by carriers or providers.

"Even if provider information is updated, it may never make it to the directory."

—Director, consumer health advocacy organization

Verification Efforts

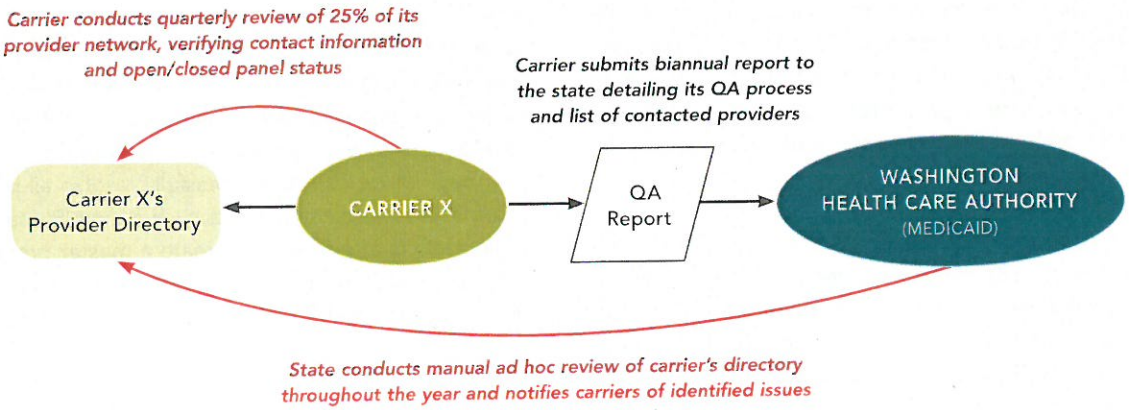
In addition to data reconciliation, some marketplaces, state Medicaid agencies, and carriers make an effort to verify provider information through routine or ad hoc audits. For example, when an issue is reported to a marketplace or state Medicaid agency, the New York and Maryland SBMs and California and Washington state Medicaid agencies reported that they or their vendors may reach out to the provider directly to confirm information and contract status. If the marketplace or agency identifies an inaccuracy with the provider's information,

"When you sit down with states and health plans, the discussion is always about what [data] each can and cannot change. Plans think they own the data and have it right. States want plans to own the data and get it right. We need to make it clear who owns the data and how best to get the data updated throughout the process — this piece is really important."

— Health information technology director, vendor

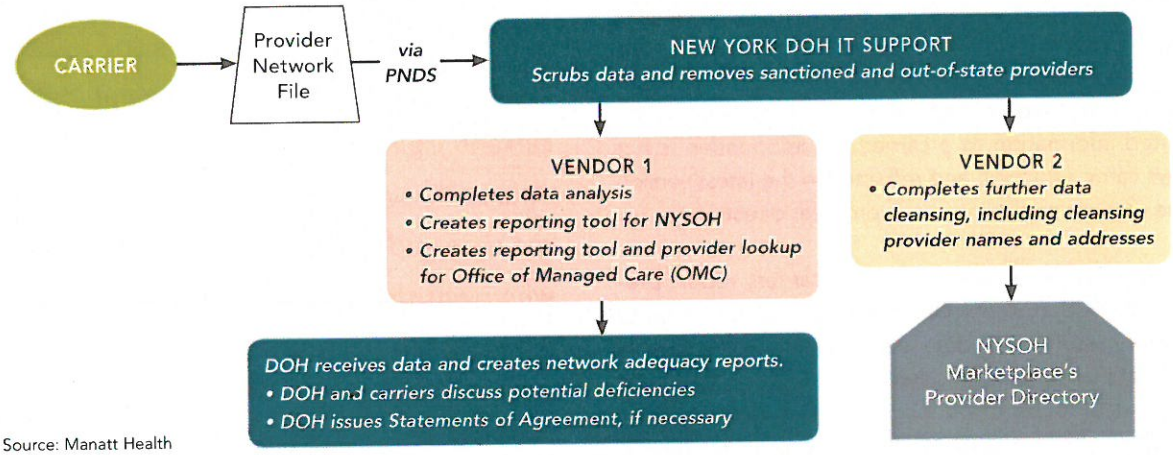
Washington Medicaid and New York State Data Integrity Processes

The **Washington Health Care Authority,** which operates the state's Medicaid program, does not produce a provider directory for its managed care plans but does actively monitor carriers' directories and confirms their accuracy. Under its contract with the Health Care Authority, a Medicaid managed care plan must verify provider information for 25% of its network every quarter, completing a review of 100% of its providers annually (see below). Carriers then submit reports to the state detailing their processes and the providers they contacted, specifying any changes that were made to the providers' information as a result of the review process. The Health Care Authority then conducts ad hoc manual reviews of participating Medicaid managed care carriers' directories throughout the year. When an issue is identified, the Health Care Authority contacts the carrier to correct the information and, depending on the extent of the issue, may conduct a full review of the carrier's provider network and place the carrier on a corrective action plan.



In **New York, the New York State Department of Health (DOH)** is the hub for data collection and analysis for state and marketplace products once carriers submit data using the Health Provider Network file and Provider Network Data System (PNDS). Carriers submit data using the PNDS and submit provider network files to DOH each quarter and, upon receipt, DOH verifies that the submissions are complete and removes sanctioned providers from carriers' networks (see below).

DOH also sends the data to two third-party vendors. One cleans the data, attempts to reconcile inconsistencies among carrier submissions, and posts the provider networks to the NY State of Health (NYSOH) website to assist consumers in selecting a health plan. A second vendor reviews and analyzes each product at the county and service-area levels to ensure carriers are compliant with network adequacy requirements.



Source: Manatt Health

they typically work with the carrier to correct the information for the carrier's next data submission rather than correct the information in their system to reflect a real-time update. The Maryland Health Connection and Covered California ask carriers to correct inaccuracies in provider data rather than making the change directly in their own systems. Marketplace staff reported that their reliance on carriers is due to concerns over data ownership and liability, and the desire that carriers themselves update underlying data.

The Maryland Health Connection identified an additional challenge with leased provider networks: Carriers that lease provider networks often do not have the ability to alter data reported by the leased networks.

Time and Resource Requirements

Organizations typically rely on time- and labor-intensive manual processes to develop and support provider directories.

All of the carrier, marketplace, and state Medicaid agency stakeholders interviewed for this project reported investing time and resources in creating and maintaining provider directories. To a large extent, processes and systems rely heavily on manual efforts to verify and update provider data. Many use a combination of manual and electronic processes to collect and publish data. All marketplaces and carriers that were interviewed reported contracting with third-party vendors to augment their internal provider directory resources and perform functions that the organizations do not have the capabilities to accomplish in-house.

"Sometimes it's quicker to just handle it manually than to put in new standards and processes."

— Project specialist, carrier

Stakeholders acknowledged that resource limitations constrain their abilities to improve processes and systems devoted to maintaining provider directories. This was most apparent among marketplaces and states that rely on federal or public funding sources, and it is a growing concern as marketplaces transition to become self-sustaining in 2016 and beyond. States like New York rely on older computer systems that were not designed to receive and process the large amounts of data required to drive a Medicaid or marketplace provider directory and to ensure its accuracy. New York is currently seeking to procure and implement a new system.

Carriers reported significantly different levels of resources dedicated to provider directories, and also struggled to uncouple their directory efforts from provider contracting, as many resources span the two functions. Carriers' resources also varied relative to their size and the number of markets in which they offer products, with some dedicating two full-time equivalents (FTEs) to provider directories and others upward of 20 FTEs. For example, a carrier operating in multiple states and offering QHPs, as well as commercial and Medicaid plans, had significantly more resources to ensure compliance with state and federal requirements than a local carrier offering only QHPs and Medicaid plans in a single state. Those with smaller teams suggested that to properly perform quality assurance, they would need significantly more personnel. The Washington Health Care Authority, which oversees six managed care plans, expressed a desire to triple their team from one to three FTEs.

"It takes a village to make the end product as effective and useful as possible. So many different departments must touch the information to get it in the system correctly and then extract it in an effective way."

— Senior director, carrier

Consumer Decisionmaking

Provider directories do not currently serve to effectively engage and inform consumers as they enroll in coverage and seek care.

Early State-Based Marketplace Efforts

Even though SBMs were not required to implement provider directories under the ACA, several took the initiative to do so to help consumers as they purchase and enroll in coverage. While stakeholders have been broadly supportive of marketplaces' provider directory efforts, issues with data quality and usability have marred these efforts to support consumer decisionmaking.

Consumer advocates noted the importance of provider directories in the marketplace enrollment process, but

also pointed out that they are relying on the carriers' directories when helping individuals enroll in coverage rather than on the marketplace's aggregated directory due to concerns over quality and accuracy. Some marketplaces suggest that consumers call the carrier or provider to ensure the provider is in-network.[29] Connect for Health Colorado will create a special enrollment period for consumers who purchased products that listed providers incorrectly and will work with consumers and carriers to resolve out-of-network claims that may have incurred as a result of inaccurate listings.

Critical Data Elements

While there was not consensus regarding the data elements required to create a directory with an adequate level of information to support consumer decisionmaking, stakeholders agreed that the following data elements would be valuable:

- Name
- Address
- Phone number
- Open/closed panel (specific to product)
- Gender
- Languages spoken by provider and office staff
- Specialties
- Accessibility
- Hours of operation
- Admitting privileges / affiliations

Some stakeholders also felt that facility information, including names, locations, and other demographic information, would be important, especially to Medicaid populations who may be used to seeking care at a specific clinic rather than with a particular provider. However, clinic data can pose an additional challenge for a provider directory. For example, a clinic with multiple locations that only reports or bills under their main location's address would only have that one location appear in a directory, unless significant work is done by directory administrators to identify all associated locations of that clinic. To date, most SBMs, including New York and Maryland, have not endeavored to list facilities like clinics due to challenges with reconciling data or their systems' technical limitations, all of which were too significant to overcome in the early stages of marketplace development.

Stakeholders also recognized that increasing the amount of data in a provider directory may lead to more opportunities for error and increased costs for maintaining that information. Recognizing this trade-off, stakeholders noted the importance of balancing the quantity and quality of information made available to consumers.

Provider Contracting

Confusion exists among providers about contracting and participating in specific carrier products and the requirements and processes needed to update provider data.

Stakeholders reported a general lack of awareness among providers with respect to certain carrier contracting practices, which can result in confusion between providers and members seeking their services. The most common instance stakeholders pointed to are all-product clauses, in which carriers include provisions in provider contracts requiring the provider to participate in all of a carrier's products. Carriers may rely on such clauses to ease the administrative burden that would be placed both on the plan and their entire contracted network of providers associated with issuing new contracts and amendments for every new product launch and change. While all-product clauses have been banned in at least six states, they remain common in California and New York.[30]

To address these concerns, the New York State Department of Public Health and Department of Financial Services plan to implement provider education guidelines for 2016 to reduce provider confusion about marketplace contracts. Both carriers and providers share responsibility for understanding and communicating the implications of all-product and other contractual obligations specified in contracts that they mutually sign.

Interviewees also pointed to the need to educate providers and their staff about the importance of updating their information and communicating changes to carriers in a timely manner. Carriers reported using the contracting process, existing network management relationships, newsletters, and other marketing opportunities to educate and remind providers about their obligations to update and communicate changes to their information under their contracts. Marketplaces expressed interest in implementing provider-facing portals where providers, after proving their identity, could verify and correct their information. The Maryland Health Connection is currently developing and testing such a portal before making it available to providers. One national carrier that operates a secure portal where providers can update

their information reported slow uptake among providers; when providers submit updates via the portal, changes are published on the carrier's online provider directory via weekly system updates.

Considerations for California

The increasing prevalence of narrow networks, coupled with the evolving health care market and shifting consumer expectations toward technology-enabled health care tools, are reinforcing the importance of establishing and maintaining accurate and integrated provider directories.[31]

Research revealed several opportunities for policymakers, carriers, providers, and advocates to improve provider directories to help inform and support consumer decisionmaking.

1. **Policy and regulatory alignment.** Policy and regulation without enforcement action appears to have failed to motivate marketplaces and carriers to ensure the accuracy and availability of provider directories. States, marketplaces, and carriers have generally not imposed sanctions or terminated carriers or providers for noncompliance with provider directory contractual provisions, policies, and regulations. The exception is the actions by New York's attorney general against noncompliant carriers, which have been imposed with monetary penalties and requirements to uphold obligations to publish accurate provider directories supported by robust quality assurance and data integrity processes.

   California's carriers are subject to oversight and guidance by two regulators — DMHC and California Department of Insurance (CDI). In addition, carriers offering QHPs are subject to Covered California's oversight as an active purchaser, with the power to set standards through contracting standards, which include standards around provider directory data integrity;[32] Medi-Cal managed care plans are also subject to contracting requirements of the Department of Health Care Services (DHCS). Regulators and public and private policymakers should consider how they convey consistent guidance and policy coupled with enforcement to set clear expectations for carriers. This is especially relevant in California, where misaligned or conflicting policies across regulators, major purchasers, and agencies could result in confusion and inefficiencies for carriers. Rather, if California's regulators, Covered California, and DHCS were to issue consistent guidance and require the same practices of carriers serving the commercial, marketplace, and Medicaid markets, carriers would have significant motivation to comply and could issue clearer and more consistent guidance to their contracted provider networks.

2. **Standards and accompanying guidance for provider directories.** The New York State Department of Health has achieved economies of scale by standardizing carriers' submission of provider data for state, marketplace, and commercial managed care products. Carriers across the state are accustomed to collecting and submitting data in the state-prescribed template, and the template collects sufficient data to support its provider directories and network adequacy review. This approach also minimizes the burden on carriers as they submit data using a single template across multiple products.

   California has taken steps in this direction by enabling health plans to use the DMHC template for both the required DMHC timely access filing and the plans' Covered California quarterly network reporting. Also, state legislation under consideration in 2015 would require DMHC and CDI to establish provider directory standards, as well as set additional requirements for provider directories.[33] The state could be well-served through continued development of a single template coupled with detailed guidance, agreed-upon standards and nomenclature of required data fields (e.g., provider and facility name, provider identifiers, practice/facility locations), and robust data submission and verification processes. The agreement among stakeholders on a single template to be used to meet both state and marketplace needs will not be easily achieved and will require clear guidance and education to help carriers successfully transition to its use.

   A separate but related issue California may consider is whether there is sufficient demand to develop a reliable, centralized resource of provider information. Today, carriers, Covered California, and Medi-Cal rely

on self-reported provider data and disparate sources against which they check provider information for accuracy and to identify if providers are sanctioned. To the extent each organization collects provider data in a unique format, aggregating and reporting these data at the marketplace or state level is increasingly difficult, and organizations would benefit from access to single, authoritative sources with up-to-date provider information.

Increased Attention in California

November 2014. DMHC audits identify significant inaccuracies in two large carriers' directories.

January 2015. State Senator Ed Hernandez introduces SB 137 to improve provider directories. Specifies time frames and processes for directory updates and directs the state to develop standard provider directory standards.

CDI issues emergency regulations to update network adequacy requirements for CDI-regulated plans. Provider directories of CDI-regulated plans must include demographic information, status of practice, and other elements.

June 2015. A California state auditor report examining DHCS's oversight of Medi-Cal managed care plans finds three carriers had significant inaccuracies in their directories and DHCS's provider directory review tool and process insufficient.

3. **Health care resources and diversity.** California's health care landscape is large and diverse. The state boasts nearly 49,000 primary care providers and over 53,000 specialists, many of whom practice in 280 delegated medical groups, IPAs, foundations, clinics, and other organizations, and provide care to over 38 million Californians.[34] The sheer size of California and the diversity of its health care institutions also have significant implications for the resources required to adequately establish and maintain accurate provider directories, especially any centralized efforts by the state or marketplace.

   The size and significance of California's health care landscape should not be underestimated by policymakers and others working to develop and maintain provider directories. If individual carriers are expected to dramatically improve the quality and timeliness of their provider directories, they will need to enhance investments in their staff and systems and have the commitment of their contracted provider partners to invest in efforts to deliver timely updates. These investments could result in some of the costs being passed along to consumers in the form of increased premiums and higher cost sharing. Similarly, at the state and marketplace levels, it will be a significant task to create and maintain more accurate provider directories, requiring an investment in resources and a commitment from leadership to prioritize provider directory efforts.

4. **Improving consumer decisionmaking and protections.** To be successful in informing consumers as they enroll in coverage and seek health care services, directories must:

   - Be accessible to consumers with various levels of health literacy
   - Take into account and address California's cultural and language diversity
   - Provide protections for consumers against inaccurate information

   First, provider directories must be developed with the consumer in mind and consider the way consumers think about and experience the health care market. Stakeholders designing and implementing directories should consider how to best serve consumers with low levels of health literacy to meaningfully inform their decisionmaking. For example, a provider directory could include definitions at appropriate reading levels that explain important aspects of the health care system, insurance coverage, and the products consumers are considering, as well as point consumers to both electronic and in-person resources to assist with coverage decisions.

   Second, directories should take into account and be responsive to the heterogeneous needs of California's diverse population. Primary language, cultural norms, and the specific needs of people with disabilities all factor into consumer decisionmaking in the health care arena. Directories can provide information related to provider and staff language capabilities,

ethnicity, and gender, which can be important factors for some consumers, and whether a provider's office or clinic is accessible according to the Americans with Disabilities Act guidelines.

Finally, when consumers buy an insurance product based on a provider directory network listing that may have inaccuracies, adequate financial protections and a clear process for recourse for consumers can be put into place. Policymakers, providers, and carriers can work together to ensure that special enrollment periods, coverage for out-of-network care, and other safeguards are afforded to consumers should they encounter and make decisions based on incorrect provider directories. For example, a misrepresentation or error in the provider directory can trigger a special enrollment period for consumers purchasing coverage through Covered California.[35] More can be done to make certain that assisters, brokers, and health plan personnel understand that provider directory errors trigger specific recourse for effected consumers and encourage them to take action so that consumers receive the health care services they need.

Appendix A: Target State-Based Marketplace Functionality

			PROVIDER DIRECTORY SEARCH FUNCTIONS									
	NUMBER OF HEALTH PLANS (2015)	TOTAL ENROLLEES (2015)	Provider Name	Provider Specialty	Hospital Name	Facility Name (e.g., labs)	Location	Carrier Name	Plan Name	Metal Level	Plan Quality Rating	Rx Drugs
CO	10	140,000	✓ Searchable by first or last name		✓	✓	✓					✓
MD	5	119,000	✓	✓			✓ Provider state, county, and/or zip	✓	✓			
NY	16	2.1 million	✓ Must search by last name and county	✓ Only with provider name			✓ Only for providers and with provider name and by county	✓		✓	✓	
WA	9	170,000	✓ Searchable by first or last name		✓		✓					

Note: SBM functionality data was verified as of February 2015.

Appendix B: List of Advisory Group Members

Ahmed Al-Dulaimi
Senior network specialist
Covered California

Bill Barcellona, MHA
Senior vice president, government affairs
California Association of Physician Groups

Beth Capell, PhD
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Health Access

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California Association of Health Plans

Elizabeth Gallagher
Director, provider services operations,
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Health Net of California

Betsy Imholz, JD
Director, special projects
Consumers Union

Tam Ma, JD
Policy counsel
Health Access

Craig Paxton, PhD
Principal
Cattaneo & Stroud

Julie Silas, JD
Senior attorney
Consumers Union

Appendix C: Federal Guidance and Action on Provider Directories

AGENCY/ ORG	REGULATION/ACTION/PROPOSAL	DATA REQUIREMENTS	FREQUENCY OF UPDATES
CMS	Advance Notice of Methodological Changes for Calendar Year (CY) 2016 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2016 Call Letter	**Providers:** whether accepting new patients; demographic information, including address, phone number, and hours Carriers must contact providers at least quarterly to verify network participation and demographic information.	In real-time for online directories
CMS	Medicaid and Children's Health Insurance Program (CHIP) Programs: Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions related to Third Party Liability (proposed 5/26, published 6/1)	**Physicians, hospitals, pharmacies, behavioral health providers, and LTSS providers:** provider name and affiliation; street address; phone number; website, as appropriate; specialty; open/closed panel; languages spoken by provider or skilled medical interpreter; and accessibility for those with physical disabilities	At least monthly for paper directories and within three business days of receipt of updated information for electronic directories
HHS	Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers (final rule and interim final rule, 2012)	**Providers:** licensure; specialty; contact information, including institutional affiliation; whether accepting new patients; accommodations for individuals with disabilities and/or limited English proficiency	None provided — suggested that timelines should strike a balance between consumer choice and the burden that updates place on carriers
HHS	Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016 (final rule)	**Providers:** whether accepting new patients, location, contact information, specialty, medical group, and any institutional affiliations	At least monthly
NAIC	Draft Health Benefit Plan Network Access and Adequacy Model Act (draft)	**Providers:** name, gender, contact information, specialty, whether accepting new patients, hospital affiliation(s), medical group affiliation(s), board certification(s), language(s) spoken by provider or staff, and office location(s) **Hospitals and facilities:** name, location, type (facilities only), and procedures performed (facilities only)	At least monthly

Endnotes

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7. "Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule," 45 CFR 155-157 (2012), www.gpo.gov (PDF).
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13. *2015 Letter to Issuers in the Federally-Facilitated Marketplaces,* Centers for Medicare & Medicaid Services, March 14, 2014, www.cms.gov (PDF).
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September 2015 | Issue Brief

Economic and Fiscal Trends in Expansion and Non-Expansion States: What We Know Leading Up to 2014

Laura Snyder and Robin Rudowitz, Kaiser Family Foundation
Lucy Dadayan and Don Boyd, Rockefeller Institute of Government

Medicaid is the nation's primary health insurance program for low-income and high-need Americans. Because of the program's joint federal-state financing structure, Medicaid has a unique role in state budgets because it is both an expenditure item and a source of federal revenue for states. States have significant flexibility within broad federal rules to administer their Medicaid programs. Policy decisions, as well as other factors such as the economy, demographics and state tax capacity are key factors in determining the types and amounts of revenue that states collect as well as how they budget those funds across programs.

Under the Affordable Care Act (ACA), Medicaid was expanded to nearly all adults with incomes at or below 138 percent FPL. However, the June 2012 Supreme Court decision effectively made the Medicaid expansion optional for states. As of September 1, 2015, 31 states including DC have adopted the Medicaid expansion.[1] (Exhibit 1.1) For those that expand, the federal government pays 100 percent of the Medicaid costs for those newly eligible from January 2014 through December 2016. The federal share then phases down gradually to 90 percent in 2020 and remains at that level thereafter, well above traditional rates. The effects of the Medicaid expansion on state budgets and economies have been key issues for policy makers.

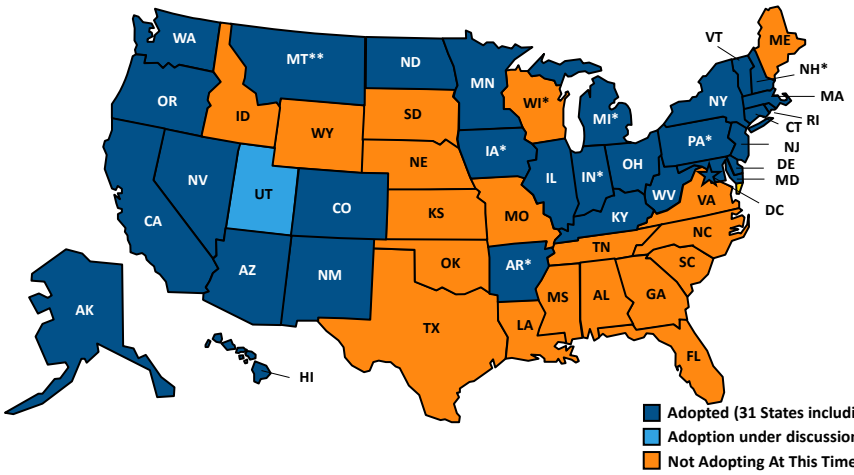
This brief, prepared with the Rockefeller Institute of Government, the public policy research arm of the State University of New York, is designed to provide some insight into the underlying economic and fiscal conditions in expansion and non-expansion states leading up to 2014. Analysis focuses on the typical (i.e. median) state for each group. This analysis will provide a framework against which to measure the impact of expansion decisions going forward. The sections focus on: demographics, tax capacity and revenue, state budgets and employment. Key findings include:

- The typical expansion state was in a better position across the factors analyzed leading up to the ACA Medicaid expansion in 2014.
- Median poverty and uninsured rates were higher in non-expansion states. (Exhibits 1.2, 1.3)
- Across different measures, the median tax capacity for expansion states has been higher. (Exhibit 1.4)
- Median tax collections per capita have historically been higher in expansion states. (Exhibit 1.5)
- The typical expansion state has historically raised more tax revenue as a share of available resources; the gap between these two groups has increased over time. (Exhibit 1.6)

- The typical expansion state spent more per capita on Medicaid and K-12 education prior to the major ACA coverage expansions. (Exhibit 1.7)
- Health-related employment remained strong during the recession for both groups of states; the typical expansion state has historically had a higher share of employment coming from the health sector. (Exhibit 1.8)

Exhibit 1.1

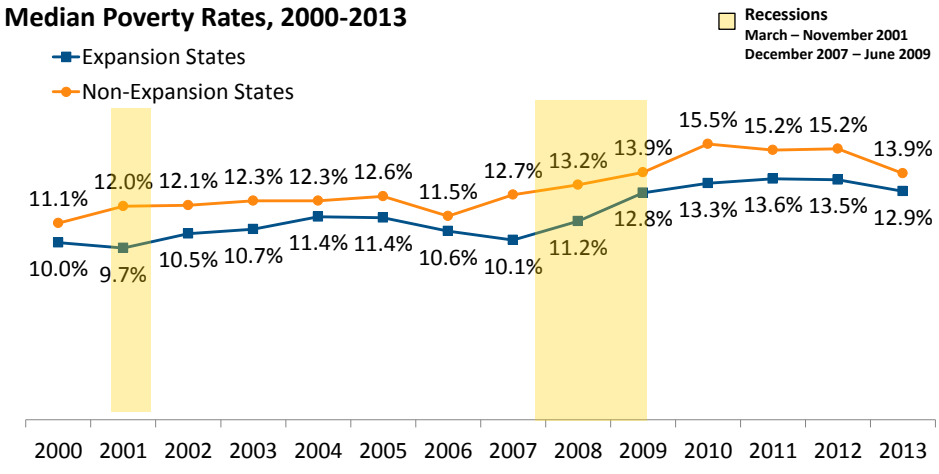
Over half of states have adopted the Medicaid expansion.



NOTES: Under discussion indicates executive activity supporting adoption of the Medicaid expansion. **MT has passed legislation adopting the expansion; it requires federal waiver approval. *AR, IA, IN, MI, PA and NH have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it is transitioning coverage to a state plan amendment. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.
SOURCE: "Status of State Action on the Medicaid expansion Decision," KFF State Health Facts, updated September 1, 2015.
http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

Exhibit 1.2

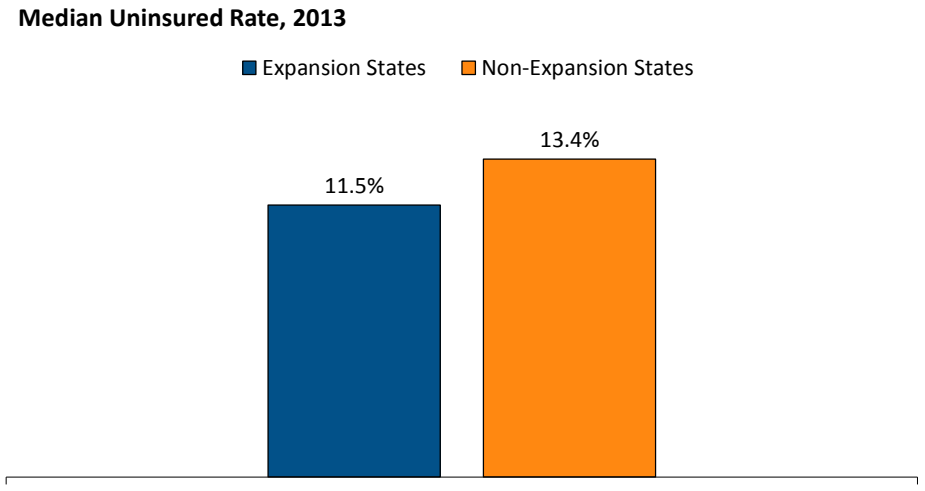
The typical non-expansion state has historically had higher rates of poverty.



NOTE: Data reflect median poverty rates for each group. Median values exclude DC.
SOURCE: KCMU/Rockefeller Institute analysis of Current Population Survey, Annual Social and Economic Supplements, U.S. Census Bureau.

Exhibit 1.3

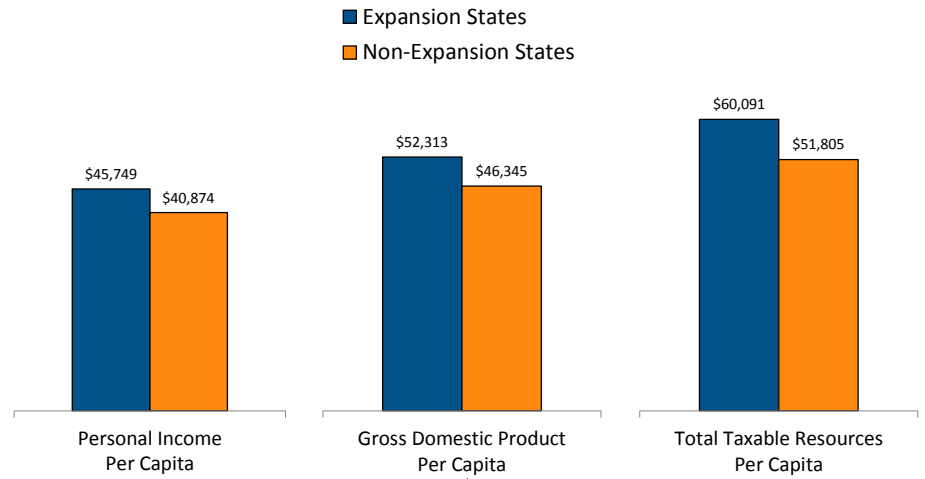
The typical non-expansion state had a higher uninsured rate prior to the major ACA coverage expansions than the typical expansion state.



NOTE: Data reflect average annual growth rates for the medians of each group. Median values exclude DC.
SOURCE: KCMU/Rockefeller Institute analysis of Current Population Survey, Annual Social and Economic Supplements, U.S. Census Bureau.

Exhibit 1.4

The typical expansion state has greater tax capacity than the typical non-expansion state, regardless of measure.

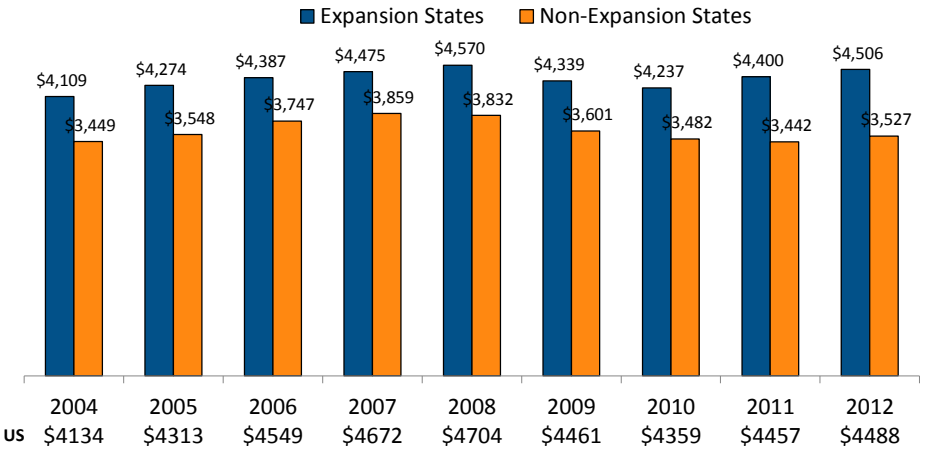


NOTES: Data reflect 2012 reporting. All data were inflated to real 2013 $ per the GDP price index. Median values exclude DC.
SOURCE: KCMU/Rockefeller Institute analysis of Per Capita Personal Income, Per Capita GDP as calculated by the Bureau of Economic Analysis. KCMU/Rockefeller Institute analysis of Total Taxable Resources per capita as reported by the U.S. Treasury Department.

Exhibit 1.5

The typical expansion state has historically collected more per capita in state and local taxes.

Median State and Local Government Tax Collections Per Capita, 2004-2012

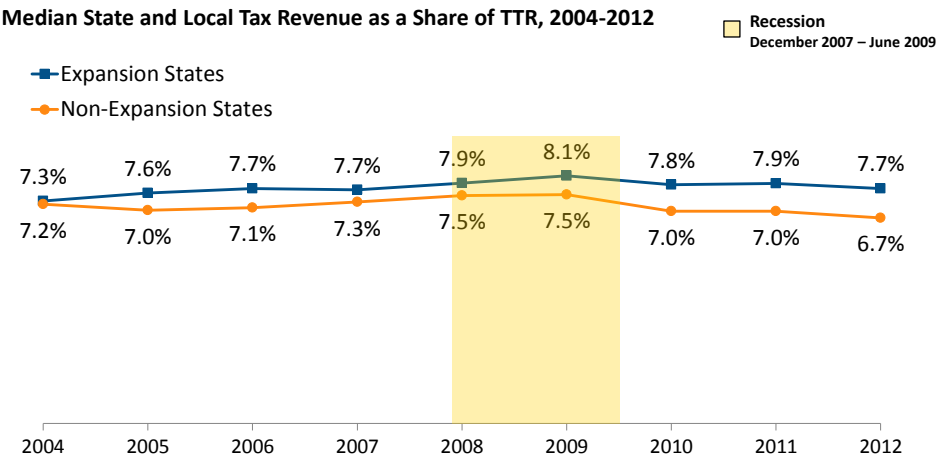


NOTE: Median values exclude DC. All data were inflated to real 2013 $ per the GDP price index.
SOURCE: KCMU/Rockefeller Institute analysis of Annual State and Local Government Tax Collections, U.S. Census Bureau.

Exhibit 1.6

The typical expansion state has raised more tax revenue as a share of total taxable resources than the typical non-expansion state.

Median State and Local Tax Revenue as a Share of TTR, 2004-2012

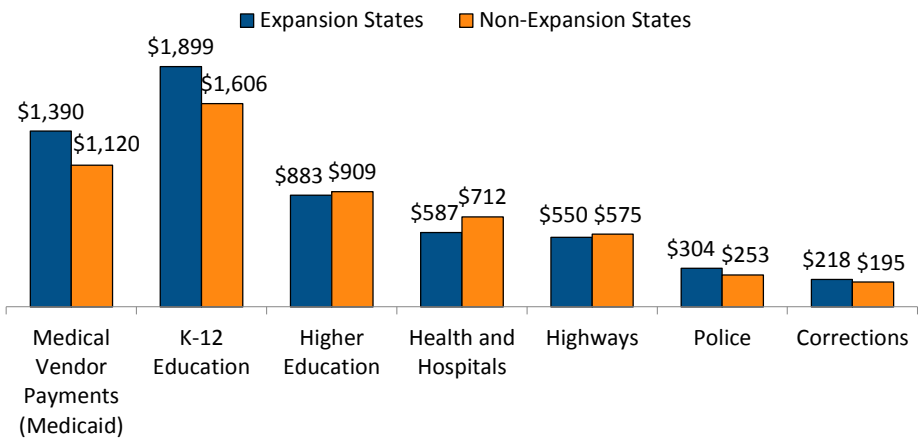


NOTES: Values reported reflect median shares for each group; DC is excluded. All data were inflated to real 2013 $ per the GDP price index. Calculations completed by the authors.
SOURCES: KCMU/ Rockefeller Institute analysis of State and Local Government Finance Survey, U.S. Census Bureau and Total Taxable Resources per capita as reported by the U.S. Treasury Department.

Exhibit 1.7

The typical expansion state spent more per capita on Medicaid and K-12 Education than the typical non-expansion state.

Median State and Local Government Expenditures per capita, 2012

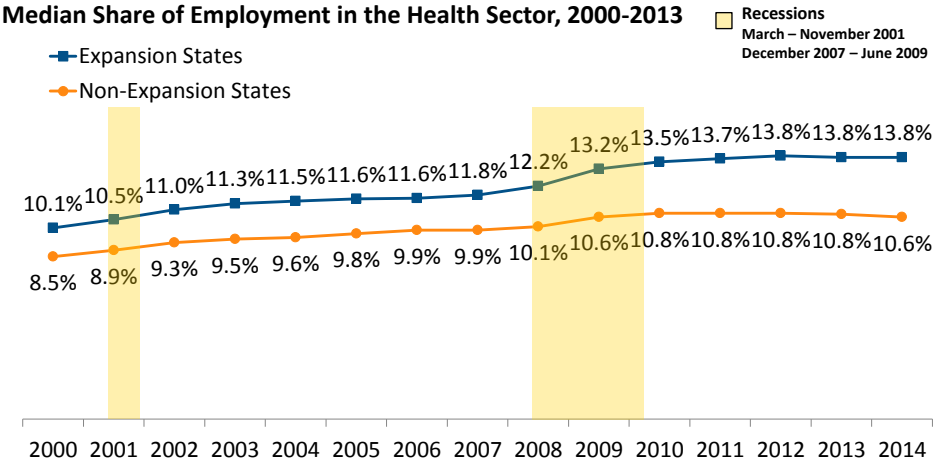


NOTE: Data reflect medians for each group; all data were inflated to real 2013 $ per the GDP price index. Median values exclude DC. Excluded are intergovernmental transfers made by state and local governments.
SOURCE: KCMU/Rockefeller Institute analysis of Census data on State and Local Government Finances, 2012.

Exhibit 1.8

The typical expansion state has historically had a higher share of employment in the health sector.

Median Share of Employment in the Health Sector, 2000-2013



NOTE: Data reflect median share of the total population that unemployment rates for each group. Data are not seasonally adjusted. Health-related employment also includes some social assistance employment. Median values exclude AK, DC and NM. Health-related employment data are not reported for NM and AK.
SOURCE: KCMU/Rockefeller Institute analysis of Bureau of Labor Statistics data.

Introduction

This brief, prepared with the Rockefeller Institute of Government, is designed to provide insight into the underlying economic and fiscal conditions in expansion and non-expansion states leading up to 2014, providing a framework against which to measure the impact of expansion decisions going forward. Each section of this paper presents a series of charts illustrating the key findings between expansion and non-expansion states followed by a summary of the key findings. The sections focus on: demographics, tax capacity and revenue, state budgets and employment. Additional details on the methodology and the variables are included in Appendix A; also included is a summary of the findings is located in the Appendix summary table.

Key Findings

How do Expansion and Non-expansion States Compare? – Demographics

The demographic make-up of a state is a reflection of state fiscal conditions and affects state spending priorities. Several key factors include age, poverty and particularly for looking at expansion vs. non-expansion states, insurance coverage.

Age

- Nationally, children make up nearly a quarter of the population, while the elderly represent almost one-seventh of the population. Since 2000, the growth among children has been relatively flat while growth among the elderly has been increasing at a faster pace. (Exhibit 2.1)
- The typical non-expansion state has a relatively higher share of the population that are children while the typical expansion state has a relatively higher share of the population that are elderly adults. Children as share of the total population is about 4% higher in a typical non-expansion state (25.1% vs. 24.1%) and people over age 65 as share of the total population is about 5% higher in a typical expansion state (14.9% vs. 14.2%). (Exhibit 2.2)
- From 2000 through 2013, both expansion states and non-expansion states have seen declines in the share of the population that are children and increases in the share that are elderly adults. (Exhibit 2.2)

Median Household Income

- Nationally, the real median household income had fallen from its pre-recession peak of over $56,000 to under $52,000 in 2012. Median household income in 2013 was still below pre-recession levels (as well as 2000 levels), but had started to increase slightly since 2012.
- The typical expansion state has historically had a higher real median household income than the typical non-expansion state. (Exhibit 2.3)
- Median household income in 2013 for the typical expansion and non-expansion states was below both pre-recession peaks and 2000 levels. (Exhibit 2.3)
- There is also variation within each group; some non-expansion states (e.g. Virginia and Utah) had some of the highest median household incomes in 2013 while some expansion states (e.g. Arkansas and West Virginia) had some of the lowest median household incomes in 2013. (Exhibit 2.4)

Poverty Rate

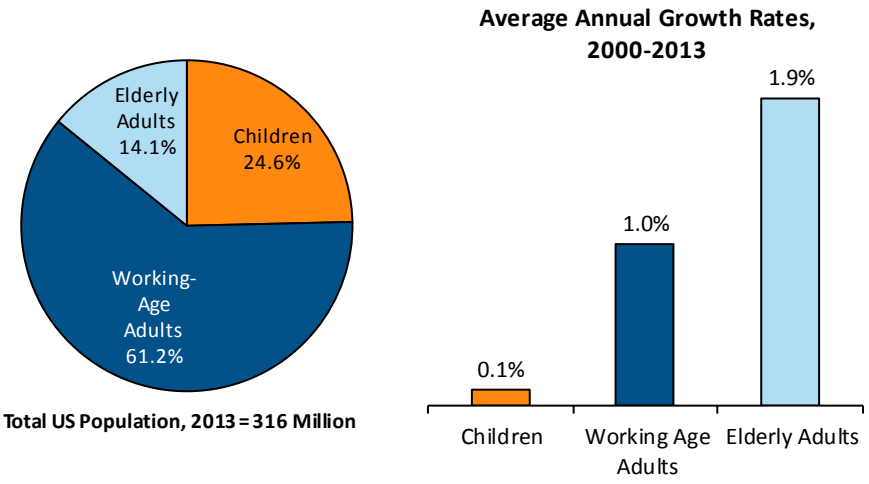
- Over the 2000-2013 period, the national poverty rate peaked in 2010 and has since slowly fallen to 14.5% in 2013.
- The typical non-expansion state has historically had a higher poverty rate than the typical expansion state. (Exhibit 2.5)
- There is also variation within each group; three of the highest-poverty states in 2013 were expansion states (Arizona, Kentucky, and New Mexico), while several non-expansion states had very low poverty rates, including South Dakota, Utah, and Virginia. (Exhibit 2.6)

Uninsured Rate

- Prior to the ACA's major coverage expansions in 2014, over half of all Americans were enrolled in private health insurance (employer and other private coverage), 15.6% were enrolled in Medicaid, 14.7% were enrolled in Medicare and 13.4% were uninsured. (Exhibit 2.7)
- The typical non-expansion state had a higher share of uninsured people prior to the ACA major coverage expansions than the typical expansion state. The number of uninsured people as share of total population was 13.4% in the typical non-expansion state, which is about 17% higher (13.4% vs. 11.5%) compared to the typical expansion state. (Exhibit 2.8)

Exhibit 2.1

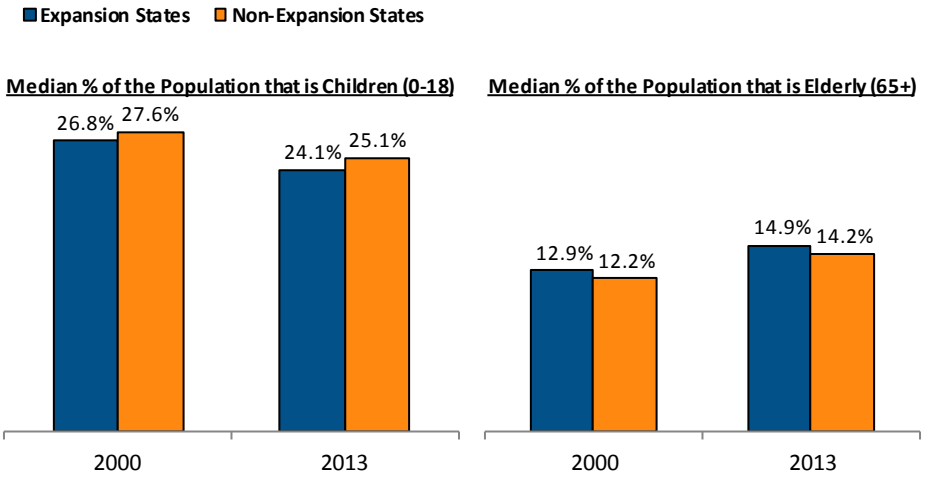
Children comprise a quarter of the population; however, the elderly are growing at a much faster pace.



NOTE: Data presented here do include DC.
SOURCE: KCMU/Rockefeller Institute analysis of Current Population Survey, Annual Social and Economic Supplements, U.S. Census Bureau.

Exhibit 2.2

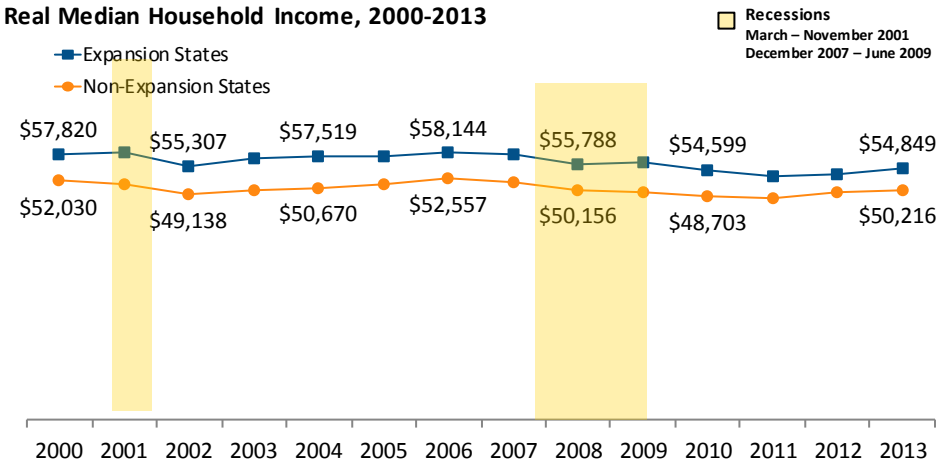
The shares of the population for children are declining and the shares for the elderly are growing in both groups.



NOTE: Data reflect the median share of the population for children (0-18) and the elderly (65+). Median values exclude DC.
SOURCE: KCMU/Rockefeller Institute analysis of Current Population Survey, Annual Social and Economic Supplements, U.S. Census Bureau.

Exhibit 2.3

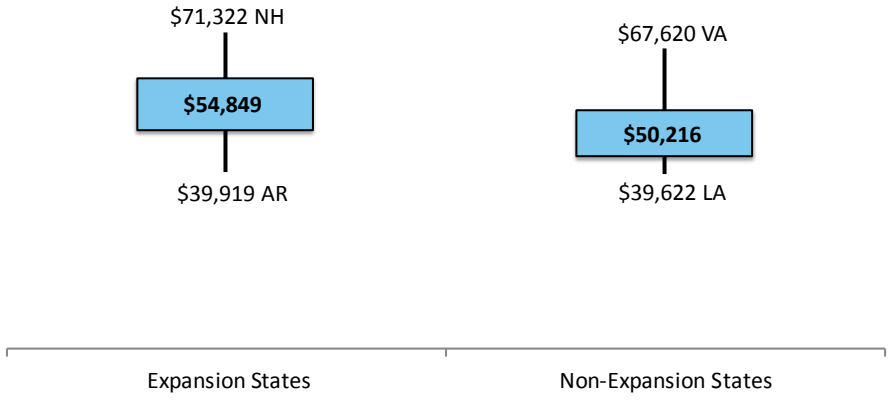
The typical expansion state has a higher median household income; however, median income remains below 2000 levels.



NOTE: Data reflect median household income for each group. All data were inflated to real 2013 $ per the GDP price index. Median values exclude DC.
SOURCE: KCMU/ Rockefeller Institute analysis of Current Population Survey, Annual Social and Economic Supplements, U.S. Census Bureau.

Exhibit 2.4

There is variation within both groups in terms of the median household income.

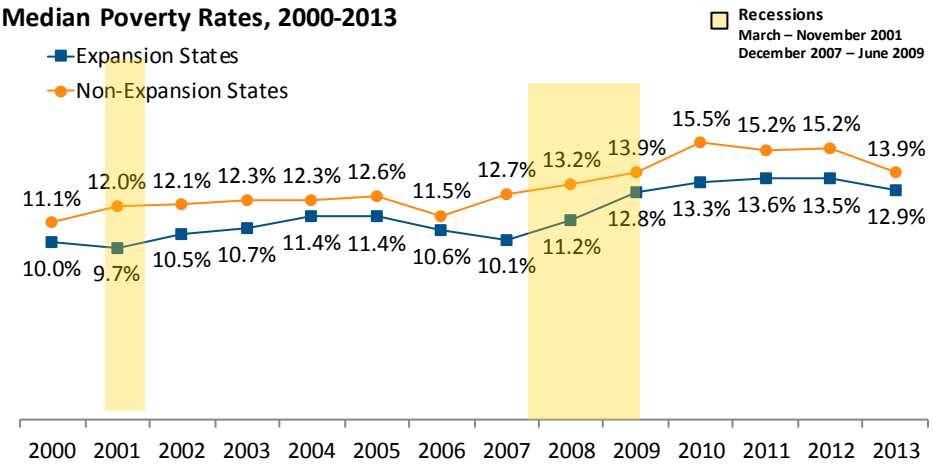


NOTE: Boxes are labeled with the median values of each group; boxes denote values between the first and third quartiles. Median values exclude DC.
SOURCE: KCMU/ Rockefeller Institute analysis of Current Population Survey, Annual Social and Economic Supplements, U.S. Census Bureau.

Exhibit 2.5

The typical non-expansion state has historically had higher rates of poverty.

Median Poverty Rates, 2000-2013

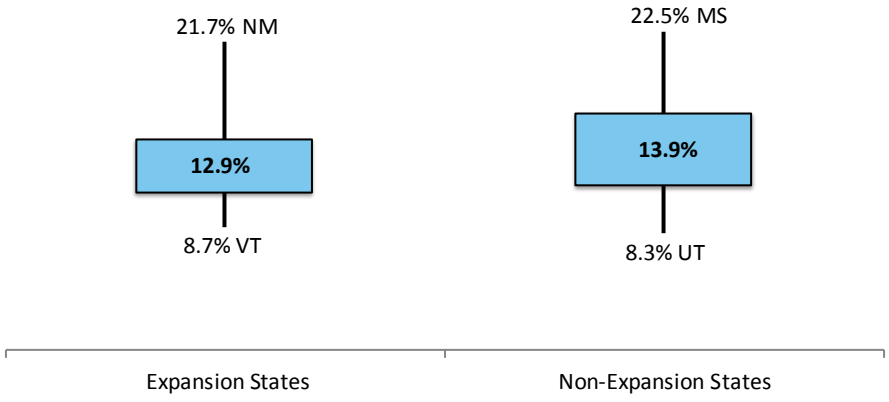


NOTE: Data reflect median poverty rates for each group. Median values exclude DC.
SOURCE: KCMU/Rockefeller Institute analysis of Current Population Survey, Annual Social and Economic Supplements, U.S. Census Bureau.

Exhibit 2.6

Within expansion and non-expansion states, there is a notable amount of variation in poverty rates.

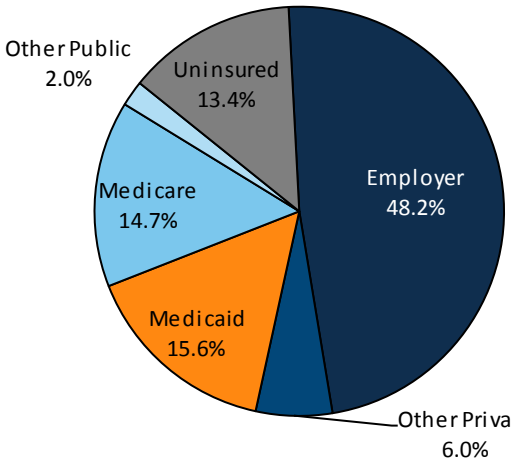
Poverty Rates, 2013



NOTE: Boxes are labeled with the median values of each group; boxes denote values between the first and third quartiles. Median values exclude DC.
SOURCE: KCMU/ Rockefeller Institute analysis of Current Population Survey, Annual Social and Economic Supplements, U.S. Census Bureau.

Exhibit 2.7

Prior to the major ACA coverage expansions, over 13% of Americans were uninsured.



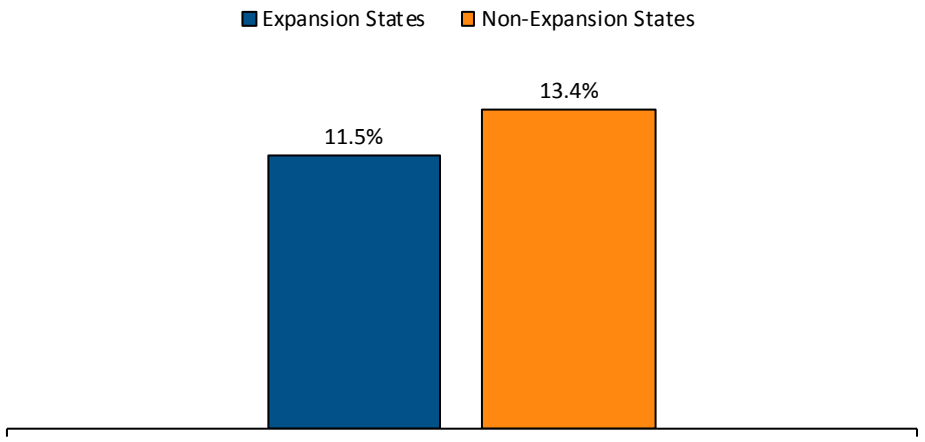
Health Insurance Coverage for Total Population, 2013

NOTE: Data include DC.
SOURCE: Kaiser Family Foundation analysis of the 2014 ASEC Supplement to the CPS.

Exhibit 2.8

The typical non-expansion state had a higher uninsured rate prior to the major ACA coverage expansions than the typical expansion state.

Median Uninsured Rate, 2013



NOTE: Data reflect average annual growth rates for the medians of each group. Median values exclude DC.
SOURCE: KCMU/Rockefeller Institute analysis of Current Population Survey, Annual Social and Economic Supplements, U.S. Census Bureau.

How do Expansion and Non-expansion States Compare? – Revenue and Tax Capacity

In debating adoption of the Medicaid expansion, many states have tried to assess the implications for state revenues. For example, some expansion states like Kentucky have noted increased tax revenues since adopting the Medicaid expansion. However, leading up to the implementation of the ACA, expansion and non-expansion states have historical differences across key measures of revenue and tax capacity including tax collections, capacity, and effort. There are also notable differences in the composition of tax revenue sources and tax policy.

Tax Collections

- At a national level, state tax capacity has been increasing since the Great Recession.
- Both groups of states saw declines in real per capital tax collections during the Great Recession; the typical expansion state has recovered faster than the typical non-expansion state. (Exhibit 3.1)

Tax Capacity

- The typical expansion state had greater tax capacity whether measured by personal income, GDP or total taxable resources (TTR) per capita. Tax capacity was about 12% to 16% higher in the median expansion state in 2012, depending on the measure. (Exhibit 3.2)
- There are some exceptions. Wyoming is a non-expansion state that had a higher TTR per capita than any expansion state in 2012 except Alaska, driven by tax revenue potential from oil and minerals. There are some expansion states (West Virginia and Kentucky) which had some of the lowest TTR per capita in this period.
- There has been a widening gap between expansion and non-expansion states in terms of their fiscal capacity. In 2000, the typical expansion state had a TTR per capita 8% higher than the typical non-expansion state ($49,109 vs. $53,070); by 2012, the difference had grown to 16% ($51,805 vs. $60,091). (Exhibit 3.3)

Tax Collections as a Share of Tax Capacity

- The typical expansion state raises much more (25% more) in state and local tax revenue per capita than the typical non-expansion state. (Exhibit 3.4)
- The typical expansion state raises more, even relative to their greater tax capacity; state and local tax revenues as a percent of TTR were about 14% higher in the typical expansion state (7.7% vs. 6.7%). Over time, tax collections as a share of TTR have increased in the typical expansion state (7.3% in 2000 vs. 7.7% in 2012) but decreased in the typical non-expansion state (7.2% in 2000 vs. 6.7% in 2012). (Exhibit 3.5)

Composition of Tax Revenue Sources

- Nationally, 32% of the $1.4 trillion tax revenue collected by state and local governments came from property taxes, followed by general sales taxes (23%) and personal income taxes (22%). Nearly $6 in $10 in tax revenues were collected by state governments; the remainder was collected by localities. (Exhibit 3.6)
- The typical non-expansion state relies much more on relatively regressive general sales taxes (28.8% compared to 18.0% in the typical expansion state.) The typical expansion state relies slightly more on relatively progressive personal income taxes. (Exhibit 3.7)
- There are some exceptions. Non-expansion states like Maine, Virginia, and Wisconsin rely little on sales taxes while expansion states like New Hampshire, Nevada and Washington do not have broad-based income taxes.

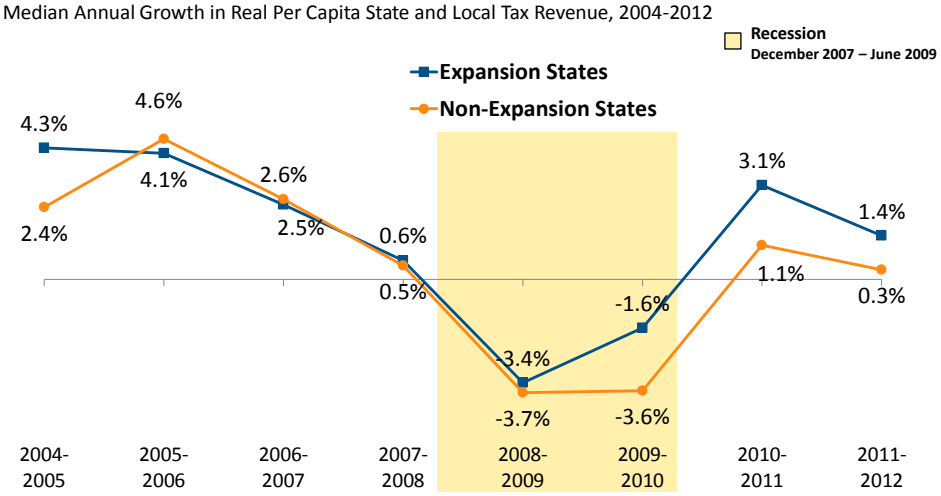
Tax Policy Changes

- The analysis of state government legislated tax changes shows that the typical expansion and non-expansion states responded to fiscal challenges created by the Great Recession differently; that the typical expansion state notably raised taxes since fiscal year 2008 while the typical non-expansion state had lowered taxes. (Exhibit 3.8)

Exhibit 3.1

Both groups saw sharp declines in revenues during the Great Recession, but the typical expansion state has recovered quicker.

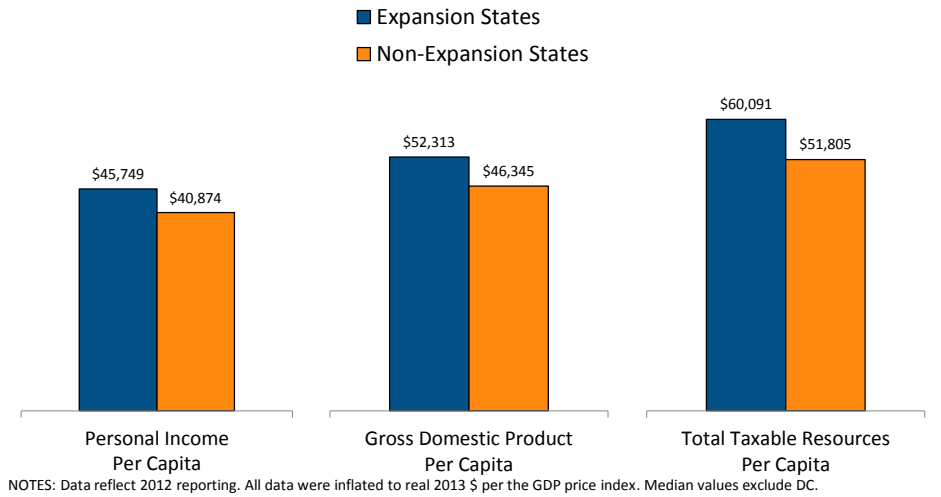
Median Annual Growth in Real Per Capita State and Local Tax Revenue, 2004-2012



NOTE: Refers to the median annual percentage change in real state and local tax collections for each group. Calculations exclude DC. All data were inflated to real 2013 $ per the GDP price index.
SOURCE: KCMU/Rockefeller Institute analysis of Annual State and Local Government Tax Collections, U.S. Census Bureau.

Exhibit 3.2

The typical expansion state has greater tax capacity than the typical non-expansion state, regardless of measure.

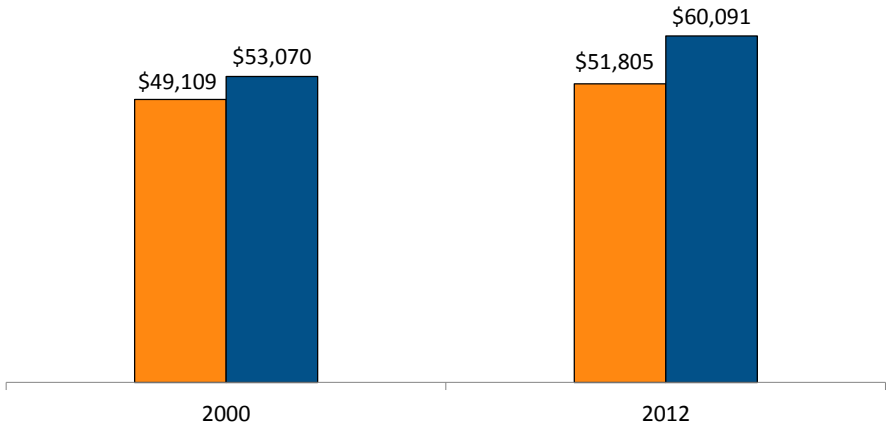


NOTES: Data reflect 2012 reporting. All data were inflated to real 2013 $ per the GDP price index. Median values exclude DC.
SOURCE: KCMU/Rockefeller Institute analysis of Per Capita Personal Income, Per Capita GDP as calculated by the Bureau of Economic Analysis. KCMU/Rockefeller Institute analysis of Total Taxable Resources per capita as reported by the U.S. Treasury Department.

Exhibit 3.3

The typical expansion state has historically had higher tax capacity; the difference has been growing over time.

Total Taxable Resources per capita, 2000 and 2012

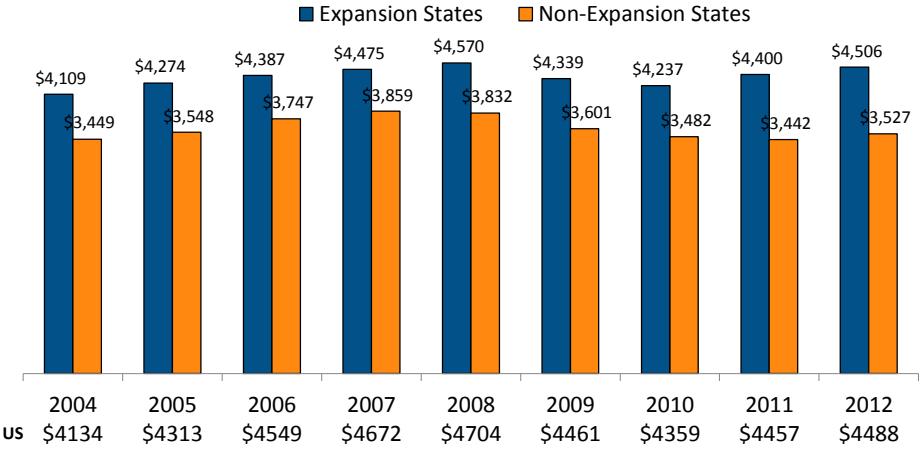


NOTES: Data reflect medians for each group; all data were inflated to real 2013 $ per the GDP price index. Median values exclude DC.
SOURCE: Total Taxable Resources per capita as reported by the U.S. Treasury Department.

Exhibit 3.4

The typical expansion state has historically collected more per capita in state and local taxes.

Median State and Local Government Tax Collections Per Capita, 2004-2012

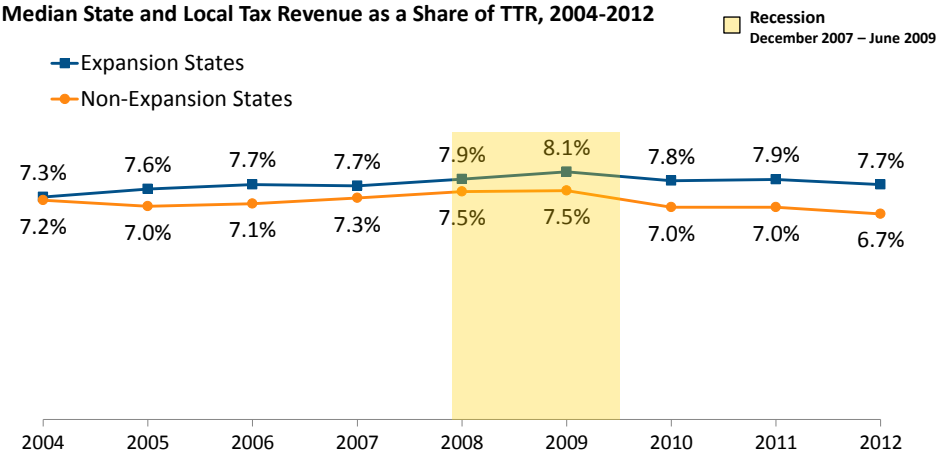


NOTE: Median values exclude DC. All data were inflated to real 2013 $ per the GDP price index.
SOURCE: KCMU/Rockefeller Institute analysis of Annual State and Local Government Tax Collections, U.S. Census Bureau.

Exhibit 3.5

The typical expansion state has raised more tax revenue as a share of total taxable resources than the typical non-expansion state.

Median State and Local Tax Revenue as a Share of TTR, 2004-2012

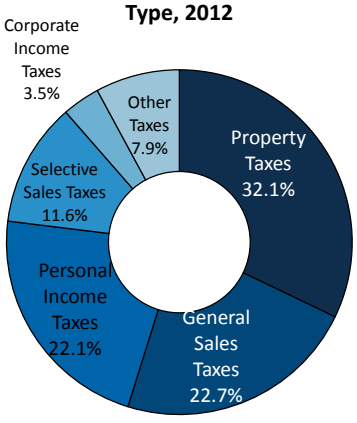


NOTES: Values reported reflect median shares for each group. All data were inflated to real 2013 $ per the GDP price index. Calculations completed by the authors. Median values exclude DC.
SOURCES: KCMU/ Rockefeller Institute analysis of State and Local Government Finance Survey, U.S. Census Bureau and Total Taxable Resources per capita as reported by the U.S. Treasury Department.

Exhibit 3.6

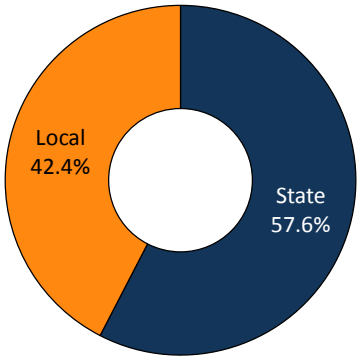
The most common sources of state and local tax revenue nationally are property, general sales and personal income taxes.

State and Local Tax Revenue by Tax Type, 2012



2012 Total Taxes Collected = $1.4 Trillion

State and Local Tax Revenue by Government, 2012



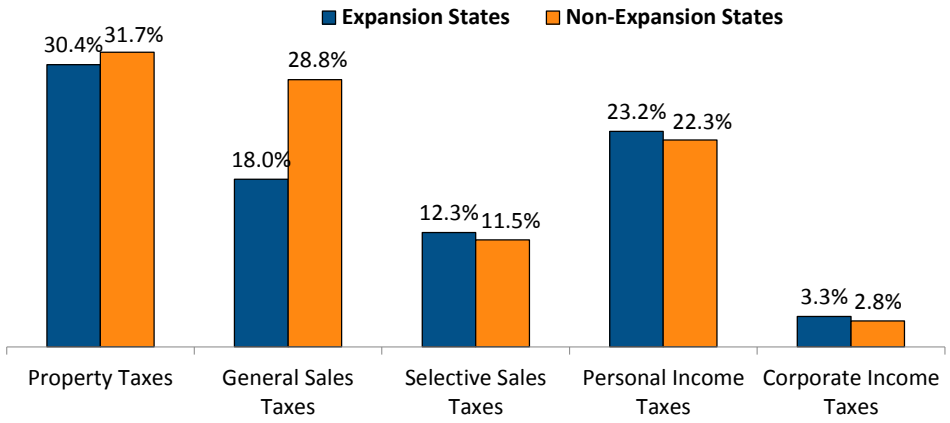
2012 Total Taxes Collected = $1.4 Trillion

NOTE: Data exclude DC. All data were inflated to real 2013 $ per the GDP price index.
SOURCE: KCMU/Rockefeller Institute analysis of State and Local Government Finance Survey, U.S. Census Bureau.

Exhibit 3.7

The typical non-expansion state relies more heavily on general sales tax revenues than the typical expansion state.

Median Share of State and Local Government Tax Revenue by Source, 2012

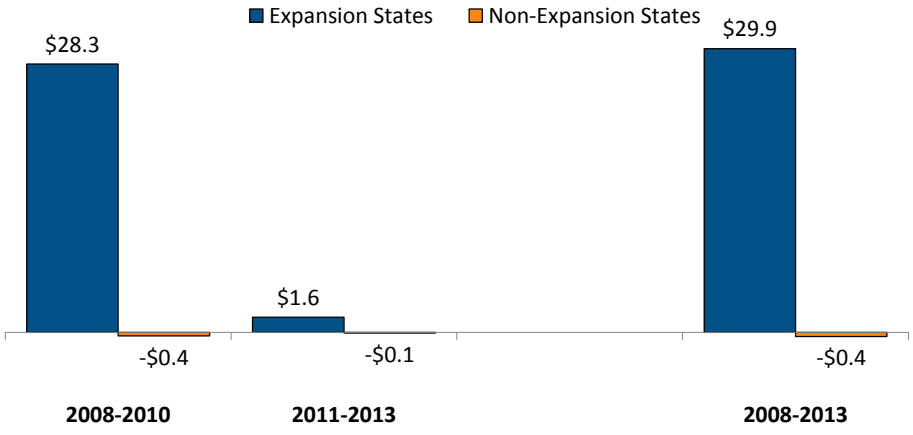


NOTE: Not all tax revenues sources are listed here; shares do not sum to 100%. Median values exclude DC.
SOURCE: KCMU/Rockefeller Institute analysis of State and Local Government Finance Survey, U.S. Census Bureau.

Exhibit 3.8

The typical expansion state has acted to increase taxes since the recession while the typical non-expansion state has cut taxes.

Median Legislated State Tax Changes for expansion and Non-expansion States per capita, SFY 2008-2013



NOTE: Excludes DC. Values reported are nominal.
SOURCE: KCMU/Rockefeller Institute analysis of data from NASBO, Fiscal Survey of States.

How do Expansion and Non-expansion States Compare? – State Budgets

A significant part of discussions in states over the adoption of the Medicaid expansion has been about state spending priorities. Unlike the federal government, states are generally required to balance their budgets; budgets therefore are a reflection of spending priorities within available resources. Several key factors include total state and local budget spending (spending from all sources – state, federal, and local) as well as spending across categories. Data in this section reflect total spending by state and local governments; this includes federal dollars spent by states and localities as well as spending from state and local sources. In state budgets, Medicaid financing is unique compared to other state spending programs due to the federal matching structure. For those states that adopt the expansion, the share of funding for Medicaid from federal dollars is expected to increase given the higher matching rate for those newly eligible under the Medicaid expansion.

Total State and Local Spending Per Capita

- Spending by state and local governments has slowed in recent years since the Great Recession; direct general expenditures actually declined in 2011 and 2012 compared to the prior year. (Exhibit 4.1)
- The typical expansion state has state and local government spending that is 17% more per-capita than the typical non-expansion state ($8,713 vs. $7,414). (Exhibit 4.2)
- Wyoming and Louisiana are notable exceptions; both are non-expansion states that spent more per-capita than many expansion states. Some expansion states (e.g. Arizona and Nevada) spent notably less than the typical non-expansion state. (Exhibit 4.3)

Distribution Across Spending Categories

- Nationally, state and local governments spent the largest amount (federal, state and local dollars) on a per capita basis for K-12 education, followed by Medicaid-related spending and higher education in FY 2012. (Exhibit 4.4)
- The typical expansion state spent more per capita on Medicaid-related spending (+24%); K-12 education (+18%); police (+20%) and corrections (+11%). (Exhibit 4.5)
- By contrast, the typical non-expansion state spent more per-capita on health and hospitals (+21%), highways (+5%) and higher education (+3%) than the typical expansion state. (Exhibit 4.5) This may be a reflection of the more rural nature of non-expansion states (hence, higher spending on highways) as well as that non-expansion states have more hospitals owned by state and local governments (leading to higher spending on health and hospitals.)[2]

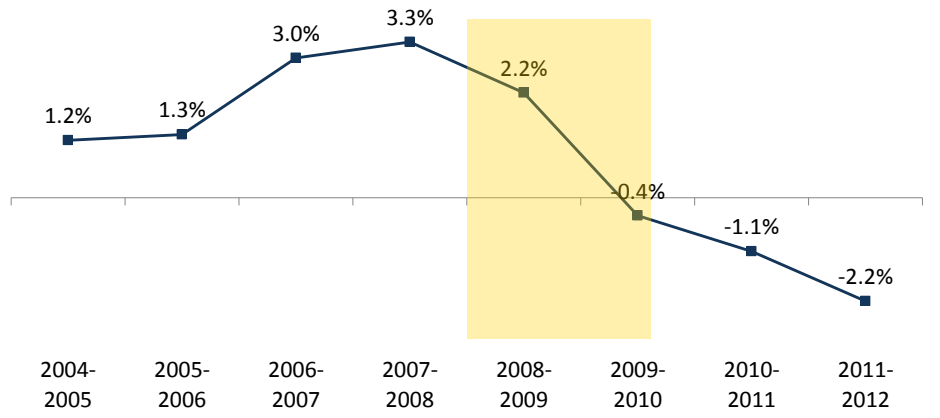
Change in spending on Medicaid, K-12, Health and Hospitals over time

- Medicaid-related spending continued to grow during the Great Recession while spending on health and hospitals slowed and spending through K-12 education declined. (Exhibit 4.6)
- Following the start of the Great Recession, the typical expansion state saw stronger growth in real per capita state-local government spending on Medicaid in comparison to non-expansion states. (Exhibit 4.7) However, real Medicaid spending per capita declined from 2011-2012, which would have included the end of additional federal matching funds temporarily extended during the Great Recession.[3]
- Following the start of the Great Recession, both groups saw declines in K-12 spending, though the declines in K-12 spending were much smaller in the typical expansion state. (-0.8% vs. -1.9% on an average annual basis from 2008 to 2012.) (Exhibit 4.7)

Exhibit 4.1

State and local government spending declined in the years following the recession.

Annual Percentage Change in Real State and Local Government Direct General Expenditures per capita, 2004 - 2012

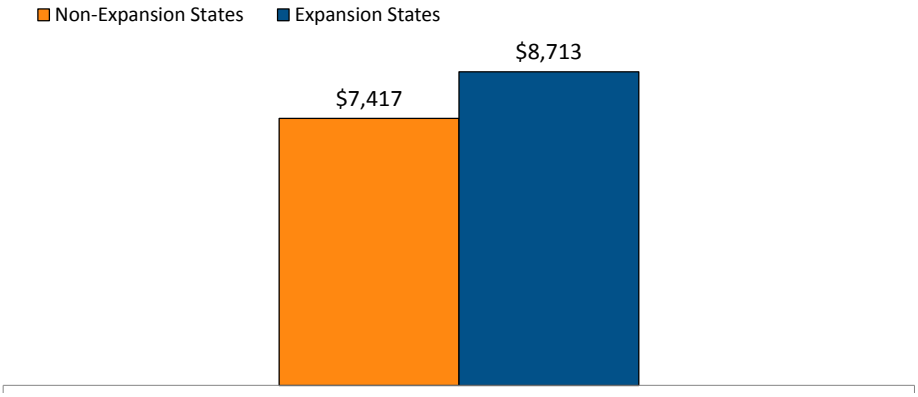


NOTE: All data were inflated to real 2013 $ per the GDP price index. Values exclude DC. Excluded are intergovernmental transfers made by state and local governments. Excluded are intergovernmental transfers made by state and local governments.
SOURCE: KCMU/Rockefeller Institute analysis of Census data on State and Local Government Finances, 2012

Exhibit 4.2

The typical expansion state spends more per capita than the typical non-expansion state.

Median Real State and Local Government Spending per capita, 2012

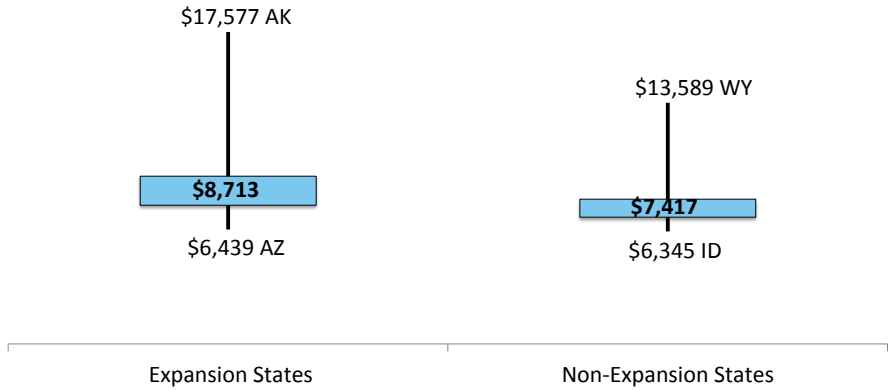


NOTE: Data reflect medians for each group; all data were inflated to real 2013 $ per the GDP price index. Median values exclude DC. State and local government spending refers to state and local direct general expenditures from all sources (state, local and federal dollars.) Excluded are intergovernmental transfers made by state and local governments.
SOURCE: KCMU/Rockefeller Institute analysis of Census data on State and Local Government Finances, 2012

Exhibit 4.3

There is wide variation across both groups in terms of state and local government expenditures per capita.

State and Local Government Expenditures Per Capita, 2012

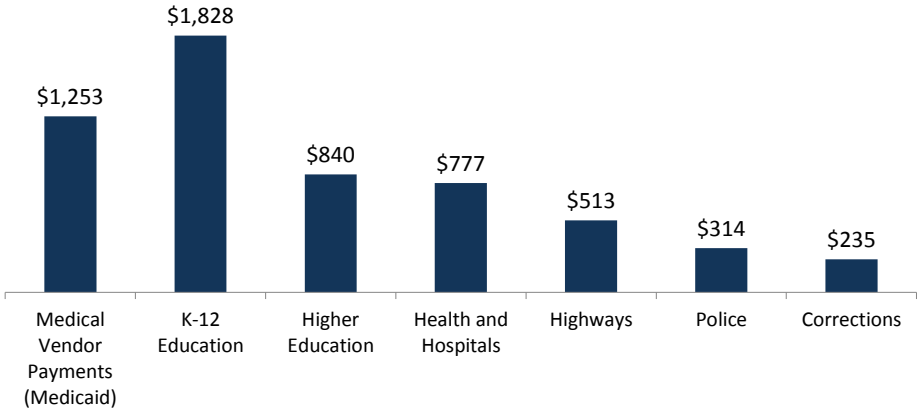


NOTE: Boxes are labeled with the median values of each group; boxes denote values between the first and third quartiles. State and local government spending refers to state and local direct general expenditures from all sources (state, local and federal dollars.) Excluded are intergovernmental transfers made by state and local governments. All data were inflated to real 2013 $ per the GDP price index. Values exclude DC.
SOURCE: KCMU/Rockefeller Institute analysis of Census data on State and Local Government Finances, 2012

Exhibit 4.4

Nationally, states and local governments spend the most on K-12 education per capita, followed by Medicaid and higher education.

State and Local Government Spending Per Capita, 2012

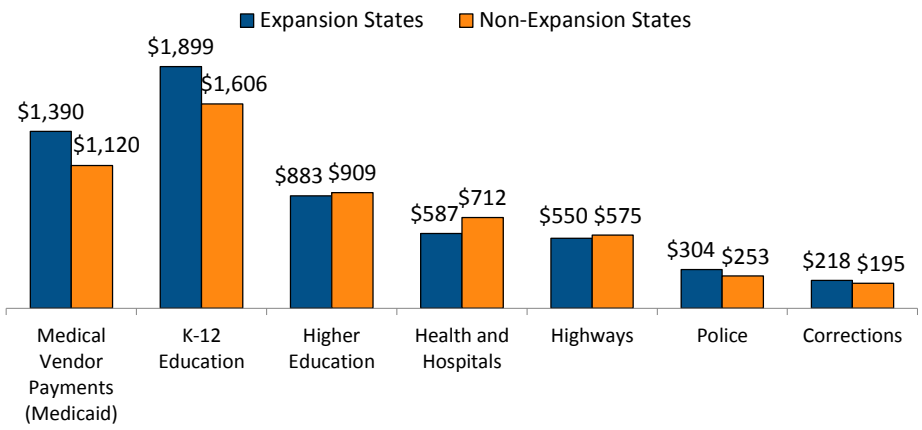


NOTE: Data reflect medians for each group; all data were inflated to real 2013 $ per the GDP price index. Median values exclude DC. State and local government spending refers to state and local direct general expenditures from all sources (state, local and federal dollars.) Excluded are intergovernmental transfers made by state and local governments.
SOURCE: KCMU/Rockefeller Institute analysis of Census data on State and Local Government Finances, 2012.

Exhibit 4.5

The typical expansion state spent more per capita on Medicaid and K-12 Education than the typical non-expansion state.

Median State and Local Government Expenditures per capita, 2012

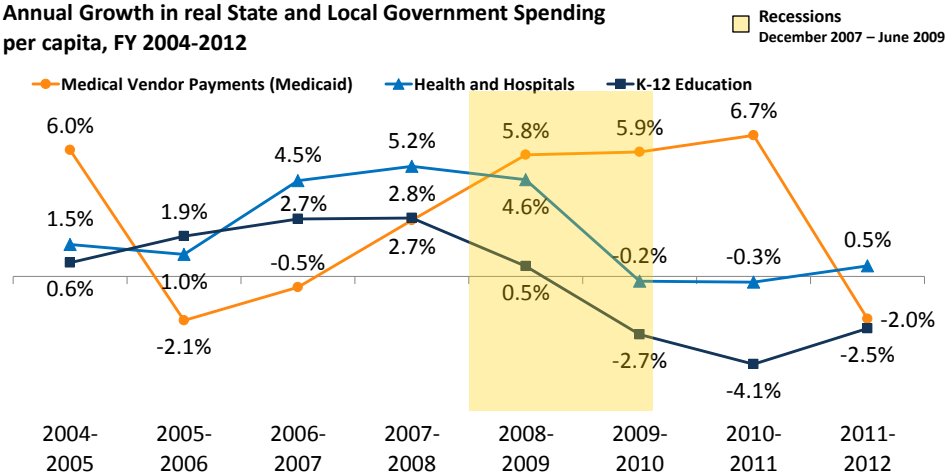


NOTE: Data reflect medians for each group; all data were inflated to real 2013 $ per the GDP price index. Median values exclude DC. State and local government spending refers to state and local direct general expenditures from all sources (state, local and federal dollars.) Excluded are intergovernmental transfers made by state and local governments.
SOURCE: KCMU/Rockefeller Institute analysis of Census data on State and Local Government Finances, 2012.

Exhibit 4.6

Medicaid spending continued to grow during the recession; health and hospital spending slowed and K-12 education spending declined.

Annual Growth in real State and Local Government Spending per capita, FY 2004-2012

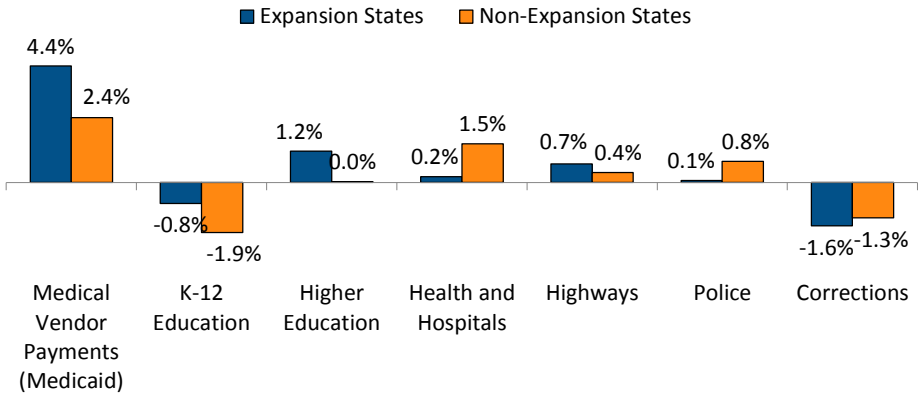


NOTE: Percentage change in total state and local expenditures by spending category. State and local government spending refers to state and local direct general expenditures from all sources (state, local and federal dollars.) Excluded are intergovernmental transfers made by state and local governments.
SOURCE: KCMU/Rockefeller Institute analysis of Census data on State and Local Government Finances, 2004-2012.

Exhibit 4.7

The typical expansion state saw stronger Medicaid spending growth, smaller cuts to K-12 education since the start of the Recession.

Median Average Annual Growth in State and Local Government Expenditures per capita, 2008-2012



NOTE: Data reflect the median average annual growth for each group; all data were inflated to real 2013 $ per the GDP price index. Median values exclude DC. State and local government spending refers to state and local direct general expenditures from all sources (state, local and federal dollars.) Excluded are intergovernmental transfers made by state and local governments.
SOURCE: KCMU/Rockefeller Institute analysis of Census data on State and Local Government Finances, 2008-2012.

How do Expansion and Non-expansion States Compare? – Employment

Also part of discussions in states over the adoption of the Medicaid expansion has been the effect on employment. State debates have also examined the potential employment gains from the new expansion spending and increased economic activity; early evidence from some expansion states like Kentucky have noted increased employment since adopting the Medicaid Expansion.

Unemployment

- After peaking in 2010 at the height of the economic downturn, the national unemployment rate in 2013 had fallen to 7.4 percent.
- During the Great Recession, both expansion and non-expansion states saw notable increases in the unemployment rate. Unemployment rates have continued to fall for the typical state in both groups since peaking in 2009 or 2010. (Exhibit 5.1)
- There is a notable amount of variation within both groups in terms of the unemployment rate. Expansion states in 2013 had employment rates ranging from 9.5% in Nevada down to 2.9% in North Dakota; Non-expansion states had unemployment rates ranging from 8.7% in Mississippi to 3.8% in South Dakota. (Exhibit 5.2)

Total Employment

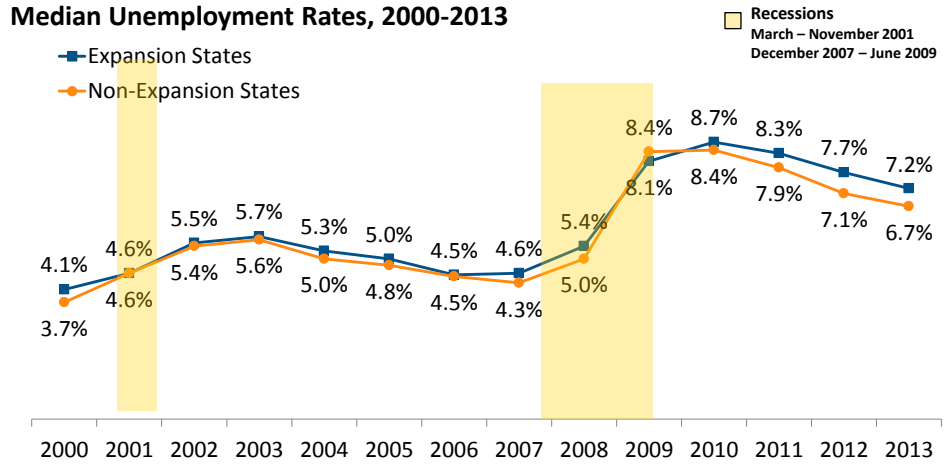
- The total number of jobs fell significantly during the economic downturn; while employment had increased in the years leading up to the major ACA coverage expansions, total nonfarm employment had yet to return to pre-Recession levels.

Health-Related Employment

- As total employment levels declined in response to the Great Recession, employment in health and related fields remained strong. (Exhibit 5.3)
- As a result, health-related employment has increased as a share of total employment over time, particularly since the Great Recession. (Exhibit 5.4)
- Health-related employment in the typical expansion state has historically been higher than in the typical non-expansion state. (Exhibit 5.5)
- All states saw strong growth in health-related employment from 2000 through 2013; however growth in this sector slowed for both groups in 2008-2013 compared to the earlier period (2000 to 2007). (Exhibit 5.6)

Exhibit 5.1

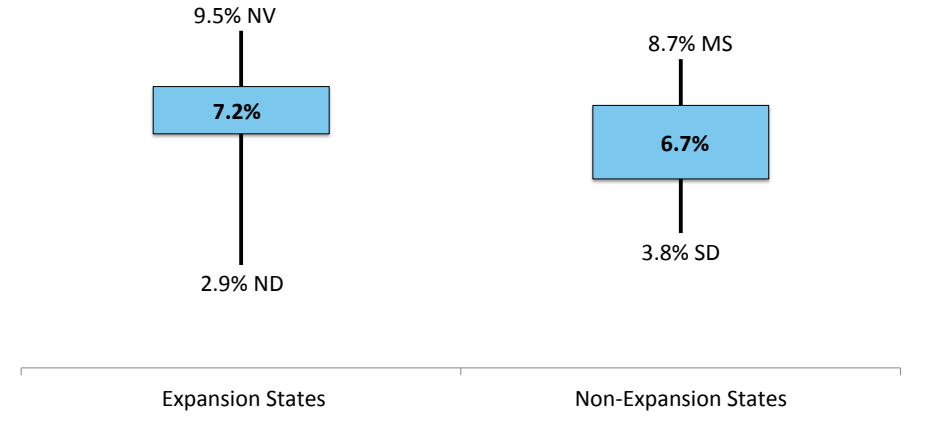
The typical expansion state has a higher rate of unemployment, but unemployment has been recently declining for both groups.



NOTE: Data reflect median unemployment rates for each group. Data are not seasonally adjusted. Median values exclude DC.
SOURCE: KCMU/Rockefeller Institute analysis of Bureau of Labor Statistics data.

Exhibit 5.2

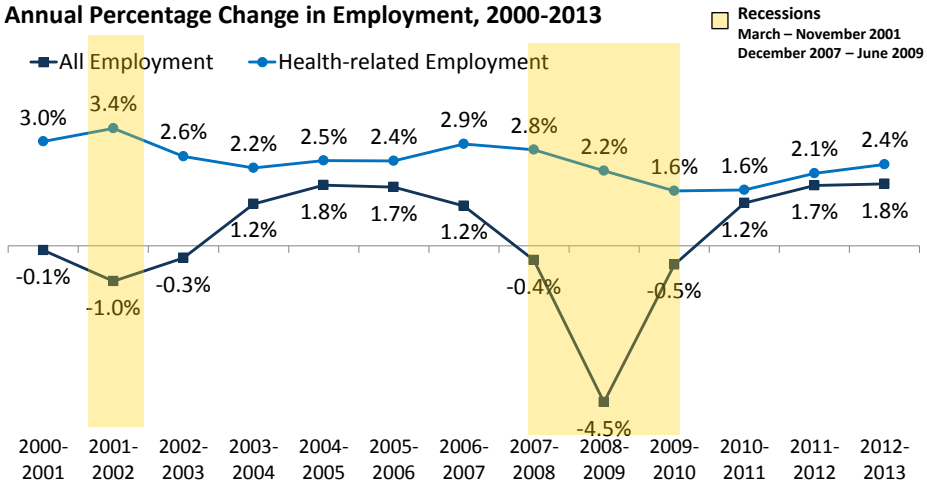
There is wide variation in unemployment rates for both groups.



NOTE: Boxes are labeled with the median values of each group; boxes denote values between the first and third quartiles. Data are not seasonally adjusted. Median values exclude DC.
SOURCE: KCMU/Rockefeller Institute analysis of Bureau of Labor Statistics data.

Exhibit 5.3

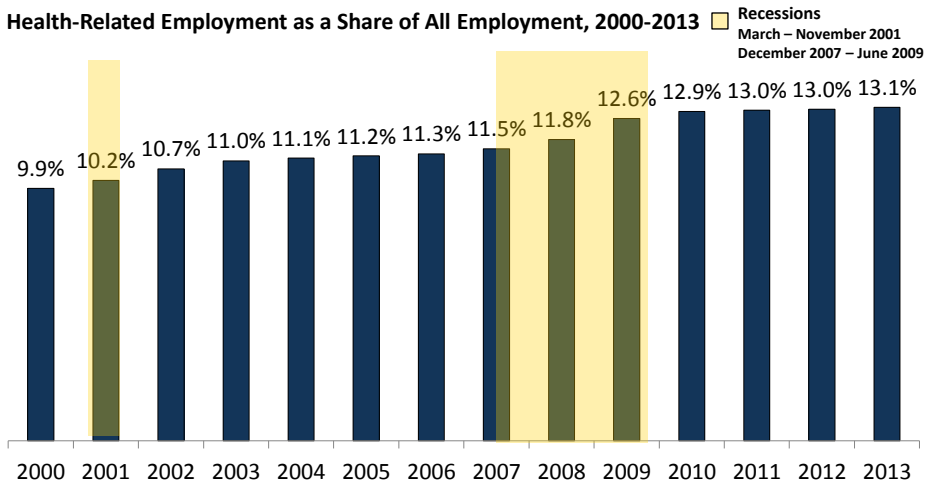
Nationally, total employment has fluctuated with changing economic conditions, but health-related employment has remained strong.



NOTE: Health-related employment also includes some social assistance employment. Data are excluded for AK, DC and NM; health-related employment is not reported for AK and NM. Data are not seasonally adjusted.
SOURCE: KCMU/Rockefeller Institute analysis of Bureau of Labor Statistics data.

Exhibit 5.4

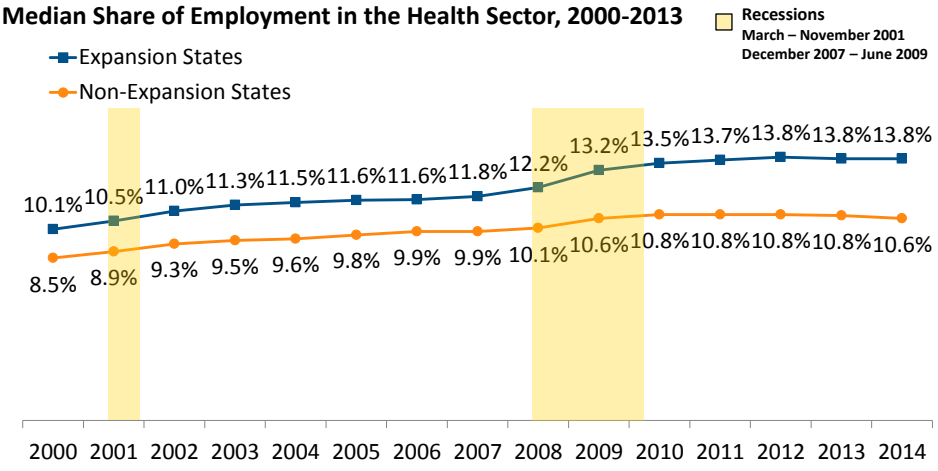
Nationally, health-related employment has been growing as a share of total employment since 2000.



NOTE: Health-related employment also includes some social assistance employment. Data exclude AK, DC, and NM; data are not reported for health-related employment.
SOURCE: KCMU/Rockefeller Institute analysis of Bureau of Labor Statistics data.

Exhibit 5.5

The typical expansion state has historically had a higher share of employment in the health sector.

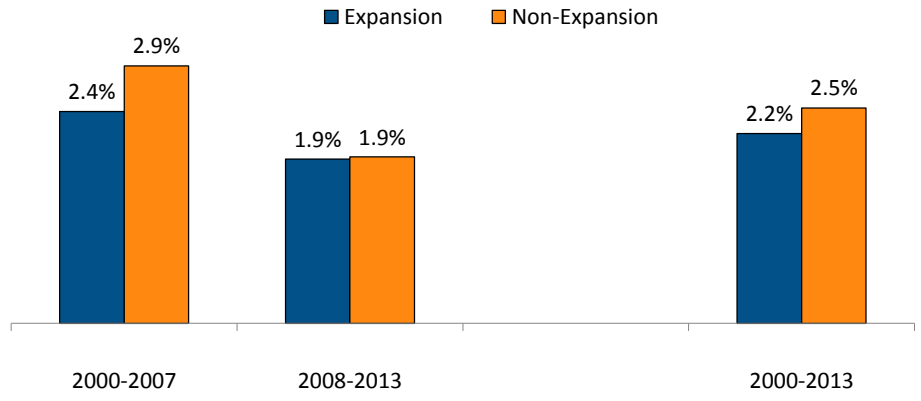


NOTE: Data reflect median share of the total population that unemployment rates for each group. Data are not seasonally adjusted. Health-related employment also includes some social assistance employment. Median values exclude AK, DC and NM. Health-related employment data are not reported for NM and AK.
SOURCE: KCMU/Rockefeller Institute analysis of Bureau of Labor Statistics data.

Exhibit 5.6

All states saw strong growth in health-related employment; however growth in this sector slowed for both groups in 2008-2013.

Average Annual Growth Rate for Health-Related Employment, 2000-2013



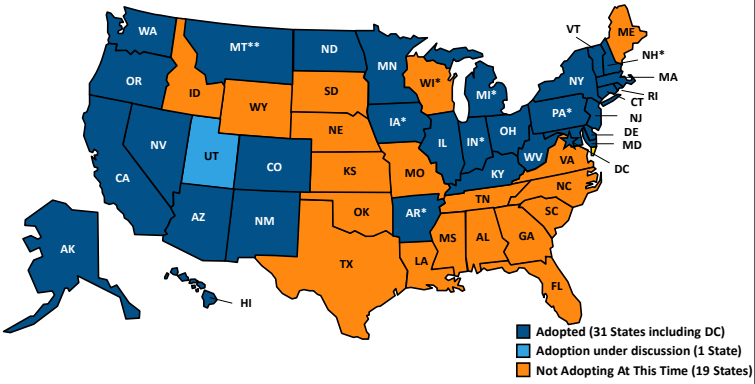
NOTES: Median average annual growth rate for health-related employment. Median values exclude DC; data are not reported for NM and AK. Health-related employment also includes some social assistance employment.
SOURCE: KCMU/Rockefeller Institute analysis of Bureau of Labor Statistics data.

Appendix A – Methodology and Definitions

This analysis focused a series of demographic, fiscal, budget and employment indicators available publicly from the Bureau of Labor Statistics, the Census Bureau, and Department of Treasury, and the Bureau of Economic Analysis. Additional information about the variables included follows. The analysis focused on differences between expansion and non-expansion states over the period from 2000 through 2013 expect for a few sources where the latest available data was for 2012. Analysis of data from the Census Survey of Government Finances, which includes state and local revenue as well as direct general expenditures regardless of fund source (state, local or federal[4]), examines the period from 2004 to 2012; the US Census did not conduct the survey for local governments for 2001 and 2003. Included as expansion states for this analysis were the 31 states that had adopted the Medicaid expansion as of September 1, 2015; however, the District of Columbia is frequently excluded from median calculations in this analysis as it is not consistently included in all data sources. Non-expansion states include the 19 states that have not adopted the expansion at this time as well as Utah where adoption of the expansion is currently under discussion. (Exhibit A.1) To examine differences between these groups, this analysis focuses on the typical expansion state and the typical non-expansion state, which is defined as the median value for each group. Additionally, all monetary values have been converted to real 2013 dollars to control for inflationary changes.

Exhibit A.1

Over half of states have adopted the Medicaid expansion.



NOTES: Under discussion indicates executive activity supporting adoption of the Medicaid expansion. **MT has passed legislation adopting the expansion; it requires federal waiver approval. *AR, IA, IN, MI, PA and NH have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it is transitioning coverage to a state plan amendment. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.
SOURCE: "Status of State Action on the Medicaid expansion Decision," KFF State Health Facts, updated September 1, 2015.
http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

DEMOGRAPHICS

Age. State spending priorities are affected by the types of populations they serve. For example, states with higher shares of older populations face higher demands for long term care services, which may lead to higher Medicaid spending as Medicaid is the largest purchaser of long term care services. In contrast, states with higher shares of children may face higher demands for education services.

Median Household Income. Household income, which is a measure of all income from those age 15 and older living in the same household, is a common measure of relative wealth of state residents.

Poverty Rates. Many government assistance programs are targeted to help low-income families. Programs administered or supported by the United States Department of Health and Human Services (HHS) use the department's federal poverty guidelines. The federal poverty guideline for a family of three in the 48 contiguous states and the District of Columbia was $19,530 in 2013.

Health Insurance. The existing status of health insurance coverage and the number of uninsured have been commonly discussed as factors in a state's decision to adopt the Medicaid expansion. Coverage varied across states due to the availability of employer-based coverage, the scope of public coverage, regulations in the non-

group market, poverty rates, and demographics. The share of the population that is uninsured highlights the gap among different coverage options.

Tax Collections and Revenue

Tax Collections. How much tax revenue is collected determines the size of state budgets that lawmakers must then allocate to different spending priorities. A number of factors play into how much is collected – the state tax capacity (how much state and local governments could potentially collect), the composition of state and local taxes (e.g. general sales taxes, property taxes, etc.) and tax policy changes lawmakers elect to make.

Tax Capacity. A state's tax capacity refers to the potential amount state and local governments could collect through taxes. There are several measures of tax capacity, such as personal income, a state's gross domestic product as well as a lesser known measure of a state's total taxable resources – a measure developed by the Treasury Department that addresses concerns with the incompleteness of other measures.

Tax Effort/Tax Collections as a Share of Capacity. Tax capacity is just one factor in determining how much tax revenue states and local governments collect. How much states and localities collect as a share of their potential is a measure of tax effort. Tax collections alone only illustrate the amount the state was able to collect; collections as a share of their capacity controls for the fact that some states are able to potentially collect more.

Composition of Tax Revenue Sources. State and local governments draw their tax revenues from different sources. The most common sources of tax revenue are property taxes, general sales taxes, personal income taxes, corporate income taxes and selective sales taxes (e.g. alcohol and tobacco.) Tax revenues are also separately collected by state and local governments.

Tax Policy Changes. Another factor in determining the amount of revenue that states collect relates to state lawmaker decisions on tax policy. As with determining spending priorities, state lawmakers also determine the tax rates and types of taxes enacted in a state.

State Budgets and Spending

Total State Budget Spending. Data in this section reflect total spending by state and local governments; this includes federal dollars spent by states and localities as well as spending from state and local sources.

Spending categories. This analysis focuses on the following categories of spending:

- **Medicaid-related spending:** Refers to medical vendor payments according to Census definitions for their annual survey of state and local government finances. This does not include all Medicaid spending, but refers to payments under public welfare programs made directly to private vendors for medical assistance and hospital or health care on behalf of low-income or other medically needy persons. It captures most, but not all, Medicaid spending.

- **Health and Hospitals:** Refers to spending related to public health programs and other activities (e.g. public health administration, vita statistics, etc.) as well as support for public or private hospitals outside of public welfare programs (e.g. Medicaid). It can include construction costs of hospitals as well.
- **K-12 Education:** Refers to spending for operation, maintenance and construction of public schools and facilities for elementary and secondary education, including vocational-technical education.

Employment

Employment. Employment, or the number of jobs, is a strong indicator of economic conditions. This analysis focused on total non-farm employment, which includes private sector and government employment.

Unemployment. Unemployment is also a strong indicator of economic conditions. The unemployment rate is measure of the share of the labor force who are not employed; individuals who are no longer looking for work or those under the age of 16 are not counted as part of the labor force and are excluded from such calculations.

Health-Related Employment. Employment in the health and social assistance sectors as defined by the NAICS definition. This includes jobs in ambulatory health care (physician office, dental offices, etc.) outpatient care centers, medial and diagnostic laboratories, hospitals, home health care, nursing facilities and among others.

Appendix Summary Table

	Expansion	Non-expansion
Demographics		
Age	Higher Median Share of the Total Population that are Elderly Adults. Shares of the population for children are declining and growing for the elderly for both groups.	Higher Median Share of the Total Population that are Children. Shares of the population for children are declining and growing for the elderly for both groups.
Median Household Income	Higher Real Median Household Income.	Lower Real Median Household Income.
Poverty Rate	Lower Median Poverty Level.	Higher Median Poverty Level.
Health Insurance	Lower Median Uninsured Rate.	Higher Median Uninsured Rate.
Revenue and Tax Capacity		
Tax Collections	Faster Recovery since the Great Recession.	Slower Recovery since the Great Recession.
Tax Capacity	Higher Median Level of Tax Capacity, Regardless of Measure. Median Level of Tax Capacity has been Increasing at a Faster Rate over Time.	Lower Median Level of Tax Capacity, Regardless of Measure. Median Level of Tax Capacity has been Increasing at a Slower Rate over Time.
Tax Effort (Collections as a Share of Capacity)	Median Collections per Capita is higher. Median Tax Collections as a Share of Tax Capacity is Higher and has been Increasing on Average.	Median Collections per Capita is lower. Median Tax Collections as a Share of Tax Capacity is Lower and has been Decreasing on Average.
Composition of Tax Revenue Sources	Typical State relies more on Personal Income Taxes.	Typical State relies more on General Sales Taxes.
Tax Policy Changes	State lawmakers have acted to raise taxes in a number of years since 2008.	State lawmakers have acted to cut taxes in a number of years since 2008.
State Budgets		
Total State and Local Budget Spending	Higher Median Total Budget Spending per capita.	Lower Median Total Budget Spending per capita.
Distribution Across Spending Categories	Higher Median Spending per capita levels on Medicaid, K-12 Education, Police and Corrections.	Higher Median Spending per capita levels for Health and Hospitals, Highways and Higher Education.
Change in Spending Across programs	Stronger Growth in Median Spending per capita for Medicaid post-recession. Smaller Decline in Median Spending per capita for K-12 Education post-recession.	Weaker Growth in Median Spending per capita for Medicaid post-recession. Larger Decline in Median Spending per capita for K-12 Education post-recession.
Employment		
Unemployment	Median Unemployment Rate has Declined in Recent Years.	Median Unemployment Rate has Declined in Recent Years.
Health Sector Employment	Health-related Employment is a Higher Share of Total Employment. Strong growth in health-related employment for both groups; growth slowed in 2008-2013.	Health-related Employment is a Lower Share of Total Employment. Strong growth in health-related employment for both groups; growth slowed in 2008-2013.

Endnotes

[1] Status of State Action on the Medicaid Expansion Decision, updated September 1, 2015. Kaiser Family Foundation, State Health Facts. http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

[2] Over a quarter of hospitals in Non-expansion states were owned by state and local governments in 2013 compared to 16% of hospitals in Expansion states. Hospitals by Ownership Type, 2013. Kaiser Family Foundation, State Health Facts. http://kff.org/other/state-indicator/hospitals-by-ownership/#.

Additionally, the higher spending per capita for higher education in the typical non-expansion state may be due, in part, to the fact that most expansion states are industrialized, urbanized, northeastern states which have extensive network of private higher education institutions. Therefore, these states maybe outliers when it comes to higher education because they don't spend as much per capita due to existence of large number of private higher education institutions.

[3] The American Recovery and Reinvestment Act (ARRA) provided states with enhanced Medicaid matching rates between October 2008 and June 2011. This enhanced match provided states with $103 billion over the 11 quarters it was in effect. This allowed for state spending on the program to fall; the only two years in the history of Medicaid when annual state funds spending decreased.

Miller, Vic, Andy Schneider, Laura Snyder and Robin Rudowitz. *Impact of the Medicaid Fiscal Relief Provisions in the American Recovery and Reinvestment Act (ARRA)*. Kaiser Commission on Medicaid and the Uninsured, October 2011. http://kff.org/medicaid/issue-brief/impact-of-the-medicaid-fiscal-relief-provisions/.

Smith, Vern et al. *Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014.* Kaiser Commission on Medicaid and the Uninsured, October 2014. http://kff.org/medicaid/report/medicaid-budget-survey-archives/.

[4] Direct expenditures spent on medical vendor payments (E74) may include funds spent from any kind of source the state or local government has available to use for. State and local government expenditures data in this survey are collected by function and do not distinguish if the source of funds used was coming from a federal, state or local fund. It may be possible that state and local governments are using federal receipts also to fund medical vendor payments which are not reflected in these expenditure statistics.

Email correspondence with officials at the Census Bureau, June 2015.

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DOI: 10.1377/hlthaff.2014.1435
HEALTH AFFAIRS 34,
NO. 9 (2015): 1554–1562

Estimating The Potential Impact Of Insurance Expansion On Undiagnosed And Uncontrolled Chronic Conditions

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ABSTRACT **Policy makers have paid considerable attention to the financial implications of insurance expansion under the Affordable Care Act (ACA), but there is little evidence of the law's potential health effects. To gain insight into these effects, we analyzed data for 1999–2012 from the National Health and Nutrition Examination Survey to evaluate relationships between health insurance and the diagnosis and management of diabetes, hypercholesterolemia, and hypertension. People with insurance had significantly higher probabilities of diagnosis than matched uninsured people, by 14 percentage points for diabetes and hypercholesterolemia and 9 percentage points for hypertension. Among those with existing diagnoses, insurance was associated with significantly lower hemoglobin A1c (−0.58 percent), total cholesterol (−8.0 mg/dL), and systolic blood pressure (−2.9 mmHg). If the number of nonelderly Americans without health insurance were reduced by half, we estimate that there would be 1.5 million more people with a diagnosis of one or more of these chronic conditions and 659,000 fewer people with uncontrolled cases. Our findings suggest that the ACA could have significant effects on chronic disease identification and management, but policy makers need to consider the possible implications of those effects for the demand for health care services and spending for chronic disease.**

The Affordable Care Act (ACA) has as its primary goal improving access to affordable, high-quality health insurance. Before implementation of the ACA, an estimated fifty million Americans were uninsured.[1] A number of recent studies have found evidence of sizable insurance coverage gains for nonelderly adults, likely as a result of the act.[2–6] The financial impacts of major illnesses on people without insurance are well known. For example, unpaid medical bills remain the leading cause of bankruptcy among Americans.[7] Beyond financial protection, a major goal of insurance expansion is to improve the health of the US population.[8] However, the potential impact of the ACA on the health of Americans remains unclear.

Understanding the association between health insurance and health effects is critical for at least two reasons. First and foremost, improving the health of the population is a fundamental goal unto itself. Second, the pathways through which insurance improves health—namely, through better diagnosis and management of health conditions—could also have substantial implications for the demand for health care services and, ultimately, for health care spending. Evidence on expected health impacts and health services use is urgently needed by policy makers as they plan for the likely effects of the ACA's full implementation.

Multiple studies have examined the direct

health effects of insurance.[9–25] The best known recent example is the Oregon Health Insurance Experiment, which reported small and inconsistent effects of Medicaid coverage on diagnosis and medication use for chronic conditions, with little overall effect on clinical measures relating to hypertension, diabetes, and cholesterol.[26] However, despite its substantial strengths, the Oregon study had limited power to detect clinical changes because of its relatively small sample sizes. In addition, results among Medicaid beneficiaries in Oregon might not be generalizable to the US population.

Several earlier analyses of nationally representative data have suggested positive associations between health insurance and the diagnosis and control of chronic diseases.[14,15,17] Contemporary national estimates of the potential effects of insurance expansion on diagnosis and treatment of chronic conditions would provide valuable information about how the ACA could affect the health of the US population during a time of continuing public debate about the act.

In this study we applied matching-based algorithms to nationally representative health examination survey data to estimate the relationships between health insurance and the diagnosis and management of diabetes, hypercholesterolemia, and hypertension. Using these results, we then estimated the likely population-level impact of insurance expansion under the ACA on the numbers of Americans who are living with these conditions either undiagnosed or uncontrolled.

Study Data And Methods

DATA We analyzed data from the National Health and Nutrition Examination Survey (NHANES), a nationally representative survey of the US civilian noninstitutionalized population.[27] The survey, which is continuously conducted, combines an interview about sociodemographic characteristics, health conditions, and risk factors with a health examination that includes laboratory tests. The National Center for Health Statistics (NCHS) administers the survey and has obtained Institutional Review Board approval for it.

We used data for the period 1999–2012 to estimate relationships between insurance and health outcomes. We focused on the most recent data (for 2011–12) to estimate current numbers of people nationwide who might benefit from insurance expansion. While data for 1999–2012 were pooled to maximize sample sizes, we conducted a sensitivity analysis in which we allowed effects to vary in the earlier (1999–2006) and later (2007–12) segments of the study period.

ANALYTIC SAMPLE AND MEASURES We restricted our analysis to adults ages 20–64. We excluded older adults because most of them have health insurance through Medicare and are therefore ineligible for coverage expansion under the ACA. Individuals were considered to have health insurance if they answered yes to the survey question, "Are you covered by health insurance or some other kind of health care plan?"

▶ **DIABETES:** To maintain a consistent definition of *undiagnosed diabetes* across survey rounds, we included only respondents who participated in the morning examination session and completed a fasting plasma glucose test in the diabetes analysis. In NHANES, participants are randomly assigned to one of two examination sessions, with those who are selected for the morning session asked to fast for nine hours beforehand. Individuals were considered to have diagnosed diabetes if they answered yes to the question, "Other than during pregnancy, have you ever been told by a doctor or health professional that you have diabetes or sugar diabetes?" Following the predominant diagnostic criteria for most of the study period, we considered participants to have undiagnosed diabetes if they had a survey-measured fasting plasma glucose level of ≥126 mg/dL and did not report a previous diagnosis of diabetes.[28] In a sensitivity analysis, we defined *undiagnosed diabetes* based on a measured hemoglobin A1c level of ≥6.5 percent.

▶ **HYPERCHOLESTEROLEMIA:** Survey respondents in the morning and afternoon examination sessions were eligible for a total serum cholesterol test. Participants were considered to have diagnosed hypercholesterolemia if they answered yes to the question, "Have you ever been told by a doctor or other health professional that your blood cholesterol level was high?" We considered participants to have undiagnosed hypercholesterolemia if their total cholesterol was ≥240 mg/dL and they did not report a previous diagnosis of the condition. As a sensitivity analysis, we restricted the analysis to participants in the morning session who had fasted before the test.

▶ **HYPERTENSION:** Participants in the morning and afternoon examination sessions were also eligible to have their blood pressure measured. We used the NCHS-recommended algorithm for computing mean systolic and diastolic blood pressure from repeated blood pressure measurements.[29]

We considered participants to have diagnosed hypertension if they answered yes to the question, "Have you ever been told by a doctor or other health professional that you had hypertension, also called high blood pressure?" We considered participants to have undiagnosed hypertension if their systolic blood pressure was ≥140 mmHg or their diastolic blood pressure

was ≥90 mmHg and if they did not report a previous diagnosis of the condition.

▶ **PHYSIOLOGICAL HEALTH INDICATORS AND MEASURES OF CONTROL:** We assessed clinical indicators for diabetes, hypercholesterolemia, and hypertension as continuous variables. We also analyzed dichotomous outcomes of control based on standard clinical definitions: HbA1c <8 percent for diabetes, total cholesterol <240 mg/dL for hypercholesterolemia, and systolic blood pressure <140 mmHg for hypertension.

STATISTICAL ANALYSES We used matching as a data preprocessing step,[30] followed by regression modeling to adjust for remaining confounding from observed covariates.[31] Our primary measures of association were risk differences for probabilities of diagnosis and control and mean differences for continuous measures. Analyses were conducted using Stata, version 12, and R, version 3.0.3.

MATCHING PROCEDURE We used a matching approach to address a limitation in several previous analyses of insurance and health outcomes that relied only on regression to adjust for observed confounders.[14,15,17] Because distributions of some potential confounders can differ greatly between the insured and the uninsured (for example, there are few wealthy uninsured people), regression estimates of associations between insurance and health outcomes can be sensitive to model specification, which can compromise the validity of a causal interpretation of the results.[30] To address this issue, for each uninsured individual in the sample, we selected as a match from the insured population an individual who was similar in terms of the following observed characteristics: sex, age, race/ethnicity, household income, marital status, current smoking status, body mass index, and survey round.

In addition to this set of matching variables, we also matched on a propensity score for having insurance, which we estimated via logistic regression predicted by the other matching variables.[32,33] Matching was done with replacement.

There are a variety of different matching algorithms available to analysts.[34] For this study we used a genetic matching algorithm. Genetic matching is a generalization of propensity score and Mahalanobis distance matching that maximizes covariate balance with an evolutionary search.[32] Preliminary testing for covariate balance showed that this approach outperformed both nearest-neighbor matching and matching on the propensity score alone for our analysis. Separate matched samples were generated for analyses of diabetes, hypercholesterolemia, and hypertension, to maximize sample sizes and balance in each case.

ESTIMATES OF ASSOCIATION We used linear regression to estimate relationships between health insurance and study outcomes within the matched samples. We controlled for the covariates listed in Exhibit 1 and an indicator for the survey round. Separately for each matched sample of respondents with diabetes, hypercholesterolemia, or hypertension, we estimated the association between insurance and the probability of diagnosis. For each of the three conditions, among those with a previous diagnosis of that condition, we estimated associations between health insurance and HbA1c, total cholesterol, and average systolic blood pressure, as well as the associations between insurance and dichotomous indicators of control in each case.

Sampling weights were omitted in regression models because the models controlled for age, sex, and race/ethnicity. Standard errors and confidence intervals for analyses on the matched samples accounted for stratification and clustering in the survey design[27] and for the sampling of insured individuals with replacement during matching.[35]

SENSITIVITY ANALYSES For the main analysis, we included respondents with private and public forms of health insurance in the insured sample.

EXHIBIT 1

Characteristics Of Uninsured Adults Ages 20–64 With Diabetes, Hypercholesterolemia, Or Hypertension, 1999–2012

Characteristic	Diabetes (n = 314)	Hypercholesterolemia (n = 1,771)	Hypertension (n = 1,799)
Mean age (years)	49.9	45.8	47.1
Male	51%	54%	52%
RACE/ETHNICITY			
Non-Hispanic white or other	30%	39%	36%
Hispanic	54	45	37
Non-Hispanic black	16	16	27
INCOME ($)			
Less than 20,000	42%	40%	455
20,000–34,999	25	27	25
35,000–54,999	17	17	14
55,000–74,999	5	5	5
75,000 or more	5	5	5
Other[a]	6	7	6
MARITAL STATUS			
Never married	13%	16%	19%
Married or living with partner	58	59	54
Widowed, divorced, or separated	29	25	27
OTHER CHARACTERISTICS			
Current smoker	26%	33%	34%
Mean body mass index	31.7	29.6	30.8

SOURCE Authors' analyses of data for 1999–2012 from the National Health and Nutrition Examination Survey. **NOTES** The analysis sample included both the uninsured adults whose characteristics are shown here and a matched sample of insured adults. For additional details, see Appendix Exhibit A2 (see Note 37 in text). [a]Refused to answer or answered "Don't know" or "Over $20,000."

This study extends existing literature that aims to understand the relationship between health insurance and health.

However, because Medicaid expansion and narrow-network plans provide important vehicles for expanded coverage under the ACA, an analysis that focused on public insurance could be enlightening. Thus, we conducted a sensitivity analysis in which we restricted the sample to the uninsured and those with public insurance only, and we then repeated the matching and estimation procedures.

POPULATION IMPACT The Congressional Budget Office (CBO) estimates that the ACA will reduce the number of nonelderly Americans without health insurance by approximately 50 percent.[36] We therefore used estimated mean differences in probabilities of diagnosis and control to predict the expected population health impacts of providing health insurance to half of all uninsured nonelderly Americans.

Population sizes were derived by combining survey-weighted prevalence estimates computed from 2011–12 NHANES data with total population estimates from the 2011–12 American Community Survey, as recommended by the NCHS for analysis of the 2011–12 NHANES. The potential impact of insurance on reducing the numbers of people who have uncontrolled disease was estimated by applying the risk differences estimated among diagnosed patients both to the diagnosed and uninsured population and to those who would be newly diagnosed after gaining insurance. Uncertainty intervals around population effect estimates accounted for sampling errors in the estimated prevalence of conditions and probabilities of diagnosis or control, as well as uncertainty in estimated insurance effects.

LIMITATIONS Our study had a number of limitations. Our matching approach improved the balance between the insured and the uninsured sample on observed characteristics, compared to that observed in the full survey data set. However, estimated effects could be biased by confounding from unobservable characteristics. Accordingly, caution is still needed in drawing causal inferences about the effects of insurance expansion.

Other limitations in the study were related to definitions and classifications for both insurance status and health outcomes. We included a sensitivity analysis that focused on public insurance. Nonetheless, it is possible that health benefits might differ between the insurance types considered in this analysis and the various forms of insurance used to expand coverage under the ACA, such as narrow network plans. Also, we defined control of each chronic condition in terms of measurement at a single point in time, whereas measures likely fluctuate over time.

Finally, the standardized definitions of disease used in this study may be more or less sensitive than those used in clinical practice. Therefore, the definitions in the study did not precisely identify which individuals would potentially be newly diagnosed under expanded insurance coverage.

Study Results

SAMPLE The starting point for our analysis was the full sample of 28,157 respondents ages 20–64 from the 1999–2012 NHANES (for a diagram of the analytic sample, see online Appendix Exhibit A1).[37] Of the 11,548 individuals for whom complete information on diabetes was available, 875 had a previous diabetes diagnosis, and 348 had undiagnosed diabetes. Sample sizes for analyses of hypercholesterolemia and hypertension were larger because participants in both morning and afternoon sessions were eligible. Of the 25,327 individuals with complete information on cholesterol, 6,026 had a previous diagnosis of high cholesterol, and 2,230 had undiagnosed hypercholesterolemia. Of the 25,576 individuals with complete information on blood pressure, 6,366 had a previous hypertension diagnosis, and 1,531 had undiagnosed hypertension.

Characteristics of the uninsured sample are shown in Exhibit 1. Matching resulted in highly comparable distributions of observed potential confounders between uninsured and insured individuals in the analytic sample, which addressed significant prematching differences in race/ethnicity and household income distributions (for a summary of covariate balance after matching, see Appendix Exhibit A2).[37]

PREVALENCE OF DISEASE In 2011–12, 9.2 percent (95% confidence interval: 6.7, 11.7) of nonelderly American adults had diabetes, and over 60 percent of them had either undiagnosed

(prevalence: 3.1 percent; 95% CI: 1.8, 4.3) or diagnosed but uncontrolled (prevalence: 2.7 percent; 95% CI: 1.5, 3.8) disease. Hypercholesterolemia and hypertension were more prevalent than diabetes—35.4 percent (95% CI: 31.9, 39.0) and 31.2 percent (95% CI: 29.0, 33.3), respectively—and were more likely to be diagnosed and controlled. The prevalence of undiagnosed hypercholesterolemia was 6.9 percent (95% CI: 5.6, 8.2), and that of diagnosed but uncontrolled hypercholesterolemia was 6.4 percent (95% CI: 5.0, 7.8). The prevalence of undiagnosed hypertension was 5.5 percent (95% CI: 4.5, 6.4), and that of diagnosed but uncontrolled hypertension was 5.2 percent (95% CI: 4.2, 6.1) (data not shown).

INSURANCE, DIAGNOSIS, AND CONTROL Health insurance was significantly associated with improved diagnosis and control of diabetes, hypercholesterolemia, and hypertension. Comparing those without insurance to similar people with insurance, the probability of diagnosis for those with insurance was 13.5 (95% CI: 4.9, 22.2) percentage points higher for diabetes, 13.5 (95% CI: 10.1, 17.0) percentage points higher for hypercholesterolemia, and 8.8 (95% CI: 5.7, 11.9) percentage points higher for hypertension (Exhibit 2). Among diagnosed cases, having insurance was associated with lower HbA1c in those with diabetes (adjusted difference: −0.58 percent; 95% CI: −1.08, −0.07), lower total cholesterol in those with hypercholesterolemia (adjusted difference: −8.0 mg/dL; 95% CI: −13.2, −2.8), and lower systolic blood pressure in those with hypertension (adjusted difference: −2.9 mmHg; 95% CI: −4.8, −1.0). Compared to uninsured patients with hypercholesterolemia, those with insurance also had significantly lower systolic blood pressure (adjusted difference: −2.3 mmHg; 95% CI: −3.9, −0.7).

Dichotomous measures of disease control indicated similar improvements with insurance, although the benefit was not significant for diabetes control at a threshold of HbA1c <8.0 percent (adjusted difference: 9.5; 95% CI: −1.5, 20.5) (Exhibit 2).[37] A sensitivity analysis that used HbA1c instead of fasting plasma glucose as an indicator of undiagnosed diabetes found similar results, with the insured having an 11.0-percentage-point (95% CI: 5.4, −16.6) greater probability of being diagnosed, compared to the uninsured (data not shown). Restricting the hypercholesterolemia analysis to the morning fasting sample led to a slightly larger difference in probability of diagnosis given insurance: 16.4 percentage points (95% CI: 10.6, 22.2).

In sensitivity analyses allowing for different effects during the periods 1999–2006 and 2007–12, none of the time differences were found to be significant. Lastly, a reanalysis that restricted the sample to a comparison between the uninsured and people with public insurance identified relationships between insurance, diagnosis, and control that were similar to those in the main analysis that included all forms of insurance (for a version of Exhibit 2 that summarizes comparisons of the uninsured and those with public insurance, see Appendix Exhibit A4).[37]

PROJECTED POPULATION IMPACT If the number of nonelderly Americans without health insurance were reduced by half, which is the expected effect of the ACA as projected by the CBO, we estimate that there would be 313,000 (95% CI: 108,000, 545,000) fewer cases of undiagnosed diabetes, 811,000 (95% CI: 565,000, 1,078,000) fewer cases of undiagnosed hypercholesterolemia, and 485,000 (95% CI: 302,000, 681,000) fewer cases of undiagnosed hypertension (Exhibit 3). These benefits would occur among 1.5 million unique individuals, some of whom might have more than one condition. This corresponds to approximately one-fifth of the currently uninsured and undiagnosed individuals for the three conditions.

EXHIBIT 2

Probabilities Of Being Diagnosed With Diabetes, Hypercholesterolemia, And Hypertension And Key Clinical Outcomes For Adults Ages 20–64, By Insurance Status, 1999–2012

	Insured	Uninsured	Adjusted difference	*p* value
DIABETES				
Diagnosed	77%	62%	13.5	0.003
Among diagnosed:				
Control	65%	55%	9.5	0.098
HbA1c (%)	7.6	8.2	−0.58	0.033
Total cholesterol (mg/dL)	196.5	204.4	−6.2	0.356
Systolic blood pressure (mmHg)	128.6	128.1	1.1	0.658
HYPERCHOLESTEROLEMIA				
Diagnosed	75%	60%	13.5	<0.001
Among diagnosed:				
Control	74%	69%	5.0	0.036
HbA1c (%)	6.1	6.1	0.09	0.216
Total cholesterol (mg/dL)	214.0	221.8	−8.0	0.003
Systolic blood pressure (mmHg)	123.1	125.3	−2.3	0.005
HYPERTENSION				
Diagnosed	83%	73%	8.8	<0.001
Among diagnosed:				
Control	73%	69%	5.5	0.006
HbA1c (%)	6.0	6.1	−0.07	0.300
Total cholesterol (mg/dL)	202.9	206.0	−3.0	0.217
Systolic blood pressure (mmHg)	130.2	132.5	−2.9	0.003

SOURCE Authors' analyses of data for 1999–2012 from the National Health and Nutrition Examination Survey. **NOTES** The column labeled "insured" refers to the sample of matched insured individuals. Adjusted differences are estimated from linear regressions fit to the matched samples, controlling for the covariates used to construct the matched samples. "Control" is HbA1c <8 percent for diabetes, total cholesterol <240 mg/dL for hypercholesterolemia, and systolic blood pressure <140 mmHg for hypertension. Full regression results appear in Appendix Exhibit A3 (see Note 37 in text).

EXHIBIT 3

Estimated Gains In Diagnosis And Control Of Diabetes, Hypercholesterolemia, And Hypertension Among Adults Ages 20–64, Assuming A 50 Percent Reduction In The Number Of Uninsured People

	Diabetes	Hypercholesterolemia	Hypertension
Currently uninsured	4,628,000	11,979,000	10,969,000
Currently uninsured and undiagnosed	1,856,000	3,917,000	2,161,000
Increase in number of diagnoses with 50% reduction in the number uninsured	313,000	811,000	485,000
Currently uninsured and diagnosed	2,771,000	8,063,000	8,807,000
Currently uninsured, diagnosed, and uncontrolled	1,176,000	2,153,000	2,159,000
Increase in number of controlled cases with 50% reduction in the number uninsured	162,000	241,000	271,000

SOURCE Authors' analyses of data for 1999–2012 from the National Health and Nutrition Examination Survey. **NOTES** The estimated impact of insurance expansion on new diagnoses of a given disease was computed as the product of the proportion of individuals in the US population with the disease but without insurance in 2011–12 multiplied by 50 percent, the estimated risk difference for the probability of diagnosis, and the size of the nonelderly American population for 2011–12 from the American Community Survey. The estimated impact of insurance on the number of individuals with newly controlled conditions was computed as the sum of the following: (1) the number of individuals in the US population with uncontrolled conditions and without insurance in 2011–12 multiplied by 50 percent and (2) the projected number of newly diagnosed individuals, assuming 50 percent insurance coverage expansion, multiplied by the estimated risk difference for the probability of control. We simulated uncertainty intervals around projected impacts by drawing values for population prevalence and risk differences from uncorrelated normal distributions, based on the estimated means and standard errors for these estimates. The total number of unique individuals predicted to benefit for at least one condition from a 50 percent expansion in insurance coverage was obtained by applying a scaling factor to the sum of the projected gains in diabetes, hypercholesterolemia, and hypertension in Exhibit 3. This scaling factor was computed from the morning examination sample by comparing the projected number of beneficiaries obtained from independently estimated samples of the three disease states to the projected number of beneficiaries obtained from applying independently acting risk differences to the joint distribution of the three disease states.

We also estimate that there would be 162,000 (95% CI: −21,000, 374,000) fewer cases of uncontrolled diabetes, 241,000 (95% CI: 25,000, 475,000) fewer cases of uncontrolled hypercholesterolemia, and 271,000 (95% CI: 82,000, 476,000) fewer cases of uncontrolled hypertension among 659,000 individuals (Exhibit 3). In a hypothetical scenario in which all nonelderly Americans had health insurance, we estimate that there would be 3.1 million more people with a diagnosis of one of these chronic conditions and 1.3 million fewer with uncontrolled cases.

Discussion

Using data from a large, nationally representative survey of the US population, we found that health insurance was associated with higher rates of diagnosis of diabetes, hypercholesterolemia, and hypertension among nonelderly adults. Moreover, we found evidence that once people were diagnosed with one or more of these conditions, having health insurance was associated with improved management and control of the conditions, and the effects were moderate in size.

Our results suggest that for the nation, if insurance expansion under the ACA reduced the number of uninsured people by 50 percent as projected, more than 1.5 million currently uninsured individuals with previously undiagnosed chronic conditions could be newly diagnosed, and an additional 659,000 individuals could achieve control for at least one condition. From a health system perspective, these are positive outcomes that would have important implications for the health of the US population.

We found significant associations between insurance status and the primary measure of effective management for each of the three conditions (for example, blood pressure control among people with hypertension). In addition, we observed an insurance effect on the better management of hypertension among those with elevated serum cholesterol. This could be related in part to the implementation of risk-based prevention strategies, in which clinicians use predicted risk of cardiovascular disease (such as the Framingham Risk Score) to assign cholesterol-lowering or antihypertensive drugs;[38] to the application of the concept of combination pharmacotherapy, in which clinicians may prescribe both an antihypertensive and a cholesterol-lowering drug to prevent cardiovascular disease;[39] or to antihypertensive effects of statins.[40] However, we did not find the same cross-risk effect for diabetes, despite the fact that hypertension control is included in guidelines for diabetes management.

This study extends existing literature that aims to understand the relationship between health insurance and health. Among observational studies that considered health outcomes, associ-

1.5 million

Newly diagnosed

If insurance expansion under the ACA reduced the number of uninsured people by 50 percent, more than 1.5 million currently uninsured individuals with previously undiagnosed chronic conditions could be newly diagnosed, and an additional 659,000 individuals could achieve control for at least one condition.

ations have been reported between insurance and increased rates of disease diagnosis,[13–15] increased rates of accessing care,[18,19] improved physiological measures of disease control,[15,17,19] and reduced mortality.[16,20,21]

Our study is qualitatively consistent with findings in earlier studies that health insurance may increase levels of diagnosis and control of disease.[13–15,17] It is most closely related to a study by Andrew Wilper and colleagues that, using a regression analysis of NHANES data for 1999–2006, found that insurance was associated with diagnoses of diabetes and elevated cholesterol but not hypertension, and with control of hypertension but not diabetes or elevated cholesterol among already diagnosed cases.[15]

Our study used contemporary data and augmented previous methodologies with an estimation strategy that incorporated matching to improve the ability to derive credible estimates of insurance effects by constructing an appropriate counterfactual population for the uninsured. We also conducted a sensitivity analysis to determine whether public forms of health insurance were associated with improved health outcomes, and we tested for temporal changes in the relationship between health insurance and health outcomes between 1999 and 2012. Finally, our study is distinct in that it translates epidemiological findings into potential population-level health impacts of insurance expansion under the ACA in nonelderly adults.

It is also useful to consider our results in light of those reported in two randomized studies in the United States. In the 1970s the RAND Health Insurance Experiment found few examples of health outcomes that were improved by having more comprehensive insurance. However, it did find that blood pressure was lower among low-income patients with clinically defined hypertension who received free care, compared to those with cost sharing.[41] More recently, the Oregon experiment found no significant effect of Medicaid coverage on diagnosis of or medication use for high cholesterol or hypertension, or on overall levels of cholesterol or blood pressure in the Medicaid population. The study did find a significant increase in the probability of diabetes diagnosis and medication use.[26]

Our results for diabetes diagnosis are consistent with those in the Oregon experiment, but we found additional significant effects relating to blood pressure and cholesterol. There are several possible reasons for these differences. Most important, our study made use of a detailed examination survey that enabled us to identify both undiagnosed and diagnosed patients with each condition and therefore to estimate effects within these groups, instead of in the population as a whole, as in Oregon. Analyzing effects in the entire population is expected to dilute the benefits among those with chronic conditions by averaging these benefits with smaller or null effects among the healthy population. Power in the Oregon experiment was further limited by including relatively small numbers of people with these three chronic conditions and by having a relatively short follow-up period (on average, seventeen months of coverage). Finally, the Oregon study was limited to observing effects relating only to Medicaid and in only one state. Effects for the uninsured adult population in the United States are unlikely to be identical to those in this particular subpopulation.

Insurance expansion should have a large and meaningful effect on both diagnoses of chronic illnesses and their subsequent treatment, which should lead to better disease control.

Of course, the Oregon study had an experimental design, which removed the potential for selection bias and unmeasured confounding that can influence results from observational studies. Given the lack of experimental evidence at the national level and among specific populations with chronic conditions, our study used a robust matching approach to optimize our ability to control for potential biases arising in unadjusted or regression-only analyses of observational data. However, none of these methods can adjust for potential bias due to unmeasured confounders, and additional public policy experiments such as the Oregon Health Insurance Experiment may be useful.

Policy Implications

A major goal of the ACA is to improve the health of the US population through insurance expansion. Our findings suggest that when it comes to chronic disease, insurance expansion should have a large and meaningful effect on both diag-

noses of chronic illnesses and their subsequent treatment, which should lead to better disease control. Moreover, our findings suggest that these health benefits can occur through expanded coverage of public forms of health insurance. While these are undoubtedly positive outcomes, our findings have specific, and nuanced, implications for policy makers.

First, there is a need to prepare the health system to handle the influx of 1.5 million people who will be newly identified as having a chronic disease. These people will need regular access to health care providers, and policy makers need to rethink their strategy for ensuring that newly insured patients can get the care they need. For example, this may require relaxing scope-of-practice rules in some places, to allow nurse practitioners and others to care more independently for these patients.

Second, patients with newly diagnosed chronic disease will surely incur greater medical expenditures than they did when they were uninsured, at least in the short term. While much of this spending is likely to be clinically beneficial, many of the existing models for forecasting future health care spending do not take these effects into account. This is an important omission, since in the long term, better management of chronic conditions might lead to reductions in health care spending because averted complications of hypertension, hypercholesterolemia, and diabetes could translate into fewer interventions needed and lower costs.

Furthermore, our findings are an important reminder of the need to focus on the quality of care for chronic disease, which remains suboptimal.[42] For increased rates of diagnosis to result in better chronic disease control, patients must receive care in systems that are effective and that ensure the provision of evidence-based care.

Conclusion

The ACA remains a watershed in US health policy. Despite the policy debates that it has spawned, there are still surprisingly few data on the act's likely impact on the health of the US population. Our study provides contemporary estimates of the relationship between health insurance and the diagnosis and control of diabetes, hypercholesterolemia, and hypertension among nonelderly adults, who are the primary target of the ACA. Our findings suggest that the ACA could have significant effects on the identification and management of chronic disease. However, more attention is needed to the potential short-term and long-term implications of these health changes for the demand for health care services and health care spending on chronic disease. ■

This work was supported by the National Institute of Diabetes and Digestive and Kidney Diseases (Grant No. 1R01 DK090435). The funding source had no role in the design, conduct, or reporting of the study. Daniel Hogan is a staff member of the World Health Organization. The authors alone are responsible for the views expressed in this article, and they do not necessarily represent the decisions, policy, or views of the World Health Organization.

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September 2015 | Issue Brief

New Analysis Shows States with Medicaid Expansion Experienced Declines in Uninsured Hospital Discharges

Robin Rudowitz and Rachel Garfield

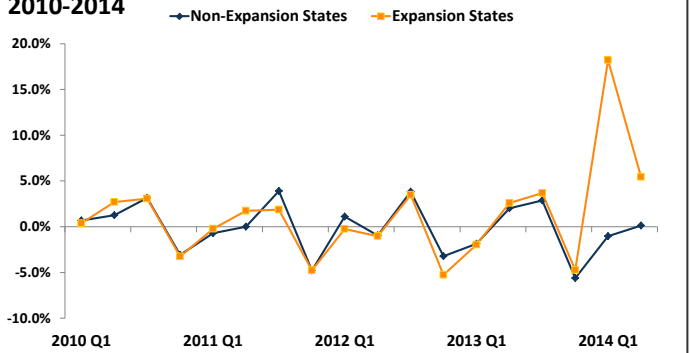
Expanded health insurance coverage through the Affordable Care Act (ACA) is having a major impact on hospital payer mix across the country. Similar to other reports recently released, new data examining hospital discharges in 16 states with data through the second quarter in 2014 show increases in Medicaid and declines in uninsured or self-pay discharges in states that implemented the Medicaid expansion. These trends hold true for all hospital discharges as well as for specific services such as mental health or asthma. This information adds to a growing body of evidence indicating that coverage expansions are affecting providers and may lead to decreases in uncompensated care for the uninsured. These 16 states include 6 states that have not implemented (Florida, Georgia, Indiana, Missouri, Virginia, and Wisconsin) and 10 states that had implemented the Medicaid expansion (Arizona, California, Colorado, Hawaii, Iowa, Kentucky, Michigan, Minnesota, New Jersey, New York) by the second quarter in 2014.

Key Findings

Prior to the ACA's major coverage expansions, growth rates for inpatient stays in expansion and non-expansion states moved in tandem, but patterns diverged starting in 2014. From 2010 through 2013, the number of quarterly Medicaid and uninsured discharges in both expansion and non-expansion states changed cyclically in a similar pattern (Figures 1 and 2). Beginning in 2014, expansion states show sharp increases in inpatient stays for Medicaid and sharp declines for uninsured compared to non-expansion states (Figures 1 and 2).

Figure 1

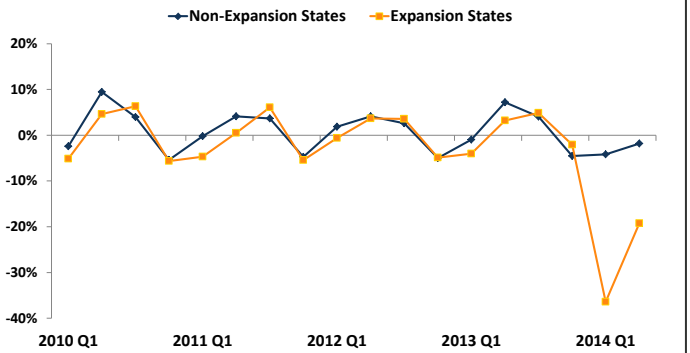
Median Quarterly Change in Inpatient Hospital Stays for Adult Hospitalizations with Medicaid as Expected Payer 2010-2014



Source: Kaiser Family Foundation analysis of hospital inpatient data from the Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases and quarterly 2014 data. Data available at: http://www.hcup-us.ahrq.gov/faststats/landing.jsp.

Figure 2

Median Quarterly Change in Inpatient Hospital Stays for Adult Hospitalizations for Uninsured Patients, 2010-2014

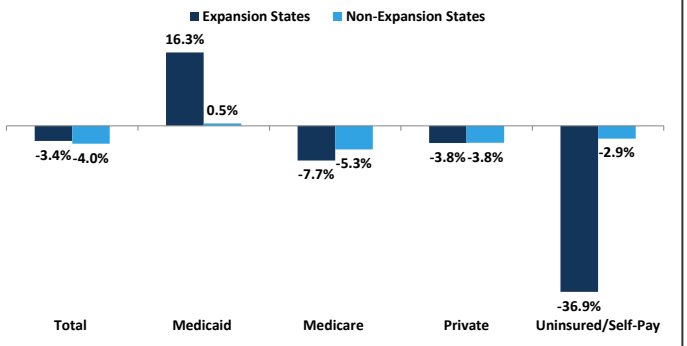


Source: Kaiser Family Foundation analysis of hospital inpatient data from the Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases and quarterly 2014 data. Data available at: http://www.hcup-us.ahrq.gov/faststats/landing.jsp.

Comparing inpatient stays by payer for 2013 to 2014 shows sharp increases for Medicaid and sharp declines in uninsured for expansion states. Data show that while inpatient stays declined by 3.4% for a typical expansion state from 2013 to 2014, Medicaid inpatient stays increased by 16.3% and uninsured stays decreased by 36.9%. A typical non-expansion state experienced a decline in inpatient stays of 4.0% with small (0.5%) increases in Medicaid stays and slight declines in uninsured inpatient stays (2.9%) (Figure 3).

Figure 3

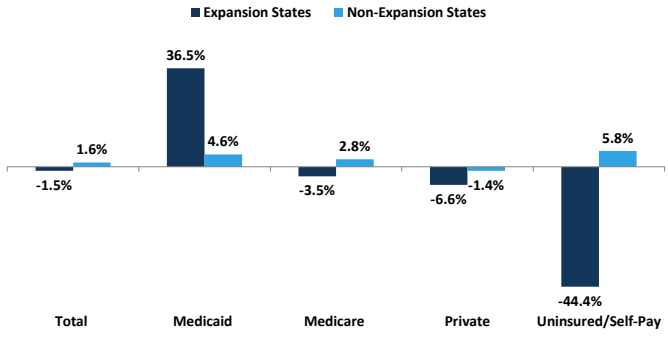
Median Percent Change in Inpatient Hospital Stays by Payer, 2013-2014



NOTE: Change is measured as change between first two quarters of 2013 and first two quarters of 2014.
Source: Kaiser Family Foundation analysis of hospital inpatient data from the Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases and quarterly 2014 data. Data available at: http://www.hcup-us.ahrq.gov/faststats/landing.jsp.

Figure 4

Median Percent Change in Inpatient Hospital Stays for Mental Health by Payer, 2013-2014



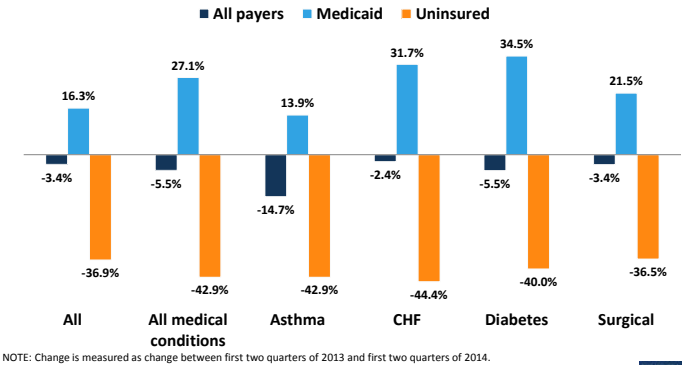
NOTE: Change is measured as change between first two quarters of 2013 and first two quarters of 2014.
Source: Kaiser Family Foundation analysis of hospital inpatient data from the Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases and quarterly 2014 data. Data available at: http://www.hcup-us.ahrq.gov/faststats/landing.jsp.

Increases in Medicaid discharges and declines in uninsured discharges for expansion states were especially pronounced for mental health. Among the states included in this analysis, adult mental health stays accounted for 5.8% of adult hospital stays in the 2nd quarter of 2014 (data not shown). A typical expansion state experienced a decrease of 1.5% in mental health inpatient stays but saw a 36.5% increase in Medicaid mental health inpatient stays and a 44.4% decline in uninsured stays for mental health. Non-expansion states saw overall mental health stays increase slightly (1.6% increase) with similar slight increases across payers except for private (Figure 4).

The 2013 to 2014 trends for expansion and non-expansion states are consistent across other types of inpatient stays. Among states in this analysis, medical conditions account for about half of all stays, surgical discharges account for about 23% of all stays, and other conditions account for much smaller shares (data not shown). These shares are similar for expansion and non-expansion states. Looking at changes in stays for other types of conditions including asthma, coronary heart failure (CHF), diabetes, and surgical care reveal similar patterns for expansion states as seen for total adult hospitalizations: while discharges declined overall, Medicaid discharges increased and uninsured discharges declined (Figure 5). For non-expansion states, stays for most conditions were flat or declined, both overall and for Medicaid and uninsured discharges. The exceptions to the pattern for non-expansion states were discharges for CHF, which rose 1.6% overall and 15.3% and 4.3% for uninsured and Medicaid, respectively, and diabetes, which rose slightly for all payers as well as Medicaid (Figure 6).

Figure 5

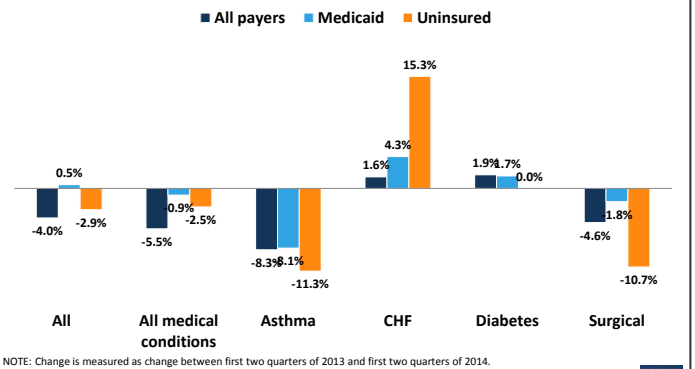
Median Percent Change in Inpatient Hospital Stays for Expansion States by Condition and Payer, 2013-2014



NOTE: Change is measured as change between first two quarters of 2013 and first two quarters of 2014.
Source: Kaiser Family Foundation analysis of hospital inpatient data from the Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases and quarterly 2014 data. Data available at: http://www.hcup-us.ahrq.gov/faststats/landing.jsp.

Figure 6

Median Percent Change in Inpatient Hospital Stays for Non-Expansion States by Condition and Payer, 2013-2014



NOTE: Change is measured as change between first two quarters of 2013 and first two quarters of 2014.
Source: Kaiser Family Foundation analysis of hospital inpatient data from the Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases and quarterly 2014 data. Data available at: http://www.hcup-us.ahrq.gov/faststats/landing.jsp.

Looking ahead, changes may converge. Data for the later quarters in 2014 (not included in this analysis) show that the percent changes from quarter to quarter were not as disparate for expansion and non-expansion states as they were for the early months in 2014. This is likely because big level changes were occurring by payer when individuals changed coverage as a result of the Medicaid expansion in expansion states. Going forward, change between expansion and non-expansion states may follow similar trends as prior to the implementation of the ACA. In addition, it will be important to assess how these changes in discharges by payer are affecting hospitals' financial position. While hospitals in expansion states saw large shifts in payer mix between Medicaid and uninsured, most hospital discharges are covered by other payers such as Medicare or private insurance. As states and hospitals continue to report data on changes in payer mix and financial performance, we will be able to gain a fuller picture of the full impact of the ACA on providers.

Methods

This data note uses data from the Healthcare Cost and Utilization Project (HCUP) to examine changes in discharges by payer for states that did and did not implement the ACA Medicaid expansion. HCUP consists of family of health care databases developed through a Federal-State-Industry partnership and sponsored by the Agency for Healthcare Research and Quality (AHRQ). Specifically, this analysis is based on data in the State Inpatient Databases (SID). The data is discharge-level data for all patients treated in community, non-rehabilitation hospitals in the state and is weighted to represent all discharges in the state. While 48 states participate in the SID, this analysis examines data from 16 states with data from 2010 through the second quarter of 2014. The 16 states include 6 states that had not implemented (Florida, Georgia, Indiana, Missouri, Virginia, and Wisconsin) and 10 states that had implemented the Medicaid expansion (Arizona, California, Colorado, Hawaii, Iowa, Kentucky, Michigan, Minnesota, New Jersey, New York) in this time period.

This data includes nearly 3 million hospital stays in the second quarter of 2014 (with 1.8 million (61%) from the expansion states and 1.2 million (39%) from the non-expansion states). Discharges in expansion and non-expansion states were concentrated in a small number of large states. For the group of expansion states, California and New York accounted for more than half of all discharges (54%), and for the non-expansion states, Florida and Georgia accounted for 56% of the discharges for the second quarter in 2014. (Table 1) Because these large states have a bigger impact on the overall experience of each group of states, we used the median for the group when examining outcomes of payer mix, percent change by quarter and when measuring change from 2013 to 2014.

The dominant payers for both expansion and non-expansion states were Medicare and private insurance. For all discharges in the second quarter of 2014, the typical expansion state had a higher percentage of Medicaid discharges compared to non-expansion states (22% versus 15%) and a lower percentage of uninsured discharges (3% versus 9%). (Table 1)

Table 1: Number and Distribution of Discharges by Payer for States Included in Analysis, 2014 Q2									
State	Total	Medicaid Discharges		Uninsured Discharges		Medicare Discharges		Private Insurance Discharges	
	#	#	As a % of Total Discharges	#	As a % of Total Discharges	#	As a % of Total Discharges	#	As a % of Total Discharges
All Expansion States									
Total	**1,836,900**	**448,350**	**24%**	**62,450**	**3%**	**778,250**	**42%**	**547,850**	**30%**
Median	**108,950**	**24,250**	**22%**	**3,075**	**3%**	**47,675**	**43%**	**35,025**	**32%**
Arizona	121,900	29,350	24%	6,500	5%	52,700	43%	33,350	27%
California	604,050	176,550	29%	20,500	3%	235,300	39%	171,700	28%
Colorado	75,950	18,100	24%	2,700	4%	28,800	38%	26,350	35%
Hawaii	18,800	5,100	27%	350	2%	6,600	35%	6,750	36%
Iowa	56,950	8,300	15%	1,100	2%	29,550	52%	18,000	32%
Kentucky	96,000	26,400	28%	2,300	2%	42,650	44%	24,650	26%
Michigan	219,950	42,250	19%	3,450	2%	107,950	49%	66,300	30%
Minnesota	87,800	15,000	17%	1,050	1%	35,050	40%	36,700	42%
New Jersey	168,250	22,100	13%	13,350	8%	75,900	45%	56,900	34%
New York	387,250	105,200	27%	11,150	3%	163,750	42%	107,150	28%
All Non- Expansion States									
Total	**1,155,850**	**191300**	**17%**	**108,450**	**9%**	**544,950**	**47%**	**311,150**	**27%**
Median	**140,525**	**21,225**	**15%**	**13,400**	**10%**	**64,550**	**46%**	**42,000**	**30%**
Florida	81,150	81,150	18%	43,650	9%	236,550	50%	108,950	23%
Georgia	31,250	31,250	16%	27,600	16%	67,950	39%	45,600	26%
Indiana	20,150	20,150	16%	8,100	6%	60,700	48%	37,350	30%
Missouri	22,300	22,300	12%	13,750	10%	64,150	46%	38,400	28%
Virginia	17,400	17,400	18%	13,050	9%	64,950	46%	47,050	33%
Wisconsin	19,050	19,050	18%	2,300	2%	50,650	48%	33,800	32%

Source: Kaiser Family Foundation analysis of hospital inpatient data from the Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases and quarterly 2014 data. Data available at: http://www.hcup-us.ahrq.gov/faststats/landing.jsp.

United States Government Accountability Office

Report to Congressional Requesters

September 2015

STATE HEALTH INSURANCE MARKETPLACES

CMS Should Improve Oversight of State Information Technology Projects

GAO-15-527

September 2015

STATE HEALTH INSURANCE MARKETPLACES

CMS Should Improve Oversight of State Information Technology Projects

GAO Highlights

Highlights of GAO-15-527, a report to congressional requesters

Why GAO Did This Study

The Patient Protection and Affordable Care Act required the establishment of health insurance exchanges—or marketplaces—to allow consumers and small employers to compare, select, and purchase health insurance plans. States can elect to establish a state-based marketplace, or cede this authority to CMS to establish a federally facilitated marketplace. To assist states in establishing their marketplaces and supporting IT systems, federal funding was made available, including grants and Medicaid matching funds. CMS has responsibilities for overseeing states' use of these funds and the establishment of their marketplaces.

The objectives of this study were to (1) determine how states have used federal funds for IT projects to support their marketplaces and the status of the marketplaces, (2) determine CMS's and states' roles in overseeing these projects, and (3) describe IT challenges states have encountered and lessons learned. To do this, GAO surveyed the 50 states and the District of Columbia, reviewed relevant documentation from the states and CMS, and interviewed CMS officials.

What GAO Recommends

GAO is recommending that CMS define and communicate its oversight roles and responsibilities, ensure senior executives are involved in funding decisions for state IT projects, and ensure that states complete testing of their systems before they are put into operation. HHS concurred with GAO's recommendations.

View GAO-15-527. For more information, contact Valerie C. Melvin, (202) 512-6304 or melvinv@gao.gov.

What GAO Found

States reported to the Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) that they spent about $1.45 billion in federal marketplace grant funding on information technology (IT) projects supporting health insurance marketplaces, as of March 2015. The majority of this spending was for state-based marketplaces (i.e., marketplaces established and operated by the states). These marketplaces reported spending nearly 89 percent of the funds on IT contracts, and CMS has ongoing efforts to track states' IT spending in more detailed categories. States also reported spending, as of December 2014, $2.78 billion in combined federal and state funds designated for Medicaid eligibility and enrollment systems—a portion of which was used for marketplace IT projects. However, the specific amount spent on marketplace-related projects was uncertain, as only a selected number of states reported to GAO that they tracked or estimated this information. Regarding the status of states' marketplace IT projects, 14 states with state-based marketplaces had developed and were operating IT systems to support their marketplaces, but, as of February 2015, not all system functions were complete. In addition, as of November 2014, 7 of 37 states using the federal marketplace system could not transfer health insurance applications between their state Medicaid systems and a key component of the federal marketplace or had not completed testing or certification of these functions. According to CMS officials, states operating their own IT systems and states using the federal marketplace system were continuing to improve the development and operation of their marketplaces in the enrollment period that began in November 2014.

CMS tasked various offices with responsibilities for overseeing states' marketplace IT projects. However, the agency did not always clearly document, define, or communicate its oversight roles and responsibilities to states as called for by best practices for project management. According to some states, this resulted in instances of poor communication with CMS, which adversely affected states' deadlines, increased uncertainty, and required additional work. CMS also did not involve all relevant senior executives in decisions to approve federal funding for states' IT marketplace projects; such involvement, according to leading practices for investment management, can increase accountability for decision making. Further, while CMS established a process that required the testing of state marketplace systems to determine whether they were ready to be made operational, these systems were not always fully tested, increasing the risk that they would not operate as intended. For their part, states oversaw their IT projects through state agencies or quasi-governmental entities, depending on marketplace type, as well as using other oversight mechanisms.

States reported a number of challenges in establishing the systems supporting their marketplaces. These fell into several categories, including project management and oversight, system design and development, resource allocation and distribution, and marketplace implementation and operation. States also identified lessons learned from dealing with such challenges, including the need for strong project management and clear requirements development. CMS has taken various actions to respond to state challenges, identify lessons learned, and share best practices with states; continuing these efforts will be important as states work to complete their marketplace systems.

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Abbreviations

CCIIO	Center for Consumer Information and Insurance Oversight
CHIP	Children's Health Insurance Program
CMCS	Center for Medicaid and CHIP Services
CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
IT	information technology
OTS	Office of Technology Solutions
PMBOK	Project Management Body of Knowledge
PPACA	Patient Protection and Affordable Care Act
SHOP	Small Business Health Options Program

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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September 16, 2015

Congressional Requesters

The Patient Protection and Affordable Care Act (PPACA),[1] signed into law on March 23, 2010, includes provisions to reform aspects of the private health insurance market and expand the availability and affordability of health care coverage. The act required the establishment of health insurance exchanges, now commonly referred to as "marketplaces," in each state and the District of Columbia[2] by January 1, 2014. These marketplaces are required to allow consumers, such as individuals and small employers, to compare, select, and purchase health insurance offered by participating private issuers of qualified health plans.[3]

The Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) is responsible for overseeing the establishment of the marketplaces, including providing funding and oversight for states' marketplace development efforts and creating a federally facilitated marketplace that can be used by states that do not choose to establish and operate their own. For their part, states are responsible for undertaking various efforts, including information technology (IT) projects needed to support the development of their own marketplaces or connections to the federal marketplace.

As with the federal marketplace, states' marketplaces began enrolling individuals in health insurance plans on October 1, 2013. However, individuals attempting to access the systems supporting the marketplaces encountered various challenges. In light of these challenges, you asked

[1]Pub. L. No. 111-148, §§ 1311(b), 1321(c), 124 Stat. 119, 173, 186 (Mar. 23, 2010) (hereafter, "PPACA"), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-52, 124 Stat. 1029 (Mar. 30, 2010). PPACA requires the establishment of health insurance exchanges, now known as marketplaces.

[2]In this report, the term "state" also refers to the District of Columbia.

[3]PPACA requires the insurance plans offered under a marketplace, known as qualified health plans, to provide a package of essential health benefits—including coverage for specific service categories, such as ambulatory care, prescription drugs, and hospitalization.

us to review the states' and CMS's actions related to the IT projects supporting states' health insurance marketplaces. Our specific objectives were to (1) determine how states have used federal funds for IT projects to establish, support, and connect to health insurance marketplaces, including amounts spent, and the overall status of their development and operation; (2) determine CMS's and states' roles in overseeing these state IT projects; and (3) describe IT challenges that states have encountered in developing and operating their marketplaces and connected systems, and lessons learned from their efforts.

To address the objectives, we administered a survey to all 50 states and the District of Columbia to collect pertinent information about the IT projects supporting their health insurance marketplaces.[4] We pre-tested the survey with marketplace and Medicaid officials from 7 states to ensure that the questions were clear, comprehensive, and unbiased, and to minimize the burden the survey placed on respondents. We developed two versions of this survey: one for states that established their own marketplaces and one for states that used the federally facilitated marketplace.[5] Based on CMS's classification of states for the first enrollment period,[6] 17 states received the state-based version of the survey, [7] and 34 states received the federally facilitated version. The survey was administered between September 30, 2014, and November 19, 2014, and focused on IT projects that supported health insurance

[4]We did not include U.S. territories, such as the Virgin Islands, in the scope of this review.

[5]This included states that relied on selected enrollment and other capabilities provided by the federally facilitated marketplace, or federally facilitated partnerships, as discussed later in this report.

[6]The first enrollment period for state marketplace operation was for plan year 2014, which began on October 1, 2013, and ended on March 31, 2014.

[7]Of the 17 states, 14 are state-based marketplaces and 3 are state-based marketplaces that use the federal marketplace IT solution, which will be discussed later in the report.

marketplaces for individuals.[8] We received responses from 46 states and the District of Columbia.[9]

To determine how states have used federal funds for IT projects to establish, support, and connect to health insurance marketplaces, and the overall status of their development and operation, we reviewed guidance that CMS provided to the states regarding federal funding for and the development of marketplaces and Medicaid eligibility and enrollment systems,[10] such as the marketplace grant funding opportunity announcement. We also reviewed sections of GAO's IT investment management framework relevant to managing project costs.[11] We then analyzed the states' survey responses regarding their project costs and development, as well as any supporting documentation that they provided concerning applicable federal marketplace grants and Medicaid funding. In addition, we reviewed CMS data on spending of marketplace grant funds and Medicaid funding for IT. Specifically, we reviewed funding and status documentation submitted by the states to CMS, including state IT spending and status summaries, and asked CMS officials responsible for reviewing the states' federal marketplace grant and Medicaid matching funding a series of questions concerning its accuracy and reliability. We determined that the funding data provided in the responses were sufficiently reliable for our purposes and noted any limitations of the state-reported spending data in the report.

[8]In addition to marketplaces for individuals, PPACA also required the creation of similar exchanges, now known as marketplaces, called Small Business Health Options Program (SHOP) marketplaces, where small employers can shop for and purchase health coverage for their employees. Our report does not focus on SHOPs.

[9]The 4 states that did not provide responses to the survey were Arkansas, Kansas, New Jersey, and Ohio. In addition, among the 47 that did respond, not all provided answers to every question.

[10]With the enactment of PPACA, changes to Medicaid eligibility and enrollment systems were needed in order for the Medicaid program to operate seamlessly with the marketplaces.

[11]GAO, *Information Technology Investment Management: A Framework for Assessing and Improving Process Maturity*, Version 1.1, GAO-04-394G (Washington, D.C.: March 2004).

To determine CMS's and states' roles in overseeing the development of marketplace IT solutions,[12] we analyzed the survey responses, HHS/CMS guidance provided to states, and CMS's policies and procedures and other documentation describing its roles and responsibilities as applicable to states' marketplace development efforts. We compared CMS's policies and procedures to best practices included in GAO's IT investment management framework[13] and to the Project Management Institute's *A Guide to the Project Management Body of Knowledge (PMBOK® Guide)* [14] to identify whether CMS had established roles and responsibilities that were consistent with industry practices. We also assessed the manner in which CMS communicated guidance and information on roles and responsibilities to the states.

Further, we reviewed CMS's funding oversight process and compared it to the sections of GAO's IT investment management framework that are relevant to the management of project cost to determine if the agency followed best practices for overseeing the marketplace investments. We also reviewed CMS's Enterprise Life Cycle guidance for systems development reviews, and reports documenting states' operational readiness reviews to assess the extent to which CMS followed its processes. We also reviewed the survey responses and supporting documentation to determine states' marketplace oversight roles and how the states viewed CMS's oversight and guidance in regard to their marketplace-related projects. Lastly, we interviewed CMS officials responsible for overseeing implementation of the state marketplaces to obtain their perspectives on their marketplace roles.

To describe IT challenges encountered in developing and operating the marketplaces and connected systems and lessons learned from these efforts, we analyzed the survey responses related to challenges and lessons learned. Specifically, in administering the survey, we asked the

[12]Marketplace IT solutions are defined as including any marketplace IT systems and services that were developed, modified, or enhanced to support a state's health insurance marketplace. Marketplace IT systems may include hardware, software, databases, eligibility and enrollment systems, and rules engines needed to run the marketplace website. Services related to IT may include call center operations and consulting.

[13]GAO-04-394G.

[14]Project Management Institute, Inc., *A Guide to The Project Management Body of Knowledge* (*PMBOK® Guide*), Fifth Edition, (Newton Square, Pa.: 2013). "PMBOK" is a trademark of the Project Management Institute, Inc.

states to rate their experiences with each of various challenges presented, based on the type of marketplace they used (i.e., one established by the state or the federally facilitated marketplace). The challenges to be considered by states that developed their own marketplaces were divided into five areas in the survey (project management and oversight, marketplace IT solution design, marketplace IT solution development, resource allocation and distribution, and marketplace implementation and operation). The challenges to be considered by states that used the federally facilitated marketplace were divided into two areas (project management and oversight and system design and development) based on the IT work each marketplace performs.

We asked states to rate their experiences with each of these challenge areas using a 5-point scale with the following response options: very great challenge, great challenge, moderate challenge, somewhat of a challenge, or little or no challenge. In analyzing the states' ratings of the challenges, we used combined counts of "very great" and "great" responses to identify the greatest challenges for each area. We then discussed the top two greatest challenges in this report. If a challenge area applied to both a state-based marketplace and a state with a federally facilitated marketplace, we selected the greatest challenges from each marketplace type.

In addition, we asked states to identify lessons learned as they applied to the categories of challenges. We then analyzed states' responses to determine the number of lessons learned reported by each state. Further, we obtained input from CMS officials responsible for overseeing states' marketplace implementation regarding their perspectives on the states' challenges and lessons learned. A more detailed discussion of our objectives, scope, and methodology is provided in appendix I.

We conducted this performance audit from April 2014 to September 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

PPACA directed each state to establish and operate a health insurance marketplace by January 1, 2014.[15] In cases where states elected not to establish and operate a marketplace, the law directed the federal government to establish and operate a health insurance marketplace on their behalf. These marketplaces were expected to provide a seamless, single point-of-access for individuals to enroll in private health insurance plans and apply for income-based financial assistance established under the law.

PPACA and HHS regulations and guidance require every state to have marketplace capabilities that enable them to carry out four key functions, among others:

- **Eligibility and enrollment.** The marketplace must enable individuals to assess and determine their eligibility for enrollment in healthcare coverage. In addition, the marketplace must provide individuals the ability to obtain an eligibility determination for other federal healthcare coverage programs, such as Medicaid and the Children's Health Insurance Program (CHIP).[16] Once eligibility is determined, individuals must be able to apply for and enroll in applicable coverage options.
- **Plan management.** The marketplace is to provide a suite of services for state agencies and health plan issuers to facilitate activities such as submitting, monitoring, and renewing qualified health plans.
- **Financial management.** The marketplace is to facilitate payments of premiums to health plan issuers and also provide additional services such as payment calculation for risk adjustment analysis and cost-sharing reductions for individual enrollments.
- **Consumer assistance.** The marketplace must be designed to provide support to consumers in completing an application, obtaining eligibility determinations, comparing coverage options, and enrolling in healthcare coverage.

[15]PPACA, § 1311(b), 124 Stat. at 173.

[16]Medicaid is a joint federal-state program that finances health care coverage for certain low-income, disabled, elderly and/or pregnant adults and children. CHIP is a federal-state program that provides health care coverage to children 19 years of age and younger living in low-income families whose incomes exceed the eligibility requirements for Medicaid.

To provide these capabilities, PPACA further required the states, as well as HHS (who delegated this role to CMS) to establish supporting automated systems and capabilities. Toward this end, states and CMS undertook projects to design, develop, implement, and operate health insurance marketplace systems.

States electing to establish their own marketplaces (hereafter referred to as a *state-based marketplace*) were required, in accordance with CMS guidance and regulations, to develop their own IT solutions, including a web portal for individual consumers to interact with and select healthcare coverage, as well as supporting systems that perform functions such as real-time eligibility queries, transferring application information to state Medicaid/CHIP agencies, sending taxpayer information to the Internal Revenue Service, and exchanging enrollment information with issuers of qualified health plans.

In addition, state-based marketplace IT solutions were required to interface with CMS systems designed to exchange information with external partners, including other federal agencies and states, and facilitate the electronic payment of insurance premiums to plan issuers. As an alternative to their web portals, these states were also required to set up call centers through which consumers could apply for coverage.

A state that operates its own marketplace can request that CMS perform eligibility and enrollment functions using federal IT systems. We refer to this as a *state-based marketplace using the federal marketplace IT solution*. This type of marketplace evolved when certain states encountered IT-related challenges during the development of their state marketplace solutions.

Further, if a state elected not to establish its own marketplace, CMS assumed some or all aspects of the marketplace operations for that state using two additional marketplace types:

- *Federally facilitated marketplace:* CMS is responsible for all aspects of establishing and operating the marketplace including the four key functions.
- *Federally facilitated partnership:* CMS is responsible for establishing and operating the eligibility enrollment and financial management functions, while the state assists with plan management and/or consumer assistance.

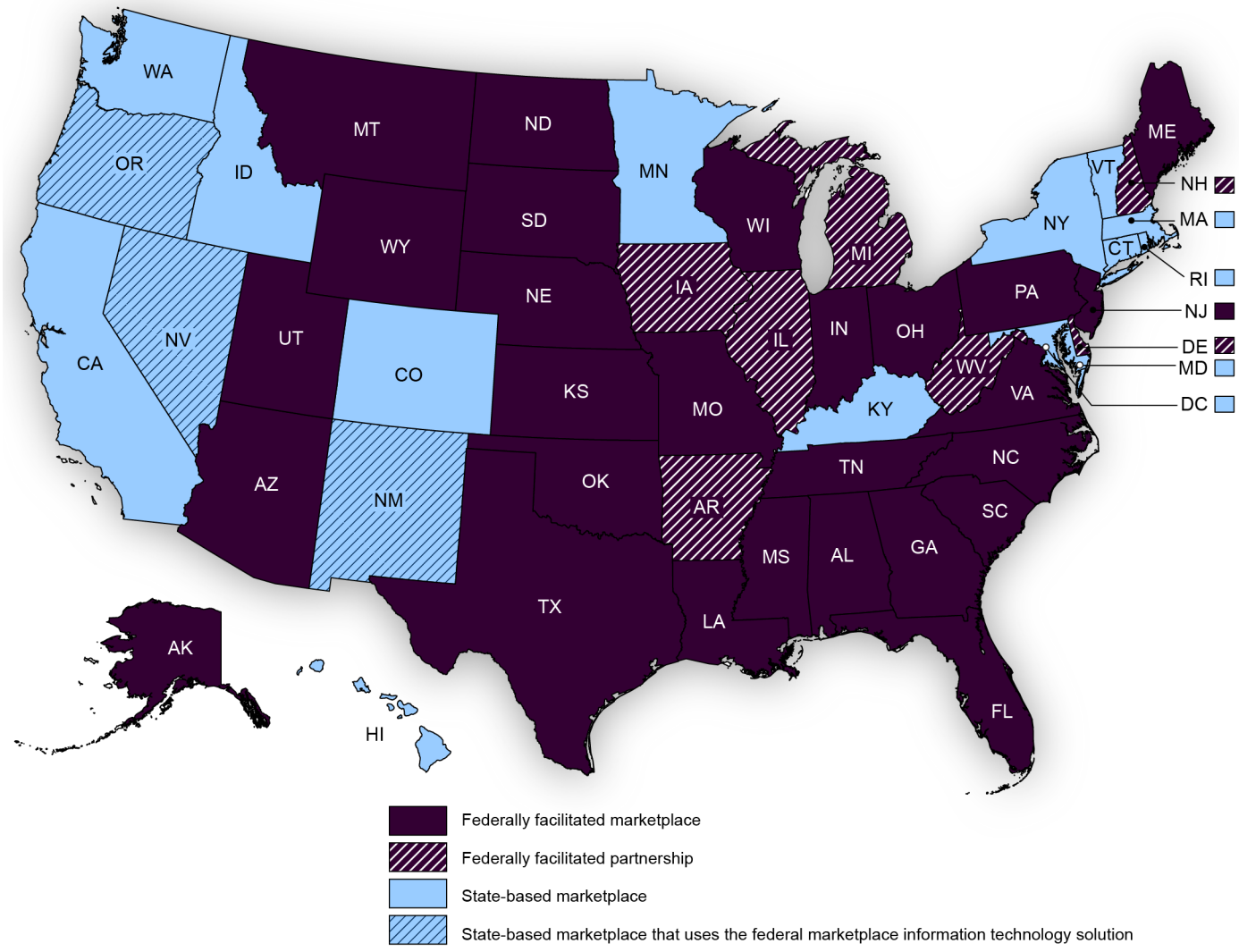
In these cases, states rely to varying degrees on the systems developed by CMS to support a federally facilitated marketplace. These include Healthcare.gov—the federal website that serves as the user interface for individuals to obtain information about health coverage, set up a user account, select a health plan, and apply for healthcare coverage—and several supporting systems. The supporting systems include a system for verifying an applicant's identity and establishing a login account; a transactional database to facilitate eligibility and enrollment, plan management, financial services, and other functions; and a data services hub that serves as a single portal for exchanging information with external partners.[17] For example, federal agencies such as the Social Security Administration (SSA), Department of Homeland Security (DHS), and Internal Revenue Service (IRS) provide or verify information used in making determinations of a person's eligibility for coverage and financial assistance.

For plan year 2015,[18] 14 states had a state-based marketplace, 3 had a state-based marketplace using the federal marketplace IT solution, 27 had a federally facilitated marketplace, and 7 had a federally facilitated partnership (see fig. 1).

[17]Specifically, these entities are the same ones that interact with the state marketplace IT solutions. These external partners include issuers of qualified health plans, and federal agencies such as the Department of Defense, Department of Homeland Security, Department of Veterans Affairs, Internal Revenue Service, Office of Personnel Management, Peace Corps, and the Social Security Administration.

[18]Open enrollment period for plan year 2015 was the second enrollment period for the state marketplaces, which began on November 15, 2014, and ended on February 15, 2015.

Figure 1: Type of Health Insurance Marketplace Used by States for Plan Year 2015

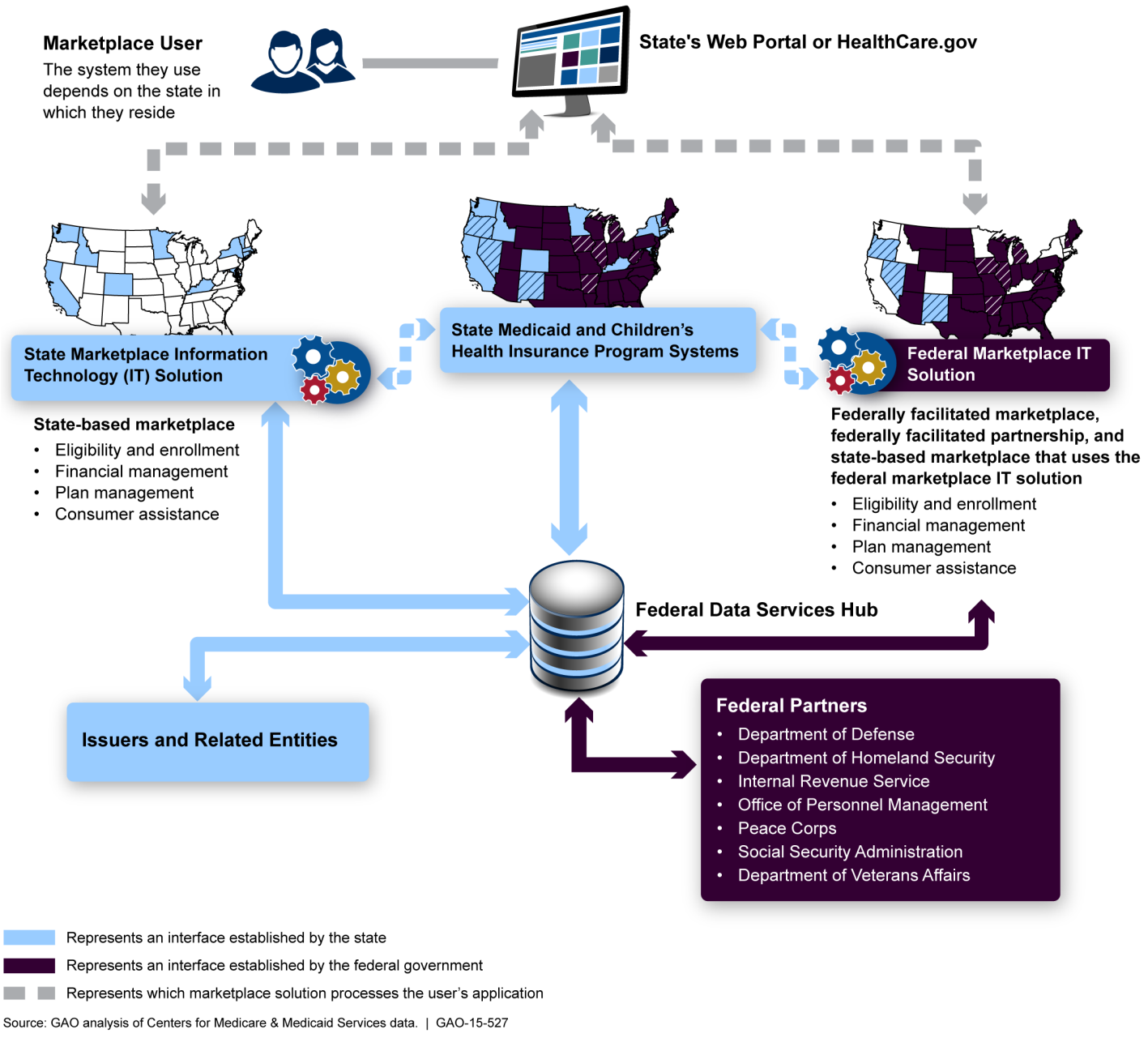


Sources: GAO analysis of Centers for Medicare & Medicaid Services data; Map Resources (map). | GAO-15-527

Depending on the type of marketplace established in his or her state, an individual user would apply for health coverage through either their state's web portal or through Healthcare.gov. The key functions required to enroll that individual would then be carried out by a combination of state and federal systems specific to the type of marketplace.

A general depiction of both the state and federal marketplace IT solutions is provided in figure 2.

Figure 2: State and Federal Marketplace Information Technology Solutions



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-15-527

Note: Federally facilitated partnerships and state-based marketplaces using the federal marketplace IT solution do not conduct all of the functions. CMS is responsible for establishing and operating the eligibility and enrollment and financial management functions, while the state assists with plan management and consumer assistance.

Federal Funding Available to States for Establishing Marketplaces

States had access to two sources of federal funding to establish their marketplaces: federal marketplace grants and Medicaid matching funds. CMS allows states to use both Medicaid matching funds and marketplace grants to pay for shared system services and functions that states needed to establish for marketplace operations,[19] such as developing a rules engine system[20] and establishing interfaces to the federal data services hub.[21] Various offices within CMS were tasked with overseeing grant reviews, Medicaid advanced planning document reviews, and IT gate reviews to ensure that states followed a standardized funding process for their marketplace-related IT projects. These offices included the Center for Consumer Information and Insurance Oversight (CCIIO), Center for Medicaid and Chip Services (CMCS), and the Office of Technology Solutions (OTS).

Marketplace Grants

PPACA authorized HHS to award federal exchange grants (now referred to as marketplace grants) for planning and establishing marketplaces. The act did not specify an exact amount of marketplace grant funding, but appropriated to HHS, out of any moneys in the Treasury not otherwise appropriated, an amount necessary to make marketplace grant awards. The act directed HHS to determine the total amount of funding that it would make available to each state for each fiscal year and authorized

[19]In addition to these technical requirements, CMS specified operational requirements—known as critical success factors—to help states prioritize the many changes that they were making to their Medicaid enrollment and eligibility systems to comply with PPACA. Due to differences among states in their approaches to establishing a marketplace, not all states needed to implement all critical success factors. For example, states running their own marketplaces would not need to implement the factor relating to sending and receiving applications to and from the federal marketplace IT solution. That particular factor would only apply to the states that were using the federal marketplace IT solution.

[20]CMS's IT guidance describes the rules engine as a system that applies the business rules associated with determining eligibility for individuals covered by using modified adjusted gross income. This includes functionality and processing logic to register, define, classify, and manage the rules; verify consistency of rules definitions; define the relationship between different rules; and relate some rules to IT applications that are affected or need to endorse these rules for such purposes as adjudicating eligibility-based on modified adjusted gross income or supporting workflow for the resolution of discrepancies.

[21]States should follow cost allocation principles outlined by the Office of Management and Budget in Circular A-87 to ensure that enhanced federal Medicaid funding is provided only for the portion of costs that are directly attributed to the Medicaid program. 75 *Fed. Reg.* at 21954 (Apr. 19, 2011).

the department to award marketplace grants to states through December 2014.[22]

On the basis of this authority, HHS established four separate programs for awarding marketplace grants to states.

- **Planning Grants:** Provided states with resources to conduct the initial research and planning needed to build a marketplace and determine how it would be operated and governed. The grants were awarded to states in 2010 and 2011 and provided 1 year of funding. A state could receive only one planning grant.[23]
- **Early Innovator Grants:** Provided funding to a state or group of states that were identified as early leaders in building their marketplaces, to assist in designing and implementing the IT infrastructure needed to operate the marketplaces. All marketplace IT components, including software and data models, developed with these grants could be adopted and modified by other states to fit their specific needs. The grants were awarded in February 2011 and the grant funds were available for 2 years. A state could only receive one of these grants.[24]
- **Establishment Grants (Level 1):** Provided funding for a 1-year project period to states pursuing any marketplace type. This funding was intended to help states undertake additional marketplace establishment activities, such as changes in response to legislative or

[22]PPACA required state-based marketplaces to be self-sustaining beginning on January 1, 2015, and authorized marketplaces to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding to support their operations. CMS has provided guidance to states noting that after January 1, 2015, grant funds may not be used to cover maintenance and operating costs, such as software maintenance, telecommunications, and base operational personnel and contractors.

[23]States were awarded up to $1 million, depending on the state's proposed activities and budget and HHS's assessment of the proposal. Overall, HHS awarded $50.7 million in planning grants. Some states chose to return a portion or, in one case, all of their grant funds awarded if they initially planned for, but did not pursue, establishing a state-based marketplace.

[24]States were awarded $262.3 million in early innovator grants. Approximately $86.1 million was returned—grant funds that were not expended and returned to CMS by the state. These grants were awarded to Kansas, Maryland, New York, Oklahoma, Oregon, Wisconsin, and a multistate consortium led by the University of Massachusetts Medical School (and consisting of Connecticut, Maine, Massachusetts, Rhode Island, and Vermont).

regulatory requirements, developing IT systems, and consulting with key stakeholders. The grants were awarded between May 2011 and December 2014. Once awarded, the funds were available for 1 year, and a state could apply for multiple grants.

- **Establishment Grants (Level 2):** Provided funding for a multi-year project period to states that have legal authority to implement a marketplace and are further along in marketplace development and are pursuing a state-based marketplace. This funding was designed to help the states carry out all marketplace activities, including consumer and stakeholder engagement and support, eligibility and enrollment, plan management, and technology development. The grants were awarded between May 2011 and December 2014. Once awarded, the grant funds remain available for up to 3 years. A state could receive only one grant.

States establishing state-based marketplaces were expected to carry out activities in a number of areas to receive these marketplace grants. These activity areas included stakeholder consultation, program integration, IT systems development, financial management, oversight and program Integrity, health Insurance market reform, and business operations of the marketplace.

Once grants were awarded, funding was disbursed using the Payment Management System, which is an HHS-administered system that provides federal agencies and grant recipients the tools to manage grant payments. Grantees submitted progress reports documenting financial expenditures and program progress through an online data collection system on a monthly and semi-annual basis.

As of December 31, 2014, CMS had awarded approximately $5.51 billion in federal marketplace grants to states.[25] Of these grant funds awarded, CMS had authorized states to spend approximately $2.16 billion on IT to support state-based marketplaces and federally facilitated partnerships as

[25]This awarded amount includes all 50 states and the District of Columbia. This amount includes awards for all marketplace grants (i.e., Planning, Early Innovator, and Establishment Level 1 and Level 2 grants). PPACA prohibits the awarding of establishment grants for marketplaces after January 1, 2015; HHS awarded grants until December 31, 2014.

of March 2015.[26] According to CMS, funds authorized for IT contracts could be designated as restricted and required prior approval from the various CMS offices mentioned previously before the funds could be spent. For states that opted to use the federally facilitated marketplace, IT funds were not provided after it was determined that these states were not establishing a state-based marketplace.

Medicaid Matching Funds

With the enactment of PPACA, changes to Medicaid eligibility and enrollment systems were needed in order for the Medicaid program[27] to operate seamlessly with the marketplaces, as well as to implement new Medicaid eligibility policies. Specifically, in all states, the Medicaid eligibility and enrollment system had to be replaced or modernized to meet the more streamlined enrollment process requirements of PPACA and its implementing policies, which included real-time transfer of applications between the state Medicaid agencies and the marketplace and immediate Medicaid eligibility determinations, regardless of the type of marketplace a state elected to use.[28]

Under federal law, states are eligible to receive funding, in the form of an enhanced federal matching rate of 90 percent (referred to as 90/10 funding), for the design, development, or installation of their Medicaid claims processing and information retrieval systems.[29] Because states' Medicaid eligibility and enrollment systems had to be replaced or modernized to meet the PPACA requirements, CMS expanded the availability of federal Medicaid funds at the enhanced matching rate of 90

[26]This amount includes IT spending by states with state-based marketplaces, including those that used the federal marketplace IT solution, federally facilitated partnerships, and two states with federally facilitated marketplaces that implemented SHOP-only marketplaces, which are Mississippi and Utah. For the purposes of this report, which is focused on IT projects supporting health insurance marketplaces for individuals, the IT spending by Mississippi and Utah is included in the amount of IT spending by states with a federally facilitated marketplace.

[27]CMS also specified critical success factors relating to states' system capability to accept streamlined applications, verify eligibility with electronic sources, and convert existing income standards and process applications based on modified adjusted gross income.

[28]In state-based marketplace states, those systems-related costs were shared and allocated between Medicaid and marketplace grant funding.

[29]42 U.S.C. § 1396b(a)(3)(A)(i). States may also qualify for a 75 percent matching rate for the operation of these systems. See 42 U.S.C. § 1396b(a)(3)(B). The 90 and 75 percent federal matching rate is referred to as "enhanced" because the rate is higher than the regular federal matching rate of 50 percent for Medicaid administrative expenses.

percent to help states pay for required changes,[30] including their interfaces to establish connections to the federal marketplace IT solution through the federal data services hub or the state marketplace IT solution. This enhanced federal matching rate is available to cover costs incurred by the states related to changes to their Medicaid eligibility systems from April 19, 2011, to December 31, 2015. All states are eligible to obtain the 90/10 funds for IT-related changes they make to their Medicaid eligibility and enrollment systems.

In addition, a state may receive funding in the form of a 75 percent federal matching rate for the maintenance and any ongoing costs of operating its upgraded Medicaid eligibility and enrollment system. The funding is generally available when the upgraded system becomes operational, and it does not expire.[31]

In updating their Medicaid eligibility and enrollment systems, states could use federal funds for full system replacements or for more limited modifications, with the scope of a state's changes depending on a number of factors, including the age of the system and the extent of integration among state programs.

Federal regulations require the approval of advanced planning documents in order for states to be able to draw down the 90/10 and 75/25 matching funds.[32] To access Medicaid matching funding, states must first submit these planning documents to CMS. In its role as the agency that oversees

[30]Federal regulations provide that federal financial participation is available at 90 percent of a state's expenditures for the design, development, installation, or enhancement of an eligibility determination system that meets the requirements specified in the regulation, and only for costs incurred for goods and services provided on or after April 19, 2011, and on or before December 31, 2015. 42 C.F.R. § 433.112(c) (2014). In April 2015, CMS issued a notice of proposed rulemaking to extend the availability of this enhanced federal match indefinitely. 45 Fed. Reg. 20455 (Apr. 16, 2015). For the purposes of this report, we use the term "90/10 funding" to refer to total spending on Medicaid eligibility IT systems; specifically, reflecting both the 90 percent federal match and the 10 percent state share of the funding.

[31]Beginning April 19, 2011, an enhanced federal financial participation of 75 percent is available for expenditures related to the operation of an upgraded eligibility determination system that meets applicable standards and conditions. States may continue to receive this enhanced match only if the system meets such standards and conditions by December 31. 2015. See 42 C.F.R. § 433.116(j) (2014).

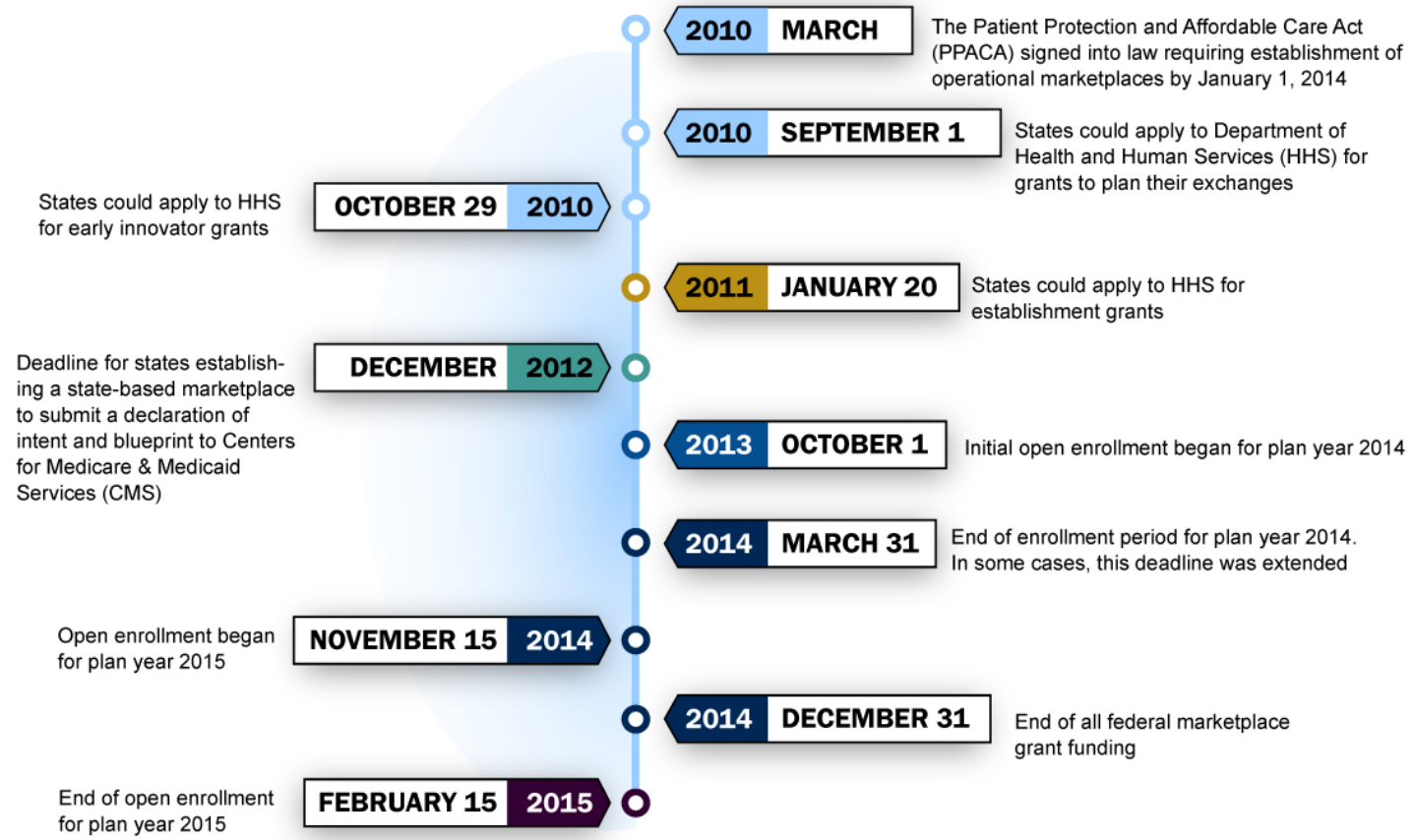
[32]42 CFR 433.112 (2014).

the Medicaid program and provides guidance and technical assistance to states related to Medicaid eligibility and enrollment system changes, CMS is to review these documents to ensure that certain technical and operational criteria are met before states are eligible for the funding. To receive approval, states must develop IT systems that meet technical standards and conditions. These standards and conditions require states to develop systems that are flexible, align with the Medicaid Information Technology Architecture principles, and promote data exchanges and the reuse of Medicaid technologies across systems and states.[33]

Figure 3 provides a timeline of the health insurance marketplaces' major activities previously mentioned, including dates when federal funding became available and enrollment time frames.

[33]The Medicaid Information Technology Architecture is an HHS IT initiative that began in 2005 and aims to stimulate an integrated business and IT transformation affecting Medicaid programs in all states by establishing national guidelines for technologies, information, and processes, among other efforts. For more information about these technical requirements, which were beyond the scope of this report, see Department of Health and Human Services, CMS, *Enhanced Funding Requirements: Seven Conditions and Standards, Medicaid IT Supplement* (MITS-11-01-v1.0), Version 1.0 (Baltimore, Md.: April 2011).

Figure 3: Timeline of Health Insurance Marketplace Activities



Source: GAO analysis of CMS data. | GAO-15-527

States Faced Development and Operations Difficulties during the First Marketplace Enrollment Period

During the first enrollment period, states faced difficulties developing and operating their marketplace IT solutions.[34] For state-based marketplaces, various sources reported[35] that technical issues varied widely, contributing to websites that froze midway through the process of applying for coverage, system crashes, and systems taken offline for days at a time, ultimately causing applicants to face long waits for eligibility determinations. One state reported technical problems serious enough to prevent any online enrollment; thus, thousands of individuals had to enroll manually using paper applications.

The problems experienced in state-based marketplaces for the first enrollment period were different in each state, but they included

- poor system performance and delays in addressing information security,
- partially completed software functionality,
- hardware problems,
- enrollment errors causing long wait times and applications to get stuck in the system,
- difficulties getting individuals' identities verified through the systems, and
- the inability to easily make changes to individuals' insurance coverage in response to events such as births or income changes.

States that relied on the federally facilitated marketplace and federally facilitated partnerships also encountered problems in the development and operation of their IT solutions during the first enrollment period. For example, in these states, consumers attempting to enroll in health plans through Healthcare.gov and its supporting systems were met with confusing error messages, slow load times for forms and pages, and in

[34]Of 17 state-based marketplaces that we identified, 15 developed and operated an IT marketplace solution in the first enrollment period. The other 2 states, Idaho and New Mexico, submitted blueprints to be state-based marketplaces, but did not operate their own IT solution and instead used the federal marketplace IT solution.

[35]Various sources include CMS documentation, state audits, and media reports.

some cases, website outages.[36] We previously reported that Healthcare.gov and its supporting systems were hindered by inadequate system capacity, numerous errors in software code, and limited system functionality—all of which impeded the systems' performance and their availability for consumers' use.[37]

Regarding state Medicaid systems, states with a federally facilitated marketplace, federally facilitated partnership, or state-based marketplace using the federal marketplace IT solution reported challenges in implementing the requirement to transfer or send and receive applications. For example, none of these types of states were able to transfer applications via the marketplace by the start of the first enrollment period on October 1, 2013.[38]

Prior GAO Reports Highlighted Concerns and Made Recommendations Related to Improving Health Insurance Marketplaces

Over the past 2 years, we have issued various reports highlighting challenges that CMS and the states have faced in implementing and operating health insurance marketplaces. For example, in an April 2013 report, we described the actions of seven states that were in various stages of developing an information technology infrastructure to establish marketplaces, including redesigning, upgrading, or replacing their outdated Medicaid and CHIP eligibility and enrollment systems.[39] Six of the seven states were also building the IT infrastructure needed to integrate systems and allow consumers to navigate among health programs, but identified challenges with the complexity and magnitude of the IT projects, time constraints, and guidance for developing their systems.[40]

[36]GAO, *Healthcare.gov: CMS Has Taken Steps to Address Problems, but Needs to Further Implement Systems Development Best Practices,* GAO-15-238 (Washington, D.C.: Mar. 4, 2015).

[37]GAO-15-238.

[38]GAO, *Medicaid: Federal Funds Aid Eligibility IT System Changes, but Implementation Challenges Persist,* GAO-15-169 (Washington, D.C.: Dec. 12, 2014).

[39]GAO, *Health Insurance: Seven States' Actions to Establish Exchanges under the Patient Protection and Affordable Care Act*, GAO-13-486 (Washington, D.C.: Apr. 30, 2013). These seven states were the District of Columbia, Iowa, Minnesota, Nevada, New York, Oregon, and Rhode Island.

[40]This report described states' actions and did not include recommendations.

In September 2014, we reported that while CMS had taken steps to protect the security and privacy of data processed and maintained by the systems that support Healthcare.gov, weaknesses remained in both the processes used for managing information security and privacy as well as the technical implementation of IT security controls.[41] Specifically, we noted that Healthcare.gov and the related systems had been deployed despite incomplete security plans and privacy documentation, incomplete security tests, and the lack of an alternate processing site to avoid major service disruptions. Accordingly, we recommended that CMS implement 22 information security controls. We also recommended that the agency improve its system security plans, privacy documentation, security tests, and alternate processing site for the systems that support Healthcare.gov. HHS concurred with all 22 of the recommendations to improve the effectiveness of its information security control and fully or partially concurred with our remaining information security program-related recommendations. The department stated that it intends to take steps to address the weaknesses, including updating its security plans, developing required computer matching agreements, and developing a backup site for Healthcare.gov.

In December 2014, we reported that all states using the federal marketplace IT solution had faced challenges transferring applications to and from that system.[42] We pointed out that none of the states using the federal marketplace IT solution in the first enrollment period were able to implement application transfers, which required the establishment of two IT connections: one connection to transfer applications found ineligible for Medicaid coverage from the state Medicaid agency to the federal marketplace IT solution, and another connection to transfer applications found ineligible for coverage from the federally facilitated marketplace to the state Medicaid agency.[43]

Most recently, in March 2015, we reported that several problems with the initial development and deployment of Healthcare.gov and its supporting systems had led to consumers encountering widespread performance

[41]GAO, *Healthcare.gov: Actions Needed to Address Weaknesses in Information Security and Privacy Controls,* GAO-14-730 (Washington, D.C.: Sept. 16, 2014).

[42]GAO-15-169.

[43]This report described states' actions and did not include recommendations.

issues when trying to create accounts and enroll in health plans.[44] We noted, for example, that CMS had not adequately conducted capacity planning, adequately corrected software coding errors, or implemented all planned functionality. In addition, the agency did not consistently apply recognized best practices for system development, which contributed to the problems with the initial launch of Healthcare.gov and its supporting systems. In this regard, weaknesses existed in the application of requirements, testing, and oversight practices. Further, we noted that HHS had not provided adequate oversight of the Healthcare.gov initiative through its Office of the Chief Information Officer.

We made recommendations aimed at improving requirements management, system testing processes, and oversight of development activities for systems supporting Healthcare.gov. HHS concurred with all of our recommendations and subsequently took or planned steps to address the weaknesses, including instituting a process to ensure functional and technical requirements are approved, developing and implementing a unified standard set of approved system testing documents and policies, and providing oversight for Healthcare.gov and its supporting systems through the department-wide investment review board.

States Spent Federal Grant and Medicaid Funds to Establish Marketplace IT Systems, although Not All Marketplace IT Functions Are Fully Operational

States reported to CMS that they spent federal marketplace grant funds, as well as Medicaid matching funds, on various IT projects to establish, support, and connect to health insurance marketplaces. Specifically, states reported spending about $1.45 billion in federal marketplace grant funds from September 2010 through March 2015. The states also reported spending federal funds designated for Medicaid eligibility and enrollment systems on marketplace-related IT projects, although the actual amount spent was uncertain, as only a selected number of states reported on our survey that they tracked or estimated this information. In this regard, from April 2011 through December 2014, states reported spending $2.78 billion in combined federal and state Medicaid funds, a portion of which was spent to support the marketplaces.

States that chose to establish state-based marketplaces were responsible for the majority of the federal marketplace grant spending. These states' efforts typically included developing web portals and supporting data

[44]GAO-15-238.

processing systems to carry out key marketplace-related functions, and establishing electronic connections in order to exchange information with various states, federal partners, and issuers.

Fourteen states with state-based marketplaces had developed and were operating IT systems to support their marketplaces; however, not all system functions were complete as of February 2015. In addition, according to a CMS status report, as of November 2014, 7 of 37 states using the federal marketplace IT solution could not transfer applications for health insurance coverage between their state Medicaid systems and the federal data services hub or had not completed testing or certification of these functions. According to CMS officials, states operating IT systems and states using the federal marketplace IT solution were continuing to improve the development and operation of their marketplaces in the second enrollment period.[45]

States Spent Most Federal Marketplace Grant Funds to Develop Systems Supporting State-Based Marketplaces and Used Medicaid Funds to Connect to Marketplaces

States reported to CMS spending approximately $1.45 billion in federal grant funds on IT projects to establish, support, and connect to health insurance marketplaces from September 2010 to March 2015.[46] States that established state-based marketplaces, including state-based marketplaces using the federal marketplace IT solution, reported having spent approximately $1.37 billion of these funds. In addition, states with a federally facilitated marketplace reported spending approximately $47 million,[47] while those with a federally facilitated partnership reported spending approximately $32 million.

[45]The second open enrollment period for state marketplace operation was for plan year 2015 and began on November 15, 2014, and ended on February 15, 2015.

[46]According to CMS officials, the agency did not define IT costs but allowed states to define for themselves what they considered to be IT costs.

[47]According to CMS officials, states with a federally facilitated marketplace were not provided IT marketplace grant funds unless these states were planning for or studying the feasibility of a state-base marketplace. This amount includes IT spending by two states with federally facilitated marketplaces that implemented SHOP-only marketplaces, which are Mississippi and Utah. For the purposes of this report, which is focused on IT projects supporting health insurance marketplaces for individuals, the IT spending by Mississippi and Utah is included in the amount of IT spending by states with a federally facilitated marketplace.

Table 1 provides a summary of the states' reported use of marketplace grant funds for their IT projects as of March 2015.[48]

Table 1: Marketplace Grant Funds Spent on States' IT Projects, by Marketplace Type, as of March 2015

(Dollars in millions)

Marketplace type (number of states)	Amount spent for IT
State-based marketplace (14)	$1,224
State-based marketplace using the federal marketplace IT solution (3)	150
State-based marketplace subtotal	**1,374**
Federally facilitated marketplace (27)	47
Federally facilitated partnership (7)	32
Federally facilitated marketplace and partnership subtotal	79
Total	**$1,454**

Source: GAO analysis of CMS data. | GAO-15-527

In addition to the $1.45 billion of reported IT spending, approximately $703 million of authorized grant funding for IT projects had not been spent as of mid-March 2015.[49] For additional details on the amount of marketplace grant funding awarded and spent, see appendix II.

States with state-based marketplaces were authorized by CMS to spend $2.02 billion for IT until December 2015, and this authorized amount per state ranged from approximately $55 million to $325 million as of March

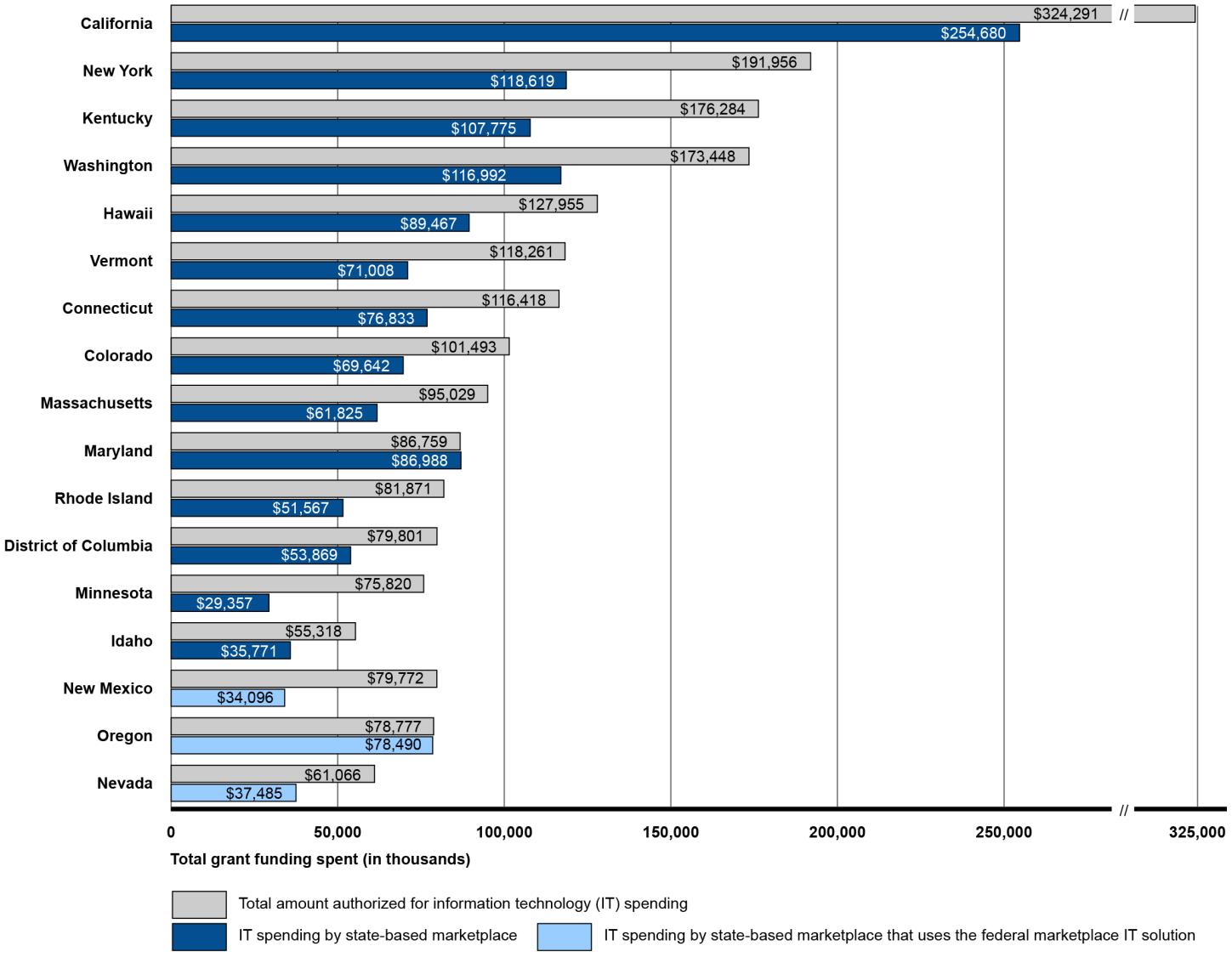
[48]In addition, CMS officials indicated that 29 states, primarily with a federally facilitated marketplace, have chosen to return a portion or, in one case, all of their grant funds awarded because the scope of states' project activities changed since the funds were initially awarded. More specifically, CMS officials stated that most of these grant funds were returned by states that decided not to undertake the activities for which the grant had been awarded, such as those that had initially planned to establish a state-based marketplace. According to CMS, as of October 2014, about $298 million had been de-obligated or returned to CMS. This was 5 percent of the $5.51 billion in total grants awarded as of December 2014. We did not verify the amount returned. CMS's report did not state whether funds de-obligated or returned were designated for IT or non-IT. Further, one federally facilitated state, Alaska, did not apply for and was not awarded any marketplace grant funding.

[49]We did not verify whether these funds remain available to states for expenditure or whether they have been reprogrammed or de-obligated.

2015.[50] As shown in figure 4, the reported spending of grant funds among the 17 states that were approved to establish state-based marketplaces, (i.e., the 14 state-based marketplaces and the 3 state-based marketplaces using the federal marketplace IT solution), ranged from approximately $29 million (in Minnesota) to approximately $254 million (in California), as of March 2015.

[50]We did not verify whether these funds remain available to states for expenditure or whether they have been reprogrammed or de-obligated.

Figure 4: Reported Grant IT Spending by State-Based Marketplaces and State-Based Marketplaces Using the Federal Marketplace IT Solution as of March 2015



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-15-527

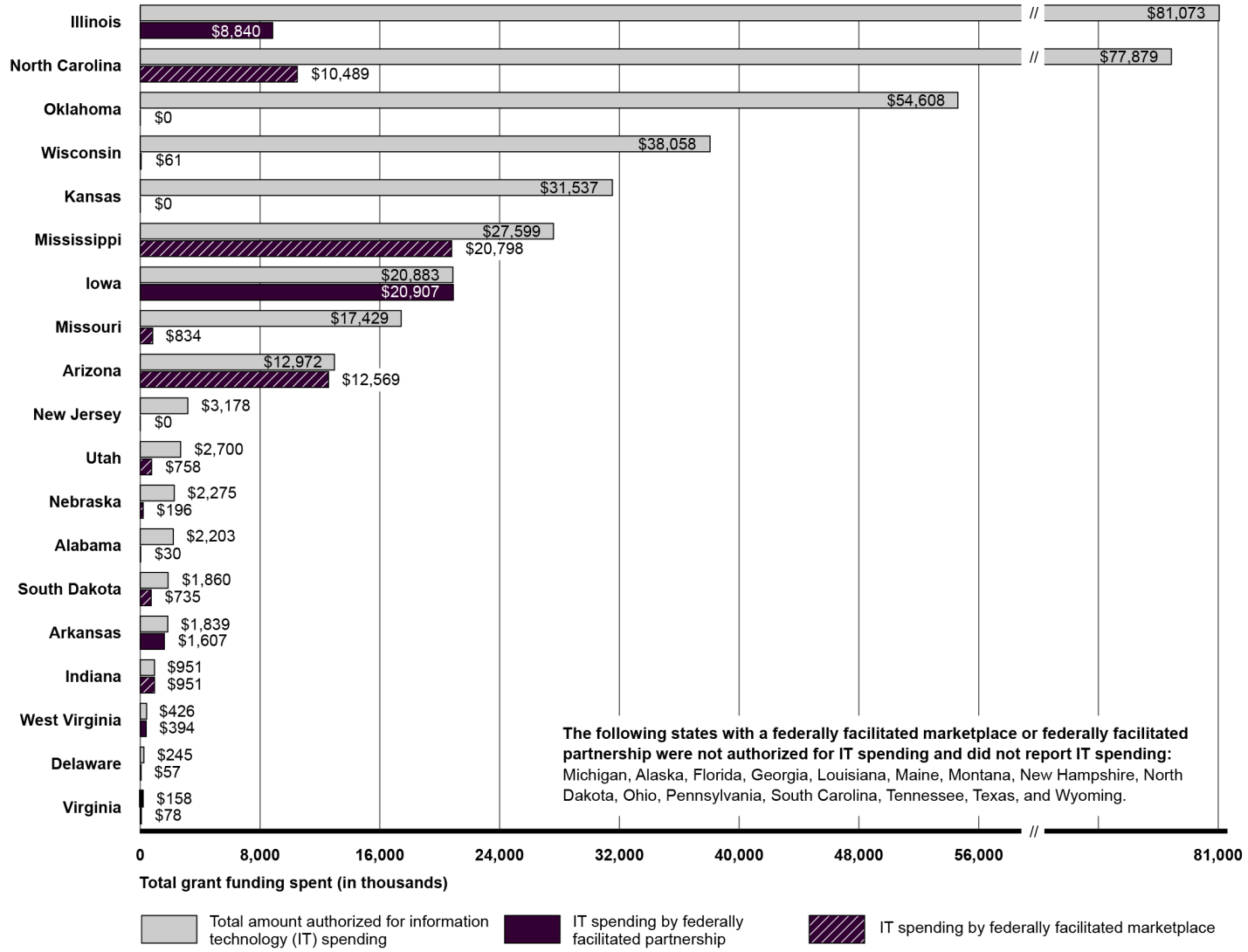
Note: We did not verify whether these funds remain available to states for expenditure or whether they have been reprogrammed or de-obligated. In the agency's responses to frequently asked questions on the use of marketplace grant funds for establishment activities, CMS stated that allowable uses of marketplace grant funds after January 1, 2015, are for establishment activities that were specifically described in the grantee's approved work plan, including stabilizing marketplace IT systems through the design, development, and testing of IT functionality. Unallowable costs related to ongoing operations include, but are not limited to, hardware/software maintenance and operations.

Regarding states with a federally facilitated marketplace or federally facilitated partnership, 19 of these states were authorized by CMS to spend $378 million for IT, and this authorized amount per state ranged from approximately $158,000 to $81 million as of March 2015.[51] These states reported marketplace grant IT spending that ranged from approximately $30,000 (in Alabama) to approximately $20 million (in Iowa), as of March 2015 (see fig. 5). The 15 other states that used these two types of marketplaces were not authorized to spend grant funds for IT projects. In June 2015, CCIIO officials told us that, with the exception of Arkansas, Mississippi, and Utah, states with a federally facilitated marketplace or federally facilitated partnership are no longer authorized to spend marketplace grant funding for information technology because they are no longer investing in the long-term creation of a modern eligibility system to be shared between a state-based marketplace and the state Medicaid program.[52]

[51]We did not verify whether these funds remain available to states for expenditure or whether they have been reprogrammed or de-obligated. According to CMS officials, states that initially planned for, but did not pursue, a state-based marketplace were required to return the funds to CMS or to re-budget the funds for non-IT costs.

[52]In June 2015, Arkansas was conditionally approved by CMS to establish a state-based marketplace, and thus can spend marketplace grant funding until December 2017. Mississippi and Utah are operating marketplaces for small businesses.

Figure 5: Reported Grant IT Spending by States with a Federally Facilitated Marketplace or Federally Facilitated Partnership as of March 2015



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-15-527

Note: We did not verify whether these funds remain available to states for expenditure or whether they have been reprogrammed or de-obligated. In June 2015, CMS officials within the Center for Consumer Information and Insurance Oversight (CCIIO) told us that, with the exception of Arkansas, Mississippi, and Utah, states with a federally facilitated marketplace or federally facilitated partnership are no longer authorized to spend marketplace grant funding for information technology because they are no longer investing in the long-term creation of a modern eligibility system to be shared between a state-based marketplace and the state Medicaid program. According to CMS officials, states that initially planned for, but did not pursue, a state-based marketplace were required to return the funds to CMS or to re-budget the funds for non-IT costs. For example, according to a state official from Wisconsin, the state returned Early Innovator grant funds in January 2012.

CMS required the states to report their grant spending for marketplace IT projects in five broad budget categories: contracts, consultants, personnel, equipment, and supplies.[53] In this regard, the 17 states that established state-based marketplaces, including state-based marketplaces that used the federal marketplace IT solution, reported spending the following approximate amounts in these categories, as of March 2015:

- $1.13 billion on contracts,
- $76.18 million on consultants,
- $39.00 million on state personnel,
- $21.06 million on equipment, and
- $720,000 on supplies.

The largest part of these reported expenditures—nearly 89 percent—was on contracts for services such as systems integration, project management, and independent validation and verification.

In addition to costs in these five categories, CMS also asked the states to report the amount of early innovator IT marketplace grant funding that they had spent. In response, these states reported that they had spent approximately $112.4 million of such funding.[54]

[53]Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, *Progress Reporting Instructions for Cooperative Agreements to Support Establishment of State-Operated Health Insurance Exchanges* (June 2012). CMS requires states to report IT spending in five categories. Some early innovator funding was awarded and spent before CMS implemented its reporting process. According to CMS, all early innovator grant spending is IT spending, but it was not always broken out into the five IT categories (contracts, personnel, supplies, equipment, and consultants).

[54]Some early innovator funding was awarded and spent before CMS implemented its reporting process. According to CMS, all early innovator grant spending is IT spending, but it was not always broken out into the five IT categories (contracts, personnel, supplies, equipment, and consultants).

The 34 states with a federally facilitated marketplace or federally facilitated partnership[55] reported spending, as of March 2015, approximately

- $69.68 million on contracts,
- $2.19 million on consultants,
- $1.66 million on state personnel,
- $5.68 million on equipment, and
- $.03 million on supplies.

These states also reported spending $.06 million of early innovator IT marketplace grant funding.

Table 2 shows marketplace grant spending for IT, by category, as of March 2015.

[55]According to CMS officials, these states initially planned to establish a state-based marketplace but later decided to partner with or rely on the federally facilitated marketplace.

Table 2: Grant Spending for IT by Centers for Medicare & Medicaid Services Budget Category as of March 2015

(Dollars in millions)

Marketplace type (number of states)	IT contracts	IT consultants	State IT personnel	IT equipment	IT supplies	Early Innovator
State-based marketplace (14)	$1,039.00	$75.97	$35.91	$20.36	$0.710	$52.45
State-based marketplace using the federal marketplace IT solution (3)	86.15	0.212	3.09	.696	0.010	59.92
State-based marketplace subtotal	**1,125.15**	**76.18**	**39.00**	**21.06**	**0.720**	**112.37**
Federally facilitated marketplace (27[a])	45.34	1.40	.617	.057	0.028	.06
Federally facilitated partnership (7[a])	24.35	0.795	1.04	5.62	0.005	-
Federally facilitated marketplace and partnership subtotal	69.68	2.19	1.66	5.68	0.033	.06
Total	**$1,194.83**	**$78.37**	**$40.65**	**$26.73**	**$0.753**	**$112.43**

Source: GAO analysis of CMS data. | GAO-15-527

Note: Data as of March 26, 2015. CMS requires states to report IT spending in five categories. Some early innovator funding was awarded and spent before CMS implemented its reporting process. According to CMS, all early innovator grant spending is IT spending, but this was not always broken out into the five IT categories: contracts, personnel, supplies, equipment, and consultants.

[a]Regarding states with a federally facilitated marketplace or federally facilitated partnership, 19 states with these types of marketplaces were authorized by CMS for IT spending as of March 2015. The 15 other states that used these two types of marketplaces were not authorized to spend grant funds for IT projects.

During the course of our work, in October 2014, CMS began collecting data on IT contract costs in new categories aimed to gather a greater level of detail across states with state-based marketplaces. These new reporting categories are system integration, project management, independent verification and validation, middleware software,[56] rules engine software, and "other."[57]

As of May 2015, 11 state-based marketplaces had reported costs in some of these new detailed cost categories.[58] However, CMS's documentation indicated that not all states reported using all the new categories. For

[56]Middleware software is the "glue" that helps programs and databases (which may be on different computers) work together. Its most basic function is to enable communication between different pieces of software.

[57]These categories are outlined in CMS's January 2015 draft instructions.

[58]Colorado, Idaho, New Mexico, Oregon, Vermont, and Washington did not report IT costs in CMS's new categories.

example, not all states reported costs in the rules engine and middleware software categories because those costs were included in the system integration category or marked in the "other" category. Specifically, only five states reported costs for developing rules engine software or middleware software. According to CCIIO officials, CMS is following up with states on missing amounts. Following through on these efforts to collect more detailed information on states' IT contract costs would increase CMS's insight into states' IT spending.

States Spent an Undetermined Portion of Their Medicaid Funds on Marketplace IT Projects

States also spent Medicaid funds for marketplace-related IT projects, such as modifying Medicaid eligibility and enrollment systems to interface with the marketplaces. Specifically, states spent some portion of approximately $2.78 billion in combined federal and state Medicaid funding from April 2011 through December 2014 for marketplace-related IT projects. Of this amount, $2.42 billion was from 90/10 funding[59] and $364 million was from 75/25 funding.[60] An undetermined portion of this spending was used to develop and maintain eligibility and enrollment systems connections to the marketplaces.

States that established state-based marketplaces, including state-based marketplaces using the federal marketplace IT solution, reported having spent approximately $757 million of the 90/10 Medicaid funds for Medicaid eligibility and enrollment systems. Further, states with a federally facilitated marketplace reported spending approximately $1.32 billion of these funds, and those with federally facilitated partnerships reported spending approximately $340 million. The amounts spent included expenditures for marketplace-related IT projects.

Of the $364 million in 75/25 Medicaid funds, states that established state-based marketplaces, including state-based marketplaces using the federal marketplace IT solution, reported having spent approximately $56

[59]As previously noted, Medicaid 90/10 matching funds will no longer be available to states after December 2015, though in April 2015, CMS issued a notice of proposed rulemaking to extend the availability of this enhanced federal match indefinitely. 45 Fed. Reg. 20455 (Apr. 16, 2015).

[60]States report expenditures of 90/10 and 75/25 funding on the CMS-64, which is called the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program. The CMS-64 aggregates states' expenditures and is used to reimburse states for their federal share of Medicaid expenditures. The information is stored in a data set called the Medicaid Budget and Expenditure System.

million. Those with a federally facilitated marketplace reported spending approximately $285 million, and those with a federally facilitated partnership reported spending approximately $23 million.

Table 3 provides a summary of states' Medicaid 90/10 and 75/25 expenditures for Medicaid eligibility and enrollment systems by marketplace type, as of December 2014.

Table 3: Medicaid Funds Spent on Medicaid Eligibility and Enrollment Systems, by Marketplace Type, as of December 2014

(Dollars in millions)

Marketplace type (number of states)	Medicaid 90/10	Medicaid 75/25	Total
State-based marketplace (14)	$562	$46	$608
State-based marketplace using the federal marketplace IT solution (3)	$195	$11	$206
State-based marketplace subtotal	**$757**	**$56**	**$813**
Federally facilitated marketplace (27)	$1,321	$285	$1,605
Federally facilitated partnership (7)	$340	$23	$363
Federally facilitated marketplace and partnership subtotal	$1,661	$308	$1,969
Total	**$2,418**	**$364**	**$2,782**

Source: GAO analysis of CMS data. | GAO-15-527

Note: Some numbers may not sum due to rounding. These amounts reflect federal and state spending. Funds could be used to make changes to Medicaid eligibility and enrollment systems, which could include modifications to interface with marketplaces as well as other non-marketplace related modifications.

While CMS required states to report the ratio of Medicaid funds to grant funds in allocating their planned spending for marketplace-related IT projects, the agency did not require states to track the actual amount of Medicaid funds spent specifically on these IT projects. Thus, the total portion of Medicaid funds spent for those purposes is unknown.

However, as part of our survey, 26 states were able to track or estimate the portion of marketplace-related IT spending for Medicaid 90/10 funds, and 17 states were able to track or estimate the portion of marketplace-

related IT spending for Medicaid 75/25 funds.[61] The states that tracked or estimated their use of Medicaid funds reported spending approximately $750 million of these funds—both 90/10 and 75/25 funds—for marketplace-related IT projects through June 2014.[62] The remaining states in our survey did not track the amount or could not provide the actual or estimated amount of Medicaid funds spent.

Based on the survey responses, states may have tracked or estimated these amounts using a variety of approaches, thus state-reported data may not be consistent across states. Table 4 shows the approximate state-reported amounts of combined federal and state 90/10 and 75/25 Medicaid funding used for marketplace-related IT projects by marketplace type.

Table 4: State Survey-Reported Marketplace-Related Medicaid IT Spending through June 2014

(Dollars in millions)

Marketplace type	90/10	75/25	Total
State-based marketplace	$250 (n=11)	$70 (n=9)	$320
Federally facilitated marketplace and partnership	$310 (n=15)	$120 (n=8)	$430
Total	**$560**	**$190**	**$750**

Source: GAO analysis of state survey responses. | GAO-15-527

Note: This represents costs reported by 11 states with a state-based marketplace for 90/10, 9 states with a state-based marketplace for 75/25, 15 states with a federally facilitated marketplace or federally facilitated partnership for 90/10, and 8 states with a federally facilitated marketplace or federally facilitated partnership for 75/25 funding. Reported spending includes federal and state funds. Because CMS did not require consistent reporting of marketplace-related IT spending, state-reported data may not be consistent across states.

[61]On our survey, for state-based marketplaces, we asked about spending of Medicaid matching funds for marketplace IT solutions. For federally facilitated states, we asked about spending on marketplace-related IT projects which included but were not limited to assessing or planning for the systems needed to become a state-based marketplace, or any systems development, modernizations, or enhancements to the state's Medicaid eligibility and enrollment system instituted for the purpose of connecting to the federal marketplace IT solution (e.g., developing interfaces to the federal services data hub and transferring accounts between Medicaid eligibility and enrollment systems and the federal marketplace IT solution).

[62]About $4.17 million of this $750 million was estimated.

States Used Federal Funds to Establish Various Aspects of Their Marketplaces

Generally, the states used federal funds (both marketplace grant and Medicaid matching funds) for various IT projects, including the establishment and operation of their marketplaces and their connection to the federal marketplace. Accordingly, the nature and extent of their efforts varied depending on which marketplace type they chose to establish.

The 17 states that were approved to establish state-based marketplaces, (i.e., the 14 state-based marketplaces and the 3 state-based marketplaces using the federal marketplace IT solution) undertook various IT projects to establish their marketplaces. These states generally used the funds to develop their IT solutions, including the web portal for individual consumer interaction (to set up user accounts, select health plans, and apply for health coverage); systems to perform the key marketplace functions (eligibility and enrollment, plan management, financial management, and consumer assistance); functionality for determining Medicaid and CHIP eligibility using new income standards;[63] functionality for sharing marketplace enrollment data with qualified health plan issuers; and interfaces with federal systems through the federal data services hub (needed to conduct eligibility verifications). In documents provided to supplement the survey responses, states also reported using their funds to cover numerous other expenses for state personnel, systems integrator contracted services, interface development and maintenance, independent verification and validation services,[64] project management, technical support, and software licenses.

Among the 34 states with a federally facilitated marketplace or federally facilitated partnership, IT projects typically involved system development to connect the states' existing Medicaid systems to CMS's federal data services hub. In addition, 17 of these states reported on our survey that they conducted projects to explore the option of developing IT systems to support a state-based marketplace (even though they ultimately chose to participate in the federally facilitated marketplace). For example, one state reported to CMS that it used grant funds to develop technical

[63]Section 2002(a) of PPACA requires states to determine income eligibility for Medicaid using modified adjusted gross income standards, which is a uniform, tax-based definition of income.

[64]Independent verification and validation is a process whereby organizations can reduce the risks inherent in system development and acquisition efforts by having a knowledgeable party who is independent of the developer determine whether the system or product meets the users' needs and fulfills its intended purpose.

requirements and an architectural design, along with a request for proposals to obtain a systems integrator for the implementation of a marketplace. Another state using the federally facilitated marketplace was awarded marketplace grant funds to support technology projects in anticipation of becoming a state-based marketplace. According to CMS officials, states that initially planned for, but did not pursue, a state-based marketplace were required to return the funds to CMS or to re-budget the funds for non-IT costs. In addition, two federally facilitated partnership states used marketplace grant funds to develop new integrated Medicaid eligibility and enrollment systems needed to support new requirements, such as determining income eligibility for Medicaid using new income standards.

States Are Continuing to Improve the Development and Operations of Their Marketplace Systems, but Not All IT Functions Are Complete

As of February 2015, the 14 states with state-based marketplaces had developed and were operating systems to support their marketplaces;[65] however, not all IT functions were complete.

In particular, CMS reported that these 14 states' marketplace systems were performing some, but not all, key functions, including those related to eligibility and enrollment, financial management, hub services, and IRS reporting:

- With regard to eligibility and enrollment functions, CMS status reports indicated that eight state-based marketplace systems were fully operational and operating without interruptions in service. The other six state-based marketplace systems were partially operational, meaning that these functions were operational but did not work as intended and may have required manual processes to supplement automated functionality.[66] States with partially operational functions used business process workarounds to complete eligibility and enrollment functions, such as manually entering and verifying

[65]These 14 state-based marketplaces are California, Colorado, Connecticut, the District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, and Washington. This does not include 3 states—Nevada, New Mexico, and Oregon—which are state-based marketplaces that use the federal marketplace IT solution.

[66]Functions were determined to be fully operational if they were fully functional without any interruptions in service and partially operational if the functions were operational but did not work as intended. Issues with partially operational functions may include the need for manual processes to supplement automated functionality or certain pieces of the functionality are not operational.

individuals for healthcare coverage. For example, in one state, applications to the state-based marketplace were sent by Medicaid as portable document format (PDF) files[67] and processed by data entry specialists. In another state, data transferred from the marketplace to Medicaid was automated, but other information was manually entered.

- With regard to financial management functions such as collecting premium payments, remitting payments to issuers, and payment calculation for reinsurance, 4 state-based marketplace systems were fully operational without interruptions in service and 8 state-based marketplace systems were partially operational and may have required manual workarounds. (These functions were not applicable for 2 state-based marketplace systems that decided to rely on issuers to conduct premium billing and processing functions.[68])
- Although all states developing state IT solutions had received approval from CMS to connect to the federal data hub, only 1 state-based marketplace state had fully completed development of hub services functions such as verifying an individual's identity and citizenship and retrieving tax information for evaluating taxpayer eligibility for insurance affordability programs. Thirteen state-based marketplace states had partially completed hub services functions, meaning that they had not yet implemented all hub services because

[67]PDF is a file format that has captured all the elements of a printed document as an electronic image that can be viewed, printed, or forwarded to someone else.

[68]States chose from three options for financial management functions: (1) collecting premiums from applicants and remitting payments to issuers, (2) collecting the first month's premium from applicants and remitting payments to issuers while the issuers directly collect subsequent premiums, and (3) having issuers collect all premiums from applicants.

the testing or development had not been completed or independent verification and validation attestation had not yet been received.[69]

- With regard to submissions to IRS regarding information such as premium tax credits,[70] 1 state had fully completed performance testing of these functions, 10 states had partially completed performance testing, and 2 states had not completed any performance testing of these functions.[71] Additionally, these functions were not applicable for 1 state, which used the federal IT system in the previous enrollment period and was not responsible for IRS reporting.

The operational status of the state-based marketplace IT systems by functional category, as of February 2015 is summarized in table 5.

[69]Hub services functions included, for example, verifying the individual's identity by calling the Remote Identity Proofing Precise Identity service, verifying Social Security number and citizenship, and retrieving tax return information for use in evaluating a taxpayer's eligibility for insurance affordability programs. States that completed these functions had fully developed, tested, and implemented these services, and an independent verification and validation contractor had attested that the functionality had been tested. States that partially completed these functions had not yet implemented or automated hub services because the testing or development had not been completed or independent verification and validation attestation had not yet been received. According to CMS officials, not all hub services were required for a state to be operational because some hub services are not directly related to initial eligibility and enrollment. In addition, states were able to implement some hub services manually as a workaround option or through local data sources.

[70]To expand access to health insurance that qualifies as minimum essential coverage, PPACA created the premium tax credit to subsidize premium costs for plans purchased by eligible individuals and families through the marketplaces.

[71]States with state-based marketplaces were required to report certain information to the IRS and to individuals who enroll in qualified health plans through the marketplace. This information ensured that individuals received the amount of premium tax credit to which they were entitled, including those individuals who did not request advance payments of the premium tax credit at initial enrollment, but claimed it on their tax return. States completed these functions when performance testing was complete. States partially completed these functions when some, but not all, performance testing had been completed. These functions were not operational in states that had not completed any performance testing for these functions.

Table 5: Operational Status of the 14 State-Based Marketplace IT Systems by Functional Category as of February 2015

State	Eligibility and enrollment	Financial management	Hub services	IRS reporting file submissions
California	●	◐	◐	◐
Colorado	◐	◐	◐	◐
Connecticut	◐	◐	◐	◐
District of Columbia	◐	●	◐	◐
Hawaii	◐	◐	◐	○
Idaho	●	●	◐	Not applicable
Kentucky	●	Not applicable	●	◐
Maryland	●	Not applicable	◐	◐
Massachusetts	●	●	◐	◐
Minnesota	◐	◐	◐	○
New York	●	◐	◐	◐
Rhode Island	◐	◐	◐	◐
Vermont	●	●	◐	●
Washington	●	◐	◐	◐

Legend:

● With regard to the status of IT systems, eligibility and enrollment and financial management functions were determined to be fully operational if they were fully functional without any interruptions in service. Hub services functions were determined to be fully complete if they were developed, tested, and implemented, and an independent verification and validation contractor had attested that the functionality has been tested. IRS reporting file submission functions were determined to be fully complete when performance testing was complete.

◐With regard to the status of IT systems, eligibility and enrollment and financial management functions were determined to be partially operational if the functions were operational but did not work as intended or included the need for manual processes to supplement automated functionality. Hub services functions were determined to be partially complete if functions had not yet implemented hub services because the testing or development had not been completed or because the attestation had not been received. IRS reporting file submission functions were determined to be partially completed when some, but not all, performance testing had been completed. This rating may also include states who had arranged to have CMS perform specific functions under these categories.

○ With regard to the status of IT systems, IRS reporting file submission functions were determined to be not operational for states that had not completed any performance testing.

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-15-527

Note: Not all states agreed with CMS's ratings of their operational status.

Further, between the first and second enrollment periods, 6 of the 17 states with state-based marketplaces and state-based marketplaces using the federal marketplace IT solution changed their IT solution. In response to our survey, these states cited a variety of reasons for doing so, such as significant flaws in the system, unsuccessful system roll out, and non-working technology.

The primary IT development and operations changes, as reported by the 6 states to CMS, were the following:

- Two states with state-based marketplaces, Oregon and Nevada, stopped development on their marketplace IT solutions and decided instead to use the federal marketplace IT solution (i.e., Healthcare.gov and related systems) for eligibility and enrollment functions.
- New Mexico had delays in developing and operating its marketplace and used the federal marketplace IT solution as its platform for eligibility and enrollment for the first enrollment period. For the second open enrollment, the state continued to use the federal marketplace IT solution for the eligibility and enrollment functionality and subsequently decided to continue using the federal marketplace IT solution indefinitely.
- Maryland changed its IT solution to one that had been successfully implemented in Connecticut for the second enrollment period.
- Massachusetts replaced its existing system and implemented a commercial-off-the-shelf technology solution for the second enrollment period.
- Idaho, which previously used the federal marketplace IT solution, developed and operated its own marketplace IT solution for the second enrollment period.[72]

According to CMS documentation regarding marketplaces using the federal marketplace IT solution, as of November 2014, 7 of 37 states using the federal marketplace IT solution could not transfer applications for health insurance coverage between their state Medicaid systems and the federal data services hub or had not completed testing or certification of these functions. Specifically, 3 of the states could not transfer—send and receive—applications for health insurance coverage between the state Medicaid and federal marketplace IT solution.[73] The other 4 states

[72]Idaho had previously acknowledged significant delays in completing benchmark activities during the first enrollment period, and thus had used the federal marketplace IT solution during the first enrollment period. According to Idaho's marketplace Executive Director, legislation enabling the creation of a state-based marketplace was not signed until March 2013, which did not allow sufficient time for successful development and deployment of its own technology.

[73]Kansas, New Jersey, and Oregon could not establish an interface to automatically transfer applications between state Medicaid and marketplace systems.

had not completed testing and certification of those functions.[74] CMS officials stated that the agency was continuing to work with the 7 states that had not fully implemented these functions to ensure implementation as soon as possible.

In addition, as of April 2015, the transfer of applications between state Medicaid systems and the federal marketplace IT solution were not taking place in real time, and according to a CMCS official, achieving this capability is a goal for 2015 or 2016. For example, in one state, it took about 15 minutes to send applications between state Medicaid systems and the federal marketplace IT solution in either direction. In another example, a state held on to applications received and sent them at the end of the day. According to CMCS officials, states using the federal marketplace IT solution continue to focus on completing their eligibility system modernization, resolving defects, and making improvements to systems so that business processes require less manual intervention.

CMS and States Established a Framework for Oversight, but CMS Oversight Was Not Always Effectively Executed

To address the requirements of PPACA and its implementing policies, CMS engaged in various activities to oversee the states' marketplace IT projects. In particular, the agency assigned oversight roles and responsibilities, put in place various reporting systems, and established a series of reviews that were to help ensure that states' systems were adequately tested and functioning as intended. Nonetheless, even with these steps, CMS did not clearly document, define, and communicate its oversight roles and responsibilities to state officials, and it did not consistently involve senior executives in the review and approval of federal funding for states' IT marketplace projects. In addition, CMS's reviews of the states' progress were not always effective in ensuring that systems and capabilities being developed to support the states' marketplaces were fully tested before they became operational.

States that established and operated their own (state-based) marketplaces generally used quasi-governmental entities to oversee their marketplace IT projects; they also relied on various oversight mechanisms, including executive steering committees, management change control boards, and technical review boards. Meanwhile, states with a federally facilitated marketplace or federally facilitated partnership oversaw their IT projects through existing state agencies.

[74]Georgia, Ohio, South Carolina, and Tennessee had not completed testing and independent certification of the account transfer function.

CMS Identified Oversight Roles and Responsibilities, but These Were Not Always Clearly Documented, Defined, or Communicated

To oversee states' efforts in undertaking IT projects to support the establishment and operation of their marketplaces, CMS identified numerous internal offices and groups to which it had assigned roles and responsibilities. As previously mentioned, three key offices—CCIIO, OTS, and CMCS—were responsible for overseeing states' efforts in establishing the marketplaces. These three offices were to conduct oversight activities, such as being involved in joint grant reviews, Medicaid advanced planning document reviews, and IT gate reviews, to ensure that states followed a standardized funding process.

Their primary roles and duties included the following:

- CCIIO led the marketplace implementation, and within that office, State Officers were assigned to be accountable for day-to-day communications with the state marketplace officials. CCIIO officials were also involved in grant funding decisions.
- OTS was responsible for systems integration and software development efforts to ensure that the functions of the marketplaces were carried out. A primary participant within OTS was the IT project manager, who was the individual responsible for monitoring, among other things, state-based marketplaces' IT development activities and support for states that transitioned from one marketplace type to another. OTS officials also provided technical reviews to State Officers to inform grant funding decisions.
- CMCS was the office responsible for coordinating and approving Medicaid matching fund requests and implementation activities related to the state health insurance marketplaces. The office carried out these responsibilities in conjunction with CCIIO. CMCS officials identified the enrollment and eligibility specialists as the primary contacts within their office.

In addition, CMS established a group called the Cross Component Committee to address marketplace-related issues across states. The committee, which included members from OTS, CCIIO, and CMCS, was tasked with overseeing the states' progress to ensure that all marketplace requirements were aligned with CMS policy. Major policy issues identified through the committee were raised to business unit directors within the agency.

CMS also informed us of other offices and groups within the agency that had roles and responsibilities for overseeing states' marketplace IT projects. Based on written and oral descriptions of the various offices and

groups, as provided by CCIIO, CMCS, and OTS officials, we compiled the information in table 6 to summarize CMS's identified roles and responsibilities for overseeing state marketplace IT projects.

Table 6: CMS Offices and Groups Responsible for State Marketplace IT Project Oversight

Office or group	State marketplace roles and responsibilities
Office of the Administrator	Directs the planning, coordination, and implementation of programs that provide access to health care, which encompasses administering Medicare, Medicaid and the Children's Health Insurance Program (CHIP). This includes responsibility for overseeing CMS as it provides funding and guidance to states for implementing the insurance reforms and health insurance marketplace provisions enacted under the Patient Protection and Affordable Care Act (PPACA). The Principal Deputy Administrator is located within the office of the Administrator.
Center for Consumer Information and Insurance Oversight (CCIIO)	Leads marketplace implementation and is to provide consumers with information on insurance coverage options. It is also to implement, monitor compliance with, and enforce rules governing the insurance market reforms enacted under PPACA. Further, it is to develop and implement policies and rules governing state-based marketplaces, oversee the operations of state-based marketplaces, and administer the federal marketplace for states that elect not to establish their own. Key officials within this office include the following: **Marketplace Chief Executive Officer:** Serves as the head of CCIIO and is responsible for managing the office's operations, to include managing the federal marketplace. The official is also responsible for directing the state marketplace group and managing relations with the state marketplaces. **State Officers:** Serve as CCIIO's primary points of contact to assigned states, with responsibility for leading and facilitating state calls, reviews, and debrief sessions. These officials are to provide federal program oversight of state marketplace grant implementation, and are considered to be the technical experts in the programmatic and grants monitoring process. In addition, they are to develop and monitor state action plans and ensure that states receive necessary guidance and assistance; create agendas for state calls; and identify and provide CCIIO leadership with updates on states' progress, challenges, risks, and technical assistance requirements. The State Officers report to the Director of the State Marketplace group, who reports to the Marketplace Chief Executive Officer. Finally, they lead and coordinate the state-based, inter-agency Establishment Review process.

Office or group	State marketplace roles and responsibilities
Office of Technology Solutions	Leads system integration for enterprise-wide and component-specific software development efforts to ensure that the functions of Medicare, Medicaid, and the marketplaces are carried out. Several groups within this office have specific marketplace responsibilities, including the following: **Rapid Program Deployments Group:** Responsible for providing executive leadership and direction to ensure successful implementation of system changes and new functionality to support PPACA. The group provides technical assistance and guidance to state entities and coordination with multiple federal agencies, to ensure conformance with IT standards required to support PPACA. **Rapid Program Deployments Group, Division of State IT Program Services:** Responsible for providing IT guidance and oversight for state-based marketplaces (including integration with any federally provided support services). This group also collaborates with the Center for Medicaid and CHIP Services (CMCS) and CCIIO to deliver state-based marketplace support. **IT Project Managers:** Monitor state-based marketplaces' IT development activities, marketplace implementation and operation reporting, and transition state activities (i.e., states with a federally facilitated marketplace or federally facilitated partnership and state-based marketplaces). Their responsibilities include holding weekly/bi-weekly calls with the states to discuss progress, review contracts, and provide feedback/input; reviewing advanced planning documents for Medicaid funding of state-based marketplace IT development activities; and providing feedback and producing state-based marketplace implementation and operational progress reports on a quarterly or as-needed basis.
Center for Medicaid and CHIP Services (CMCS)	Serves as CMS's focal point for assistance with formulation, coordination, integration, and implementation of all national program policies and operations relating to Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP).[a] CMCS is also the lead for management, oversight, budget, and performance issues relating to Medicaid, CHIP, BHP, and the related interactions with states and the stakeholder community. CMCS utilized its Data and Systems Group Division of State Systems to coordinate and approve Medicaid funding requests and implementation activities related to the state health insurance marketplaces in conjunction with CCIIO. Key groups and officials within this office include the following: **Data and Systems Group, Division of State Systems:** Develops CMCS national Medicaid IT policies and guidance and coordinates and approves state funding requests and implementation activities related to the state and federal health insurance marketplaces with CCIIO. Develops and implements new applications for state system enhancements and reviews and certifies Medicaid eligibility systems. **Eligibility and Enrollment Specialists**: CMS identified this as a primary role in oversight of state marketplace IT projects, but responsibilities of this position were not defined in CMS policy or procedures.
Office of Acquisition and Grants Management (OAGM)	Reviews and provides guidance on grant services for state marketplaces.
Office of Communications (OC)	Serves as CMS's focal point for internal and external strategic and tactical communications. The office advises the Administrator regarding all activities related to the media. It also provides consultation, advice, and training to CMS's senior staff with respect to relations with the news media. This office has membership on other boards that discuss state marketplace IT projects.

Office or group	State marketplace roles and responsibilities
Marketplace Operations Board	Tasked with providing strategic and tactical direction and guidance for the implementation of marketplace program requirements, as well as with managing and integrating the planning, development, and operations of the marketplace program across CMS. The board, which concluded its activities in August 2014, reported to the Office of the Administrator through the Chief Operating Officer/Marketplace board. Voting members of this board included representatives from CCIIO, CMCS, OC, Offices of Hearings and Inquiries, Consortium for Medicare Health Plans Operations, and OTS.
CMS Cross Component Committee	Reviews and discloses all of CMS's communications with the state marketplaces and other stakeholders, include holding meetings, and distributing policies, IT guidance, and correspondence, to ensure that these communications and interactions are shared among all CMS staff. The Committee is responsible for raising any unresolved issues to the business unit directors, who then raise them to the Marketplace Operations Board as appropriate. The CCC includes leadership members from CMCS, OIS, and CCIIO.
Health Reform Operations Board	Resolves intra-agency challenges related to implementation of Medicaid expansion and the state health insurance marketplaces. The Health Reform Operations Board is a collaborative forum of individuals with responsibility for facilitating discussions on key policy and operational issues that impede progress on marketplace activities, directing the formulation of work groups to support efficiencies, and assigning resources as necessary to effect the implementation of the marketplace.[b]
IT Exchange Steering Committee	Serves as a collaborative body for addressing and resolving persistent inter-agency challenges related to the implementation of state marketplaces. The Steering Committee is made up of three workgroups (i.e., data sharing and privacy, security harmonization, and operational oversight) with an Executive Secretariat who acts as a liaison between the Steering Committee and departments. There are seven departments and agencies represented on the committee.[c]
State Operations and Technical Assistance Teams	Established by CMS in April 2012 to create an efficient and responsive pathway for CMS to provide support and technical assistance to states on matters related to implementation of the Medicaid and CHIP provisions of PPACA.[d] The State Operations and Technical Assistance teams serve as a point of contact for information sharing related to implementation of building the infrastructure to accommodate Medicaid coverage.

Source: GAO analysis of CMS data. | GAO-15-527

Note: Unless otherwise indicated, the boards and committees listed in the table above were operational as of May 2015.

[a]The Basic Health Program gives states the ability to provide more affordable coverage for low-income residents and improve continuity of care for people whose income fluctuates above and below Medicaid and CHIP levels.

[b]The Deputy Chief Operating Officer serves as the chairperson of the Health Reform Operations Board. Membership of the Health Reform Operations Board includes senior executives from CCIIO, CMCS, OC, the Office of Financial Management, the Office of Acquisition and Grants Management, and the Consortium for Medicare Health Plans Operations. The Deputy Chief Operating Officer serves as the chairperson of the Health Reform Operations Board.

[c]The Federal Chief Information Officer, the Health Program Associate Director, and the U.S. Chief Technology Officer, in the Executive Office of the President were to serve as co-Chairpersons for the Affordable Care Act IT Steering Committee. Membership of the IT Exchange Steering Committee includes senior executives from CMS, IRS, the Department of Homeland Security, the Department of Defense, the Department of Veterans Affairs, the Social Security Administration, and the Peace Corps.

[d]Membership of this group includes state Medicaid and CHIP Directors and CMS officials from CMCS's Office of the Center Director, the Children and Adults Health Programs Group, the Data and Systems Group, the Consortium for Medicaid and CHIP Operations, and the Associate Regional Administrator for Medicaid.

In addition to establishing marketplace roles and responsibilities, CMS identified various reporting systems that were to be used to assist federal officials in overseeing state marketplace IT project funding and progress. For example, the agency relied on state marketplace information that it compiled in multiple computer systems to make funding decisions and provide technical assistance to state officials.[75] CMS also maintained or utilized other systems that allowed states to apply for marketplace grant funding online and to transfer funds to states to establish and operate their marketplace.[76] Additional systems allowed states to report to CMS on their grant IT expenditures; upload documentation related to their marketplace IT projects, such as project plans and testing and requirements documents; and share best practices with each other.[77]

Project management best practices emphasize the importance of clearly documenting, defining, and communicating project roles and responsibilities during the organizational planning process.[78] During this process, to make the most effective use of the people involved with a project, best practices cite the importance of identifying, documenting, and clearly assigning project roles, responsibilities, and reporting relationships. Effective communication means that the information is provided in the right format, at the right time, to the right audience, and with the right impact. Adequate communications planning avoids problems such as delays in message delivery, insufficient communication to stakeholders, and misunderstanding or misinterpretation of the message communicated.

According to best practices identified in the Project Management Institute's *Guide to the Project Management Body of Knowledge*, a key document needed to ensure that communication is carried out effectively

[75]These funding and technical assistance-related computer systems were Grant Solutions and the State Exchange Resource Tracking System.

[76]These application and payment systems were Grants.gov and the Payment Management System.

[77]These expenditure reporting and documentation sharing systems were the On-Line Data Collection System and the Collaborative Application Lifecycle Tool.

[78]GAO-04-394G and Project Management Institute, Inc., *A Guide to The Project Management Body of Knowledge* (*PMBOK® Guide*), Fifth Edition, (Newton Square, Pa.: 2013). "PMBOK" is a trademark of the Project Management Institute, Inc.

is a communications management plan.[79] The communications management plan describes how project communications will be planned, structured, monitored, and controlled in a comprehensive document, including stakeholder communication requirements; the method of updating and refining the communications management plan as the project progresses and develops; and charts the information flow in the project. Among other things, it should include persons or groups who are responsible for communicating and receiving the information, the process and associated time frames for escalating issues that cannot be resolved at lower levels, and workflows that show the order of information authorization. In addition, according the Project Management Institute's *Guide to the Project Management Body of Knowledge*, a communications management plan is a comprehensive document that contains the entire scope of the project and is updated regularly to reflect the current communication and stakeholders.

However, while CMS established roles and responsibilities to help oversee marketplace activities, the agency did not always clearly document, define, and communicate marketplace IT project roles and responsibilities to the states. Despite the complexity inherent in overseeing marketplace IT project efforts across 50 states and the District of Columbia, CMS did not have a comprehensive communication plan that clearly documented and defined its state marketplace oversight structure and all the associated roles and responsibilities of key organizations and officials that were involved in state marketplace oversight. Instead, the agency's definition and communication of roles and responsibilities were dispersed among various websites, operating procedures, and other documents, such as those we used in developing table 6. For example, roles for officials such as the CMS Administrator and Principal Deputy Administrator were located on the agency's website, while other roles and responsibilities, such as those of the CCIIO State Officers, were described in one of the agency's standard operating procedures. Additionally, CMS officials within CCIIO and CMCS stated that some roles and responsibilities are embedded in memorandums of agreement.

[79]Project Management Institute, Inc., *A Guide to The Project Management Body of Knowledge* (*PMBOK® Guide*), Fifth Edition, (Newton Square, Pa.: 2013). "PMBOK" is a trademark of the Project Management Institute, Inc.

Further, while the agency had documented selected stakeholder responsibilities in a matrix that CCIIO, OTS, and CMCS officials said applied to state marketplace IT projects, this document only identified responsibilities specifically associated with CMS's development of the Healthcare.gov web portal supporting the federally facilitated marketplace and did not include all the personnel associated with oversight of the state marketplaces. Specifically, it did not identify all stakeholders that would be included in a more comprehensive communications plan developed for the management of state marketplace IT projects, including the CCIIO State Officers, the Marketplace Chief Executive Officer, and relevant state officials.

The agency also provided a standard operating procedure for marketplace communications and technical assistance[80] that contained selected CMS roles and instructions for providing technical assistance to states. However, the procedure was identified as a draft document from January 2013, and was limited to addressing technical assistance, which did not represent the full range of stakeholder and IT oversight activities. For example, the document did not identify all groups that are to receive pertinent information, a process identifying time frames and the management chain for escalating the communication of information, or workflows for issuing and disseminating guidance to states.

Further, officials within CCIIO, CMCS, and OTS did not recognize certain organizations as having a role in marketplace IT activities, even though they should have done so. For example, while the officials told us that the Office of Communications does not have a role in states' marketplace IT oversight, this office is identified as a member in the charters of key committees and boards responsible for state marketplace IT project oversight, including the Cross Component Committee, Marketplace Oversight Board, and Health Reform Operations Board.

In discussing this matter, CCIIO and CMCS officials acknowledged that they had not created a comprehensive communication plan containing all relevant oversight roles and responsibilities. According to these officials, certain roles and responsibilities were not defined and documented because they were considered to be general public knowledge for which

[80]Department of Health and Human Services, Centers of Medicare & Medicaid Services, *Standard Operating Procedure – Coordination of CMS Exchange IT, FFE and Hub On-boarding Communications and Technical Assistance Draft Version 0.2* (Jan. 10, 2013).

no detailed documentation was necessary. They added that, in the absence of a specific document or process, states were informed of who their points of contact were by e-mail or weekly calls. Further, these officials noted that all communications to the states were routed through the CCIIO State Officers, thus replacing the need for a comprehensive communications management plan.

As previously described, CMS provided oversight and technical assistance to states in establishing their marketplaces. In responding to our survey, states with a state-based marketplace, including those using the federal marketplace IT solution, provided generally positive ratings of the clarity, completeness, and timeliness of CMS's communication, while federally facilitated states, including federally facilitated partnerships, provided a higher rate of dissatisfaction.[81] Similarly, state-based marketplace states provided generally positive ratings of the clarity, completeness, and timeliness of CMS's guidance, while federally facilitated states provided a higher rate of dissatisfaction.[82]

While states with all marketplace types reported in our survey being generally satisfied with the level of CMS oversight and assistance, several states identified instances of delayed or insufficient communications with CMS. Specifically, of the 36 states that responded to our survey question regarding CMS's overall oversight and assistance, 25 states rated it as just right, 4 rated it as more than enough, and 7 rated it as less than enough. Further, of the 17 states that provided comments, 5 spoke positively about CMS's support and 1 spoke positively about the completeness and timeliness of CMS guidance.

[81]States reported that they were satisfied, dissatisfied, or neither satisfied nor dissatisfied with CMS communication. Of the 16 state-based states that rated CMS's communication, 14 states were satisfied with the clarity, 14 were satisfied with the completeness, and 10 were satisfied with the timeliness. Of the 24 states with a federally facilitated marketplace or federally facilitated partnership that rated CMS's communication, 12 were dissatisfied with the clarity, 13 were dissatisfied with the completeness, and 17 were dissatisfied with the timeliness.

[82]States reported that they were satisfied, dissatisfied, or neither satisfied nor dissatisfied with CMS guidance. Of the 16 state-based states that rated CMS's guidance, 13 states were satisfied with the clarity, 13 were satisfied with the completeness, and 9 were satisfied with the timeliness. Of the 24 states with a federally facilitated marketplace or federally facilitated partnership that rated CMS's guidance, 14 were dissatisfied with the clarity, 15 were dissatisfied with the completeness, and 20 were dissatisfied with the timeliness.

The remaining 11 states provided both mixed and negative comments regarding the completeness and timeliness of CMS guidance that included roles and responsibilities.[83] For example, these states noted that they generally had experienced some type of delay in message delivery from CMS, insufficient communication with the stakeholders, and misunderstandings or misinterpretations of the messages communicated. For example, these states generally reported that they lacked complete and timely policy and business guidance from CMS, which impacted their IT development deadlines, created rework, and necessitated moving forward to develop solutions without knowing if the agency would approve or disapprove of their marketplace solutions.

Overall, responses to our survey questions indicate that CMS may not have always provided the level of consistent and comprehensive communication of roles and responsibilities that is necessary to support states in effectively establishing and operating their marketplace systems. Having a comprehensive communications management plan that identifies and conveys the roles and responsibilities of key organizations and officials could be a valuable resource as states move forward on any further marketplace IT efforts.

Federal Funding Decisions for State Marketplace IT Projects Did Not Always Include Senior-Executive-Level Oversight

To oversee its own IT projects, such as the development of Healthcare.gov and related systems, CMS created a process called the eXpedited Lifecycle Process.[84] This process required reviews and approvals by senior-level CMS executives, generally the Director or Deputy Director of the agency's IT unit—OTS—and business units, including CCIIO, CMCS, and OAGM. According to the agency's guidance, these senior-level executives should be individuals who have the authority to speak for, vote for, and otherwise make commitments on behalf of their business units. This approach is consistent with best practices in GAO's IT investment management framework, which emphasizes the importance of having senior executive-level decision makers, such as the heads of IT and business units, involved in

[83]As previously discussed, CMS's guidance to states included documentation such as memorandums of agreement that, among other things, described roles and responsibilities for CMS and state officials.

[84]The eXpedited Lifecycle Process is CMS's system development life-cycle process. The purpose of these reviews is to provide management and stakeholders with the opportunity to assess project work to date and identify any potential issues.

investment decisions.[85] Such involvement by senior executives provides accountability for investment decisions and helps ensure that these decisions are consistent and reflect the goals of the agency.

Similar to the eXpedited Lifecycle Process, CMS created its Establishment Review process, which states were required to comply with (as part of their cooperative agreements with CMS) in order to receive marketplace grant funding. The Establishment Review process is a structured grant monitoring approach that consists of multiple technical reviews for assessing the state's progress and associated IT project documentation. States must obtain CMS approval to access restricted IT grant funds[86] by passing technical review gates associated with the planning, design, and implementation of their projects.

However, unlike the eXpedited Lifecycle Process that CMS uses to manage its own investments at the federal level, the Establishment Review process did not include representation from all relevant senior executives in the agency to review and approve the planned marketplace IT projects prior to releasing federal funding to the states. Specifically, CMS's standard operating procedure for State Officers identified the IT and business units involved in the Establishment Review process, which included CCIIO, CMCS, OTS, and OAGM, among others. However, with the exception of the Director of CCIIO, it did not clearly require involvement by the heads of the other IT and business units involved in this process. For example:

- CMS did not demonstrate that senior-level executives from all relevant business and IT units were involved in the initial approval of grant awards. According to the operating procedure and officials from these business and IT units, the agency's Objective Review Committee was tasked with reviewing state applications for federal marketplace grants. This committee consisted of subject matter experts from both inside and outside the federal government who scored applications during a review in which the State Officer participated to answer questions. The State Officer then prepared federal marketplace grant

[85]GAO-04-394G.

[86]As noted previously, a portion of the marketplace grant funds provided to states was restricted for IT contractual spending until states were able to show development progress.

funding recommendations to OAGM and the Deputy Director of the State Exchange Group within CCIIO, who made the final decision on grant awards. However, it was unclear who these subject matter experts were or whether there were executives at the appropriate level involved with these decisions.

- CMS did not provide evidence that senior executives from all relevant business and IT units were involved in approving the release of restricted IT funds from marketplace grants as states progressed with their projects. According to CMS's standard operating procedure and officials in CCIIO and OAGM, decisions to release restricted state IT funding were made by the Deputy Director of the State Exchange Group within CCIIO and OAGM grant management officers, who were responsible for reviewing and providing guidance on grant services for state marketplaces. These decisions were based on input from CCIIO State Officers, who served as primary points of contact to assigned states, and IT project managers in OTS, who were responsible for monitoring state-based marketplaces' IT development activities. However, these officials did not hold executive-level positions.

- CMS did not provide evidence of executive-level involvement in the approval of Medicaid funds for marketplace IT projects. CMCS officials stated that they followed CMS's Establishment Review process in order for states to receive Medicaid matching funds and that the approval of these funds was a coordinated effort between CCIIO and CMCS. However, they did not identify the specific officials responsible for approving these funds or provide evidence to show the approval process included senior executives from CMCS, CCIIO, and other relevant business units.

CCIIO, CMCS, and OTS officials told us that they believed their Establishment Review process included the appropriate officials to review and approve state requests for federal funding. These officials added that they used their existing organizational structure to oversee decisions regarding marketplace grants and Medicaid funds.

However, without the involvement of senior executives from all relevant IT units, such as OTS and business units such as CCIIO and CMCS to review and approve all federal funds invested in the state marketplace IT projects, CMS has less assurance that decisions are being coordinated among officials with a perspective across their respective business units and the agency as a whole. By ensuring such executive involvement, CMS would increase accountability for decisions to fund states' IT

projects and better ensure these decisions are well informed and make efficient use of federal funds.

CMS Reviews of State Marketplace IT Projects Did Not Fully Ensure State Systems Were Ready for Operation

As part of its marketplace oversight, CMS established a process to review states' progress on related IT projects. This framework, called the Enterprise Life Cycle, requires states to provide CMS specific artifacts supporting their projects, such as the concept of operations, system test documents, and project plans, among others. The framework focuses on incremental reviews of the projects at distinct stages, or "gates." For each review, states are expected to show CMS an acceptable level of progress and maturity in their projects' development before proceeding to the next project phase. Table 7 describes the various Enterprise Life Cycle gate reviews.

Table 7: Enterprise Life Cycle Gate Reviews

Review	Description
Architectural Review	The purpose of this review is to ensure the state has a clear and well-defined system concept of operations and comprehensive project management plan. The project scope and boundary must be clearly defined at this point, and each state must be able to demonstrate a Medicaid information technology architecture (MITA) assessment and roadmap to MITA compliance for any Medicaid-related aspects of their project.
Project Baseline Review	The Project Baseline Review is to demonstrate that the project planning process is largely complete and that a fully developed concept of operations and project management plan have been established and baselined.
Final Detailed Design Review	This review is to demonstrate that a complete set of system designs has been produced, that the design is founded on a complete set of requirements, and the project is ready to proceed with system development activities. This includes demonstrating that all systems, subsystems, interfaces, and operational threads are fully specified, documented, and baselined. CMS expects that an independent party has validated the system requirements and the system and detailed designs before it conducts this review.
Operational Readiness Review	The Operational Readiness Review is to determine whether the system is ready to go into production. The state must demonstrate it has concluded all system testing and completed any remedial actions; all operator and user training for the support staff; and all privacy, security, and accreditation activities.
Annual Operational Analysis Review	During the Operations and Maintenance Phase, the Operational Analysis Review examines the operating status of the system through a variety of key performance indicators and determines whether the system is performing in an efficient and effective manner.

Source: GAO analysis of CMS information. | GAO-15-527

These reviews were important because they were intended to demonstrate that the state marketplaces were ready to go live. In particular, during the operational readiness reviews, states establishing state-based marketplaces were required to demonstrate that they had met requirements, such as concluding all system testing, before the IT projects could proceed from development to operations. The Enterprise

Life Cycle guidance defines this review as the agency's determination that the state marketplace is ready to go into production. Based on these operational readiness reviews, CMS was to either approve the state's system for operation or grant a conditional approval to proceed if the system was substantially compliant with the requirements of the review.

However, the operational readiness reviews did not always meet the agency's stated goal to ensure that states' marketplace systems were ready for production. For the first enrollment period, CMS conducted operational readiness reviews of 15 state-based marketplaces in August and September 2013.[87] However, CMS conditionally passed all of those states without fully ensuring that they had conducted all required system testing and demonstrated that their systems were ready for production as called for in its Enterprise Life Cycle guidance. For example, CMS documentation from these operational readiness reviews showed the following:

- Maryland demonstrated several eligibility and enrollment functions. However, the state had only completed approximately half of the planned user acceptance testing and had over 100 outstanding high-priority defects. In addition, almost 500 total defects had yet to be resolved.
- Nevada also demonstrated several eligibility and enrollment functions. However, the state had not submitted test reports for all end-to-end system testing, and user acceptance testing was in progress. The report identified 42 critical or major defects that needed to be addressed.
- Massachusetts demonstrated several eligibility and enrollment functions. However, the state had not completed testing and reported 1,170 open defects.

Nonetheless, all state-based marketplace systems were conditionally approved and went live on October 1, 2013. Consumers in many states subsequently experienced widespread problems when using these IT solutions to apply for health insurance coverage during the first

[87]These 15 state-based marketplaces are California, Colorado, Connecticut, the District of Columbia, Hawaii, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New York, Oregon, Rhode Island, Vermont, and Washington. Idaho and New Mexico were state-based marketplaces that used the federal marketplace IT solution.

enrollment period, and in four states these problems were so severe that the states switched to a different solution.[88]

According to CMS officials, these four states implemented new marketplace IT solutions or used the federal marketplace IT solution in the second open enrollment period and successfully conducted enrollment even if some states had to create manual workarounds. However, according to CMS documentation, as of November 2014, eight states continued to have outstanding follow-up items from their operational readiness reviews that had not been addressed. In May 2015, officials in CCIIO, CMCS, and OTS stated they were actively working with these states to complete their outstanding open items.

CCIIO officials further noted that the Enterprise Life Cycle gate reviews were not intended to be "pass or fail," but to set the appropriate level of expectations for the status and progress of marketplace development and implementation and to identify areas where states may require assistance. In addition, CCIIO officials stated that, if all the milestones were not met during the gate review, they planned to conduct more frequent follow-up to improve the state's position. They also said that although the IT component did not work for certain states, the agency granted conditional approvals because the states were able to build workarounds and put manual processes in place to allow individuals to submit applications and enroll in health coverage. Officials in OTS added that, although they made suggestions for improvements, states could choose whether or not to implement CMS's recommendations.

However, when CMS granted states conditional approval to go live, they did not ensure states' systems had been fully tested, which is part of the structured and disciplined approach to oversight that is outlined in the agency's Enterprise Life Cycle. By not ensuing that systems were completely tested, the agency lacked assurance that the states' marketplace IT systems would performed as intended which, in some cases, resulted in applicants facing long waits for eligibility determinations, websites freezing midway through the process of applying for coverage, and systems being taken offline for days at a time, forcing applicants to enroll manually.

[88]The four states that switched IT solutions after the first enrollment period were Massachusetts, Maryland, Nevada, and Oregon.

States' Oversight Roles Varied Depending on Marketplace Type

The extent and manner of oversight that states exercised over marketplace IT projects depended in large part on the type of marketplace they chose to establish. For state-based marketplaces, state officials were responsible for overseeing various IT activities associated with the development and operations of their marketplaces. Specifically, states were required to oversee the planning involved with becoming a state-based marketplace. Thus, among other things, state officials were responsible for ensuring that key functionality requirements in areas such as eligibility and enrollment, plan management, consumer assistance, and financial management, were included in the development of the marketplace.

Additionally, these states were responsible for overseeing contractors, who carried out various marketplace IT project-related activities, such as system integration, platform builds, project management, independent verification and validation, and security assessments. State officials were to follow CMS policy and guidance when establishing the marketplaces, including preparing project artifact deliverables, such as the marketplace concepts of operation, system test documents, and project plans. They also were to comply with financial and performance reporting requirements of CMS's Enterprise Life Cycle process.

To oversee their marketplaces, 13 of 17 states with state-based marketplaces, including those using the federal marketplace IT solution, reported on our survey that they established "quasi-governmental" entities, which were created by state legislation to oversee marketplace activities and interface with CMS to fulfill the state's marketplace responsibilities. These entities are governed by a board made up of representatives from consumer groups and health insurance issuers, since CMS policy requires a balance of consumer and business interests on the board. The board is responsible for governance of the marketplace, making key marketplace decisions, and holding regularly scheduled meetings.

By contrast, 4 of these 17 states reported on our survey that they chose to operate their marketplace through an existing state agency, such as a state department of health or Medicaid agency. If a state-based marketplace was housed within an existing state agency, then that marketplace was typically led by directors or an advisory board, and the leadership team typically reported to the governor's office.

States with state-based marketplaces, including those using the federal marketplace IT solution, reported on our survey that they also established

various committees and boards to assist state officials in overseeing the marketplace's IT funding and progress. These oversight committees and boards included steering committees, management change control boards, and technical review boards, among others.

- **Steering committees:** All states with state-based marketplaces had established this type of committee. A steering committee is to provide leadership, direction, and support for IT projects.[89] For example, one state's steering committee was reported to be made up of senior leadership from various agencies within the state and was responsible for ensuring that marketplace IT goals aligned with various state agencies' goals. In addition, the committee served as a forum for project strategy development and operations, policy, and technology recommendations to its board of directors.
- **Management change control boards:** Thirteen of the 17 states with state-based marketplaces established this type of board. A management change control board is to oversee a project's scope and requirements.[90] For example, one state reported that its management change control board was chaired by its project director and oversaw not only changes to the scope and requirements, but also its marketplace project schedule, costs, and deliverables.
- **Technical review boards:** Nine of the 17 states with state-based marketplaces established this type of board. A technical review board provides technical findings and recommendations to project stakeholders.[91] For example, one state reported that its technology committee provided leadership and helped to analyze the impact of the marketplace on existing IT standards and informed other teams and stakeholders about policy changes that could impact the project.

In addition, 7 of the 17 states with state-based marketplaces, including those using the federal marketplace IT solution, reported on our survey

[89]GAO, *Information Technology: A Framework for Assessing and Improving Enterprise Architecture Management*, GAO-03-584G (Washington, D.C.: April 2003, Version 1.1).

[90]Project Management Institute, Inc., *A Guide to The Project Management Body of Knowledge* (*PMBOK® Guide*), Fifth Edition, (Newton Square, Pa.: 2013). "PMBOK" is a trademark of the Project Management Institute, Inc.

[91]GAO, *Information Technology Management: Governmentwide Strategic Planning, Performance Measurement, and Investment Management Can Be Further Improved*, GAO-04-49 (Washington, D.C.: January 2004).

that they used additional oversight mechanisms beyond these three. Specifically, one state reported that its marketplace and state administration established an integrated project management office to assist with coordination of Medicaid and tax credit applications and eligibility functions. Another state reported using a cross-agency group made up of agencies involved in marketplace eligibility functions from both IT and policy perspectives.

Further, all states relying on the federally facilitated marketplace and federally facilitated partnerships that responded to our survey indicated that they used existing state agencies to oversee implementation of their marketplace IT projects. Existing state agencies included state departments of health or Medicaid agencies, which coordinated directly with CMS. In addition, these states' officials oversaw the contractors who were responsible for various marketplace-related activities, such as building interfaces to connect the state systems to the federal data services hub for transferring information between the federally facilitated marketplace and state Medicaid programs.

States Encountered Challenges and Identified Lessons Learned and Best Practices in Managing, Overseeing, Developing, and Operating Marketplace IT Systems

States encountered various challenges in their efforts to design, develop, and implement marketplace IT systems.[92] States with state-based marketplaces reported experiencing challenges in each of five areas identified in our survey: *project management and oversight, marketplace IT solution design, marketplace IT solution development, resource allocation and distribution*, and *marketplace implementation and operation*. In addition, states with a federally facilitated marketplace reported facing challenges in two areas identified in the survey: *project management and oversight and system design and development.*

While states operating both state-based and federally facilitated marketplace IT solutions[93] reported in the survey that they faced similar issues, various challenges were more common for states developing their own IT solution because the scope of their efforts was larger than that of states with a federally facilitated marketplace. For example, those with state-based marketplaces generally reported experiencing issues with marketplace eligibility and enrollment functions; while for states with a federally facilitated marketplace, those functions were performed by CMS.

To varying extents, states identified lessons learned and best practices from their experiences with and efforts to address the challenges. CMS was aware of state challenges and took various actions to provide technical assistance. It also has taken steps to facilitate the sharing of the lessons learned and related best practices, which will continue to be important as states work to complete the remaining functions for their marketplace systems.

[92]We surveyed state marketplace officials in the 50 states and the District of Columbia. Forty-seven states responded, but not every state chose to rate every challenge identified.

[93]In this section, the federally facilitated marketplace IT solution includes federally facilitated partnership marketplaces and the state-based marketplace IT solution includes state-based marketplaces that use the federal marketplace IT solution.

Project Management and Oversight Challenges Include Compressed Time Frames and Project Governance, Oversight, and Decision Making

Compressed time frames was rated as the greatest challenge[94] by officials of both states with a state-based marketplace and states with a federally facilitated marketplace. Specifically, 13 of 17 states with state-based marketplaces and 20 of 30 states[95] with a federally facilitated marketplace considered compressed time frames a great or very great challenge, and it was also reported as a factor driving other challenges. State officials noted that their IT project schedules were constrained by the need to deliver functionality in time for the first enrollment period beginning on October 1, 2013. For example, one state-based marketplace official reported that compressed time frames affected the state's development and testing time, which impacted all phases of testing (system, integration, performance, and user acceptance).

Project governance, oversight, and decision making was also rated as one of the greatest challenges in the project management and oversight area by officials of both states with a state-based marketplace and states with a federally facilitated marketplace. Specifically, 10 of 17 states with state-based marketplaces and 8 of 30 states with a federally facilitated marketplace rated project governance, oversight, and decision making as a great or very great challenge.

Based on our analysis of narrative survey responses, 14 states with state-based marketplaces and 15 states with a federally facilitated marketplace also identified lessons learned or best practices in the area of project management and oversight. For example, regarding compressed time frames, a best practice identified by 1 state was to double the amount of lead time normally expected when planning for implementation of complex IT projects. Another state reported a lesson learned regarding compressed time frames, which was related to IT systems design and development. This state learned that taking a two-phased approach whereby the state modified its legacy Medicaid eligibility system first, and then proceeded with a full-scale system upgrade, helped meet deadlines while avoiding significant problems that had arisen in other states.

[94]Ratings of very great and great on the state survey were combined when determining the two greatest challenges in each area.

[95]Of the 34 states with a federally facilitated marketplace IT solution, 4 did not respond to our survey. States that did not complete a survey were Arkansas, Kansas, New Jersey, and Ohio.

States also reported lessons learned and best practices related to project governance, oversight, and decision making. For example, one state reported reshaping its project management team and, thus, making progress for the second open enrollment season. A second state realized too late that it needed more governance and a dedicated program management office. This state's officials also said that it was important to recognize that the marketplace is an IT project as well as an insurance project, and that it was critical to have a proper mix of both sides to ensure success.

State-Based Marketplace IT Solution Design and Development Challenges Include Interfacing with Insurers and Developing Website Eligibility Functions

Developing interfaces and interoperability with insurers was rated as one of the greatest challenges by 9 of 17 states with state-based marketplaces.[96] For example, 1 state reported challenges with a system that was supposed to allow users to pay for and enroll in insurance plans; however, that basic feature was not appropriately developed by launch or for months afterward. The state hired a contractor to reconcile enrollment and premium tax credit issues between its insurance carriers and its IT solution, but all issues were not resolved, and the state was still working through this process when officials responded to our survey.

Developing state marketplace website eligibility functions for both state Medicaid and Qualified Health Plans was also rated as one of the greatest challenges by 9 of the 17 states. For example, one state official reported that their applicants could not have their eligibility determined for Qualified Health Plans, Medicaid, and premium tax credits without the assistance of specially trained customer service representatives or community partners and agents. Another state's original IT solution was not working appropriately, so officials approached CMS, who offered to let the state use the Healthcare.gov platform for eligibility and enrollment. A third state cited numerous multi-stage workarounds to circumvent defects in eligibility and enrollment functionality. This included, for example, 100 percent manual validation of all enrollment files.

Although 8 states with state-based marketplaces identified lessons learned or best practices in the marketplace IT solution design and development area, with one exception, states did not specifically identify lessons learned related to *developing interfaces and interoperability with*

[96]We consolidated marketplace IT solution design and marketplace IT solution development for the state-based marketplaces.

insurers or developing state marketplace website eligibility functions. One state reported that it learned that projects like this should begin with simple rules on eligibility, and then add complexity. Further, this state decided to maintain Medicaid and CHIP enrollees in its legacy system using a close approximation of eligibility rules to ensure that there was no disruption in coverage with the launch of a new system. New applications for Medicaid and CHIP were determined in the new system while renewals for current enrollees were determined in the legacy system. This was to enable more time for adequate testing and further development of Medicaid and CHIP rules in the new system.

System Design and Development Challenges for States Using the Federally Facilitated Marketplace Include Systems Integration Testing and Changes to Requirements

Conducting systems integration testing was rated as one of the greatest challenges by 12 of 30 states with a federally facilitated marketplace. For example, 1 state reported that limited development and testing time affected all phases of testing including system, integration, performance, and user acceptance testing. Another state reported that the interface between the state and the federally facilitated marketplace was delayed due to implementation delays in the federal marketplace IT solution. These delays resulted in last-minute changes to the federal systems, both known (but communicated late) and unknown. Each federal system change required the state to also change, and such changes and delays resulted in the state missing deadlines. Other states specifically cited a lack of end-to-end testing between the federal IT systems and states, as well as integrating and testing with the federal marketplace and the federal data services hub, as challenges.

Changes to requirements was rated as one of the greatest challenges by 19 of 30 states with a federally facilitated marketplace. For example, one state official said that “the aggressive time frame made an impact to the design. Systems always evolve, but the aggressive schedule forced design trade-offs along the way.” A second state reported that the compressed time frame caused CMS to continually define requirements throughout implementation and into operations, resulting in the reprogramming of multiple design changes. Lastly, another state official commented on multiple challenges related to changes in requirements. This state official said that changes and delays due to clarification of CMS requirements in areas such as use of the federal data services hub and identity proofing caused significant rework and some critical functionality to be deferred, which, because of the aggressive time frame, impacted operations.

A second state official emphasized developing a comprehensive set of requirements. The state invested time to develop a comprehensive set of

requirements for all known areas of the system and included broad requirements referencing CMS guidance documents when detail from CMS was insufficient. The state then required vendors to explicitly identify which requirements would be met with delivered functionality, and which requirements would need to be augmented with customizations or additional software applications. This kept most of the systems development in scope and resulted in less than a 10 percent increase in the negotiated fixed price due to change orders. A third state identified a best practice regarding guidance and policy—which drive requirements—noting that they should be finalized before states are tasked with implementing system changes and testing.

Our analysis of narrative survey responses showed that 14 states with a federally facilitated marketplace reported lessons learned or best practices related to IT systems design and development, including those associated with changes to requirements or the development of requirements. For example, one state official said that there were many changes leading all the way up to open enrollment. Only after this occurred did officials recognize that they needed to lock down the scope of work and disallow "nice-to-haves" to focus on critical functionality.

Resource Allocation and Distribution Challenges Include Adequate Staff and Funding

Adequate number of staff was rated as one of the greatest challenges by 9 of 17 states with state-based marketplaces. In one case, a state official reported that the state had only approved the hiring of approximately one-third of the staff it requested and, as of October 2014, had never hired a certified project manager to oversee their state's marketplace-related IT projects. Similarly, staffing limitations forced another state to ask its staff to work overtime, in some cases more than 60 hours a week for months on end, in order to complete the work required prior to open enrollment, resulting in burnout and the loss of key staff soon after the start of the first open enrollment period.

Adequate funding to sustain a state's marketplace system was rated as one of the greatest challenges by 6 of 17 states with state-based marketplaces. For example, one state official reported that, in order to meet open enrollment deadlines and reduce schedule risks, the state decided to use a commercial off-the-shelf product instead of open-source products, which led to an increase in life-cycle costs.

Our analysis of narrative survey responses found that five states reported lessons learned or best practices related to resource allocation and distribution. For one state, the most significant lesson learned was the amount of testing resources required for all associated types of IT testing.

Due to this, the state has identified a need for additional business analyst positions and subject matter expert knowledge.

Marketplace Implementation and Operation Challenges Include Call Center Operations and System Performance

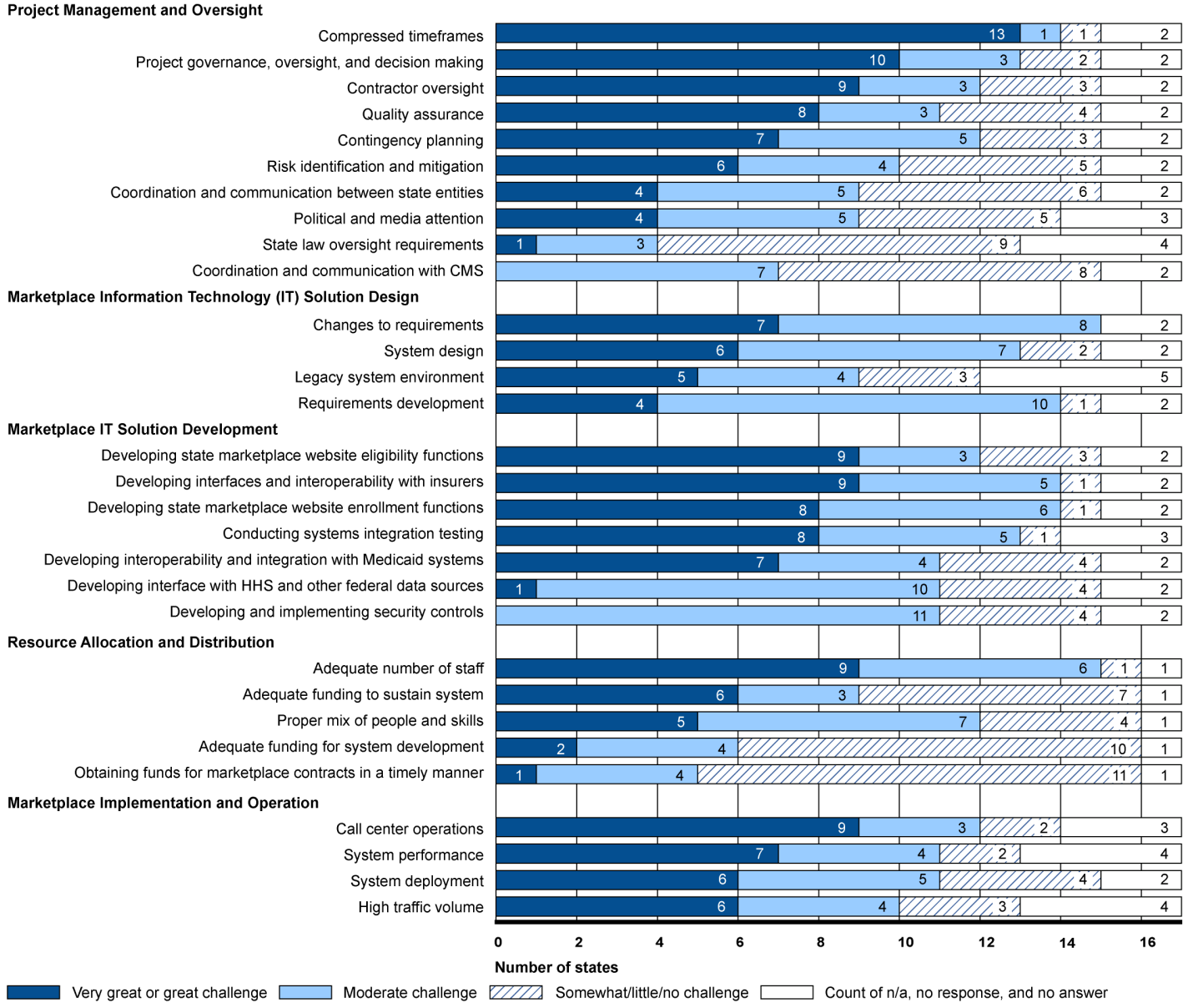
Call center operations was rated as one of the greatest challenges by 9 of the 17 states with state-based marketplaces. For example, one state official reported that due to challenges with system performance, their call center experienced high-traffic volume, and this affected the average time to handle a call, abandonment rates of calls, and operations. Another state reported that insufficient time for staff training led to inefficiencies in call center operations.

System performance was rated as one of the greatest challenges by 7 of the 17 states with state-based marketplaces. For example, 1 state cited significant challenges in implementation and operation because its software did not work as advertised. Also, as mentioned above, system performance problems affected call center operations. This was compounded in part because of the surge in users attempting to use the online marketplace that occurred in the period immediately after going live.

Our analysis of narrative survey responses showed that two states with state-based marketplaces identified best practices or lessons learned related to the operation and implementation of marketplace-related IT systems. For example, one state cited the importance of contingency planning that enabled state deployment of additional system capacity when volume exceeded expectations. Another state reported that the inability to develop and refine marketplace technology resulted in significant operational costs, which could have been avoided with a less aggressive time frame.

Figure 6 summarizes the challenges in each of the five areas rated by states with state-based marketplaces. Figure 7 depicts the challenges that states with a federally facilitated marketplace rated in each of their two respective areas.

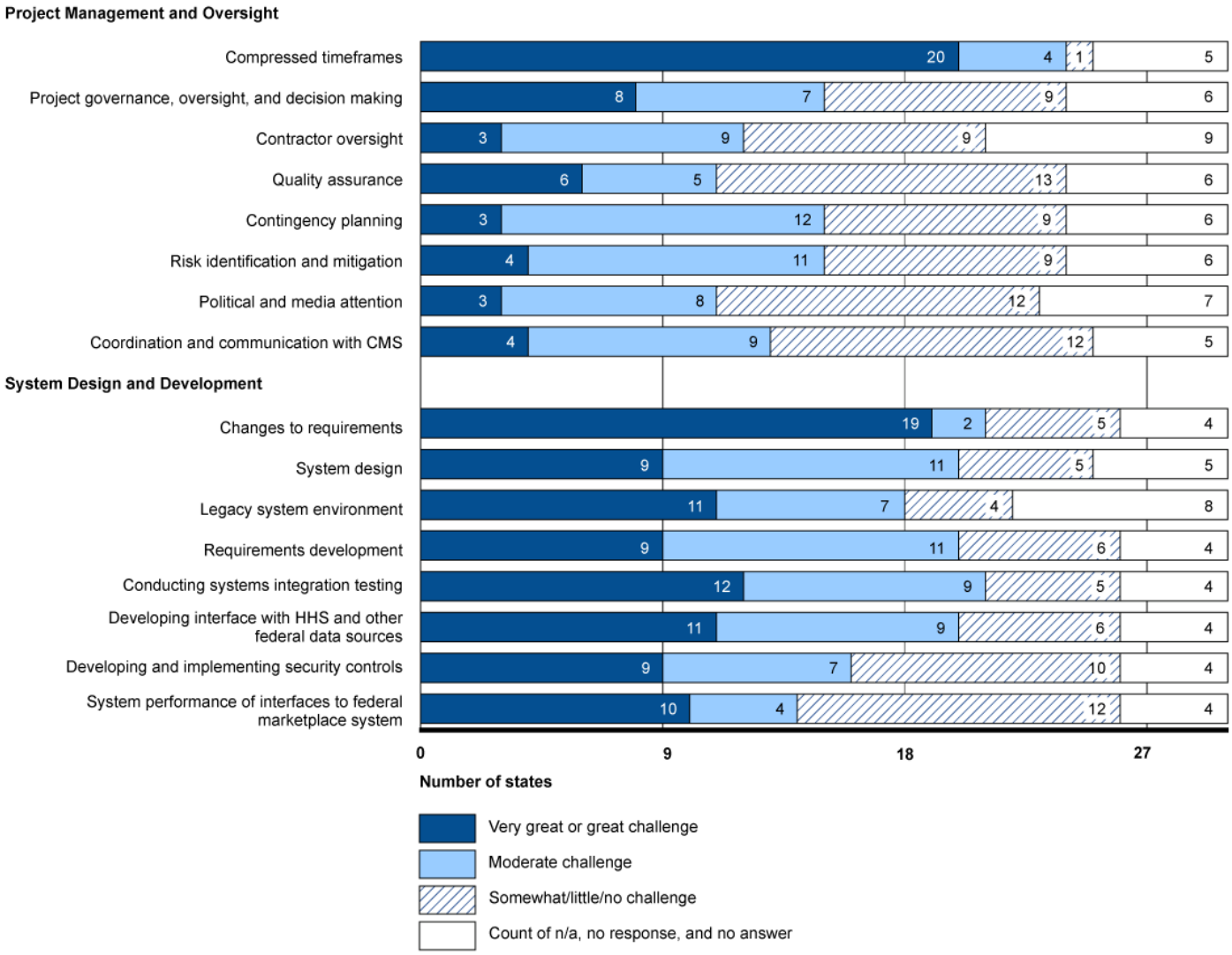
Figure 6: Challenges Rated by States with State-Based Marketplaces



Source: GAO analysis of state survey data. | GAO-15-527

Note: Marketplace solution design and development were consolidated when analyzing state survey responses. CMS (Centers for Medicare & Medicaid Services); HHS (U.S. Department of Health and Human Services).

Figure 7: Challenges Rated by States with a Federally Facilitated Marketplace



CMS (Centers for Medicare & Medicaid Services)
HHS (U.S. Department of Health and Human Services)

Source: GAO analysis of state survey data. | GAO-15-527

CMS Responded to Challenges and Facilitated the Sharing of Lessons Learned and Best Practices

CMS was aware of states' challenges and responded to them by engaging in various outreach to and communication efforts with the states. According to CCIIO officials, once an issue or challenge was identified, CMS responded in a number of ways. Specifically, according to these officials, the agency provided technical assistance that included discussions with CMS subject matter experts to ensure that appropriate information and resources were available to address challenges. For example, the officials said they conducted site visits with state marketplace officials during which they discussed management and other issues and made recommendations for improvement, as needed. Other state challenges that CMS officials indicated they were aware of included issues with compressed schedules, state governance, legislative requirements, vendor management, personnel and resources, and call-center operations.

Additionally, CMS made efforts to both directly share and facilitate the sharing of identified lessons learned and best practices among the states. CCIIO officials reported that lessons learned and best practices were shared through various methods such as discussion forums, including bi-weekly forum meetings with senior state officials, conference calls, and weekly newsletters distributed to grantees, and through various reporting and document sharing systems maintained by CMS.

In taking steps to respond to state challenges, identify lessons learned, and share best practices with states, CMS performs an essential role of advising state officials and others involved with health insurance marketplace IT projects. It will be important for CMS to continue doing so as states work to complete the remaining functions for their marketplace systems.

Conclusions

States spent approximately $1.45 billion in federal marketplace grant funds to help establish IT systems supporting their health insurance marketplaces, as well as a portion of Medicaid funds. As of the second enrollment period, states had largely established these systems, although some of their functions remain to be implemented.

While CMS was tasked with overseeing states' development of their marketplace IT systems, limitations in CMS's efforts resulted in oversight that was not always effectively executed. Specifically, because roles and responsibilities were not always clearly defined, documented or communicated, as recommended by leading practices for project management, a number of states faced hurdles in communicating with

stakeholders and receiving timely CMS guidance. In addition, although called for by leading practices in investment management, relevant senior executives in the agency were not always involved in overseeing decisions to fund states' marketplace IT projects, resulting in less accountability for such decisions. Further, because CMS's reviews of state IT projects did not ensure state systems were fully tested as called for in CMS's guidance, systems were put into place that, in some cases, did not perform as intended. States also had a key oversight role, which varied depending on the type of marketplace.

Finally, states reported a number of challenges and lessons learned in establishing their marketplaces, with state-based marketplaces encountering some unique challenges. CMS has taken various actions to facilitate the sharing of these challenges and lessons learned, as well as best practices among the states, and it will be important for CMS to continue these efforts as states work to complete the remaining functions for their marketplace systems.

Recommendations for Executive Action

To improve the oversight of states' marketplace IT projects, we recommend that the Secretary of Health and Human Services direct the Administrator of the Centers for Medicare & Medicaid Services to take the following three actions:

- clearly document, define, and communicate to all state marketplace officials and stakeholders the roles and responsibilities of those CMS officials involved in overseeing state marketplaces in a comprehensive communication management plan;
- ensure that all CMS senior executives from IT and business units who are involved in the establishment of state marketplace IT projects review and approve funding decisions for these projects; and
- ensure that states have completed all testing of marketplace system functions prior to releasing them into operation.

Agency Comments and Our Evaluation

We received written comments on a draft of this report, signed by HHS's Assistant Secretary for Legislation. In the comments (reprinted in appendix III), the department stated that it concurred with all three of our recommendations. The department added that it had taken various actions that were focused on improving its oversight and accountability for states' marketplace efforts.

While the actions discussed are important, the department did not always identify specific activities being taken or planned that would address the full extent of the recommendations. Specifically, with respect to our recommendation that CMS clearly document, define, and communicate its roles and responsibilities for overseeing state marketplaces in a comprehensive communication management plan, the department noted that a State Officer is assigned to each state to serve as the primary point of contact and that CMS's roles and responsibilities are communicated through this official. The department also stated that these roles and responsibilities are documented in several resources, including standard operating procedures and weekly newsletters to state officials. However, the department did not indicate that CMS would develop a communications management plan to provide a comprehensive and consistent means of identifying and conveying the roles and responsibilities of key CMS organizations to all states and the District of Columbia. As we noted in our report, CMS's standard operating procedures and other documents did not identify all the relevant stakeholders or activities involved in its oversight process. Thus, we maintain that a comprehensive communications management plan would be a valuable resource as states move forward on any further marketplace IT efforts.

With respect to our recommendation that CMS include senior executives from all relevant IT and business units in funding decisions for state marketplace IT projects, HHS stated that the department already includes senior executives in its funding decisions for these projects. However, as noted in our report, CMS did not provide evidence that key senior executives from CCIIO, CMCS, and OTS were involved in various funding decisions associated with the states' IT projects. For example, CMS did not demonstrate that senior-level executives from all relevant business and IT units were involved in the initial approval of grant awards or the release of restricted IT funds from marketplace grants as states progressed with their projects. In addition, CMS did not provide evidence of senior executive involvement in the approval of Medicaid funds for marketplace IT projects. By ensuring such executive involvement, CMS would increase accountability for decisions to fund states' IT projects and ensure that these decisions are well informed in order to make efficient use of federal funds.

With respect to our recommendation to ensure that states have completed all testing of marketplace system functions prior to releasing them into operation, HHS noted that it will continue to follow its guidelines to determine if state marketplace system functions are ready for release.

The department added that it will continue to work closely with state-based marketplaces to improve their systems and verify that system requirements are met. We agree that following its review guidance as defined is important. In particular, as noted in our recommendation, CMS should ensure that states' systems are fully tested before approving them for release into production, rather than relying on workarounds and manual processes.

HHS also provided technical comments, which we incorporated in the report as appropriate. Among these comments, the CMS liaison in the Office of Legislation sent an e-mail on September 10, 2015, stating that the amount of total marketplace grant spending for the District of Columbia that CMS provided to us based on its March 2015 report was incorrect. Accordingly, we revised our analysis and relevant areas of our report to reflect the new amount provided by the agency.

We also provided relevant excerpts of this report to each of the 50 states and the District of Columbia and received responses, via e-mail or in writing, from officials in 15 states. Officials from 5 of these states (Alaska, Arizona, Maine, Nevada, and Rhode Island) said they had no comments.

Among the remaining 10 states, 6 states (Alabama, Idaho, Indiana, Minnesota, Washington, and Wisconsin) commented on our discussion of their marketplace grant data. According to these states, the data we reported on marketplace grant funding were not always consistent with their own data. However, the grant funding discussed in our report reflects state-reported data that CMS provided and represents a consistent source and time frame of data for all states as of March 2015; thus, we did not revise our discussion of the reported data in the report. However, we did revise the report to clarify that the state-reported data that CMS provided could lag behind actual state marketplace grant data for a specific date.

In addition, officials from 6 of the 10 states commented on the status of their systems development and operation.

- In e-mail comments, the Grant Compliance Officer of Covered California provided details on specific functionality Covered California was still implementing. For example, its small business marketplace was using manual workarounds for its automated payment functionality until the system is completed. Regarding the hub services and IRS reporting submission functions, the official said that California will continue to enhance and improve efficiencies of the hub

services for the health insurance renewal process, and will complete performance testing of IRS reporting submissions.

- In written comments, the Executive Director of the District of Columbia Health Benefit Exchange Authority did not agree with some of the characterizations in our report. Specifically, the Executive Director concurred with our characterization of the status of the financial management functions as fully complete and IRS reporting functions as partially complete, but did not agree that the District of Columbia's eligibility and enrollment and hub services functions were only partially complete. Regarding the eligibility and enrollment functions, the Executive Director said that our characterization was misleading and unsupported because these functions were only partially operational for one specific function and that the marketplace received permission from CMS to implement an alternate method for implementing another specific function; thus, the overall eligibility and enrollment function should have been considered fully operational.

  Our characterization of eligibility and enrollment functions as partially operational was based on CMS's February 2015 operational status report which consisted of a larger list of functions than the Executive Director cited and states were expected to automate all these functions. While we recognize that the District of Columbia was able to enroll applicants through its system, CMS's report indicated that these specific functions, which support important provisions of PPACA, were not complete or fully automated. Regarding hub services, the Executive Director said that the District of Columbia requested and received permission from CMS not to deploy a specific function for plan year 2015 but has begun testing this function for plan year 2016. Since the District of Columbia was still testing this hub service, it had not fully developed, tested, and implemented this functionality required by CMS. The District of Columbia Health Benefit Exchange Authority's comments are reprinted in appendix IV.

- In e-mail comments, the Executive Director of the Office of the Kentucky Health Benefit Exchange requested that we clarify the partial rating for IRS required submissions because the Executive Director believed that the state had been fully compliant with these requirements. However, according to CMS's February 2015 operational status report, Kentucky had not completed the most recent annual submission of IRS data which is used to ensure that individuals received the correct amount of premium tax credit.

- In written comments, the Interim Chief Executive Officer of MNsure, the Minnesota marketplace, generally agreed with the operational status ratings for the functional categories. But the official also noted

that while the functions may be rated as partially operational, our report did not recognize that MNsure delivered the required services and in some cases used manual workarounds to temporarily meet the functional requirements. We recognized that states implemented workarounds to deliver services, but our report focuses on the status of fully automated functionality delivered by states' IT projects. For example, regarding eligibility and enrollment functions, although MNsure sent automated notices for most consumers, due to system limitations it was unable to issue automated notices to some consumers renewing coverage and therefore created manual notices for these consumers.

In addition, regarding financial management functions, the Interim Chief Executive Officer said MNsure was billing small business customers using a manual process in February 2015, but has since incorporated automation into the process. Further, the official noted that MNsure opted to have certain financial management functions performed by CMS. While MNsure made progress in this area, we are reporting the status according to CMS's February 2015 operational status report, which is a consistent source and time frame of data for all states, and these financial management functions were categorized as not operational in the report. Regarding hub services, the Interim Chief Executive Officer generally agreed with the status and stated that MNsure will continue to plan for testing of these functions. Regarding IRS reporting, the official generally agreed with the status and stated that the delays for submitting files to IRS were due to additional quality assurance work. The MNsure Minnesota marketplace's comments are reprinted in appendix V.

- In e-mail comments, the Deputy Director of the New York State Department of Health disagreed that financial management, hub services and IRS reporting file submissions functions were partially operational as of February 2015, and believed that the ratings should reflect fully operational or fully complete. In addition, the Deputy Director stated that the state should not receive partial ratings because it opted to have CMS perform certain financial management functions, determined alternate methods for completing certain hub services functions, and was waiting for solutions from CMS regarding IRS reporting file submissions. Although New York opted to have certain financial management functions performed by CMS, the agency's February 2015 operational status report categorized these functions as not operational. Further, while CMS may have allowed certain alternate methods or workarounds for hub services functions, CMS's operational status report indicated that these specific functions were not complete or fully automated. Even though New York may

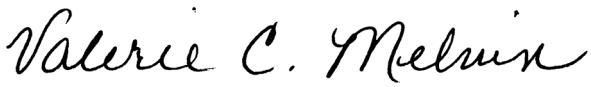
have been waiting for a solution from CMS to complete its IRS reporting file submissions, CMS's report noted that this function was not fully complete.

- In written comments, the Chief Executive Officer of the Washington Health Benefit Exchange concurred with our characterization of the status of eligibility and enrollment functions and IRS reporting file submissions but did not agree that its financial management and hub services functions were only partially operational. The Chief Executive Officer stated that our report lacked the necessary details for him to review in order to respond to these characterizations. We later provided details from CMS's February 2015 operational status report that we evaluated to determine the status of the state's marketplace. Subsequently, the official stated that certain financial management functions were incomplete because the state opted to have these functions performed by CMS. Nonetheless, CMS's February 2015 operational status report categorized these functions as not operational. For hub services, the official noted that the Washington Healthplanfinder successfully used multiple services offered by the federal hub to verify Social Security numbers, citizenship, lawful presence, income, and other eligibility factors and that the marketplace has tested these services. However, CMS's February 2015 operational status report noted that it had only partially completed certain hub services for verifying eligibility. The Washington Health Benefit Exchange's comments are reprinted in appendix VI.

Other technical comments provided via e-mail by marketplace and Medicaid officials within these states were considered and incorporated into our final report as appropriate

We are sending copies of this report to the Secretary of Health and Human Services and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

Should you or your staffs have questions on matters discussed in this report, please contact me at (202) 512-6304. I can also be reached by e-mail at melvinv@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix VII.



Valerie C. Melvin, Director
Information Management and Technology Resources Issues

List of Congressional Requesters

The Honorable Orrin Hatch
Chairman
The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Lamar Alexander
Chairman
Committee on Health, Education, Labor and Pensions
United States Senate

The Honorable Ron Johnson
Chairman
The Honorable Thomas R. Carper
Ranking Member
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Charles E. Grassley
Chairman
Committee on the Judiciary
United States Senate

The Honorable Claire McCaskill
Ranking Member
Permanent Subcommittee on Investigations
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
House of Representatives

The Honorable Jason Chaffetz
Chairman
The Honorable Elijah E. Cummings
Ranking Member
Committee on Oversight and Government Reform
House of Representatives

The Honorable Paul Ryan
Chairman
The Honorable Sander M. Levin
Ranking Member
Committee on Ways and Means
House of Representatives

The Honorable Greg Walden
Chairman
Subcommittee on Communications and Technology
Committee on Energy and Commerce
House of Representatives

The Honorable Joseph R. Pitts
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

The Honorable Tim Murphy
Chairman
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
House of Representatives

The Honorable Mark Meadows
Chairman
Subcommittee on Government Operations
Committee on Oversight and Government Reform
House of Representatives

The Honorable Jim Jordan
Chairman
Subcommittee on Health Care, Benefits, and Administrative Rules
Committee on Oversight and Government Reform
House of Representatives

The Honorable William Hurd
Chairman
Subcommittee on Information Technology
Committee on Oversight and Government Reform
House of Representatives

The Honorable Mike Coffman
Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

The Honorable Charles Boustany, Jr.
Chairman
Subcommittee on Human Resources
Committee on Ways and Means
House of Representatives

The Honorable Peter Roskam
Chairman
The Honorable John Lewis
Ranking Member
Subcommittee on Oversight
Committee on Ways and Means
House of Representatives

The Honorable Michael Bennet
United States Senate
The Honorable Richard Blumenthal
United States Senate

The Honorable Robert P. Casey, Jr.
United States Senate

The Honorable Al Franken
United States Senate

The Honorable Tim Kaine
United States Senate

The Honorable Amy Klobuchar
United States Senate

The Honorable Joe Manchin III
United States Senate

The Honorable Jeffrey A. Merkley
United States Senate

The Honorable Bill Nelson
United States Senate

The Honorable Jeanne Shaheen
United States Senate

The Honorable Jon Tester
United States Senate

The Honorable John Thune
United States Senate

The Honorable Mark R. Warner
United States Senate

The Honorable Ron Barber
House of Representatives

The Honorable Tulsi Gabbard
House of Representatives

The Honorable Duncan Hunter
House of Representatives

The Honorable Darrell Issa
House of Representatives

The Honorable Mike Kelly
House of Representatives

The Honorable Ann McLane Kuster
House of Representatives

The Honorable Daniel W. Lipinski
House of Representatives

The Honorable Patrick E. Murphy
House of Representatives

The Honorable Scott Peters
House of Representatives

The Honorable Kyrsten Sinema
House of Representatives

The Honorable Filemon Vela
House of Representatives

Appendix I: Objectives, Scope, and Methodology

Our objectives were to (1) determine how states have used federal funds for IT projects to establish, support, and connect to health insurance marketplaces, including amounts spent, and the overall status of their development and operation; (2) determine CMS's and states' roles in overseeing these state IT projects; and (3) describe IT challenges that states have encountered in developing and operating their marketplaces and connected systems, and lessons learned from their efforts.

To address the three objectives, we designed and administered a web-based survey to collect information about the state health insurance marketplace IT projects in the 50 states and the District of Columbia. We developed two versions of this survey: one for states with state-based marketplaces, including those using the federal marketplace IT solution, and one for states with a federally facilitated marketplace or federally facilitated partnership.[1] Seventeen states received the state-based version of the survey, and 34 states received the federally facilitated version. Generally, the survey asked state program officials about

- federal and state funding for developing and operating state marketplace-related IT projects,
- state marketplace and project types,
- CMS's and state's marketplace oversight roles and tools, and
- challenges and lessons learned with state marketplace IT development and operations.

Out of the original population of state health marketplaces in the 50 states and the District of Columbia,[2] 46 states[3] and the District of Columbia submitted survey responses; however, not all respondents provided

[1]Under the Patient Protection and Affordable Care Act, each state could establish and operate its own marketplace, referred to as a state-based marketplace. In addition, a state with a state-based marketplace could request that CMS perform eligibility and enrollment functions through utilization of the federal marketplace IT solution. A federally facilitated marketplace was established and operated in a state that did not elect to establish a state-based marketplace. Federally facilitated partnerships are a variation of a federally facilitated marketplace in which CMS establishes and operates the marketplace and states assist CMS in carrying out certain functions of the marketplace, such as plan management and consumer assistance.

[2]We did not include U.S. territories, such as the Virgin Islands, in the scope of this review.

[3]States that did not complete a survey were Arkansas, Kansas, New Jersey, and Ohio.

answers to every question. We did not independently verify the data the states provided in each case, but we did, in selected cases, compare them to equivalent CMS data. We also relied on CMS-provided data, rather than survey data, in most cases because we received more up-to-date and complete information from CMS. The survey was administered between September 30, 2014, and November 19, 2014. The status of state marketplace types is as of the end of the second enrollment period—which ended on February 15, 2015.

Several weeks before the survey period began, we notified recipients that they would be receiving it and confirmed that they were the appropriate state contacts. We also followed up with non-respondents several times before the survey period ended.

In developing the surveys, we took steps to ensure the accuracy and reliability of responses. We pre-tested the survey with marketplace and Medicaid officials from seven states to ensure that the questions were clear, comprehensive, and unbiased, and to minimize the burden the questionnaire placed on respondents.

To determine how states have used federal funds to establish, support, and connect to health insurance marketplaces and the overall status of their development and operation, we reviewed CMS guidance regarding federal funding and development for marketplaces such as the marketplace grant funding opportunity announcement, instructions for marketplace reporting,[4] guidance for marketplace and Medicaid IT systems,[5] and blueprint guidance for approval of state marketplace types. We also reviewed best practices for IT investment management and managing program costs.[6] We then reviewed CMS funding and status

[4]Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, *Progress Reporting Instructions for Cooperative Agreements to Support Establishment of State-Operated Health Insurance Exchanges* (June 2012).

[5]Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Guidance for Exchange and Medicaid Information Technology (IT) Systems, Version 2.0* (May 2011), and *Supplemental Guidance on Cost Allocation for Exchange and Medicaid Information Technology (IT) Systems, Questions and Answers* (Oct. 5, 2012).

[6]GAO, *Information Technology Investment Management: A Framework for Assessing and Improving Process Maturity*, Version 1.1, GAO-04-394G (Washington, D.C.: March 2004), and *GAO Cost Estimating and Assessment Guide: Best Practices for Developing and Managing Capital Program Costs*, GAO-09-3SP (Washington, D.C.: March 2009).

documentation, including notices of grant awards and state IT spending and status summaries. We also analyzed state survey responses on costs and development status, including state documentation on federal grant and Medicaid costs.

To assess the reliability of CMS's data on state-reported IT spending to establish, support, and connect to marketplaces, we assessed the reliability of the systems used to collect the information. We asked officials responsible for entering and reviewing the grants information a series of questions about the accuracy and reliability of the data. Among the sources of data used for our study, we reviewed a spreadsheet compiled by CMS Center for Consumer Information and Insurance Oversight officials that contained state-reported grant funding data and marketplace IT project status information drawn from three separate information systems: CMS's On-Line Data Collection System,[7] Grant Solutions,[8] and the Payment Management System.[9] The spreadsheet was a consistent source of information that reflected the same cost factors for all states as of March 2015.[10] Specifically, the spreadsheet tracked, among other things, the type and total amount of grant funding provided and available to each state, as well as the time period for expending those funds. We also reviewed the data to determine if there were any outliers and other obvious errors in the data. For any anomalies in the data, we followed up with CMS to either understand or correct those anomalies. We determined that the data were sufficiently reliable for our purposes and noted any limitations in our report. While our report

[7]The On-Line Data Collection System is the system of record for grant reporting and offers a snapshot of overall progress that has been self-reported by the state grantee. State grantees use the system to submit progress reports that contain budget reports and progress reports on the completion of program requirements. These reports were submitted by state grantees on a monthly and semi-annual basis.

[8]Grant Solutions is a system that allows CMS to conduct business from pre-award to post-award of grants. It is the primary means of communication between state grantees and the CMS grants management and program staff. It allows CMS State Officers to review state grantee requests, prepare recommendation memorandums for post-award requests, and monitor state grantee documentation uploads.

[9]The Payment Management System allows CMS to pay state grantees awarded funds. State grantees use the system to draw down federal grant funds and submit federal financial reports.

[10]According to CMS, this data could lag about two months from states' actual expenditures because states had to close and reconcile their accounting data.

discusses state-reported IT spending based on CMS data, we did not verify the accuracy of the data states reported to CMS.

We also reviewed our recent report on Medicaid funding for eligibility IT system changes,[11] which addressed state-reported Medicaid expenditure data from CMS-64—a form that states complete quarterly to obtain federal reimbursement for services provided or administrative costs incurred. We updated our review of states' reported expenditures, beginning with the quarter ending June 30, 2011, the first quarter for which 90/10 funds were available to states, through the quarter ending December 31, 2014.[12] To determine the reliability of the CMS-64 data, we reviewed related documentation and our prior records of interviews with CMS officials describing how these data are collected and processed; we also examined other research that has used these data to report state expenditures.[13] We determined that the data we used in this report were sufficiently reliable and noted any limitations in our report.

In addition, we reviewed and analyzed CMS documentation of states' marketplace status and operation progress and challenges to summarize the status of marketplaces. We reviewed states' survey responses regarding changes in and the status of developing and operating their marketplace IT solutions. We also reviewed CMS state marketplace operational status reports as of February 2015 and the CMS State Exchange Resource Tracking System as of April 2015. We did not independently verify the accuracy of CMS's data on states' operational status. We also obtained input from CMS regarding funding and status of marketplaces through interviews with knowledgeable officials.

To determine CMS's and states' roles in overseeing these state IT projects, we analyzed applicable federal laws and regulations, CMS

[11]GAO, *Medicaid: Federal Funds Aid Eligibility IT System Changes, but Implementation Challenges Persist,* GAO-15-169 (Washington, D.C.: Dec. 12, 2014).

[12]States submit all Medicaid data electronically and must attest to their completeness and accuracy. These data are preliminary in nature, in that they are subject to further review, and are likely to be updated as states have up to 2 years after incurring costs to submit claims for 90/10 funding.

[13]Our prior work related to state reporting on the CMS-64 noted that reviewed states did not correctly report program integrity-related overpayments collected by the state on the CMS-64. See GAO, *Medicaid: CMS Should Ensure That States Clearly Report Overpayments*, GAO-14-25 (Washington, D.C.: Dec. 6, 2013).

marketplace policies and guidance, documentation on applicable CMS marketplace roles and responsibilities and state marketplace governance structures, state survey responses regarding their governance structures, and state survey responses and ratings regarding the effectiveness of CMS guidance, oversight, and related systems.

We also compared CMS's policies and procedures to best practices included in GAO's IT investment management framework and to the Project Management Institute's *A Guide to the Project Management Body of Knowledge (PMBOK® Guide)* to determine whether CMS had roles and responsibilities clearly documented and communicated in its policies and procedures.[14] Further, we reviewed CMS's funding oversight processes and compared them to relevant sections of GAO's IT investment management framework to determine if CMS followed best practices for overseeing IT investments. We used our survey results to describe how the states viewed CMS's oversight and guidance in regard to the marketplace-related IT projects.

We also reviewed CMS's Enterprise Life Cycle guidance for systems development reviews and reports from states' operational readiness reviews from August and September 2013 to assess the extent to which CMS followed its process. In addition, we reviewed state survey responses and other state-provided documents to determine states' marketplace oversight roles. Further, we interviewed CMS officials responsible for the oversight and implementation of the state marketplaces to obtain their perspective on their marketplace roles.

To describe IT challenges encountered in developing and operating the marketplace and connected systems as well as lessons learned from these efforts, we analyzed state survey responses related to challenges, lessons learned, and best practices identified by state officials and documentation such as CMS meeting presentations. For the state surveys, we identified a variety of marketplace-related IT challenges based on our analysis of CMS and state documentation and interviews, and grouped these challenges according to several broad areas. State-based marketplace challenges were divided into five areas in the survey (project management and oversight, marketplace IT solution design,

[14]GAO-04-394G and *Project Management Institute, Inc., A Guide to The Project Management Body of Knowledge* (*PMBOK® Guide*), Fifth Edition, (Newton Square, Pa.: 2013). "PMBOK" is a trademark of the Project Management Institute, Inc.

marketplace IT solution development, resource allocation and distribution, and marketplace implementation and operation), while federally facilitated challenges were divided into two areas (project management and oversight and system design and development) based on the IT work each marketplace performs. For the purposes of our report, we consolidated the marketplace IT solution design and marketplace IT solution development challenge areas for the state-based marketplaces.

In both the state-based and federally facilitated versions of our survey, we asked states to rate their experience with each of these identified challenges using a 5-point scale with the following response options: very great challenge, great challenge, moderate challenge, somewhat of a challenge, or little or no challenge. In our report, we combined the very great and great state ratings. We then analyzed states' ratings of challenges and using counts of the "very great" and "great" responses, we selected the greatest (i.e., the top two) challenges from each area for discussion in this report. If a challenge area applied to both states using a state-based marketplace and states with a federally facilitated marketplace, the greatest challenges from each marketplace type were selected.

Further, we asked each state to identify whether they had identified best practices or lessons learned within each challenge area of our survey, and to include specific examples of those best practices and lessons. We reviewed all written survey responses regarding states' lessons learned to ensure these lessons were appropriately categorized into each identified challenge area. Based on our qualitative analysis of the states' survey responses, we identified the number of states that provided lessons learned and then provided examples of the best practices or lessons learned that related to the greatest challenges in each area, if there were any. We also interviewed CMS and state officials responsible for the oversight and implementation of the state marketplaces to determine what the agency did to identify and share states' challenges, best practices, and lessons learned.

We conducted this performance audit from April 2014 to September 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II: Health Insurance Marketplace Grant Funding and State-Reported Expenditures

To help states establish a marketplace, the Patient Protection and Affordable Care Act (PPACA) authorized the Department of Health and Human Services (HHS) to award federal exchange (now referred to as marketplace) grants for planning and implementation activities, as well as for the first year of a marketplace's operation. States were required to report marketplace grant spending, including IT spending, to HHS's Centers for Medicare & Medicaid Services (CMS).[1]

The following table shows the amount of marketplace grants awarded;[2] the amount of grants spent or drawn down;[3] the amount authorized for IT; and the amount spent for IT as of March 2015, for the four different marketplace types—state-based, state-based using the federal marketplace IT solution, federally facilitated, and federally facilitated partnership marketplaces.

[1]Within the Department of Health and Human Services, the Centers for Medicare & Medicaid Services Center for Consumer Information and Insurance Oversight officials are responsible for administering and overseeing the marketplace grant program.

[2]The amount awarded includes awards for all marketplace grants (i.e., Planning, Early Innovator, and Establishment Level 1 and Level 2 grants) as of December 2014. PPACA prohibits the awarding of establishment grants for marketplace after January 1, 2015. HHS has clarified, however, that states seeking federal funding to establish marketplace could be awarded such funds until December 31, 2014.

[3]CMS provided the amounts spent for states with a state-based marketplace, 6 states with a federally facilitated partnership, and 2 states with a federally facilitated marketplace operating a Small Business Health Options Program (SHOP) marketplace, as of March 12, 2015. We used CMS data on the amount drawn down, or transferred from CMS's account to the state's account, by 25 states with a federally facilitated marketplace and 1 federally facilitated partnership state, as of October 2014.

Table 8: Health Insurance Marketplace Grant Funding and State-Reported Expenditures as of March 2015

State	Marketplace grant funding awarded[a]	Amount spent or drawn down[b]	Amount authorized for IT[c]	Amount spent for IT[c]	Amount of award returned[d]
State-Based Marketplace					
California	$1,065,683,056	$709,586,314	$324,291,051	$254,679,837	$470,106
New York	575,079,804	310,813,717	191,955,956	118,618,902	-
Washington	302,333,280	208,008,002	173,447,754	116,991,593	-
Kentucky	289,303,526	181,959,022	176,283,857	107,774,666	530,912
Massachusetts	233,803,787	157,941,600	95,029,024	61,824,931	-
Hawaii	205,342,270	119,017,222	127,954,826	89,466,694	-
Vermont	199,718,542	122,325,496	118,261,146	71,007,937	-
District of Columbia	195,141,151	93,270,792	79,800,641	53,869,056	-
Maryland	190,130,143	141,157,242	86,759,499	86,988,256	-
Minnesota	189,363,527	82,478,292	75,820,343	29,357,263	-
Colorado	184,986,696	134,904,604	101,492,717	69,641,979	-
Connecticut	175,870,421	147,481,172	116,417,689	76,832,735	-
Rhode Island	152,574,494	86,766,775	81,871,006	51,567,415	20,019
Idaho	105,290,745	50,477,275	55,317,610	35,770,590	-
Subtotal	4,064,621,442	2,546,187,525	1,804,703,119	1,224,391,854	1,021,037
State-Based Marketplace using the federal marketplace IT solution					
Oregon	305,206,587	293,166,188	78,777,499	78,489,963	-
New Mexico	123,281,600	57,107,864	79,772,448	34,095,639	-
Nevada	101,001,068	61,457,310	61,066,015	37,484,596	-
Subtotal	529,489,255	411,731,362	219,615,962	150,070,198	0
Federally Facilitated Partnership					
Illinois	164,902,306	51,176,583	81,072,923	8,839,799	71,412
Arkansas	158,039,122	34,607,568	1,839,023	1,607,023	44,928
Iowa	59,683,889	44,291,394	20,882,919	20,907,431	1,837,625
Michigan	41,517,021	933,779			9,915,298
Delaware	22,236,059	15,648,086	245,095	57,393	-
West Virginia	20,832,828	12,473,579	426,333	394,163	-
New Hampshire	15,919,960	8,495,239	0	0	-
Subtotal	483,131,185	167,626,228	104,466,293	31,805,809	11,869,263
Federally Facilitated Marketplace					
North Carolina	87,357,314	13,836,843	77,879,326	10,488,801	73,520,471
Oklahoma	55,608,456	897,980	54,608,456	0	54,710,476
Mississippi[e]	42,712,661	30,817,357	27,598,656	20,798,404	329,875

State	Marketplace grant funding awarded[a]	Amount spent or drawn down[b]	Amount authorized for IT[c]	Amount spent for IT[c]	Amount of award returned[d]
Wisconsin	39,057,947	1,025,565	38,058,074	61,357	38,032,382
Pennsylvania	34,832,212	1,008,488			31,882,212
Kansas	32,537,465	1,010,390	31,537,465		31,527,075
Arizona	30,877,097	16,141,598	12,971,889	12,568,993	-
Missouri	21,865,716	2,279,248	17,428,933	833,725	19,586,468
Virginia	15,862,889	1,778,255	158,487	77,989	-
Alabama	9,772,451	3,487,666	2,203,114	29,835	6,284,785
Tennessee	9,110,165	2,552,497			6,549,951
New Jersey	8,897,316	1,183,490	3,178,300	0	7,713,826
Indiana	7,895,126	6,917,054	950,658	950,658	337,367
South Dakota	6,879,569	1,846,528	1,859,847	735,001	3,795,085
Maine	6,877,676	999,841			5,877,835
Nebraska	6,481,838	2,392,066	2,275,000	195,849	942,000
Utah[e]	6,407,987	1,338,434	2,699,600	757,960	26,323
Florida	1,000,000	0			1,000,000
Georgia	1,000,000	989,730			10,270
Montana	1,000,000	999,971			29
North Dakota	1,000,000	996,016			3,984
Ohio	1,000,000	918,095			81,905
South Carolina	1,000,000	304,996			695,004
Texas	1,000,000	96,425			903,575
Louisiana	998,416	29,391			969,025
Wyoming	800,000	578,652			-
Alaska	0	0			0
Subtotal	431,832,301	94,426,576	273,407,805	47,498,572	284,779,923
Total	**5,509,074,183**	**3,219,971,691**	**2,402,193,179**	**1,453,766,433**	**297,670,223**

Source: CMS data. | GAO-15-527

Notes: Because these data are a compilation of multiple grants, some of which may no longer be available for state spending, and due to differences in reporting source and timing, numbers do not sum across columns. In some cases, the amount spent for IT was greater than the amount authorized for IT because states were allowed to re-budget funds.

[a]Marketplace grant awards are as of December 2014 because no grants were awarded after December 31, 2014. The amount awarded includes awards for all marketplace grants (i.e., Planning, Early Innovator, and Establishment Level 1 and Level 2 grants).

[b]CMS provided the amounts spent for states with state-based marketplaces, 6 states with a federally facilitated partnership, and 2 states with a federally facilitated marketplace operating a Small Business Health Options Program (SHOP) marketplace, as of March 12, 2015. We used CMS data on the amount drawn down, or transferred from CMS's account to the state's account, by 25 states with a federally facilitated marketplace and 1 federally facilitated partnership state, as of October 2014. According to CMS, these data could lag about 2 months behind states' actual expenditures

because states had to close and reconcile their accounting data. Further, some states were 2 or more months late in reporting.

[c]The amounts authorized for IT and spent for IT are as of March 26, 2015. According to CMS, these data could lag about 2 months behind states' actual expenditures because states had to close and reconcile their accounting data. Further, some states were 2 or more months late in reporting. According to CMS officials, federally facilitated states were not provided IT marketplace grant funds unless these states had planned to be a state-based marketplace. In June 2015, CMS officials within the Center for Consumer Information and Insurance Oversight (CCIIO) told us that with the exception of Arkansas, Mississippi, and Utah, states with a federally facilitated marketplace or federally facilitated partnership are no longer authorized to spend marketplace grant funding for IT because they are no longer investing in the long-term creation of a modern eligibility system to be shared between a state-based marketplace and the state Medicaid program. According to CMS officials, states that initially planned for, but did not pursue a state-based marketplace were required to return or re-budget IT funds. For example, according to a state official from Wisconsin, the state returned Early Innovator grant funds in January 2012.

[d]The amount returned is as of October 2014. According to CCIIO officials, the amounts returned were based on a manual entry process performed by HHS officials within the Office of Finance. We did not verify the amounts returned, and CMS indicated that the report provided to GAO did not include all amounts returned.

[e]Two states, Mississippi and Utah, who implemented a SHOP-only marketplace, had a federally facilitated marketplace for individuals. For the purposes of this report, the IT spending by Mississippi and Utah is included in the amount of IT spending by states with a federally facilitated marketplace.

Appendix III: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

AUG 0 4 2015

Valerie Melvin
Director, Information Management and Technology Resources Issues
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Melvin:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*State Health Insurance Marketplaces: CMS Should Improve Oversight of State Information Technology Projects*" (GAO-15-527).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: STATE HEALTH INSURANCE MARKETPLACES – CMS SHOULD IMPROVE OVERSIGHT OF STATE INFORMATION TECHNOLOGY PROJECTS (GAO-15-527)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report on the state health insurance Marketplaces. HHS is committed to overseeing states' establishment and operation of Marketplaces as part of the Patient Protection and Affordable Care Act (ACA). As the GAO noted, the majority of SBM states provided positive ratings of the clarity, completeness, and timeliness of HHS's communication, and were generally satisfied with the level of HHS oversight and assistance.

The Marketplaces play a critical role in achieving one of the ACA's core goals: reducing the number of uninsured Americans by providing affordable, high-quality health insurance. During Open Enrollment for the 2015 coverage year, about 11.7 million Americans selected plans through the Marketplaces. On March 31, 2015, about 10.2 million consumers had "effectuated" coverage, which means those individuals paid for Marketplace coverage and still had an active policy on that date. As of March 31, 2015, effectuated enrollment was 2.9 million for the State-based Marketplaces (SBMs), including those SBMs that use the HealthCare.gov eligibility and enrollment platform.

Section 1311 of the ACA outlines federal requirements for establishing Marketplaces and makes available grant funding for states to fulfill those responsibilities. These include, but are not limited to, establishing a governance structure, developing and implementing stakeholder outreach and educational campaigns (including a call center), certifying qualified health plans (QHPs), determining eligibility for QHP enrollment and financial assistance, and creating Marketplace information technology (IT) solutions and system functionality. To assist states in implementing the ACA's requirements, HHS has awarded funding, provided technical assistance, and conducted monitoring of the SBMs. HHS has been following the HHS Grants Policy Statement, along with applicable federal statutes and regulations, in administering the 1311 funding to the states.

During the approval processes for SBMs prior to the first open enrollment for Marketplaces in October 2013, HHS worked with states so they could successfully allow consumers and small employers to compare, select and purchase health insurance plans. This included states meeting key functional requirements and milestones set by HHS, and developing systems and processes, as needed, to enroll consumers into health coverage in a timely manner. HHS provided additional follow-up to states that did not meet milestones, and granted conditional approvals if states were able to build workarounds and put manual processes in place to allow individuals to submit applications and enroll in health coverage during the first Open Enrollment period. Due to the tight establishment and implementation timeframes for SBM states, some SBMs deferred automating functionality and utilized operational workarounds to provide their consumers the best possible eligibility and enrollment experience. Even with the challenges of building and setting up systems within a compressed timeframe, nearly 2.2 million (2,153,421) persons

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: STATE HEALTH INSURANCE MARKETPLACES – CMS SHOULD IMPROVE OVERSIGHT OF STATE INFORMATION TECHNOLOGY PROJECTS (GAO-15-527)

selected a Marketplace plan during the first three months of the initial open enrollment period, including almost 1 million (956,991) consumers in SBMs.[1]

HHS has promulgated program integrity regulations to safeguard taxpayer funds and is focused on continuous improvement of SBM management and operations through an array of effective technical assistance activities to SBMs. These improvement efforts have included implementation of oversight and accountability measures. Improvements have also included new practices based on our experiences as SBMs engaged in their initial years of operation. Those efforts include:

1. **Continuous monitoring and assistance for SBMs.** HHS has conducted and continues to conduct weekly meetings with SBMs to discuss IT development, customer service issues, Medicaid eligibility integration, operational issues, issuer relationships, and consumer and market trends and dynamics. Additionally, HHS holds bi-weekly meetings with the SBM Chief Executives to discuss a variety of business, budget, and regulatory issues. HHS will also continue to conduct on-site visits to each SBM to examine infrastructure, operations, budget, marketing, staffing, and key business functions. Technical assistance to states is ongoing.

2. **Prioritize and coordinate Marketplace requirements and deliverables through systems integrators for the SBMs.** As is the case with any large operation that serves many consumers, HHS and the SBMs continue to prioritize program functionality to enhance the user experience, including managing customer traffic and the call center customer experience, and increasing system flexibility, scalability, and efficiency. Systems integrators provide program expertise and coordinate the work between the Marketplace and its contractors to improve accountability, resource efficiency, and prioritization of deliverables. HHS encourages SBMs to follow the best practice of using a systems integrator, which is now a consistent practice across the SBMs. HHS will continue to require that SBMs establish clear, concise business requirements; set measurable, incremental milestones; and prioritize goals.

3. **Competitive selection and strict management of contractors and vendors.** SBMs are accountable for managing vendor and contractor performance, according to federal and state law. SBMs typically select vendors from a competitive procurement process with transparent performance expectations, performance service-level agreements, and key criteria for vendor selection. HHS continues to aid SBMs in improving their vendor selection process, establishing better contract administration practices, and refining contractor monitoring activities, so that SBMs are fulfilling the terms and conditions of federal grants and contractors are fulfilling their respective requirements. Contracts

[1] ASPE Issue Brief, Health Insurance Marketplace: January Enrollment Report, For the period: October 1, 2013 – December 28, 2013; January 13, 2014;
http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib_2014jan_enrollment.pdf

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: STATE HEALTH INSURANCE MARKETPLACES – CMS SHOULD IMPROVE OVERSIGHT OF STATE INFORMATION TECHNOLOGY PROJECTS (GAO-15-527)

utilizing these best practices emphasize performance and establish strict deliverables to track continued progress and mitigate cost overruns.

4. **Require the SBMs to report financial and programmatic information**. SBMs must submit to HHS a State-based Marketplace Annual Reporting Tool (SMART), which provides a compilation of key regulatory reporting requirements. The SMART builds on grants management activities and strengthens the oversight and monitoring activities implemented by HHS and is instrumental in monitoring the transition of states from grant funding to self-sustainability. The SMART, which is due to HHS on an annual basis starting in April 2015, is run in accordance with applicable laws and regulations (e.g., Program Integrity Rule). The SMART includes requirements for financial statements, reports on eligibility determination errors, accessibility of information, incidences of fraud and abuse, performance monitoring data, and consumer satisfaction data. In addition, as part of the SMART, SBMs must engage an external independent auditing entity to conduct an annual financial and programmatic audit. The SMART confirms that a SBM has completed its reporting requirements and assists HHS in evaluating and monitoring the financial and programmatic status of SBMs going forward.

HHS used a structured and cross-component approach to oversight of Marketplaces and established roles and responsibilities to help oversee Marketplace activities. HHS provided guidance to states and streamlined state communications. All communications to the states were coordinated through a State Officer (SO).

HHS is committed to continued support of states as they work to strengthen their Marketplaces, including enhancements, maintenance, and operations of their IT systems.

GAO Recommendation

The Government Accountability Office (GAO) recommends that the Administrator of the Centers for Medicare & Medicaid Services (CMS) clearly document, define, and communicate to all state marketplace officials and stakeholders the roles and responsibilities of those CMS officials involved in overseeing state marketplaces in a comprehensive communication management plan.

HHS Response

HHS concurs with GAO's recommendation. As the GAO noted, the majority of SBM states provided positive ratings of the clarity, completeness, and timeliness of HHS's communication, and were generally satisfied with the level of HHS oversight and assistance. HHS has streamlined communications to states by appointing a SO to each state to serve as a primary point of contact within. The SO is not only a technical expert, but also develops and monitors state action plans and provides states necessary guidance and assistance. HHS communicates to SBM officials and stakeholders the many roles and responsibilities of HHS officials involved in overseeing SBMs through the SO. HHS documents these responsibilities in several resources, including Standard Operating Procedures (SOPs) and weekly newsletters to state officials. HHS also coordinated communications across agencies through a workgroup which was responsible for monitoring and

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: STATE HEALTH INSURANCE MARKETPLACES – CMS SHOULD IMPROVE OVERSIGHT OF STATE INFORMATION TECHNOLOGY PROJECTS (GAO-15-527)

tracking communications to states and other stakeholders across HHS organizations involved in state engagement activities.

GAO Recommendation
The Government Accountability Office (GAO) recommends that the Administrator of the Centers for Medicare & Medicaid Services (CMS) ensure that all HHS senior executives from IT and business units who are involved in the establishment of state marketplaces IT projects review and approve funding decisions for these projects.

HHS Response
HHS concurs with GAO's recommendation. HHS already includes senior executives from IT and business units in funding decisions for state marketplace IT projects. To conduct a thorough review of state funding applications, HHS created a multi-disciplinary team that includes representatives from throughout HHS who review the projects based on their areas of expertise. This team is responsible for identifying the IT costs requested in the projects to determine if the costs are reasonable, given the state's IT approach and status of its Marketplace activities, and to identify any questions or risks relating to the funding request. All final funding decisions are then made by HHS senior executives.

GAO Recommendation
The Government Accountability Office (GAO) recommends that the Administrator of the Centers for Medicare & Medicaid Services (CMS) ensure that all states have completed all testing of marketplace system functions prior to releasing them into operation.

HHS Response
HHS concurs with GAO's recommendation. HHS will continue to follow its guidelines to determine if state Marketplace system functions are ready for release. To obtain timely Federal grant funding approval of a state Marketplace's IT development projects, a state must show that it has largely completed the objectives of each phase through a formal review process before proceeding to the next phase. HHS continues to work closely with the SBMs to improve their systems and will continue to verify that SBMs' system requirements are met.

Appendix IV: Comments from the District of Columbia Health Benefit Exchange Authority

August 4, 2015

Valerie C. Melvin
Information Technology Team
U.S. Government Accountability Office

Dear Ms. Melvin:

I appreciate the opportunity to review the Government Accountability Office (GAO) draft report GAO-15-527 excerpts for the District of Columbia and to provide you with feedback. We do not agree with some of the characterizations in the report.

As background, the District's online health insurance marketplace DC Health Link, opened for business on time on October 1, 2013 with functioning individual and small business marketplaces. Although we were the last state to start the IT build, we were recognized as one of only four states to open on time and stay open. Our small business marketplace (SHOP) offered employer and employee choice and for the first time, small businesses have the purchasing power that large employers have had for years.

DC Health Link has served more than 138,000 people. More than 23,000 District residents have purchased private health insurance coverage through DC Health Link's marketplace for individuals and families, more than 95,000 District residents have been determined eligible for Medicaid, and nearly 20,000 people have been covered through DC Health Link's small business marketplace (this figure includes approximately 16,000 Congressional staff and Members of Congress).

In the first year of operation, we cut the District's uninsured rate by an estimated 43%. Our success was not accomplished alone. It truly took a village with support of policymakers, strong commitment of sister agencies, and many partners including navigator and assister organizations, brokers, as well as business partners including the Restaurant Association Metropolitan Washington, Greater Washington Hispanic Chamber of Commerce, and the DC Chamber of Commerce.

Below addresses draft Table 5 called "Operational Status of the 14 State-Based Marketplaces by Functional Categories as of February 2015." We concur with the characterizations for Financial Management and IRS reporting. However, we do not agree with the characterization that DC is only partially complete for Eligibility/Enrollment and Hub Services.

IRS Reporting File Submissions

We concur with GAO's report which finds partial completion of IRS reporting requirements. However, the reason for partial completion is due to the late guidance from the IRS that prevented us from providing reports in the format requested.

1225 Eye Street NW, 4th Floor, Washington, DC 20005

IRS reporting encompasses H41 annual reporting related to IRS Form 1095-A and H36 monthly reporting. DC Health Benefit Exchange Authority (HBX) had timely annual reporting and is working toward successful monthly reporting in the IRS required format.

HBX was timely in issuing 1095-As and in H41 annual reporting on 1095-A forms. Required paper copies were mailed to DC Health Link customers. Additionally, HBX provided consumers with access to PDF 1095-As and corrected 1095-As via a secure webpage. HBX developed a process to handle reports of errors in 1095-A reporting. Very few errors were found. HBX corrected errors that were reported by insurance carriers and issued corrected 1095-As. Consumer-reported errors with verification of error in most cases were corrected the same day.

The IRS H36 monthly reporting requirement initially presented a challenge. The commercial off-the-shelf products (COTS products) HBX uses were designed prior to detailed IRS guidance. The COTS products were not designed to retain data on changes in customers' circumstances that occur throughout the year. Additionally, the products were not designed to allow reporting in the format the IRS requires. The IRS guidance on implementing monthly reporting requirements was not available until May 2014. The IT development work for 2014 was planned in 2013 before that guidance was available. Software was already in production.

In response to the new IRS guidance, we took steps to ensure that our system of record had change in circumstance data for IRS reporting purposes. On the issue of IRS acceptable format for the data, we immediately informed the IRS that the COTS product does not have the IRS format. We sought an alternate approach where we would send all of the data to IRS and IRS could apply its own logic to our data in order to group it in the way it wants the data to be grouped. Unfortunately, our proposed alternate approach was not accepted by IRS.

To ensure H36 monthly reporting in a format newly required by the IRS, we had to build the functionality specifically for that purpose. We have successfully submitted the H36 monthly report with the 2014 data. H36 monthly reports with 2015 data and subsequent monthly reports are planned to begin August 2015.

Hub Services

The draft report labels DC as having "partially complete" hub services, which GAO defines as had not been implemented, because testing and development had not been completed, or because attestations had not been received. An email from GAO staff further clarified that this characterization for DC is based on only one factor, redetermination.

Since the launch of DC Health Link we have successfully used multiple services offered by the federal hub to verify Social Security numbers, citizenship, lawful presence, income, and other eligibility factors. The Accenture Independent Verification and Validation team attested that DC Health Link successfully completed end-to-end testing prior to go-live in October of 2013. During federal hub outages, particularly during the first open enrollment period, DC required documentation of any eligibility factors that could not be verified electronically.

These services continue to function as expected in our eligibility determination process, and we regularly monitor reports of the calls we are making to the federal hub. Consequently, it is more appropriate to characterize DC as fully complete.

Additionally, the only factor GAO staff used to label DC as "partially complete" is redeterminations. DC's redeterminations are automated using synchronous services. We received permission to not deploy batch redeterminations. The Renewal and Redetermination Verification service (RRV) set up to allow batch hub service calls for annual QHP renewals for plan year 2015 was not available for testing until September 30, 2014. This timing was too late to test the service given our release schedule for other functionality required for 2015 renewals. DC requested and received a waiver that allowed us to use the synchronous services for 2015 renewals. We are enhancing our renewal batch jobs for 2016 renewals and have already begun testing the RRV service for 2016.

The proper characterization for Hub Services is fully complete and the report should reflect that.

Eligibility and Enrollment

The draft report labels DC as having a "partially operational" status which GAO defined as "if the functions were operational but did not work as intended." An email from GAO staff further clarified that this characterization for DC is based on solely the following two factors: reporting (Individual Market) and redetermination. The "partially operational" characterization is misleading and unsupported given that small businesses and individuals shop and enroll in affordable quality private health insurance coverage every day using the District's IT platform, DCHealthLink.com. The proper characterization for eligibility and enrollment is "fully operational."

A lack of one report to cause a label of "partially operational" for a critical area such as eligibility and enrollment is misleading and a disservice to the credibility of the GAO research and reports.

Furthermore, as discussed above, HBX successfully renewed customers using an automated non-batch redeterminations process. Because the batch renewal functionality became available late in September 2014 and given our release schedule, to mitigate risk, HBX received permission from CMS to use an automated non-batch redetermination process. The methodology that allows GAO staff to use one functionality in two different categories (2 of 4) measuring "State Market Place IT Status" undermines the conclusions in the report.

We strongly believe that the GAO should be looking at automated functionality that actually results in eligibility and enrollment of individuals and families. When we opened for business, our customers were able to shop and enroll in qualified health plans using DCHealthLink.com. We opened for business with basic core functionality and have been adding new functionality since.

Thousands of our customers use DCHealthLink.com to shop and to enroll on-line successfully in affordable private health insurance coverage. Consequently, the appropriate characterization for DC is "fully operational."

GAO Research Timing

GAO initiated the research for this report with an extensive survey for state-based marketplaces to complete during the two months leading up to the second open enrollment period under the ACA – two of the busiest months for staff. HBX strongly urges GAO to consider the timing of future work in the context of health insurance marketplaces' core programmatic mission of providing access to affordable, quality health coverage for individuals, families, small businesses and their employees.

Also, HBX, similar to other state-based marketplaces, is subject to many local and federal oversight audits. With limited staff it is a significant resource pressure to be subject to multiple requests and/or audits at the same time. In addition to oversight audits, HBX also receives GAO government requests. Requests from the GAO at times include requests from different subject areas. It would be very helpful and allow HBX to be more efficient with limited resources if the GAO coordinated its own work across divisions and with other federal oversight and audit entities. That coordination could help reduce the significant burden in responding to multiple, overlapping requests simultaneously, but could also lead to the narrowing of duplicative work across oversight agencies.

Conclusion

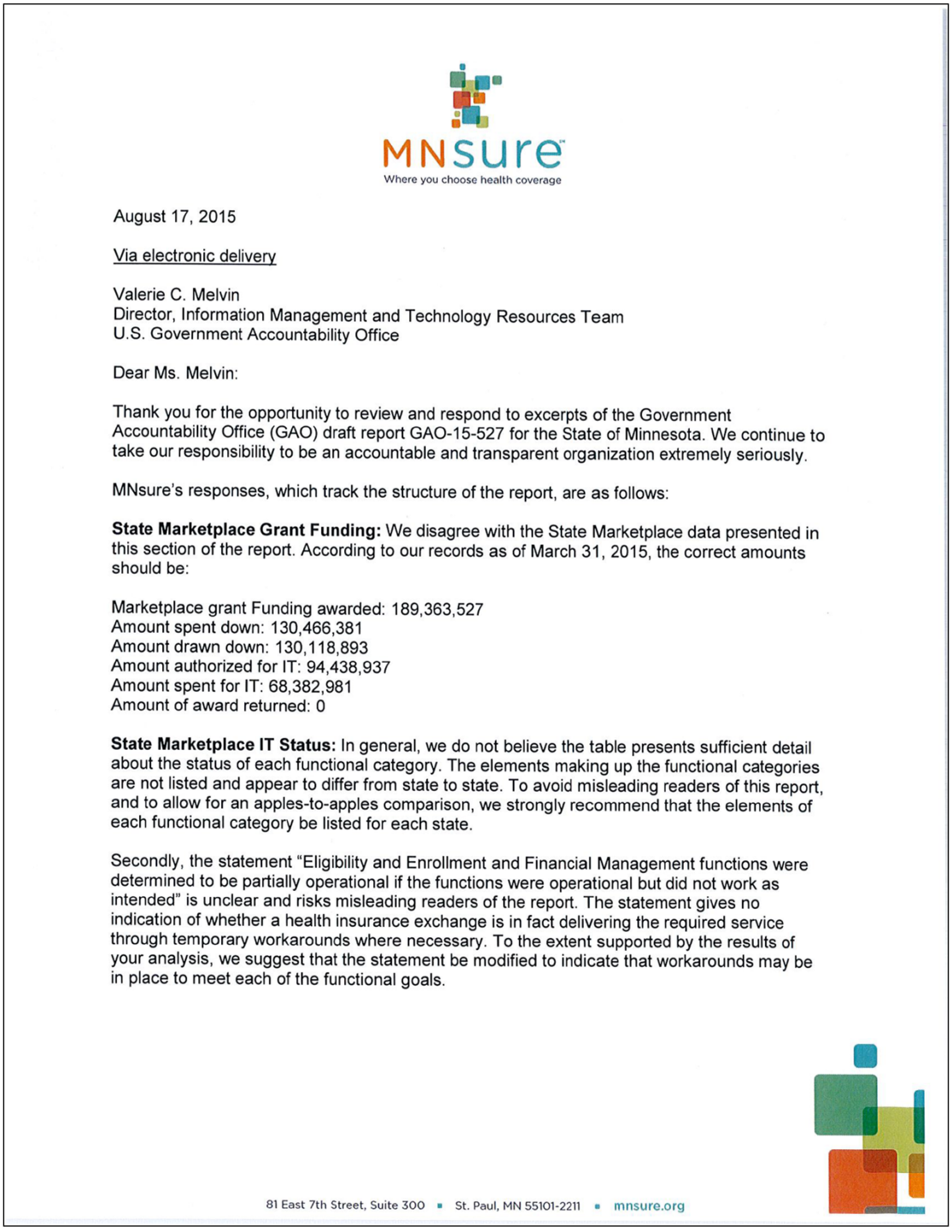
HBX's mission is to ensure that every person who lives or works in the District and the District's small businesses have access to quality affordable health insurance based on real competition by the insurance industry for the benefit of insurance consumers.

We appreciate the work of the GAO and appreciate the opportunity to provide this feedback.

Very truly yours,

Mila Kofman, J.D.
Executive Director
DC Health Benefit Exchange Authority

Appendix V: Comments from MNsure



MNsure
Where you choose health coverage

August 17, 2015

Via electronic delivery

Valerie C. Melvin
Director, Information Management and Technology Resources Team
U.S. Government Accountability Office

Dear Ms. Melvin:

Thank you for the opportunity to review and respond to excerpts of the Government Accountability Office (GAO) draft report GAO-15-527 for the State of Minnesota. We continue to take our responsibility to be an accountable and transparent organization extremely seriously.

MNsure's responses, which track the structure of the report, are as follows:

State Marketplace Grant Funding: We disagree with the State Marketplace data presented in this section of the report. According to our records as of March 31, 2015, the correct amounts should be:

Marketplace grant Funding awarded: 189,363,527
Amount spent down: 130,466,381
Amount drawn down: 130,118,893
Amount authorized for IT: 94,438,937
Amount spent for IT: 68,382,981
Amount of award returned: 0

State Marketplace IT Status: In general, we do not believe the table presents sufficient detail about the status of each functional category. The elements making up the functional categories are not listed and appear to differ from state to state. To avoid misleading readers of this report, and to allow for an apples-to-apples comparison, we strongly recommend that the elements of each functional category be listed for each state.

Secondly, the statement "Eligibility and Enrollment and Financial Management functions were determined to be partially operational if the functions were operational but did not work as intended" is unclear and risks misleading readers of the report. The statement gives no indication of whether a health insurance exchange is in fact delivering the required service through temporary workarounds where necessary. To the extent supported by the results of your analysis, we suggest that the statement be modified to indicate that workarounds may be in place to meet each of the functional goals.

81 East 7th Street, Suite 300 ▪ St. Paul, MN 55101-2211 ▪ mnsure.org

The following are specific comments on the functional categories

Eligibility and Enrollment: We generally agree with the operational status indicator for this functional category. However, as indicated above we strongly suggest that the status include a qualifier that state-based exchanges may be performing some functions via workarounds. For example, although MNsure sends automated notices for most consumers, due to system limitations we were unable to issue automated notices to some consumers renewing coverage. In these cases, we created and disseminated manual notices for these consumers.

Financial Management: We generally agree with the operational status indicator for this functional category. However, we do not believe that one of the functions (a state-operated reinsurance program) should be included as part of this evaluation. Because all state-based marketplaces have discretion in operating a reinsurance program, we recommend that reinsurance-related factors be excluded from the evaluation of this functional category. MNsure elected not to operate a reinsurance program.

With regard to SHOP billing, in February 2015, MNsure was billing its SHOP customers through a manual billing process. Since then we have incorporated automation into the SHOP billing process and improved internal controls.

Hub Services: We generally agree with the operational status indicator for this functional category. As of March 31, 2015, testing and attestation of Verified of Legal Presence (VLP) 33 Step 1 was complete. We continue to plan for testing of VLP Steps 2 and 3.

IRS reporting file submissions: We generally agree with the status indicator for this functional category. MNsure began submitting the IRS 1095 EOM files in April 2015. MNsure also submitted the annual 2014 IRS file in April 2015. The delays were caused in part by additional quality assurance work that was performed.

In conclusion, we appreciate the opportunity to respond to the excerpts of the draft and look forward to the final report.

Sincerely,

Allison O'Toole
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Appendix VI: Comments from the Washington Health Benefit Exchange

July 30, 2015

Valerie C. Melvin
Director, Information Management and Technology Resources Issues
Information Technology Team
U.S. Government Accountability Office

Re: GAO Study of States' Health Insurance Marketplace IT Projects - Washington

Dear Ms. Melvin:

The Washington Health Benefit Exchange (WAHBE/the Exchange) appreciates the opportunity to review the Washington State related excerpts of the Government Accountability Office's draft report entitled STATE HEALTH INSURANCE MARKETPLACES: CMS Should Improve Oversight of State Information Technology Projects (GAO-15-527). We do not agree with some of the characterizations in the report.

As background, Washington State's online health insurance marketplace Washington Healthplanfinder, opened for business on time on October 1, 2013 with functioning individual and small business marketplaces. Seven days into the first open-enrollment period, the high utilization of Healthplanfinder and the easy to use features led one Washington Post reporter to write an article about our site entitled, "*Here's what Obamacare looks like when it works*" (Sarah Kliff, October 8, 2013).

To date, over one in four Washington residents have obtained health insurance through Washington Healthplanfinder. Washington's integrated system offers one door for public and private health insurance. More than 164,000 Washington residents are enrolled in private health insurance and over half a million new adults (more than 533,000) are enrolled in Medicaid. This exceeds Medicaid projections for January 2018.

With the help of an extensive on-the-ground network of brokers, navigators and other community partners, the uninsured rate in Washington was reduced by nearly 40 percent in our first year of operation. Notably, this decline was the fourth highest in the nation. We are pleased that a significant number of 'young invincibles' are among the newly insured. This population was targeted through innovative partnerships with organizations like Live Nation, who delivered important messaging at concert venues across the state. Washington Healthplanfinder also conducted university and sport-based enrollment events, and partnered with the White House to promote a PSA that encouraged residents to get covered starring Seattle Seahawks quarterback Russell Wilson and cornerback Richard Sherman.

810 Jefferson St. SE | P.O. Box 657 | Olympia, Washington 98507
Direct: 360.688.7700 | Fax: 360.688.7332

Washington's enrollment success has had a positive fiscal impact across the state. As a premium aggregator, the Exchange received and managed nearly $560 million in premium payments in 2014 alone. Over $330 million in federal subsidies were obtained through

Healthplanfinder to help Washington residents pay for premiums and over $54 million in federal subsidies were obtained to reduce consumer costs of hospital and provider visits. In addition, hospital data from January 2014 through September 2014 shows a 44 percent decrease in charity care and 47 percent decrease in bad debt across the state.

Below addresses draft ***Table 5: Operational Status of the 14 State-Based Marketplaces by Functional Categories as of February 2015.*** We concur with the characterization for the Eligibility and Enrollment. However, we do not agree with the characterization that Washington is only partially operational for Financial Management, Hub Services, and IRS Reporting File Submissions.

Financial Management
The draft report states that a characterization of "partially operational" is "if the functions were operational but did not work as intended." The report explanation is not sufficient and lacks details needed to respond.

When we opened for business, our customers were able to shop, enroll, and pay for qualified health plans for January 1, 2014 coverage using Healthplanfinder.

Hub Services
The draft report states that a characterization of "partial" completion is related to functions being partially complete because they had not been implemented, because testing and development had not been completed, or because attestations had not been received. The report explanation is not sufficient and lacks details needed to respond.

The Washington state based marketplace leverages federally-managed services through integration points between the Washington Healthplanfinder www.wahealthplanfinder.org and the Federal Data Services Hub. Washington Healthplanfinder successfully uses multiple services offered by the federal hub to verify Social Security numbers, citizenship, lawful presence, income, and other eligibility factors. More specifically the Washington Healthplanfinder has interacted with the following FDSH services since go-live in October 2013:

- The Remote Identity Proofing Service which connects with Experian and provides the Precise Identity Service to confirm the identity of HPF customers.
- The SSA Composite Service which provides confirmation of citizenship, verification of SSN, verification of death, verification of incarceration, along with access to Title II Monthly and Annual Data.
- The Verify Annual Household Income and Family Size service for verification of annual income and family composition with the IRS.
- The Verify Lawful Presence Service (Step1 and Step 2) used to verify immigration or naturalized status for customers who attest being non-citizens.

- The Verify Non-Employer Sponsored Minimal Essential Coverage (Non-ESI MEC) which provides access to Medicare, Veteran Health Administration (VHA), Tricare and Peace Corps coverage.
- The Advance Payment Computation service for calculating the maximum tax credit amount available for the household when purchasing coverage.

Consumption of these services was thoroughly tested in partnership with CMS. Access to the production version of the services required attestation from the Independent Verification and Validation vendor prior to go-live in October 2013. Documentation regarding these tests and attestations activities and results is available on the CMS CALT repository.

IRS Reporting File Submissions
The Exchange concurs with GAO's report which finds partial completion of IRS reporting requirements. However, the reason for partial completion is due to lack of details and late guidance from the IRS that prevented the Exchange from submitting the reports in the format requested.

Conclusion
The Washington Health Benefit Exchange appreciates the work of the GAO and welcomes the opportunity to provide this feedback.

We look forward to continuing to work with federal and state partners to implement the Affordable Care Act and better the health and well-being of Washington residents.

Sincerely,

Richard K. Onizuka, PhD
Chief Executive Officer

Appendix VII: GAO Contact and Staff Acknowledgments

GAO Contact

Valerie C. Melvin, (202) 512-6304, or melvinv@gao.gov

Staff Acknowledgments

In addition to the contact named above, Tammi Kalugdan (assistant director), Christie Motley (assistant director), Christopher Businsky, Debra Conner, Sandra George, David Hong, Kendrick Johnson, Lee McCracken, Monica Perez-Nelson, Jerome Sandau, Brandon Sanders, Andrew Stavisky, Karin Wallestad, Merry Woo, and Elizabeth Wood made key contributions to this report.

September 8, 2015

Key Facts You Need to Know About: Helping Families That Include Immigrants Apply for Health Coverage

Families that include immigrants may experience barriers when applying for health coverage. The following key facts explain issues that families may face and provides information about key concerns families with immigrants may have when completing the application process. *(For more information on immigrant eligibility, please see Key Facts You Need to Know About Immigrant Eligibility for Health Insurance Affordability Programs.)*

PART I: Eligibility policies affecting immigrants in Medicaid, the Children's Health Insurance Program (CHIP), and the federal and state Marketplaces.

Will enrolling in insurance affordability programs have an impact on immigrants when they apply to change their immigration status?

No. When individuals apply for legal permanent resident status, immigration authorities determine whether someone is likely to become dependent on the government for subsistence, commonly referred to as a "public charge." This evaluation does *not* take into account whether someone applied for or received Medicaid, CHIP, or subsidized coverage in the Marketplaces. Thus, applying for or receiving these benefits does not have a negative impact on immigrants when they apply to change their status. There is an exception: people receiving long-term institutional care through Medicaid may be considered dependent on the government.

Can people apply for health coverage for other household members even if they are not applying for coverage for themselves (or are ineligible)?

Yes, households of people applying for insurance affordability programs can include both applicants and non-applicants. During the application process, the person completing the application will state who is in the household and which household members are applying for coverage. Non-applicants must include information such as their income and plans for tax filing, but they are not required to provide information about their immigration or citizenship status.

Is having a Social Security number (SSN) an eligibility requirement for insurance affordability programs?

For Medicaid and CHIP, individuals seeking coverage for themselves are generally required to provide their SSNs if they are eligible for one (unless they have a religious objection to getting an SSN). If they are eligible for but do not have an SSN, they must apply for one and the

Medicaid or CHIP agency must offer to help them apply. They cannot be denied coverage while their application for an SSN is being processed.

Individuals seeking to enroll in a Marketplace plan for themselves must provide an SSN if they have one.

Is an SSN required if an individual is applying for premium tax credits for a family member and not himself?

Individuals applying for premium tax credits for their dependents or spouse and not for themselves only need to provide their SSN if: (1) they have an SSN, and (2) they filed a tax return for the year for which tax data would be used to verify their household income and family size. (Eligibility for the 2015 coverage year uses information from the 2013 tax return year to verify that information.) Providing SSNs of non-applicants who have them is strongly encouraged. The Marketplaces use SSNs to conduct data matches with trusted data sources like the Social Security Administration (SSA) and the Internal Revenue Service (IRS). When these matches can successfully verify key information like income, consumers may not have to submit proof of their circumstances.

Will a parent applying for Medicaid or CHIP coverage for his child but not for himself be required to provide an SSN?

Parents who apply for Medicaid or CHIP for their children do not have to provide an SSN. If they have one and choose to provide it, this may help the Medicaid agency electronically verify income for the family, but it is not required.

Can a person who has an Individual Taxpayer Identification Number (ITIN) to file taxes use that number instead of an SSN on the application?

No. ITINs are not the same as SSNs. The application will verify SSNs with the Social Security Administration, which cannot verify ITINs. Someone who uses an ITIN to file taxes is not required to provide an SSN on the application and should skip the question in the application. (The application will make multiple requests for the SSN; each time the consumer should skip it.)

Can someone include a tax dependent that lives abroad in his application?

Applicants must include information on all members of the household, including any tax dependents living abroad, for the purpose of determining the applicant's household size and income. Dependents living abroad will generally not be eligible to enroll in health insurance coverage. The Healthcare.gov application asks for the address of all tax dependents but does not accept foreign addresses. Consumers can put in the address of the tax filer in place of the address for tax dependents who live abroad.

Can information provided in the application be used for immigration civil enforcement purposes?

No. Medicaid, CHIP, and the Marketplaces use the U.S. Citizenship and Immigration Services' (USCIS) Systematic Alien Verification for Entitlements (SAVE) program to verify the citizenship or immigration status of people applying for coverage. *However*, this data match is only for the purpose of confirming that applicants meet the immigration or citizenship status requirement to enroll in an insurance affordability program. The USCIS has issued guidance that information about applicants or households obtained for health insurance eligibility will not be used for civil immigration enforcement purposes.

PART II: Applying for premium tax credits in the Federally-Facilitated Marketplace

Who needs to complete remote identity proofing (i.e. ID proofing) to submit an application on Healthcare.gov?

The Federally-Facilitated Marketplace (FFM) uses Healthcare.gov to process applications for and enroll eligible applicants in health coverage. Healthcare.gov requires the person designated as the household contact in an application (who must be an adult) to successfully complete ID proofing to ensure that he is who he says he is before he can use the online process to apply for coverage, select health insurance plans, report changes, or renew coverage.

Why are some people not able to complete the ID proofing process on Healthcare.gov?

Experian, the entity that verifies identity for Healthcare.gov, creates personalized questions that the household contact must answer to prove his identity in the application. Experian often cannot generate a sufficient number of questions for household contacts with limited or no credit history. Also, consumers have sometimes found questions generated by Experian difficult to answer.

What happens when ID proofing cannot be completed on Healthcare.gov?

When Healthcare.gov cannot complete ID proofing online, it gives household contacts a unique reference code and instructs them to call the Experian Help Desk to complete ID proofing over the phone.

What happens when ID proofing cannot be completed over the phone with Experian?

Household contacts who cannot complete ID proofing over the phone have to submit supporting documents to prove their identity if they wish to submit an application online. They can upload electronic versions of the documents to their Healthcare.gov accounts, or can mail copies to:

Health Insurance Marketplace
465 Industrial Boulevard
London, KY 40750-0001

Table 1 lists the documents that can be used to verify identity. When mailing copies, it is important to include the unique reference ID number provided during the online ID proofing process so the documents can be matched to the correct account.

What if consumers do not have any of the documents listed to complete Healthcare.gov's ID proofing process?

Household contacts who do not have any of the documents needed to complete the ID proofing process will not be able to submit an application online on Healthcare.gov. Instead, they may complete the application by mailing a completed paper application form or may apply over the phone by contacting the Marketplace call center at 1-800-318-2596 (TTY: 1-855-889-4325). They should ask to receive notices about their application by mail. If they qualify for Marketplace coverage, they will need to go through the Marketplace call center to select and enroll in a plan. To evaluate their health plan options before enrolling, applicants can use the "See plans" tool on Healthcare.gov. Once enrolled, they will need to report any changes and complete the renewal process through the Marketplace call center.

How does Healthcare.gov verify citizenship?

In the FFM, when applicants attest to being U.S. citizens and provide an SSN, their information is

checked against information in SSA's records to verify citizenship.

SSA does not have citizenship records for some citizens, including many who were born outside the U.S. If citizenship cannot be verified electronically through SSA, applicants are asked if they are a naturalized or derived citizen. Some applicants who are naturalized or derived citizens can have their status verified instantly by providing numbers found in their Certificate of Citizenship or Certificate of Naturalization that will be matched with information in the SAVE program.

The SAVE program cannot immediately verify citizenship status of all derived and naturalized citizens. When this occurs, applicants will have to upload proof of their citizenship to their Healthcare.gov accounts (see list of acceptable proof in Table 2). Applicants can also mail document copies to:

Health Insurance Marketplace
465 Industrial Boulevard
London, KY 40750-0001

While their citizenship is being verified, applicants who otherwise meet all eligibility requirements can enroll in Medicaid, CHIP, or a Marketplace plan during a "reasonable opportunity period" or "inconsistency period."

How does Healthcare.gov verify immigration status?

In the FFM, all non-citizens applying for coverage for themselves must attest to having an "eligible immigration status." They then must select a document type to use to prove their immigration status. They will be asked to provide one or two numbers from their document; Healthcare.gov will use this information to attempt to immediately verify their immigration status through the SAVE program.

The SAVE program cannot immediately verify the status of all immigrants. When this occurs, applicants will have to upload proof of their immigration status to their Healthcare.gov accounts (see list of acceptable proof in Table 3). Applicants can also mail document copies to:

Health Insurance Marketplace
465 Industrial Boulevard
London, KY 40750-0001

While the applicant gathers and sends in documents and the agency receives and processes them, the applicant can enroll in Medicaid, CHIP, or a Marketplace plan if he meets all other eligibility requirements during a "reasonable opportunity period" or "inconsistency period."

Why are some lawfully present immigrants who are eligible for subsidies not able to immediately enroll in subsidized coverage?

Lawfully present immigrants who have income within the Medicaid eligibility range but are ineligible for Medicaid due to their immigration status can qualify for premium tax credits and cost-sharing reductions even if their income falls below the poverty line. (Generally, consumers must have income between 100-400 percent of the poverty line to qualify for premium tax credits and cost sharing reductions.) However, Healthcare.gov has system limitations that can result in an incorrect eligibility determination for some of these individuals.

If Healthcare.gov can instantly verify that a consumer is lawfully present but ineligible for Medicaid because of his immigration status, the applicant should receive the correct determination of eligibility for subsidies.

If Healthcare.gov cannot instantly verify that the consumer's immigration status makes him ineligible for Medicaid, then the consumer will receive an incorrect eligibility determination for subsidies. This is because Healthcare.gov will

assume the consumer is eligible for Medicaid based on immigration status until the consumer provides proof of his immigration status, which shows he is ineligible for Medicaid. One of two erroneous determinations will occur:

- **Healthcare.gov incorrectly assesses or determines he is eligible for Medicaid** if the consumer otherwise appears to meet the income and other applicable requirements for Medicaid eligibility.
- **Healthcare.gov incorrectly determines he is ineligible for Marketplace subsidies and he is treated as if he were in the coverage gap.** This can occur in states that have not expanded Medicaid. If the consumer does not meet the Medicaid income or other applicable requirement and his income is below the poverty line, Healthcare.gov assumes the consumer is in the coverage gap and does not send his case file to Medicaid. These individuals are told they are only eligible to purchase a Marketplace plan at full cost — without subsidies.

What steps need to be taken to get the correct determination for individuals incorrectly assessed or determined eligible for Medicaid?

Consumers must be determined ineligible for Medicaid based on their immigration status before they can get the correct eligibility determination for Marketplace subsidies. When Healthcare.gov incorrectly assesses or determines individuals as eligible for Medicaid, it sends the individual's case file to the state Medicaid agency. The Medicaid agency will ask the consumer to provide proof of his immigration status. After the consumer provides proof and is denied Medicaid based on his immigration status, he will be referred back to Healthcare.gov and instructed to update his application to indicate he has been denied eligibility for Medicaid based on immigration status.

After a consumer notes on the application that he has been denied Medicaid due to immigration status, he should receive a correct determination of eligibility for premium tax credits and cost-sharing reductions.

What steps need to be taken to get the correct determination for individuals incorrectly determined ineligible for Marketplace subsidies and treated as if they were in the coverage gap?

These consumers must also be determined ineligible for Medicaid based on their immigration status before they can get the correct eligibility determination for Marketplace subsidies. Healthcare.gov periodically sends these consumers who may have gotten an incorrect eligibility determination a notice informing them that they may qualify for premium tax credits and cost-sharing reductions and that they must submit documents to prove their immigration status. When documents are received and processed by the Marketplace, eligible consumers are instructed to return to Healthcare.gov and indicate they have been denied Medicaid due to their immigration status.

Are there any alternative steps individuals can take to get the correct eligibility determination?

In some cases consumers can get a Medicaid denial due to immigration status more quickly by applying for Medicaid directly through the state Medicaid agency. Once denied Medicaid eligibility based on immigration status by the state agency, consumers can return to Healthcare.gov and indicate they have been denied Medicaid due to immigration status.

Table 1: Documents to Satisfy the Identity Proofing Requirement
ONE of the following:
Driver's license (issued by state or territory)
Voter registration card
U.S. passport or U.S passport card
U.S. military draft card or record
School identification card
Certificate of Naturalization (Form N-550 or N-570) or Certificate of U.S. Citizenship (Form N-560 or N-561)
Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
Employment Authorization Document containing a photograph (Form I-766)
Identification card issued by the federal, state, or local government
Foreign passport, or identification card issued by a foreign embassy or consulate containing a photograph
Military dependent identification card
Native American tribal document
U.S. Coast Guard Merchant Mariner document
or, TWO of the following:
U.S. public birth record
Marriage certificate
Employer identification card
Property deed or title
Social Security card
Divorce decree
High school or college diploma (including high school equivalency diplomas)
Source: www.healthcare.gov/help/how-do-i-resolve-an-inconsistency

Table 2: Documents to Verify Citizenship
U.S. passport
Certificate of Citizenship
Certificate of Naturalization
State-issued enhanced driver's license (currently available from Michigan, Vermont, New York, and Washington)
Document from a federally recognized Indian tribe that includes the individual's name, the name of the tribe, and membership, enrollment, or affiliation with the tribe
Individuals who do not have one of the above documents can provide one document from each of the lists below (totaling two documents)
ONE of the following:
U.S. public birth certificate
Consular Report of Birth Abroad (FS-240, CRBA)
Certification of Report of Birth (DS-1350)
Certification of Birth Abroad (FS-545)
U.S. Citizen Identification Card (I-197 or the prior version, I-179)
Northern Mariana Card (I-873)
Final adoption decree showing the person's name and U.S. place of birth
U.S. Civil Service Employment Record showing employment before June 1, 1976
Military record showing U.S. place of birth
U.S. medical record from a clinic, hospital, physician, midwife, or institution showing a U.S. place of birth
U.S. life, health, or other insurance record showing U.S. place of birth
Religious record showing U.S. place of birth recorded in the U.S.
School record showing the child's name and U.S. place of birth
Federal or state census record showing U.S. citizenship or U.S. place of birth
Documentation of a foreign-born adopted child who received automatic U.S. citizenship (IR3 or IH3)
AND ONE of the following: **(that has a photograph or other information, like your name, age, race, height, weight, eye color, or address)**
Driver's license issued by a state or territory or ID card issued by the federal, state, or local government
School identification card
U.S. military card or draft record or military dependent's identification card
U.S. Coast Guard Merchant Mariner document
Voter registration card
A clinic, doctor, hospital, or school record, including preschool or day care records (for children under 19 years old)
Two documents containing consistent information that proves your identity, like employer IDs, high school or college diplomas, marriage certificates, divorce decrees, property deeds, or titles
Source: www.healthcare.gov/help/how-do-i-resolve-an-inconsistency

Table 3: Documents to Verify Immigration Status
Permanent Resident Card, "Green Card" (I-551)
Refugee travel document (I-571)
Temporary I-551 stamp (on Passport or I-94/I-94A)
Arrival/Departure Record (I-94/I-94A)
Certificate of Eligibility for Nonimmigrant Student Status (I-20)
Employment Authorization Card (I-766)
Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
Administrative order staying removal issued by Department of Homeland Security
Office of Refugee Resettlement eligibility letter (if under 18)
Reentry Permit (I-327)
Machine-readable immigrant visa (with temporary I-551 language)
Foreign passport
Arrival/Departure Record in foreign passport (I-94)
Certificate of Eligibility for Exchange Visitor Status (DS-2019)
Notice of Action (I-797)
Document indicating withholding of removal (or withholding of deportation)
Document indicating a member of a federally recognized Indian tribe or American Indian born in Canada
Resident of American Samoa card
Other documents
Source: www.healthcare.gov/help/immigration-document-types

The COMMONWEALTH FUND

TRACKING TRENDS IN HEALTH SYSTEM PERFORMANCE

SEPTEMBER 2015

To Enroll or Not to Enroll? Why Many Americans Have Gained Insurance Under the Affordable Care Act While Others Have Not

Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015

Sara R. Collins, Munira Gunja, Michelle M. Doty, and Sophie Beutel

Abstract According to the most recent Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015, an estimated 25 million adults remain uninsured. To achieve the Affordable Care Act's goal of near-universal coverage, policymakers must understand why some people are enrolling in the law's marketplace plans or in Medicaid coverage and why others are not. This analysis of the survey finds that affordability—whether real or perceived—is playing a significant role in adults' choice of marketplace plans and the decision whether to enroll at all. People who have gained coverage report significantly more positive experiences shopping for health plans than do those who did not enroll. Getting personal assistance—from telephone hotlines, navigators, and insurance brokers, among other sources—appears to make a critical difference in whether people gain health insurance.

For more information about this brief, please contact:

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Commonwealth Fund pub. 1837
Vol. 28

BACKGROUND

The third open enrollment period for the Affordable Care Act's health insurance marketplaces begins on November 1, 2015, for coverage beginning January 2016. This will give the estimated 25 million working-age adults who still lack health insurance and are eligible for coverage the opportunity to sign up.[1] In addition, people who currently have insurance—either through the marketplaces or the individual market—will need to reenroll during this period if they want their coverage to continue through next year.

Some people, however, may choose not to enroll in coverage. To help policymakers increase the number of people with health insurance, it's important to understand why some people have enrolled while others have

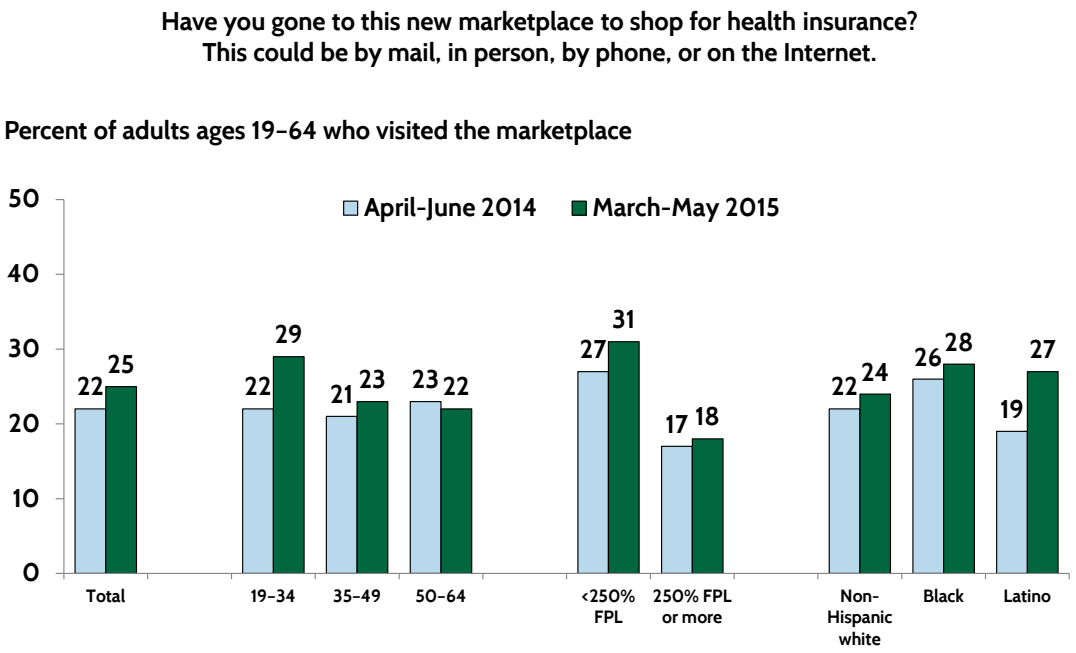
not. Earlier research, based on results from the Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015, identified possible reasons why people remain uninsured, including the fact that 20 states have yet to expand eligibility for Medicaid and a general lack of knowledge among many uninsured adults about the marketplaces and the availability of financial assistance.[2] In this latest analysis of the survey, we gain more insight by looking at the experiences of adults who took the first steps toward gaining coverage by visiting the marketplaces but who did not ultimately enroll. Additional findings from the survey can be found in an online tool at http://www.commonwealthfund.org/acaTrackingSurvey/index.html.

SURVEY FINDINGS

Visiting the Health Insurance Marketplaces and Shopping for Coverage

One-quarter of all U.S. working-age adults had visited a marketplace to shop for health insurance by March–May 2015; even higher rates were reported by young adults and people with low and moderate incomes (Exhibit 1). The share of Latinos who visited the marketplaces climbed significantly over the first two enrollment periods, rising from 19 percent to 27 percent.

Exhibit 1. One-Quarter of All U.S. Working-Age Adults Have Visited the Health Insurance Marketplaces

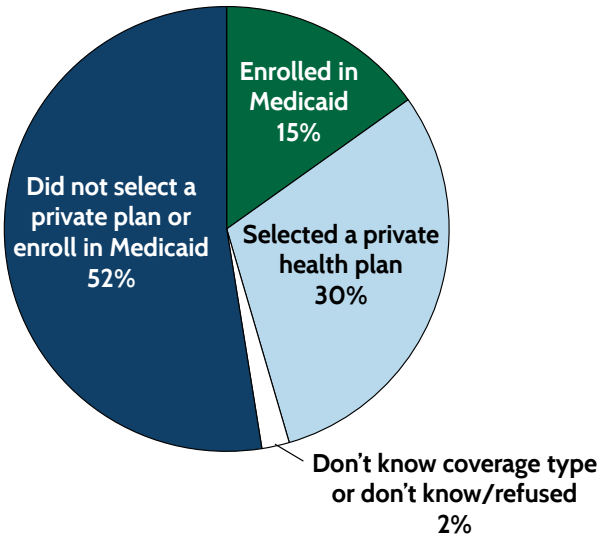


Source: The Commonwealth Fund Affordable Care Act Tracking Surveys, April–June 2014 and March–May 2015.

Nearly half (47%) of adults who went to the marketplaces and shopped for health insurance over the past two years ultimately enrolled in plans: 30 percent said they selected a private health plan, 15 percent enrolled in Medicaid, and 2 percent either did not know their coverage type or refused to respond (Exhibit 2).[3]

Despite concerns that young adults might not sign up for the law's coverage options, 19-to-34-year-olds comprise more than one-third (38%) of the current combined enrollment in

Exhibit 2. Just Under Half of Adults Who Have Visited the Marketplace Enrolled in a Marketplace Plan or Medicaid



Adults ages 19–64 who went to the marketplace

Notes: Segments may not sum to 100 percent because of rounding. Analysis includes adults who visited the marketplace and are either currently enrolled or were enrolled in marketplace or Medicaid coverage in the past two years, adults who signed up for coverage through marketplace but are not sure if it is Medicaid or private coverage, and adults who do not know or refused to respond to the type of coverage.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015.

marketplace and Medicaid plans among working-age adults (Exhibit 3). Young adults represent 31 percent of adult enrollees in the marketplaces, proportionate to their share of the adult population.[4] Medicaid has been a critical source of new insurance coverage in this age group: 46 percent of new adult Medicaid enrollees are ages 19 to 34.

Making the Decision to Enroll

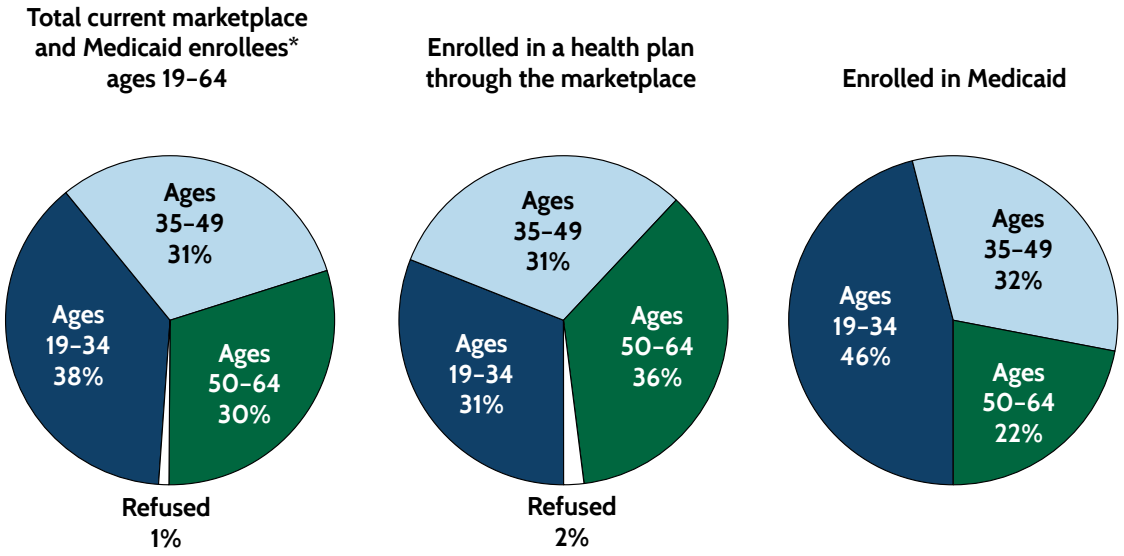
In this analysis, we examine the decision-making of people who enrolled in marketplace plans or Medicaid compared with those who did not enroll. Going forward we refer to these two groups "enrollees" and "nonenrollees."

Enrollees

Premiums and out-of-pocket costs figured most prominently in decisions regarding choice of marketplace plan. Two-thirds (66%) of adults who either had enrolled in private plans through the marketplace for the first time or switched health plans in the most recent open enrollment period said that the amount of the premium (41%) or the amount of the deductible and copayments (25%) was the most important factor in their decision (Exhibit 4). A smaller share of adults (22%) said that having their preferred doctor, health clinic, or hospital included in the plan's network was the most important reason. In a companion issue brief, we examine reported premium costs and deductibles by adults with marketplace plans.

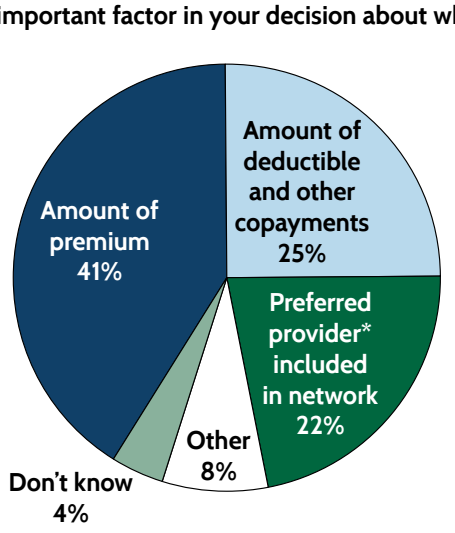
Consistent with these findings, many adults opted for a limited network of doctors and hospitals in exchange for lower premiums. Among people who either enrolled in a marketplace plan for the first time or changed plans in the most recent open enrollment period, more than half (53%) said they had the option of choosing a less expensive plan featuring fewer doctors or hospitals (Exhibit 5). Of those, more than half (54%) selected the limited-network plan.

Exhibit 3. Young Adults Comprise 31 Percent of Marketplace Enrollment and 46 Percent of Medicaid Enrollment



* Includes those currently enrolled in marketplace coverage, those who signed up for Medicaid through the marketplace, those who signed up for coverage through the marketplace but are not sure if it is Medicaid or private coverage, and those who have been enrolled in Medicaid for less than two years.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015.

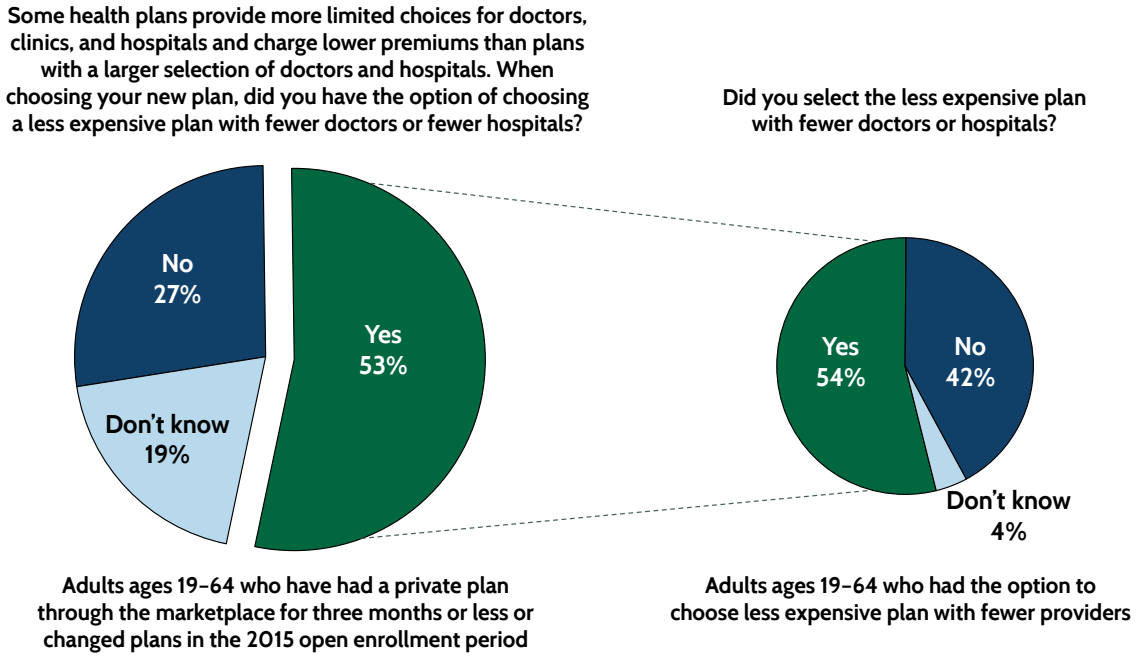
Exhibit 4. Premiums and Cost Exposure Were the Most Important Factors in Plan Selection Among Marketplace Enrollees



Adults ages 19–64 who have had a private plan through the marketplace for three months or less or changed plans in the 2015 open enrollment period

* Actual question wording: preferred doctor, health clinic, or hospital included in plan's network.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015.

Exhibit 5. Half of Marketplace Enrollees Who Reported Having the Option to Choose a Narrow Network Policy Said They Did So



Note: Segments may not sum to 100 percent because of rounding.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015.

Nonenrollees

We asked adults who had visited the marketplaces but did not enroll in a marketplace plan or Medicaid about their reasons for not enrolling; respondents could select more than one response.

Half (51%) of nonenrollees said they did not enroll because they ultimately found health insurance through another source (Exhibit 6). These may have been people with changes in life circumstances such as a job loss or divorce, who shopped for insurance but ended up getting covered in another way.

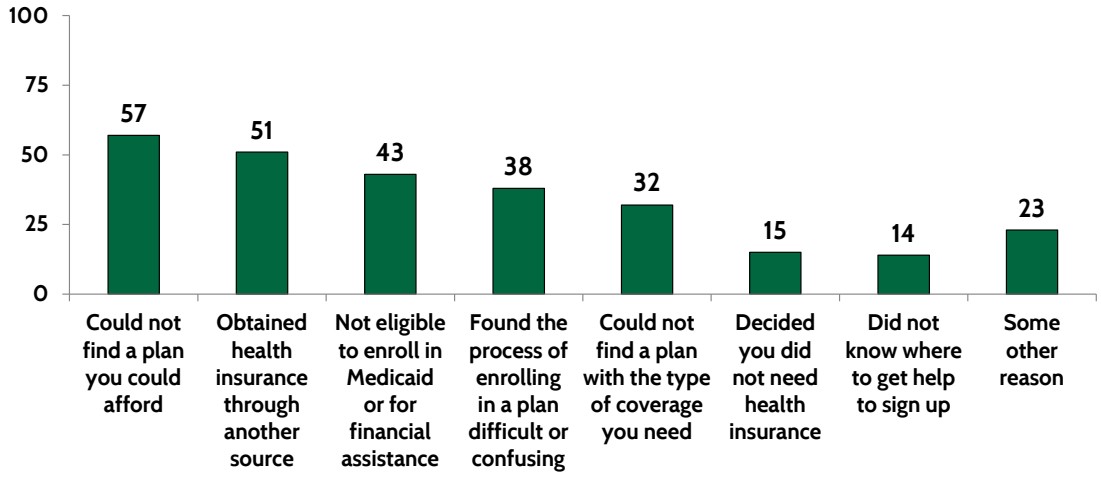
Affordability was a key reason people did not enroll in plans. More than half (57%) of adults who visited the marketplaces but did not enroll said they could not find a plan they could afford. Excluding the adults who also said they gained coverage elsewhere,[5] the majority of those who did not enroll because they couldn't find affordable plans had lower incomes. More than half (54%) had incomes in the range that made them eligible for subsidies (i.e., from 100 percent to 400 percent of the federal poverty level, or $11,670 to $46,680 in annual income for an individual) (data not shown).[6] Thirty percent had incomes under 100 percent of poverty. An estimated 26 percent (and thus nearly all of those with incomes under 100 percent of poverty) were likely in the so-called Medicaid coverage gap. That is, they were living in states that had not expanded eligibility for Medicaid at the time of the survey and had incomes under 100 percent of poverty and thereby not eligible for marketplace subsidies.[7] About 11 percent had incomes that exceeded the threshold that made them eligible for subsidies (i.e., 400 percent of poverty).

Many adults (43%) said they did not enroll because they were not eligible for subsidized coverage or Medicaid. Again, excluding those who gained coverage elsewhere,[8] most people who gave this reason had lower incomes: 50 percent had incomes that made them eligible for subsidies, and

Exhibit 6. Among Marketplace Visitors Who Didn't Enroll, More than Half Said They Couldn't Find an Affordable Plan

Can you tell me why you did not obtain a private health insurance plan or Medicaid coverage when you visited the marketplace? Was it because...?

Percent of adults ages 19–64 who visited the marketplace but did not select coverage



Source: The Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015.

33 percent had incomes under 100 percent of poverty (data not shown).[9] An estimated 27 percent—most of those with incomes under 100 percent of poverty—were likely in the Medicaid coverage gap. About 14 percent had incomes above the threshold that made them eligible for subsidies.[10]

Other adults who did not enroll were overwhelmed by the process. About four of 10 adults (38%) who did not sign up for coverage said they found the process of enrolling difficult or confusing.[11]

Shopping and Enrollment Experiences

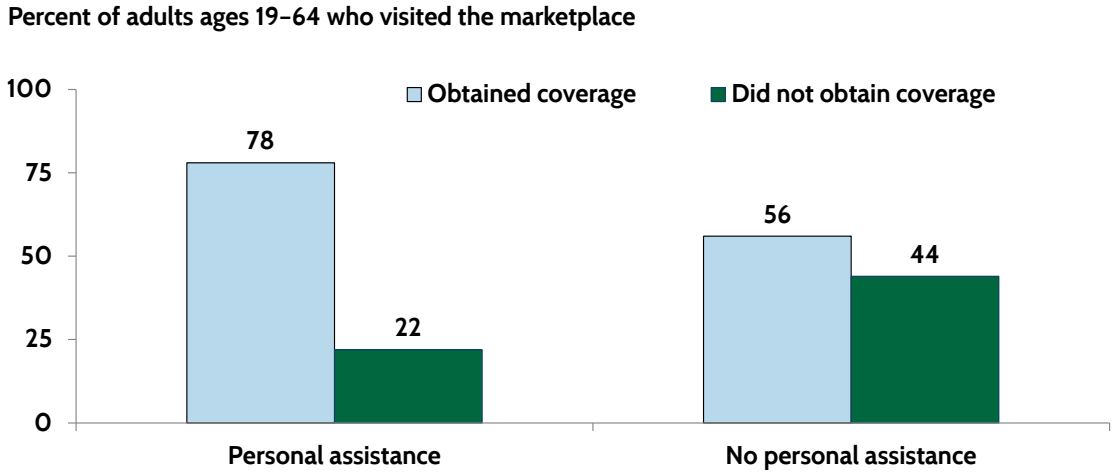
We compared the shopping and enrollment experiences of enrollees and nonenrollees. In the analysis we excluded those who told us they had enrolled in another source of coverage from the group of nonenrollees.

Personal Assistance

Receiving personal assistance appears to make a significant difference in whether a person signs up for coverage. People with incomes in the range that made them eligible for subsidies, those who are part of racial and ethnic minority groups, those with a high school education or less, and older adults were the most likely to report they had received personal assistance such as from a telephone hotline, insurance broker, navigator, or some other source (Appendix Table 1). When we controlled for demographic differences, 78 percent of adults who said they had received assistance enrolled in a marketplace plan or Medicaid (Exhibit 7).[12] In contrast, only 56 percent of those who did not receive personal assistance ultimately enrolled.

Exhibit 7. Nearly Eight of 10 Adults Who Received Personal Assistance Obtained Coverage

When you shopped for health insurance, did you ever receive any personal assistance to help you select an insurance plan? This could have included calling a telephone hotline or getting help from an insurance broker, navigator, or in some other way.



Notes: Percentages were adjusted for race, education, poverty, age and health status. "Obtained coverage" includes those who visited the marketplace and have had marketplace or Medicaid coverage for two years or less. "Did not obtain coverage" does not include those who obtained coverage through another source.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015.

Comparing Health Plans

Visitors to marketplace websites in most states encounter an array of health plans that differ by premium cost, copayments and deductibles, and covered providers.[13] Health care services covered by plans should be largely the same because each must cover the same essential health benefits, as required by the law. We asked people who visited the marketplaces how difficult or easy it was to compare health plans on the basis of premium costs, benefits covered, out-of-pocket costs, and provider networks.[14] Looking only at adults who had incomes above the threshold that made them eligible for marketplace plan subsidies, those who enrolled were significantly more likely than those who did not to report an easy time identifying differences among plans on those dimensions (Exhibit 8).[15]

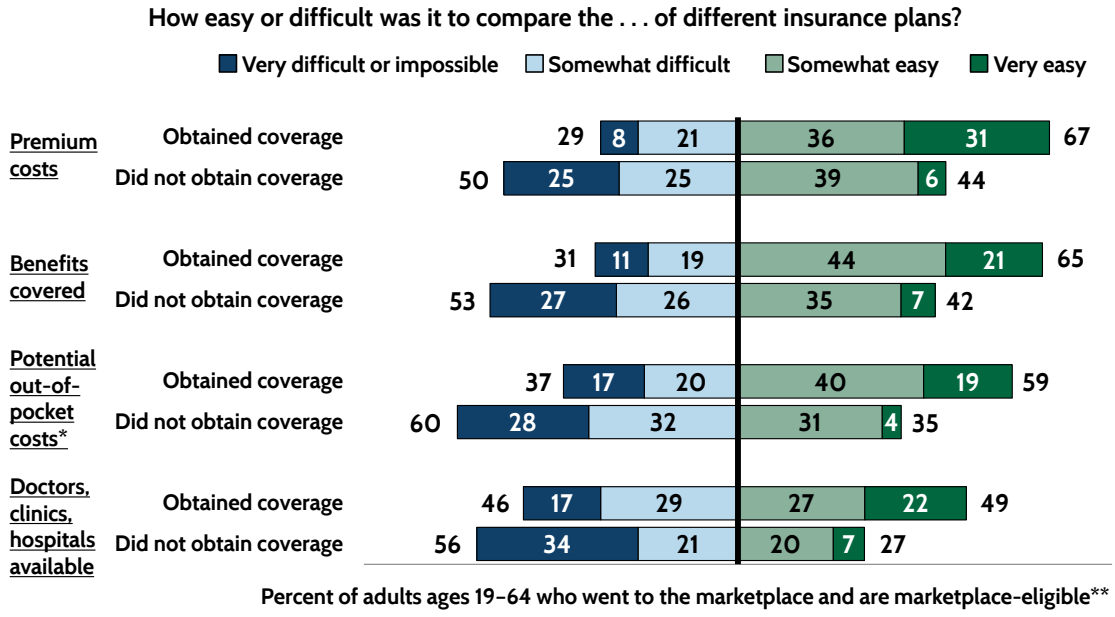
Finding an Affordable Plan

Adults who enrolled in marketplace plans were significantly more likely to report they had an easy time finding an affordable health plan than those who did not enroll (Exhibit 9). Fifty-seven percent of adults who enrolled in marketplace plans said it was very or somewhat easy to find a plan they could afford compared with 15 percent of those who did not enroll. Marketplace enrollees were also significantly more likely to report relative ease in finding plans with the type of coverage they needed than those who did not enroll (63% v. 36%).[16]

Overall Shopping Experience

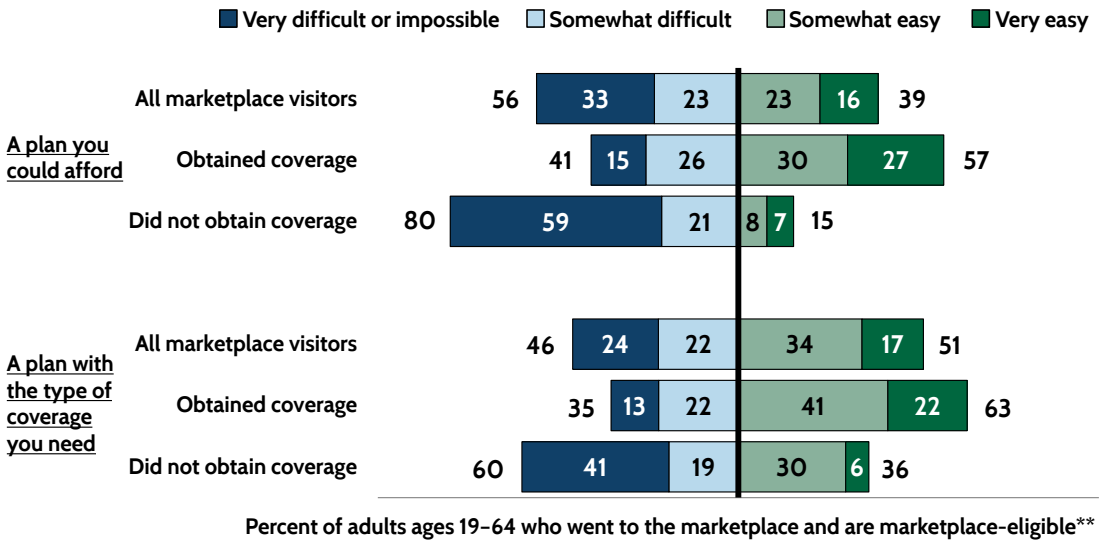
People who ultimately enrolled in either Medicaid or a marketplace plan were significantly more likely than those who did not to give high ratings to their overall experience. More than half (52%) of adults who obtained coverage rated their experience as good or excellent compared with 18 percent of those who did not enroll (Exhibit 10).[17]

Exhibit 8. Marketplace Visitors Who Did Not Select a Plan Had Greater Difficulty Comparing Plans Than Those Who Enrolled



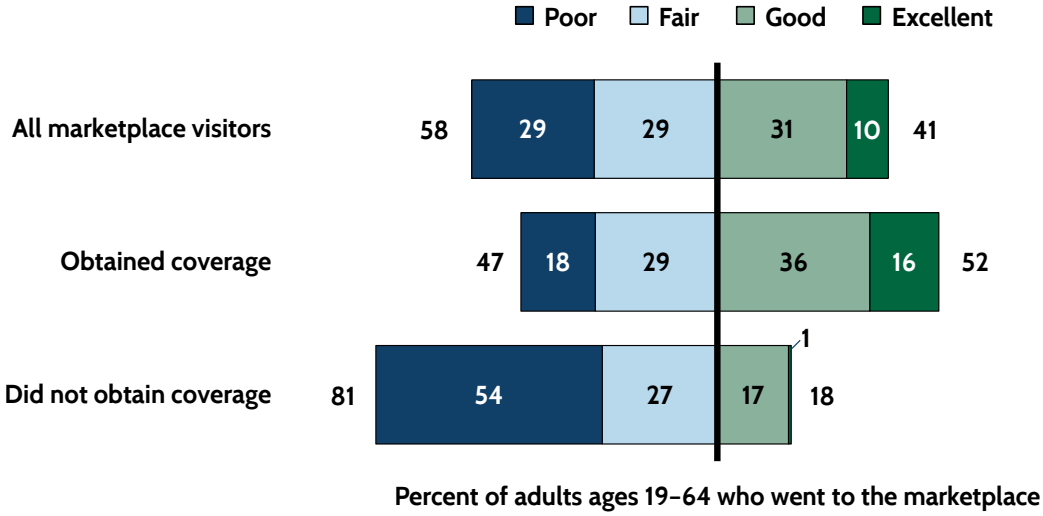
Notes: Bars may not sum to 100 percent because of "don't know" responses or refusal to respond; segments may not sum to subtotals because of rounding. * Potential out-of-pocket costs from deductibles and copayments. "Obtained coverage" includes those who visited the marketplace and have had marketplace coverage for two years or less. "Did not obtain coverage" does not include those who obtained coverage through another source. ** Marketplace-eligible includes adults in expansion states who are above 138% FPL and adults in nonexpansion states who are above 100% FPL.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015.

Exhibit 9. Marketplace Visitors Who Did Not Select a Plan Had Greater Difficulty Finding Affordable Plans Than Those Who Enrolled



Notes: Bars may not sum to 100 percent because of "don't know" responses or refusal to respond; segments may not sum to subtotals because of rounding. "Obtained coverage" includes those who visited the marketplace and have had marketplace coverage for two years or less. "Did not obtain coverage" does not include those who obtained coverage through another source. ** Marketplace-eligible includes adults in expansion states who are above 138% FPL and adults in nonexpansion states who are above 100% FPL.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015.

Exhibit 10. Marketplace Visitors Who Did Not Obtain Coverage Were More Likely to Rate Their Experience as Fair or Poor



Notes: Bars may not sum to 100 percent because of "don't know" responses or refusal to respond; segments may not sum to subtotals because of rounding. "Obtained coverage" includes those who visited the marketplace and have had marketplace or Medicaid coverage for two years or less. "Did not obtain coverage" does not include those who obtained coverage through another source.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015.

CONCLUSION

The survey findings suggest strategies policymakers might pursue to continue to reduce the number of Americans who lack health insurance.

Affordability was a primary reason nearly 50 million Americans lacked health insurance before the Affordable Care Act and it clearly remains a top concern for people seeking coverage today.[18] One startling finding is the fact that among those adults who said they did not enroll because they could not find an affordable plan and did not enroll through a different source, more than half (54%) had incomes that made them eligible for subsidies. It is unclear whether the subsidies are insufficient across income levels to help all those eligible enroll or whether there is a lack of clear information about the subsidy assistance and the actual net costs of insurance to potential enrollees.

The implications of this latter problem—that many people may not have the information they need to help them buy coverage on their own—are evident throughout the survey findings. For example, compared with people who enrolled, those who did not ultimately enroll had much greater difficulty comparing plans based on premium costs, potential out-of-pocket costs, provider network, and benefits covered.

The findings also suggest that getting assistance during the enrollment process may have helped people better understand the trade-offs between their health plan choices. We find that receiving personal assistance or not during the enrollment process made a significant difference in whether people signed up for coverage. Other recent research also has found that navigators and other types of assisters are powerful predictors of successful enrollment.[19]

Finally, the decision by 20 states not to expand eligibility for Medicaid is keeping people from gaining coverage. More than a quarter (26%) of adults who shopped for health insurance in the marketplaces and cited affordability as a reason for not enrolling likely fell into the Medicaid coverage gap. For low-income adults in these 20 states, the inability to afford health insurance remains a reality.

HOW THIS SURVEY WAS CONDUCTED

The Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015, was conducted by SSRS from March 9, 2015, to May 3, 2015. The survey consisted of 16-minute telephone interviews in English or Spanish and was conducted among a random, nationally representative sample of 4,881 adults, ages 19 to 64, living in the United States. Overall, 2,203 interviews were conducted on landline telephones and 2,678 interviews on cellular phones, including 1,729 with respondents who lived in households with no landline telephone access. To view the survey questionnaire, please click here.

This survey is the third in a series of Commonwealth Fund surveys to track the implementation and effects of the Affordable Care Act. The first was conducted by SSRS from July 15 to September 8, 2013, by telephone among a random, nationally representative U.S. sample of 6,132 adults ages 19 to 64. The survey had an overall margin of sampling error of +/– 1.8 percent at the 95 percent confidence level.

The second survey in the series was conducted by SSRS from April 9 to June 2, 2014, by telephone among a random, nationally representative U.S. sample of 4,425 adults ages 19 to 64. The survey had an overall margin of sampling error of +/– 2.1 percent at the 95 percent confidence level. The sample for the April–June 2014 survey was designed to increase the likelihood of surveying respondents who were most likely eligible for new coverage options under the ACA. As such, respondents in the July–September 2013 survey who said they were uninsured or had individual coverage were asked if they could be recontacted for the April–June 2014 survey. SSRS also recontacted households reached through their omnibus survey of adults who were uninsured or had individual coverage prior to the first open enrollment period for 2014 marketplace coverage.

The March–May 2015 sample also was designed to increase the likelihood of surveying respondents who had gained coverage under the ACA. SSRS also recontacted households reached through their omnibus survey of adults between November 5, 2014, and February 1, 2015, who were uninsured, had individual coverage, had a marketplace plan, or had public insurance. These households were then recontacted for the March–May 2015 survey. All waves of the survey oversampled adults with incomes under 250 percent of poverty to further increase the likelihood of surveying respondents eligible for the coverage options as well as allow separate analyses of responses of low-income households. The measure used to designate insurance type was modified in 2015 using new follow-up questions that were asked of those adults who reported having more than one type of coverage.

The data are weighted to correct for the stratified sample design, the use of recontacted respondents from the omnibus survey, the overlapping landline and cellular phone sample frames, and disproportionate nonresponse that might bias results. The data are weighted to the U.S. 19-to-64 adult population by age, gender, race/ethnicity, education, household size, geographic division, and population density using the U.S. Census Bureau's 2013 American Community Survey and weighted by household telephone use using the U.S. Centers for Disease Control and Prevention's 2014 National Health Interview Survey.

The resulting weighted sample is representative of the approximately 187.8 million U.S. adults ages 19 to 64. Data for income, and subsequently for federal poverty level, were imputed for cases with missing data, utilizing a standard regression imputation procedure. The survey has an overall margin of sampling error of +/– 2.1 percentage points at the 95 percent confidence level. The landline portion of the main-sample survey achieved a 16.9 percent response rate and the cellular phone main-sample component achieved a 13.3 percent response rate. The overall response rate, including the recontacted sample, was 12.8 percent.

Notes

[1] S. R. Collins, P. W. Rasmussen, M. M. Doty, and S. Beutel, *Americans' Experiences with Marketplace and Medicaid Coverage—Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015* (New York: The Commonwealth Fund, June 2015); and R. A. Cohen and M. E. Martinez, *Health Insurance Coverage: Early Estimates from the National Health Interview Survey, January–March 2015* (Washington, D.C.: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Aug. 2015).

[2] At the time the survey was conducted, 22 states had not yet expanded eligibility for their Medicaid programs. Since the survey, two states (Alaska and Montana) have moved forward with plans to expand eligibility. Collins, Rasmussen, Doty, and Beutel, *Americans' Experiences with Marketplace and Medicaid Coverage,* 2015.

[3] About 1 percent of adults who visited said they enrolled but did not know what type of coverage they had.

[4] Collins, Rasmussen, Doty, and Beutel, *Americans' Experiences with Marketplace and Medicaid Coverage*, 2015.

[5] Of the group who said they did not enroll because they couldn't find an affordable plan, 38 percent said they found coverage through a different source (data not shown). The sample size for this analysis was 290.

[6] Breaking this down further, 39 percent had incomes that made them eligible for the most generous subsidies (100%–249% of poverty) and 15 percent had incomes between 250 percent and 399 percent of poverty (data not shown).

[7] It is possible that some adults in this income range may have been eligible for coverage under their state's existing Medicaid program.

[8] Of those who didn't think they were eligible for subsidized coverage or Medicaid, 40 percent found coverage through a different source (data not shown). The sample size for this analysis was 231.

[9] Thirty-four percent had incomes between 100 percent and 249 percent of poverty and 16 percent had incomes between 250 percent and 399 percent of poverty.

[10] Undocumented immigrants are not eligible for either the law's Medicaid expansion or marketplace plans. While we do not ask specifically about immigration status in the survey, among those who did not sign up because they said they were ineligible for financial assistance, 14 percent indicate that they were born outside of the United States. However, this measure most likely overstates the number of people who were not eligible because of their immigration status.

[11] Forty-one percent of those who found the process difficult or confusing said they found coverage through a different source (data not shown).

[12] Adjusted percentages were estimated based on a logistic regression model that controlled for race, education, poverty, age, and health status.

[13] Choice of health plans both inside and outside the marketplaces varies both across states and within states. See K. Swartz, M. A. Hall, and T. S. Jost, *How Insurers Competed in the Affordable Care Act's First Year* (New York: The Commonwealth Fund, June 2015).

[14] For trend data on this question from October 2013–March-April 2015, see our interactive survey data tool, http://www.commonwealthfund.org/acaTrackingSurvey/index.html.

[15] Looking at the full group of visitors to the marketplace, a higher level of education did not appear to make a significant difference in whether people reported that it was very or somewhat easy to compare health plans on these four dimensions.

[16] For trend data over 2013–2015, see our interactive survey data tool, http://www.commonwealthfund.org/acaTrackingSurvey/index.html.

[17] For trend data over 2013–2015, see our interactive survey data tool, http://www.commonwealthfund.org/acaTrackingSurvey/index.html.

[18] In 2013, 66 percent of the under-65 uninsured population earned less than 200 percent of poverty, or $23,000 for an individual and $47,000 for a family of four. Analysis of the 2014 Current Population Survey by Claudia Solis-Roman and Sherry Glied of New York University for The Commonwealth Fund.

[19] B. Sommers, B. Maylone, K. H. Nguyen et al., "The Impact of State Policies on ACA Applications and Enrollment Among Low-Income Adults in Arkansas, Kentucky, and Texas," *Health Affairs*, June 2015 34(6):1010–18.

Appendix Table 1. Demographics of Adults Who Visited the Marketplace and Received Personal Assistance

	Adults ages 19–64 who visited the marketplace and received personal assistance (%)
Unweighted n	623
Total	46
Race/Ethnicity	
Non-Hispanic White	39
Black	58
Latino	64
Age	
19–34	41
35–49	47
50–64	50
Poverty Status	
Below 100% poverty	44
100%–399% poverty	52
400% poverty or more	35
Education	
Less than high school	54
High school	51
College/Technical school	46
College graduate or higher	40
Health Status	
Fair/Poor health status, or any chronic condition or disability	47
No health problem	45

Source: The Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015.

About the Authors

Sara R. Collins, Ph.D., is vice president for Health Care Coverage and Access at The Commonwealth Fund. An economist, Dr. Collins joined the Fund in 2002 and has led the Fund's national program on health insurance since 2005. Since joining the Fund, she has led several national surveys on health insurance and authored numerous reports, issue briefs, and journal articles on health insurance coverage and policy. She has provided invited testimony before several Congressional committees and subcommittees. Prior to joining the Fund, Dr. Collins was associate director/senior research associate at the New York Academy of Medicine. Earlier in her career, she was an associate editor at *U.S. News & World Report,* a senior economist at Health Economics Research, and a senior health policy analyst in the New York City Office of the Public Advocate. Dr. Collins holds a Ph.D. in economics from George Washington University.

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Acknowledgments

The authors thank Robyn Rapoport, Erin Czyzewicz, and Matt Anderson of SSRS; and David Blumenthal, Don Moulds, Deb Lorber, Chris Hollander, Paul Frame, Jen Wilson, David Squires, and Sarah Berk of The Commonwealth Fund.

Editorial support was provided by Deborah Lorber.

The
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By Stacey McMorrow, Sharon K. Long, Genevieve M. Kenney, and Nathaniel Anderson

DOI: 10.1377/hlthaff.2015.0757
HEALTH AFFAIRS 34,
NO. 10 (2015): –

DATAWATCH

Uninsurance Disparities Have Narrowed For Black And Hispanic Adults Under The Affordable Care Act

Black and Hispanic adults have long experienced higher uninsurance rates than white adults. Under the Affordable Care Act, differences in uninsurance rates have narrowed for both black and Hispanic adults compared to their white counterparts, but Hispanics continue to face large gaps in coverage.

The Affordable Care Act (ACA) was intended to increase the accessibility and affordability of health insurance. Since racial and ethnic minorities make up a disproportionate share of uninsured Americans,[1] the law was also expected to reduce some of the persistent disparities in the US health care system.[2] Early evidence suggests that the ACA has steadily increased the number of Americans who have health coverage, including significant gains among racial and ethnic minorities.[3]

Using early release data from the 2014 National Health Interview Survey (NHIS), we found that by the fourth quarter of 2014 the uninsurance rate for Hispanic adults, including both citizens and noncitizens, had fallen to 31.8 percent from 40.1 percent in the third quarter of 2013—which was just before the first ACA open enrollment period (Exhibit 1). Over the same period, non-Hispanic black adults (hereafter black adults) saw a decline in uninsurance from 25.5 percent to 17.2 percent, and non-Hispanic white adults (hereafter white adults), who started with a much lower level of uninsurance, saw a smaller but still significant decline, from 14.8 percent to 10.5 percent. (Detailed estimates are shown in online Appendix Table 1.)[4]

Several components of the ACA were expected to contribute to coverage gains for all racial and ethnic groups, both among the uninsured whom the act made newly eligible for financial assistance and among those who had been previously eligible for Medicaid or other coverage but who had not enrolled. These include the expansion of Medicaid eligibility to low-income nonelderly adults, federal subsidies for coverage through state-based and federally facilitated health insurance Marketplaces, the individual mandate, expanded investments in outreach designed to promote enrollment, and a new emphasis on enrollment simplification and coordination across Medicaid and the Marketplaces.[5]

In practice, however, the ability of the ACA to reduce racial and ethnic disparities in coverage has been limited by at least two factors. First, the 2012 Supreme Court ruling in *National Federation of Independent Business v. Sebelius* made Medicaid expansion optional for the states, and only twenty-eight states and the District of Columbia had implemented the ACA Medicaid expansion as of July 2015. As a consequence, a large "coverage gap" can occur in states that do not expand Medicaid. This is because people with incomes

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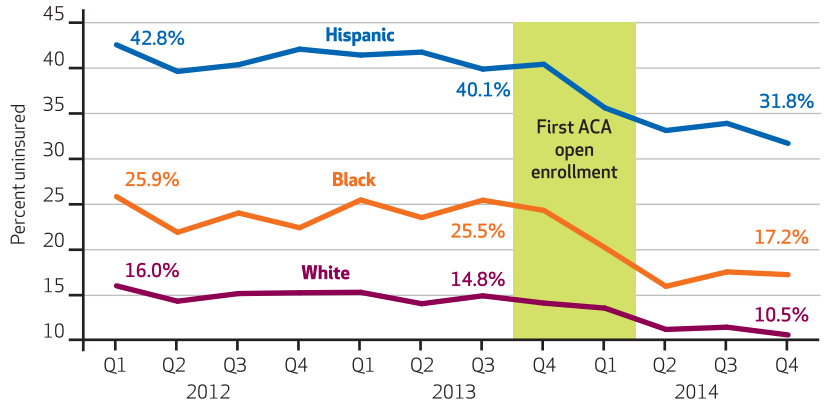
EXHIBIT 1

Percentages Uninsured For Adults Ages 18–64, By Race And Ethnicity, 2012–14



SOURCE Authors' analysis of data for 2012–14 from the National Health Interview Survey. **NOTES** Uninsured is at the time of the survey. Black and white are non-Hispanic black and non-Hispanic white, respectively. ACA is Affordable Care Act.

below the federal poverty level are not eligible to receive subsidies to purchase Marketplace coverage—subsidies that are available only to those with incomes of 100–400 percent of poverty. But many poor adults are not eligible for Medicaid in states that did not expand eligibility under the ACA. This uneven implementation of the Medicaid expansion disproportionately affects the black population. Approximately 1.4 million more blacks are expected to be uninsured, based on December 2014 expansion decisions, than if all states expanded Medicaid.[6]

Second, undocumented immigrants are ineligible for Medicaid and cannot purchase subsidized coverage through the Marketplaces. This dramatically affects the ACA's potential to reduce uninsurance for Hispanics, an estimated 16 percent of whom are undocumented immigrants.[6]

In this study we used data from the NHIS to examine changes through December 2014 in insurance coverage for white, black, and Hispanic adults ages 18–64. We also explored how both absolute and relative disparities in uninsurance changed following the first ACA open enrollment period for black and Hispanic adults compared to white adults, both in states that opted to expand Medicaid and in those that did not.

Study Data And Methods

The NHIS, the principal source of information on the health of the US civilian noninstitutionalized population, is conducted annually by the National Center for Health Statistics of the Centers for Disease Control and Prevention. We used data for 2012–14 to generate estimates of the share of adults without insurance. We focused on the second and third quarters of 2014, a period after the first ACA open enrollment period, and the second and third quarters of 2013, a period just before that enrollment period. As noted above, our analysis focused on three groups: non-Hispanic whites, non-Hispanic blacks, and Hispanics. Because of sample size constraints, we excluded people who reported belonging to other or multiple races. We concentrated on nonelderly adults because they are the primary targets of ACA coverage expansion.

We calculated two measures of disparities. First, we calculated the "absolute disparity," which reflects the difference—or gap—in the percentage uninsured between whites and blacks and between whites and Hispanics. Second, we calculated the "relative disparity," which reflects the ratio of the percentage uninsured for blacks or Hispanics to that for whites. Each measure conveys different but important information with regard to disparities.[7] We examined the changes in these disparity measures over time for adults in all states and separately for adults in states that did and did not expand Medicaid.[8]

We adjusted all estimates for age and sex to account for differences in the composition of the racial and ethnic groups that might contribute to differences in coverage. We did not make adjustments for socioeconomic characteristics, which means that our disparity measures reflect any differences in coverage that are associated with differences in income, education, and other factors that vary across racial and ethnic groups.

The Institute of Medicine (IOM) defines *health care disparities* as all differences not due to health status.[9] While we did not control for health status directly, age and sex are highly correlated with it. Thus, our approach may be interpreted as broadly consistent with the IOM's definition.[10]

This analysis had several limitations. First, we could not identify citizenship or legal resident status in the NHIS early release files, which means that we could not narrow our analysis to those individuals who would be eligible for Medicaid and Marketplace coverage. Second, we examined only the changes in disparities that followed the first ACA open enrollment period. As a result, we present an early look at how disparities are changing under the ACA. Finally, we could not isolate the effects of the ACA from effects of other changes that were occurring during this time period, including an improving economy.

Study Results

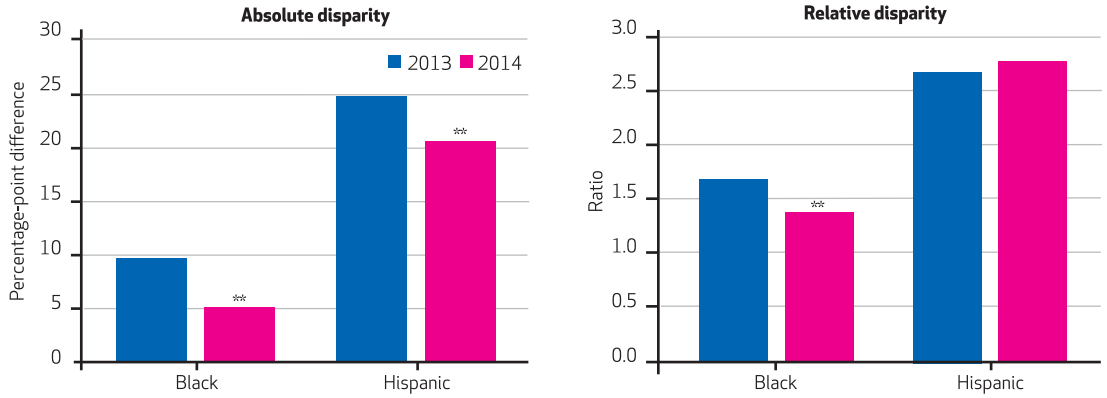
Uninsurance rates declined significantly among adults in all three racial and ethnic groups (Exhibit 1). These changes resulted in declines in the absolute and relative disparities in the percentage uninsured for black adults (Exhibit 2). For Hispanics, the absolute disparity narrowed by 4.2 percentage points. The relative disparity increased for Hispanics, but the change from 2013 to 2014 was not significant.

When we examined changes in uninsurance separately for states that did and did not expand Medicaid, we found that uninsurance rates declined for all groups in expansion states and for blacks and Hispanics in nonexpansion states (Exhibit 3). However, white adults saw no significant decline in uninsurance in nonexpansion states. In addition, expansion states had lower uninsurance rates than did nonexpansion states for all groups in both 2013 and 2014.

All three groups experienced some gains in coverage under the ACA, but the effects on disparities varied across groups, across states, and across measures of disparities. For black adults in expansion states, for example, the absolute disparity in the percentage uninsured was 7.4 percentage points in 2013, which fell to

EXHIBIT 2

Absolute And Relative Disparities In Percentages Uninsured For Black And Hispanic Adults Ages 18–64, 2013–14



SOURCE Authors' analysis of data for the second and third quarters of 2013 and 2014 from the National Health Interview Survey. **NOTES** These estimates of disparities compared the second and third quarters of 2013 to the same period in 2014. There were no meaningful differences in the results when we compared full-year national estimates for 2013 and 2014. Uninsured is at the time of the survey. Black is non-Hispanic black. Absolute disparity is the difference between the percentage uninsured for blacks or Hispanics and the percentage uninsured for whites. Relative disparity is the ratio of the percentage uninsured for blacks or Hispanics to the percentage uninsured for whites. All absolute disparities are significantly different from 0 ($p < 0.05$), and all relative disparities are significantly different from 1 ($p < 0.05$). Significance in the figure refers to differences between 2013 and 2014. **$p < 0.05$

4.1 percentage points in 2014 (Exhibit 4). The absolute disparity for black adults in nonexpansion states was more than cut in half between 2013 and 2014, falling from 11.1 percentage points to 4.8 percentage points. The decline in the relative disparity for blacks was significant in nonexpansion states but not in expansion states.

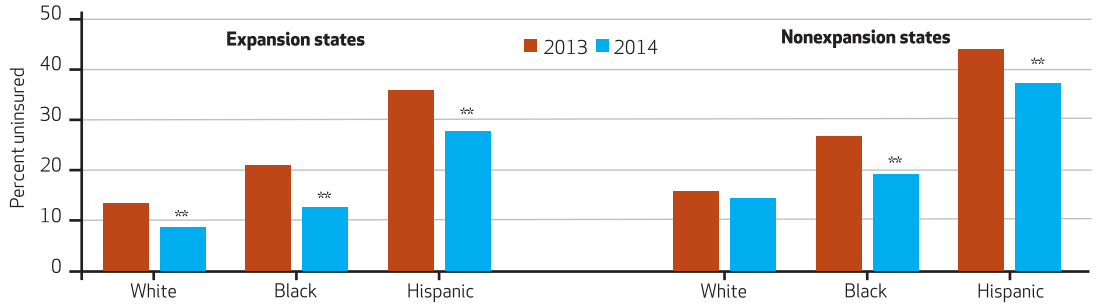
For Hispanic adults, the absolute disparity declined in both expansion and nonexpansion states, but large gaps remained (Exhibit 5). In 2014 the absolute disparity for Hispanic adults was 19.3 percentage points in expansion states and 23.0 percentage points in nonexpansion states. Somewhat surprisingly, relative disparities increased for Hispanics in expansion states. In those states Hispanics were 3.2 times more likely to be uninsured than whites in 2014, compared to 2.7 times in 2013.

Discussion

We found significant improvements in insurance coverage for all racial and ethnic groups between the second and third quarters of 2013 and the same period of 2014, which translated into reductions in absolute disparities in the uninsurance rates for blacks and Hispanics in both expansion and nonexpansion states. However, the

EXHIBIT 3

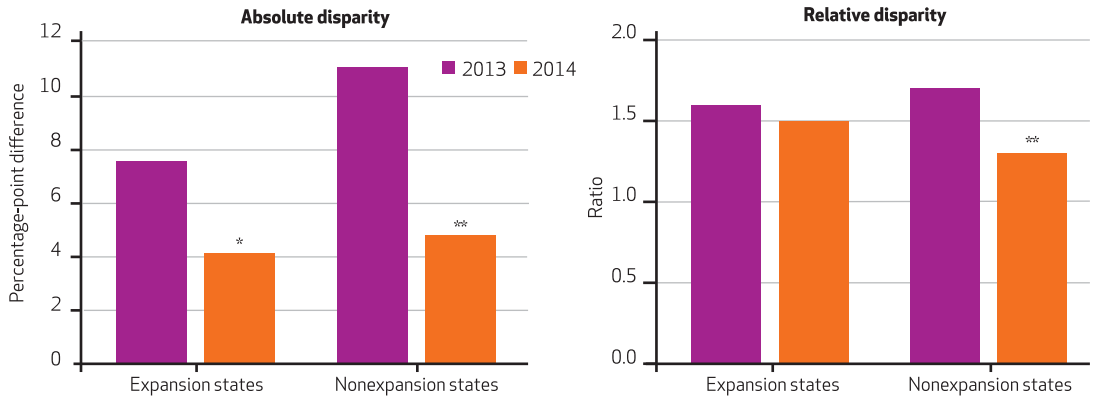
Percentages Uninsured For Adults Ages 18–64, By Race And Ethnicity And By States' Medicaid Expansion Status, 2013–14



SOURCE Authors' analysis of data for the second and third quarters of 2013 and 2014 from the National Health Interview Survey. **NOTES** Uninsured is at the time of the survey. Black and white are non-Hispanic black and non-Hispanic white, respectively. Expansion states are those that expanded Medicaid eligibility as of October 31, 2013 (for details, see Note 8 in text). Significance refers to differences between 2013 and 2014. **$p < 0.05$

EXHIBIT 4

Absolute And Relative Disparities In Percentages Uninsured For Non-Hispanic Black Adults Ages 18–64, By States' Medicaid Expansion Status, 2013–14



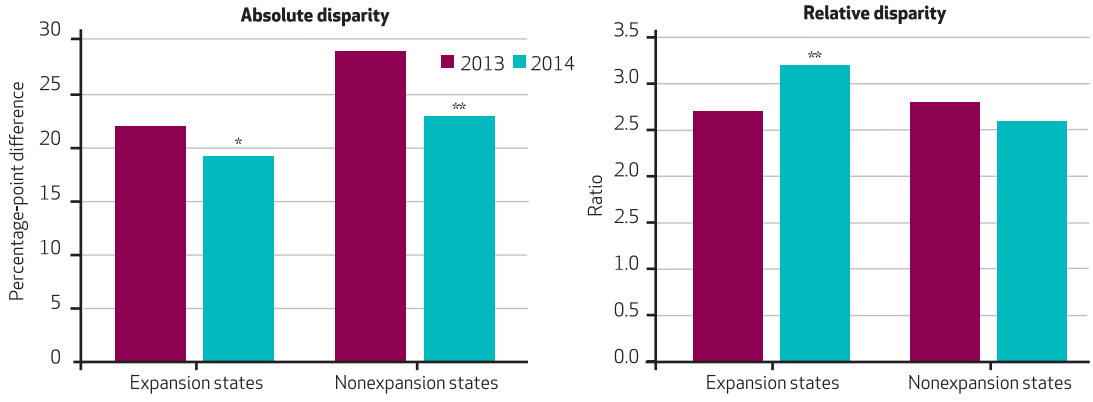
SOURCE Authors' analysis of data for the second and third quarters of 2013 and 2014 from the National Health Interview Survey. **NOTES** These estimates of disparities compared the second and third quarters of 2013 to the same period in 2014. There were no meaningful differences in the results when we compared full-year national estimates for 2013 and 2014, but we do not yet have state identifiers for the 2014 full-year file. Expansion states are explained in the Notes to Exhibit 3. Uninsured is at the time of the survey. Absolute and relative disparity are defined in the Notes to Exhibit 2. All absolute disparities are significantly different from 0 ($p < 0.05$), and all relative disparities are significantly different from 1 ($p < 0.05$). Significance in the figure refers to differences between 2013 and 2014. *$p < 0.10$ **$p < 0.05$

changes in relative disparities in uninsurance were mixed, with Hispanics in expansion states actually seeing a significant increase in the relative disparity and blacks in nonexpansion states experiencing a significant decline in the relative disparity. The coverage gains for blacks in nonexpansion states may be due to strong Marketplace enrollment[11] and to increased participation among those previously eligible for Medicaid (possibly the result of a variant of the so-called woodwork or welcome-mat effect).[12] The lack of coverage gains for whites in these states (Exhibit 3) likely reflects many factors, including differences in attitudes toward the ACA by race.[13]

Furthermore, despite improvements in absolute disparities over time, significant gaps in the uninsurance rate remained for blacks and Hispanics, compared to whites, in expansion and

EXHIBIT 5

Absolute And Relative Disparities In Percentages Uninsured For Hispanic Adults Ages 18–64, By States' Medicaid Expansion Status, 2013–14



SOURCE Authors' analysis of data for the second and third quarters of 2013 and 2014 from the National Health Interview Survey. **NOTES** These estimates of disparities compared the second and third quarters of 2013 to the same period in 2014. There were no meaningful differences in the results when we compared full-year national estimates for 2013 and 2014, but we do not yet have state identifiers for the 2014 full-year file. Expansion states are explained in the Notes to Exhibit 3. Uninsured is at the time of the survey. Absolute and relative disparity are defined in the Notes to Exhibit 2. All absolute disparities are significantly different from 0 ($p < 0.05$), and all relative disparities are significantly different from 1 ($p < 0.05$). Significance in the figure refers to differences between 2013 and 2014. *$p < 0.10$ **$p < 0.05$

nonexpansion states in 2014. The persistence of gaps of up to 23 percentage points for Hispanics likely reflects immigrants' restricted access to Medicaid and subsidies for Marketplace coverage. It will therefore be important to monitor disparities for the undocumented immigrant population as ACA implementation continues.

Substantial additional progress on reducing disparities in uninsurance under the ACA will require expanding Medicaid in all states. For example, one recent study projected that with all states expanding Medicaid eligibility, the absolute black-white disparity in the uninsurance rate would be reduced to 2.6 percentage points.[6] Targeted education, outreach, and enrollment efforts related to Medicaid and the Marketplaces may also be particularly important for members of racial and ethnic minority groups, who have been shown to have more limited health insurance literacy than their white counterparts.[14] Navigators and other people who provide assistance with enrollment will also be critical to the success of coverage expansions, and ensuring that assistance is available for non–English speakers will be particularly important for the Hispanic population.[15] ■

This work was funded by the Robert Wood Johnson Foundation. An earlier version of this article was presented at the AcademyHealth Annual Research Meeting in Minneapolis, Minnesota, June 14, 2015. The authors are grateful to Jason Gates for research assistance and to Patricia Barnes and her staff at the Research Data Center of the National Center for Health Statistics for their help with this study. The findings and conclusions are those of the authors and do not reflect the views of the Research Data Center, the National Center for Health Statistics, or the Centers for Disease Control and Prevention or of the Urban Institute, its trustees, or its funders. [*Published online September 16, 2015.*]

NOTES

1 Artiga S. Health coverage by race and ethnicity: the potential impact of the Affordable Care Act [Internet]. Washington (DC): Kaiser Commission on Medicaid and the Uninsured; 2013 Mar [cited 2015 Aug 19]. Available from: https://kaiserfamilyfoundation.files.wordpress.com/2014/07/8423-health-coverage-by-race-and-ethnicity.pdf

2 Clemans-Cope L, Kenney GM, Buettgens M, Carrol C, Blavin F. The Affordable Care Act's coverage expansions will reduce differences in insurance rates by race and ethnicity. Health Aff (Millwood). 2012; 31(5):920–30.

3 Long SK, Karpman M, Kenney GM, Zuckerman S, Wissoker D, Shartzer S, et al. Taking stock: gains in health insurance coverage under the ACA as of March 2015 [Internet]. Washington (DC): Urban Institute; 2015 Apr 16 [cited 2015 Jun 26]. Available from: http://hrms.urban.org/briefs/Gains-in-Health-Insurance-Coverage-under-the-ACA-as-of-March-2015.html

4 To access the Appendix, click on the Appendix link in the box to the right of the article online.

5 Kenney GM, Huntress M, Buettgens M, Lynch V, Resnick D (Urban Institute, Washington, DC). State and local coverage changes under full implementation of the Affordable Care Act [Internet]. Menlo Park (CA): Henry J. Kaiser Family Foundation; 2013 Jul 31 [cited 2015 Aug 20]. Available from: http://kff.org/health-reform/report/state-and-local-coverage-changes-under-full-implementation-of-the-affordable-care-act/

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U.S. Department of Health & Human Services

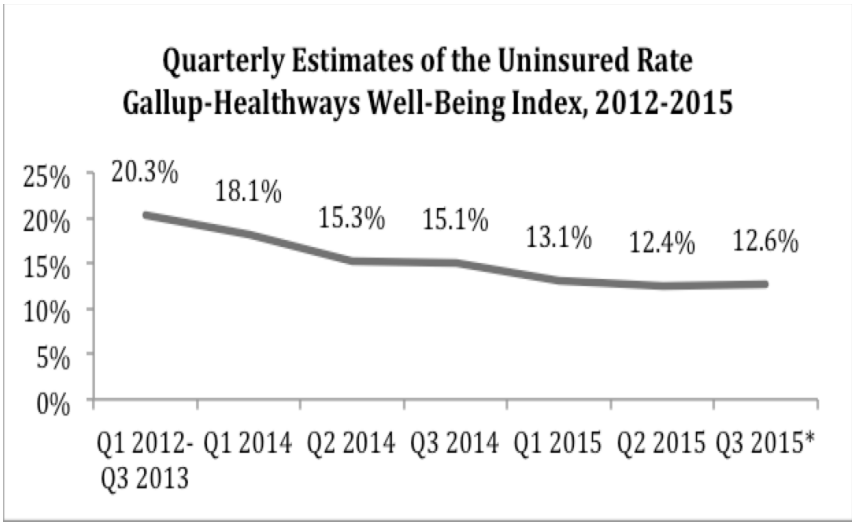
ASPE

OFFICE OF THE ASSISTANT SECRETARY
FOR PLANNING AND EVALUATION

HEALTH INSURANCE COVERAGE AND THE AFFORDABLE CARE ACT

09/22/2015

In March 2015, ASPE estimated that 16.4 million uninsured people had gained health insurance coverage as several of the Affordable Care Act's coverage provisions took effect. Using updated data, ASPE now estimates that 17.6 million uninsured people have gained health insurance coverage. Coverage gains refer to different sources of coverage, including Medicaid, the Health Insurance Marketplace, and individual market coverage; therefore, gains are not limited to Marketplace-eligible individuals.



	Q1 2014	Q3 2014	Q1 2015	Q3 2015*
Number gained coverage since baseline	4.3 million	10.3 million	14.3 million	15.3 million

- 15.3 million adults gained health insurance coverage since the beginning of open

SIMILAR CONTENT

enrollment in October 2013 through September 12, 2015. Over that period, the uninsured rate declined from 20.3 percent to 12.6 percent — a 38 percent (or 7.7 percentage point) reduction in the uninsured rate.

- 2.3 million additional young adults (aged 19-25) gained health insurance coverage between the enactment of the Affordable Care Act in 2010 and the start of open enrollment in October 2013 due to the ACA provision allowing young adults to remain on a parent's plan until age 26.

(Q1 2012-Q3 2013)							

*Data are through 9/12/2015.

Source: Office of the Assistant Secretary for Planning and Evaluation (ASPE) analysis of Gallup-Healthways Well-Being Index survey data through 9/12/15. The baseline period is from Q1 2012 to Q3 2013. All models use nationally-representative survey weights and adjust for age, sex, race, ethnicity, employment, state of residence, marital status, rural location, and a linear time trend in order to control for changes in the economy, population composition, and non-policy factors affecting health insurance coverage. Models do not adjust for income due to changes in Gallup methodology beginning on June 1, 2015. Historical estimates have been updated to reflect the new methodology and differ from those in ASPE's analysis from March 2015 (http://aspe.hhs.gov/health-insurance-coverage-and-affordable-care-act-aspe-issue-brief-march-2015). See technical notes for additional details.

Uninsured Rates by Race and Ethnicity

The uninsured rate declined across all race/ethnicity categories since the baseline period. There were greater declines in the uninsured rate among African Americans and Hispanics than among Whites.

- Among Whites, the uninsured rate declined by 6.0 percentage points, from a baseline uninsured rate of 14.3 percent to 8.3 percent, resulting in 7.4 million adults gaining coverage.
- Among African Americans, the uninsured rate declined by 10.3 percentage points, from a baseline uninsured rate of 22.4 percent to 12.1 percent, resulting in 2.6 million adults gaining coverage.
- Among Hispanics, the uninsured rate declined by 11.5 percentage points, from a baseline uninsured rate of 41.8 percent to 30.3 percent, resulting in about 4.0 million adults gaining coverage.

		Q1 2014	Q3 2014	Q1 2015	Q3 2015*	UNINSURED RATE IN Q3 2015*	NUMB GAIN COVER

	BASELINE UNINSURED RATE	CHANGE IN PERCENTAGE POINTS FROM BASELINE TREND					SINC BASEL
Whites	14.3	-1.5	-4.8	-5.7	-6.0	8.3	mill
African Americans	22.4	-3.8	-6.6	-9.8	-10.3	12.1	mill
Hispanics	41.8	-3.4	-5.4	-10.5	-11.5	30.3	mill

*Data are through 9/12/2015.

Source: Office of the Assistant Secretary for Planning and Evaluation (ASPE) analysis of Gallup-Healthways Well-Being Index survey data through 9/12/15. The baseline period is from Q1 2012 to Q3 2013. All models use nationally-representative survey weights and adjust for age, sex, race, ethnicity, employment, state of residence, marital status, rural location, and a linear time trend in order to control for changes in the economy, population composition, and non-policy factors affecting health insurance coverage. Models do not adjust for income due to changes in Gallup methodology beginning on June 1, 2015. Historical estimates have been updated to reflect the new methodology and differ from those in ASPE's analysis from March 2015 (http://aspe.hhs.gov/health-insurance-coverage-and-affordable-care-act-aspe-issue-brief-march-2015). See technical notes for additional details.

Uninsured Rates by State Medicaid Expansion Status

Health insurance coverage gains continued to be especially strong in Medicaid expansion states.

- **Expansion states** experienced a decline in their uninsured rate of 8.1 percentage points, from an average baseline rate of 18.2 percent to 10.1 percent.
- **Non-expansion states** experienced a decline in their uninsured rate of 7.3 percentage points, from an average baseline rate of 23.4 percent to 16.1 percent.

		Q1 2014	Q3 2014	Q1 2015	Q3 2015*	

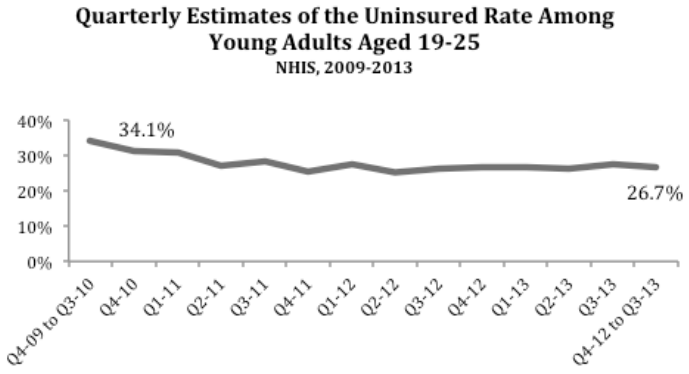
	BASELINE UNINSURED RATE		CHANGE IN PERCENTAGE POINTS FROM BASELINE TREND			UNINSURED RATE IN Q3 2015*
Expansion	18.2	-2.5	-6.0	-7.5	-8.1	10.1
Non-expansion	23.4	-2.0	-4.2	-7.0	-7.3	16.1

*Data are through 9/12/2015.

Source: Office of the Assistant Secretary for Planning and Evaluation (ASPE) analysis of Gallup-Healthways Well-Being Index survey data through 9/12/15. The baseline period is from Q1 2012 to Q3 2013. All models use nationally-representative survey weights and adjust for age, sex, race, ethnicity, employment, state of residence, marital status, rural location, and a linear time trend in order to control for changes in the economy, population composition, and non-policy factors affecting health insurance coverage. Models do not adjust for income due to changes in Gallup methodology beginning on June 1, 2015. Historical estimates have been updated to reflect the new methodology and differ from those in ASPE's analysis from March 2015 (http://aspe.hhs.gov/health-insurance-coverage-and-affordable-care-act-aspe-issue-brief-march-2015). See technical notes for additional details. Medicaid expansion states include AZ, AR, CA, CO, CT, DE, DC, HI, IL, IN, IA, KY, MD, MA, MI, MN, NV, NH, NJ, NM, NY, ND, OH, OR, PA, RI, VT, WA, and WV.

Uninsured Rates for Young Adults

Young Adults: Coverage gains for young adults aged 19-25 started in 2010 with the ACA's provision enabling them to stay on their parents' plans until age 26. From the baseline period through the start of open enrollment in October 2013, the uninsured rate for young adults declined from 34.1 percent to 26.7 percent, which translates to 2.3 million young adults gaining coverage.*



** Source: Office of the Assistant Secretary for Planning and Evaluation (ASPE) analysis of Gallup-Healthways Well-Being Index survey data through 9/12/15. The

- Since October 2013, an additional 3.2 million young adults aged 19-25

gained coverage.**
- In total, an estimated 5.5 million young adults gained coverage from 2010 through September 12, 2015, which is statistically unchanged from March 4, 2015.

*Source: National Health Interview Survey; see technical notes for methods

baseline period is from Q1 2012 to Q3 2013. All models use nationally-representative survey weights and adjust for age, sex, race, ethnicity, employment, state of residence, marital status, rural location, and a linear time trend in order to control for changes in the economy, population composition, and non-policy factors affecting health insurance coverage. Models do not adjust for income due to changes in Gallup methodology beginning on June 1, 2015. Historical estimates have been updated to reflect the new methodology and differ from those in ASPE's analysis from March 2015 (http://aspe.hhs.gov/health-insurance-coverage-and-affordable-care-act-aspe-issue-brief-march-2015). See technical notes for additional details.

Uninsured Rates by Gender

The uninsured rate declined for both males and females since the baseline period. There was a greater decline in the uninsured rate among females than among males.

- Males experienced a decline in their uninsured rate of 7.3 percentage points, from an average baseline rate of 21.8 percent to 14.5 percent, resulting in 7.3 million adult males gaining coverage.
- Females experienced a decline in their uninsured rate of 8.1 percentage points, from an average baseline rate of 18.9 percent to 10.8 percent, resulting in nearly 8.2 million adult women gaining coverage.

	BASELINE UNINSURED RATE	Q1 2014	Q3 2014	Q1 2015	Q3 2015	UNINSURED RATE IN Q3 2015*	NUMBE GAINEI COVERA SINCE BASELI
		CHANGE IN PERCENTAGE POINTS FROM BASELINE TREND					
Male	21.8	-2.1	-5.4	-6.8	-7.3	14.5	7 millio
Female	18.9	-2.4	-5.1	-7.7	-8.1	10.8	8 millio

Source: Office of the Assistant Secretary for Planning and Evaluation (ASPE) analysis of Gallup-Healthways Well-Being Index survey data through 9/12/15. The baseline period is from Q1 2012 to Q3 2013. All models use nationally-representative survey weights and adjust for age, sex, race, ethnicity, employment, state of residence, marital status, rural location, and a linear time trend in order to control for changes in the economy, population composition, and non-policy factors affecting health insurance coverage. Models do not adjust for income due to changes in Gallup methodology beginning on June 1, 2015. Historical estimates have been updated to reflect the new methodology and differ from those in ASPE's analysis from March 2015 (http://aspe.hhs.gov/health-insurance-coverage-and-affordable-care-act-aspe-issue-brief-march-2015). See technical notes for additional details.

TAGS

Health Insurance Insurance, Health Models, Statistical Population Employment Evaluation Studies Policy Income Medicaid

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