Reports and Research

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9.4 Million Fewer Families Are Having Problems Paying Medical Bills

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At a Glance

- The share of nonelderly adults with problems paying family medical bills over the previous year declined from 22.0 percent in September 2013 to 17.3 percent in March 2015.
- Problems paying medical bills declined among adults in both Medicaid expansion states and nonexpansion states.
- Adults are more likely to have problems paying medical bills if they have low incomes, are uninsured or have a high-deductible health plan, or have higher health care needs because of fair or poor health.
- Nearly three-quarters of adults with problems paying medical bills reported forgoing needed health care because they could not afford it.

Federal and nonfederal survey data show strong gains in health insurance coverage following implementation of key provisions of the Affordable Care Act (ACA) in 2014 and early 2015 (Carman and Eibner 2014; Collins, Rasmussen, and Doty 2014; Long et al. 2015; Martinez and Cohen 2015; Office of the Assistant Secretary for Planning and Evaluation 2015).[1] Research comparing Medicaid enrollees with uninsured adults suggests that these coverage gains will increase access to and reduce the costs of health care for those who have gained coverage (Baicker et al. 2013; Coughlin et al. 2013; Finkelstein et al. 2012; Long et al. 2012). Early evidence on changes under the ACA supports this expectation, with a declining share of nonelderly adults reporting that their families had problems paying medical bills between 2012 and 2014 (Cohen 2015; Collins et al. 2015).

In this brief, we build on our analyses of changes in health insurance coverage under the ACA using the Urban Institute's Health Reform Monitoring Survey (HRMS; Long et al. 2015) and those early studies of changes in the burden of health care costs to examine changes in health care affordability under the ACA through March 2015. We also highlight gaps in the financial protection against medical bills provided by insurance coverage and explore the characteristics and health care challenges of those who have problems paying medical bills.

What We Did

This brief draws on data collected from the HRMS between the first quarter of 2013 and the first quarter of 2015. In each quarter, we ask our sample of nonelderly adults (ages 18 to 64) a question adapted from the National Health Interview Survey about whether they or anyone in their families had problems paying or were unable to pay medical bills in the past 12 months. We refer to adults who report such problems as adults with problems paying family medical bills.

We focus on estimated changes in the share of adults reporting that they or someone in their families had problems paying medical bills between September 2013, just before the ACA's first Marketplace open enrollment period, and March 2015, just after the second open enrollment period ended. We show trends in problems paying medical bills for all nonelderly adults and for adults by state Medicaid expansion status as of March 2015.[2] Following our analysis of changes over time in the share of adults with problems paying family medical bills, we draw on the March 2015 HRMS

data to explore the prevalence of problems paying family medical bills among different demographic and socioeconomic subgroups, among uninsured adults, and among adults with high-deductible health plans. We also examine the extent of unmet need for health care because of concerns about affordability among adults who have problems paying family medical bills.

Each round of the HRMS is weighted to be nationally representative. We use these weights and regression adjustment to control for differences in the demographic and socioeconomic characteristics of the respondents across the different rounds of the survey.[3] We focus on statistically significant changes in problems paying family medical bills over time (defined as changes relative to September 2013 that are significantly different from zero at the 5 percent level or lower), and provide a 95 percent confidence interval (CI) for key estimates. To extrapolate our estimates from the survey to the overall population, we use projections for the size of the 2015 population from the US Census Bureau.[4] Although the estimated changes coincide with the implementation of ACA coverage expansions, we are not attempting to disentangle the changes in health care affordability resulting from coverage gains under the ACA from the changes caused by other factors that affect affordability, including those related to the business cycle.

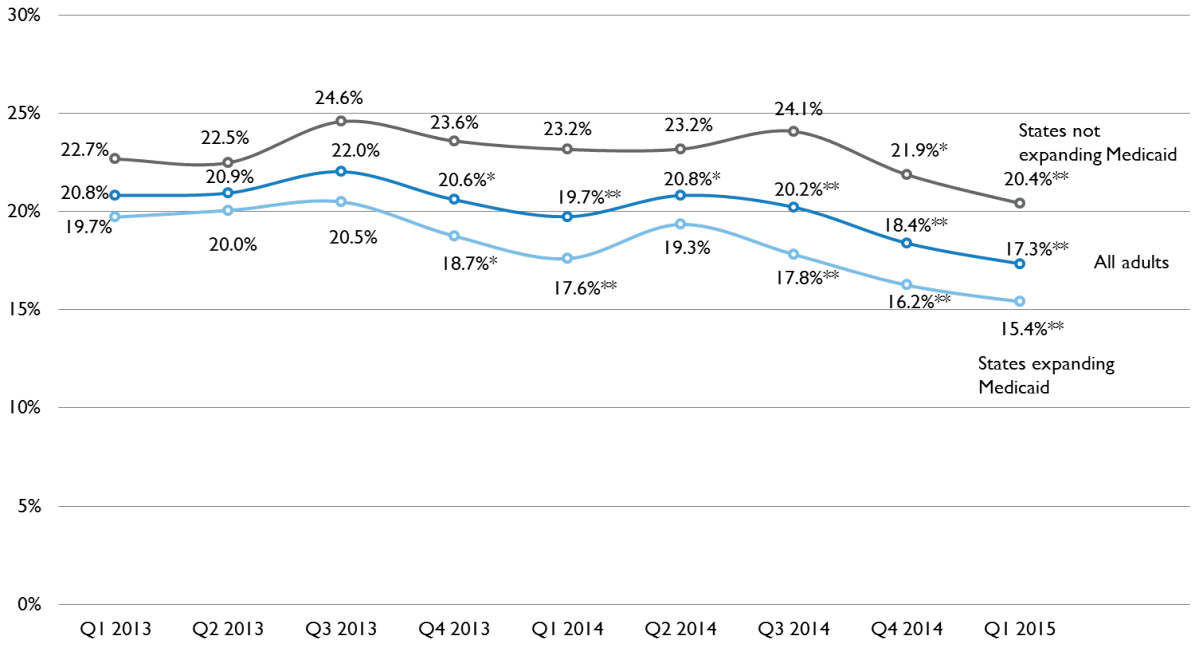
What We Found

The share of adults with problems paying family medical bills fell 21.3 percent between September 2013 and March 2015.

In March 2015, 17.3 percent of adults had problems paying family medical bills, down from 22.0 percent in September 2013, for a decline of 21.3 percent (figure 1).[5] Applying the estimated 4.7 percentage-point (95% CI [3.3, 6.1]) decrease in the share with problems paying medical bills to the estimated national population of nonelderly adults yields an estimated decline of 9.4 million (95% CI [6.6 million, 12.2 million]) adults with problems paying family medical bills between September 2013, just before the rollout of the Medicaid expansions and the Marketplace, and March 2015.

There were gains in health care affordability for adults in both Medicaid expansion and nonexpansion states. As shown, the share of adults in Medicaid expansion states with problems paying family medical bills fell 5.1 percentage points (95% CI [3.5, 6.7]), from 20.5 percent to 15.4 percent, while the share of adults with problems paying family medical bills in nonexpansion states fell 4.2 percentage points (95% CI [1.4, 6.9]), from 24.6 percent to 20.4 percent.

Figure 1. Share of Adults Ages 18 to 64 with Problems Paying Family Medical Bills in the Past 12 Months, Overall and by State Decision to Expand Medicaid, Quarter 1 2013 to Quarter 1 2015

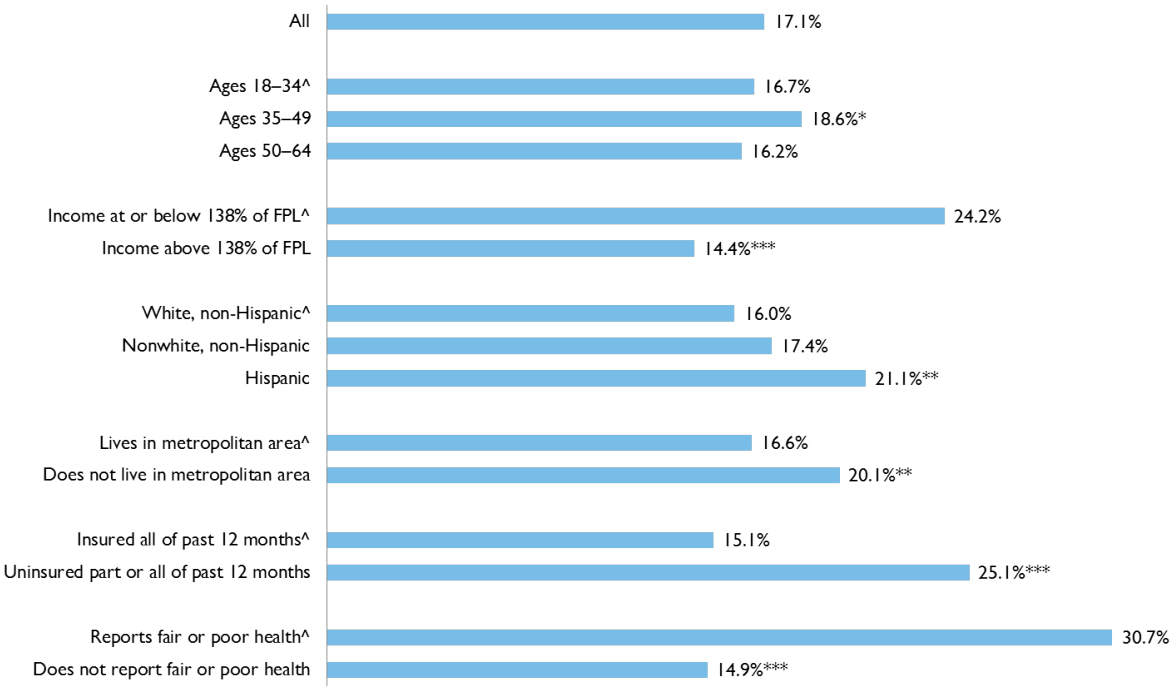


Source: Health Reform Monitoring Survey, quarter 1 2013 through quarter 1 2015.
Notes: Estimates are regression adjusted. Medicaid expansion status is as of March 2015.
*/** Estimate differs significantly from quarter 3 2013 at the .05/.01 levels, using two-tailed tests. We only report significance of differences for estimates after quarter 3 2013.

Adults are more likely to have problems paying medical bills if they have low incomes, are uninsured or have a high-deductible health plan, or have higher health care needs because of fair or poor health.

Among adults who were uninsured for part or all of the previous 12 months, one-quarter (25.1 percent) reported problems paying family medical bills over the same period, compared with 15.1 percent of full-year insured adults (figure 2).

Figure 2. Share of Adults Ages 18 to 64 with Problems Paying Family Medical Bills, Overall and by Demographic Subgroups, Quarter 1 2015

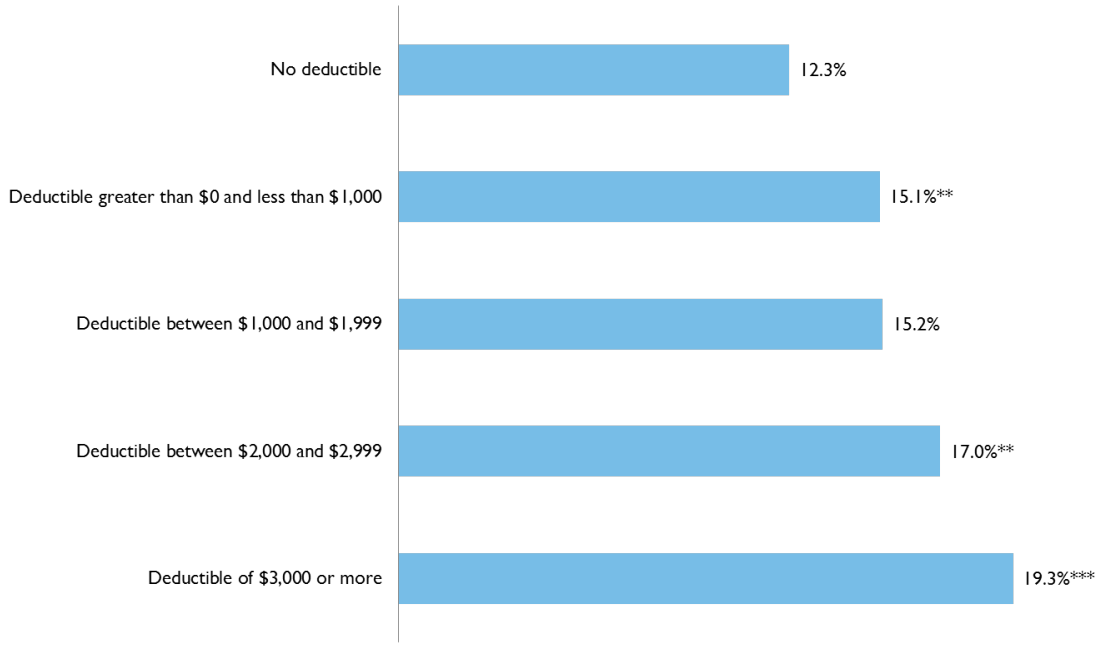


Source: Health Reform Monitoring Survey, quarter 1 2015.
Note: FPL is federal poverty level. Estimates may differ from those in figure 1 because these estimates are not regression adjusted.
*/**/*** Estimate differs significantly from those in the reference group, denoted by ^, at the .10/.05/.01 levels, using two-tailed tests.

Adults were also more likely to have problems paying family medical bills if they had low incomes or had more significant health care needs. For instance, 24.2 percent of adults with incomes at or below 138 percent of the federal poverty level (FPL) had problems with medical bills, compared with 14.4 percent of adults with incomes above that threshold. Nearly one-third (30.7 percent) of adults reporting that they were in fair or poor health had problems with medical bills, as opposed to 14.9 percent of other adults.

Among full-year insured adults, higher deductibles under their health plans are associated with more frequent problems paying family medical bills (figure 3). Only 12.3 percent of full-year insured adults with health plans without a deductible reported problems paying family medical bills, compared with almost one in five adults with a health plan that has a deductible of $3,000 or more.

Figure 3. Share of Adults Ages 18 to 64 Insured for the Past 12 Months with Problems Paying Family Medical Bills, By Health Insurance Plan Deductible Amount, Quarter 1 2015

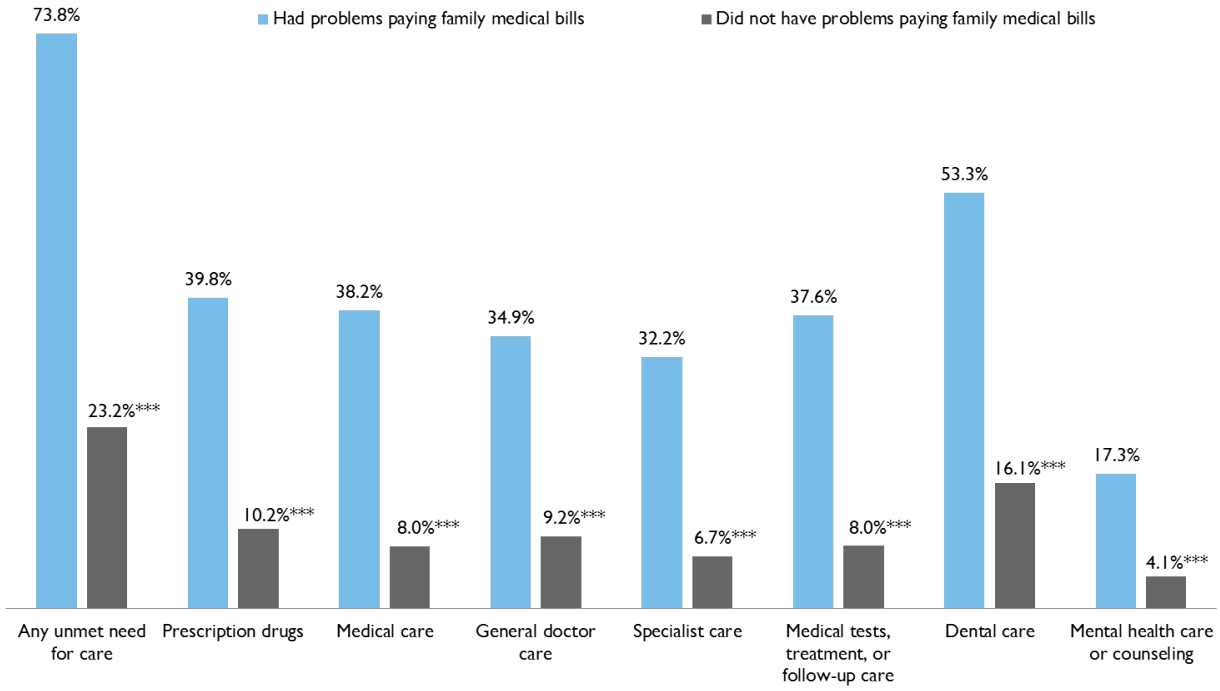


Source: Health Reform Monitoring Survey, quarter 1 2015.
Note: Estimates not shown for the 2.4 percent of adults insured for the past 12 months who did not report or were not sure of their deductible amount.
*/**/*** Estimate differs significantly from those with no deductible at the .10/.05/.01 levels, using two-tailed tests.

Adults with problems paying family medical bills are much more likely than other adults to forgo needed health care because they cannot afford it.

Though adults who struggle to pay family medical bills may respond by incurring debt, reducing spending on other needs, or drawing down savings, HRMS data show that a large proportion of these adults go without needed health care because they cannot afford it. As shown in figure 4, nearly three in four adults (73.8 percent) with problems paying family medical bills reported an unmet need for at least one of seven types of health care services because they could not afford it, compared with less than one-quarter of adults (23.2 percent) who did not have problems paying family medical bills. Adults with medical bill problems were most likely to go without dental care or prescription drugs because they could not afford it.[6]

Figure 4. Among Adults Ages 18 to 64 with and without Problems Paying Family Medical Bills in the Past 12 Months, Share with Unmet Needs for Care in Past 12 Months, Quarter 1 2015



Source: Health Reform Monitoring Survey, quarter 1 2015.
*/**/*** Estimate differs significantly from those with problems paying family medical bills in the past 12 months at the .10/.05/.01 levels, using two-tailed tests.

What It Means

The share of adults with problems paying family medical bills in the previous 12 months fell an estimated 4.7 percentage points between September 2013 and March 2015. Overall, an estimated 9.4 million fewer adults had problems paying family medical bills over the previous year in March 2015 than did in September 2013. However, identifying the extent to which the decline in medical bill problems was the result of coverage gains rather than other factors such as the improving economy is beyond the scope of this policy brief.

Though adults who maintain continuous health insurance coverage are much less likely to have problems paying family medical bills than those with spells of uninsurance, our results show that insurance coverage leaves gaps in financial protection from medical bills for many adults. Among adults who maintain continuous coverage for a full year, problems with medical bills are more prevalent for those with higher annual per-person health plan deductible amounts. A recent study shows that 76 percent of nonelderly, nonpoor households with private insurance have sufficient liquid financial assets to cover a midrange single deductible of $1,200 or family deductible of $2,400 (Claxton, Rae, and Panchal 2015).

Since 2006, health plan deductibles have risen steadily for adults with employer-sponsored insurance, with 18 percent of covered workers enrolled in health plans with deductibles of $2,000 or more as of 2014 (Claxton et al. 2014). High deductibles are also common among the most popular

plans in the health insurance Marketplaces. For example, the average single coverage, silver plan deductible for a 40-year-old nonsmoker is nearly $3,000 (Gabel et al. 2014). ACA provisions that reduce deductibles and other out-of-pocket cost burdens, such as cost-sharing reductions for silver plans purchased by those with incomes up to 250 percent of FPL, are likely to mitigate the burden of family medical bills.

Beyond the financial burden associated with problems paying medical bills, we find that nearly three-quarters of the adults who have problems paying family medical bills forgo needed health care because they cannot afford it. Expansions of health insurance coverage under the ACA are likely to reduce but not eliminate problems with the affordability of health care, while ACA policies designed to limit cost sharing may expand access to care that would otherwise be viewed as unaffordable.

References

Baicker, Katherine, Sarah L. Taubman, Heidi L. Allen, Mira Bernstein, Jonathan H. Gruber, Joseph P. Newhouse, Eric C. Schneider, Bill J. Wright, Alan M. Zaslavsky, Amy Finkelstein, and the Oregon Health Study Group. 2013. "The Oregon Experiment – Effects of Medicaid on Clinical Outcomes." *New England Journal of Medicine* 368 (18): 1713–22.

Carman, Katherine Grace, and Christine Eibner. 2014. *Changes in Health Insurance Enrollment since 2013.* Santa Monica, CA: RAND Corporation.

Claxton, Gary, Matthew Rae, and Nirmita Panchal. 2015. *Consumer Assets and Patient Cost Sharing.* Menlo Park, CA: Kaiser Family Foundation.

Claxton, Gary, Matthew Rae, Nirmita Panchal, Anthony Damico, Heidi Whitmore, Nathan Bostick, and Kevin Kenward. 2014. *Employer Health Benefits 2014 Annual Survey.* Menlo Park, CA and Chicago, IL: Kaiser Family Foundation and Health Research and Educational Trust.

Cohen, Robin A. 2015. *Problems Paying Medical Bills Among Persons under Age 65: Early Release of Estimates from the National Health Interview Survey, 2011-June 2014.* Hyattsville, MD: National Center for Health Statistics.

Collins, Sara R., Petra W. Rasmussen, and Michelle M. Doty. 2014. *Gaining Ground: Americans' Health Insurance Coverage and Access to Care after the Affordable Care Act's First Open Enrollment Period*. New York: The Commonwealth Fund.

Collins, Sara R., Petra W. Rasmussen, Michelle M. Doty, and Sophie Beutel. 2015. *The Rise in Health Care Coverage and Affordability since Health Reform Took Effect.* New York: The Commonwealth Fund.

Coughlin, Teresa A., Sharon K. Long, Lisa Clemans-Cope, and Dean Resnick. 2013. *What Difference Does Medicaid Make?* Menlo Park, CA: Kaiser Family Foundation.

Finkelstein, Amy, Sarah Taubman, Mira Bernstein, Jonathan Gruber, Joseph P. Newhouse, Heidi Allen, Katherine Baicker, and the Oregon Health Study Group. 2012. "The Oregon Health Insurance Experiment: Evidence from the First Year." *Quarterly Journal of Economics* 127 (3): 1057–1106.

Gabel, Jon R., Heidi Whitmore, Sam Stromberg, Matthew Green, Daniel S. Weinstein, and Rebecca Oran. 2014. *Analysis Finds No Nationwide Increase in Health Insurance Marketplace Premiums.* New York: The Commonwealth Fund.

Long, Sharon K., Karen Stockley, Elaine Grimm, and Christine Coyer. 2012. *National Findings on Access to Health Care and Service Use for Nonelderly Adults Enrolled in Medicaid.* MACPAC Contractor Report No. 2.

Long, Sharon K., Michael Karpman, Genevieve M. Kenney, Stephen Zuckerman, Douglas Wissoker, Adele Shartzer, Nathaniel Anderson, and Katherine Hempstead. 2015. *Taking Stock: Gains in Health Insurance Coverage under the ACA as of March 2015*. Washington, DC: Urban Institute.

Martinez, Michael E., and Robin A. Cohen. 2015. *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–September 2014.* Hyattsville, MD: National Center for Health Statistics.

Office of the Assistant Secretary for Planning and Evaluation. 2015. *Health Insurance Coverage and the Affordable Care Act.* Washington, DC: US Department of Health and Human Services.

About the Series

This brief is part of a series drawing on the HRMS, a quarterly survey of the nonelderly population that is exploring the value of cutting-edge Internet-based survey methods to monitor the ACA before data from federal government surveys are available. The briefs provide information on health insurance coverage, access to and use of health care, health care affordability, and self-reported health status, as well as timely data on important implementation issues under the ACA. Funding for the core HRMS is provided by the Robert Wood Johnson Foundation and the Urban Institute.

For more information on the HRMS and for other briefs in this series, visit www.urban.org/hrms.

About the Authors

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Notes

[1] Jenna Levy, "In U.S., Uninsured Rate Dips to 11.9% in First Quarter," *Gallup*, April 13, 2015.

[2] The list of states that have expanded Medicaid is increasing over time as more states decide to implement the ACA expansion. States that expanded Medicaid by March 1, 2015, are AZ, AR, CA, CO, CT, DE, DC, HI, IL, IN, IA, KY, MD, MA, MI, MN, NH, NV, NJ, NM, NY, ND, OH, OR, PA, RI, VT, WA, and WV. Several of those states, including CA, CT, DC, and MN, expanded Medicaid under the ACA before 2013.

[3] We control for the variables used in the poststratification weighting of the KnowledgePanel (the Internet-based survey panel that underlies the HRMS) and the poststratification weighting of the HRMS. These variables are sex, age, race and ethnicity, language, education, marital status, whether any children are present in the household, household income, family income as a percentage of FPL, homeownership status, Internet access, urban or rural status, and census region. We also control for citizenship status and participation in the previous quarter's survey (i.e., whether the respondent completed the survey in the previous quarter, was sampled in the previous quarter but did not complete the survey, or was not sampled in the previous quarter). The basic patterns shown for the regression-adjusted measures are similar to

those based solely on simple weighted estimates. In presenting the regression-adjusted estimates, we use the predicted share with problems paying family medical bills in each quarter for the same nationally representative population. For this analysis, we base the nationally representative sample on survey respondents from the most recent 12-month period from the HRMS (i.e., quarter 1 of 2015 and quarters 2–4 of 2014).

[4] We use projections for the size of the 2015 population from the US Census Bureau. These files give population projections by race, ethnicity, and sex of all ages from 2014 to 2060 based on estimated birth rates, death rates, and net migration rates. Using the "Table 1" file (which has a 2015 projected population of 321,368,864), we summed the 2015 population projections for all 18-to-64-year-olds to arrive at 199,903,264 nonelderly adults in 2015. See US Census Bureau, "2014 National Population Projections: Downloadable Files," US Department of Commerce, last modified December 10, 2014.

[5] Because of the relatively high estimated share of adults in families with problems paying medical bills in quarter 3 2013, we also tested the significance of differences in estimates for quarter 1 2015 relative to quarter 1 2013. The differences were significant for all nonelderly adults, adults in Medicaid expansion states, and adults in Medicaid nonexpansion states.

[6] While this analysis focuses on all adults in the sample, similar patterns emerge if the sample is limited to the full-year insured.

ACA Implementation—Monitoring and Tracking

Medicaid Expansion, the Private Option, and Personal Responsibility Requirements:

The Use of Section 1115 Waivers to Implement Medicaid Expansion Under the ACA

May 2015

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URBAN INSTITUTE

With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010 (ACA). The project began in May 2011 and will take place over several years. The Urban Institute has been documenting changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at **www.rwjf.org** and **www.healthpolicycenter.org**. The qualitative component of the project is producing analyses of the effects of the ACA on enrollment (including Medicaid expansion), insurance regulation and marketplace competition.

EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA) expanded Medicaid eligibility to all nonelderly adults with incomes up to 138 percent of the federal poverty level (FPL). In 2012, however, the United States Supreme Court issued a ruling that effectively made Medicaid expansion optional. As of April 1, 2015, 28 states and the District of Columbia had expanded Medicaid and several additional states were exploring expansion. The financial incentives for states to expand Medicaid and reduce the number of uninsured have led some governors and legislators who strongly oppose the ACA to support Medicaid expansion in their states—if they can develop their own programs not allowed under standard Medicaid rules.

Under Section 1115 of the Social Security Act, the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (HHS) may grant states waivers from certain Medicaid requirements and allow states to operate time-limited demonstrations to experiment with new approaches to Medicaid. As of April 1, 2015, CMS had approved Section 1115 waivers in all six states that had applied for such approval as an alternative to a standard Medicaid expansion: Arkansas, New Hampshire, Indiana, Iowa, Michigan, and Pennsylvania. This paper describes and analyzes key components of the Medicaid expansion programs in these six states based on analysis of the Section 1115 waiver applications, proposed amendments, CMS' approval documents, summaries and press reports, and interviews with national experts and state officials, providers, insurance company representatives, and consumer advocates in the study states.

The following are our key observations:

First, these waivers have enabled states that were not prepared to implement a standard expansion to extend Medicaid coverage to hundreds of thousands of people who otherwise would have likely remained uninsured. Respondents from all six states reported that a standard expansion would not have been approved in their states.

Second, the use of premium assistance and payment of cost-sharing reductions to place Medicaid enrollees into qualified health plans (QHPs) in the ACA marketplace could have several advantages, including 1) providing access to a broader mix of providers, 2) promoting continuity of care when people move between eligibility for Medicaid and marketplace subsidies, 3) contributing to expanded competition in the marketplace, which in turn would lower premiums, and 4) lowering federal government subsidy costs in the marketplace and the costs of QHPs for individuals not eligible for subsidies as a result of lower premiums.

On the other hand, several potential disadvantages of placing Medicaid enrollees into QHPs were identified by some respondents, including the concern that 1) enrollees would not have effective access to wrap-around benefits required under Medicaid and not offered in the QHPs, 2) states would not effectively implement the medical frailty screens that divert less healthy individuals into traditional Medicaid, and 3) federal and state costs would be higher for covering these individuals.

Third, with respect to charging premiums or other monthly contributions, some supporters of these provisions assert that having beneficiaries make some financial contribution increases individual responsibility for health care utilization, makes participation less demeaning, and exposes Medicaid enrollees to private insurance models. However, evidence from prior research consistently indicates that low-income individuals are highly sensitive to premiums and that charging premiums or premium-like monthly contributions will lead to a reduction in enrollment, countering the goal of expanding coverage to all eligible adults. If the net result of premium payments or other monthly contributions, which are a component of all these waivers except for New Hampshire's, is lower initial enrollment and higher disenrollment rates, this would seem contrary to the purpose of the Medicaid expansion and of a Section 1115 waiver.

Fourth, the use of the Health Savings Account models that require individuals to make small contributions into an account that is then used to cover portions of their health care costs is likely to be inefficient. The administrative costs of maintaining tens of thousands of individual accounts with very small monthly contributions from enrollees are likely to be significantly higher than the benefits, including any changes in utilization of services that might result.

Fifth, the evidence regarding the effectiveness of wellness programs generally is weak. The states that implemented these wellness programs in 2014 encouraged enrollees to obtain a wellness exam and complete a health risk assessment (HRA). But if healthy behavior programs went beyond wellness exams, protected vulnerable groups with certain health conditions, and led to innovative program designs that improved health and well-being for participants, then experimenting with such programs could test whether healthy behavior incentives improve the health of enrollees and are cost effective.

These waivers require an ongoing evaluation by the states and review by CMS to determine whether they will meet their stated objectives and which of these provisions are worth retaining and which are not. Public transparency in how all of these programs are implemented and evaluated will be essential in determining what lessons these programs may offer CMS and other states.

BACKGROUND

The Patient Protection and Affordable Care Act (ACA) expanded Medicaid to cover all nonelderly adults with incomes up to 138 percent of the federal poverty level (FPL).[1] Before the ACA, Medicaid provided health coverage primarily to children, pregnant women, parents of dependent children, and the aged, blind, and disabled. Some states provided coverage to childless adults, but such coverage was limited, could not rely on additional federal funding, and required a waiver under Section 1115 of the Social Security Act.[2] The ACA's Medicaid expansion was originally estimated to cover approximately 15.1 million newly eligible adults throughout the United States.[3] In 2012, however, the Supreme Court of the United States held that the Department of Health and Human Services (HHS) could not require states to implement the ACA's Medicaid expansion by withholding funding for their overall Medicaid programs, essentially making the Medicaid expansion optional.[4]

As of April 1, 2015, 28 states and the District of Columbia had expanded Medicaid and several additional states were exploring expansion. In April, 2015, Montana's governor and legislature came to an agreement over a proposed Medicaid expansion waiver in that state. Medicaid expansion is caught up in the highly partisan politics surrounding the ACA, but the financial incentives for states to expand Medicaid and reduce the number of uninsured have led some governors and legislators who strongly oppose the ACA to support Medicaid expansion in their states, although often with significant conditions attached. A recent example is Tennessee Governor Bill Haslam (R) who called a special session of the legislature in February 2015 to consider a Medicaid expansion called "Insure Tennessee" and told legislators, "This is not Obamacare."[5] Legislators in Tennessee, however, quickly rejected Haslam's proposal. In many states with political leaders who generally oppose the ACA, governors and legislators have engaged in extensive debates and negotiations over both whether and how to expand Medicaid.

Beginning with the state of Arkansas, which sought and received permission from HHS' Center for Medicare and Medicaid Services (CMS) to expand Medicaid through a Section 1115 waiver by providing premium assistance to place Medicaid expansion beneficiaries into qualified health plans (QHPs) in the ACA marketplace, more states have been developing alternative approaches to Medicaid expansion that build on commercial insurance and employer-sponsored insurance models. Although it has not approved all changes sought by leaders in these states, as of April 1, 2015, CMS had approved Section 1115 waivers in all six states that had applied for such approval as an alternative to a standard Medicaid expansion: Arkansas, New Hampshire,

Indiana, Iowa, Michigan, and Pennsylvania. No two states submitted the same proposal to CMS. Moreover, over time, state legislative proposals to expand Medicaid increasingly have included provisions that CMS had not approved in earlier waivers. In January 2015, CMS approved Indiana's waiver, which included significant provisions that CMS had not previously approved. Thus the environment for Medicaid expansion remains fluid and subject to both local political and economic factors and CMS approval.

This paper addresses the Medicaid expansion programs in the six states that sought and received authority from CMS as of April 1, 2015 to implement the Medicaid expansion through a Section 1115 demonstration. Under Section 1115, CMS has the authority to waive certain requirements of the Act's Medicaid provisions and allow states to experiment with new approaches to payment and management systems through a time-limited demonstration that is designed to further the goals of the Medicaid program.

For this study, we analyzed the Section 1115 waiver applications, proposed amendments, CMS' approval documents, and state summaries and press reports describing the programs and providing some of the political context for the waiver applications in each of the study states. We also interviewed national experts and state officials, providers, insurance company representatives, and consumer advocates in the study states.

This study addresses the use of premium assistance to place individuals in QHPs in the ACA marketplace. We refer to this model as the "private option"—the name Arkansas adopted for its program—to distinguish premium assistance for QHPs from premium assistance to place Medicaid enrollees in employer-sponsored insurance plans. This study also addresses a range of provisions modeled after commercial insurance, including the imposition of premiums, the imposition of monthly contributions designed to cover actual or anticipated cost-sharing obligations, health savings type accounts, and healthy behavior incentives. Respondents reported that supporters of these provisions describe them as requiring Medicaid enrollees to have "skin in the game." For ease of reference, we refer to them collectively as "personal responsibility requirements," although this is a term favored by proponents of these provisions, and not necessarily descriptive of their effect.

Although there is disagreement over the scope of CMS' authority to approve some of the specific proposals states have made to expand Medicaid through a Section 1115 waiver, this study does not address those legal issues. And although states have proposed other provisions, such as health care delivery and payment reforms and restrictions on benefits and work requirements, the "private option" and "personal responsibility" requirements modeled after commercial insurance are the focus of this study.[6] The approaches taken by these six states and approved by CMS are representative of the range of approaches to both the private option and the personal responsibility requirements that other states have been considering.

We first provide an overview of these Section 1115 Medicaid expansion waivers, summarize the approaches states are taking, and describe the response of CMS as of March 2015, when it approved New Hampshire's Section 1115 waiver. We then discuss each of the six states in the order they submitted and received approval for their Section 1115 waivers. Although Pennsylvania's newly elected governor has announced that Pennsylvania will implement the standard Medicaid expansion by the end of 2015, we include Pennsylvania in this study because it received CMS approval for its plan. We then discuss several themes that emerged from our analysis and conclude by identifying trends and issues to watch in the future related to these demonstrations.

CMS' RESPONSE TO STATE PROPOSALS TO EXPAND MEDICAID USING A SECTION 1115 WAIVER

Section 1115 of the Social Security Act allows states, subject to HHS approval, to conduct "experimental, pilot, or demonstration" projects that alter certain eligibility, benefits, cost-sharing, financing, and other federal Medicaid requirements if those changes promote the objectives of the Medicaid program.[7] Section 1115 waivers are time limited and must have specific goals, be evaluated to determine if they meet the stated goals of the demonstration project, and be budget neutral, meaning that they do not cost the federal government more than coverage of the eligible population would have cost without the waiver. In years preceding ACA Medicaid expansion, states used Section 1115 waivers, among other things, to provide coverage to childless adults.[8]

In March 2013, after Arkansas began negotiations with CMS over its private option plan, CMS issued guidance describing the parameters of what it would consider in a private option proposal as part of a Section 1115 expansion waiver.[9] CMS stated that any such proposal must (1) give beneficiaries a choice of at least two QHPs,

(2) ensure that beneficiaries enrolled in QHPs receive wrap-around benefits and cost-sharing assistance as needed to match Medicaid requirements, (3) may not place the medically frail or other high-need populations into QHPs, and (4) end by December 31, 2016. CMS also advised that states targeting adults between 100 and 138 percent of FPL might be more successful in receiving approval for a private option.

Since issuing its March 2013 guidance, CMS has approved six Section 1115 Medicaid expansion waivers. CMS has rejected proposals to tie Medicaid benefits to work search requirements (Pennsylvania and Indiana) and to waive benefits requirements for beneficiaries placed in QHPs, except for allowing a series of temporary waivers of the requirement that Medicaid cover nonemergency transportation to beneficiaries (Indiana, Iowa, and Pennsylvania).[10] With the exception of authorizing some increased cost sharing for the non-emergent use of an emergency room, CMS has also limited cost sharing to copayment and coinsurance levels already permitted in Medicaid under federal law, including $4 copayments for most outpatient services for enrollees at or under 100 percent of FPL and copayments/coinsurance at or under 10 percent of the Medicaid agency's costs for outpatient services for those above 100 percent of FPL.[11]

Although several states received approval to charge enrollees monthly contributions to cover actual cost sharing incurred in prior months (Michigan) or estimated future costs (Arkansas, Iowa, and Indiana), CMS has not increased the nominal cost-sharing caps on individual services under federal regulations and those states' approved state plans. Nor has CMS allowed any state to make such payments a condition of enrollment for individuals at or under FPL. Until Indiana's waiver was approved, CMS had also rejected proposals to eliminate retroactive coverage for Medicaid beneficiaries and lockout proposals that would have enabled states to terminate Medicaid benefits and bar beneficiaries from re-enrolling for an indefinite or specific period of time if they failed to pay approved premiums or cost sharing. Indiana's lockout policy only applies to enrollees above the federal poverty level.

Of the study states, only Arkansas, Iowa, and New Hampshire proposed a private option to provide premium assistance for beneficiaries to enroll in QHPs; Indiana and Michigan used existing Medicaid managed care organizations, as did Iowa for those at or under 100 percent of FPL. Pennsylvania created a new Medicaid managed care program for the expansion population. With the exception of New Hampshire, all of the study states proposed one or more personal responsibility provisions, including charging premiums or other monthly contributions, and/or creating health accounts and healthy behavior incentives, which are modeled generally on commercial insurance. The following section describes the private option and personal responsibility provisions in the Section 1115 waivers in the six study states and the local context for developing those proposals. We describe them in the order in which they were approved by CMS, reflecting the evolution of the scope of CMS' approvals.

SECTION 1115 MEDICAID EXPANSION WAIVERS APPROVED BY CMS

Arkansas Health Care Independence Program

Arkansas was the first state to seek and receive approval (in September 2013) for a Section 1115 waiver to expand Medicaid. Arkansas originally sought approval for a private option demonstration project, using premium assistance and payment of cost-sharing obligations to place all newly eligible adults up to 138 percent of FPL—except for those determined medically frail—into QHPs in the ACA marketplace. In its initial waiver application, Arkansas did not seek to impose any personal responsibility requirements on beneficiaries, but the 2013 legislation required the creation of "Independence Accounts" and imposition of monthly cost-sharing contributions beginning in 2015. Arkansas thus sought an amendment to its waiver to implement those provisions, which CMS approved at the end of December 2014. Table 1 summarizes key elements of the waiver.

As of February 15, 2015, 233,518 people were determined eligible and 219,000 had completed enrollment in a QHP through Arkansas' Medicaid private option, and nearly 65,000 non-Medicaid enrollees had signed up for QHPs through the marketplace.[12] Thus 77 percent of the enrollees in Arkansas QHPs are Medicaid expansion enrollees.

Political Context for Medicaid Expansion in Arkansas

With a population of nearly 3 million people, Arkansas had very strict Medicaid eligibility criteria prior to 2014 and nearly 1 in 5 adults was uninsured. Half of these adults—nearly 250,000—were under 138 percent of FPL and eligible for the ACA's Medicaid expansion.[13] Before the ACA, most Medicaid enrollees in Arkansas were covered through fee-for-service reimbursement rather than through capitated managed care. Arkansas' then-Democratic governor, Mike

Table 1: Summary of Key Provisions in Arkansas' Section 1115 Medicaid Expansion Waiver: Arkansas Health Care Independence Program

Policy	Description
Premium Assistance in QHPs	Yes. Mandatory for all nonexempt enrollees at all income levels.
Monthly Premiums or Contributions	Yes. Referred to by CMS as monthly contributions to Arkansas "Independence Accounts." Monthly contributions for different income levels not to exceed 2% of annual household income. Above 50–100% FPL = $5/month; above 100–115% FPL = $10/month; above 115–129% FPL = $17.50/month; above 129–138% FPL = $25/month
Cost sharing	Cost sharing (copayments and coinsurance) is covered through the monthly contributions. No cost-sharing for enrollees under 50% FPL; nonexempt enrollees at or above 50% FPL will be responsible for cost-sharing amounts allowed under Medicaid rules and state plan with an aggregate cap of 5% of monthly or quarterly income.
Disenrollment or Lockout if Fail to Pay Monthly Contributions	No, but enrollee incurs debt to the state. Enrollees above 100–138% FPL who do not make a monthly contribution will be required to pay QHP copayments or coinsurance (consistent with Medicaid rules and the state plan) at the point of service in order to receive services.
Health Accounts	Yes. Administered by a third-party administrator.
Healthy Behavior Incentives	No

Sources: Centers for Medicare and Medicaid Services, Special Terms and Conditions—Arkansas Health Care Independence Program (Private Option), Number 11-W-00287/6 (amended January 1, 2015). http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf (accessed April 2015).

Centers for Medicare and Medicaid Services, "Medicaid and the Affordable Care Act: Premium Assistance." Washington, DC: March 2013. http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf (accessed April 2015).

Beebe, pushed for the private option in Arkansas. Though there was a Democratic majority in the House in 2012, respondents reported there was strong overall resistance to the ACA in Arkansas and that this increased following the 2012 elections, when both the Senate and the House had Republican majorities for the first time since Reconstruction.

The Arkansas private option model offered the dual advantage of buying "private" health insurance for Medicaid beneficiaries, while increasing marketplace competition by bringing in a large volume of potential consumers. A state fact sheet described several benefits including integration, efficiency, and "market-driven provider reimbursement" that could bring more providers into the Medicaid coverage system.[14] State officials promoted the private option as a way to develop better-than-Medicaid provider reimbursement rates for a new Medicaid population and to help reduce the churn (movement of people in and out of eligibility for different programs) typically seen in the Medicaid population, thereby creating opportunities for better continuity of care. Additionally, the state's marketplace would benefit from the addition of Medicaid-funded participants, potentially doubling the number of covered lives, which potentially could bring in new insurers and increase competition in the Arkansas nongroup health insurance market. As one source explained, Arkansas did not embrace "Obamacare" but rather promoted "private enterprise," "competition," and required beneficiaries to have "skin-in-the-game," while using federal funds to expand coverage.

In early 2013, state officials negotiated with CMS over the basic contours of a private option. Following agreement with CMS on basic principles, the Arkansas legislature adopted the Health Care Independence Act of 2013.[15] The provider and payer communities backed the expansion efforts in Arkansas.

Arkansas' Private Option

The Arkansas private option includes all newly eligible adults in the expansion population at or below 138 percent of FPL, except those assessed as medically frail or otherwise exempt.[16] Consistent with CMS' March 2013 guidance, and in order to provide insurers with a favorable risk pool in the marketplace, the state estimated that approximately 10 percent of those eligible for Medicaid expansion would be assessed as medically frail with higher costs of care and be placed in traditional fee-for-service Medicaid.

Private option enrollees are eligible to enroll in silver plans that meet the actuarial value requirements of the program. The state covers both the cost of the premiums and all cost sharing except for the nominal cost sharing described below. All insurers offering plans in the marketplace in Arkansas are required to participate in the Medicaid private option. Beginning in 2015, all insurers must offer at least one silver plan that meets the requirements of the Medicaid private option, and those plans must contain only the essential health benefits included in the state's essential health benefits benchmark plan for the nongroup market. The state will

reimburse providers at fee-for-service rates for wrap-around benefits not included in the state's marketplace benchmark plan: nonemergency transportation and Early Periodic Screening Diagnosis and Treatment services for individuals participating in the demonstration who are under age 21. Private option beneficiaries "will be permitted to choose among all silver plans covering only Essential Health Benefits that are offered in their geographic area."[17]

The Arkansas Marketplace

Competition in the Arkansas marketplace increased between 2014 and 2015, both in terms of insurer participation across the state and price. The three insurers selling QHPs to individuals in the marketplace also offer plans to the Medicaid private option enrollees. On average the cost of the second lowest-cost silver plan in Arkansas dropped 3 percent in 2015.[18] For rating purposes, Arkansas is divided into seven geographic rating regions. In 2014, only Blue Cross Blue Shield plans were sold in all regions; in 2015 all marketplace issuers are selling plans statewide. Traditionally, Blue Cross Blue Shield has dominated the health insurance market in Arkansas with almost a 70–80 percent market share. There are two Blue Cross Blue Shield plans in the marketplace–one is a Multi-State Plan and the other is the Blue Cross Blue Shield of Arkansas plan, but both are comparable. Centene sells plans under the name Ambetter, and QualChoice, which last year was bought out by Catholic Health Initiatives, also participates in the Arkansas marketplace.

Personal Responsibility Requirements in the Arkansas Plan

Under the Arkansas private option, the state Medicaid program pays the premiums and cost-sharing reductions to the insurers. For those in the 100–138 percent of FPL category, enrollees may be charged nominal cost sharing at point of service consistent with prevailing Medicaid rules, subject to an aggregate cap of 5 percent of household income; the program covers the cost of any other cost sharing above what Medicaid normally allows. In 2014, there were no cost-sharing requirements for individuals under 100 percent of FPL. In 2015, the exemption from cost sharing was lowered to those whose income is below 50 percent of FPL, so those between 50 and 100 percent of the FPL are now subject to cost-sharing requirements as well.

The Arkansas Health Care Independence Act of 2013 authorized the imposition of monthly contributions and the creation of individual accounts beginning in 2015, comparing these accounts to "a health savings account or medical savings account."[19] On December 31, 2014, CMS approved Arkansas' request for amendments to the waiver to allow for the creation of the Arkansas Independence Accounts. Under the waiver amendment, and as shown in Table 2, Arkansas may charge enrollees a range of monthly contributions based on their income, subject to a maximum charge of 2 percent of household income: [20]

The contributions are to be used by enrollees to cover copayments and coinsurance, but those charges are limited and must be "consistent with federal requirements regarding Medicaid cost sharing and with the State's approved state Plan" and listed in Attachment B to CMS' Special Terms and Conditions (STCs).[21] Those amounts vary depending on income level and type of service, but charges for most services for enrollees at all income levels are capped at $4/visit.

The payments made into the Independence Accounts are to be administered by a third-party administrator, which is also responsible for issuing debit/credit cards to the enrollees. Pursuant to STC 44, the state also contributes funds to the Independence Accounts to ensure that the individual's copayment and coinsurance obligations are covered, presumably in a case where someone has utilization that exceeds the amounts contributed. Enrollees at or below 100 percent of FPL are given the option whether to make the monthly contributions. If they do not make the monthly contributions, they must still use the debit/credit card to pay copayments and coinsurance owed at point of service, but will be billed by the third-party administrator for those charges. If they fail to pay those charges, they will incur a debt to the state, which the state may seek to collect.

Table 2: Arkansas Health Care Independence Program Monthly Charges for Nonmedically Frail Adults in the Medicaid Expansion Program Approved by CMS as of January 1, 2015

	> 50–100% of FPL	> 100–115% of FPL	> 115–129% of FPL	> 129–138% of FPL
Monthly Contributions	$5	$10	$17.50	$25

Source: Centers for Medicare and Medicaid Services, Special Terms and Conditions 44—Arkansas Health Care Independence Program (Private Option), Number 11-W-00287/6 (amended January 1, 2015). http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf (accessed April 2015).

Enrollees below 100 percent of FPL, however, cannot be denied services if they do not pay those charges at the point of service.

Enrollees above 100–138 percent of FPL will be required to make a contribution to their Independence Accounts and to pay their copayment and coinsurance obligations with the debit/credit cards. If enrollees above 100–138 percent of FPL do not make monthly contributions, they can be denied services if they do not pay the copayments or coinsurance at the point of service.

Even though enrollees are not subject to higher cost sharing than they could have been charged under the Medicaid state plan, the requirement to make a monthly contribution to offset future cost sharing places a burden on enrollees who are not incurring such charges at the time they pay the contributions. Moreover, by creating these accounts, the state has in effect removed the option providers have under Medicaid to waive cost-sharing charges at point of service. The individual's obligation to pay for cost sharing runs to the state, through the third-party administrator, rather than to the provider. For all enrollees, the state will contribute enough funds to ensure that the individual's copayment and coinsurance obligations are covered. For all enrollees who contribute to their Independence Accounts for at least six months in a calendar year (which may be nonconsecutive months), they will also be entitled to certain credits, which may be used to pay for future QHP premium payments, employer-sponsored insurance (ESI), or Medicare premiums if the individual continues to reside in Arkansas and loses eligibility for Medicaid. Individual credits are capped at $200 over the lifetime of the waiver.

Consumer advocates and critics of the Independence Accounts and cost-sharing requirements say that the cost to manage and administer the program will far outweigh the nominal charges to be collected through the accounts. One report suggested that the cost of managing these accounts would be $15 million per year.[22]

Budget Neutrality

Under HHS policy, Section 1115 waivers must be budget neutral, which means that they may not cost the federal government more than it would have cost to cover the same individuals under traditional Medicaid. The budget neutrality of the Arkansas private option made headlines when the Government Accountability Office released a report saying that the nearly $4 billion spending limit that HHS approved for Arkansas' private option was approximately $778 million more than what the spending limit would have been if it was based on the state's actual payment rates for services under the traditional Medicaid program.[23] Arkansas officials had projected that, in order to attract enough providers in traditional fee-for-service Medicaid to cover the expansion population, provider rates—and average costs per beneficiary—would have increased significantly with a standard expansion. This assumption was critical to the state's budget neutrality analysis.

On the other hand, the state's budget neutrality assumptions did not include savings that might be realized from lower premiums with the increased marketplace competition. Though some of this projected savings would benefit non-Medicaid enrollees, as noted above, in Arkansas the vast majority of QHP enrollees are Medicaid enrollees. State officials projected that an increase in volume of patients in QHPs would lead to greater competition and downward price pressure on provider reimbursement rates, resulting in an across-the-board 5 percent cut in provider reimbursements in the marketplace, which in turn would lower the cost of premiums in QHPs, benefiting both Medicaid and non-Medicaid enrollees in the marketplace and reducing subsidy costs paid by the federal government.[24]

The Future of the Section 1115 Expansion Waiver in Arkansas

In 2014, Arkansas elected a Republican governor, Asa Hutchinson, who announced that he supports continuation of the private option through 2016, but called for creation of a task force to determine the future of the program in 2017 and beyond, when the state will have to start paying for a portion of the coverage. He said the purpose of the task force is "to find an alternative health coverage model to ensure healthcare services for vulnerable populations currently covered by the Private Option."[25] In Arkansas, a 75 percent vote in both the House and Senate is required every year to pass appropriations bills, which include the State Medicaid budget. The legislature approved continued funding of the private option in February 2015 with more than three-quarters of the legislators' approval.

Iowa Health And Wellness Plan

Iowa's Section 1115 expansion waiver is a hybrid system, placing adults at or below 100 percent of FPL into Medicaid managed care plans operated by Managed Care Organizations (MCOs), while relying on the private option to place adults above 100–138 percent of FPL into QHPs. Iowa sought two separate waivers to implement its new plan: the Iowa Marketplace Choice Plan addresses the private option for nonelderly adults above 100–138 percent of FPL, and the Iowa Wellness Plan covers nonelderly adults who are at or below 100 percent of FPL or who are determined to be "medically frail" and therefore not required to obtain coverage through a QHP. The plan also provides premium assistance to individuals with access to "cost-effective" ESI who are eligible for Medicaid. Iowa

launched the expansion in 2014 and, in 2015, has started to implement personal responsibility provisions, charging premium-like contributions to adults beginning at 50 percent of FPL and providing healthy behavior incentives that enable beneficiaries to obtain a waiver from those payments. Table 3 summarizes key elements of the waiver.

As of March 30, 2015, 31,089 people were enrolled in the Iowa Marketplace Choice Plan and 91,717 were enrolled in the Iowa Wellness Plan, for a total of 122,806 enrollees in Iowa's expansion programs.[26]

The Political Context for Expansion in Iowa

Iowa's Republican Governor, Terry Branstad initially opposed Medicaid expansion.[27] But the state's general assembly is closely divided between Republicans who agreed with the governor and Democrats who supported expansion. In 2013, the Democratic majority in the state Senate approved a standard Medicaid expansion.[28] The Republican-led state House of Representatives, approved a partial expansion of Medicaid, but the Senate rejected the House bill.[29] The governor and legislative leaders eventually negotiated an eleventh-hour compromise, resulting in adoption of the Iowa Health and Wellness Plan on the final day of the 2013 legislative session.[30]

Prior to the Medicaid expansion, Iowa had a Section 1115 waiver called "IowaCare" that provided limited benefits through a limited provider network to adults up to 200 percent of FPL. IowaCare, which covered approximately 68,600 adults in fiscal year 2013, was scheduled to terminate at the end of 2013 and, according to a state fact sheet, was implemented to both expand access to coverage and "provide financial stability for safety net hospitals that have significant amounts of uncompensated care."[31] Without some type of Medicaid expansion, thousands of people in Iowa would have lost coverage and Iowa hospitals would have seen a significant increase in uncompensated care. This may explain, in part, why hospitals in Iowa reportedly agreed to a provision in the final legislative compromise that could make Iowa hospitals liable for increased fees to help

Table 3: Summary of Key Provisions in Iowa's Two Section 1115 Medicaid Expansion Waivers: The Iowa Marketplace Choice Plan and the Iowa Wellness Plan

Policy	Description
Premium Assistance in QHPs	Yes. Applies to nonexempt enrollees above 100–138% FPL who do not have an offer of cost-effective employer-sponsored insurance. Participation of this population in QHPs was to be mandatory, but because there is only one available QHP in Iowa in 2015, enrollees may opt to participate in Medicaid managed care in 2015.
Monthly Premiums or Contributions	Yes. Referred to by CMS as "premiums." No premiums charged enrollees in their first year in the program. Flat monthly premium of $10/month for nonexempt enrollees above 100–138% FPL and $5/month for nonexempt enrollees above 50–100% FPL not to exceed 5% of quarterly aggregate household income. Enrollees are exempt from premium if they self-attest to financial hardship at the time they are invoiced for a monthly payment (must self-attest to financial hardship each time a payment is due).
Cost sharing	The premiums are "in lieu" of other cost sharing, except the state charges a copayment for nonemergency use of the emergency room consistent with the state plan.
Disenrollment or Lockout if Fail to Pay Monthly Contributions	No lockout, but enrollees above 100–138% FPL may be disenrolled for nonpayment of premium; they are allowed to re-enroll without a lockout period, but outstanding payments will be subject to recovery by the state. No one at or below 100% FPL may be disenrolled for failure to pay premiums. All enrollees who fail to make their payments incur a debt to the state.
Health Accounts	No individual accounts are created to hold the enrollees' premium contributions, but the state keeps track of the amounts paid and amounts owed.
Healthy Behavior Incentives	Yes. Completion of Healthy Behaviors can lead to waiver of premiums for the following year.

Note: Iowa received approval for two separate Section 1115 demonstrations: the Iowa Marketplace Choice Plan applies to individuals above 100–138 percent of FPL; the Iowa Wellness Plan applies to individuals at or below 100 percent of FPL. This table summarizes provisions in both plans.

Sources: Centers for Medicare and Medicaid Services, Special Terms and Conditions, Iowa Marketplace Choice Plan, Number 11-W-00288/5 (amended December 30, 2013). http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Market-Place-Choice-Plan/ia-marketplace-choice-plan-stc-01012014-12312016-amended-122013.pdf (accessed April 2015); Cover Letter and Amended Special Terms and Conditions, Iowa Marketplace Choice Plan, Number 11-W-00288/5 (December 30, 2014). http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-ca.pdf (accessed April 2015); Cover Letter and Amended Special Terms and Conditions, Iowa Wellness Plan, Number 11-W-00289/5 (December 30, 2014). http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-ca.pdf (accessed April 2015); Centers for Medicare and Medicaid Services, "Medicaid and the Affordable Care Act: Premium Assistance." Washington, DC: March 2013. http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf (accessed April 2015).

cover a shortfall if the federal government reduces the federal matching rate to below 90 percent in future years.[32]

The Private Option in Iowa: The Iowa Marketplace Choice Plan

As approved by CMS in December 2013, the Marketplace Choice Plan authorizes Iowa to require adults at or above 100–138 percent of FPL to participate in QHPs in exchange for the state providing premium assistance and cost-sharing assistance for those plans. Once determined eligible for the program, individuals are given the opportunity to complete a health care needs questionnaire to determine whether they are medically frail. Those assessed as medically frail are placed in the Iowa Wellness Plan's managed care program. Individuals may opt out of this assessment or, if determined to be medically frail, may choose to select a QHP rather than participate in the MCO program. For individuals who have "cost-effective" ESI, the state may provide premium assistance for that coverage consistent with its state plan.

Under CMS's initial Special Terms and Conditions, and consistent with CMS' March 2013 guidance, all participants in the Marketplace Choice Plan were required to have at least two QHPs to select from in their geographic region.[33] Iowa had only two insurers that offered statewide coverage in the federally facilitated marketplace in 2014—Coventry and CoOportunity Health, a new ACA health insurance cooperative. Both initially participated in the Iowa Marketplace Choice Plan in 2014. But the dominant insurance carrier in the nongroup market in Iowa, Wellmark Blue Cross Blue Shield, did not participate in the federally facilitated marketplace in 2014 or 2015.[34] And in September 2014, CoOportunity Health announced that it was withdrawing from the Marketplace Choice Plan, leaving only one QHP available to beneficiaries in the Marketplace Choice Plan in Iowa.[35]

The Personal Responsibility Requirements in the Iowa Plan

Both of Iowa's two Section 1115 expansion waivers contain monthly premium provisions, which go into effect after a beneficiary has been enrolled in the program for 12 consecutive months. Thus the payments did not begin for any beneficiaries until 2015. The payments are made to the state, not to the health plans.

Premium payments. Beneficiaries in the Marketplace Choice Plan who are at or above 100 percent of FPL but not more than 138 percent of FPL are required to make contributions of $10/month after their first year in the program, subject to a quarterly aggregate cap of 5 percent of household income.[36] The contributions may be waived if the individual completes certain healthy behaviors. For 2015, beneficiaries who completed a HRA and a wellness exam in 2014 will be entitled to a waiver from the monthly contributions. Beneficiaries may also seek a financial hardship waiver at the time they receive each invoice and may self-attest to the hardship. Beneficiaries may be disenrolled from the program if they have premiums past due greater than 90 days, but they are allowed to re-enroll and may not be locked out of the program.

Under the Iowa Wellness Plan waiver, beneficiaries between 50 and 100 percent of FPL may be charged a premium of $5/month subject to the same quarterly aggregate cap of 5 percent of household income, the one-year delay, the healthy behaviors waiver, and self-attestation of financial hardship. Although the failure to pay creates a debt to the state, beneficiaries at or under 100 percent of FPL may not be disenrolled from the program. Medically frail beneficiaries are exempt from the premium payment requirements in Iowa.

Copayments. According to CMS' Special Terms and Conditions, the document describing the conditions of the Section 1115 waiver, the premium payments are imposed "in lieu of other cost sharing" and enrollees are not liable for cost sharing except for copayments for nonemergency use of the emergency room consistent with Iowa's approved state plan.

Healthy Behaviors Incentives. All beneficiaries are entitled to a waiver of the premium payment amounts if they complete the Healthy Behaviors incentives. In the first year, this requires completion of a HRA and a wellness exam. In future years, the state may require individuals to take steps to address unhealthy behaviors, consistent with protocols that are approved by CMS.

The Future of the Section 1115 Expansion Waiver in Iowa

The future of the private option is unclear in Iowa, now that consumers do not have a choice of QHPs. Iowa has altered the Marketplace Choice Plan and no longer requires beneficiaries above 100 percent of FPL to enroll in a QHP. Instead, beneficiaries are now permitted to choose between the remaining QHP and the Wellness Plan's Alternative Benefits Plan; the state will place people automatically in the Wellness Plan if they do not choose the QHP.[37] Thus, unlike Arkansas and New Hampshire, enrollment in a QHP is no longer mandatory in Iowa.

Healthy Michigan

Michigan's Medicaid expansion program, Healthy Michigan, utilizes personal responsibility provisions—premiums, cost sharing and healthy behavior incentives—but does not place beneficiaries into QHPs or other

Table 4: Summary of Key Provisions in Michigan's Section 1115 Medicaid Expansion Waiver: Healthy Michigan

Policy	Description
Premium Assistance in QHPs	No. Enrollees placed in existing Medicaid managed care plans.
Monthly Premiums or Contributions	Yes. After six months in the program, monthly premiums for nonexempt enrollees above 100–138% FPL up to 2% of annual household income. Paid into the MI Health Accounts.
Cost sharing	Yes. After six months in the program, copayment liability for nonexempt enrollees is billed on a quarterly basis based on actual utilization of services in a prior three-month period. Copayment liability may not exceed amounts allowed under Medicaid rules and state plan with an aggregate cap of 5% of household income. Paid into the MI Health Accounts.
Disenrollment or Lockout if Fail to Pay Monthly Contributions	No, but enrollee incurs debt to the state. Enrollees above 100–138% FPL who do not make a monthly contribution will be required to pay QHP copayments or coinsurance (consistent with Medicaid rules and the state plan) at the point of service in order to receive services.
Health Accounts	Yes. Administered by a third-party administrator.
Healthy Behaviors Incentives	Yes, but copays must reach 2% of enrollee's income before a reduction in payments will be applied based on healthy behaviors.

Sources: Centers for Medicare and Medicaid Services, Cover Letters and Special Terms and Conditions, Healthy Michigan Section 1115 Demonstration, Number 11-W-00245/5, including technical corrections and attached protocols (August 29, 2014). http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-ca.pdf (accessed April 2015).

commercial insurance plans. Michigan places new beneficiaries into existing MCO plans and, according to respondents, never seriously considered using QHPs given the long history of managed care in the state Medicaid program and the large number of MCO providers. Table 4 summarizes key elements of the waiver.

The Political Context for Expansion in Michigan

In February 2013, Republican Governor Rick Snyder announced his support for Medicaid expansion in Michigan.[38] Joined by provider organizations and the Michigan Association of Health Plans, the governor made his announcement as part of his 2014 budget recommendation. Both houses of the state legislature have Republican majorities. After several months of negotiations with legislators, the governor signed the bill into law in September 2013.[39] Though a "small majority" of Republicans voted against the measure, it passed both houses of the legislature with bipartisan support, but did not start until April 2014.[40]

Medicaid Managed Care in Michigan

As one respondent told us, Michigan had a "sophisticated" Medicaid managed care system before the ACA. The program began in 1996 and included 13 MCOs when expansion began on April 1, 2014. None of the Michigan MCOs provides coverage in every county.[41] Michigan started a separate managed care program for behavioral health services in 1998. These two separate managed care programs are used for the expansion population.

Under the Healthy Michigan program, all beneficiaries are placed in one of the existing MCO plans available in the beneficiary's county. Enrollment brokers are available to help the beneficiary choose a plan, but beneficiaries are auto-enrolled in plans if they do not exercise that option.

The state did not issue a new Request for Proposals for its MCO plans in 2014; it relied instead on preexisting managed care contracts to serve the expansion population. The state is expected to issue a new Request for Proposals in 2015, and respondents said that they expect the composition of the Michigan MCOs to change when the state awards new managed care contracts.

Enrollment in the Medicaid expansion program began April 1, 2014. As of March 31, 2015, 605,000 people had enrolled in the program.[42] Despite the influx of so many new patients, informants said that to date there seems to have been sufficient provider capacity. Some concern was expressed in our interviews, however, about whether there are enough behavioral health providers participating in Michigan's Medicaid program to meet the needs of the new enrollees.

The Personal Responsibility Components of Michigan's Expansion

Approved by CMS in December 2013 and launched on April 1, 2014, the Healthy Michigan Section 1115 waiver contains the following key elements:[43]

Premium payments. Beneficiaries between 100 and 138 percent of FPL are subject to monthly premiums not to

exceed 2 percent of their household income. Beneficiaries are not charged for these contributions until they have participated in the program for six months.

Copayments. All beneficiaries are subject to the copayment provisions, but cost sharing is limited to what is already permitted under Medicaid regulations and Michigan's state plan.[44] Under the plan, providers no longer collect copayments from beneficiaries; instead, the state calculates what the copayment liability would have been based on actual utilization during preceding months. Beneficiaries are billed quarterly for the copayments, and those amounts may not exceed the average monthly copayments incurred during that prior period. Even though these are the same amounts nonexpansion enrollees owe under the state plan, in practice providers may choose to waive the cost-sharing amounts, rather than attempt to collect them; under Michigan's expansion waiver program, the state bills all enrollees for these charges.[45] Total copayment charges may not exceed 5 percent of a beneficiary's household income; for those who pay premiums (those between 100 and 138 percent of FPL), the copayment liability may not exceed 3 percent of the beneficiary's income plus the 2 percent in premium charges. Beneficiaries are not charged for these contributions until after participating in the program for six months. Although the state initially proposed basing these cost-sharing payments on the prior six month's experience, Michigan's protocols provide that the state will calculate each enrollee's initial copayment experience based on the enrollee's first three months in the program and recalculate the copayment liability quarterly.

Healthy Behaviors Incentives. All beneficiaries are entitled to receive incentive payments to offset their premium and copayment liability by participating in a Healthy Behaviors Incentive Program, which includes an annual examination by a primary care provider and completion of a HRA. Health plans are permitted to create incentives (e.g., paying a set fee for helping a patient complete the HRA) to encourage providers to participate, and the plans are subject to a withholding of a set percentage of their capitation rates by the state contingent on beneficiaries completing the HRAs.

MI (pronounced "my") Health Accounts. MI Health Accounts are the mechanism used to track and collect premiums and cost-sharing payments and to provide credit for meeting healthy behaviors incentives. The accounts are managed by a third-party administrator, Maximus. Cost-sharing amounts collected for those under 100 percent of FPL based on past utilization are transferred to the health plans. Premium payments are paid to a health plan only after the plan pays out a certain amount (first-dollar amount) in provider claims. Premium payments may carry over from one year to the next in a MI Health Account.

If a person leaves the Medicaid program, the amounts remaining may only be used in the form of a voucher to cover the cost of paying the premium for a private health insurance plan. Though the state may not terminate people from coverage or deny them services for failure to pay their premiums and copayments, respondents reported that the state is considering using a tax lien to help enforce these obligations.

Beginning in October 2014, six months after the first group of individuals had enrolled, the first invoices for the premiums and copayment liabilities were sent to beneficiaries. According to an analysis of the population in Healthy Michigan, as of July 15, 2014, only about 16 percent of beneficiaries had incomes above the FPL.[46] One respondent told us they believed that less than 10 percent of the expansion population was above the FPL. It thus appears that a relatively small percentage of the expansion population will be responsible for the monthly premium contributions, although all enrollees are subject to payment of prior cost-sharing amounts through the average monthly billings.

Several respondents noted that they believed that the administrative costs of monitoring the accounts, generating and distributing the quarterly statements, updating income and claims information, tracking healthy behavior compliance, and handling the payments will cost far more than the money that beneficiaries will ever pay into the system. But proponents of these provisions countered that they reflect a policy goal of requiring Medicaid beneficiaries to have responsibility for at least some portion of their medical costs, to familiarize beneficiaries with elements of private insurance, and to create incentives for healthy behaviors. One state official also emphasized that a key element of Healthy Michigan was to promote important public health goals, such as incentivizing immunizations.

The Future of the Section 1115 Expansion Waiver in Michigan

The authorizing legislation requires the Michigan Department of Community Health, which operates the state's Medicaid program, to submit two different waiver requests to CMS to implement the law. The first waiver request was approved and is discussed above. But the legislation also requires the Department of Community Health to submit an additional waiver request by September 1, 2015 that would require individuals between 100 and 138 percent of FPL who have had medical assistance for 48 "cumulative months" to choose between paying total cost sharing up to 7 percent of income (as compared to a maximum of 5 percent under the approved waiver for both premiums and cost sharing) or go into the marketplace and become eligible for premium

tax credits and cost-sharing reductions. This latter provision goes well beyond the scope of what CMS has approved to date and what may be allowed under federal law.

Governor Snyder's proposal, and the final legislation, also provided a mechanism for Michigan to set aside funds to cover the state's anticipated costs in 2017 and beyond, when the federal government's 100 percent match for the expansion population will be reduced. The set-aside funds are expected to come from the savings the state will realize between 2014 and 2017, because it will no longer incur certain expenditures in pre-ACA state programs that are being replaced by the expansion.

If Michigan does not submit, or CMS does not grant, the state's second waiver request or if the state does not realize the full savings required over the next three years to cover the state's match for the program in 2017 and beyond, it is not clear how the legislature and the governor might respond or what the legal effect on Michigan's expansion might be.

Healthy Pennsylvania

At the end of August 2014, CMS approved Healthy Pennsylvania, Pennsylvania's application for a Section 1115 waiver, under which the state expanded Medicaid effective January 1, 2015 by placing newly eligible beneficiaries into new managed care health plans that would run independently from and parallel to existing MCO plans.[47] Pennsylvania also received CMS approval to charge monthly premiums to newly eligible beneficiaries above 100–138 percent of FPL beginning in January 2016. CMS, however, did not approve several proposals relating to benefits, contributions, and work requirements.[48] Moreover, in early 2015, Pennsylvania's newly elected Democratic governor, Tom Wolf, announced that he would phase out the Healthy Pennsylvania program and implement a standard Medicaid expansion before the end of 2015.

In 2013 roughly 1.4 million people, or 13 percent of Pennsylvania's nonelderly adult population, were uninsured.[49] Medicaid expansion was expected to extend eligibility to an estimated 600,000 people in the state.[50] Opposed to the ACA but wanting to expand Medicaid, Republican Governor Tom Corbett initially faced significant opposition in the legislature but eventually was able to garner the support needed. He framed the plan as a "private coverage option." Some respondents reported that Pennsylvania initially planned to follow the Arkansas private option model by bringing newly eligible enrollees into the marketplace and potentially increasing market competition among the plans. But the proposal changed instead to expanding the well-established MCO structure in Pennsylvania and placing the expansion population in a second managed care market in the state that would run parallel to the existing MCO market and be subject to the Medicaid managed care rules. The new MCO plans would offer the same benefits as those offered in the marketplace. This new MCO market was divided into nine geographical regions, similar to those set up for the QHPs on the marketplace.

At the same time, the Corbett administration also sought approval to divide all Medicaid beneficiaries—not just the expansion population—into two groups that would receive different benefits: a high-risk plan for high utilizers, including the medically frail, and a low-risk plan for most enrollees who would either be in the new expansion MCO plans or the traditional MCO plans. The two plan designs had different benefits, with the high-risk plan having more comprehensive benefits than the low-risk plan, but both plans still having less generous benefits compared to what traditional Medicaid offered in the state. Consumer advocates and some providers opposed the two-plan design strategy.

Providers also expressed concern about the provider reimbursement rates in the new MCO market. Providers had anticipated that reimbursement rates in the new managed care market would be closer to QHP marketplace rates, but respondents reported that the provider rates in the new MCO market are closer to what traditional Medicaid pays. This in turn raised concerns about network adequacy because there would be fewer provider contracts with the new plans. Some respondents also expressed concerns over the capacity of the new MCO market to adequately cover mental health services.

Governor Corbett also received a waiver to implement several personal responsibility provisions beginning in 2016. Those approved provisions included (1) charging monthly premiums to nonexempt individuals between 100 and 138 percent of FPL up to 2 percent of household income, (2) waiving cost sharing for enrollees subject to the premium payments except for the state plan amounts for nonemergency use of the emergency department, (3) creating healthy behaviors incentives that could reduce the premium payments owed, and (4) disenrolling people who did not pay their premiums for three consecutive months but enabling them to re-enroll without a waiting period.

Governor Wolf has announced that he will implement a standard Medicaid expansion by the fall of 2015. He is eliminating the high risk/low risk distinction in the Medicaid

Table 5: Summary of Key Provisions in Pennsylvania's Section 1115 Medicaid Expansion Waiver: Healthy Pennsylvania

(Note that Pennsylvania will implement a standard expansion by the end of 2015.)

Policy	Description
Premium Assistance in QHPs	No. Enrollees were placed in new Medicaid managed care plans in 2015 that were created for the expansion population. Enrollees will be transferred to traditional MCOs by the end of 2015.
Monthly Premiums or Contributions	Yes, but will not be implemented. Beginning in 2016, the state was authorized to charge monthly premiums to nonexempt enrollees above 100–138% FPL up to 2% of annual household income. State could have submitted a premium model proposal for CMS to consider for enrollees with incomes at or below 100% FPL in later years.
Cost sharing	Regular cost sharing under state plan applied in 2015. Cost sharing would have been waived for those paying premiums except for state plan amounts for non-emergency use of the emergency room.
Disenrollment or Lockout if Fail to Pay Monthly Contributions	Never implemented. No lockout, but enrollees above 100–138% FPL could have been disenrolled for nonpayment of premium; they would have been allowed to re-enroll without a lockout period, but outstanding payments would have been subject to recovery by the state.
Health Accounts	No individual accounts were proposed to hold the enrollees' premium contributions, but the state would have kept track of the amounts paid and amounts owed.
Healthy Behaviors Incentives	Yes, but will not be implemented. Could have reduced premiums owed.

Sources: Centers for Medicare and Medicaid Services, Cover Letter and Special Terms and Conditions, Healthy Pennsylvania Section 1115 Demonstration, Number 11-W-00295/3 August 28, 2014. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/pa-healthy-ca.pdf (accessed April 2015).

program, phasing out the new expansion MCO programs, and will not implement any of the personal responsibility provisions that had been approved for 2016. Table 5 summarizes key elements of the waiver.

Healthy Indiana Plan (HIP) 2.0

Indiana's Section 1115 expansion waiver, approved by CMS on January 27, 2015, relies primarily on Medicaid managed care plans. It does not place any beneficiaries in QHPs but includes an optional premium assistance program for eligible adults with access to ESI. Indiana's Section 1115 waiver also has the most significant premium contribution requirements of any approved plan to date, requiring every enrollee—regardless of income—to pay a monthly contribution. Moreover, for the first time, CMS approved a lockout provision; CMS authorized Indiana to lock people above 100–138 percent of FPL out of Medicaid coverage for up to six months after they have been disenrolled for failing to pay their premiums. CMS also authorized the state to eliminate retroactive coverage, a waiver it had not granted previously to any other state seeking a Section 1115 expansion waiver, and acknowledged the state's plan to implement a voluntary job search and training initiative for beneficiaries, but noted that it was being implemented "outside this demonstration."[51] Indiana began to enroll people in the expansion program on February 1, 2015. Table 6 summarizes key elements of the waiver.

The Political Context for Expansion in Indiana

In 2008, Indiana began implementing a limited Section 1115 waiver to enroll nonelderly adults in what it called its Healthy Indiana Plan (HIP). HIP, which used a variation on health savings accounts (HSAs), became the basis for Indiana's August 2014 application to expand Medicaid through a Section 1115 waiver. Indiana has a Republican governor and Republican majorities in both houses of the legislature. Governor Mike Pence announced in 2013 that he would only expand Medicaid if he could do so through HIP. Unlike other states where there were extensive negotiations between legislators and the governor, respondents reported that there was bipartisan support for using HIP as the basis for Indiana's waiver request, particularly given that the governor would not support a standard Medicaid expansion.

There were extensive negotiations between Pence and CMS over Indiana's proposed HIP 2.0. Pence estimated that between 334,000 and 598,000 people would be covered under the plan.[52] According to a state respondent, Indiana launched HIP 2.0 as soon as CMS approved the waiver, transitioning approximately 170,000 enrollees from other Medicaid programs into HIP 2.0 on February 1, 2015. As of early April 2015, approximately 137,000 new applicants had enrolled in HIP 2.0.

Medicaid Managed Care in Indiana

Indiana has used risk-based managed care in some of its Medicaid programs for 20 years. Three MCOs provide

Table 6: Summary of Key Provisions in Indiana's Section 1115 Medicaid Expansion Waiver: HIP 2.0

Policy	Description
Premium Assistance in QHPs	No. Enrollees placed in existing Medicaid managed care plans, but provider reimbursement rates in the HIP managed care plans are higher than standard Medicaid reimbursement rates.
Monthly Premiums or Contributions	Yes. CMS refers to these as both "premiums" and "monthly contributions" to individual health accounts. All nonexempt enrollees must pay at least $1/month, regardless of income or 2% of annual household income, whichever is greater.
Cost sharing	No copayments if the enrollee stays current on monthly premiums. Enrollees who remain in the program (see disenrollment/lockout provision below) are responsible for making copayments at the point of service in amounts allowed under Medicaid rules and state plan with an aggregate cap of 5% of quarterly household income. Through Section 1916(f) of the Social Security Act, CMS also granted Indiana approval to charge higher copayments for multiple visits to an emergency room for nonemergency services. Individuals will be charged $8 for the first nonemergency visit in a 12-month period and $25 for other nonemergency visits during the same period.
Disenrollment or Lockout if Fail to Pay Monthly Contributions	Yes. Indiana is the only state authorized to disenroll and lock out individuals otherwise eligible for coverage for failure to pay a monthly contribution within 60 days from the first day of the coverage month for which the contribution is owed. Disenrollment and lockout only apply to enrollees above 100–138% FPL. The lockout period is six months. Medically frail enrollees may not be disenrolled.
Health Accounts	Yes. Medicaid Managed Care Organizations are responsible for maintaining these accounts for their HIP 2.0 members and billing and collecting the contributions.
Healthy Behaviors Incentives	HIP 2.0 provides an incentive for enrollees to obtain preventive health services, which would entitle them to a partial reduction in their monthly contributions.

Note: Indiana also was granted a one-year waiver from the Medicaid requirement that it provide retroactive coverage for up to three months prior to the date of an individual's application if the individual would have been eligible during that time period. This waiver may be renewed, but the state must submit data regarding whether there were gaps in coverage that could be "remediated" by providing retroactive coverage.

Sources: Centers for Medicare and Medicaid Services, Cover Letter and STCs, Healthy Indiana Plan (HIP) 2.0, Number 11-W-00296/5. Approved February 1, 2015 through January 31, 2018. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf (accessed April 2015).

statewide coverage for HIP 2.0. When the state first implemented HIP in 2008, it required the MCOs to pay physicians at prevailing Medicare rates, a requirement that has continued in HIP 2.0. One respondent reported that because of these higher reimbursement rates, more providers have participated in HIP than in other Medicaid programs. As of April 2015, several hundred new providers had reportedly enrolled in HIP 2.0 since its launch.

Personal Responsibility Components of Indiana's Expansion

Indiana's waiver has a complicated set of requirements affecting different populations within the newly eligible population. The contribution requirements are built around Personal Wellness and Responsibility (POWER) accounts, which were an integral part of HIP 1.0 and are modeled after HSAs. They are also designed to incentivize people to make their monthly payments by providing a more generous benefits package (called "HIP Plus"), which includes dental and vision coverage, for those who stay current on their monthly payments. These additional benefits are not required benefits for adults eligible for Medicaid expansion under the ACA. Although CMS' approval refers to these payments as "premiums," a state respondent emphasized that state officials refer to them as monthly "contributions" analogous to monthly payments into a HSA.

Premium payments/contributions. As was true in other Section 1115 waiver approvals, CMS has distinguished between individuals at or below the poverty level and those above 100–138 percent of FPL. But unlike the other waivers, CMS authorized Indiana to charge premiums for those below 50 percent of FPL. All beneficiaries are required to pay 2 percent of household income or $1/month, whichever is greater. Thus all enrollees—regardless of income—must pay at least $1/month. Enrollees who pay these amounts will be eligible for HIP Plus.[53]

Premiums are based on the beneficiary's household income, as determined at the time of the initial enrollment or annual redetermination. Each beneficiary has his or her own account, but the total contributions within a household cannot exceed 2 percent of the household's monthly income. The beneficiary's MCO is responsible for billing and collecting the contribution; monthly invoices must state

how beneficiaries should report a change in income and the consequences of failing to pay the premium.[54]

In general, beneficiaries above 100–138 percent of FPL who fail to make their monthly premium contributions within a 60-day grace period will be disenrolled and locked out of the program for six months. The MCO is required to provide at least two written notices to the beneficiary regarding the amount owed and when it must be paid to avoid disenrollment. The notices must also set forth the option to request a screening for medical frailty (which exempts individuals from the disenrollment penalty) and the beneficiary's appeal rights.

Adults whose incomes are at or below 100 percent of FPL will be enrolled in HIP Basic if they do not pay their monthly premiums within the 60-day grace period. The HIP Basic plan provides all mandatory Essential Health Benefits but does not include vision or dental benefits. Individuals at or below 100 percent of FPL may not be disenrolled or locked out of HIP 2.0 for failure to pay their premiums or the copayments described below.

Copayments. CMS has authorized Indiana to test a graduated copayment for nonemergent use of the emergency room. Following an $8 charge for the first nonemergency visit to the ER, the state is authorized to charge up to $25 for recurring nonemergency visits in a 12-month period.

Except for this copayment for nonemergency use of the emergency room, HIP 2.0 exempts beneficiaries from copayments if they pay their monthly premiums into their POWER accounts. Only HIP Basic enrollees are subject to these other copayments. Beneficiaries at or below 100 percent of FPL who do not pay their monthly premiums will be enrolled in HIP Basic and charged copayments at point of service consistent with Medicaid regulations, subject to a 5 percent monthly or quarterly aggregate cap, including a $4 copayment for a doctor's visit and $75 for a hospitalization.[55] HIP Plus enrollees above 100–138% of FPL who do not pay their premiums will be disenrolled rather than transferred to HIP Basic.[56]

POWER Accounts. According to CMS' Special Terms and Conditions, "[t]he POWER account is styled like a health savings account arrangement under a consumer-directed health plan."[57] The POWER account funds will cover the first $2,500 in claims for each beneficiary in a Medicaid managed care plan; the remaining claims will be covered through capitation rates or other payments made by the state to the MCO. Preventive services are not charged to the POWER accounts.

The state will fund the POWER accounts on an annual basis in an amount equal to the difference between the beneficiary's required contribution and $2,500. The MCO is responsible for fully reimbursing the providers up to the full $2,500 regardless of the beneficiary's current balance. If an enrollee has any of his or her own contributed funds left in the account at the end of the year, those funds will be rolled over and will reduce the enrollee's liability for the next year; the rollover amount will be doubled if the enrollee obtains "age and gender appropriate preventive services." This is the only healthy behavior incentive in HIP 2.0.

If an individual loses eligibility for HIP 2.0 or leaves the program and there are leftover funds that the enrollee contributed, following payment of any remaining debt to the MCO, the enrollee may receive a refund from the state. The amount of the refund is determined based on the individual's pro rata share of the total amount remaining in the account. Unlike other states, Indiana refunds the contributions to the enrollee rather than requiring the funds to be used for other health coverage programs. This is consistent with the state's position that these payments are not premiums.

The New Hampshire Health Protection Program

On March 4, 2015, CMS approved New Hampshire's Section 1115 waiver to provide premium assistance to enroll eligible adults into QHPs.[58] New Hampshire estimates that approximately 45,000 low-income adults will be placed in QHPs under the program.[59] New Hampshire has used a three-step approach to implement its plan: (1) a mandatory Health Insurance Premium Payment Program for individuals with access to cost-effective ESI, including the payment of enrollees' cost-sharing charges; (2) a bridge program to cover the new adult group in MCO plans beginning August 2014 through December 31, 2015, which did not require a Section 1115 waiver; and (3) a mandatory QHP premium assistance program that will begin on January 1, 2016, which will also include payments by the Medicaid program to the QHPs to cover the cost-sharing reductions for enrollees.

Under New Hampshire's waiver, newly eligible beneficiaries above 100–138 percent of FPL will be responsible only for cost sharing that is already permitted under Medicaid law; those at or under 100 percent of FPL will have no cost sharing obligations. Except for standard Medicaid cost sharing for those between 100 and 138 percent of FPL, New Hampshire did not include any mandatory premiums, contributions, health accounts, or healthy behaviors incentives in its proposal. As is true for other cost sharing plans approved by CMS, cost sharing will be capped at 5 percent of quarterly household income. Enrollees will have no deductibles, and premiums and other cost-sharing

Table 7: Summary of Key Provisions in New Hampshire's Section 1115 Medicaid Expansion Waiver: The New Hampshire Health Protection Program

Policy	Description
Premium Assistance in QHPs	Yes. Mandatory for all nonexempt enrollees at all income levels beginning in 2016.
Monthly Premiums or Contributions	No.
Cost sharing	Cost sharing (copayments and coinsurance) is limited to allowable amounts under Medicaid rules and the state plan.
Disenrollment or Lockout if Fail to Pay Monthly Contributions	N/A
Health Accounts	N/A
Healthy Behaviors Incentives	No

Note: New Hampshire may submit data to CMS to establish that there is "seamless coverage" that does not result in coverage gaps for individuals eligible for the program in the period before they file their Medicaid application. CMS will review the data and may grant New Hampshire a waiver of the Medicaid requirement that it must provide retroactive coverage for up to three months prior to the date of an individual's application if the individual would have been eligible during that time period.

Sources: Centers for Medicare and Medicaid Services, Special Terms and Conditions, New Hampshire Health Protection Program Premium Assistance, Number 11-W-00298/1. March 4, 2015. http://www.dhhs.state.nh.us/pap-1115-waiver/documents/pa_termsandconditions.pdf (accessed April 2015); Centers for Medicare and Medicaid Services, "Medicaid and the Affordable Care Act: Premium Assistance." Washington, DC: March 2013. http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf (accessed April 2015).

expenses will be paid by the state. Table 7 summarizes key elements of the waiver.

The Political Context for Expansion in New Hampshire

New Hampshire had several key goals in designing its expansion through this three-step process. First and foremost, New Hampshire needed a bipartisan plan in order to adopt the Medicaid expansion. Although New Hampshire's governor and house of representatives were Democratic, the Republican-controlled Senate objected to a traditional Medicaid expansion. According to respondents, utilizing a private option made expansion politically feasible in New Hampshire. A bipartisan bill was passed and signed into law in March 2014.[60]

Second, New Hampshire wanted to take advantage of the 100 percent federal funding available until 2016. The first phase of the Medicaid expansion plan allowed New Hampshire to expand quickly without a Section 1115 waiver. Moreover, because there was only one carrier in the New Hampshire marketplace in 2014, there would have been only one option for Medicaid beneficiaries if New Hampshire initially expanded using QHPs rather than MCOs. In light of CMS' March 2013 guidelines stating that Medicaid beneficiaries must have a choice of at least two plans, it was unlikely that CMS would have approved the private option in New Hampshire with only one carrier in the marketplace. By using the bridge program, New Hampshire was able to expand quickly using MCOs and give the marketplace more time to have multiple insurers participate in time for Medicaid beneficiaries to enroll in QHPs. Coverage for the new adult group became effective on August 15, 2014 and as of March 17, 2015, 37,009 people had enrolled.[61]

Third, the second phase of the program will allow New Hampshire to implement a private option by requiring most beneficiaries to participate in QHPs in exchange for the Medicaid program providing premium and cost-sharing assistance. The state's Section 1115 waiver application states that it seeks to attract more insurers to the marketplace and thereby increase competition. Under state law, if CMS had not approved the private option by March 31, 2015, the bridge program would have terminated effective June 30, 2015.[62]

New Hampshire's Private Option

In the first phase of New Hampshire's Medicaid expansion, New Hampshire has used its existing Health Insurance Premium Payment Program to cover newly eligible adults through employer-sponsored coverage. If an employer-sponsored plan is available and is deemed to be cost-effective, the state will pay the enrollee's portion of the premium and cost-sharing expenses.

Eligible individuals who do not have an offer of cost-effective health insurance through their employer have been enrolled in an existing MCO plan (or in a QHP on a voluntary basis if cost effective) through the newly created bridge program. Under the waiver, when the state implements the private option in 2016, the state plans to promote continuity of coverage and care by automatically enrolling individuals who are in MCO plans into comparable QHPs offered by the same MCOs if such plans are available; beneficiaries

will have the option to select an alternative plan during the enrollment period.[63] People will be allowed to select from at least two silver QHPs, and if they do not select one, they will be auto-assigned to one. For new applicants, the state will provide fee-for-service coverage until the individual can be enrolled in a QHP. New Hampshire's STCs provided that "[t]he QHPs available for selection by the beneficiary will be determined by the Medicaid agency."[64]

New Hampshire will provide wrap-around benefits through fee-for-service Medicaid that are not covered by QHPs, including nonemergency transportation, Early Periodic Screening Diagnosis and Treatment services for those under age 21 and what STC 36 describes as "certain limited adult dental and adult vision services." New Hampshire sought a waiver from the requirement that it provide retroactive coverage to applicants. While not rejecting the request, CMS established several requirements before waiver of retroactive coverage will be permitted. CMS is requiring the state to submit data "to establish that there is seamless coverage that does not result in gaps in coverage prior to the time that a Medicaid application is filed" and to describe its renewal process and related data to determine whether individuals are losing coverage at the time of renewal.[65] Only if and when CMS determines that there is sufficient data to establish that retroactive coverage prior to the date of the application is not necessary to fill gaps in coverage, will New Hampshire be allowed to provide coverage beginning at the date of application.

As approved by CMS, New Hampshire's goals for the Section 1115 expansion waiver include 1) reducing coverage disruptions and promoting continuity of care, 2) having wider provider networks and higher provider payment rates, and 3) lowering costs through increased competition in the marketplace. There already may be signs of the latter. Four new insurers entered the New Hampshire marketplace in 2015. In 2014, only Anthem Blue Cross Blue Shield offered plans on the marketplace, however in 2015, Anthem was joined by Assurant, Harvard Pilgrim, Minuteman, and Community Health Options. Assurant is a large national commercial carrier, Harvard Pilgrim is a regional carrier, and Minuteman and Community Health Options are co-ops entering from neighboring states (Massachusetts and Maine respectively). The substantial increase in insurer participation is likely one of the driving forces behind the 17.5 percent drop in the premium of the second lowest cost silver plan between 2014 and 2015.[66] For the 2015 plan year, Minuteman displaced Anthem as the lowest- and second lowest-cost silver plans. Respondents reported that they believed that the Medicaid private option (which passed in March 2014) was a major reason for this increased competition in the New Hampshire marketplace.

The Future of the Section 1115 Expansion Waiver in New Hampshire

New Hampshire's private option is valid for 2016 with the possibility of two additional years, contingent on the legislature's support. The expansion is contingent on 100 percent federal funding and will expire on December 31, 2016 or earlier if the federal government does not keep its commitment to finance 100 percent of the cost of expansion through the end of 2016.[67] The program will have to be reauthorized by the state legislature when the state begins paying for a portion of the costs.[68] Following the 2014 election, the New Hampshire House of Representatives shifted from Democrat to Republican, which could have an impact on implementation of the program in 2016 and renewal of the plan in later years.

Other States Are Considering Expansion Alternatives

Several other states have also been looking at alternatives to a standard Medicaid expansion. Under Montana's legislation, all nonexempt enrollees would be charged 2 percent of household income and individuals above 100 to 138 percent of FPL would be disenrolled from the program and locked out for a period of time for nonpayment of premiums. By early March 2015, the legislatures in Tennessee, Wyoming, and Utah had rejected their governors' call for a Medicaid expansion waiver, but the proposals they and other states have considered are informative. Both Tennessee and Wyoming were considering utilizing HSAs as a means for instituting personal responsibility.[69] Tennessee and Utah were both looking at using healthy behaviors incentives and premiums, but only Tennessee was looking at using lockouts, at least before CMS approved the Indiana lockout provision.[70]

DISCUSSION

Several states have proposed policy changes to traditional Medicaid in an effort to expand the program, add coverage, and bring in federal dollars in ways that are acceptable to state political leaders. Respondents in all six states reported that a standard expansion would not have been approved in their states. In general, many leaders in the states that have debated these alternatives have a strong aversion to traditional Medicaid, and tend to support placing

stronger requirements on beneficiaries of public programs in general. The Medicaid expansion debate has created an opportunity for public officials in those states to advocate for policies that reflect those broader philosophic views, such as imposing work requirements on enrollees. The proposed alternatives include placing people in private insurance plans through the marketplaces (in QHPs). This has been attractive because it places enrollees in private health insurance plans instead of government administered fee-for-service plans or managed care plans that are subject to significant governmental oversight—including contractual obligations placed on the MCOs by state Medicaid agencies. According to some respondents, QHPs differ from Medicaid fee-for-service programs or existing Medicaid managed care programs in the minds of many legislators.

In addition, proposed alternatives include a range of personal responsibility provisions such as imposing monthly premiums, requiring premium-like monthly contributions to cover either past or anticipated future cost-sharing expenses, using variations on the model of health savings accounts used in high-deductible ESI plans, and providing incentives for healthy behaviors. This new set of policy prescriptions raises a number of questions about how well they can promote the goals of the Medicaid program. CMS has responded to these waiver applications by placing restrictions on what states can do and has rejected some proposals, such as tying benefits to work-related requirements. However, CMS seems to be growing increasingly receptive to certain state requests, as shown by the recent approval of the Indiana waiver, for example, which includes a lockout period for nonpayment of premiums, elimination of retroactive coverage, and charging premiums to people below 50 percent of FPL. The benefit of CMS flexibility is the expansion of coverage to many more Americans than would have had it if their states refused to participate in the Medicaid expansion. However, it remains to be seen whether these newly designed programs will significantly inhibit participation and/or access to care relative to more traditional approaches to Medicaid eligibility expansion.

Premium Assistance for QHPs

Arkansas led the way in using premium assistance to place its entire expansion population—except the medically frail and other exempt populations—into QHPs within its marketplace; New Hampshire will do the same in 2016. Iowa used premium assistance to place nonexempt enrollees in QHPs but on a more limited basis (for those at 100–138 percent of FPL) and has run into challenges providing consumers with choices among QHPs. Michigan, Indiana, Iowa (for those below 100 percent of FPL), and Pennsylvania enrolled individuals in Medicaid managed care plans. Placing individuals in QHPs within exchanges seems to have a number of advantages, but whether it makes sense for a state depends largely on that state's current Medicaid managed care program and its QHP market. It also depends on whether states can effectively provide access to wrap-around services and to safety net providers for enrollees in QHPs, and whether they can adequately identify the medically frail. Finally, some respondents from Arkansas emphasized how complex it was to implement the private option and coordinate with the marketplace and participating health plans, noting that states seeking to implement a private option may have to invest considerable time and resources into making it work effectively for Medicaid enrollees.

Medicaid managed care is a precursor to QHPs in the sense that individuals were placed into managed care plans run by private entities. Sometimes these were commercial insurance plans; in other cases they were national Medicaid managed care organizations, and still others were local plans begun and operated by safety net facilities. If the state has a robust managed care program that is well designed, with strong provider networks and good access to care, it may make sense to place the expansion population in Medicaid managed care rather than in QHPs. A major advantage of well-run Medicaid managed care plans is that they have experience with Medicaid populations and the complexity of the benefits package. Providing full benefits is less complicated because there is no need to cover wrap-around services; they are already part of the Medicaid managed care benefits package.

Critics of the private option contend that it will cost significantly more than traditional Medicaid, add complexity for enrollees accessing wrap-around benefits required under Medicaid but not included in the QHP benefits packages, and take away the ability to hold managed care plans accountable for delivery of benefits and adherence to Medicaid requirements under the obligations of the MCO contracts. Concerns have also been raised regarding whether enrollees will have adequate access to safety net providers in QHPs and how effectively states will implement the medical frailty screens that divert less healthy individuals into traditional Medicaid. Finally, some respondents have raised concerns that moving the relatively healthier portion of the Medicaid population into QHPs might make it even harder to attract providers to serve those Medicaid enrollees with more complex health care needs who remain in the traditional Medicaid program.

QHPs offer a number of potential advantages. The use of QHPs could reduce the problems associated with churn; when individuals have income changes, they may not have to change insurance plans. All three states that adopted the

private option identified reduction of churn and increased continuity of care during coverage transitions between Medicaid and eligibility for subsidies in the marketplace as a major goal of their programs.[71]

Proponents of the private option also contend that individuals would more or less be in the mainstream of health insurance coverage in the country by enrolling in a private health insurance plan, without the stigma—rightly or wrongly—sometimes attached to Medicaid. Providers are also likely to be better paid and participate at higher rates in QHPs than in traditional Medicaid or Medicaid managed care plans. Provider participation, of course, can vary among plans and may depend on the breadth of networks in the QHPs. Some are relatively narrow networks paying Medicaid-like rates, in which case there may be less of an advantage. But in many states where the insurance market is heavily dominated by single insurers, typically a Blue Cross plan, placing the Medicaid expansion population in QHPs could make these markets more competitive.

Finally, proponents also contend that placing the expansion population into QHPs will increase competition in the marketplace and thereby lower premiums. In Arkansas, insurers offered plans in more regions in 2015, increasing competition in most areas of the state. New Hampshire has seen several new entrants to its marketplace since it launched plans to implement a private option Medicaid expansion, though it is not completely clear whether new insurers entered the marketplace because of the anticipated expansion. If a number of insurers enter and the marketplace is larger than expected, this should increase competition and lower premiums. This increase will provide benefits for a broader population within these states, not just Medicaid enrollees. There will be more choice, more price competition, and lower premiums, which will result in lower subsidy costs to the federal government and lower prices to marketplace enrollees who are not eligible for federal subsidies.

CMS has required states adopting premium assistance for QHPs to incorporate the cost-sharing limitations from standard Medicaid; all other cost sharing is covered by the Medicaid program.[72] On balance, moving the Medicaid expansion population into QHPs in many states seems to offer considerable promise. Setting aside the role of personal responsibility provisions and assuming that enrollees continue to receive the wrap-around benefits that would otherwise be available to them in a standard expansion, the key questions are whether placing the Medicaid population in QHPs really stimulates more competition and constrains marketplace premiums, whether network providers are paid more than in Medicaid, whether provider networks are adequate, and whether coverage gaps are reduced when people transition between eligibility for Medicaid and eligibility for marketplace subsidies.

Premiums and Cost Sharing

Several states have adopted premiums up to 2 percent of income for those between 100 and 138 percent of FPL. These charges are expected to offset costs somewhat, but more important to proponents is their contention that monthly contributions will increase enrollees' responsibility for their health coverage and familiarize enrollees with private insurance models. Some states are also turning standard Medicaid copayment obligations into premium-like monthly contributions and extending these "contributions" to individuals below the poverty level. In Indiana, even individuals with zero income are expected to pay $1/ month, although CMS has not permitted any state to disenroll or lock out anyone at or under FPL for failure to make any of these payments.

As reflected in the premiums charged in the CHIP program, there has been bipartisan support for some of these provisions in the past. But they raise a number of questions. Most moderate- and high-income Americans are used to paying premiums, as well as cost sharing, in their insurance plans. But the Medicaid expansion population has much lower incomes. Whether these standard provisions of private insurance should be applicable to such populations is questionable. Even 2 percent of income at these levels is considerable and, based on earlier research, charging such amounts is highly likely to result in lower enrollment or higher rates of disenrollment. Budgetary savings are unlikely to be significant because these premiums and contributions are still small relative to health care costs, but savings could be more significant if these payment requirements deter people from enrolling or using necessary care. Deterring enrollment seems inconsistent with the goals of a Section 1115 waiver and with the ACA.

There is plenty of evidence that suggests that low-income individuals are highly sensitive to premiums when enrolling in programs.[73] Ku et al. found that participation rates in Medicaid were 67 percent with zero premiums, but fell to 57 percent with premiums equal to 1 percent of income, and 45 percent with premiums at 2 percent of income.[74] Kenney et al. found that higher premiums reduced enrollment of a CHIP population and had greater effects the lower the family income.[75] Prior to the ACA, Oregon increased premiums on the population of childless adults below FPL from $6 to $20/month. The result was a 50 percent reduction in enrollment. Researchers found that premiums disproportionately affected low-income individuals and that individuals with health problems were more likely to enroll.[76] Abdus et al. used the Medical

Expenditure Panel Survey[77] to estimate the impact of premiums on CHIP. They found that a $10 monthly premium for those above 150 percent of FPL resulted in a 1.6 percentage point reduction in enrollment, while a $10 monthly premium on those between 101 and 150 percent of FPL resulted in a 6.7 percentage point reduction in enrollment.[78]

Though the impact of premiums varies in these studies, they clearly indicate that premiums would lead to lower enrollment, although how much is uncertain. For example, some states disenroll individuals for not paying premiums, but then allow them to re-enroll. In Indiana, there is a six-month lockout period. The use of premiums at very low income levels that may have serious effects on enrollment outcomes seems inconsistent with the purposes of the Medicaid program and the goal of the ACA, which is to expand enrollment.

Individual Health Accounts

One popular element of the personal responsibility initiatives is to introduce some form of personal account that proponents often compare to HSAs. These were initially introduced in Michigan, were added more recently in Arkansas, and are most prominent now in Indiana, building on an existing program there. HSAs have become popular for high-income individuals with high deductible insurance plans. In the case of the higher-income population, on top of an insurance plan with a high deductible, individuals are allowed to set up a HSA, typically with an employer contribution. Both employer and employee contributions are made pre-tax, and are thus more valuable the higher one's marginal tax bracket. As individuals build up funds in these accounts, they can be used to pay for services, including those subject to the deductible.

Health savings accounts are designed to equalize the tax treatment of out-of-pocket contributions and premiums, allowing unused portions of the savings accounts to increase tax free. The theory is that individuals have a strong incentive to use the funds in their accounts judiciously because the funds could be carried over and used for health services when needed in the future. The approach is intended to encourage people to be careful users of services and reduce unnecessary utilization. There is some evidence that high deductible plans may contribute to lower rates of growth in health spending.[79] The effect of the HSA feature, however, is less clear.

The accounts being implemented in the Medicaid context in these states are intended as variations on HSAs, applied to low-income populations. In the typical plan, individuals would make contributions to the accounts instead of making premium payments to the insurer or copayments to providers. In one case (Michigan), after an enrollee has been in the plan for six months, the state calculates the monthly contribution amount based on actual copayments that enrollee would have been charged for his or her utilization of services in the initial three months in the program, and charges the enrollee that amount payable over three months; these amounts are recalculated quarterly. In other cases (Arkansas, Iowa, and Indiana), contributions are set independently of actual utilization; instead enrollees pay a monthly flat rate based on income. Typically, these payments are made in lieu of copayments at the point of service. Because CMS has only allowed states to charge enrollees the nominal copayments allowed under existing Medicaid rules, low utilizers of health care services will slowly accumulate funds in their accounts.

The incentives in these kinds of accounts for low-income populations are quite different than those that apply to higher-income populations with HSAs. Except for Michigan, individuals make contributions to their accounts regardless of their use of services. The incentives to use services more carefully is already in place through allowable Medicaid copayments. These copayments have led to reduced utilization,[80] including that of essential as well as arguably unnecessary services, but now the incentives for individuals change from paying a price when they use services to having, as many respondents noted, "skin in the game" in the form of a monthly payment that is charged regardless of utilization of services. These monthly payments are more like premiums than the out-of-pocket costs for which higher-income people use their HSA balances.

If the purpose of these accounts is to reduce unnecessary utilization, traditional Medicaid copayments already create such incentives. It would seem that replacing copayments at point of service with regular monthly contributions would tend to reduce those incentives. Individuals' balances will accumulate over time, very slowly since the payments are small, and the size of the balances will depend on how much health services are used. In most states, individual contributions to the accounts would be used to cover enrollees' copayment requirements; the remainder of the provider payment would be paid by Medicaid. In Indiana, the individual's contribution is combined with the significantly larger contribution by the state and paid out like a deductible to cover claims. In both types of systems, individuals could also have savings simply because they are healthy. In this case they get a financial benefit essentially because of good luck. Balances that remain can generally be used if individuals leave Medicaid to cover premiums in ESI or Medicare. In Indiana, individuals may receive refunds for their pro-rata share of unused balances (essentially the remaining share of

their own contributions) after they leave the program. For this population, however, these are probably very weak incentives to reduce unnecessary utilization.

In addition to likely being a weak deterrent to unnecessary use of services, HSAs for the poor are highly likely to be administratively inefficient. The amounts collected from individuals would be small relative to health care costs. Because there are large numbers of individuals in these programs, there would be a relatively large number of small monthly transactions. Similarly, the money that flows out of these accounts, also small amounts each time a service is used, would have to be managed. Several respondents indicated that the administrative costs will likely far exceed the benefits in terms of fees collected and lower utilization. But some proponents contend there are benefits merely from having enrollees manage HSAs—because it familiarizes them with private insurance models, including the requirement to contribute to the costs of obtaining care. The utilization effects would have to be very large to offset the higher administrative costs. Although these payments may lead to lower enrollment rates and more disenrollment, it is unlikely they will lead to more appropriate use of care by enrollees.

Healthy Behaviors Incentives

Some states have also used premiums, cost sharing and individual health accounts to create incentives for enrollees to engage in healthy behaviors. States usually offer to reduce or eliminate premiums or cost sharing or both if individuals engage in healthy behaviors. Typically, in the first year, these incentives involve having a wellness exam and completing a HRA, but in the future could eventually include other features as well, such as incentives for receiving immunizations. Low-income populations have higher rates of obesity, smoking, and substance abuse than the general population,[81] so in principle, encouraging healthy behaviors may be a positive. But the evidence for the effectiveness of such wellness programs is not clear cut.[82] A complete physical exam is expensive and could lead to more utilization of services in the short run, though possibly improving health and reducing utilization in the long run.

For wellness programs to work, they must change habits (e.g., encourage individuals to stop smoking, reduce weight, reduce or eliminate alcohol consumption or drug abuse, and increase physical fitness). Whether merely having a physical exam can change personal behavior is a large unknown. The ACA authorized $100 million for the Medicaid Incentives for the Prevention of Chronic Disease (MIPCD) program "to test the effectiveness of providing incentives directly to Medicaid beneficiaries of all ages who participate in MIPCD prevention programs, and change their health risks and outcomes by adopting healthy behaviors."[83] These programs may provide evidence regarding the effectiveness of particular strategies to meet specific prevention goals such as weight loss and tobacco cessation.

If individuals do not change health habits or do not comply with wellness programs, then these Section 1115 healthy behaviors programs will be ineffective and costly. Depending on how they are structured, they also could punish people who have certain medical conditions. On the other hand, if healthy behaviors incentives were to encourage people to participate in fully covered programs that have been proven effective, it might be worth the cost of experimentation. If states make serious investments in the design of these programs and, as a result, individuals make essential lifestyle changes, their health status will likely improve and long-term Medicaid expenditures could be lower, thereby promoting Medicaid's goals. But there is currently no convincing empirical evidence that wellness programs will have this effect.

CONCLUSION

The bottom line is that some state initiatives under Section 1115 may be effective, while others are unlikely to achieve their stated objectives. But regardless of their ultimate effectiveness, all of them have extended health coverage to large numbers of people, which appears to be the rationale behind CMS's approval of these approaches.

Moving people into QHPs appears to be worth the experimentation; doing so could improve access and stimulate private insurance markets in the states that adopt QHPs, but these plans will likely be more expensive than traditional Medicaid.

The premium contribution policies will likely reduce enrollment. This is also true of policies that turn copayments into premium-like monthly contributions. And the same result is even more likely when, as in Indiana, the state is permitted to implement a lockout—but there will likely be a deterrent effect in any case. The administrative and financial challenge of making monthly payments or having to re-enroll if dropped from the program creates more barriers for eligible individuals.

Using HSA principles in Medicaid seems dubious as well. Health savings accounts have high administrative costs and

will probably eliminate any deterrent effect on utilization that arises from charging copayments at point of service under standard Medicaid. The attraction of HSAs for the privately insured are the associated tax advantages, and no such advantages apply to the low-income population. Whether incentives for healthy behaviors will be effective is currently unknown, but might be worth some experimentation, for example, if tied to counseling and other programs that have been determined effective, such as in helping people lose weight or cease tobacco use.

The reality is that Medicaid is not a high-cost program when enrollees' health status is taken into account, as shown by Hadley et al. and Coughlin et al,[84] and as reflected in CBO budget projections that score Medicaid expansions to be considerably less costly than private expansions.[85] Adopting policies that will reduce enrollment, may impede access to particular services, or add to costs appears to be inconsistent with Medicaid's goals and with the purpose of Section 1115 demonstration waivers, although the trade-off is getting states to adopt the coverage expansion.

All of the policy options discussed in this paper have been part of one or more of the Section 1115 waivers approved by CMS for the Medicaid expansion population in the six states we have covered. These waivers require an ongoing evaluation by the states and review by CMS to determine whether they will meet their stated objectives.[86] Key questions that result from our review that should be considered in an evaluation are as follows:

First, with respect to placing Medicaid expansion enrollees in QHPs, the questions are these: Will use of QHPs be budget neutral for federal and state Medicaid budgets? Will there be other savings to the federal government because of lower subsidy costs for non-Medicaid enrollees in those states' QHPs? Will access to providers under QHPs be the same, better, or worse than access through a standard Medicaid expansion? Will beneficiaries have better access to specialists? Will they have the same or better access to safety net hospitals and other safety net providers? Will individuals with serious medical conditions be properly identified as medically frail? Even if not the goal of a Section 1115 waiver, will putting the Medicaid expansion population in QHPs stimulate the marketplace, providing spillover benefits to individuals not eligible for Medicaid but eligible for subsidies, and to individuals above 400 percent of FPL who would benefit from lower premiums?

The second set of questions relates to premiums and other monthly contribution requirements: What is the impact of these contributions on enrollment and disenrollment? If enrollment is lower, what are the characteristics of those who do not enroll that otherwise would have enrolled? Who are the beneficiaries most likely to disenroll? Do healthier people tend to stay out of the program until they need health care services? What are the cost implications of covering those individuals who remain in Medicaid compared to the savings that states might have expected from charging premiums or other monthly contributions?

Third, in HSA proposals: What are the administrative costs relative to the expected benefits, however defined? How difficult is it for individuals and providers to interact with an HSA-like system? What are the effects on utilization of eliminating copayments at point of service and using savings accounts to cover those costs? Has utilization increased or decreased? Are these changes positive or negative relative to imposition of copayments? What services appear to be affected?

Fourth, with respect to health behaviors, how do states move beyond basic physical exams to design programs that achieve the goals of healthy lifestyles? What program designs are effective in reducing smoking, obesity, and substance abuse? Do healthy behaviors incentives in Medicaid change people's behaviors or improve health outcomes? Do any of these programs have punitive (cost-increasing) effects for those with health problems or who are logistically challenged in participating?

Finally, in all these areas, what lessons do these programs, if any, offer other states? To answer that overarching question, public transparency in the implementation and evaluation of these programs will be essential.

ENDNOTES

1. Throughout this paper we refer to the upper limit for coverage under the ACA's Medicaid expansion as 138 percent of FPL. Although the ACA set 133 percent of FPL as the upper limit for expansion, it also authorized a 5 percent across-the-board income disregard, thus setting the maximum effective coverage at 138 percent of FPL. States in this study used 133 percent or 138 percent of FPL to describe some of their proposals; for consistency we use 138 percent of FPL.
2. Rudowitz, R, Artiga, S and Musumeci, M, *The ACA and Recent Section 1115 Medicaid Demonstration Waivers*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation. November 2014. http://files.kff.org/attachment/the-aca-and-recent-section-1115-medicaid-demonstration-issue-brief (accessed April 2015).
3. Kenney, G, Dubay, L, Zuckerman, S and Huntress, M, "Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults Would Not Be Eligible for Medicaid." Washington, DC: Urban Institute. July 2012. http://www.urban.org/UploadedPDF/412607-Opting-Out-of-the-Medicaid-Expansion-Under-the-ACA.pdf (accessed April 2015). *See also* Congressional Budget Office, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," Table 1. Washington, DC: Congressional Budget Office (CBO). March 2012. http://www.cbo.gov/sites/default/files/03-13-Coverage%20Estimates.pdf (accessed April 2015). CBO estimated that by 2016, approximately 17 million more people would have been enrolled in Medicaid and CHIP under the ACA.
4. *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012).
5. Office of Tennessee Governor Bill Haslam, "Haslam Makes Case for Insure Tennessee to General Assembly." Press release, February 2, 2015. https://news.tn.gov/node/13492 (accessed April 2015).
6. Several recent reports address these Section 1115 Medicaid expansion waivers. *See* Medicaid and CHIP Payment Advisory Commission (MACPAC), March 2015 Report to Congress on Medicaid and CHIP, Chapter 5, "Premium Assistance: Medicaid's Expanding Role in the Private Insurance Market." Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2015/03/Premium-Assistance-Medicaid%E2%80%99s-Expanding-Role-in-the-Private-Insurance-Market.pdf (accessed April 2015); Cross-Call, J and Solomon, J, *Approved Demonstrations Offer Lessons for States Seeking to Expand Medicaid Through Waivers*. Washington, DC: Center on Budget and Policy Priorities (updated March 4, 2015). http://www.cbpp.org/research/approved-demonstrations-offer-lessons-for-states-seeking-to-expand-medicaid-through-waivers; Rudowitz, R, Artiga, S and Musumeci, M, *The ACA and Medicaid Expansion Waivers*. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation (updated February 2015). http://files.kff.org/attachment/issue-brief-the-aca-and-medicaid-expansion-waivers
7. 42 U.S.C. § 1315. For more information about Section 1115 waivers and how they work in the context of Medicaid expansion, *see* Rosenbaum, C and Hurt, C, *How States are Expanding Medicaid to Low-Income Adults through Section 1115 Demonstration Waivers*. Washington, DC: Commonwealth Fund. December 2014. http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/dec/1794_rosenbaum_states_expanding_medicaid_section_1115_rb_v3.pdf?la=en (accessed May 2015); Rudowitz, R, Artiga, S, and Musemeci, M, *The ACA and Recent Section 1115 Medicaid Demonstration Waivers*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation. November 2014. http://files.kff.org/attachment/the-aca-and-recent-section-1115-medicaid-demonstration-issue-brief (accessed April 2015).
8. For a discussion of these pre-expansion waivers, *see* Rudowitz, R, *The ACA and Recent Section 1115 Medicaid Demonstration Waivers*.
9. Centers for Medicare and Medicaid Services (CMS), "Medicaid and the Affordable Care Act: Premium Assistance." Washington, DC: CMS. March 2013. http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf (accessed April 2015).
10. CMS, for example, has rejected state requests to waive the requirement that 19–20 year-olds receive Early Periodic Screening and Diagnostic Tests or the provision of federal law allowing consumers freedom of choice in selecting a family planning provider.
11. For more information on Medicaid rules for charging premiums and cost-sharing to Medicaid enrollees, including maximum allowable copayment amounts for different services at different income levels, *see* "Cost Sharing Out of Pocket Costs," Centers for Medicare and Medicaid Services. http://www.medicaid.gov/medicaid-chip-program-information/by-topics/cost-sharing/cost-sharing-out-of-pocket-costs.html (accessed April 2015); Medicaid and CHIP MAC Learning Collaborative, "Overview of Medicaid Cost Sharing and Premium Requirements." November 25, 2014. http://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/learning-collaborative-state-toolbox/downloads/cost-sharing-premium-requirements.pdf (accessed April 2015).
12. Brantley, M, "Arkansas health marketplace enrollment nears 65,000." Arkansas Blog at *Arkansas Times*, February 18, 2015. http://www.arktimes.com/ArkansasBlog/archives/2015/02/18/arkansas-health-marketplace-enrollment-nears-65000 (accessed March 2015).
13. Arkansas Department of Human Services, Arkansas 1115 Waiver Application, at 10, and accompanying Cover Letter from Arkansas Governor Mike Beebe. August 2, 2013. http://humanservices.arkansas.gov/dms/Documents/Final%201115%20Waiver%20Materials%20for%20Submission.pdf (accessed May 2015).
14. Arkansas Department of Human Services, "Arkansas' Approach to Low Income Premium Assistance." March 13, 2013. http://humanservices.arkansas.gov/director/Documents/Arkansas percent20Medicaid percent20Private percent20option percent20letter percent203.13.13.pdf (accessed January 2015).
15. Arkansas Health Care Independence Act of 2013, Arkansas Code Annotated, § 20-77-2401 et seq. (2015). The final version of the legislation is available at ftp://www.arkleg.state.ar.us/acts/2013/Public/ACT1498.pdf.
16. Consistent with its 2013 guidance, CMS has exempted from approved QHP premium assistance programs those populations that are exempt under Social Security Act § 1937(a)(2)(B) from the benchmark benefits package for the general expansion population, including, among others, individuals eligible for Medicare and Medicaid, the blind or disabled, some pregnant women and the medically frail. Centers for Medicare and Medicaid Services, "Medicaid and the Affordable Care Act: Premium Assistance." Washington, DC: CMS. March 2013. http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf (accessed April 2015).
17. Centers for Medicare and Medicaid Services, Special Terms and Conditions, STC 30, Arkansas Health Care Independence Program (Private Option), Section 1115 Demonstration, Number 11-W-00287/6 (amended January 1, 2015). http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf (accessed May 2015). *See also* Arkansas Insurance Department, 2015 Plan Year Requirements for Qualified Health Plan Certification in the Arkansas Federally-Facilitated Partnership Marketplace. Bulletin no. 9-2014, at 11-12. April 11, 2014. http://www.insurance.arkansas.gov/Legal/Bulletins/9-2014.pdf (accessed May 2015).
18. Department of Health and Human Services, Health Plan Choice and Premiums in the 2015 Health Insurance Marketplace—HHS-ASPE Research Brief (updated January 8, 2015). http://aspe.hhs.gov/health/reports/2015/premiumreport/healthpremium2015.pdf (accessed April 2015).
19. Arkansas Code Annotated, § 20-77-2405(j)(1)(2015).
20. Centers for Medicare and Medicaid Services, STC 44, Arkansas Health Care Independence Program (Private Option), Number 11-W-00287/6 (amended January 1, 2015). http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf (accessed May 2015).
21. *Ibid*. STCs 42, 44, 45, and Attachment B.
22. Brantley, M, "Reform to private option could cost more than it produces." Arkansas Blog at *Arkansas Times*, Jan 1, 2014. http://www.arktimes.com/ArkansasBlog/archives/2015/01/01/reform-to-private-option-could-cost-more-than-it-produces (accessed April, 2015).
23. Iritani, K, Government Accountability Office, "Medicaid Demonstrations: HHS's Approval Process for Arkansas's Medicaid Expansion Waiver Raises Cost Concerns." Letter to Orrin Hatch and Fred Upton, August 8, 2014. http://www.gao.gov/assets/670/665265.pdf (accessed April 2015).
24. Arkansas Department of Human Services, "Financial Impact of Arkansas' Private Option Plan for Insurance Premium Assistance." 2013. http://humanservices.arkansas.gov/director/Documents/Explaining%20cost%20estimates%20for%20premium%20assistance%203%2018%2013.pdf (accessed April, 2015).

25. Office of Arkansas Governor Asa Hutchinson, "Transcript of Governor Asa Hutchinson's Healthcare Speech." Press release, January 22, 2015. http://governor.arkansas.gov/press-releases/detail/transcript-of-governor-asa-hutchinsons-healthcare-speech (accessed May 2015).
26. Iowa Department of Human Services, "Overall Iowa Health and Wellness Plan Enrollment: As of March 30, 2015. http://dhs.iowa.gov/sites/default/files/IHAWPEnrollmentMaps_March2015.pdf (accessed April 2015).
27. Ward, J, "Terry Branstad, Iowa Governor, Won't Expand Medicaid In Light Of Supreme Court Ruling." *Huffington Post*, July 2, 2012. http://www.huffingtonpost.com/2012/07/02/terry-branstad-iowa-medicaid_n_1643428.html (accessed May 2015).
28. Boshart, R, "Iowa Senate Passes Medicaid Expansion Bill." *KCRG.com*, March 25, 2013 (story updated April 14, 2014). http://www.kcrg.com/news/local/Iowa-Senate-Passes-Medicaid-Expansion-Bill-199975091.html (accessed May 2015).
29. Boshart, R, "Iowa Senate Rejects Branstad's Health-Care Alternative." *Sioux City Journal*, May 1, 2013. http://siouxcityjournal.com/news/state-and-regional/iowa/iowa-senate-rejects-branstad-s-health-care-alternative/article_68aec303-5e53-5c3c-bedd-f0bdfa6065cf.html (accessed May 2015).
30. Murphy, E, "Jochum: Iowa Legislature Reaches Agreement on Health Care." *THonline*, May 22, 2013. http://www.thonline.com/news/breaking/article_f6f5e3e4-c311-11e2-9b15-001a4bcf6878.html (accessed May 2015); Henderson, O K, "Branstad Signs Iowa's Response to Medicaid Expansion," Radio Iowa, June 20, 2013. http://www.radioiowa.com/2013/06/20/branstad-signs-iowas-response-to-medicaid-expansion-audio/ (accessed May 2015). The Iowa Health and Wellness Plan was included in an omnibus appropriations bill. *See* 2013 Iowa Acts, Senate File 446, sections 166–173 and 185–187 http://coolice.legis.iowa.gov/Cool-ICE/default.asp?Category=billinfo&Service=Billbook&menu=false&ga=85&hbill=SF446 (accessed May 2015). For a summary of the bill's provisions relating to the Iowa Health and Wellness Plan, *see* Legislative Services Agency, Iowa General Assembly,"2013 Summary of Legislation, Iowa General Assembly, Regular Session," 31–34. https://www.legis.iowa.gov/DOCS/GA/85GA/Session.1/Summary/summary.pdf (accessed May 2015).
31. Iowa Department of Human Services, Fact Sheet on IowaCare. https://dhs.iowa.gov/sites/default/files/IowaCare_Narrative.pdf (accessed May 2015).
32. Daly, R, "Reform Update: Hospitals in Iowa Help Break Medicaid Expansion Impasse." *Modern Healthcare*, May 28, 2013. http://www.modernhealthcare.com/article/20130528/NEWS/305289966?template=print (accessed May 2015); Iowa Code § 249N.3(5)(b)(2013).
33. Centers for Medicare and Medicaid Services, STC 27(b), Iowa Marketplace Choice Plan, Number 11-W-00288/5 (amended December 30, 2013). http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Market-Place-Choice-Plan/ia-marketplace-choice-plan-stc-01012014-12312016-amended-122013.pdf (accessed May 2015).
34. Bartalone, P, "A Single Insurer Holds Obamacare Fate in Two States." Capital Public Radio and *Kaiser Health News*, September 22, 2014. http://kaiserhealthnews.org/news/single-insurer-holds-obamacare-fate-in-two-states-iowa-south-dakota/ (accessed May 2015).
35. Leys, T, "CoOportunity Pulling out of Iowa Medicaid Expansion Plan." *Des Moines Register*, October 17, 2014. http://www.desmoinesregister.com/story/news/health/2014/10/17/cooportunity-health-iowa-medicaid-expansion-plan-aca/17439203/ (accessed January 2015). In January 2015, the Iowa Insurance Commissioner announced that he was going to seek the liquidation of CoOportunity Health. Matthews, A W, "State Regulator to Shut Down Insurer CoOportunity Health." *WSJ.com*, January 23, 2015. http://www.wsj.com/articles/state-regulator-to-shut-down-insurer-cooportunity-health-1422052829?KEYWORDS=medicare&autologin=y&utm_campaign=KHN_percent3A+First+Edition&utm_source=hs_email&utm_medium=email&utm_content=15737623&_hsenc=p2ANqtz-_S28nDeg5DFR6riolJQPWspyVBkN23o4I_NuGMt4eGRZcfMJSRS_KvB2bfftBarzQSQ1HkjWT8VhszsqBl9rkAiRlsfA&_hsmi=15737623 (accessed May 2015).
36. The fact sheet for the Iowa Marketplace Choice Plan posted on the CMS website also states that the premiums must be "consistent with marketplace premiums" and are based on 2 percent of income. *See* Centers for Medicare and Medicaid Services, Iowa Marketplace Choice Plan Section 1115 Demonstration Fact Sheet, 1–2. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-fs.pdf (accessed May 2015).
37. Letter from Cindy Mann to Julie Lovelady, December 30, 2014. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-ca.pdf (accessed May 2015).
38. Office of Governor Rick Snyder, "Snyder Calls for Medicaid Expansion to Improve Health, Save Money; Greater Access to Care, Lower Business Costs among Benefits." Press release, February 6, 2013. http://www.michigan.gov/snyder/0,4668,7-277-57577_57657-294479--,00.html (accessed May 2015).
39. State of Michigan, 97th Legislature, Regular Session of 2013, Enrolled House Bill No. 4714, Act No. 107, Public Acts of 2013. http://www.legislature.mi.gov/documents/2013-2014/publicact/pdf/2013-PA-0107.pdf (accessed May 2015).
40. Oosting, J, "Michigan Gov. Rick Snyder Signs Historic Medicaid Plan into Law: This Is About 'Family' Not 'Politics.'" *MLive*, September 16, 2013. http://www.mlive.com/politics/index.ssf/2013/09/michigan_gov_rick_snyder_signs_6.html (accessed May 2015).
41. Centers for Medicare and Medicaid Services, "Managed Care in Michigan." (Summary of Michigan's Medicaid Managed Care system). *See* http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/michigan-mcp.pdf (accessed May 2015).
42. Office of Governor Rick Snyder, "Gov. Rick Snyder: Healthy Michigan Plan Has Enrolled More Than 600,000 People in First Year." Press release, April 14, 2015. http://www.michigan.gov/snyder/0,4668,7-277-57577_57657-351257--,00.html (accessed April 2015).
43. Michigan already had an approved Section 1115 demonstration waiver called the "Medicaid Nonpregnant Childless Adults Waiver" or "Adult Benefits Waiver." The Section 1115 expansion Waiver approved by CMS was an amendment to that demonstration project and provided that the Adult Benefits Waiver program would end once the expansion took effect on April 1, 2014. CMS initially approved the Healthy Michigan expansion waiver on December 30, 2013. *See* http://www.michigan.gov/documents/snyder/Healthy_Michigan_1115_Demonstration_Approval_12302013_443466_7.pdf (accessed December 2014). Following Michigan's submission of a request to make technical corrections to the waiver, on August 29, 2014, CMS issued amended STCs with technical corrections. *See* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-ca.pdf (accessed May 2015).
44. Allowable copayments are $50 for nonemergent hospital admissions and range from nominal payments of $1 to $3 for other services. *See* Gates A, Rudowitz, R, and Musumeci, M, *Medicaid Expansion in Michigan*. Menlo Park, CA: Kaiser Family Foundation. January 2014. http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-michigan/ (accessed May 2015).
45. It is unclear how often providers waive copayments at the point of service. Marton et al., for example, analyzed several policy changes in Medicaid programs in Idaho and Kentucky following passage of the 2005 Deficit Reduction Act. The authors found little impact for new copayments in Kentucky on utilization of services, which was "somewhat inconsistent" with the general literature on cost-sharing. They noted that they did not have administrative data to assess how much providers were actually collecting the copayments, noting that providers have authority to waive copayments in certain circumstances. Marton, J, Kenney, G, Pelletier, J, Talbert, J, and Klein, J, "The Effects of Medicaid Policy Changes on Adults' Service Use Patterns in Kentucky and Idaho." *Medicare & Medicaid Research Review* 2(4), 2012. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4006377/
46. Ayanian, J Z, Clark, S J, Tipirneni, R, "Launching the Healthy Michigan Plan—The First 100 Days." *New England Journal of Medicine* 371(17):1573–1575, October 23, 2014. http://www.nejm.org/doi/pdf/10.1056/NEJMp1409600 (accessed May 2015).
47. Centers for Medicare and Medicaid Services, Healthy Pennsylvania Section 1115 Demonstration. Cover Letter and STCs, Project Number 11-W-00295/3. August 28, 2014. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/pa-healthy-ca.pdf
48. For an analysis comparing what Pennsylvania proposed to what CMS approved, *see* Pennsylvania House Appropriations Committee, "Gov. Corbett's *Healthy PA* Submitted vs. Approved Plan." Fast Facts, September 10, 2014. http://www.pahouse.com/Files/Documents/Appropriations/series/2817/DPW_HealthyPA_Comparison_FF_091014.pdf (accessed April 2015).
49. Kaiser Family Foundation, "Health Insurance Coverage of Adults 19-64." Menlo Park, CA: Kaiser Family Foundation. 2013. http://kff.org/other/state-indicator/adults-19-64/ (accessed April 2015).
50. Office of Pennsylvania Governor Tom Corbett, "Governor Corbett Announces Historic Approval of New Healthy Pennsylvania Program." August 28, 2014. http://www.media.pa.gov/Pages/DPW_details.aspx?newsid=111 (accessed April 2015).

51. Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, "Medicaid Expansion in Indiana." Fact Sheet, February 2015. http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-indiana/ (accessed April 2015); *see* Centers for Medicare and Medicaid Services, Healthy Indiana Plan (HIP) 2.0. Cover Letter and STCs, Number 11-W-00296/5. Approved February 1, 2015–January 31, 2018. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf (accessed April 2015).
52. Millman, J, "Another Conservative Governor Finds a Way to Expand Medicaid." *The Washington Post*, May 15, 2014. http://www.washingtonpost.com/blogs/wonkblog/wp/2014/05/15/another-conservative-governor-finds-a-way-to-expand-medicaid/
53. Rosenbaum, S, Mehta, D and Hurt, C, "Healthy Indiana Plan Charges Monthly Fees for Medicaid." *The Commonwealth Fund Blog*, February 11, 2015. http://www.commonwealthfund.org/publications/blog/2015/feb/healthy-indiana-plan (accessed March 2015).
54. Centers for Medicare and Medicaid Services, STC VII-3. Healthy Indiana Plan (HIP) 2.0, Number 11-W-00296/5 Approved February 1, 2015–January 31, 2018. http://www.in.gov/fssa/hip/files/IN_HIP_2.0_CMS_Approved_STCs_1_27_15.pdf (accessed April, 2015).
55. Office of Indiana Governor Mike Pence, "Governor Pence Unveils HIP 2.0 Plan to Provide Consumer-Driven Health Care Coverage for Uninsured Hoosiers." Press release, May 15, 2014. http://www.in.gov/activecalendar/EventList.aspx?fromdate=1/1/2014&todate=1/31/2015&display=Month&type=public&eventidn=171492&view=EventDetails&information_id=201108 (accessed May 2015); Goodnough, A, "Indiana Will Allow Entry to Medicaid for a Price." *NYTimes.com*, January 27, 2015. http://www.nytimes.com/2015/01/28/us/politics/indiana-will-allow-entry-to-medicaid-for-a-price.html?smid=tw-share&_r=1 (accessed May 2015).
56. Centers for Medicare and Medicaid Services, Section 1115 Medicaid Demonstration Fact Sheet. Healthy Indiana Plan (HIP) 2.0. January 27, 2015. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-fs.pdf (accessed May 2015); Schubel, J. and Cross-Call, J, "Indiana's Medicaid Expansion Waiver Proposal Needs Significant Revision." Washington, DC: Center on Budget and Policy Priorities. October 17, 2014. http://www.cbpp.org/cms/?fa=view&id=4217#_ftn1 (accessed May 2015).
57. Centers for Medicare and Medicaid Services, Cover Letter and STCs, STC VII-1. Healthy Indiana Plan (HIP) 2.0, Number 11-W-00296/5. January 27, 2015. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf
58. Centers for Medicare and Medicaid Services, STCs, New Hampshire Health Protection Program Premium Assistance, Number 11-W-00298/1. March 4, 2015. http://www.dhhs.state.nh.us/pap-1115-waiver/documents/pa_termsandconditions.pdf (accessed April 2015); New Hampshire Department of Health and Human Services, Building Capacity for Transformation: Section 1115 Demonstration Waiver Application. May 30, 2014. http://www.dhhs.nh.gov/section-1115-waiver/documents/application-05302014.pdf (accessed April 2015).
59. Letter from Governor Margaret Wood Hassan to Hon. Sylvia Mathews Burwell, Secretary, U.S. Department of Health and Human Services, Re: New Hampshire Section 1115 Demonstration Waiver for Premium Assistance. November 20, 2014. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-pa.pdf (accessed May 2015).
60. New Hampshire 2014 Legislative Session, Chapter 3, SB 413-FN-A. http://www.gencourt.state.nh.us/legislation/2014/SB0413.html (accessed May 2015).
61. New Hampshire Department of Health and Human Services, "Percent of Individuals in Open New Hampshire Health Protection Program Cases—Total = 37,009." http://www.dhhs.nh.gov/ombp/nhhpp/documents/percentage-county.pdf (accessed April 2015).
62. New Hampshire Revised Statutes Annotated 126-A:5, XXV(d). http://www.gencourt.state.nh.us/rsa/html/x/126-A/126-A-5.htm (accessed May 2015).
63. Letter from Governor Margaret Wood Hassan to Hon. Sylvia Mathews Burwell, Secretary, U.S. Department of Health and Human Services, New Hampshire's Final Application for a Section 1115 Demonstration Waiver for Premium Assistance. November 20, 2014. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-pa.pdf (accessed April 2015).
64. Centers for Medicare and Medicaid Services, STC 25, New Hampshire Health Protection Program Premium Assistance, Number 11-W-00298/1. March 4, 2015. http://www.dhhs.state.nh.us/pap-1115-waiver/documents/pa_termsandconditions.pdf (accessed May 2015).
65. Centers for Medicare and Medicaid Services, STC 21, New Hampshire Health Protection Program Premium Assistance, Number 11-W-00298/1. March 4, 2015. http://www.dhhs.state.nh.us/pap-1115-waiver/documents/pa_termsandconditions.pdf (accessed May 2015).
66. Holahan, J, Blumberg, L J, and Wengle, E, "Marketplace Premium Changes Throughout the United States. 2014–2015." Washington, DC: Urban Institute. March 2015. http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000149-Marketplace-Premium-Changes-Throughout-the-United-States-2014-2015.pdf (accessed April 2015).
67. Bachrach, D, Boozang, P, and Guyer, J, "Manatt on Medicaid: New Hampshire Elects to Expand Medicaid Using Private Plans." *Manatt.com*, April 2, 2014. http://www.manatt.com/uploadedFiles/Content/4_News_and_Events/Newsletters/HealthLaw@Manatt/Manatt_on_Medicaid_NH_Expansion.pdf (accessed April 2015)
68. "Medicaid Expansion Signed into Law in New Hampshire." *Union Leader*, March 27, 2014. http://www.unionleader.com/article/20140327/NEWS0621/140329239 (accessed December 2014).
69. Office of Tennessee Governor Haslam, "Insure Tennessee" one-pager. (accessed April 2015); Graf, T. "Medicaid Expansion, State Health Facilities Top Priorities for 2015." *Star Tribune Communications*, January 6, 2015. http://trib.com/news/state-and-regional/govt-and-politics/medicaid-expansion-state-health-facilities-top-priorities-for/article_d54b81a1-a69a-5fc7-8854-1cfea3560c8c.html (accessed February 2015).
70. Kaiser Commission on Medicaid and the Uninsured, "Proposed Medicaid Expansion in Tennessee." January 2015. http://files.kff.org/attachment/fact-sheet-proposed-medicaid-expansion-in-tennessee (accessed February 2015); Office of Tennessee Governor Bill Haslam, "Insure Tennessee" one-pager. https://news.tn.gov/sites/default/files/INSURE%20TENNESSEE%20one%20pager.pdf (accessed April 2015); Utah State Legislature, "Healthy Utah" slide show. http://le.utah.gov/interim/2014/pdf/00005404.pdf (accessed February 2015).
71. Prior research suggests that the bigger coverage transition from churn may be movement from Medicaid to ESI. Buettgens M, Nichols A, and Dorn S, "Churning Under the ACA and State Policy Options for Mitigation." Washington, DC: Urban Institute. 2012. http://www.urban.org/UploadedPDF/412587-Churning-Under-the-ACA-and-State-Policy-Options-for-Mitigation.pdf (accessed April 2015).
72. As explained elsewhere, the notable exception is cost sharing for nonemergent use of the emergency room and the way in which CMS has begun to characterize premium-like payments for those under 100 percent of FPL as "contributions" to cover claims.
73. Machledt, D, and Perkins, J, "Medicaid Premiums and Cost Sharing." National Health Law Program. March 25, 2014. http://www.healthlaw.org/about/staff/david-machledt/all-publications/Medicaid-Premiums-Cost-Sharing#.VShjcxPF9Fg (accessed April 2015).
74. Ku, L, and Coughlin, T, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences." *Inquiry* 36(4):471–480, 1999–2000 Winter.
75. Kenney, G, Allison, R A, Costich, J F, Marton, J, and McFeeters, J, "Effects of Premium Increases on Enrollment in SCHIP: Findings from Three States" *Inquiry* 43(4):378–392, 2006–2007 Winter.
76. Oregon Health Research and Evaluation Collaborative, "Research Brief: Changes in Enrollment of OHP Standard Clients." January 2004. http://www.statecoverage.org/files/Research%20Brief%20-%20Changes%20in%20Enrollment%20of%20OHP%20Standard%20Clients.pdf (accessed May 2015); Carlson, M J, Wright, B J, and Gallia, C, "The Impact of Program Changes on Health Care for the Oregon Health Plan Standard Population: Early Results from a Prospective Cohort Study." Office of Oregon Health Policy and Research. March 2004.
77. The Medical Expenditure Panel Survey is a set of large-scale surveys of individuals and families, health care providers, and employers that addresses the use and cost of health care and health care coverage. For more information on the survey, *see* http://meps.ahrq.gov/mepsweb/
78. Adbus, S, Hudson, J, Hill, S C, and Thomas, M S, "Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children." *Health Affairs* 33(8):1353–1360, August 2014. http://content.healthaffairs.org/content/33/8/1353.full.pdf+html (accessed March 2015).

79. Rand Corporation, "Analysis of High Deductible Health Plans." http://www.rand.org/pubs/technical_reports/TR562z4/analysis-of-high-deductible-health-plans.html (accessed April 2015).

80. Ku, L, Dexchamps, E, and Hilman, J, "The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program." Washington, DC: Center on Budget and Policy Priorities. November 2, 2004. http://www.cbpp.org/research/the-effects-of-copayments-on-the-use-of-medical-services-and-prescription-drugs-in-utahs (accessed April 2015); Ku, L, and Wachino, V, "The Effect of Increased Cost-sharing in Medicaid: A Summary of Research Findings." Washington, DC: Center on Budget and Policy Priorities. July 7, 2005. http://www.cbpp.org/sites/default/files/atoms/files/5-31-05health2.pdf (accessed May 2015); Tamblyn, R, Laprise, R, Hanley, J A, Abrahamowicz, M, Scott, S, Mayo, N, Hurley, J, Grad R, Latimer, E, Perreault, R, McLeod, P, Huang, A, Larochelle, P, and Mallet L, "Adverse Events Associated with Prescription Drug Cost-sharing among Poor and Elderly Persons." *Journal of the American Medical Association* 285(4):421–429, 2001; LoSasso, A, and Lyons, J, "The Effects of Copayments on Substance Abuse Treatment Expenditures and Treatment Reoccurrence," *Psychiatric Services* 55(12):1605–11, December 2002.

81. Pampel, F, Krueger, P, and Denney, J, "Socioeconomic Disparities in Health Behaviors." *Annual Review of Sociology* 36:349–370, August 2010. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3169799/ (accessed April 2015).

82. Fakt, A, and Carroll, A E, "Do Wellness Programs Work? Usually Not." *NYTimes.com*. September 11, 2014. http://www.nytimes.com/2014/09/12/upshot/do-workplace-wellness-programs-work-usually-not.html?_r=0&abt=0002&abg=1 (accessed March 2015); Horwitz, J R, Kelly, B D, and DiNardo, J E, "Wellness Incentives in the Workplace: Cost Savings through Cost Shifting to Unhealthy Workers." *Health Affairs* 32(2): 468–476, March 2013. http://content.healthaffairs.org/content/32/3/468.full.pdf (accessed March 2015).

83. Centers for Medicare and Medicaid Services Innovation Center, "MIPCD States Awarded." http://innovation.cms.gov/initiatives/MIPCD/MIPCD-The-States-Awarded.html (accessed April 2015).

84. Hadley, J, and Holahan, J, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry* 40(4):323–42, Winter 2003; Coughlin, T, Long, S K, Clemans-Cope, L, and Resnick, "What Difference Does Medicaid Make? Assessing Cost Effectiveness, Access, and Financial Protection under Medicaid for Low-Income Adults." Menlo Park, CA: Kaiser Family Foundation. May 2013. https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf (accessed March 2015).

85. Congressional Budget Office, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision." Washington, DC: Congressional Budget Office. July 2012. http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf (accessed April 2015).

86. The Government Accountability Office released a report in April 2015 that called on HHS to develop more specific criteria and require more documentation to support Section 1115 waivers. United States Government Accountability Office, Report to Congressional Requesters, GAO-15-239, *Medicaid Demonstrations: Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives*. Washington, DC: GAO (April 2015). http://www.gao.gov/assets/670/669581.pdf (accessed May 2015).

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Most Adults with Medical Debt Had Health Insurance at the Time the Debt Was Incurred

Michael Karpman and Sharon K. Long

May 21, 2015

At a Glance

- Nearly one-quarter of adults report family medical bills that they are paying off over time, and medical debt is most common among middle-income adults.
- Among those adults with medical debt, 7 in 10 reported incurring all of the debt during periods when they and their family members had health insurance.
- Middle-income adults are more likely than other adults to incur medical debt from needed services that are not covered by health plans and from plan cost-sharing requirements.

Medical debt has long been a challenge for American families, leading to financial problems and unmet health care needs (Doty, Edwards, and Holmgren 2005; Herman, Rissi, and Walsh 2011; Himmelstein et al. 2009; Kalousova and Burgard 2013; Pollitz et al. 2014; Zeldin and Rukavina 2007). The Affordable Care Act (ACA) is expected to reduce medical debt by both expanding access to health insurance coverage and increasing the financial protection that insurance provides against large medical bills. ACA provisions include requirements that plans cover a standard set of essential health benefits, prohibitions against denying coverage to adults or charging them more for insurance based on preexisting conditions, income-based cost-sharing reductions for adults purchasing coverage through health insurance Marketplaces, elimination of annual limits on coverage, and the establishment of limits on annual out-of-pocket costs for covered, in-network services. These provisions, which went into effect on January 1, 2014, should reduce the accumulation of medical debt for those with health insurance coverage going forward, but they do not address medical debt acquired during periods of uninsurance or debt that was acquired in earlier periods.

In this brief, we use the Urban Institute's Health Reform Monitoring Survey (HRMS) to examine medical debt—medical bills that are being paid off over time—among nonelderly adults (ages 18 to 64) and their families as of December 2014. We explore the reasons why families incur medical debt and how experiences with medical debt differ by family income. Our analysis sheds light on the potential gains from insurance coverage and policies designed to protect insured individuals from financial risk by enhancing the adequacy of coverage.

What We Did

Drawing on HRMS data collected in December 2014, we focus on nonelderly adults who report that they or someone in their family have medical bills that are being paid off over time.[1] This includes bills being paid off with a credit card, through personal loans, or through bill-paying arrangements with providers, as well as debt from the current year or earlier years.

We refer to those who report family medical bills that are being paid off over time as adults with medical debt, and we analyze medical debt for all adults and by family income groups. We focus on adults in three income groups based on the eligibility thresholds for the ACA's Medicaid expansion and Marketplace subsidies: low income (at or below 138 percent of the federal poverty level [FPL]), middle income (between 139 and 399 percent of FPL), and high income (at or above

400 percent of FPL). For some parts of the analysis, we also examine adults with public and private coverage separately.

Adults with medical debt are asked if that debt was from periods with or without health insurance. For those who report medical debt from periods with insurance coverage, they are asked whether the medical bills were for services that were not covered by the health plan; co-payments or coinsurance for services under the health plan; or bills that were paid before the health plan's deductible was applied. Respondents could choose multiple response options. For this analysis, we combine responses for the last two categories to analyze the share with medical debt resulting from cost sharing under a health plan.

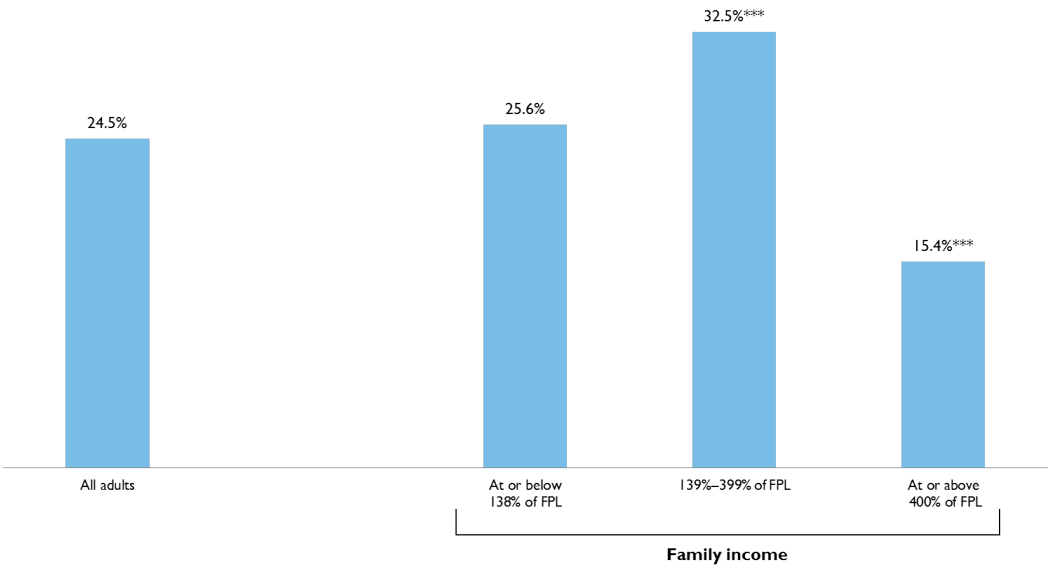
Though the question asking respondents whether they have medical debt was adapted from the 2014 National Health Interview Survey, questions on whether the medical bills underlying the debt were from periods with or without health insurance and the reasons for receiving those medical bills were developed for the HRMS.

What We Found

Nearly 1 in 4 adults reports medical debt, and medical debt is most common among middle-income adults.

An estimated 24.5 percent of adults report family medical bills that are being paid off over time, with middle-income adults more likely to report medical debt than adults in other income groups (figure 1). Nearly one-third (32.5 percent) of middle-income adults have medical debt, compared with 25.6 percent of low-income adults and 15.4 percent of high-income adults. These results are generally consistent with patterns seen in other survey data on medical debt (Cohen and Kirzinger 2014; Collins et al. 2015) and show that many adults do not pay all of their medical bills at the time they are received.

Figure 1. Share of Adults Ages 18 to 64 with Medical Debt, Overall and by Family Income, Quarter 4 2014



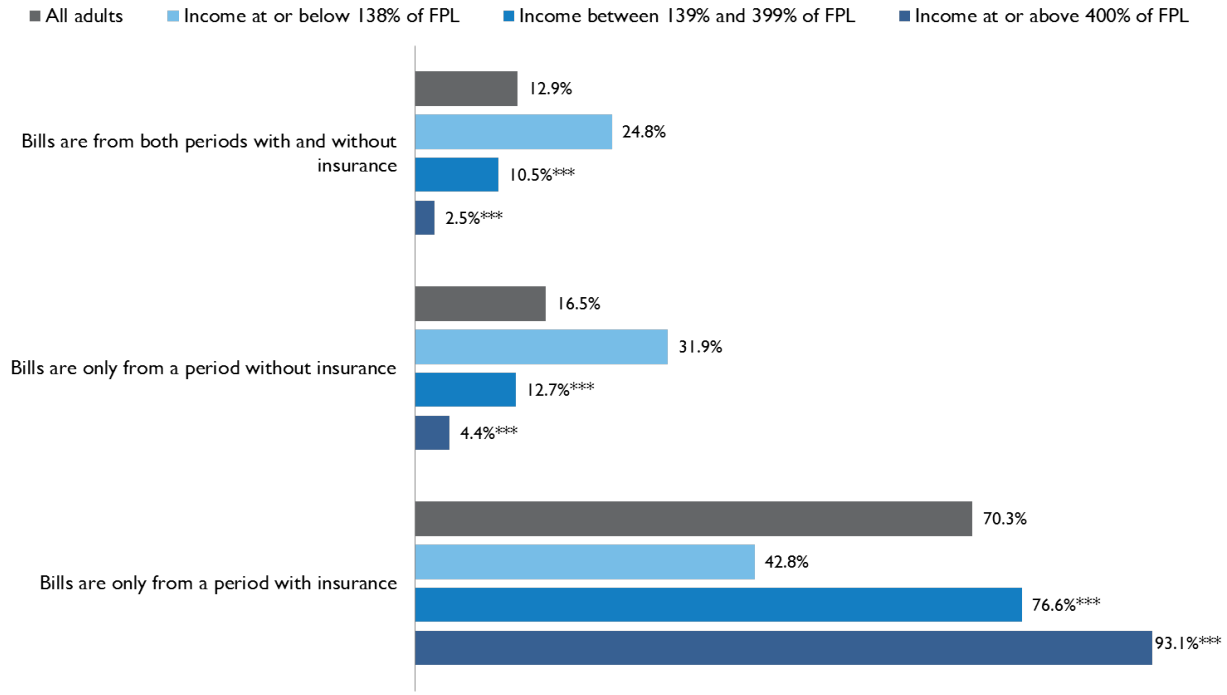
Source: Health Reform Monitoring Survey, quarter 4 2014.
Note: FPL is federal poverty level.
*/**/*** Estimate differs significantly from those with family incomes at or below 138 percent of FPL at the 0.10/0.05/0.01 level, using two-tailed tests.

Among those with medical debt, 7 in 10 adults incurred all of this debt during periods with health insurance coverage.

Most adults with family medical bills that are being paid off over time report that some or all of the bills underlying that debt were from periods when they or their family member had insurance. This includes 70.3 percent who report that all of their debt was accrued during periods with insurance and 12.9 percent who report that their debt was from periods both with and without insurance (figure 2).[2] Only 16.5 percent incurred all of their medical debt from periods without insurance. These estimates are similar to the results of an earlier study showing that 70 percent of nonelderly adults who reported medical debt stated that they or their family member had insurance at the time of receiving care that led to the medical debt (Doty, Edwards, and Holmgren 2005).

However, insurance status at the time the debt was incurred varies significantly by income, with low-income adults more likely to incur debt from periods without insurance and adults with high incomes more likely to incur debt from periods with insurance. For example, nearly one-third (31.9 percent) of low-income adults with medical debt reported that the debt was only from periods without insurance, compared with 12.7 percent of middle-income adults and 4.4 percent of high-income adults (figure 2).

Figure 2. Insurance Coverage Status at the Time Bills Were Incurred, Overall and by Family Income, among Adults Ages 18 to 64 with Medical Debt, Quarter 4 2014



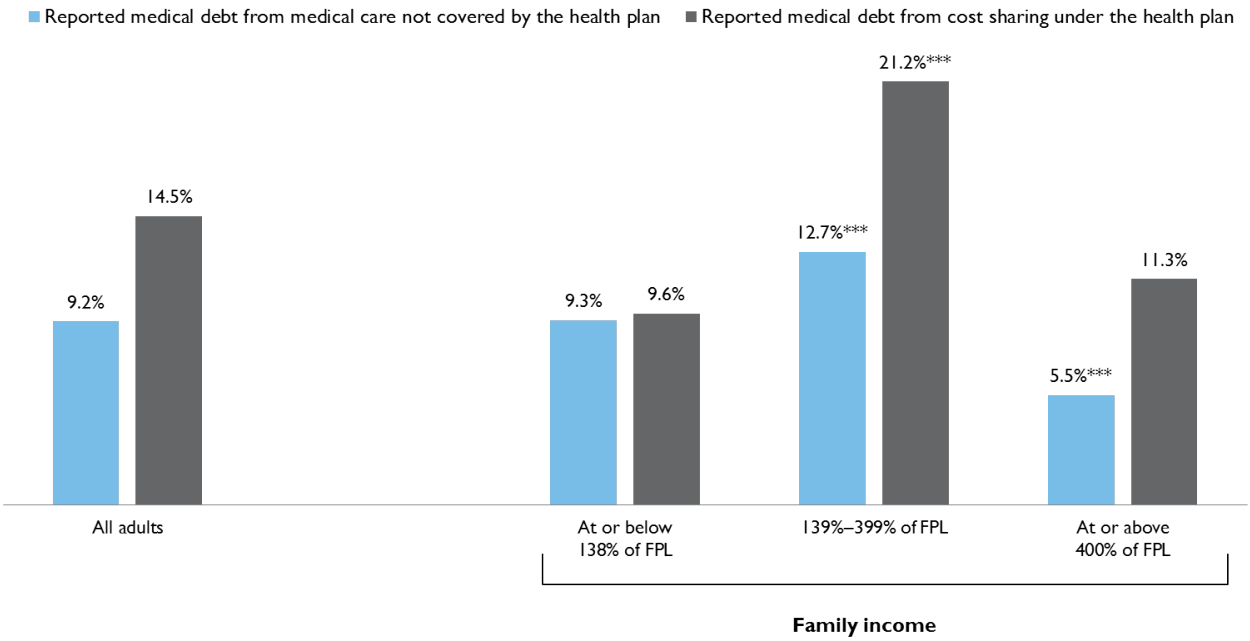
Source: Health Reform Monitoring Survey, quarter 4 2014.
Note: FPL is federal poverty level. Among adults with medical debt, 0.2 percent did not report whether the debt was from a period of insurance or uninsurance.
*/**/*** Estimate differs significantly from those with family incomes at or below 138 percent of FPL at the 0.10/0.05/0.01 level, using two-tailed tests.

Middle-income adults are more likely than other adults to incur medical debt from services not covered by a health plan and from cost sharing.

Nearly 1 in 10 adults (9.2 percent) reports medical debt incurred during periods with insurance from services that were not covered by a health plan, and just over 1 in 7 adults (14.5 percent) report

medical debt from cost sharing under a health plan (figure 3). Approximately the same share of adults reported medical debt from co-payments and coinsurance as the share reporting medical debt from a deductible (11.0 percent and 11.1 percent, respectively; data not shown).

Figure 3. Share of Adults Ages 18 to 64 with Medical Debt from Care Not Covered by Health Plan and from Cost Sharing under Health Plan, Overall and by Family Income, Quarter 4 2014



Source: Health Reform Monitoring Survey, quarter 4 2014.
Notes: FPL is federal poverty level. Medical debt from cost sharing includes debt from copayments or coinsurance for medical care under the health plan and debt from paying the deductible under the health plan. Debt could be due to both cost sharing and medical care not covered by the health plan.
*/**/*** Estimate differs significantly from those with family incomes at or below 138 percent of FPL at the 0.10/0.05/0.01 level, using two-tailed tests.

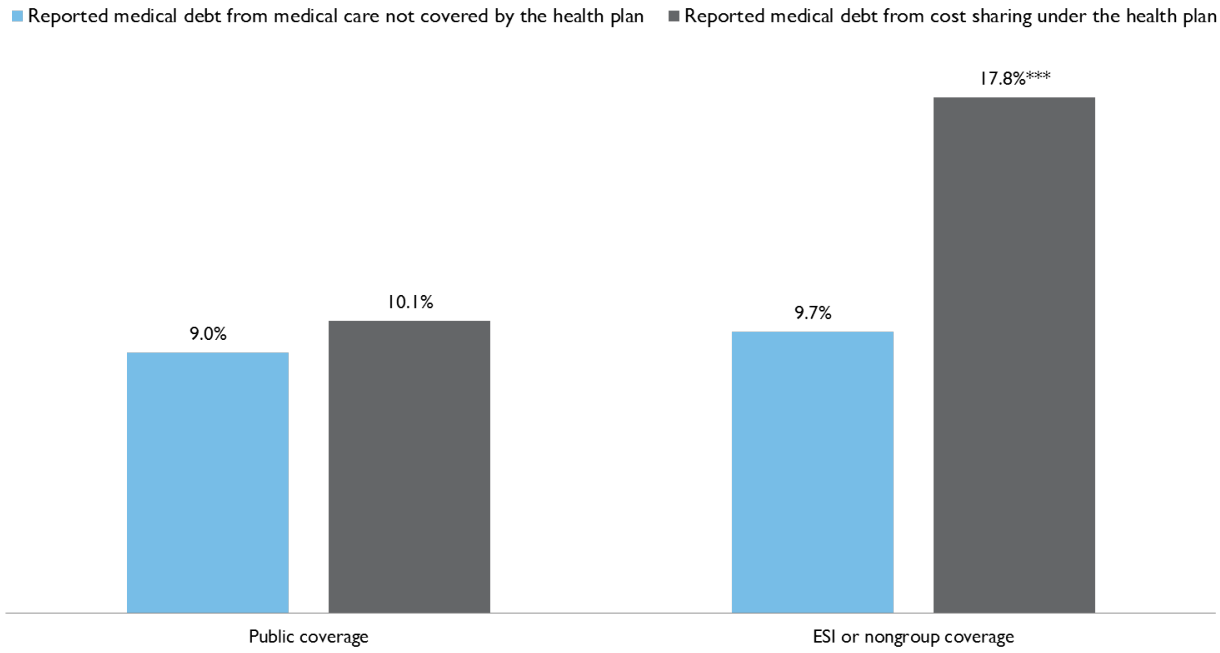
Middle-income adults are more likely to report medical debt from these sources than other adults. As shown in figure 3, 12.7 percent of all middle-income adults report medical debt from uncovered services, compared with 9.3 percent of low-income adults and 5.5 percent of high-income adults. The differences among income groups were even larger with respect to medical debt from cost sharing. Over one in five middle-income adults (21.2 percent) reported medical debt from cost sharing, compared with 9.6 percent of low-income adults and 11.3 percent of high-income adults. Middle-income adults were also more likely than other adults to report debt from different types of cost sharing, with 15.7 percent reporting debt from co-payments or coinsurance and 16.3 percent with debt from a deductible (data not shown).

As noted above, family medical debt among low-income adults is less likely to be from periods with insurance than family medical debt among adults in other income categories. Among those with medical debt from periods with insurance, low-income adults were the most likely to report debt from care that was not covered by a health plan (53.5 percent versus 44.9 percent for middle-income adults and 37.5 percent for high-income adults; data not shown) and the least likely to report debt from cost sharing (55.5 percent versus 75.1 percent for middle-income adults and 77.2 percent for high-income adults; data not shown). These differences in the sources of medical debt are likely caused, at least in part, by the varying structures of public and private coverage.

Compared with private coverage, cost sharing is more limited under Medicaid and other public sources of coverage, particularly for families with incomes at or below 100 percent of FPL.[3] However, states have some flexibility to limit the range and scope of benefits provided to adults under Medicaid, including limiting optional benefits such as dental and vision care. Middle- and high-income families often have access to private plans offering a more generous range of benefits.

Although we do not have information on the type of insurance coverage held by adults or their family members at the time their medical debt was incurred, we examined the source of family medical debt for adults with different insurance coverage types at the time of the survey. We found that adults with public coverage at the time of the survey were less likely than those with employer-sponsored or nongroup coverage to report medical debt from cost sharing under a health plan (10.1 percent versus 17.8 percent; figure 4) but about equally likely to report medical debt from services that were not covered by a health plan (9.0 percent versus 9.7 percent).

Figure 4. Share of Adults Ages 18 to 64 with Medical Debt from Care Not Covered by Health Plan and from Cost Sharing under Health Plan, by Coverage Type at Time of Survey, Quarter 4 2014



Source: Health Reform Monitoring Survey, quarter 4 2014.
Notes: ESI is employer-sponsored insurance. Public coverage includes Medicare or Medicaid. Medical debt from cost sharing includes debt from copayments or coinsurance for medical care under the health plan and debt from paying the deductible under the health plan. Debt could be due to both cost sharing and medical care not covered by the health plan.
*/**/*** Estimate differs significantly from those with public coverage at the 0.10/0.05/0.01 level, using two-tailed tests.

What It Means

Medical debt continued to be an issue for American families at the end of 2014, with an estimated one in four nonelderly adults reporting medical debt. Further, medical debt is more of a challenge for middle-income adults, who lack the public coverage options available to low-income adults and lack the financial resources of high-income adults. Of some concern, most adults incurred their family medical debt during periods with health insurance coverage. Therefore, expanding health

insurance coverage under the ACA may reduce but not eliminate the burden of medical debt for families.

Our finding that much of the reported medical debt was incurred during periods with insurance coverage suggests that changes in covered services and cost-sharing requirements would cushion the impacts of higher medical bills for low- and middle-income families. Medical debt resulting from uncovered services was reported by 9.3 percent of low-income adults and 12.7 percent of middle-income adults. Though this study does not identify the types of services that are missing from the health plans, previous work has shown that dental care, which is seldom covered by Medicaid or private health insurance plans, is often difficult to afford for low-income adults (Long 2014). Improving access to dental care under Medicaid and the Marketplace, which is not addressed under the ACA, would likely have a significant impact on medical debt for low- and middle-income adults.

Medical debt caused by cost-sharing is also common, affecting more than 1 in 5 middle-income adults and about 1 in 10 low-income and high-income adults. Given that one-quarter of nonpoor, nonelderly households with private insurance do not have enough liquid assets to cover a midrange deductible of $1,200 for single coverage (Claxton, Rae, and Panchal 2015), policies to further reduce cost sharing could potentially lower the number of families with medical debt. For instance, Basic Health Programs established in Minnesota and New York offer lower cost sharing than health plans available through the Marketplace.[4] In addition, greater transparency around health plan types and provider networks for plans sold through the Marketplace could improve plan choice and raise consumers' awareness of their exposure to out-of-network and tiered network cost sharing (Blumberg et al. 2014).

References

Blumberg, Linda J., Rebecca Peters, Erik Wengle, and Rachel Arnesen. 2014. *Physician Network Transparency: How Easy Is It for Consumers to Know What They Are Buying?* Washington, DC: Urban Institute.

Claxton, Gary, Matthew Rae, and Nirmita Panchal. 2015. *Consumer Assets and Patient Cost Sharing.* Menlo Park, CA: Kaiser Family Foundation.

Claxton, Gary, Matthew Rae, Nirmita Panchal, Heidi Whitmore, Anthony Damico, and Kevin Kenward. 2014. "Health Benefits in 2014: Stability in Premiums and Coverage for Employer-Sponsored Plans." *Health Affairs* 33 (10): 1851–60.

Cohen, Robin A., and Whitney K. Kirzinger. 2014. *Financial Burden of Medical Care: A Family Perspective.* Hyattsville, MD: National Center for Health Statistics.

Collins, Sara R., Petra W. Rasmussen, Michelle M. Doty, and Sophie Beutel. 2015. *The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect.* New York: The Commonwealth Fund.

Doty, Michelle M., Jennifer N. Edwards, and Alyssa L. Holmgren. 2005. *Seeing Red: Americans Driven Into Debt by Medical Bills.* New York: The Commonwealth Fund.

Herman, Patricia M., Jill J. Rissi, and Michele E. Walsh. 2011. "Health Insurance Status, Medical Debt, and Their Impact on Access to Care in Arizona." *American Journal of Public Health* 101 (8): 1437–43.

Himmelstein, David U., Deborah Thorne, Elizabeth Warren, and Steffie Woolhandler. 2009. "Medical Bankruptcy in the United States, 2007: Results of a National Study." *The American Journal of Medicine* 122: 741–46.

Kalousova, Lucie, and Sarah A. Burgard. 2013. "Debt and Forgone Medical Care." *Journal of Health & Social Behavior* 54 (2): 203–19.

Long, Sharon K. 2014. *Beyond Coverage: The High Burden of Health Care Costs on Insured Adults in Massachusetts.* Boston, MA: Blue Cross Blue Shield Foundation of Massachusetts.

Pollitz, Karen, Cynthia Cox, Kevin Lucia, and Katie Keith. 2014. *Medical Debt among People with Health Insurance.* Menlo Park, CA: Kaiser Family Foundation.

Zeldin, Cindy, and Mark Rukavina. 2007. *Borrowing to Stay Healthy: How Credit Card Debt Is Related to Medical Expenses.* New York: Demos.

About the Series

This brief is part of a series drawing on the HRMS, a quarterly survey of the nonelderly population that is exploring the value of cutting-edge Internet-based survey methods to monitor the ACA before data from federal government surveys are available. The briefs provide information on health insurance coverage, access to and use of health care, health care affordability, and self-reported health status, as well as timely data on important implementation issues under the ACA. Funding for the core HRMS is provided by the Robert Wood Johnson Foundation and the Urban Institute.

For more information on the HRMS and for other briefs in this series, visit www.urban.org/hrms.

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Notes

[1] The HRMS question on medical debt is adapted from the National Health Interview Survey. However, our estimates may understate the share of adults with medical debt if respondents do not include bills that they are unable to pay when reporting whether they have "bills being paid off over time." In addition to reporting the share of adults with bills being paid over time, some studies using National Health Interview Survey data have separately reported the estimated share of adults who currently have medical bills that they are unable to pay at all (Cohen and Kirzinger 2014).

[2] Previous studies have also shown that most adults with medical debt had insurance at the time their debt was incurred (Doty, Edwards, and Holmgren 2005).

[3] For Medicaid deductible and co-payment amounts, see Centers for Medicare and Medicaid Services, "Cost Sharing Out of Pocket Costs," accessed March 27, 2015. For an analysis of cost-sharing amounts among plans sold in the federal Marketplace, see Gary Claxton and Nirmita Panchal, "Cost Sharing Subsidies in Federal Marketplace Plans," last updated February 11, 2015. For an analysis of cost-sharing amounts under employer-sponsored plans, see Claxton et al. (2014).

[4] New York State of Health, "Press Release: NY State of Health Announces the Expansion of Private Health Insurance Coverage through Innovative New Program," April 17, 2015; Cheryl Fish-Parcham, "Why Minnesota and New York Are Pursuing Basic Health Programs," Families USA, November 18, 2014.

By Julie M. Donohue, Eros Papademetriou, Rochelle R. Henderson, Sharon Glave Frazee, Christine Eibner, Andrew W. Mulcahy, Ateev Mehrotra, Shivum Bharill, Can Cui, Bradley D. Stein, and Walid F. Gellad

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Early Marketplace Enrollees Were Older And Used More Medication Than Later Enrollees; Marketplaces Pooled Risk

ABSTRACT Little is known about the health status of the 7.3 million Americans who enrolled in insurance plans through the Marketplaces established by the Affordable Care Act in 2014. Medication use may provide an early indicator of the health needs and access to care among Marketplace enrollees. We used data from January–September 2014 on more than one million Marketplace enrollees from Express Scripts, the largest pharmacy benefit management company in the United States. We compared the characteristics and medication use between early and late Marketplace enrollees and between all Marketplace enrollees and enrollees with employer-sponsored insurance. Among Marketplace enrollees, we found that those who enrolled earlier (October 2013–February 2014) were older and used more medication than later enrollees. Marketplace enrollees, as a whole, had lower average drug spending and were less likely to use most medication classes than the employer-sponsored comparison group. However, Marketplace enrollees were more likely to use medicines for hepatitis C and particularly for HIV.

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The Affordable Care Act (ACA) authorized the creation of federal and state-based Marketplaces for individuals to purchase health insurance. The Congressional Budget Office (CBO) estimates that twenty-two million will enroll in health insurance plans through the Marketplaces by 2016.[1] Between October 1, 2013, and April 19, 2014—the end of the special enrollment period—eight million Americans enrolled in a Marketplace plan; by September 2014, the Obama administration reported that more than seven million had paid premiums and were still enrolled.[2,3]

Little is known about the health status of Marketplace enrollees,[4,5] information necessary for determining whether the insurance exchanges have effectively pooled risk by attracting both young, healthy enrollees as well as older, less healthy enrollees. Adverse selection in the Marketplace—disproportionately higher enrollment by those who are less healthy—would result in higher future insurance premiums and, therefore, threaten to reduce overall future enrollment. In estimating the ACA's costs, the CBO and Congress's Joint Committee on Taxation anticipated that people in poorer health would disproportionately enroll in the first year, with those in better health joining in later years.[1] Health insurers have expressed concern that 2014 Marketplace enrollees are in even poorer health than expected.[6]

One effective way to capture the health status of Marketplace enrollees is by examining their prescription drug usage. Measures of such usage have been widely used to predict hospitalization, costs, and mortality.[7–9] Unlike other administrative claims, for which providers may bill insurance companies weeks or months after the service was provided, prescription drug claims are

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commonly processed electronically the day the prescription is filled and thus provide a more immediate measure of health status.

We used data from Express Scripts Inc., the largest pharmacy benefit manager in the United States, to compare the characteristics and medication use patterns of more than one million Marketplace enrollees to those of a matched sample in employer-sponsored insurance plans. We also examined whether the characteristics of Marketplace enrollees varied by when they enrolled and whether, consistent with the CBO's expectations, early enrollees were disproportionally sicker than later enrollees.

Study Data And Methods

DATA SOURCES We analyzed data on enrollment, prescription drug use, and expenditures for people who have their pharmacy benefits managed by Express Scripts, which has approximately eighty-five million enrollees. Express Scripts establishes networks of pharmacies, processes claims, offers mail-order services, and creates formularies for more than 3,000 clients including health plans, self-insured national employers, unions, and government agencies. Enrollment files contained enrollment date, plan type (for example, employer sponsored or Marketplace), and the age, sex, and five-digit ZIP code of the member. Express Scripts enrollment dates correspond to the date on which an insurance company notified Express Scripts that a person had coverage in a Marketplace plan and should receive pharmacy benefits. We obtained ZIP code–level data from the Census Bureau's American Community Survey on race, educational attainment, family income, and census region. Pharmacy claims data included dates of each prescription fill, quantity dispensed, days supplied, drug name, dose, medication class, the amount the plan paid the pharmacy, and patient copayment or coinsurance.

STUDY SAMPLE We identified 1.03 million people from birth to age sixty-four who were enrolled in a health insurance Marketplace plan contracting with Express Scripts by May 31, 2014, and stayed enrolled in that plan through September 30, 2014. Based on national estimates, these 1.03 million people represented more than 14 percent of all Marketplace enrollees.[2,3] Marketplace members who dropped coverage after enrolling were excluded ($N = 132,132$), as were members enrolled in both a Marketplace plan and a non-Marketplace plan at some point in 2014 ($N = 10,635$).

Express Scripts' research database contains data on employers and insurers that consent to having their data used for research purposes. From that database, which includes information about 12.4 million people, we constructed a comparison group. Compared to Marketplace enrollees, the 12.4 million comparison-group enrollees were more likely to be younger than age eighteen (23 percent versus 5 percent), were less likely to be female (51 percent versus 55 percent), and had a different geographic distribution. Therefore, using one-to-one matching on age, sex, and census region, we generated a comparison population of 1.03 million enrollees with employer-sponsored coverage. Descriptive characteristics of the 12.4 million available for the comparison group are shown in online Appendix Exhibit 1.[10]

DEPENDENT VARIABLES We constructed three sets of measures of drug usage and spending. The first was per member per month number of prescriptions filled (number of thirty-day prescriptions divided by the number of months in which members were enrolled). Prescriptions were standardized to a thirty-day-equivalent supply (that is, a ninety-day prescription counted as three). The second set of measures—per member per month total spending, plan spending, and out-of-pocket spending—was calculated by dividing the total dollar amount of interest by total number member-months. Total expenditures were the sum of plan cost (exclusive of any discounts or rebates from pharmaceutical manufacturers) and members' out-of-pocket expenses. Finally, we calculated rates of use for twenty therapeutic categories that account for a large share of use and spending.[11] Half were for specialty medications, defined by Express Scripts as injectable and noninjectable drugs used to treat chronic, complex conditions that meet at least one of the following criteria: frequent dosing adjustments or intensive clinical monitoring; intensive patient training and compliance assistance; limited distribution; and specialized handling or administration.

INDEPENDENT VARIABLES The key independent variable was whether the enrollee was in a Marketplace or comparison group plan. We profiled enrollees on the basis of age, sex, and ZIP code–level information on educational attainment (percentage with a high school diploma or more), median family income, and race/ethnicity (percentage non-Hispanic white versus other). We also included a variable indicating prior coverage in an insurance company contracting with Express Scripts in 2013. We did not have information on coverage through insurance plans that did not contract with Express Scripts.

ANALYSIS We completed several descriptive analyses to compare medication use among Marketplace enrollees and the comparison group—

One effective way to capture the health status of Marketplace enrollees is by examining their prescription drug usage.

and within the Marketplace group—between early and late enrollees. First, we compared enrollees on the basis of socioeconomic and demographic characteristics and region, testing for differences between the Marketplace group and the comparison group using *t*-tests or chi-square tests, as appropriate. Second, we plotted trends in monthly per member per month prescriptions to examine the time it took for Marketplace enrollees to obtain and fill prescriptions. We plotted separate trends by month of initial enrollment. Third, we examined differences in per member per month use and spending between all Marketplace enrollees and the comparison group, and between early Marketplace enrollees who enrolled between October 2013 and February 2014 and late Marketplace enrollees who enrolled between March and May 2014, to determine whether there was variability in health needs and access to care based on the timing of enrollment.

We used linear, logistic, and negative binomial regression models to estimate differences between all Marketplace enrollees and the employer-sponsored group. We focused on per member per month plan, member, and total expenditures, per member per month prescription fills overall and for traditional and specialty medications, and rates of utilization in each of the twenty therapeutic categories. All analyses were performed using SAS/STAT 9.3 software.

To maintain the privacy of protected health information, no individual-level data were provided to non–Express Scripts coauthors. As such, this study was deemed exempt by the RAND Corporation's Institutional Review Board.

LIMITATIONS While our study is unique in providing timely information on more than one million Marketplace enrollees, it has several limitations. First, we recognize the significant differences between our comparison group and Marketplace enrollees on socioeconomic status and prior coverage. The comparison group provided a reasonable benchmark rather than a comparison group with identical characteristics. Second, while Express Scripts clients are located in every state, Express Scripts Marketplace enrollees are not necessarily representative of all Marketplace enrollees. However, the age and sex distribution for Express Scripts Marketplace enrollees is very similar to that in the national enrollment.[2] Third, there may have been a lag between when a person enrolled in the Marketplace and when Express Scripts was informed of the enrollment that we were unable to capture in our analysis. Fourth, we lacked information on patient diagnoses, indications for medication use, and nondrug health care use and thus could not describe the health of enrollees beyond their prescription drug use. Finally, we were unable to include all Express Scripts enrollees in the analysis since some clients prohibit the use of their data for research purposes. It is unknown whether these exclusions biased our results in one way or another, if at all. Regardless, our study included more than 14 percent of all Marketplace enrollees in the country and is one of the earliest large-scale examinations of health care use in the exchange plans.

Study Results

DEMOGRAPHIC AND SOCIOECONOMIC CHARACTERISTICS Of the 1,032,057 Marketplace enrollees in our study sample, 335,916 (32.5 percent) enrolled in a Marketplace plan between October 1, 2013, and February 28, 2014 (early enrollees), and 696,141 (67.5 percent) enrolled between March 1, 2014, and May 31, 2014 (later enrollees). There was a decline in the mean age of enrollees by month of enrollment from 46.5 years to 42.2 years in the first five months of 2014, as shown in Appendix Exhibit 2.[10]

After matching, there were no significant differences in age, sex, or region between the total sample of Marketplace enrollees and the comparison group (Exhibit 1). There were, however, differences in socioeconomic characteristics. Relative to the comparison group with employer-sponsored coverage, Marketplace enrollees lived in ZIP codes where median family income was 9 percent lower ($53,480 versus $58,969). There were also racial/ethnic differences with Marketplace enrollees living in ZIP codes with a lower proportion of white, non-Hispanic residents (68.4 percent versus 73.0 percent,). Only 32.8 percent of Marketplace enrollees had been previously covered in an Express Scripts client plan, compared to 91.2 percent of comparison-group enrollees. Comparing early versus late

EXHIBIT 1

Descriptive Characteristics Of The Study Sample Of Marketplace Enrollees And Comparison Group Of Employer-Sponsored Insurance Enrollees

	Health insurance Marketplace			
	Early enrollees[a] (*n* = 335,916)	Late enrollees[b] (*n* = 696,141)	Total (*N* = 1,032,057)	Post-match comparison group[c] (*N* = 1,032,057)
Age, years (mean)	46.0	42.7	43.7	43.7
AGE (YEARS)				
Younger than 18	4.8%	5.3%	5.2%	5.2%
18–26	7.4	9.8	9.0	9.0
27–35	12.8	16.2	15.1	15.1
36–45	13.6	17.1	15.9	15.9
46–55	22.0	23.9	23.3	23.3
56–64	39.4	27.6	31.5	31.5
Sex				
Female	55.8%	54.7%	55.1%	55.1%
SOCIOECONOMIC STATUS[d]				
High school grad or more	88.0%	86.0%	86.6%	87.6%
Median family income	$56,199	$52,169	$53,480	$58,969
White, non-Hispanic	75.5%	65.1%	68.4%	73.0%
CENSUS REGION				
East North Central	6.6%	5.9%	6.2%	6.2%
East South Central	8.5	9.1	8.9	8.6
Mid-Atlantic	20.8	14.2	16.3	16.3
Mountain	5.4	3.6	4.2	4.2
New England	10.7	6.3	7.7	7.7
Pacific	13.9	5.9	8.5	8.5
South Atlantic	18.1	35.8	30.0	30.0
West North Central	12.0	14.1	13.4	13.4
West South Central	3.9	5.2	4.8	4.8
PREVIOUSLY COVERED IN EXPRESS SCRIPTS[e]				
Yes	43.5%	27.6%	32.8%	91.2%

SOURCE Express Scripts, Inc. [a]Enrolled in an Express Scripts client plan through health insurance Marketplace by end of February 2014. [b]Enrolled in an Express Scripts client plan through health insurance Marketplace between March 1 and May 31, 2014. [c]Comparison group drawn from more than twelve million non-Marketplace Express Scripts enrollees matched on age, sex, and region on a one-to-one basis. There are no significant differences between groups on these variables. For all other variables, differences are significant at $p < 0.001$. [d]From Census Bureau, 2008–12 American Community Survey, matched by ZIP code. [e]Enrolled in an Express Scripts client plan at some point in calendar year 2013.

Marketplace enrollees, those enrolling early tended to be older and live in areas with higher educational attainment and median family income. In addition, early Marketplace enrollees were more likely than later enrollees to have prior Express Scripts coverage (43.5 percent versus 27.6 percent) (Exhibit 1).

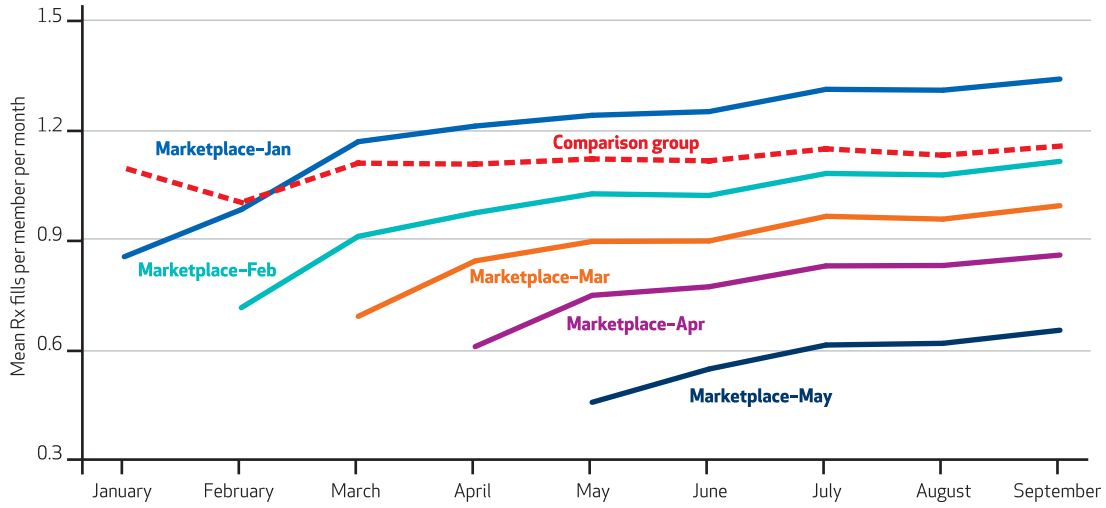
MEDICATION USE BY MONTH OF ENROLLMENT Marketplace enrollees had very different starting levels of medication use depending on when they enrolled (Exhibit 2). In their first month of enrollment, January enrollees filled 0.86 prescriptions per member per month. Successive cohorts (by month of enrollment) had a lower mean number of fills in their first month of enrollment (0.72 for February enrollees, 0.69 for March, 0.61 for April, and only 0.46 for May). Each group experienced a substantial increase in medication use over the study period, although the groups enrolling in later months had consistently lower medication use than the early enrollees even by September 2014 (Exhibit 2).

DRUG USE AND SPENDING Marketplace enrollees were less likely than the comparison group to have any drug usage in the nine-month study period (55.0 percent versus 63.5 percent). There was a substantial difference between early and late Marketplace enrollees in medication use (66.5 percent versus 50.0 percent) (Exhibit 3). (A fuller version of Exhibit 3 is available in Appendix Exhibit 3.)[10]

Marketplace enrollees also filled fewer prescriptions than the comparison group in the nine-month study period (10.9 versus 15.2, for an adjusted difference of 4.45). Again, there were large differences in the number of prescriptions filled between early enrollees (14.8) and late enrollees (8.4). Marketplace enrollees filled

EXHIBIT 2

Monthly Prescriptions Filled, By Month Of Enrollment In The Marketplace And The Employer-Sponsored Comparison Group, 2014



SOURCE Express Scripts Inc. **NOTES** Mean per member per month prescriptions filled in all medication classes by month of enrollment. The comparison group includes the 90.8 percent of members in that group who enrolled in Express Scripts by January 31, 2014.

EXHIBIT 3

Prescription Drug Use And Spending Among Marketplace Enrollees And The Comparison Group, 2014

	Unadjusted				Adjusted differences (all Marketplace versus comparison)	
	Early enrollees	Late enrollees	All Marketplace	Comparison group	Difference/ratio	*p* value
ANY UTILIZATION						
Number	223,483	344,900	568,383	655,565	—[a]	—[a]
Percent	66.5	50.0	55.0	63.5	—[a]	—[a]
NUMBER OF THIRTY-DAY PRESCRIPTIONS, JANUARY–SEPTEMBER						
Mean	14.8	8.4	10.9	15.2	−4.45	****
Median	8.6	4.5	5.8	9.0	—[a]	—[a]
Percent generic	86.3	88.2	87.2	81.5	—[a]	—[a]
					Adjusted ratio (all Marketplace versus comparison)	
TOTAL SPENDING						
Mean PMPM	$95	$55	$72	$93	0.71	****
Traditional	56	32	42	67	0.52	****
Specialty	38	22	29	26	1.02	
PLAN SPENDING						
Mean PMPM	78	44	58	77	0.65	****
Traditional	42	23	31	52	0.43	****
Specialty	36	21	27	25	0.97	
OUT-OF-POCKET DRUG SPENDING						
PMPM	17	11	13	16	0.92	****
Traditional	14	9	11	15	0.80	****
Specialty	3	2	2	1	1.36	****

SOURCE Express Scripts Inc. **NOTES** Definitions of early and late enrollees, and sample sizes, are in the Exhibit 1 Notes. Specialty medications are defined as injectable and noninjectable drugs used to treat chronic complex conditions that meet at least one of the criteria described in the text. PMPM is per member per month. [a]Not applicable. ****$p < 0.001$

a greater proportion of their prescriptions for generic drugs than did their counterparts in the comparison group (87.2 percent versus 81.5 percent).

Prescription drug spending among Marketplace enrollees as a whole was lower than in the comparison group ($72 versus $93), for an adjusted ratio of 0.71. There were some significant differences in spending on traditional versus specialty pharmaceuticals between Marketplace enrollees and the comparison group. Monthly total spending on traditional medicines was lower among all Marketplace enrollees relative to the comparison group ($42 versus $67) whereas monthly spending on specialty medicines was similar to that of the comparison group ($29 versus $26), for an adjusted ratio of 1.02.

Marketplace enrollees, as a whole, had slightly lower monthly out-of-pocket expenses ($13 versus $16, adjusted ratio 0.92), likely as a result of the fact that they filled 4.5 fewer prescriptions during the study period. Marketplace enrollees as a whole had substantially greater out-of-pocket spending for specialty drugs than did the comparison group (adjusted ratio of 1.36).

USE OF SPECIFIC DRUG CATEGORIES Exhibit 4 shows the differences in use of five traditional and five specialty pharmaceutical categories, comparing all Marketplace enrollees to the comparison group with employer-sponsored coverage. Marketplace enrollees were less likely to use each of the traditional medication classes we examined. They had lower likelihood of use of most of the specialty classes but significantly higher use of drugs to treat hepatitis C (odds ratio: 1.26; 95% confidence interval: 1.10, 1.45) and HIV (OR: 3.70; 95% CI: 3.49, 3.92). (A fuller version of Exhibit 4 is available in Appendix Exhibit 4.)[10]

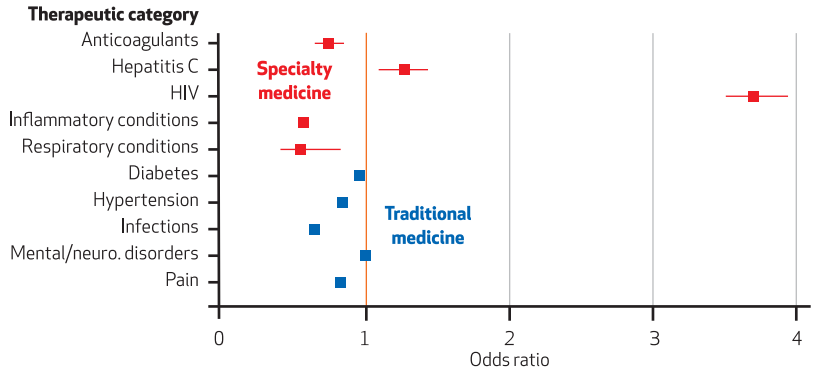
$72

Per month

Prescription drug spending among Marketplace enrollees as a whole was lower than in the comparison group ($72 versus $93 per month).

EXHIBIT 4

Odds Ratios Of Any Use Of Specific Therapeutic Categories Among Marketplace Enrollees Versus The Comparison Group, January–September 2014



SOURCE Express Scripts Inc. **NOTES** Exhibit shows odds ratios and 95% confidence intervals from logistic regression models that include an indicator for Marketplace (versus comparison group). Exhibit shows odds ratios for five traditional categories, for chronic and acute conditions, and for five specialty categories used to treat complex chronic conditions that require specialized administration or intensive patient monitoring.

Discussion

Our study has three key findings that have implications for understanding the impact of the ACA. First, we found marked differences in age and medication use between early Marketplace enrollees versus those who enrolled later. Second, Marketplace enrollees, as a whole, had both lower overall drug spending and medication use than did the comparison group with employer-sponsored coverage and lower use of most of the medication classes we examined. Third, Marketplace enrollees had nearly four times higher odds of using HIV medications than the comparison group. Out-of-pocket expenses for specialty medicines were 36 percent higher among Marketplace enrollees than in the comparison group as well.

People enrolling in Marketplace plans by January were four years older and filled twice as many prescriptions in the first month of enrollment than people who enrolled in a Marketplace plan in May. This suggests that the enrollment dynamics that the CBO predicted would play out during the first three years of the ACA[1]—that enrollees with higher expected costs would sign up first—were evident in just the first few months of implementation. The Department of Health and Human Services (HHS) also made a strong last-minute push to enroll young adults in health insurance, including multiple celebrity endorsements and social media campaigns.[12]

Our descriptive analyses, which showed lower medication use among Marketplace enrollees relative to a comparison group with employer-sponsored coverage, are suggestive that the ACA Marketplaces did not experience adverse selection in their first year. However, we cannot necessarily rule out adverse selection, for two reasons. First, we were unable in our data set to compare the medication use of first-year Marketplace enrollees with the millions who were eligible for coverage but had not yet enrolled. Second, the increasing trend in prescription use in each group of exchange enrollees by month of enrollment (Exhibit 2) underscores the importance of updating these comparisons in year two and beyond. Some of the differences in usage between Marketplace and comparison group enrollees may be attributable to the extended time it can take previously uninsured Marketplace enrollees to obtain care and have unrecognized conditions diagnosed and treated.[13]

Only one-third of Marketplace enrollees in our sample had prior coverage in an Express Scripts

Marketplace enrollees had substantially higher use of HIV medications compared to the employer-sponsored coverage group.

client plan, although we did not have information on prior coverage through other sources. Early enrollees were more likely than later enrollees to have prior coverage with an Express Scripts plan, which suggests that early enrollees may have been more likely to be engaged in care prior to the ACA. HHS has reported that 87 percent of enrollees in the federally facilitated Marketplace who applied for financial assistance were previously uninsured.[2] National surveys that have included unsubsidized enrollees and enrollees in states operating their own Marketplaces have found that 39–57 percent of Marketplace enrollees were previously uninsured.[5,14]

While an in-depth comparison of benefit design features in Marketplace versus employer-sponsored plans was beyond the scope of this article, we did examine out-of-pocket expenses for prescription drugs among both types of Express Scripts enrollees. Overall, out-of-pocket expenses for all drugs were lower in the Marketplace, likely because of the lower overall use of such drugs in Marketplace enrollees relative to the comparison group. However, Marketplace enrollees who had similar use of specialty medication classes to the comparison group nevertheless had substantially higher out-of-pocket drug spending on specialty drugs. According to HHS, 85 percent of Marketplace enrollees selected plans with an actuarial value of 70 percent or lower, meaning that the plan would cover approximately 70 percent or less of their actual medical expenses.[2] In contrast, the average actuarial value of employer-sponsored plans is 80 percent.[15] In fact, a recent analysis found that Marketplace plans had lower premiums but higher deductibles and prescription drug cost sharing than employer-sponsored plans.[16] While some low-income enrollees may receive cost-sharing reductions that effectively increase plan generosity, others may be ineligible either because their incomes are too high or because they enrolled in low-actuarial-value bronze plans that do not qualify for cost-sharing reductions. Given that the Marketplaces were meant to provide coverage primarily for those with incomes of 100–400 percent of the federal poverty level, these differences in out-of-pocket spending emphasize the importance of examining the impact of benefit design on Marketplace enrollees' ability to pay for medications.[17]

Among all of the differences in medication use between Marketplace enrollees and the employer-sponsored comparison group, HIV stands out particularly. The ACA was predicted to play an important role in expanding coverage to people with HIV, many of whom were uninsured prior to expansion.[18–20] Many living with HIV do not receive regular treatment with the recommended combination multidrug antiretroviral therapy in spite of its enormous effectiveness, and a major barrier is cost.[21] Our early findings are suggestive of the ACA's having an impact on HIV treatment. On the other hand, some Marketplace enrollees were likely already receiving antiretroviral therapy through federally funded programs (for example, the Ryan White HIV/AIDS Program) or other sources.[22] Some of the increased spending on HIV drugs for Marketplace enrollees may represent shifting of payment from public sources to private plans.

Conclusion

Our analysis of more than one million health insurance Marketplace enrollees provides an early description of the demand for health care among Marketplace enrollees. We found that Marketplace enrollees, as a whole, had lower drug usage and total drug spending relative to a comparison group with employer-sponsored coverage. However, use varied dramatically among Marketplace enrollees depending on the timing of enrollment, with greater prescription use among earlier enrollees, who also faced higher out-of-pocket expenses than people in employer-sponsored plans. Regardless of the timing of enrollment, Marketplace enrollees had substantially higher use of HIV medications compared to the employer-sponsored coverage group. Given the unprecedented expansion in insurance coverage with the ACA, these changes, and their impact on vulnerable groups, will need to be closely monitored. ■

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NOTES

1 Congressional Budget Office. Updated estimates of the effects of the insurance coverage provisions of the Affordable Care Act [Internet]. Washington (DC): CBO; 2014 Apr [cited 2015 Apr 20]. Available from: http://www.cbo.gov/sites/default/files/45231-ACA_Estimates.pdf

2 Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Health insurance Marketplace: summary enrollment report for the initial annual open enrollment period [Internet]. Washington (DC): HHS; 2014 May 1 [cited 2015 Apr 20]. Available from: http://aspe.hhs.gov/health/reports/2014/marketplaceenrollment/apr2014/ib_2014apr_enrollment.pdf

3 Pear R. Health care act still covers 7.3 million. New York Times. 2014 Sep 19;Sect. A:17.

4 Commonwealth Fund. Gaining ground: Americans' health insurance coverage and access to care after the Affordable Care Act's first open enrollment period [Internet]. New York (NY): Commonwealth Fund; 2014 [cited 2015 Apr 21]. Available from: http://www.commonwealthfund.org/publications/issue-briefs/2014/jul/health-coverage-access-aca

5 Hamel L, Norton M, Levitt L, Claxton G, Cox C, Pollitz K, et al. Survey of non-group health insurance enrollees [Internet]. Menlo Park (CA): Henry J. Kaiser Family Foundation; 2014 Jun [cited 2015 Apr 21]. Available from: http://kff.org/health-reform/report/survey-of-non-group-health-insurance-enrollees/

6 Armour S. Fewer uninsured face fines as health law's exemptions swell. Wall Street Journal. 2014 Aug 6.

7 Von Korff M, Wagner EH, Saunders K. A chronic disease score from automated pharmacy data. J Clin Epidemiol. 1992;45(2):197–203.

8 Clark DO, Von Korff M, Saunders K, Baluch WM, Simon GE. A chronic disease score with empirically derived weights. Med Care. 1995;33(8):783–95.

9 Putnam KG, Buist DS, Fishman P, Andrade SE, Boles M, Chase GA, et al. Chronic disease score as a predictor of hospitalization. Epidemiology. 2002;13(3):340–6.

10 To access the Appendix, click on the Appendix link in the box to the right of the article online.

11 Express Scripts Lab. The 2013 drug trend report [Internet]. St. Louis (MO): Express Scripts Lab; 2014 Apr [cited 2015 Apr 21]. Available from: http://lab.express-scripts.com/~/media/pdfs/drug trend report/express scripts 2013 drug trend report.ashx

12 Dooley E. Can Zach Galifianakis and Lance Bass save Obamacare? [Internet]. New York (NY): ABC News; 2014 Mar 12 [cited 2015 Apr 21]. Available from: http://abcnews.go.com/blogs/politics/2014/03/can-zach-galifianakis-and-lance-bass-save-obamacare/

13 McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ. Use of health services by previously uninsured Medicare beneficiaries. N Engl J Med. 2007;357(2):143–53.

14 Carman KG, Eibner C. Changes in health insurance enrollment since 2013. Santa Monica (CA): RAND Corporation; 2014.

15 Gabel JR, Lore R, McDevitt RD, Pickreign JD, Whitmore H, Slover M, et al. More than half of individual health plans offer coverage that falls short of what can be sold through exchanges as of 2014. Health Aff (Millwood). 2012;31(6):1339–48.

16 Buttorff C, Andersen MS, Riggs KR, Alexander GC. Comparing employer-sponsored and federal exchange plans: wide variations in cost sharing for prescription drugs. Health Aff (Millwood). 2015;34(3):467–76.

17 James AE 3rd, Gellad WF, Primack BA. Implications of new insurance coverage for access to care, cost-sharing, and reimbursement. JAMA. 2014;311(3):241–2.

18 Snider JT, Juday T, Romley JA, Seekins D, Rosenblatt L, Sanchez Y, et al. Nearly 60,000 uninsured and low-income people with HIV/AIDS live in states that are not expanding Medicaid. Health Aff (Millwood). 2014;33(3):386–93.

19 Kates J, Garfield R. The ACA and people with HIV: the ACA's impact and the implications of state choices. Health Affairs Blog [blog on the Internet]. 2014 Mar 3 [cited 2015 Apr 21]. Available from: http://healthaffairs.org/blog/2014/03/03/the-aca-and-people-with-hiv-the-acas-impact-and-the-implications-of-state-choices/

20 Kates J, Garfield R, Young K, Quinn K, Frazier E, Skarbinski J. Assessing the impact of the Affordable Care Act on health insurance coverage of people with HIV [Internet]. Menlo Park (CA): Kaiser Family Foundation; 2014 Jan 7 [cited 2015 Apr 21]. Available from: http://kff.org/report-section/assessing-the-impact-of-the-affordable-care-act-on-health-insurance-coverage-of-people-with-hiv-issue-brief/

21 Hall HI, Frazier EL, Rhodes P, Holtgrave DR, Furlow-Parmley C, Tang T, et al. Differences in human immunodeficiency virus care and treatment among subpopulations in the United States. JAMA Intern Med. 2013;173(14):1337–44.

22 Department of Health and Human Services, Health Resources and Services Administration. Clarifications regarding use of Ryan White HIV/AIDS Program Funds for premium and cost-sharing assistance for private health insurance [Internet]. Rockville (MD): HRSA; 2014 Jun 6 [cited 2015 Apr 2015]. Available from: http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1305premiumcostsharing.pdf

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California Hospital Networks Are Narrower In Marketplace Than In Commercial Plans, But Access And Quality Are Similar

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ABSTRACT Do insurance plans offered through the Marketplace implemented by the State of California under the Affordable Care Act restrict consumers' access to hospitals relative to plans offered on the commercial market? And are the hospitals included in Marketplace networks of lower quality compared to those included in the commercial plans? To answer these questions, we analyzed differences in hospital networks across similar plan types offered both in the Marketplace and commercially, by region and insurer. We found that the common belief that Marketplace plans have narrower networks than their commercial counterparts appears empirically valid. However, there does not appear to be a substantive difference in geographic access as measured by the percentage of people residing in at least one hospital market area. More surprisingly, depending on the measure of hospital quality employed, the Marketplace plans have networks with comparable or even higher average quality than the networks of their commercial counterparts.

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After years of legal and political turmoil, the major provisions of the Affordable Care Act (ACA) have gone into effect and now provide health insurance coverage to millions of Americans. Many of these people obtained coverage from a health plan purchased through an insurance exchange, or Marketplace. However, concerns have been raised that favorable premiums and standardized benefits are provided at the expense of access to health care providers and to high-quality care.

In this analysis we compared the hospital networks available to California consumers in two types of insurance in the initial Marketplace enrollment period: private commercial coverage and coverage obtained through the state insurance Marketplace, called Covered California. We sought to answer two questions. First, are the networks of hospitals available through Marketplace plans narrower than those provided in comparable commercial plans? Second, how do these networks compare in terms of the quality of the available hospitals?

To answer these two questions, we gathered data from Covered California to identify insurers that were offering plans and to identify their associated hospitals. We found insurers in each region that offered comparable plans through both Covered California and the commercial market. The resulting dyads of plans hold constant region, insurer, and plan type, which allows for a direct comparison of networks. We then compared the networks in terms of percentages of hospitals in the region, percentages of residents in the region within hospital markets, and average quality of included hospitals using three different quality measures. Although the hospital networks for Marketplace plans do appear to be, on average, narrower than those for the commercial plans, the Marketplace networks have comparable quality for two of the quality measures and actually have higher average quality for the third.

The ACA And Insurance Marketplaces

The ACA serves as the most fundamental transformation of the US health care system since Lyndon Johnson's Great Society.[1] A key component is the insurance exchange, or Marketplace, whose main role is to improve the amount and quality of information available to consumers shopping for health insurance by facilitating plan comparisons, assessing and regulating plan quality, and streamlining enrollment. Equally important is the Marketplace's role in assessing consumers' eligibility for state Medicaid programs and the Children's Health Insurance Program (CHIP), as well as the determination of eligibility for federal subsidies for the purchase of insurance. While offering a program floor and federal backstop—that is, by setting certain minimum standards and by ensuring access to coverage under a federal Marketplace in states that refuse to establish their own—the ACA allows states substantial leeway in determining Marketplace governance, structure, and function.

Despite a divided state government with a Republican governor and a strongly Democratic legislature, California was the first state to establish a health insurance Marketplace, Covered California, in late 2010.[2] Enrollment in Covered California started October 1, 2013. Implementation in California, while not without problems,[3,4] was deemed a success by politicians and residents alike[5] as the state surpassed its initial enrollment estimates of 487,000–696,000 enrollees, with 728,410 people registered by the end of January 2014.[6] Overall, Californians have been overwhelmingly supportive of the reform.[7]

Network Adequacy Under The ACA

In section 1311, the ACA tasks the secretary of health and human services (HHS) and the states with addressing network adequacy issues for plans sold in the Marketplaces through its qualified health plan provisions. *Network adequacy* refers to a health plan's ability to provide access to a sufficient number of primary care and specialty physicians within the plan's network as well as all health care services included under the terms of the contract. HHS implemented these requirements by rulemaking in March 2012, providing states with state-based insurance Marketplaces substantial leeway in the determination of network adequacy.[8] In states with federally facilitated Marketplaces, HHS either resorted to existing state adequacy standards or relied on National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) requirements.[9]

Network adequacy in Covered California is based on both federal and state regulations. In addition to the aforementioned regulatory authority of HHS, Covered California plans are regulated by the California Department of Insurance or the California Department of Managed Health Care, depending on the type of coverage offered. In addition, Covered California puts additional requirements on qualified health plans offered in the Marketplace with respect to network adequacy in terms of the number of general and specialty providers, as well as their geographic location. In California, carriers must also maintain the same provider networks across coverage tiers; that is, across all plans ranging from bronze to platinum.[10]

Although the debate about narrow networks predates the ACA,[11] the law's implementation has added publicity and urgency to the public debate. The discussion about narrow networks has also provided new ammunition to Republicans, who have used it to illustrate what they deem to be another failure of the ACA.[12] It has also put the Obama administration in an awkward position between supporting low premiums, characteristic of plans with narrow networks, on the one hand, and broad access on the other. Not surprisingly, controversies have erupted around the nation in the wake of the first enrollment period, as about half of all plans sold in Marketplaces nationwide were so-called narrow networks.[13] California has been described as "ground zero" for this controversy with particularly heated debates about the complete exclusion of Cedars-Sinai Medical Center and the partial exclusion of the UCLA Medical Center from many of these plans.[14] Concerns about deliberate consumer misinformation—for example, providing outdated and overstated network information to consumers—resulted in California's insurance commissioner issuing emergency regulations in early 2015, although concerns largely focused on providers and not hospitals.[15]

The Centers for Medicare and Medicaid Services (CMS) has reacted to this controversy by proposing new rules for the 2015 enrollment period that would require insurers to submit their networks to CMS for evaluation of "reasonable access," while also increasing the percentage of "essential community providers" required to be included.[14] In addition, states such as Maine have sought to require insurers to disclose explicitly the narrowness of their networks.[16] Other states have discussed "any willing provider" or "freedom of choice" laws as a response.[17]

Study Data And Methods

We obtained the data for this analysis from a variety of sources. We based our analysis on Cov-

ered California's nineteen pricing regions for the 2013–14 enrollment period (Exhibit 1).[18,19] Hospital data, including quality information, were obtained from California's Office of Statewide Health Planning and Development (OSHPD). We excluded all specialty and psychiatric facilities from our data set and focused solely on general acute care hospitals as defined by OSHPD. Based on the OSHPD data, we were left with a total of 338 hospitals in the nineteen regions. The number of hospitals per region ranged from 5 to 84, with a mean of 19.0 and a median of 13.5.[20]

In terms of insurance carriers, we focused on insurers that offered comparable products in the commercial insurance market and Covered California. We refer to the two markets as "insurance types." We selected the four major California insurance carriers for inclusion in our sample, all of which provide complete and comprehensive coverage to their customers. In addition to Blue Cross, which is California's largest provider of individual coverage inside and outside of the exchange (47 percent and 30 percent of covered individuals in these markets, respectively), we selected Blue Shield (19 percent and 29 percent), Health Net (3 percent and 18 percent), and Kaiser Permanente (20 percent and 18 percent).[19] Together, these four carriers cover 89 percent and 95 percent of the respective markets. Both Blue Cross and Blue Shield provide insurance Marketplace coverage in all nineteen pricing regions, whereas Health Net provides coverage in thirteen regions, and Kaiser Permanente does so in fourteen regions. In the Marketplace, these carriers offer three major types of coverage: health maintenance organization (HMO), preferred provider organization (PPO), and exclusive provider organization (EPO). We refer to these as "types of plans."

Data on provider networks were obtained from Covered California. Commercial plan information was obtained directly from the insurance carriers' websites. Because of the unique integrated model offered by Kaiser Permanente, we conducted all analyses with and without Kaiser Permanente hospitals included in the data set. All of our results hold across specifications. We generally present only the results obtained from the data sets excluding Kaiser

EXHIBIT 1

Pricing Regions And Health Insurance Companies For Covered California, 2013–14 Enrollment Period

Region	Counties	Blue Cross	Blue Shield	Health Net	Kaiser Permanente
1	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba	PPO	EPO	—[a]	—[a]
2	Marin, Napa, Solano, and Sonoma counties	PPO	EPO	PPO	HMO
3	El Dorado, Placer, Sacramento, Yolo	PPO, HMO	PPO	—[a]	HMO
4	San Francisco	EPO	PPO	PPO	HMO
5	Contra Costa	PPO	PPO	PPO	HMO
6	Alameda	PPO	EPO	—[a]	HMO
7	Santa Clara	PPO, HMO	PPO	PPO	HMO
8	San Mateo	PPO	PPO	PPO	HMO
9	Monterey, San Benito, Santa Cruz	PPO	EPO	PPO	—[a]
10	Mariposa, Merced, San Joaquin, Stanislaus, Tulare	PPO	PPO	PPO	—[a]
11	Fresno, Kings, Madera	PPO, HMO	PPO	—[a]	HMO
12	San Luis Obispo, Santa Barbara, Ventura	PPO	PPO	—[a]	—[a]
13	Imperial, Inyo, Mono	PPO	PPO	—[a]	—[a]
14	Kern	PPO	PPO	PPO	HMO
15	Los Angeles[b]	PPO, HMO	PPO	PPO, HMO	HMO
16	Los Angeles[b]	EPO, HMO	PPO	PPO, HMO	HMO
17	San Bernardino, Riverside	PPO, HMO	PPO	PPO, HMO	HMO
18	Orange	EPO, HMO	PPO	PPO, HMO	HMO
19	San Diego	EPO, HMO	PPO	PPO, HMO	HMO

SOURCE Covered California. **NOTES** PPO is preferred provider organization. HMO is health maintenance organization. EPO is exclusive provider organization. [a]Region is not being served by this carrier. [b]Because of its size and diversity, Los Angeles County was divided into two separate pricing regions (15 and 16).

Permanente hospitals unless stated otherwise.

Data for quality comparisons came from three sources: the Agency for Healthcare Research and Quality (AHRQ) and the California OSHPD, the Leapfrog Hospital Survey, and the "Top Performers Ranking" produced by the Joint Commission.

Finally, for comparing hospital market coverage, we obtained demographic information from the 2010 census.

Study Results

The simplest measure of narrowness is to compare the number of hospitals in a network in a region for a particular carrier/plan type/insurance type combination to the total number of hospitals in that region. The percentage of hospitals participating in Marketplace plans varied widely from a low of 13 percent to a high of 100 percent in several cases. The average percentage of hospitals in plans offered through the Marketplace was 71 percent, with a standard deviation of 21 percentage points and a median of 76 percent.[21]

A more informative approach compares the respective percentages not to the absolute number of hospitals in a region but instead to a comparable commercial plan. Hence, we also computed the ratio of hospitals in the comparable Marketplace and commercial plans by region, taking into account not only the region in the denominator but also the carrier and plan type.

On average, the Marketplace network amounted to about 83 percent of the commercial network (standard deviation: 22 percentage points; median: 87 percent). The percentages ranged from 14 percent to 140 percent.

Similarly, we compared Marketplace and commercial networks as dyads (see online Appendix Exhibit A1).[22] Not surprisingly, out of the fifty-eight possible comparisons in our data set, in thirty-eight cases the Marketplace network was more limited than the commercial network in terms of the number of hospitals included. In seventeen cases the networks included the same number of hospitals, and in three cases the Marketplace network was actually more extensive than the commercial network. These descriptive findings were supported by a *t*-test comparing differences for all fifty-eight dyads, which is significant at the 0.001 level.

FACILITY ACCESS: ARE CARRIERS USING THE SAME HOSPITALS? We also assessed how similar the networks were with the Pearson correlation coefficient, which measures the linear correlation between two variables or, in our case, networks. In the case of Kaiser Permanente, the correlation was 1.00, as both networks overlap 100 percent. Outside of Kaiser Permanente, the highest correlation, 0.75, existed between the networks of the Blue Shield EPO plans followed by the Health Net PPO plans at 0.74. The lowest correlation, 0.16, was between the Blue Cross EPO plan networks.

Comparing the percentages of hospitals by carrier and by plan (again excluding Kaiser Permanente), we found that in six out of the seven cases, more than two-thirds of hospitals were either in both networks or in neither network (Exhibit 2). Only in one case was this overlap as low as 30 percent. In five of the cases the majority of hospitals was in both networks. In all cases the percentage of hospitals in only the Marketplace network is the smallest of all cells. Hence, with only a few exceptions, Marketplace networks are reduced versions of commercial networks.

GEOGRAPHIC ACCESS: TRAVEL DISTANCES TO OBTAIN HOSPITAL CARE Having established that Marketplace networks generally are smaller in size than their commercial network counter-

EXHIBIT 2

Comparison Of Percentages Of Hospitals Included In And Excluded From Commercial And Marketplace Plans, 2013–14 Enrollment Period

Insurance carrier and plans	Percent of hospitals common to both networks	Percent of hospitals only in commercial networks	Percent of hospitals only in Marketplace networks	Percent of hospitals in neither network
Blue Cross HMO	78.3%	8.6%	1.7%	11.4%
Blue Cross EPO	21.3	70.2	0.0	8.5
Blue Cross PPO	76.5	16.9	0.6	6.0
Blue Shield EPO	76.6	4.7	3.1	15.6
Blue Shield PPO	57.4	28.5	0.8	13.2
Health Net HMO	27.0	23.0	8.8	41.2
Health Net PPO	71.8	6.4	3.2	18.6
Kaiser Permanente HMO	100.0	0.0	0.0	0.0

SOURCES Authors' calculations of data obtained from Covered California and insurance carriers. **NOTES** HMO is health maintenance organization. EPO is exclusive provider organization. PPO is preferred provider organization.

parts, the question arises how this affects people seeking care. In particular, how many people have to travel long distances to seek hospital care as a result of these limitations in access? To answer this question, we used geographic information systems (GIS) software to establish hospital market areas with a radius of fifteen miles around each hospital in our data set.[23] We next assessed the percentage of people, per Marketplace region, who resided within at least one hospital market area for each commercial and each Marketplace network. We then compared these numbers to the total number of residents in the respective region, using 2010 census-tract data. The resulting percentage dyads are presented in Exhibit 3.

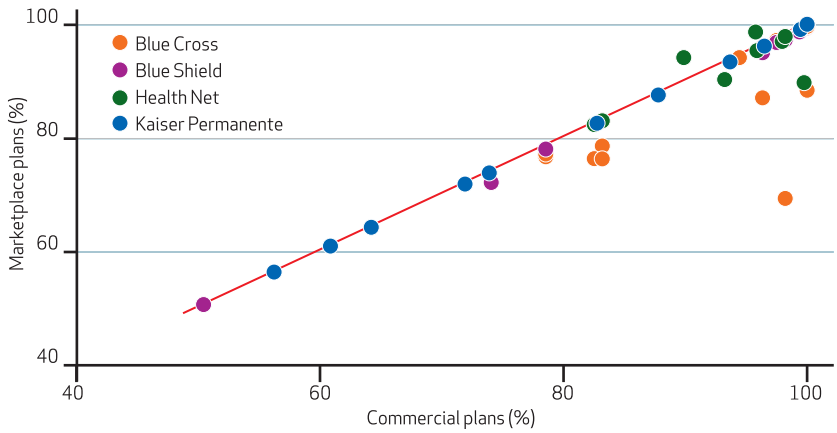
On average, 92 percent of residents were within at least one hospital market area in Marketplace plans. The number was slightly higher for commercial networks, which reached about 93 percent of people. Overall, thirty-one Marketplace networks and thirty-three commercial networks (out of seventy each) included 100 percent of residents in at least one hospital market area. At the same time, at least 20 percent of potential subscribers to fourteen Marketplace plans did not reside within any hospital market area. Five of these were Kaiser Permanente plans, which, because of a unique model of care, are by definition limited. Moreover, in about eight cases (out of seventy), Marketplace plans reached only about 50–75 percent of people. Interestingly, commercial and Marketplace plans provided essentially similar—that is, limited—coverage in these cases. Particularly affected in seven of the fourteen cases were people residing in the central part of the state (regions 11, 12, and 13). Hence, although the vast majority of people reside within at least one hospital market region, there may be considerable problems of access for a number of people in various regions. However, these disparities apply generally and not solely to Marketplace-based plans. Not surprisingly, only two cases landed above the line of equal proportions; that is, in only two instances did commercial networks reach fewer residents than Marketplace plans in terms of hospital market areas. Furthermore, a large number of cases fell onto or very near the line, with the majority of cases bundled close to 100 percent on both axes (Exhibit 3). The descriptive statistics were again confirmed by a *t*-test comparing all seventy dyads, which is significant at the 0.03 level. However, substantively this difference amounts to only a 1-percentage-point difference.

COMPARING NETWORK QUALITY Do narrow networks provide, on average, worse care than broader networks? To answer this question, we created an index made up of twelve AHRQ quality indicators reported by all California hospitals to the OSHPD. Six of these indicators are the risk-adjusted mortalities for certain conditions, while the remaining six are risk-adjusted mortalities for six medical procedures. For each item, we dichotomized the variables based on whether the respective hospital was below or above the statewide average. We next created an additive quality index ranging from 0 to 12, with 12 being the highest possible quality (that is, the hospitals scored below the state average for all twelve mortalities). We then averaged this index for each plan by region (see Appendix Exhibit A2).[22] Quality scores were essentially the same for commercial and Marketplace plans. The average quality score was 8.04 for commercial networks and 8.00 for Marketplace networks. Overall, the data are relatively clustered in the center of the quality index. A *t*-test for all fifty-eight dyads did not approach significance ($p = 0.22$). The correlation coefficient for all dyads is 0.92. California OSHPD data thus indicate that there was no difference, as measured here, between Marketplace and commercials plans in terms of this quality measure.

We considered two additional measures that may capture different dimensions of quality. First, we used nineteen measures from the Leapfrog Hospital Survey data. We largely followed the survey's approach and scored each item from 0 (hospital declined to respond) to 4 (hospital fully meets standards). We then summed all individual scores and divided them by the highest possible score for the respective hospital. We then averaged this fraction for each plan by re-

EXHIBIT 3

Geographic Access Comparison: Dyads Of Commercial And Marketplace Plans Available To California Populations That Are Within At Least One Hospital Market, 2013–14 Enrollment Period



SOURCE Authors' calculations of census data. **NOTES** Thirty-six dyad observations were identical for commercial and Marketplace at 98 percent, 99 percent, or 100 percent across all plan types. The red line represents equal access.

gion (see Appendix Exhibit A3).[22] Overall, the Leapfrog data were much more dispersed than the AHRQ/OSHPD-derived quality index data. Again, most dyads appear to hover around the line of equal quality. There appears to be a slight quality advantage for Marketplace plans. The average percentage for Marketplace plans just surpasses 40 percent whereas the average score for commercial plans falls just below 39 percent. A *t*-test on all fifty-eight dyads did not find the difference to be statistically different from zero ($p = 0.23$). The correlation coefficient for all dyads is 0.87. As with the AHRQ/OSHPD measure, we found no difference between Marketplace and commercial networks.

Finally, we used data from the Joint Commission's "Top Performers Ranking" to create an indicator variable. We then compared the percentage of hospitals that were top performers in Marketplace networks to those in the comparable commercial network (Exhibit 4). The average percentage for Marketplace networks is 26, and the average percentage for commercial networks is 20. This indicator of quality shows the most variation of the three measures and favors Marketplace networks, with a large number of cases falling above the line of equal quality. These findings were confirmed by a *t*-test, which reaches significance at the 0.001 level. The correlation coefficient for all dyads is 0.84. Using the top-performers measure, it appears that Marketplace networks offer better-quality care than commercial networks.

Discussion

We analyzed differences in hospital networks across similar plan types, by region and by insurer, offered both in the Marketplace and commercially. Our analyses offer the advantage of controlling directly for the confounding factors of insurer, plan type, and region by comparing differences in access and quality within plan dyads. This contributes to the internal validity of our analysis. However, our focus on one state, which may be unusual in its implementation of its Marketplace, raises some concerns about external validity and, therefore, calls for caution in assuming that our findings apply nationally.

Our analyses confirm that Marketplace networks tend to be narrower than those for comparable commercial plans. The obvious implication is that people in the Marketplace generally have fewer hospitals from which to obtain care. However, it appears that, on average, in contrast to narrower facility choice, Marketplace plans only marginally restrict geographic access as measured by the percentage of people residing in at least one hospital market area. Nevertheless, people in certain areas may be confronted with considerable distances to the nearest hospital, although this is often the case for commercial plans as well.

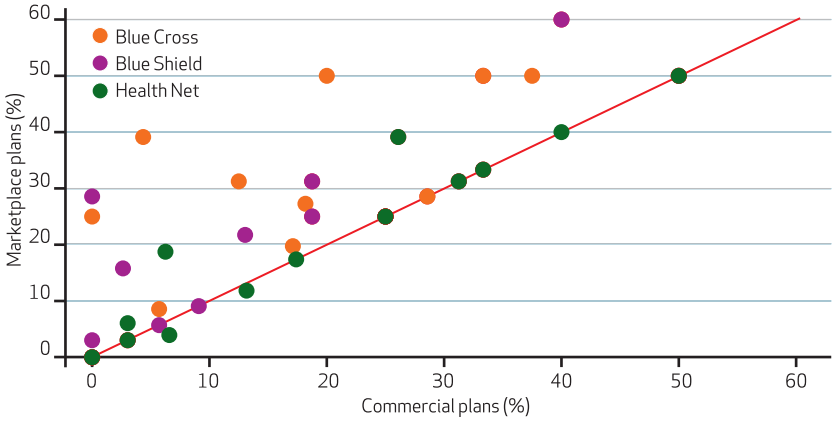
What do we know about why insurers seek to restrict hospital choice? Insurers have used a variety of tools to rein in rapidly increasing health care costs for decades, including consumer cost sharing,[24] product tiering,[24] and managed care.[25] In response to the recent wave of vertical and horizontal integration in hospital markets across the country,[26] insurers have sought to reestablish a greater degree of countervailing power by offering hospitals willing to negotiate discounts higher volumes through narrower networks. Requirements under the ACA have further encouraged these trends.[27] Insurers seem to have been successful in their efforts.[28] Overall, there is evidence that shows substantial cost reductions from the use of narrower networks.[29] However, quality aspects of care have been markedly understudied thus far.[30]

Not surprisingly, even before the advent of the ACA, concerns about the adequacy of health plan networks provoked strong emotions and heated debates.[11] As a result, several states had passed network adequacy legislation before the ACA was enacted.[31] Similarly, the federal government has established network adequacy standards for Medicaid and Medicare managed care, as have various private accreditation organizations such as the NCQA and URAC.

Having confirmed the common perception that Marketplace plans are often narrower than commercial plans, our analyses paint a somewhat surprising picture of the difference in the average quality of hospitals in these networks. We drew on data from three sources specifically

EXHIBIT 4

Quality Comparison: Dyads Of Commercial And Marketplace Plans In California, By Rating In The Joint Commission's Hospital Top Performers Data, 2013–14 Enrollment Period



SOURCE Authors' calculations of Joint Commission data. **NOTE** The red line indicates equal quality.

developed to assess hospital quality. Two of the measures we employed show no substantive difference in the average quality of the networks. However, a third measure indicates that the average quality in the Marketplace networks is actually higher than that in the commercial networks. It seems plausible that insurers are deliberately excluding some hospitals that have not been designated as top performers.

How should we interpret these quality results? We can assume that both carrier and consumer strongly favor high-quality/low-cost providers over high-cost/low-quality providers. However, preferences are less clear with respect to the other remaining two cases, as the carrier and the consumer do not necessarily value both dimensions similarly. Consumers likely value quality of care much more than concerns about the cost of care because they are relatively insulated from the costs of treatment under the insurance arrangement, if copayments and coinsurance are modest. At the same time, carriers are particularly concerned about the costs of care, especially because of the relatively brief contract periods between carrier and consumer in the United States. Nonetheless, the reputation of certain hospitals may add value to a carrier's network by attracting additional consumers. However, insurers' concern about the quality of care may be driven primarily by concerns about the cost of care; low-quality of care may lead to more costly care, even in the short term.

As a final point, we note that assessing the average quality of a network depends on the choice of quality measure. In particular, our Joint Commission measure gave results that differed from those of our other two measures. This suggests that the measures are capturing different dimensions of quality that might not be highly correlated. Absent clear criteria for choosing among the measures, future research on network quality should assess the robustness of findings using multiple quality measures.

Conclusion

The debate about narrow networks under the ACA is reminiscent of the managed care revolution that resulted in considerable consumer backlash and a litany of litigation and legislation over provider limitations and out-of-network charges in the 1990s[25,32] as well as the ill-fated Clinton administration health reform efforts.[33] Our analysis shows that plans offered to consumers through the first enrollment period of Covered California appear to offer access to somewhat narrower networks than are available from comparable commercial plans. Geographic access appears less different. Most interestingly, the average quality of hospitals in the Marketplace networks does not appear lower and may actually be higher than in the commercial networks. These results suggest that narrower Marketplace networks do not necessarily restrict geographic access and, more importantly, do not reduce access to high-quality care compared to the networks of standard commercial plans. However, overall access to hospital services remains an important issue to be addressed both inside and outside of the ACA's Marketplaces. Nonetheless, from a political, equity, and policy perspective, our comparisons of the quality of care between networks and our findings contribute to the assessment of the ACA and, we hope, inform the political debate surrounding it. ■

The authors thank Stephanie Mabrey for her research assistance and the Robert M. La Follette School of Public Affairs at the University of Wisconsin-Madison for project assistant support.

NOTES

1 Haeder SF. Beyond path dependence: explaining healthcare reform and its consequences. Policy Stud J. 2012;40(Suppl 1):65–86.

2 Haeder SF, Weimer DL. You can't make me do it: state implementation of insurance exchanges under the Affordable Care Act. Public Adm Rev. 2013;73(Suppl 1):S34–47.

3 Karlamangla S. California says 14,500 must redo Obamacare applications after glitch. Los Angeles Times [serial on the Internet]. 2014 Feb 28 [cited 2015 Mar 12]. Available from: http://articles.latimes.com/2014/feb/28/business/la-fi-mo-malfunction-redo-covered-california-apps-20140228

4 Terhune C, Karlamangla S. California website for Obamacare back up after 5-day outage. Los Angeles Times [serial on the Internet]. 2014 Feb 24 [cited 2015 Mar 12]. Available from: http://articles.latimes.com/2014/feb/24/business/la-fi-mo-health-exchange-website-20140224

5 Cadelago C. California voters' support for health care law inches up. Sacramento Bee [serial on the Internet]. 2014 Aug 19 [cited 2015 Mar 12]. Available from: http://www.sacbee.com/news/politics-government/article2607041.html

6 Viebeck E. Calif. beats Obamacare sign-up goal weeks early. The Hill [serial on the Internet]. 2014 Feb 19 [cited 2015 Mar 12]. Available from: http://thehill.com/policy/healthcare/198744-calif-we-beat-o-care-enrollment-goal

7 Metz D, Strimple G. Findings of a statewide survey on expanding access to health coverage [Internet]. Los Angeles (CA): California Endowment; 2014 Sep 30 [cited 2015

Mar 12]. Available from: http://www.calendow.org/uploadedFiles/Health_Happends_Here/FM3-GS_Strat-Final%20Memo.pdf
8 NAIC Health Insurance and Managed Care (B) Committee. Plan management function: network adequacy white paper [Internet]. Kansas City (MO): National Association of Insurance Commissioners; 2012 Jun 27 [cited 2015 Mar 12]. Available from: http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf
9 Center for Consumer Information and Insurance Oversight. 2015 letter to issuers in the federally-facilitated Marketplaces [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2014 Mar 14 [cited 2015 Mar 12]. Available from: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf
10 McCarty S, Farris M. ACA implications for state network adequacy standards [Internet]. Princeton (NJ): Robert Wood Johnson Foundation; 2013 [cited 2015 Mar 12]. Available from: http://www.rwjf.org/en/library/research/2013/08/aca-implications-for-state-network-adequacy-standards.html
11 Enthoven AC, Singer SJ. The managed care backlash and the task force in California. Health Aff (Millwood). 1998;17(4):95–110.
12 Norman B. Obamacare: anger over narrow networks [Internet]. Arlington (VA): Politico Pro; 2014 Jul 22 [cited 2015 Mar 12]. Available from: http://www.politico.com/story/2014/07/obamacare-health-care-networks-premiums-109195.html
13 Demko P. Nearly half of exchange products offer narrow networks, McKinsey study says. Modern Healthcare [serial on the Internet]. 2014 Jun 10 [cited 2015 Mar 12]. Available from: http://www.modernhealthcare.com/article/20140610/blog/306109998
14 Klein P. Regulators struggle with Obamacare's narrow networks problem. Washington Examiner [serial on the Internet]. 2014 Sep 8 [cited 2015 Mar 12]. Available from: http://www.washingtonexaminer.com/regulators-struggle-with-obamacares-narrow-networks-problem/article/2552849
15 Ngai EYC. California insurance commissioner issues emergency regulations affecting narrow provider networks [Internet]. Western Springs (IL): National Law Review; 2015 Jan 12 [cited 2015 Mar 12]. Available from: http://www.natlawreview.com/article/california-insurance-commissioner-issues-emergency-regulations-affecting-narrow-prov
16 AIS Health. Inside health insurance exchanges: exchange briefs. 2014; 4(7):7–8.
17 "Any willing provider" laws at the very least require carriers to enter into network negotiations with providers seeking to join their networks. Stricter forms require carriers to accept providers into their networks if they accept their rates and conditions. "Freedom of choice" laws allow consumers to seek treatment from providers outside their carrier's network. For details, see Corlette S, Volk J, Berenson RA, Feder J. Narrow provider networks in new health plans: balancing affordability with access to quality care [Internet]. Washington (DC): Georgetown University Health Policy Institute; 2014 May [cited 2015 Mar 12]. Available from: http://www.urban.org/UploadedPDF/413135-New-Provider-Networks-in-New-Health-Plans.pdf
18 We also note that carriers may have restricted networks outside of the Marketplace, as has been the case in several other states (see Note 19). However, we have no evidence that this occurred in California, and the lack of newspaper coverage on the topic may indicate that this was not the case. Our analysis here focuses on the comparison between commercial and Marketplace networks for 2013–14 only.
19 Cox C, Ma R, Claxton G, Levitt L. Sizing up exchange market competition [Internet]. Menlo Park (CA): Henry J. Kaiser Family Foundation; 2014 Mar 1 [cited 2015 Mar 12]. Available from: http://kff.org/health-reform/issue-brief/sizing-up-exchange-market-competition/
20 Note that from here on forward, we combined the two Los Angeles County regions, 15 and 16, into one region.
21 For commercial plans, percentages range from 45 percent to 100 percent with a mean of 86 percent (standard deviation 15 percentage points) and a median of 88 percent.
22 To access the Appendix, click on the Appendix link in the box to the right of the article online.
23 Garnick DW, Luft HS, Robinson JC, Tetreault J. Appropriate measures of hospital market areas. Health Serv Res. 1987;22(1):69–89.
24 Robinson JC. Hospital tiers in health insurance: balancing consumer choice with financial motives. Health Aff (Millwood). 2003;22:w3-135–46. DOI: 10.1377/hlthaff.w3.135
25 Enthoven AC, Schauffler HH, McMenamin S. Consumer choice and the managed care backlash. Am J Law Med. 2001;27(1):1–15.
26 Cuellar AE, Gertler PJ. How the expansion of hospital systems has affected consumers. Health Aff (Millwood). 2005;24(1):213–9.
27 Corlette S, Lucia K, Ahn S. Implementation of the Affordable Care Act: cross-cutting issues: six-state case study on network adequacy [Internet]. Washington (DC): Urban Institute; 2014 Sep [cited 2015 Mar 12]. Available from: http://www.rwjf.org/content/dam/farm/reports/reports/2014/rwjf415649
28 AIS Health. Narrow networks: HMO redux or effective rate-reducing strategy? Inside Health Insurance Exchanges. 2013;3(4):4–5.
29 Morrisey MA. Competition in hospital and health insurance markets: a review and research agenda. Health Serv Res. 2001;36(1 pt 2):191–221.
30 National Committee for Quality Assurance. Network adequacy and exchanges [Internet]. Washington (DC): NCQA; 2013 [cited 2015 Mar 12]. Available from: http://www.ncqa.org/Portals/0/Public%20Policy/Exchanges&NetworkAdequacy_2.11.13.pdf
31 Noble A. Insurance carriers and access to healthcare providers: network adequancy [Internet]. Washington (DC): National Conference of State Legislatures; 2014 Nov 30 [cited 2015 Mar 12]. Available from: http://www.ncsl.org/research/health/insurance-carriers-and-access-to-healthcare-providers-network-adequacy.aspx
32 However, the case against managed care was much broader, including concerns about physician autonomy, executive compensation, and administrative costs, among other things, and not solely as a result of narrow provider networks.
33 Hacker JS. The road to nowhere: the genesis of President Clinton's plan for health security. Princeton (NJ): Princeton University Press; 1997.

THE HENRY J. KAISER FAMILY FOUNDATION

REPORT

May 2015

Coverage Expansions and the Remaining Uninsured

A LOOK AT CALIFORNIA DURING YEAR ONE OF ACA IMPLEMENTATION

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Funded by:

Blue Shield of California Foundation

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Executive Summary

Under the ACA, millions of individuals have gained coverage through new provisions, effective as of January 2014, to expand Medicaid and provide premium tax credits for coverage purchased through Health Insurance Marketplaces. In California, coverage gains were substantial, with 2.7 million people gaining Medi-Cal coverage and nearly 1.7 million people determined eligible for enrollment through Covered California between October 2013 and September 2014.[1] California is a bellwether state for understanding the impact of the ACA. The state's sheer size and its high rate of uninsured prior to ACA implementation means that its experience in implementing the ACA has implications for national coverage goals. In addition, California was an early and enthusiastic adopter of the ACA; the state implemented an early Medicaid expansion through its Low-Income Health Program (LIHP) and was the first to create a state-based Marketplace.

While much attention has been paid to enrollment in new coverage options and changes in the uninsured over the past year, less is known about how this coverage has affected people's lives. To help fill this gap, the Kaiser Family Foundation is conducting a series of comprehensive surveys of the low and moderate-income population. This report uses the California sample of the 2014 Kaiser Survey of Low-Income Americans and the ACA, funded by the Blue Shield of California Foundation, to examine Californian adults that gained coverage and remained uninsured in 2014. It also provides information on how the newly insured view their coverage and any problems they have encountered in using their coverage; how the remaining uninsured and newly insured fare with respect to access to medical care and financial burden; and why people in California continue to lack coverage and their plans for obtaining coverage in 2015. Additional detail on the survey methods is available online.

Background: ACA Implementation in California

Leading up to full implementation of the ACA and during the first year of major coverage expansions, California actively pursued opportunities to expand coverage for residents, conducted outreach and enrollment to bring people into new coverage options, and organized systems to deliver care. The state's 2010 "Bridge to Reform" §1115 Medicaid Demonstration Waiver included early expansion of Medicaid in most counties through the Low-Income Health Program (LIHP), and in 2014, Medi-Cal coverage was expanded statewide to low-income citizens and legal immigrants. As of 2014, middle-income residents are eligible for premium subsidies to purchase coverage through Covered California. The state took steps to simplify and streamline enrollment such as automatically transitioning individuals from LIHP to Medi-Cal, creating a single online portal for Covered California and Medi-Cal applications, and adopting the Express Lane Enrollment Project to target adults and children enrolled in California's Supplemental Nutrition Assistance Program. The state also invested heavily in outreach and enrollment efforts for both Medi-Cal and Covered California. These included statewide marketing campaigns, community mobilization and targeted efforts to reach vulnerable populations.

Despite all these efforts, the state—like all states—experienced outreach and enrollment challenges in 2014. Organizations and individuals in California cited a shortage of in-person assisters, problems with cultural and linguistic resources, technological issues with the Covered California website, and a Medi-Cal backlog, which led to delayed or abandoned applications. The agency received criticism for not doing more to reach hard-to-reach populations, particularly Hispanics and immigrants with Limited English Proficiency (LEP). These challenges notwithstanding, the state enrolled unexpectedly large numbers of people in 2014. In late 2014 and

2015, the state was taking action to address many of the challenges it faced during the first open enrollment period.

Who gained coverage and who remained uninsured?

Examining characteristics of the previously insured, newly insured and remaining uninsured are important to understanding who gained and who was left out of coverage in 2014 and targeting ongoing outreach.

The newly insured and remaining uninsured populations resemble each other with respect to income, age, and health status and have different characteristics from the previously insured. The vast majority of newly insured (94%) and uninsured adults (86%) in California meet the income requirements for Medi-Cal or subsidies in Covered California (below 400% FPL), compared to just over half of the previously insured (57%). In addition, the share of uninsured (21%) and newly insured (22%) who are young adults (age 19-25) were about the same, while previously insured were less likely to be young adults (13%). While there are no significant differences in the share of uninsured (37%) and newly insured adults (30%) who say their health is fair or poor, uninsured adults are less likely than adults with coverage to have a diagnosed medical condition. These patterns indicate that older or sicker individuals did not disproportionately take up coverage in 2014.

However, the insured and uninsured populations in California differ on some important factors, such as race/ethnicity, work status, gender and immigration status. Mirroring historical patterns and legal barriers to coverage, the remaining uninsured population is more likely than the insured to be Hispanic, to be male and to be undocumented. The high share of remaining uninsured who are Hispanic may reflect barriers in outreach to this population or eligibility limits based on immigration. Though most newly insured and uninsured adults are in a family with a full or part-time worker, the specific work profile differs between groups: newly insured adults are less likely than remaining uninsured adults to be in a family with a full-time worker (versus only a part-time worker). With new coverage provisions in place as of 2014, there were more options for health insurance outside employment, and groups traditionally left out of the employer based system—such as part-time workers or low-wage workers—had new avenues for coverage.

Who is covered by different programs in California?

Understanding the profile of the population covered by different types of insurance in the state is essential to designing effective health plans to serve their needs. With the expansion of Medi-Cal, the program grew to include individuals not traditionally covered by the program, which has changed the profile of the overall program in some ways. The profile of Covered California enrollees shows that the program is playing an essential role in covering groups that have been left out of coverage expansions in the past.

Medi-Cal and Covered California enrollees are more likely to be racially diverse and are made up primarily of working adults without dependent children. Whereas half of those with other private insurance identify as White Non-Hispanic, two-thirds of Medi-Cal and 60% of Covered California enrollees identify as a person of color. Adults without dependent children have generally been excluded from public coverage and assistance in the past, but in 2014, 62% of adult Medi-Cal enrollees and 72% of adult Covered California enrollees did not have dependents. Further, about half of Medi-Cal and nearly three-quarters of Covered California adults are in a working family, though a larger share of adults in Covered California are in a

family with a full-time (49% vs. 26%) or part-time (23% vs. 19%) worker. By gender, nearly two-thirds (64%) of adults covered by Medi-Cal are female, compared with about half of adults with Covered California or other private coverage.

Though the adult Medi-Cal population is younger than that of other coverage groups, enrollees have poorer health status. Forty percent of adult Medi-Cal enrollees are under age 34, compared to about a third of Covered California adults and adults with other private coverage. Notably, more than half of adults enrolled in Covered California are over age 45. Nonetheless, Medi-Cal retains many of its traditional roles of serving many individuals with substantial health needs: In 2014, Medi-Cal beneficiaries were more likely than adults with other types of coverage to say their physical health or mental health was fair or poor and more likely to have an ongoing health condition.

WHAT HAS HAPPENED TO ACCESS TO CARE FOR THE INSURED AND REMAINING UNINSURED?

The ultimate goal of expanding health insurance coverage is to help people access the medical services that they need. The survey findings reinforce a large body of literature showing that adults with coverage have better access to care than those who remain without coverage.

Newly insured adults were more likely to change where they usually go for care than their previously insured counterparts, but clinics remain an important source of care for newly insured adults. Newly insured adults were more likely than those who remained uninsured to have a usual source of care and a regular doctor at their usual source of care. Of those, nearly a fifth (19%) reported changing where they usually go for care since gaining coverage, and most said it was due to their insurance. These rates were higher than those among the previously insured. Still, both uninsured and newly insured adults with a usual source of care are most likely to use a clinic or health center for that care, compared with previously insured adults who were most likely to use a doctor's office or HMO. When asked why they chose their site of care, more than a third (37%) of uninsured adults say they use their usual source of care because it is affordable, compared with 40% of newly insured who chose it because it was convenient.

Adults with insurance coverage were more likely than the uninsured to have used medical services or received preventive care. More than half (58%) of newly insured adults said that they used at least one medical service since gaining their coverage, and nearly half (47%) had received a preventive visit or check-up. Still reflecting some unmet need, more than a third of newly insured adults (35%) reported that they postponed or went without needed care, the same share as the uninsured. Among those who do have coverage, postponing care could be related to several factors, including difficulty finding a provider, problems navigating the health system and health insurance networks, misunderstanding of how to use coverage and when to seek care, or concerns about out-of-pocket costs.

Though most adults did not report problems getting appointments, adults with Covered California or Medi-Cal were more likely than those with other private coverage to say a provider would not see them due to coverage. Compared to only 3% of adults with other private coverage, 13% of adults with Covered California and 8% of adults with Medi-Cal say a provider would not take them as a patient because of their coverage. Medi-Cal enrollees also reported higher rates of long waits for

appointments (21%) than those with other private coverage. Like the forces underlying choice of usual source of care, these issues may reflect continuing problems with network adequacy, despite the existence of state standards for network adequacy and patient access.

How do people view their coverage?

People's views of their plan may affect not only their use of their coverage but also the likelihood that they re-enroll in coverage or change plans. Survey findings indicate that, while most people do not report problems with their plan, additional education may be needed to help newly insured people understand their coverage.

Newly insured adults were less likely to prioritize scope of coverage or provider networks in choosing their plan than previously insured adults. Less than a fifth (19%) of newly insured adults say they chose their plan because of the benefits covered, compared to 33% of previously insured adults, and only 14% say they chose their plan based on provider network (versus 26% of previously insured). Rather, newly insured adults were most sensitive to price when choosing their plan, with nearly a third saying they chose based on price. These patterns likely reflect regulations requiring similar scope of benefits across new plans and ongoing price sensitivity among low and middle income adults.

Across coverage groups, most insured adults did not report having difficulty with the plan selection process or other specific problems with their health plan. There were no significant differences across groups comparing services, costs, or provider networks across plans, though the newly insured were more likely than the previously insured to report at least one difficulty (48% versus 34%). When asked specifically if they encountered various problems with their coverage, such as scope of coverage, costs, or customer service, newly insured adults reported similar or lower rates than previously insured.

Newly insured adults were less likely than previously insured to understand the details of their plan and to give their health plan high ratings. Compared with the previously insured, newly insured adults were less likely to say they understand the services their plan covers (65% vs. 80%) or how much they would have to pay when they visit a health care provider (66% vs. 84%) "very well" or "somewhat well." Though 70% of newly insured adults rate their coverage as "excellent" or "good" (versus "not so good" or "poor"), this rate was lower than that among previously insured adults (87%). It is possible that newly insured adults face challenges in understanding the complexity of insurance coverage, especially since many adults who were uninsured before the ACA reported that they had never had health insurance.

How does coverage affect financial security?

Health care costs can be a major burden for low-income families. Survey findings indicate that while coverage can ameliorate some of the financial challenges that low and moderate income adults face, many will continue to face financial challenges in other areas of their lives.

Many Covered California enrollees report difficulty paying their monthly premium. Nearly half of newly insured adults (47%) say it is somewhat or very difficult to afford their monthly premium, compared to just 27% of adults who were insured before 2014. Further, 44% of Covered California enrollees report difficulty paying their monthly premium, versus a quarter of adults with other types of private coverage.

However, coverage does provide financial protection from medical bills and eases concern over affording medical care. Compared to the uninsured, both newly insured and previously insured adults report lower rates of difficulty paying medical bills and living with worry about their ability to afford medical care in the future.

Many newly insured adults still face financial insecurity in areas outside of health care costs. While coverage provides some financial protection from medical bills, there were no significant differences in the share of uninsured and newly insured adults reporting difficulty paying for necessities, saving money, or paying off debt. Previously insured adults were less likely than uninsured to report these challenges.

Why are people still uninsured and what are their coverage options?

Though much attention was paid to the difficulties with the application and enrollment process during the 2014 open enrollment period, logistical issues were not a leading reason why people went without insurance in 2014. Rather, lack of awareness of new coverage options and financial assistance appear to be a major barrier.

Most adults who were uninsured in fall 2014 had not tried to get ACA coverage, and perceptions of cost and eligibility were a common reason for not obtaining coverage. The main reason that all uninsured gave for why they lack coverage is that it is too expensive (44%). Among the roughly one-third of uninsured who tried to sign up for ACA coverage, the most common reason people gave for not having ACA coverage was being told they were ineligible (38%) or because it was too expensive (21%). Still, when asked directly about application difficulty, most uninsured adults who sought ACA coverage reported difficulty with at least one aspect of the process, and most tried more than one avenue.

Few adults who were uninsured at the end of 2014 had plans to obtain ACA coverage in 2015. Only about half of uninsured adults indicated that they plan to get coverage in 2015, and few who do identified Medicaid or Marketplace coverage as their goal. Rather, higher shares indicate that they don't know where they will get coverage or plan to get coverage through a job. However, few are likely to gain coverage through an employer either because they are self-employed or not in a working family (38%), or because the employer does not offer coverage (32%) or coverage for which they are eligible (8%).

Policy Implications

As we enter the second year of new coverage under the ACA, information on people's experience during the first year can inform ongoing efforts to extend and improve health coverage in California.

Covering the Remaining Uninsured

Cost continues to prevent many uninsured adults from seeking coverage. While some uninsured adults are ineligible for assistance, most can receive some help under the law. Thus, there may be a continuing lack of awareness of new coverage options and financial assistance. Messages that focus on low-cost or free coverage being available to most uninsured may help address these barriers to seeking and obtaining coverage.

Given the high share of remaining uninsured who are Hispanic, targeted outreach to this group is appropriate. In the early stages of ACA implementation in the state, there was much attention to the Hispanic population but administrative barriers in reaching them. In 2015, the state made efforts to reach this

population, resulting in higher enrollment among this population. Still, ongoing efforts are needed to enroll eligible Hispanics and to serve those who may be ineligible for coverage due to their immigration status.

Community outreach may help engage many remaining uninsured. A minority of uninsured adults who sought ACA coverage had contact with a provider, community group, or other outreach worker, and many hard-to-reach groups, such as young adults, immigrants, and people with limited English proficiency, require such one-on-one assistance. In 2015, outreach resources will shrink, making these efforts more difficult.

Providing needed services to the remaining uninsured

Clinics and health centers remain core providers for the uninsured and will require ongoing support to serve this population. Safety net providers are likely to play an important, ongoing role in serving the uninsured. However, experts note that these providers are also adapting to meet the changing health care environment, including becoming "providers of choice" to retain patients as they gain coverage.

While some uninsured are able to navigate the system when they need care, most are not and face serious consequences as a result. Experts noted that access to care for the uninsured varies by region within the state. Particularly in rural areas, provider shortages exist for both insured and uninsured people. In addition, not all counties provide services to the undocumented, and those that do vary greatly in the scope of these services. Since people will continue to lack coverage under the ACA, planned efforts to deliver services to the underserved may be necessary.

Improving care for the insured

While most adults with coverage have positive views and experience with their health plan across coverage type, consumer education about health insurance and health care may be needed. According to experts in the state, during outreach, assistors noted that many people appeared to not understand basic aspects of their health plan. While initial outreach efforts were focused on enrollment, education about coverage and health care is the next phase of bringing people into the health care system.

While coverage eases financial strain of health care, many newly insured adults are in precarious financial situations and still report affordability problems. While premium and cost-sharing subsides in Covered California are set at the federal level, continued attention to whether affordability measures are sufficient may provide insight into people's take-up and use of new coverage.

Continued attention is needed to ensure those who have coverage are able to access care. Some newly insured adults still report access barriers. These barriers could be related to several factors, including network adequacy or difficulty finding a provider, problems navigating the health system and insurance networks, misunderstanding of how to use coverage and when to seek care, or concerns about out-of-pocket costs.

Introduction

In January 2014, the major coverage provisions of the 2010 Affordable Care Act (ACA) went into full effect in California and across the country. These provisions include the creation of a new Health Insurance Marketplace, known in the state as Covered California, where middle income families (between around $27,000 and $79,000 for a family of three in 2014) can receive premium tax credits to purchase coverage and, in states like California that opted to expand their Medicaid program, the expansion of Medi-Cal eligibility to low-income adults (about $27,000 or less for a family of three in 2014). With these provisions, millions have gained coverage and access to needed health care services.

While much attention has been paid to enrollment in new coverage options and changes in the uninsured over the past year, less is known about how this coverage has affected people's lives. To help fill this gap, the Kaiser Family Foundation is conducting a series of comprehensive surveys of the low and moderate-income population. These projects include both national surveys and a specific focus on California.

California is a bellwether state for understanding the impact of the ACA. Through a Medicaid waiver, the state was an early adopter of the Medicaid expansion, covering over 650,000 people by 2013 through its Low-Income Health Program (LIHP). The state was also the first to create a state-based Marketplace, and California engaged in an aggressive, multi-faceted outreach and enrollment campaign to reach and enroll individuals eligible for Medi-Cal or Covered California. The state's efforts have led to substantial gains in coverage: Medi-Cal enrollment grew by 30% (2.8 million people) between the pre-open enrollment period in the fall of 2013 and the end of 2014,[2] and roughly 1.7 million people applied and were determined eligible for Covered California health plans between October 2013 and October 2014.[3] In addition, California's sheer size means that the state's experience in implementing the ACA has implications for national goals of reducing the total number of uninsured.

Findings from the 2013 Kaiser Survey of Low-Income Americans and the ACA, fielded prior to the start of open enrollment for 2014 ACA coverage, provided a baseline snapshot of health insurance coverage, health care use and barriers to care, and financial security among insured and uninsured adults at the starting line of ACA implementation and discussed how those findings could inform early implementation.[4] The 2013 survey included both a national sample and a California sample, funded by the Blue Shield of California Foundation. In fall 2014, we conducted a second wave of the Kaiser Survey of Low-Income Americans and the ACA nationally and in California (again with support from the Blue Shield of California Foundation) to understand how these factors have changed under the first year of the law's main coverage provisions. The survey, which included a state-representative sample of 4,555 nonelderly (age 19-64) California adults, was conducted between September 2 and December 15, 2014, with the majority of interviews (67%) conducted prior to November 15, 2014 (the start of open enrollment for 2015 Marketplace coverage; Medicaid enrollment is open throughout the year). In addition to the survey, qualitative interviews were conducted with key stakeholders throughout the state to provide policy context and insight into survey findings. Additional detail on the survey methods is available online.

This report, based on the California sample of the 2014 Kaiser Survey of Low-Income Americans and the ACA, examines the populations that gained coverage and remained uninsured in 2014. It describes the characteristics of these groups in California, comparing them to those who had coverage before 2014. It also

provides information on how the newly insured view their coverage and any problems they have encountered in using their coverage; examines how the remaining uninsured and newly insured fare with respect to access to medical care and financial burden; and analyzes why people in California continue to lack coverage and their plans for obtaining coverage in 2015. Where relevant, the report also includes trended data from 2013.

Background: ACA Implementation in California

As the nation's most populous state, California faced a daunting challenge in expanding coverage under the ACA. Prior to ACA implementation, California had the largest number of uninsured of any state in the country. In 2010, when the ACA was passed, 6.8 million people in the state (or 18.5%) were uninsured,[5] and California alone accounted for 14% of all uninsured people nationwide. 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[6] (which made such coverage unaffordable for many). Public coverage through the state's Medicaid program, Medi-Cal, was limited to only some groups of low-income adults, leaving many without an affordable coverage option. California is also a highly diverse state, with a majority of the population identifying as a race other than White[7] and nearly half of residents speaking a language other than English in the home.[8] Services for the uninsured in the state were largely devolved to California's 58 counties, leading to variation in existing financing and availability of services for residents who lacked insurance coverage or regular care.

Leading up to full implementation of the ACA and during the first year of major coverage expansions, California actively pursued opportunities to expand coverage for residents, conducted outreach and enrollment to bring people into new coverage options, and organized systems to deliver care. While these efforts resulted in substantial coverage gains, the state—like all states—faced some early challenges under the ACA.

Early Implementation Efforts and Coverage Gains

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 for low-income adults not otherwise eligible for Medi-Cal, known as the Low Income Health Program (LIHP). The majority of counties participated in LIHP, and by the end of 2013, over 650,000 people were enrolled in the program.[9] As discussed below, these individuals were either auto-enrolled in Medi-Cal or transferred to Covered California when these options became available in January 2014.[10]

LIHP also enacted innovative strategies to redesign the delivery of health care within California's safety net system, including the development of robust provider networks and the integration of physical and behavioral health care, among others.[11] As part of the "Bridge to Reform" waiver, California was also the first state in the country to adopt the Delivery System Reform Incentive Program (DSRIP) to assist California's safety-net hospitals expand access to primary care, improve care and health outcomes, and increase efficiency.[12]

Even with the availability of coverage through LIHP, millions of Californians lacked coverage at the end of 2013. Some of these individuals are ineligible for assistance due to their immigration status (estimates revealed that about a fifth of uninsured California adults in 2013 were undocumented immigrants[13]), but many were

likely eligible for Medi-Cal or Covered California subsidies. A majority of uninsured adults on the eve of full ACA implementation (52%) had family income below 138% of poverty, and most (71%) were either working themselves or had a spouse who worked. Compared to insured adults in the state, uninsured adults were more likely to be Hispanic and more likely to be young adults. These characteristics helped shape efforts to reach the eligible uninsured in 2014 and provide needed services to the ineligible population.

Medi-Cal Expansion and Covered California

As of January 2014, California expanded Medi-Cal statewide to cover low-income adults. In addition, subsidized coverage was available for moderate income adults who purchased insurance through the state's health insurance marketplace, Covered California.

Under the Medi-Cal expansion, Medi-Cal was extended to all citizens and legal immigrants who have been in the country for over five years with income up to or at 138% FPL ($16,105 for an individual or $27,210 for a family of three in 2014). Eligible lawfully residing immigrant pregnant women in this income range are exempt from the five year waiting period for coverage and can receive full-scope Medi-Cal,[14] and pregnant women with incomes between 109% and 208% FPL are eligible for Medi-Cal pregnancy-only coverage.[15] Income-eligible legal immigrants who have been in the country less than five years became eligible for full-scope, state-only funded Medi-Cal beginning in January 2014 and were scheduled to transition to Covered California in January 2015;[16] however, this transition has been delayed.[17] When the transition takes place, these individuals will receive an affordability wraparound, ensuring that premiums, out-of-pocket costs, and covered services are the same as if they were enrolled in Medi-Cal. Undocumented immigrants who satisfy the income and residency requirements are eligible for limited scope Medi-Cal benefits, including emergency room services, long-term care, kidney dialysis, and prenatal care.[18]

California operates its own insurance marketplace, known as "Covered California," as an independent public agency. 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 between 139% and 400% of poverty are eligible for premium tax credits, and people with incomes between 139 and 250% of poverty are also eligible for cost-sharing subsidies. In addition, small businesses (up to 50 workers) can offer coverage to their workers via Covered California's Small Business Health Options Program (SHOP). 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. Undocumented immigrants are prohibited from purchasing insurance in the Marketplace. Statewide, the average premium rate for the lowest cost Bronze plan was $219 per month in 2014 and $304 per month for the lowest cost silver plan.[19]

Covered California 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, individuals may continue to apply for Medi-Cal through their county Medi-Cal office. Covered California's online application system, also known as the California Health Care Eligibility, Enrollment and Retention System (CalHEERS), coordinates with counties' social services department through an online system called Statewide Automated Welfare Systems (SAWS).

On October 1, 2013, individuals and small businesses could begin shopping for health insurance plans. Coverage purchased through Covered California and coverage under the Medi-Cal expansion started in January 2014. Individuals who had gained coverage under the early LIHP expansion were auto-enrolled in coverage. Specifically, roughly 630,000 LIHP members were auto-enrolled in Medi-Cal, and an additional 25,000 were transitioned into Covered California.[20] Open enrollment for Covered California ended on March 15, 2014 (though applications in progress were granted an extension[21]), while Medi-Cal enrollment was open throughout the year.

Outreach and Enrollment Throughout 2014

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 funds and funds from private foundations, including $23 million from the California Endowment,[22] most of which were distributed to localities, for local outreach efforts. These local outreach efforts included (among other things) support for Medi-Cal Certified Enrollment Counselors, outreach to hard-to-reach populations, and marketing to increase awareness and understanding of new coverage options[23, 24, 25] Experts believe that the local efforts to enroll eligible individuals were a key factor in driving high enrollment rates. In addition, 125 health centers operating over 1,000 sites throughout the state received federal grants to help with outreach and enrollment assistance,[26] and experts noted that these providers were also crucial to enrollment efforts.

Alongside its extensive outreach efforts, California also took various steps to simplify and streamline enrollment. In addition to transitioning people from LIHP to Medi-Cal, the state also uses Hospital Presumptive Eligibility (PE) and adopted the Express Lane Enrollment Project. Under the PE program, hospitals can assist patients who are receiving services in the hospital in applying for temporary Medi-Cal benefits, producing an immediate eligibility determination based on the information provided in the application.[27] The Express Lane Enrollment Project targeted adults and children enrolled in CalFresh, California's Supplemental Nutrition Assistance Program (SNAP). Through a waiver, the state was able to use CalFresh income eligibility to grant Medi-Cal eligibility to CalFresh enrollees without the need for an application or a determination for 12 months.[28]

Despite all these efforts, the state experienced some challenges in enrollment in 2014. Organizations and individuals encountered challenges with the Covered California in-person assister training process, including an insufficient number of training sessions, which led to a shortage of Certified Enrollment Counselors (CECs).[29] In addition, educators and enrollment counselors cited problems with cultural and linguistic resources, including poorly translated materials that left many people confused, and a shortage of linguistically-appropriate materials.[30] Some of these issues were addressed toward the end of open-enrollment and leading up to the second enrollment period, which began in the fall of 2014.[31] In particular, Covered California made improvements to its Spanish-language website, added more bi-lingual employees and held community events in areas with large Hispanic populations.

In addition, though people began applying for coverage on October 1, 2013, the interface between CalHEERS and SAWS was not functional until late January 2014,[32] thus delaying the enrollment process for consumers and health plans. A combination of technological issues as well as pending documentation on the part of applicants resulted in a Medi-Cal backlog of approximately 900,000 applications by May 2014. The agency did its best to work through these applications; however, as recently as February 2015, roughly 45,000 applications were still awaiting eligibility determinations.[33]

The Covered California website also contained small technical glitches across both the English and Spanish versions of the site that sometimes made navigating the site difficult or impossible. For example, the site would shut down while undergoing updates. Consumers and counselors reported long waits when seeking assistance through Covered California's telephone hotlines, and counselors reported dropped calls while waiting to be transferred to multilingual call center representatives.[34] The agency received criticism for not offering the Spanish-language paper applications until half-way through open-enrollment, posing a problem for users who did not have access to high-speed internet.[35]

These challenges notwithstanding, the state enrolled unexpectedly large numbers of people in 2014. By October 2014, nearly 1.7 million people applied and were determined eligible for Covered California health plans, doubling base projections of 816,000[36] and representing about half of the marketplace-eligible population.[37] The vast majority (83%) of people who enrolled received financial assistance (compared to 85% nationally).[38] Los Angeles County alone accounted for over 400,000 enrollees.[39] More than half of all enrollees into Covered California received enrollment help from a Certified Insurance Agents (36%), Certified Enrollment Counselor (8%), Service Center Representatives (10%), or other assister or navigator.[40] Though ten health insurance companies offered plans in the Marketplace, the vast majority of people in Covered California chose a plan offered by one of the state's four largest insurers—Anthem, Blue Shield of California, Kaiser Permanente or Health Net.[41]

Enrollment in the Medi-Cal program grew by 30%, or 2.8 million people, between October 2013 and the end of 2014.[42] Of the approximately 1.9 million who enrolled in Medi-Cal between October 2013 and the end of the open enrollment period (March 15, 2014), 1 million applied through the Covered California portal and county offices, 630,000 transitioned from LIHP, and 180,000 applied through the state's Express Lane Program.[43] While some enrollees may have been eligible for Medi-Cal before the ACA, more than half (59%) are likely newly-eligible under the expansion.[44]

Despite the various challenges, California made substantial gains in reaching and enrolling millions of people throughout the state during the first year of coverage expansions under the ACA. In 2015, the state is building on these gains and addressing many of the issues that arose in the first year.

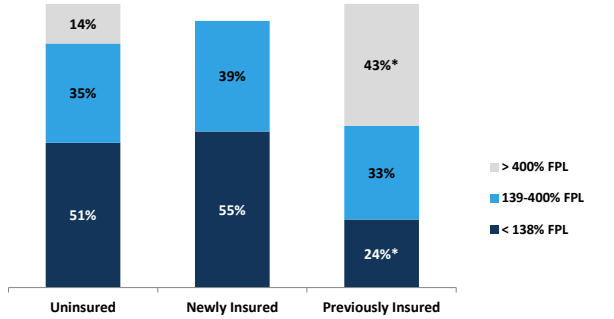
Who gained coverage and who remained uninsured?

In many ways, the "newly insured" population (those who gained coverage in 2014 and were uninsured before gaining that coverage) and "remaining uninsured" population (those who lacked coverage in fall 2014) resemble each other. For example, they are similar with respect to income, age, and health status, and they have different characteristics from the "previously insured" population (people who had coverage before 2014 and still had it in 2014). These patterns likely reflect the characteristics of the population that has historically

lacked coverage. However, the insured and uninsured populations in California differ on some important factors, such as race/ethnicity, work status, gender, immigration status, and family status. These differences are important to understanding who was left out of coverage expansions in 2014 and targeting ongoing outreach to the remaining uninsured.

More than half of the newly insured and remaining uninsured populations have family income at or below 138% of poverty, the income range for the Medicaid expansion. As was the case before 2014,[45] more than half of uninsured adults (51%) have family incomes at or below 138% of poverty, or about $27,000 for a family of three. Over a third (35%) has family incomes in the range for tax credits (139 to 400% of poverty). This distribution is similar to the newly insured population, the vast majority of whom (94%) had incomes in the range for financial assistance under the ACA. In contrast, the previously insured population is significantly less likely than either the uninsured or newly insured to be low-income and significantly more likely to be higher income (greater than 400% of poverty). This pattern reflects the longstanding association between having low income and lacking insurance coverage. Provisions in the ACA aim to make coverage more affordable for low and middle-income families.

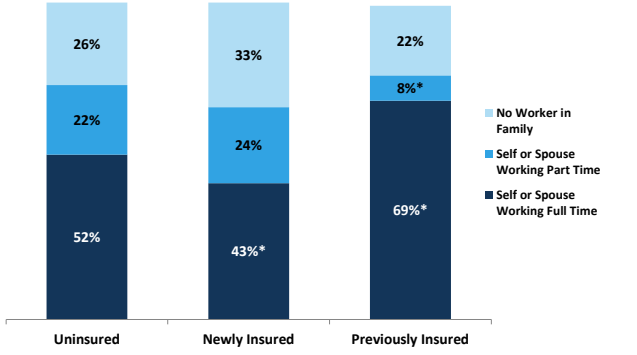
Figure 1
Income Distribution Among Nonelderly Adults in California, by Insurance Coverage in Fall 2014



NOTES: Includes adults ages 19-64. The federal poverty level (FPL) in 2014 was $27,210 for a family of three. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "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. Totals may not sum to 100% due to rounding. Share of newly insured with incomes >400% FPL not shown because estimate does not meet standard for statistical reliability.
* Significantly different from Uninsured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

A majority of both the remaining uninsured and newly insured are in a family with at least one worker. Nearly three quarters of uninsured adults are in a family in which either they or their spouse is working, a pattern that has held since before the ACA.[46] More than half (52%) are in a family with a full-time worker. While there is no difference in the share of newly insured adults in a working family overall, newly insured adults are less likely than remaining uninsured adults to be in a family with a full-time worker. Those who have been insured since before 2014 are more likely to have a full-time worker and less likely to have a part-time worker in the family. These patterns reflect the historical ties between work and health insurance, since most people who had coverage before the ACA obtained that coverage through a job. With new coverage provisions in place as of 2014, there were more options for health insurance outside employment, and groups traditionally left out of the employer based system—such as part-time workers or low-wage workers—had new avenues for coverage.

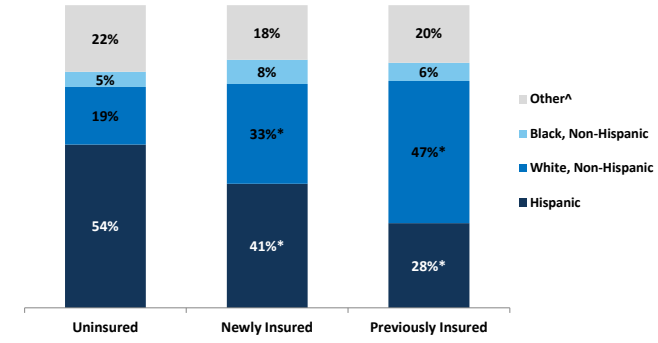
Figure 2
Family Work Status Among Nonelderly Adults in California, by Insurance Coverage in Fall 2014



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. "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. Those who refused or did not know answers to work status questions not shown. * Significantly different from Uninsured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Hispanics are disproportionately represented among the remaining uninsured population. Reflecting historical patterns of the uninsured being more likely to be people of color than the insured,[47] the remaining uninsured and the newly insured are both more likely than the previously insured to be Hispanic and less likely to be White. However, the remaining uninsured population is more likely to be Hispanic than either the newly insured or previously insured population: 54% of the remaining uninsured population is Hispanic, a share significantly higher than among the newly insured or previously insured. This pattern likely reflects a combination of factors, including language barriers and immigration policy. Experts believe that lower enrollment among Hispanics may be related to the delay in having accurate Spanish-language enrollment materials.[48] Another notable barrier was fear among some mixed-immigration status families that applying for coverage for eligible family members may expose other family members to risk of deportation. Last, the higher share of remaining uninsured who are Hispanic may reflect eligibility limits based on immigration status.

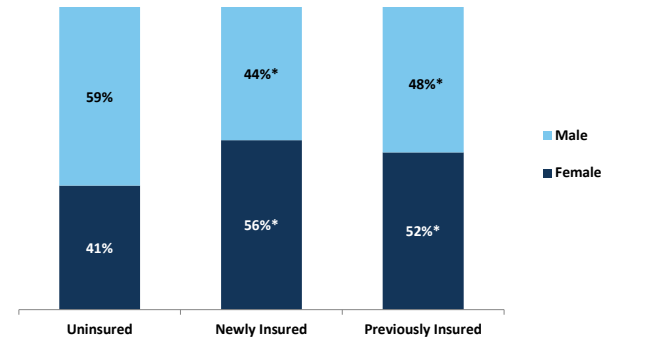
Figure 3
Race/Ethnicity of Nonelderly Adults in California, by Insurance Coverage in Fall 2014



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. "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. ^Comprises Asian, Pacific Islander, American Indian, Alaskan Native, "Other", and "Don't Know."
* Significantly different from Uninsured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

The newly insured population is more likely to be female than their counterparts who remained without coverage. More than half (56%) of the newly insured population is female, a share significantly higher than that among the remaining uninsured (41%) but not significantly different from the previously insured. This pattern may reflect different take-up rates between men and women: Compared to 2013, the uninsured population in 2014 is more likely to be male.[49] Women have historically had a lower uninsured rate than men, and the gender patterns in who gained coverage in California may reflect this historical and national pattern.[50]

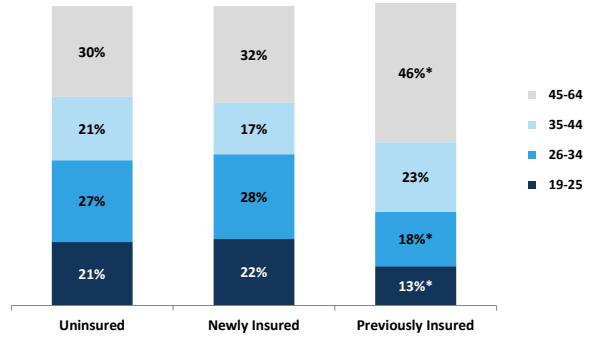
Figure 4
Gender of Nonelderly Adults in California, by Insurance Coverage in Fall 2014



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. "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.

The remaining uninsured population is of similar age distribution as adults who gained coverage in 2014. While many were concerned that younger adults would disproportionately opt not to enroll in coverage, the share of uninsured and newly insured who were young adults (age 19-25) were about the same, and the share of the uninsured who were young adults in 2014 was the same as in 2013.[51] However, both the uninsured and the newly insured populations were younger than the group of adults who were previously insured. About a fifth of the uninsured (21%) and newly insured (22%) populations were young adults, ages 19 through 25, compared to just 13 percent of the previously insured. About half of the uninsured and about half of the newly insured were under age 35, compared to just 31 percent of the continuously insured. This pattern reflects the fact that those who lacked coverage prior to 2014 were more likely to be young, since younger adults have looser ties to employment and lower incomes.

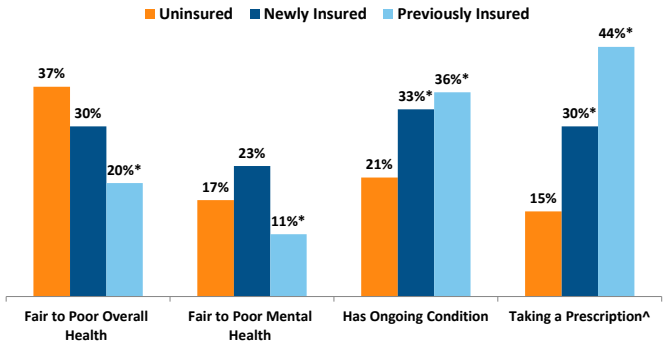
Figure 5
Age of Nonelderly Adults in California, by Insurance Coverage in Fall 2014



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. "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.

While there are no significant differences in the share of uninsured and newly insured adults who say their health is fair or poor, uninsured adults are less likely than adults with coverage to have a diagnosed medical condition. Compared to 2013, the uninsured in 2014 have a similar health profile;[52] more than a third of uninsured adults (37%) and 30% of newly insured adults rate their overall health as fair or poor, in contrast to just 20% of previously insured adults. About a fifth (17% of uninsured and 23% of newly insured) report their mental health is fair or poor, compared to just 11% of the previously insured. However, the remaining uninsured are less likely than either the newly insured or previously insured to report being under care for a chronic condition: Insured adults are more likely than the uninsured to say that they have an ongoing medical condition that requires regular care, and both newly insured and previously insured adults are more likely than the uninsured to say they take a prescription on a regular basis. Comparing the newly insured and previously insured populations reveals that the previously insured are less likely to report fair/poor physical or mental health and are more likely to take a prescription. These patterns may reflect the fact that uninsured individuals are more likely than insured to have undiagnosed illnesses,[53] and people with stable insurance coverage are more likely to receive regular and specialty care.[54]

Figure 6
Health Status Among Nonelderly Adults in California, by Insurance Coverage in Fall 2014



NOTE: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "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. ^Does not include birth control.
* Significantly different from Uninsured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

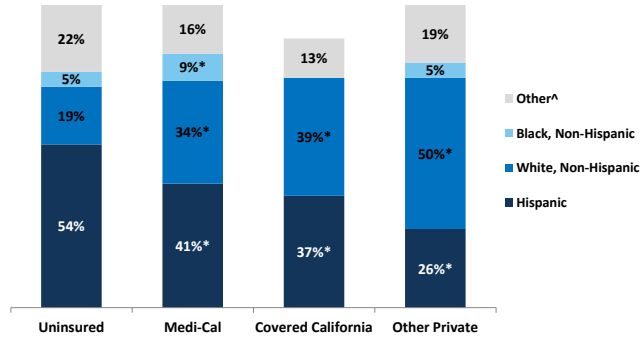
Who is covered by different programs in California?

Understanding the profile of the population covered by different types of insurance in the state is essential to designing effective health plans to serve their needs. Historically, the adult population served by Medicaid was primarily made up of parents with very low incomes, individuals with disabilities, and pregnant women. With the expansion of Medi-Cal, the program grew to include individuals not traditionally covered by the program (such as non-disabled, non-parents), which has changed the profile of the overall program somewhat. However, given that new enrollment built off a much larger base, Medi-Cal retains many of its traditional roles of serving many individuals with substantial needs. The profile of Covered California enrollees shows that the program is playing an essential role in covering groups that have been left out of coverage expansions in the past.

Medi-Cal and Covered California enrollees are more racially diverse than the group of Californians with other private coverage. As in the past, a majority (two-thirds) of Medi-Cal enrollees identify as a person of color: 41% are Hispanic, 9% are Black, and 16% identify as Asian, Pacific Islander, American Indian, Alaskan Native, or other race. Covered California enrollees are also racially diverse, with 60% identifying as a race/ethnicity other than white, 37% of whom are Hispanic. In contrast, about half of adults with other private coverage in the state are White, non-Hispanic. This diversity indicates the need for these programs to design culturally-appropriate outreach and enrollment materials and to be sensitive to cultural issues in designing coverage and provider networks. It also highlights the importance of these programs for addressing long-standing disparities in health coverage and access for minority populations.

Figure 7

Race/Ethnicity of Nonelderly Adults in California, by Insurance Type in Fall 2014

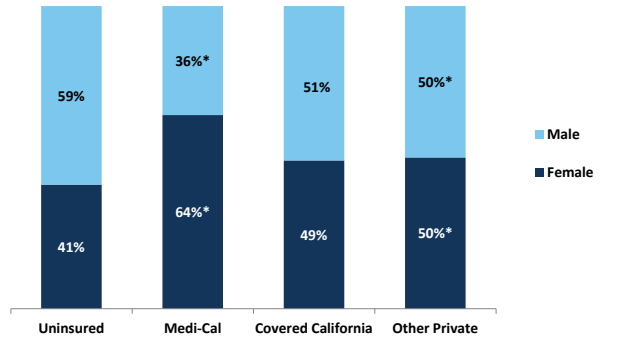


NOTES: Includes adults ages 19-64. "Uninsured" includes people who lacked coverage as of the interview date. ^Comprises Asian, Pacific Islander, American Indian, Alaskan Native, "Other", and "Don't Know."
* Significantly different from Uninsured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Medi-Cal enrollees are more likely to be female than adults with other types of coverage. Whereas about half of adults with Covered California or other private coverage are female, nearly two-thirds (64%) of adults covered by Medi-Cal are female, a share equivalent to that in 2013.[55] This difference may reflect pre-ACA eligibility restrictions for Medi-Cal, which limited adult coverage to custodial parents, pregnant women, and individuals with disabilities.

Figure 8

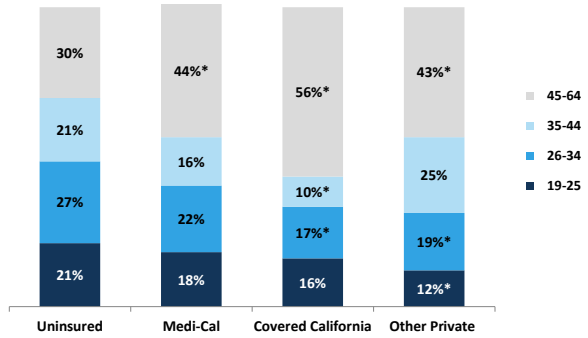
Gender of Nonelderly Adults in California, by Insurance Type in Fall 2014



NOTES: Includes adults ages 19-64. "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.

The adult Medi-Cal population is younger than that of other coverage groups, particularly Covered California enrollees. Forty percent of adult Medi-Cal enrollees are under age 34, compared to about a third of adults in Covered California or with other private coverage. Since 2013, the share of adults covered by Medi-Cal who are under age 34 has increased.[56] This pattern may reflect income, since younger adults have looser ties to employment and thus lower incomes. Notably, more than half of adults enrolled in Covered California are over age 45, an age at which obtaining non-group coverage outside the Marketplace or without financial assistance could be difficult or costly.

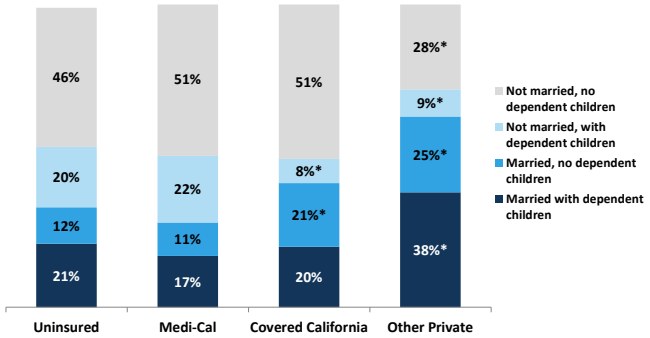
Figure 9
Age of Nonelderly Adults in California, by Insurance Type in Fall 2014



NOTES: Includes adults ages 19-64. "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.

A majority of adult enrollees in both Medi-Cal and Covered California are adults without dependent children, a group that has generally been excluded from publicly-financed health coverage in the past. More than six in ten (62%) adult Medi-Cal enrollees and more than seven in ten (72%) adult Covered California enrollees do not have dependent children. In the past, adults without dependent children could only qualify for Medi-Cal if they were disabled or pregnant, though many non-parent adults gained LIHP coverage before 2014. Adults with other private coverage in 2014 were most likely to be married, perhaps reflecting the availability of family coverage in the private market.

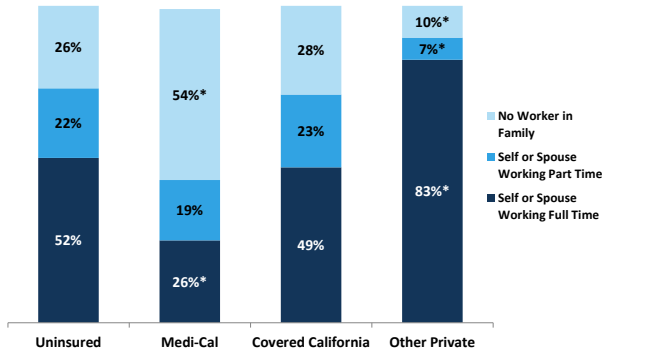
Figure 10
Family Status of Nonelderly Adults in California, by Insurance Type in Fall 2014



NOTE: Includes adults ages 19-64. "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.

About half of Medi-Cal and nearly three-quarters of Covered California adults are in a working family. Because Medi-Cal is designed to reach people at the lowest end of the income spectrum, it is not surprising that a smaller share of adults covered by the program is in a working family than that for other types of coverage. About a quarter (26%) of Medi-Cal adults are either working full-time or have a spouse who works full-time, and about a fifth (19%) are working part-time or have a spouse who works part-time. Given these individuals' low incomes, they are likely working in jobs that pay low wages, and they are unlikely to have access to coverage through their job. Notably, the share of adults with Medi-Cal coverage

Figure 11
Family Work Status Among Nonelderly Adults in California, by Insurance Type in Fall 2014



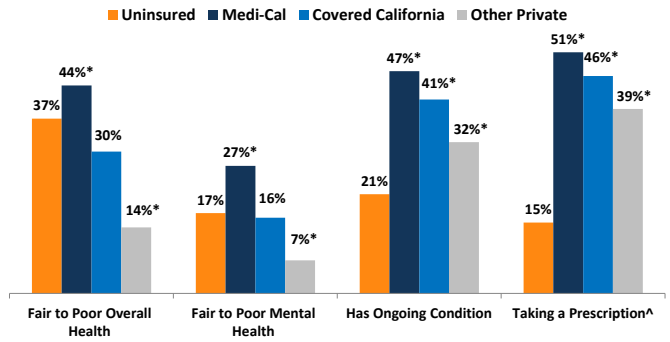
NOTES: Includes adults ages 19-64. "Uninsured" includes people who lacked coverage as of the interview date. Those who refused or did not know answers to work status questions not shown. * Significantly different from Uninsured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

who are in a working family increased significantly between 2013 and 2014,[57] reflecting both new eligibility pathways for working adults and the improving economy. A larger share of adults in Covered California are in a family with a full-time (49%) or part-time (23%) worker; to meet eligibility for subsidized coverage, these individuals do not have access to affordable coverage through a job. Not surprisingly, most people with other private coverage are working.

Reflecting Medi-Cal's role in caring for people with substantial health needs, Medi-Cal enrollees have poorer health status than adults with other types of coverage. Medi-Cal beneficiaries were more likely than adults with other types of coverage to say their physical health or mental health was fair or poor; they were also more likely to have an ongoing health condition or be taking a prescription on a regular basis. As Medi-Cal's scope has expanded under the ACA, the share who report health problems has declined significantly.[58] Covered California adults were more likely to have health problems than adults with private health coverage; many of these adults were uninsured before gaining coverage and may have health problems that accumulated while they lacked coverage.

Figure 12

Health Status Among Nonelderly Adults in California, by Insurance Type in Fall 2014



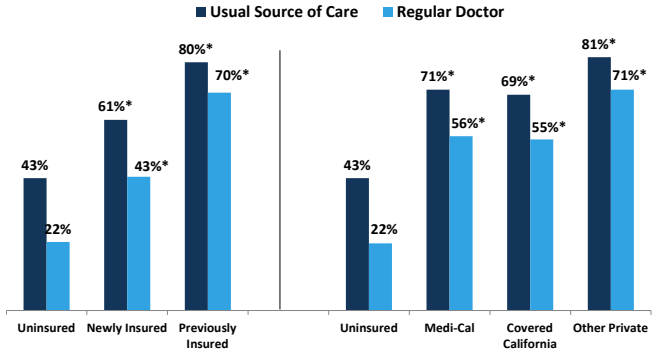
NOTE: Includes adults ages 19-64. "Uninsured" includes people who lacked coverage as of the interview date. ^Does not include birth control. * Significantly different from Uninsured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

What has happened to access to care for the insured and remaining uninsured?

The ultimate goal of expanding health insurance coverage is to help people access the medical services that they need. A large body of literature has documented that people with insurance are more likely to be linked to regular care, are less likely to postpone care when they need it, and have an easier time accessing services. The survey findings reinforce those findings, indicating that adults who gained coverage in 2014 have better access to care than those who remained without coverage. In addition, the survey findings provide insight into patterns of care among the newly insured and remaining uninsured. While some newly insured adults changed where they regularly go for care, many continue to seek services from community clinics and health centers, which have historically served under-served populations such as the uninsured.

Adults who gained coverage are more likely to be linked to care than those who remained uninsured. Newly insured adults were more likely than those who remained uninsured in fall 2014 to have a usual source of care, or a place to go when they are sick or need advice about their health (not counting the emergency room); they were also more likely to have a regular doctor at their usual source of care. Previously insured adults were also more likely than the uninsured to have a regular site of care and regular provider. These findings hold across coverage type. Having a usual source of care or regular doctor is an indicator of being linked to the health care system and having regular access to services. These patterns reinforce a large body of research that finds that gaining coverage is associated with improved access to care. However, results also indicate that the newly insured are less likely than the previously insured to have a usual source of care or regular doctor. This finding may indicate that newly insured adults are still navigating the health care system and are not as settled into regular care as their previously insured counterparts. Compared to 2013, there was no change in the share of Medi-Cal enrollees who reported having a usual source of care or regular doctor, while uninsured adults in 2014 were less likely than those in 2013 to say they have a usual source of care (but not a regular doctor).[59]

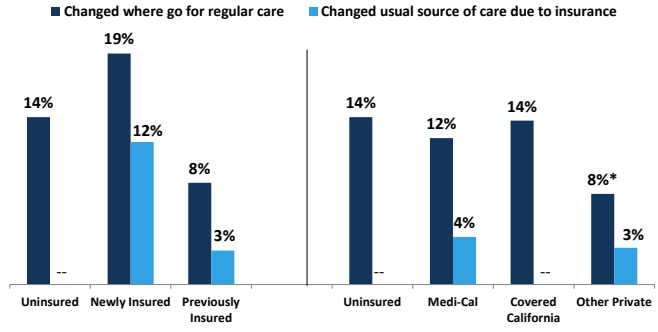
Figure 13
Share of Nonelderly Adults in California with a Usual Source of Care or Regular Provider, by Insurance Coverage and Type in Fall 2014



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. "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. "Usual Source of 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.

Newly insured adults were more likely to change where they usually go for care than their previously insured counterparts. Nearly a fifth (19%) of newly insured adults who have a usual source of care reported that they changed the place they usually go for care since gaining their coverage. Uninsured adults in 2014 were not significantly more likely to say they changed their usual source of care compared to uninsured adults in 2013, and there were no significant differences between the rates of uninsured and newly insured adults changing their usual source of care in 2014. However, newly insured adults in 2014 were more likely than previously insured adults to change their usual source of care. Most newly insured adults who changed their site of care reported that it was due to their insurance, a significantly higher rate than the previously insured. There were no significant differences in the likelihood of Medi-Cal or Covered California enrollees changing their usual source of care, and Medi-Cal enrollees in 2014 were no more likely than those in 2013 to say they changed where they usually go for care.

Figure 14
Change in Usual Source of Care Among Nonelderly Adults in California, by Insurance Coverage and Type in Fall 2014
Among those with a usual source of care, share who:



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. "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. "Usual Source of Care" does not include care received at an emergency department. *Significantly different from Uninsured at the p<0.05 level. Missing values are not shown because estimate does not meet standard for statistical reliability.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

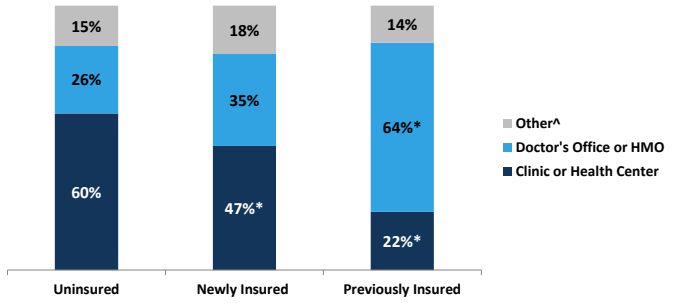
Clinics remain an important source of care for both the uninsured and the newly insured. Both uninsured and newly insured adults with a usual source of care are most likely to use a clinic or health center for that care. In contrast, previously insured adults were most likely to use a doctor's office or HMO as their usual source of care. Historically, clinics and health centers were crucial "safety net" providers for uninsured

people, and the share of uninsured adults using clinics as their usual source of care was unchanged since 2013. Though some of the newly insured have changed their source of care, many continue to rely on these providers. Experts in the state note that this pattern could reflect community health centers' efforts to retain patients after helping them enroll in health coverage or patient preferences for these providers, which have a strong tradition and mission of culturally competent care and community environments. According to policy experts from county health systems, this pattern also may reflect lack of understanding of new health care options among the newly insured.

Figure 15

Type of Place Used for Usual Source of Care Among Nonelderly Adults in California, by Insurance Coverage in Fall 2014

Among those with a usual source of care, share using:

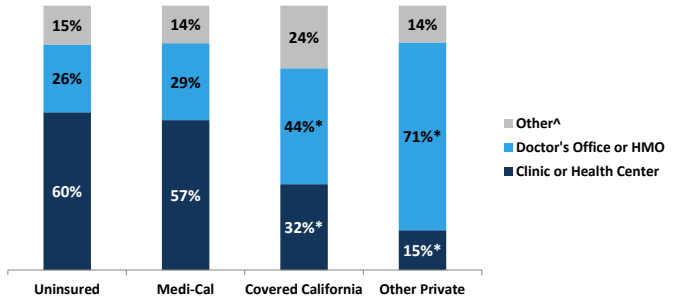


NOTES: Includes adults ages 19-64. "Other" includes urgent care centers, hospital outpatient departments, some other location, and don't know/refused. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked coverage as of the interview date. "Usual Source of 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 16

Type of Place Used for Usual Source of Care Among Nonelderly Adults in California, by Insurance Type in Fall 2014

Among those with a usual source of care, share using:



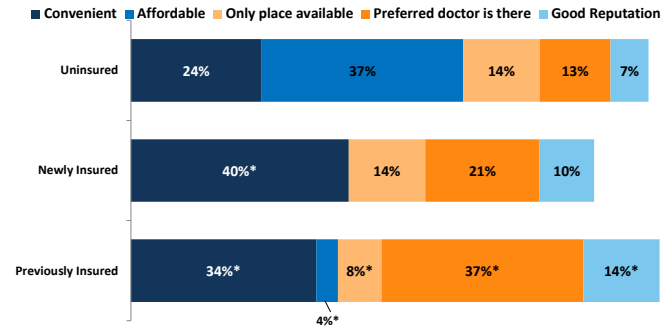
NOTES: Includes adults ages 19-64. "Other" includes urgent care centers, hospital outpatient departments, some other location, and don't know/refused. "Uninsured" includes people who lacked coverage as of the interview date. "Usual Source of Care" does not include care received at an emergency department. *Significantly different from Uninsured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Comparing site of care by type of coverage reveals that those enrolled in Covered California (44%) or other private coverage (71%) were more likely than Medi-Cal enrollees (29%) to choose a doctor's office as their usual source of care, with adults with other private coverage most likely to do so. Medi-Cal enrollees were most likely to use clinics or health centers for their usual care (57%). This pattern is in line with pre-ACA patterns, which showed that a plurality of adults with Medi-Cal used clinics or health centers for their regular care.[60] Comparing the 2013 and 2014 surveys indicates that a significantly larger share of Medi-Cal adults with a usual source of care is relying on clinics. This change could indicate that, as uninsured adults gain Medi-Cal coverage, they still use the clinics and health centers that they relied on when they were uninsured.

Uninsured adults are most likely to choose their site of care based on affordability, whereas newly insured adults are most likely to choose based on convenience. In the past, many uninsured adults reported that they chose their usual source of care because it was affordable, a pattern that is also seen among adults who were uninsured in 2014. More than a third (37%) of uninsured adults say they use their usual source of care because it is affordable, a share not significantly different than the uninsured in 2013 reported. In contrast, adults who gained coverage in 2014 were more likely to say they chose their usual source of care because it was convenient (40%). Previously insured adults were most likely to choose their site of care because their preferred provider is there (37%). As the newly insured establish relationships with a regular doctor at their usual source of care, it is possible that they too will begin to seek out routine care at a place where their preferred doctor is available.

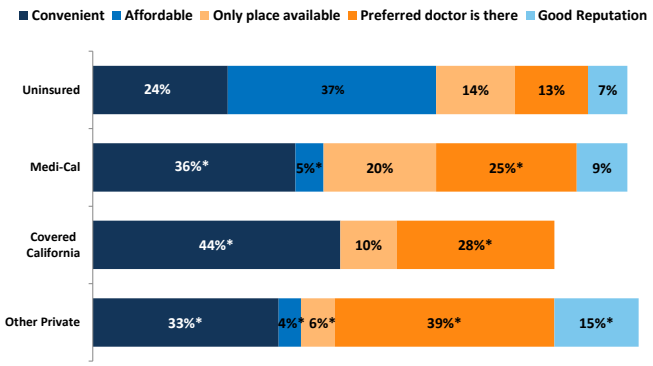
Looking at reason for choosing site of care by coverage, Medi-Cal enrollees were more likely than those in Covered California and other private insurance to report choosing their usual source of care because it was the only place available. Ten percent of Covered California enrollees reported choosing their usual source of care because it was the only place available, compared with 20% of Medi-Cal enrollees and 6% of those with other private insurance. Though Medi-Cal managed care plans are held to state standards of network adequacy and patient access, experts report that low reimbursement rates make contracting with providers difficult, especially in rural areas. There was no change from 2013 to 2014 in the share of Medi-Cal enrollees who reported they chose their usual source of care because it is the only place available. According to a state Medicaid expert, long-standing federal and state standards of network adequacy have required managed care plans to grow their network to meet demand in the past and will continue to do so as needed.

Figure 17
Main Reason for Choosing Usual Source of Care Among Nonelderly Adults in California, by Insurance Coverage 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. "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. "Usual Source of Care" does not include care received at an emergency department. *Significantly different from Uninsured at the p<0.05 level. Missing values are not shown because estimate does not meet standard for statistical reliability.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

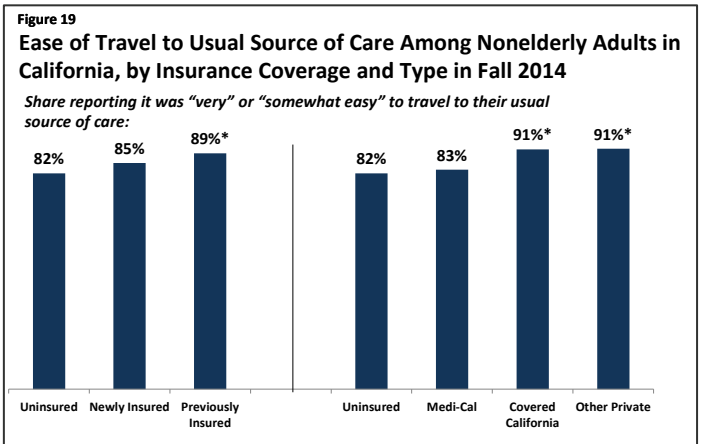
Figure 18
Main Reason for Choosing Usual Source of Care Among Nonelderly Adults in California, by Insurance Type in Fall 2014



NOTES: Includes adults ages 19-64. "Uninsured" includes people who lacked coverage as of the interview date. "Usual Source of Care" does not include care received at an emergency department. *Significantly different from Uninsured at the p<0.05 level. Missing values are not shown because estimate does not meet standard for statistical reliability.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Uninsured adults and newly insured adults report greater difficulty than previously insured adults in traveling to their regular site of care. Among adults with a usual source of care, most report that it is "very easy" or "somewhat easy" to travel there. However, there was no significant difference in the share of newly insured and uninsured adults who reported ease in traveling to care, while previously insured adults were more likely than uninsured to report ease of traveling to care. Within types of coverage, adults with Covered California and other private coverage were more likely than the uninsured to say it was easy to travel to care. These patterns may reflect the need for the uninsured to find a source of care that is affordable, which may require farther travel. In addition, those with private coverage were also more likely than those with Medi-Cal to report ease of travel to their usual source of care. Taken together, these findings also suggest that the difference may be due to lower provider density in areas where those with the lowest incomes live or the need for lower-income people to rely more heavily on public transit than their own vehicle. There was no change from 2013 to 2014 in the

Figure 19
Ease of Travel to Usual Source of Care Among Nonelderly Adults in California, by Insurance Coverage and Type in Fall 2014



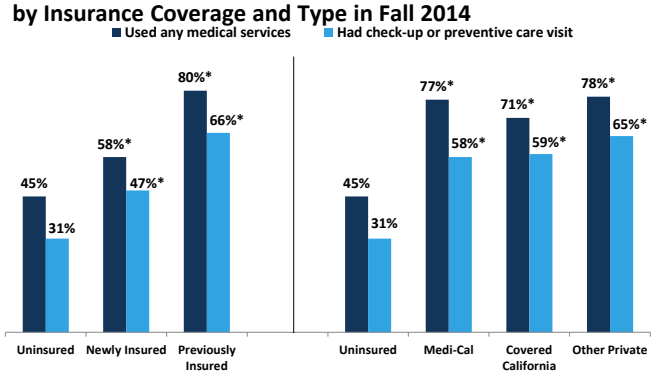
NOTES: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked coverage as of the interview date. "Usual Source of 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.

share of uninsured or Medi-Cal enrollees reporting difficulty traveling to their usual source of care.

Mirroring patterns for being linked to care, adults with insurance coverage were more likely than the uninsured to have used medical services or received preventive care. More than half (58%) of adults who gained coverage in 2014 said that they used at least one medical service since gaining their coverage, and nearly half (47%) had received a preventive visit or check-up. These rates were significantly higher than those the uninsured reported for 2014 but were lower than the previously insured reported for 2014. There were no differences in the share of adults reporting visits by coverage type, with the exception of adults with other private coverage being more likely than adults with Medi-Cal to have a preventive visit. Again, these findings are not unexpected given the large body of research showing that people without insurance coverage are less likely to use care, including preventive care. Compared to 2013, Medi-Cal beneficiaries were less likely to report using care but no more or less likely to report using preventive care. Among uninsured adults, there were no changes in utilization rates between 2013 and 2014.

Figure 20

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



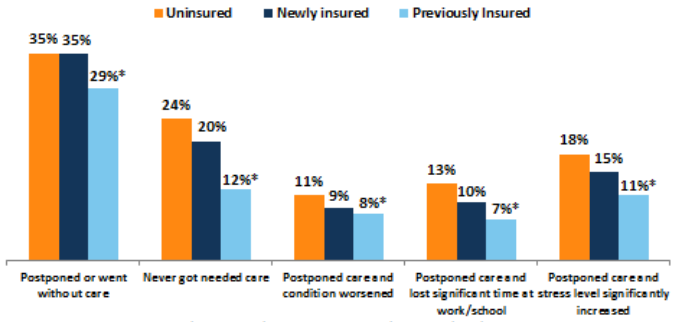
NOTES: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked 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.

Still reflecting some unmet need, many newly insured adults reported postponing or delaying needed services. More than a third of newly insured adults (35%) reported that they postponed or went without needed care since gaining their coverage, the same share as the uninsured and a higher share than the previously insured. Similar patterns were seen for the shares reporting that they never received care or that postponing care had negative consequences such as a condition worsening, loss of time at work or school, or substantial stress. When comparing these outcomes by type of coverage, similar patterns persist, though Covered California enrollees were less likely than uninsured adults or adults in Medi-Cal to say that they never received the care they needed or that postponing care led them to miss work or school. Notably, Medi-Cal enrollees were *more* likely than uninsured adults to report postponing needed care; this outcome may be due to Medi-Cal enrollees' poorer health status and the greater frequency with which they may need complex services. People with a large number of complex needs may be more likely to encounter access barriers for some services than those with more limited needs. Compared to 2013, Medi-Cal enrollees in 2014 were no more likely to say they postponed care and were less likely to say that their condition worsened or their stress increased as a result of postponing care. The high rates of unmet need among the uninsured corroborate existing evidence that this group goes without needed care due to cost, though the uninsured in 2014 were less likely to postpone care than the uninsured in 2013. Among those who do have coverage, postponing care could be related to several factors, including difficulty finding a provider, problems navigating the health system and health insurance networks, misunderstanding of how to use coverage and when to seek care, or concerns about out-of-pocket costs.

Figure 21

Unmet Need for Care Among Nonelderly Adults in California, by Insurance Coverage in Fall 2014

Share reporting:

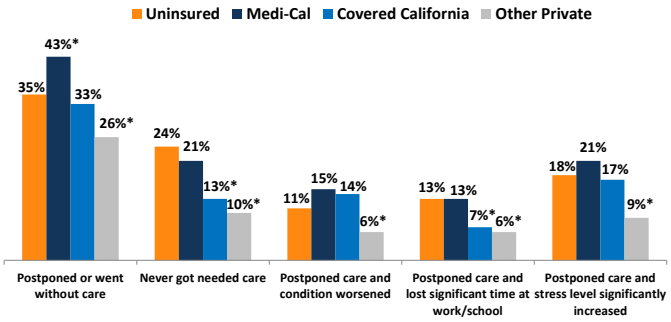


NOTES: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked 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.

Figure 22

Unmet Need for Care Among Nonelderly Adults in California, by Insurance Type in Fall 2014

Share reporting:



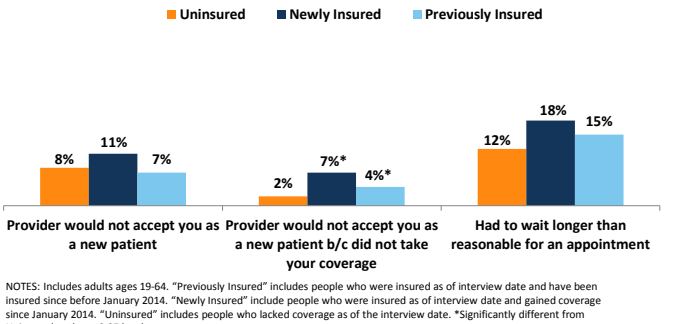
NOTES: Includes adults ages 19-64. "Uninsured" includes people who lacked coverage as of the interview date. *Significantly different from Uninsured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Though most adults did not report problems getting appointments, some insured adults say a provider would not take them as a patient due to coverage. Though a very small share (7%) of newly insured or previously insured (4%) adults reported this problem, both these groups were more likely than the uninsured to say a provider would not accept them as a patient due to coverage. The low rates of these problems among the uninsured (2%) likely reflect this group's lower propensity to seek care, as detailed elsewhere, although uninsured adults in 2014 were more likely than those in 2013 to say they were told a provider would not take them as a patient. There were no significant differences in the share reporting not being taken as a new patient for any reason or reporting having to wait longer than they thought reasonable for an appointment. However, when examined by type of coverage, differences do emerge, with adults in Covered California or Medi-Cal being more likely to report being told that a provider would not take them as a patient than adults with other private coverage. Medi-Cal enrollees in 2014 were no more likely to say a provider would not take them as a patient than those in 2013. Like the forces underlying choice of usual source of care, these issues may reflect continuing problems with network adequacy, despite the existence of state standards for network adequacy and patient access.

Figure 23

Problems Getting Medical Appointments Among Nonelderly Adults in California, by Insurance Coverage in Fall 2014

Share reporting:

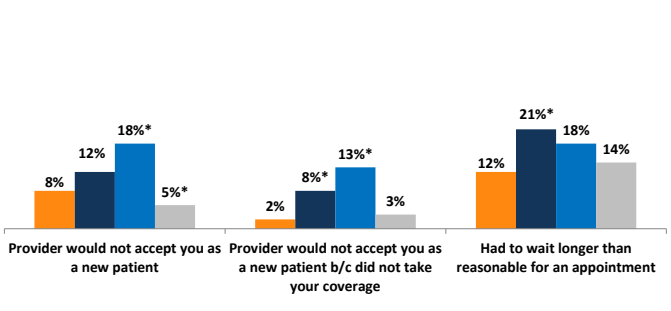


NOTES: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. "Uninsured" includes people who lacked 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.

Figure 24

Problems Getting Medical Appointments Among Nonelderly Adults in California, by Insurance Type in Fall 2014

Share reporting:

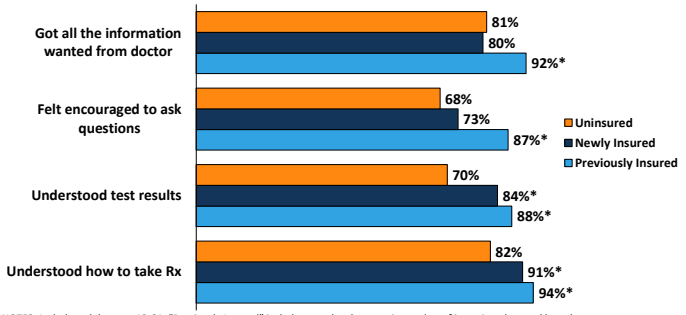


NOTES: Includes adults ages 19-64. "Uninsured" includes people who lacked coverage as of the interview date. *Significantly different from Uninsured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Among adults who received care, most adults across coverage types report effective communication with their providers about their care. Once people get into care, health literacy—or "patients' ability to obtain, process, and understand the basic health information and services they need to make appropriate health decisions"[61]—plays an important role in how that care affects health outcomes. Health literacy depends on a range of factors related to patients (e.g., engagement in care), providers (e.g., how the information is communicated), service setting (e.g., the length of time of the interaction), and the nature of the visit (e.g., the complexity of health information). Survey results reveal that both previously insured and newly insured both reported understanding their test results or how to take their medication either "always" or "most of the time" that they saw a provider in higher proportions than the uninsured. However, on outcomes of getting all the information you wanted from the provider or feeling encouraged to ask questions, the newly insured were no more likely than the uninsured to report experiencing these always or most of the time.

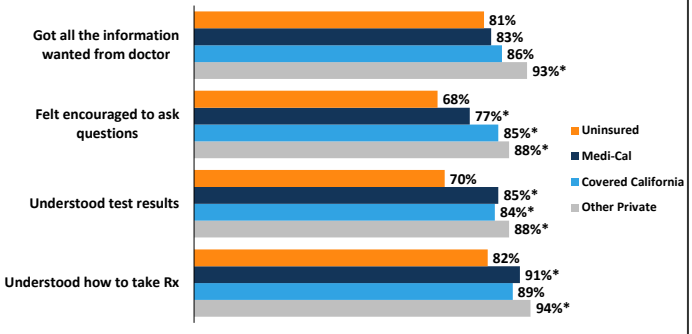
Comparing results by coverage type reveals few differences, though Medi-Cal enrollees were less likely than adults with other private coverage to report getting all the information they wanted or feeling encouraged to ask questions. A statewide analysis of consumer ratings of doctor communication for all health plans found that Medi-Cal managed care plans received a "poor" rating relative to national benchmarks and thresholds, but ratings varied greatly across plans.[62] This pattern may stem from income differences between the groups, since low-income Californians are less likely than higher-income Californians to give high ratings of communication with their provider, patient satisfaction, or patient engagement.[63] Gaps in patient-satisfaction and engagement stem from low-income Californians reporting lower rates of feeling connected to the health care system or to seeing the same provider over time.[64]

Figure 25
Effective Communication with Providers Among Nonelderly Adults in California, by Insurance Coverage 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. "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.

Figure 26
Effective Communication with Providers Among Nonelderly Adults in California, by Insurance Type in Fall 2014



NOTES: Includes adults ages 19-64. "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.

How do people view their coverage?

People's views of their plan may affect not only their use of their coverage but also the likelihood that they re-enroll in coverage or change plans. Survey results reveal that newly insured adults were very sensitive to cost in choosing their plan, placing a priority on cost over benefits and provider networks. A minority of all insured adults reported problems in selecting their plan or using their plan. However, newly insured adults were more likely than previously to say they do not understand the details of their plan and were more likely to give their

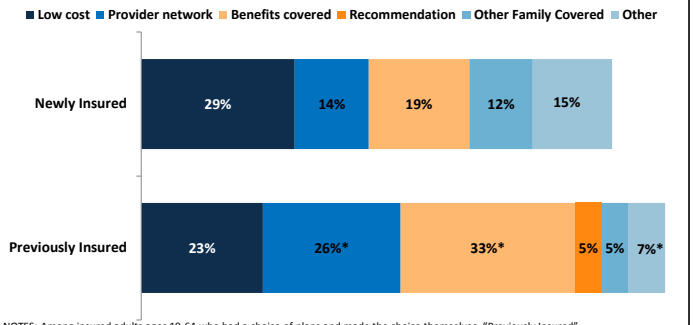
plan a low rating. These findings indicate that additional education may be needed to help people understand their coverage.

Newly insured adults were less likely to prioritize scope of coverage or provider networks in choosing their plan than previously insured adults. Among adults who say they had a choice of plans and made the choice themselves, less than a fifth (19%) of newly insured adults say they chose their plan because of the benefits covered, compared to 33% of previously insured adults, and only 14% say they chose their plan based on provider network (versus 26% of previously insured). Newly insured adults were most likely to say they chose their plan because of low cost (29%); while this share was higher than the previously insured (23%), the difference was not statistically significant. Newly insured adults may have been less likely to choose based on benefits because new regulations set a minimum scope of coverage across new plans (so-called "essential health benefits"), but "grandfathered" pre-existing plans are not held to the same requirement. Alternatively, newly insured adults may be more sensitive to price than their previously insured counterparts, even with the availability of financial assistance for coverage.

Price was a particularly important factor in choice of plans among Covered California enrollees, 37% of whom said they chose their plan because of cost (versus 11% of Medi-Cal and 25% of adults with private coverage). In Covered California, premiums varied by region, ZIP code, metal level and age, but benefits were standardized across plans.[65] Compared to other coverage groups, Medi-Cal enrollees were less likely to choose a plan based on price and more likely to choose a plan based on other factors such as other family members being enrolled in the plan. In Medi-Cal, plan benefits are largely standardized. Further, enrollees face limited or no out-of-pocket costs for services, so the small share indicating that they chose based on price may indicate confusion about their plan.

Figure 27

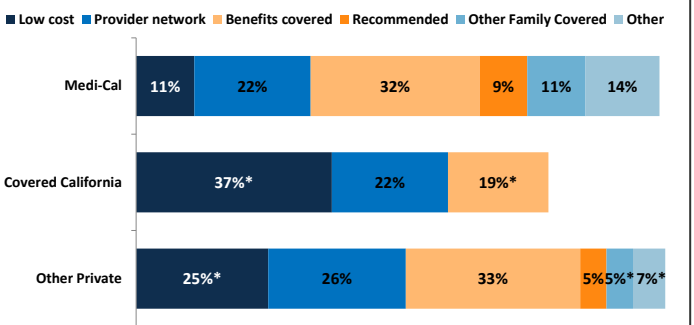
Main Reason for Choosing Health Plan, Among Insured Nonelderly Adults in California Who Had a Choice, by Insurance Coverage in Fall 2014



NOTES: Among insured adults ages 19-64 who had a choice of plans and made the choice themselves. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. *Significantly different from Newly Insured at the p<0.05 level. Share of newly insured who chose a plan based on a recommendation not shown because estimate does not meet standard for statistical reliability.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Figure 28

Main Reason for Choosing Health Plan, Among Insured Nonelderly Adults in California Who Had a Choice, by Insurance Type in Fall 2014



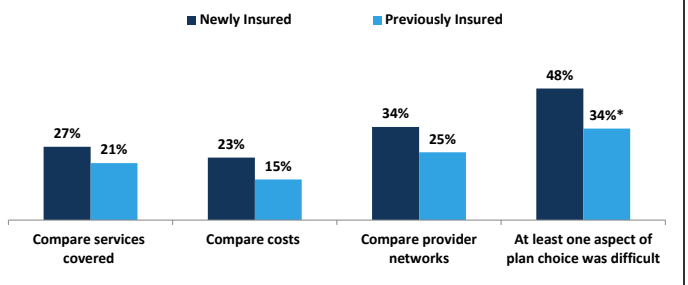
NOTES: Among insured adults ages 19-64 who had a choice of plans and made the choice themselves. *Significantly different from Medi-Cal at the p<0.05 level. Share of people in Covered California who chose a plan based on a recommendation, other family covered or other reason not shown because estimate does not meet standard for statistical reliability.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Across coverage groups, most insured adults did not report difficulty with the plan selection process. While rates of difficulty comparing services, costs, or provider networks across plans varied slightly by timing of coverage and coverage type, there were no significant differences across groups. Still, notable shares reported having difficulty with at least one aspect of plan choice, and the newly insured were more likely than the previously insured to report at least one difficulty (48% versus 34%). The most common difficulty across all coverage groups was comparing provider networks, a finding that echoes patterns nationwide. California, along with several other states, requires all participating Marketplace plans to offer standardized

benefit designs, allowing consumers to accurately compare plans based on cost and network alone, since benefits are identical for all plans.[66] In Medi-Cal, benefits and cost sharing are standardized across plans.

Figure 29

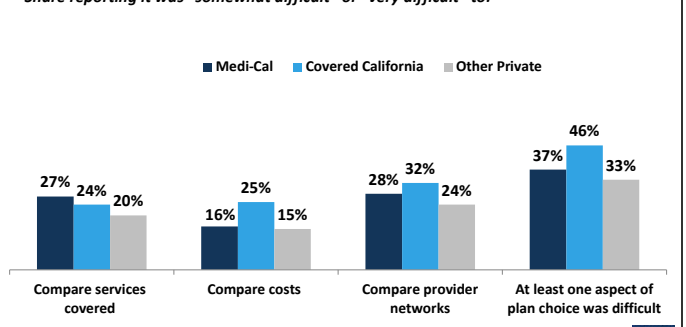
Views of Plan Selection Process Among Nonelderly Adults in California Who Chose a Health Plan, by Insurance Coverage in Fall 2014



NOTES: Among insured adults ages 19-64 who had a choice and made the choice themselves. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. *Significantly different from Newly Insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Figure 30

Views of Plan Selection Process Among Nonelderly Adults in California Who Chose a Health Plan, by Insurance Type in Fall 2014



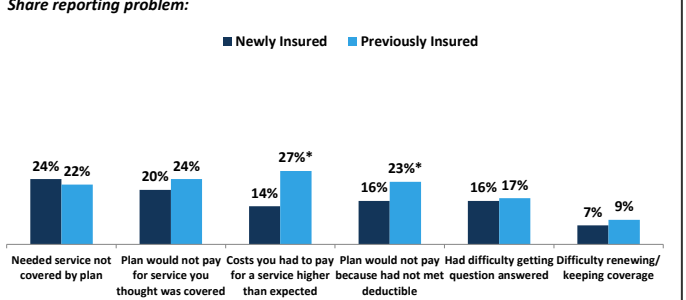
NOTES: Among insured adults ages 19-64 who had a choice and made the choice themselves. *Significantly different from Medi-Cal at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Newly insured adults were no more likely than previously insured to report a specific problem with their health plan. When asked specifically if they encountered various problems with their coverage, such as benefits, costs, or customer service, newly insured adults reported similar or lower rates than previously insured. Specifically, there were no significant differences in shares reporting needing a service that was not covered, being denied coverage for a service they thought was covered, having difficulty getting a question answered, or renewing coverage. Newly insured adults were less likely than previously insured to say they faced higher than expected out-of-pocket costs or that they had not yet met their deductible.

Comparing problems with plan by type of coverage reveals mixed results for different types of problems. Medi-Cal enrollees were less likely than those with Covered California or other private coverage to report cost-related problems, such as facing higher than expected costs or not meeting a deductible. In Medi-Cal, enrollees do not have deductibles and face very limited or no out-of-pocket costs; the fact that any Medi-Cal enrollees reported these problems may reflect service use outside their Medi-Cal plan or may reflect misunderstanding of their

Figure 31

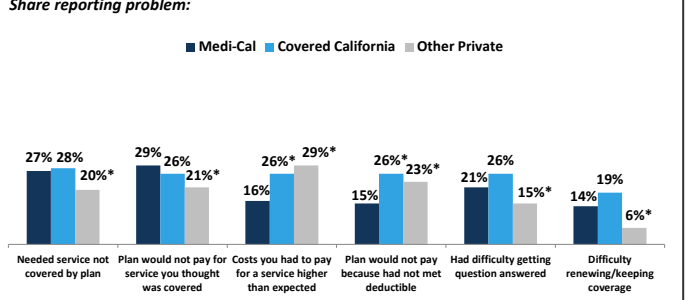
Problems with Current Coverage Among Insured Nonelderly Adults in California, by Insurance Coverage in Fall 2014



NOTE: Includes insured adults ages 19-64. Shares exclude those who say they had event but it was not a problem for them. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014. *Significantly different from Newly Insured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Figure 32

Problems with Current Coverage Among Insured Nonelderly Adults in California, by Insurance Type in Fall 2014



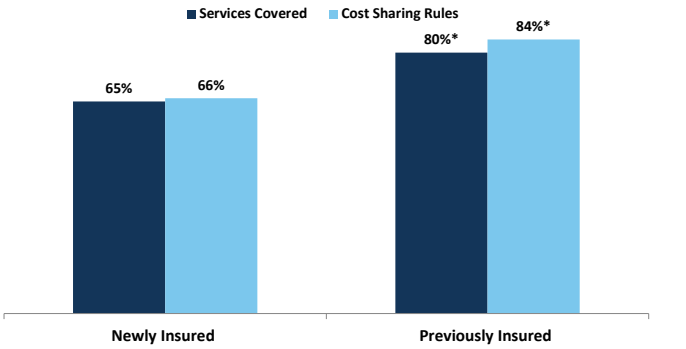
NOTE: Includes insured adults ages 19-64. Shares exclude those who say they had event but it was not a problem for them.
*Significantly different from Medi-Cal at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

plan. On problems related to scope of coverage (e.g., needing a service not covered or being denied coverage for a service) or administrative issues (e.g., getting a question answered or renewing coverage), there were no significant differences between Medi-Cal and Covered California, but adults with other private coverage were less likely to report such problems.

Newly insured adults were also more likely than previously insured to not understand the details of their plan. About two thirds of newly insured adults said they understand the services their plan covers (65%) or how much they would have to pay when they visit a health care provider (66%) "very well" or "somewhat well." In contrast, previously insured adults were more likely to say they understood the scope of benefits (80%) or cost sharing rules (84%) of their plans. It is possible that newly insured adults face challenges in understanding the complexity of insurance coverage, especially since many adults who were uninsured before the ACA reported that they had never had health insurance.[67] When looking by coverage type, there are no significant differences in the share of Medi-Cal or Covered California enrollees reporting understanding these features of their plans. However, adults with other private coverage (most of whom are previously insured) were more likely to understand their plan.

Figure 33
Understanding of Health Insurance Coverage Among Insured Nonelderly Adults in California, by Insurance Coverage in Fall 2014

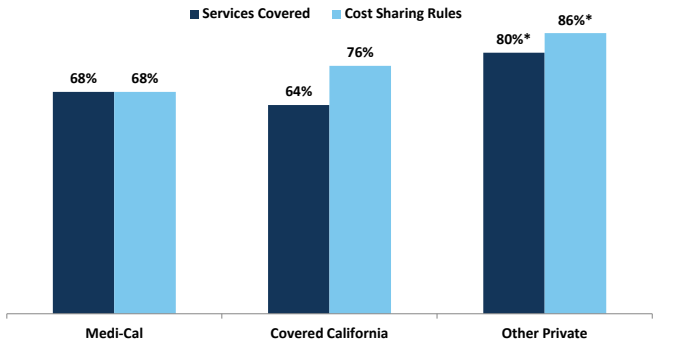
Share who say they understand "very well" or "somewhat well":



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

Figure 34
Understanding of Health Insurance Coverage Among Insured Nonelderly Adults in California, by Insurance Type in Fall 2014

Share who say they understand "very well" or "somewhat well":

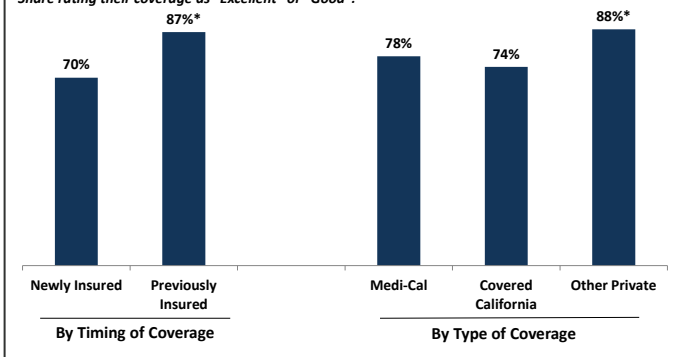


NOTES: Includes insured adults ages 19-64. *Significantly different from Medi-Cal at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Though most newly insured adults give their health plan high ratings, they were less likely than the previously insured to do so. Seven in ten newly insured adults rate their coverage as "excellent" or "good" (versus "not so good" or "poor"). While these findings show high rates of satisfaction, adults who had coverage before 2014 were more likely to give their plan a high rating, with 87% saying their coverage was excellent or good. There were no significant differences between Medi-Cal and Covered California in the share of people giving their plan a high rating; those with private coverage, on the other hand, were more likely to give their plan a high rating. Findings that newly

Figure 35
Rating of Health Insurance Coverage Among Insured Nonelderly Adults in California, by Insurance Coverage in Fall 2014

Share rating their coverage as "Excellent" or "Good":



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

insured adults were less likely to understand their plan but no more likely to have experienced difficulty with their plan indicate that health insurance literacy may be affecting plan ratings.

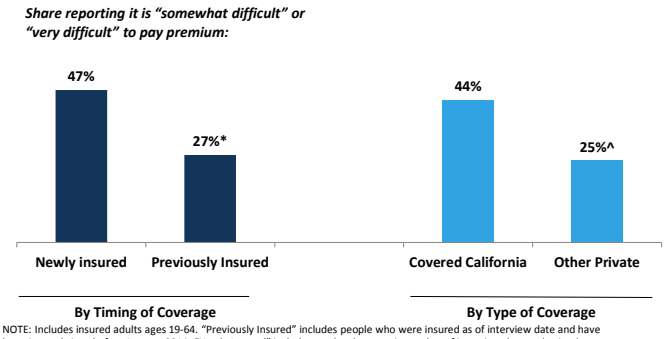
How does coverage affect financial security?

Health care costs can be a major burden for low-income families. While many newly insured adults report difficulty affording their monthly premium, they also report lower rates of problems with medical bills and lower rates of worry about future medical bill than their uninsured counterparts. However, newly insured adults still face financial insecurity: they are more likely than those who had coverage before 2014 to worry about future medical bills, and they face general financial insecurity at rates similar to the uninsured. These patterns may indicate that while coverage can ameliorate some of the financial challenges that low and moderate-income adults face, many will continue to face financial challenges in other areas of their lives.

Many Covered California enrollees report difficulty paying their monthly premium. Among adults who say that they pay a monthly premium for their health coverage, nearly half of newly insured adults (47%) say it is somewhat or very difficult to afford this cost, compared to just 27% of adults who were insured before 2014. When looking specifically by type of coverage, 44% of Covered California enrollees (not all of whom are newly insured) report difficulty paying their monthly premium, versus a quarter of adults with other types of private coverage. Medi-Cal enrollees do not pay monthly premiums for their coverage. Statewide, the average premium rate for the second-lowest cost silver plan in Covered California was $325 per month,[68] compared to $226 nationally.[69] While most people in Covered California received premium subsidies to offset some or most of this cost,[70] subsidy levels are set at the federal level and do not account for the relatively high cost of living in the state that requires a greater share of family finances to go to other areas such as housing, food, or transportation.[71]

Figure 36

Difficulty Affording Health Insurance Premiums Among Nonelderly Adults in California, by Insurance Coverage and Type in Fall 2014

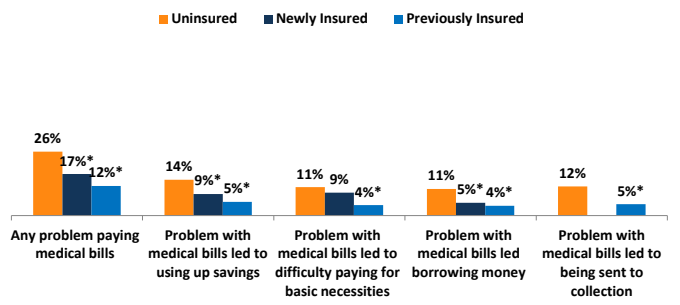


NOTE: Includes insured adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "Newly Insured" include people who were insured as of interview date and gained coverage since January 2014.
*Significantly different from Newly Insured at the p<0.05 level. ^Significantly different from CoveredCA at p<.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

However, coverage does provide financial protection from medical bills and eases concern over affording medical care. Compared to the uninsured, both newly insured and previously insured adults report lower rates of difficulty paying medical bills. Despite being less likely to use services, over a quarter (26%) of uninsured adults report a problem paying medical bills, a rate higher than both the newly insured and previously insured. Uninsured adults were also more likely to report serious consequences from medical bills, such as using up their savings, having difficulty paying for necessities, borrowing money, or being sent to collection. The uninsured were significantly more likely than the previously insured to report that medical bills led to difficulty paying for basic necessities; however, compared to the newly insured, there was no significant difference in medical bills leading to problems paying for necessities.

Figure 37

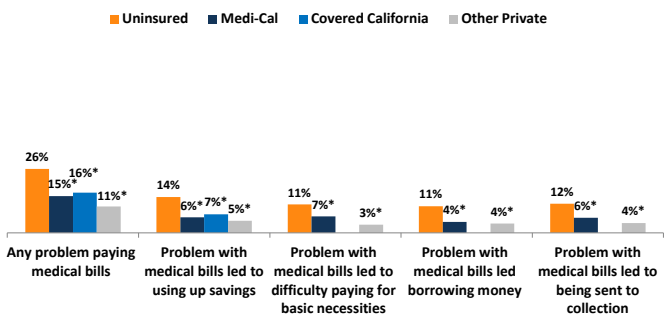
Problems Paying Medical Bills Among Nonelderly Adults in California, by Insurance Coverage in Fall 2014



NOTE: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "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. Share of Newly Insured reporting that medical bills led them to be sent to collection not reported because estimate does not meet minimum standards for statistical reliability. * Significantly different from Uninsured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Figure 38

Problems Paying Medical Bills Among Nonelderly Adults in California, by Insurance Type in Fall 2014

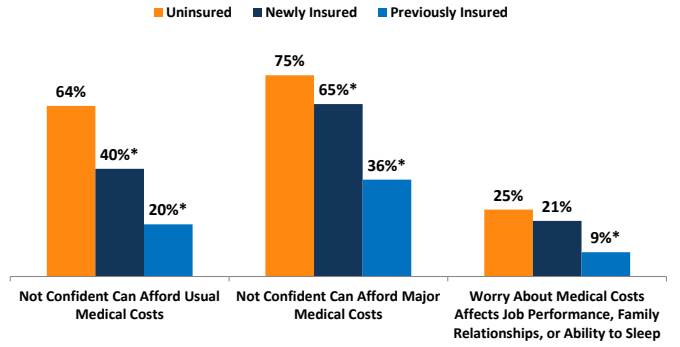


NOTE: Includes adults ages 19-64. "Uninsured" includes people who lacked coverage as of the interview date. Share of Covered California reporting problems as a result of medical bills besides that of using up savings not reported because estimate does not meet minimum standards for statistical reliability. * Significantly different from Uninsured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

When comparing the uninsured to adults with different types of coverage, including Medi-Cal, Covered California, or other private coverage, adults with each type of coverage were less likely than the uninsured to report problems paying medical bills. However, likely reflecting differences in income between these groups, adults with Medi-Cal coverage were significantly more likely than those with other private coverage to report difficulty paying for basic necessities as a result of medical bills (7% versus 3%) and problems paying medical bills (15% versus 11%). As mentioned earlier, Medi-Cal enrollees pay nothing or very little for their medical care, so the share reporting problems related to medical bills may indicate confusion about their plan or

Figure 39

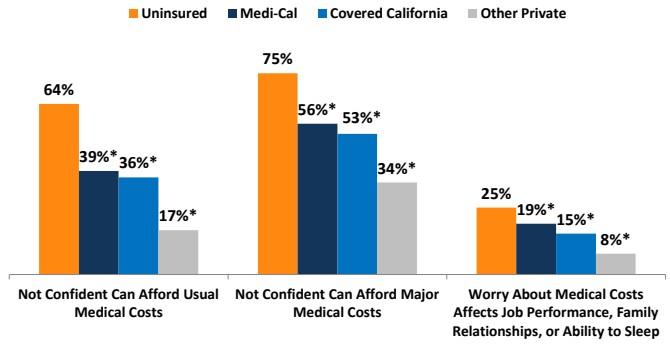
Financial Insecurity Over Medical Costs Among Nonelderly Adults in California, by Insurance Coverage in Fall 2014



NOTE: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "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 Uninsured at the p<0.05 level.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Figure 40

Financial Insecurity Over Medical Costs Among Nonelderly Adults in California, by Insurance Type in Fall 2014



NOTE: Includes adults ages 19-64. "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.

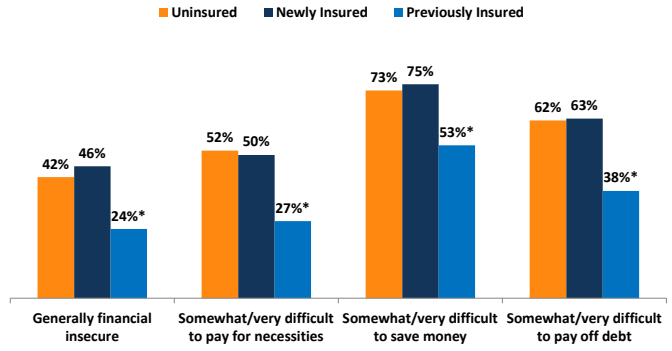
services they received that are not covered by their plan. Compared to 2013, there was no significant change in the share of uninsured or Medi-Cal respondents reporting problems with medical bills.[72]

In addition to being less likely to report experiencing financial strain due to medical bills, insured adults are less likely than uninsured to report living with worry about their ability to afford medical care in the future. Nearly two-thirds (64%) of uninsured adults say they lack confidence in their ability to afford the cost of care for services they typically require, and three-quarters say they lack confidence in their ability to afford the cost of a major illness. In contrast, both newly insured and previously insured adults reported lower rates of insecurity, a finding that holds across types of coverage. Compared to 2013, uninsured adults in 2014 were less likely to say they lack confidence in affording major medical costs, perhaps reflecting an improving economy.[73]

Newly insured adults were no more likely than uninsured adults to say that worry over affording medical costs has affected their job performance, family relationships or ability to sleep, a finding that may reflect their difficulty paying premiums. Further, in contrast to reported problems with medical bills, newly insured adults were more likely than previously insured adults to report financial insecurity over future medical bills. It is possible that newly insured adults have less confidence in the protection offered by their coverage, that their recent experience without coverage led them to be more concerned about future coverage and costs, or that their lower incomes leads to general financial insecurity.

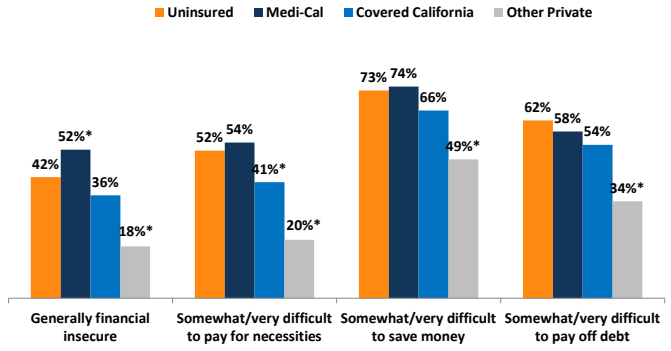
Many newly insured adults still face financial insecurity in areas outside of health care costs. While coverage provides some financial protection from medical bills, there are no significant differences between newly insured adults and uninsured adults with respect to general financial challenges in other areas of their lives. For example, there are no significant differences in the share of uninsured and newly insured adults reporting general financial insecurity or in the share reporting difficulty paying for necessities, saving money, or paying off debt. However, previously insured adults were less likely than uninsured to report these financial challenges. Compared to 2013, uninsured adults in 2014 were less likely to report being generally financially insecure, perhaps reflecting improving economic conditions. In addition, compared to 2013, both Medi-Cal beneficiaries and uninsured adults in 2014 reported lower rates of difficulty affording basic necessities and of saving money (there was no change in the share reporting difficulty paying off debt).[74]

Figure 41
Financial Security Among Nonelderly Adults in California, by Insurance Coverage in Fall 2014



NOTE: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "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.

Figure 42
Financial Security Among Nonelderly Adults in California, by Insurance Type in Fall 2014



NOTE: Includes adults ages 19-64. "Previously Insured" includes people who were insured as of interview date and have been insured since before January 2014. "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.

Looking by coverage type, Medi-Cal beneficiaries are more likely than the uninsured to report being generally financially insecure and as likely to report difficulty affording necessities, saving money, or paying off debt. This finding is not surprising, given that Medicaid is targeted to adults with the lowest incomes.

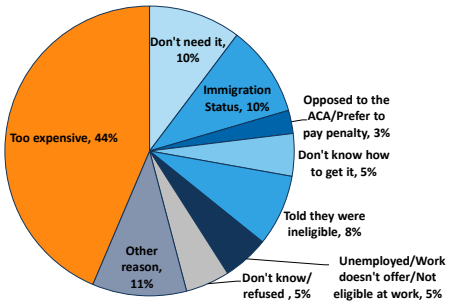
Why are people still uninsured and what are their coverage options?

Though much attention was paid to the difficulties with the application and enrollment process during the 2014 open enrollment period, logistical issues in applying for coverage do not appear to be a leading reason why people went without insurance in 2014. Rather, lack of awareness of new coverage options and financial assistance appear to be a major barrier. In addition, confusion about eligibility is evident among the remaining uninsured. As of fall 2014, uninsured adults were largely uncertain about whether they would seek coverage in 2015 or where they will get it, and only a small share of those eligible say they plan to seek ACA coverage.

Cost remains a major barrier to coverage. While the ACA aimed to make coverage more affordable, for many (44%), the high cost of coverage is still the main reason that adults say they are uninsured. Many also cite limitations on eligibility for coverage, such as immigration status (10%) or being told they are ineligible (8%). A very small share (3%) says they are uninsured because they are either opposed to the ACA or prefer to pay the penalty. Notably, compared to the uninsured before the ACA, uninsured adults in fall 2014 were less likely to name job-related barriers as a reason for lacking coverage: 5% of uninsured adults named a job-related reason for lacking coverage in 2014, compared to over a quarter in 2013 (data not shown). As outreach efforts continue, the uninsured may be growing more aware of insurance options available outside of employer coverage, even while they perceive these options as unaffordable to them.

Figure 43
Reasons for Being Uninsured Among Uninsured Nonelderly Adults in California, Fall 2014

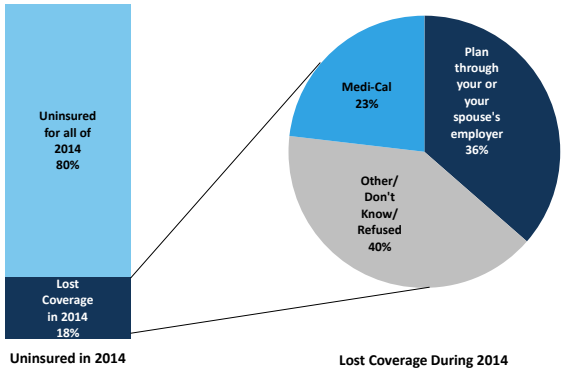
When asked in their own words, the remaining uninsured said that the main reason they were without insurance was…



NOTE: Includes uninsured adults ages 19-64.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Coverage transitions remain a challenge to continuous coverage. As in the past, lack of coverage remains a long-term issue for most: eight in ten uninsured adults report that they had lacked coverage for all of 2014. However, nearly one in five actually had coverage at some point in 2014 but lost that coverage. This pattern is similar to that seen in the past: millions of people gain, lose, or change their health coverage throughout the year, and for some, these transitions lead to spells of uninsurance. As in the past, many (36%) who lost coverage in 2014 indicated that they lost employer-based coverage, but about a quarter who lost coverage in 2014 reported that they

Figure 44
Length of Time Uninsured and Previous Coverage Among Uninsured Nonelderly Adults in California, Fall 2014

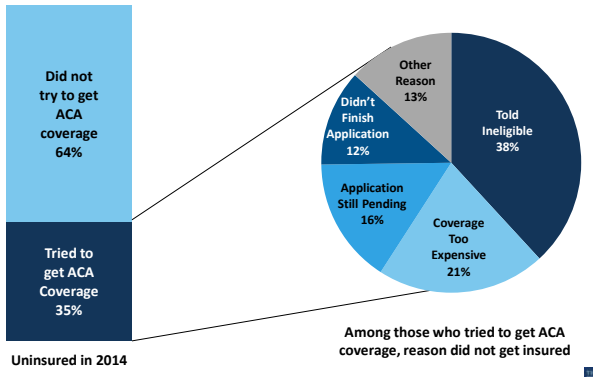


NOTE: Includes uninsured adults ages 19-64. Data excludes those who did not know or refused to say whether they had coverage at any point in 2014. Among those who lost coverage in 2014. "Other" includes Medicare, coverage through a parent, non-group, and other forms of coverage.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

lost Medi-Cal. Some people may have in fact become ineligible for Medi-Cal but opted not to purchase other coverage, while others may have not renewed their coverage. People who became eligible for Medi-Cal before January 2014 had to re-apply for coverage at their annual renewal period, since the eligibility rules and forms had changed since they first became eligible.[75] As adopted, the ACA envisioned a continuum of coverage with various coverage options available as people's circumstances changed (such as job loss or income change), but implementing these transitions is administratively challenging.

Most adults who were uninsured in fall 2014 had not tried to get ACA coverage; however, among those who did, perceptions of cost and eligibility were a more common reason for not obtaining coverage than application problems. Nearly two-thirds (64%) of uninsured adults did not try to get coverage from either Medi-Cal or Covered California in 2014. However, among those who did try to get ACA coverage, the most common reason people gave for not having ACA coverage was that they were told they were ineligible (38%), and more than a fifth (21%) said it was because the coverage was too expensive. Though smaller shares said that they didn't get coverage due to problems with the application process, such as still having a pending application (16%) or not completing the application process (12%), the findings do indicate that many people encountered difficulty in applying for coverage. This distribution mimics what took place at the national level, where only about a third (37%) of the remaining uninsured adults had tried to obtain Medicaid or Marketplace coverage in 2014, and of those that tried, the most commonly cited reason provided for their lack of insurance was being told they were ineligible (data not shown).

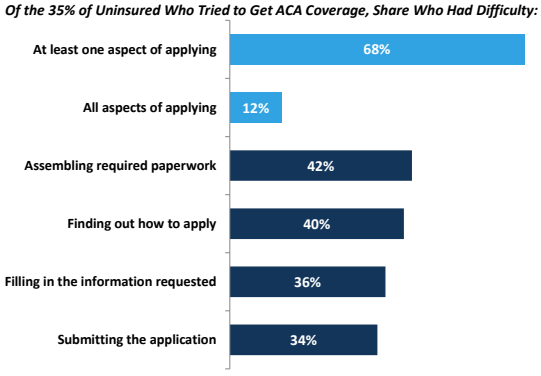
Figure 45
Attempts to Obtain and Reason for Not Getting ACA Coverage, Among Uninsured Nonelderly Adults in California, Fall 2014



NOTE: Includes uninsured adults ages 19-64. Data may not sum to 100% due to rounding.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

When asked directly if they found the application process difficult, most uninsured encountered problems with at least one aspect of applying. Though the remaining uninsured who applied for ACA coverage did not name application difficulties as a leading reason for not obtaining coverage, most (68%) did say they found at least one aspect of the application process difficult. However, no single aspect stands out as the most difficult: more than one in four (42%) reported difficulty assembling the required paperwork, and more than a third reported difficulty finding out how to apply (40%), filling in the information requested (36%), or submitting the application (34%). Very few (12%) uninsured adults found all aspects of the application process to be difficult. Enrollment assistance to help those who encountered difficulty was available in California through a variety of avenues, but, as discussed below, many who remained uninsured said they did not seek assistance through these options.[76]

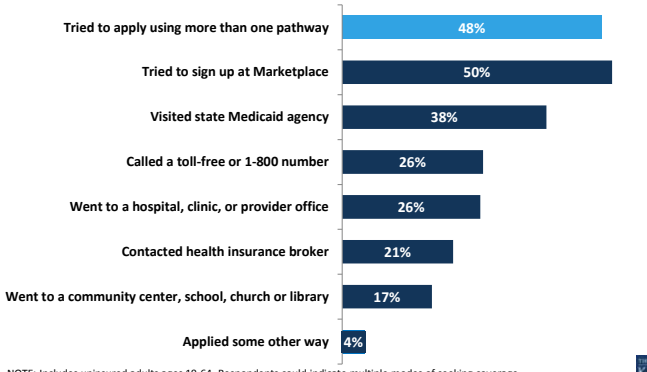
Figure 46
Difficulty Applying for ACA Coverage, Among Uninsured Nonelderly Adults in California, Fall 2014
Of the 35% of Uninsured Who Tried to Get ACA Coverage, Share Who Had Difficulty:



NOTE: Includes uninsured adults ages 19-64. Respondents could indicate multiple types of difficulty.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Among those who tried to get ACA coverage, most reported trying multiple avenues, and most tried to get coverage directly from the state or federal government. While the ACA envisioned a streamlined, "no wrong door" application and enrollment process, most people who sought ACA coverage in 2014 said they pursued multiple pathways to coverage. About half (48%) of uninsured adults who sought ACA coverage tried more than one pathway, a similar pattern to that seen among those who successfully gained coverage. The most common way that the uninsured sought ACA coverage was by visiting the Covered California website (50%). About a quarter (26%) reported that they called a toll-free number to get help, and more than a third (38%) visited a Medi-Cal agency. Many uninsured adults pursued other avenues for getting coverage—such as going to a provider for help (26%), contacting a health insurance broker (21%), or going to community agencies, schools, churches, or libraries (17%).

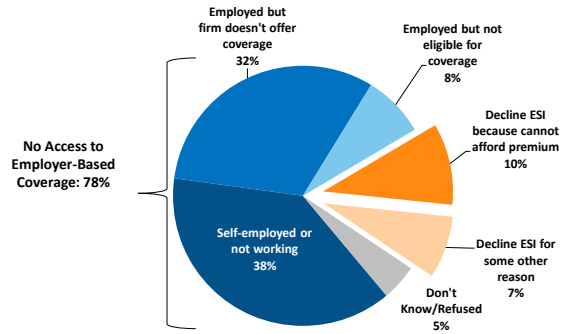
Figure 47
Pathways to Applying for ACA Coverage, Among Uninsured Nonelderly Adults in California, Fall 2014



NOTE: Includes uninsured adults ages 19-64. Respondents could indicate multiple modes of seeking coverage.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Few uninsured adults are likely to gain coverage through an employer. As in the past,[77] very few uninsured adults have access to coverage through their own or a spouse's job, either because they are self-employed or not in a working family (38%), or because the employer does not offer coverage (32%) or coverage for which they are eligible (8%). Some uninsured adults do have access to coverage through their own or a spouse's job, but most who do report that this coverage in unaffordable to them. Many uninsured adults work for an employer who will not be required to offer coverage under the ACA because they have fewer than 50 workers.

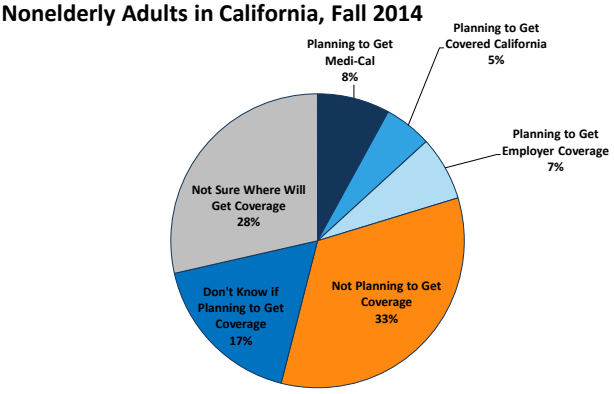
Figure 48
Access to Employer-Sponsored Insurance Among Uninsured Nonelderly Adults in California, Fall 2014



NOTE: Includes uninsured adults ages 19-64. Includes access to coverage through a spouse's job.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Even though most uninsured adults are now eligible for coverage, few uninsured adults had plans to obtain ACA coverage in 2015. Only about half of uninsured adults indicate that they plan to get coverage in 2015, and few who do identified Medicaid or Marketplace coverage as their goal. Rather, higher shares indicate that they don't know where they will get coverage. According to an estimate reported out of UCLA's Center for Health Policy Research, between 3.2 and 4 million people will remain uninsured in California in 2015.[78] Many of these individuals (about

Figure 49
Plans for Obtaining Insurance in 2015, Among Uninsured Nonelderly Adults in California, Fall 2014



NOTE: Includes uninsured adults ages 19-64.
SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

1.5 million) are undocumented and therefore barred from purchasing insurance on Covered California and from receiving full-scope Medi-Cal benefits, but many are eligible for coverage through Medi-Cal or Covered California. Eligible individuals may be unaware of new coverage options or may still find coverage unaffordable. Outreach to inform them of the availability of financial assistance may help reach these individuals.

Policy Implications

As we enter the second year of new coverage under the ACA, information on people's experience during year one can inform ongoing efforts to extend and improve health coverage in California. While the survey findings can inform a broad range of these efforts, key themes and implications include:

Covering the Remaining Uninsured

Though open enrollment for Covered California is closed, Medi-Cal enrollment is open throughout the year. Analysis of the remaining uninsured population's income indicates that most fall into the income range for Medi-Cal; thus, ongoing efforts throughout 2015 can bring more people into coverage. In addition, findings related to outreach can inform planning for future Covered California open enrollment periods.

Many low-income, working adults gained coverage in 2014, and ongoing coverage expansions have the potential to reach many more. Adults who gained coverage in 2014 were largely low (below 139% of poverty) or middle (between 139 and 400% of poverty) income, and a majority were in a working family. Further, most who gained coverage were people of color. These findings indicate that coverage expansions are playing an important role in filling gaps in availability of coverage for low-income workers, and expansions may also help long-standing racial and ethnic disparities in access to health care. Like their counterparts who gained coverage, most adults who remained uninsured at the end of 2014 were low or middle income, were in a family with a worker, and were people of color. Extending coverage to the eligible remaining uninsured has the potential to continue efforts to reach those who have historically been left out of coverage. In addition, there is limited evidence that older or sicker adults disproportionately gained coverage in 2014; while some of the remaining uninsured may be hard-to-reach populations, survey findings indicate that this group has a need and desire for coverage. Stakeholders in the state noted that efforts to reach these populations were ongoing.

Cost continues to prevent many uninsured adults from seeking coverage. While many people focused on website glitches and administrative barriers during 2014, uninsured adults say that the reason they still lack coverage is because it's too expensive, with most not even trying to get ACA coverage, and many who did still saying they are ineligible or believe the coverage is too costly. While some uninsured adults are ineligible for assistance, most can receive some help under the law. Thus, there may be a continuing lack of awareness of new coverage options and financial assistance, particularly among those who are likely eligible for Medi-Cal. Alternatively, it is possible that many are aware of available financial assistance but still believe that coverage is still too costly. Subsidies for Covered California are set at the federal level and are available on a sliding scale, and premium contributions can range from 2% of income for those below 133% FPL to 9.5% of income to those between 300%-400%FPL. Even with financial assistance, people within these higher income groups may find it difficult to afford these premiums, particularly in a high-cost state such as California. Experts reiterated survey findings about cost, noting that, in their enrollment efforts, Medi-Cal was an "easier

sell" because enrollees do not pay premiums. Stakeholders commented that, aside from the state providing additional subsidies with its own funds, which was unlikely in the current budget environment, there was little they could do to address affordability issues in Covered California. In addition, the average level of subsidy received by Covered California enrollees ($5,200) implies that most who signed up for that coverage during the first years' open enrollment had lower incomes.[79] Officials would now like to focus on drawing in middle-income residents, which may be challenging because they will not receive large subsidies. Messages that focus on low-cost or free coverage being available to most uninsured Californians and the importance of having coverage for financial protection may help address this challenge. Other states are pursuing approaches to further lowering cost of coverage for low-income residents, such as developing a Basic Health Plan that covers low-income (up to 200% FPL) residents through state-contracting plans outside the Marketplace[80] or using an existing Medicaid waiver to provide wraparound subsidies to Marketplace-eligible individuals previously eligible for state-financed or Medicaid coverage.[81]

Given the relatively high share of the remaining uninsured of Hispanic race/ethnicity, targeted outreach to this group is appropriate. In the early stages of ACA implementation in the state, there was much attention to this population but administrative barriers in reaching them. For example, there were delays in making Spanish-language materials available. Glitches on the Spanish version of the Covered California site were generally addressed only after those on the English site had been resolved. Further, Spanish-language paper forms did not become available until halfway through the open-enrollment period,[82] which was particularly problematic since research carried out for Covered California showed that non-English speaking families generally do not use the internet.[83] In addition, many stakeholders felt that Spanish-language outreach materials and advertisements were poorly translated, overall failing to resonate culturally for many individuals within the Hispanic community. Many of the issues with Spanish-language materials have been resolved, and the state has also taken steps to address fears among people with mixed citizenship status families. In December of 2014, Covered California announced a partnership with national and state immigrant rights organizations to inform Californians that personal details disclosed in health coverage applications are secure and confidential.[84] Data from the second open enrollment period indicate that Covered California's increased advertising and in-person outreach, targeted at hard-to-reach populations, were effective. Hispanics, African-Americans and young adults were all represented in higher proportions compared to the first open enrollment period, with new enrollment of subsidy-eligible Hispanics surging by 6 percentage points from 31% in year one to 37% in year two.[85] Still, even with successful outreach efforts, some Hispanics in the state are likely to remain ineligible for coverage due to the ban on most undocumented immigrants receiving coverage. State efforts have extended limited Medi-Cal services to undocumented immigrants with state-only funding, and some counties have local initiatives to provide coverage to undocumented adults. However, these programs are not available statewide, and currently undocumented adults with incomes above Medi-Cal limits are ineligible for any assistance in most counties.

Community outreach may reach many remaining uninsured. Most adults who did gain coverage in 2014 did not report problems with the plan selection or enrollment process, indicating that enrollment issues do not necessarily pose a barrier to coverage. Most uninsured adults who sought ACA coverage visited the Covered California website or the Medi-Cal agency, with far fewer having contact with a provider, community group, or other outreach worker who may be able to provide one-on-one assistance. Experts note that outreach efforts in 2014 focused on enrolling as many people as possible with the resources available, which meant some

hard-to-reach groups were not the primary focus. Many hard-to-reach groups, such as young adults, immigrants, and people with Limited English Proficiency (LEP), may require one-on-one assistance to enroll in coverage. In 2015, outreach resources will shrink, making these efforts more difficult. Given that most remaining uninsured adults are in a working family but work for an employer who is unlikely to offer (or be required to offer) coverage, engaging employers in these efforts may be a promising approach. In addition, experts noted that efforts varied largely across counties, so state-level engagement may be needed.

Providing Needed Services to the Remaining Uninsured

Even if outreach efforts are successful, some Californians will continue to lack coverage due to ongoing eligibility gaps or affordability concerns. Survey findings indicate that the uninsured continue to lack adequate access to care and will require assistance in accessing needed health services.

Clinics and health centers remain core providers for the uninsured and will require ongoing support to serve this population. Though uninsured adults are less likely than insured to have a usual source of care, those that do are most likely to name a clinic or health center (versus doctor's office, HMO, or other location). Many clinics offer services at greatly reduced cost or on a sliding scale relative to income, which makes them affordable options for the uninsured. Indeed, most uninsured adults said they chose their site of care based on affordability. California safety net providers are likely to play an ongoing, core role in serving the uninsured. However, experts note that these providers are also adapting to meet the changing health care environment in California, including becoming "providers of choice" to retain patients as they gain coverage and expanding primary care capacity to meet demand.

While some uninsured are able to navigate the system when they need care, most are not and face serious consequences as a result. Some uninsured people report that they receive regular care, preventive services, and can access care when they need to, but these individuals are the exception: survey results repeatedly indicate inferior access to care for people who lack insurance coverage compared to those who have coverage. In addition, the uninsured face negative financial consequences of having to pay out-of-pocket for care. Experts noted that access to care for the uninsured varies by region within the state. Some areas, particularly rural areas, have provider shortages for both insured and uninsured people. In addition, while some counties provide services to undocumented individuals, not all do, and those that do vary greatly in the scope of these services. Some local initiatives aim to address access barriers among the uninsured by providing insurance or insurance-like coverage, rather than just direct services, for low-income uninsured people. For example, Healthy San Francisco and My Health LA (MHLA) provide limited coverage for uninsured residents of San Francisco or LA county, respectively, regardless of immigration status. Programs such as these could increase access to health services for California's uninsured and underinsured and could serve as models for other localities. Since people will continue to lack coverage under the ACA, planned efforts to deliver services to those who lack coverage when they need them may be necessary.

Improving Care for the Insured

While coverage gains have resulted in increased access to care and financial protection, there is still a need to improve affordability and access for the insured. Newly insured individuals may need help navigating the health system, and plans and providers may need further refinement to meet the new need for care.

While most adults with coverage have positive views and experience with their health plan across coverage type, consumer education about health insurance and health care may be needed. Large majorities of insured Californians across coverage types gave their plans excellent or good ratings, most said they understood their plan, and small numbers reported problems with their plans. However, compared to adults who had coverage before 2014, newly insured adults were less likely to understand the details of their plan and, for some outcomes, more likely to report problems communicating with their provider. Experts in the state noted that, during outreach, assistors found that they had to explain very simple concepts about health insurance (e.g., what it means to have a deductible, how a co-payment works, how to pay premiums); they also noted that many people appeared to not understand what their plan covered (e.g., that all plans covered preventive care) or how to use their insurance once they obtained it. They noted that while initial outreach efforts were focused on signing people up rather than educating them about how to use coverage, education about health insurance and health care is the next phase of bringing people into the health care system.

While coverage eases the financial strain of health care, many newly insured adults are in precarious financial situations and still report affordability problems. Compared to adults who remained uninsured in the state, newly insured Californians report lower rates of problems with medical bills and more financial security from usual or major medical costs. Still, cost remains a concern for insured adults. Covered California enrollees are especially sensitive to costs, with most picking their plan based on cost and many saying it is still difficult to afford the premium. Newly insured adults also reported higher rates of financial insecurity about medical bills than adults who were insured before 2014. While premium and cost-sharing subsides are set at the federal level, and Medi-Cal already limits enrollees' out-of-pocket expenses to very low (if any) levels, continued attention to whether affordability measures in place are sufficient may provide insight into people's take-up and use of new coverage.

Newly insured individuals may need interventions to help them navigate the system to access needed care. Though newly insured adults report better access than their uninsured counterparts, on some measures, they are more likely to report barriers to care than adults who had coverage since before 2014. For example, newly insured adults were more likely than previously to say it was difficult to travel to care, that a provider would not take them as a new patient, or that they postponed needed care. These barriers could be related to several factors, including difficulty finding a provider, problems navigating the health system and health insurance networks, misunderstanding of how to use coverage and when to seek care, or concerns about out-of-pocket costs. In discussing barriers to care among the newly insured, experts frequently mentioned issues related to network adequacy. In Medi-Cal, low reimbursement rates have made it difficult to contract with providers in some cases, and the state is monitoring networks closely. In Covered California, experts noted that some plans established narrow networks to contain costs and added that some provider directories were inaccurate. Advocates in the state have pushed for legislation to address these issues, and in January 2015, the state issued an emergency regulation to address network issues in Covered California.[86] In addition, the state is focusing on continuing delivery system transformation in Medi-Cal to provide better coordinated care for people. Under the proposed Section 1115 waiver renewal, the state aims to undertake efforts such as behavioral health/physical health integration, increase attention to social determinants of health and access, system redesign for ambulatory care, and care coordination for high-need populations, among other initiatives.[87]

Attention to coverage transitions and coordinated care may help people from losing coverage. Nearly a fifth of adults who were uninsured in fall 2014 said that they had lost their coverage since the start of 2014. One way in which the state is trying to improve coverage transitions is by enrolling Medi-Cal beneficiaries transitioning from Covered California into the same plan (if available) with no lapse in coverage. In addition, when patients are transitioned to a different plan, they have the right to request continuity of care by being matched to plans that include their primary care physician.[88]

ENDNOTES

[1] California Department of Health Care Services, *California Eligibility and Enrollment Report: Insurance Affordability Programs for October 2013 through September 2014*, http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/CA_EligibilityandEnroll_ABx1_1-Quarterly.pdf

[2] CMS, Medicaid & CHIP Monthly Application, Eligibility Determination, and Enrollment Reports and Updated Data, March - December, 2014, as of February 23, 2015. December 2014 data are preliminary. Enrollment reports and updated data are available from CMS, http://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-enrollment-data/medicaid-and-chip-application-eligibility-determination-and-enrollment-data.html

[3] California Department of Health Care Services, *California Eligibility and Enrollment Report: Insurance Affordability Programs for October 2013 through September 2014*, http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/CA_EligibilityandEnroll_ABx1_1-Quarterly.pdf and CMS, Medicaid & CHIP Monthly Application, Eligibility Determination, and Enrollment Reports and Updated Data, March - December, 2014, as of February 23, 2015. December 2014 data are preliminary. Enrollment reports and updated data are available from CMS, http://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-enrollment-data/medicaid-and-chip-application-eligibility-determination-and-enrollment-data.html

[4] Licata R, Arguello R, Garfield R 2014. *The Uninsured at the Starting Line in California: California findings from the 2013 Kaiser Survey of Low-Income Americans and the ACA*,Kaiser Family Foundation, http://kff.org/uninsured/report/the-uninsured-at-the-starting-line-in-california-california-findings-from-the-2013-kaiser-survey-of-low-income-americans-and-the-aca/

[5] U.S. Census Bureau, 2010 American Community Survey

[6] California Health Care Almanac, *California Employer Health Benefits Survey: Workers Feel the Pinch* (California HealthCare Foundation, January 2014), http://www.chcf.org/publications/2014/01/employer-health-benefits

[7] Kaiser Family Foundation estimates based on the Census Bureau's March 2014 Current Population Survey (CPS: Annual Social and Economic Supplements). http://kff.org/other/state-indicator/distribution-by-raceethnicity/

[8] U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits , http://quickfacts.census.gov/qfd/states/06000.html.

[9] California Department of Health Care Services. *LIHP September2013 Monthly Enrollment* (November 15, 2013).

[10] California Department of Health Care Services, "California's Low Income Health Program Transitions Hundreds of Thousands of New Members to Medi-Cal" (December, 2013), http://www.dhcs.ca.gov/formsandpubs/publications/opa/Documents/2013/13-07%20LIHP%20Medi-Cal%20Expansion%2012-31-13%20Final%20Version.pdf

[11] UCLA Center For Health Policy Research, Health Economics and Evaluation Research, *Safety Net Delivery System Redesign in California: Innovations in the Low Income Health Program (LIHP)* (November 2013), http://healthpolicy.ucla.edu/publications/Documents/PDF/SafetyNetRT_FINAL_10-10-13.pdf

[12] Gates A, Rudowitz R, Guyer J, 2014. *An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers*. Kaiser Family Foundation, http://kff.org/medicaid/issue-brief/an-overview-of-delivery-system-reform-incentive-payment-waivers/

[13] Kaiser Family Foundation, *California's Uninsured on the Eve of ACA Open Enrollment (*2013) http://kff.org/report-section/ca-uninsured-executive-summary/#endnote_link_note2.

[14] Department of Health Care Services (DHCS). Full Scope Medi-Cal Coverage and Affordability and Benefit Program for Low-Income Pregnant Women and Newly Qualified Immigrants (NQI) Scenarios. Available at: http://www.dhcs.ca.gov/services/medi-cal/Documents/AffordabilityBenefitProgramEligibilityChart8-18-2014-draft.pdf.

[15] California Department of Health and Human Services, *May 2014 Medi-Cal Estimate*, http://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2014_May_Estimate/M1407_Regular_PC_Tab.pdf

[16] California Pan-Ethnic Health Network, *Summary of Medi-Cal Coverage for Immigrants.* (Oct 2013), http://cpehn.org/sites/default/files/resource_files/cpehnimmigrantcoveragemedi-cal.pdf

[17] California Department of Health Care Services, Communication documents for NQIs and Affordability & Benefit Program (Meeting dates consultation July 25, 2014 through September 5, 2014), http://www.dhcs.ca.gov/services/medi-cal/Documents/NQI%20notices/NQI_Stakeholder_Comments_DHCS_responses.pdf

[18] California Immigrant Policy Center, *How the Affordable Care Act Impacts Immigrant & Migrant Populations in California*, (2014) http://www.caimmigrant.org/wp-content/uploads/2014/10/ACAs-Impact-on-Immigrants-CA.1.30.14-1.pdf

[19] Covered California, Health Plans Booklet (2014), https://www.coveredca.com/PDFs/CC-health-plans-booklet-rev4.pdf.

[20] California Department of Health Care Services, "California's Low Income Health Program Transitions Hundreds of Thousands of New Members to Medi-Cal" (December 2013), http://www.dhcs.ca.gov/formsandpubs/publications/opa/Documents/2013/13-07%20LIHP%20Medi-Cal%20Expansion%2012-31-13%20Final%20Version.pdf.

[21] Covered California Blog, *Covered California's Historic First Open Enrollment Finished with Projections Exceeded; Agents, Counselors, Community Organizations and County Workers Credited as Reason for High Enrollment in California*, (April 2014) http://news.coveredca.com/2014/04/covered-californias-historic-first-open.html

[22] The California Endowment, *The Department of Health Care Services and The California Endowment Announce $23 Million in Grants to Boost County-Based Medi-Cal Enrollment Efforts* (January 2014), http://tcenews.calendow.org/releases/department-of-health-care-services-and-the-california-endowment-announce-23-million-in-grants-to-boost-county-based-medi-cal-enrollment-efforts

[23] California Department of Health Care Services, *Outreach and Enrollment Workgroup* (November 2013), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/OEworkgroup.aspx

[24] California Health Benefit Exchange. Outreach and Education Grant Webinar (September 27, 2012), http://www.healthexchange.ca.gov/StakeHolders/Pages/2012StakeholderArchive.aspx

[25] California Health Benefit Exchange. Outreach and Education Grant Webinar (September 27, 2012), http://www.healthexchange.ca.gov/StakeHolders/Pages/2012StakeholderArchive.aspx

[26] Health Resources and Services Administration, *California: Health Center Outreach & Enrollment Assistance*, (FY 2014) http://www.hrsa.gov/about/news/2013tables/outreachandenrollment/ca.html

[27] California Department of Health Care Services, *Hospital Presumptive Eligibility (PE) Program*, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/HospitalPE.aspx

[28] California Department of Health Care Services, *Express Lane Program*, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/ExpressLane.aspx

[29] California Senate Committee on Health, *First Open Enrollment for Affordable Care Act Implementation, Summary of Outcomes and Challenges*, http://shea.senate.ca.gov/sites/shea.senate.ca.gov/files/Outreach%20%20Enrollment%20White%20Paper%20Final.pdf

[30] California Senate Committee on Health, *First Open Enrollment for Affordable Care Act Implementation, Summary of Outcomes and Challenges*, http://shea.senate.ca.gov/sites/shea.senate.ca.gov/files/Outreach%20%20Enrollment%20White%20Paper%20Final.pdf

[31] Covered California Blog, *Covered California Outlines Additional Initiatives Tailored to Boost Latino Enrollment*, (February 2014), http://news.coveredca.com/2014/02/covered-california-outlines-additional.html

[32] California Department of Health Care Services, Memo Related to Processing Single Streamlined Applications, (January 2014) http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL%20I13-14.pdf.

[33] California Health Line, *Judge Rules on Medi-Cal Backlog Suit, Orders State to Adhere to 45-Day* Deadline (January 2015), http://www.californiahealthline.org/capitol-desk/2015/1/judge-finally-rules-on-backlog-lawsuit-orders-state-to-adhere-to-45-day-deadline

[34] California Pan-Ethnic Health Network, *Improving Enrollment of Communities of Color in Health Coverage: Recommendations from First Responders to Covered California and Medi-Cal.(* June, 2014), http://shea.senate.ca.gov/sites/shea.senate.ca.gov/files/CPEHN_ImprovingEnrollmentforCommunitiesofColor_2014.pdf

[35] California Senate Committee on Health, *First Open Enrollment for Affordable Care Act Implementation, Summary of Outcomes and Challenges*, http://shea.senate.ca.gov/sites/shea.senate.ca.gov/files/Outreach%20%20Enrollment%20White%20Paper%20Final.pdf.

[36] Covered California Blog, *Covered California's Historic First Open Enrollment Finishes with Projections Exceeded; Agents, Counselors, Community Organizations and County Workers Credited as Reason for High Enrollment in California,* (April 2014) http://news.coveredca.com/2014/04/covered-californias-historic-first-open.html

[37] Enrollment data from: California Department of Health Care Services, *California Eligibility and Enrollment Report: Insurance Affordability Programs for October 2013 through September 2014*, http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/CA_EligibilityandEnroll_ABx1_1-Quarterly.pdf
Eligible population data from: Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels and 2014 Current Population Survey. For a detailed explanation of our methodology, please see Methodology for Estimating the Number of People Eligible for Premium Tax Credits Under the Affordable Care Act

[38]Addendum to Health Insurance Marketplace Summary Enrollment Report, October 1, 2013 - March 31, 2014, Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (HHS); May 1, 2014

[39] Covered California Blog, *Covered California Enrollment Surges in Los Angeles County to More Than 400,000; Interest in Medi-Cal Remains High (* May 2014*)* http://news.coveredca.com/2014/05/covered-california-enrollment-surges-in.html

[40] Enrollment data from: California Department of Health Care Services, *California Eligibility and Enrollment Report: Insurance Affordability Programs for October 2013 through September 2014*, http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/CA_EligibilityandEnroll_ABx1_1-Quarterly.pdf

[41] Enrollment data from: California Department of Health Care Services, *California Eligibility and Enrollment Report: Insurance Affordability Programs for October 2013 through September 2014*, http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/CA_EligibilityandEnroll_ABx1_1-Quarterly.pdf

[42] CMS, Medicaid & CHIP Monthly Application, Eligibility Determination, and Enrollment Reports and Updated Data, March - December, 2014, as of February 23, 2015. December 2014 data are preliminary. Enrollment reports and updated data are available from CMS, http://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-enrollment-data/medicaid-and-chip-application-eligibility-determination-and-enrollment-data.html

[43] Covered California Blog, *Covered California's Historic First Open Enrollment Finishes wth Projections Exceeded; Agents, Counselors, Community Organizations and County Workers Credited as Reason for High Enrollment in California,* (April 2014), http://news.coveredca.com/2014/04/covered-californias-historic-first-open.htmlhttp://news.coveredca.com/2014/04/covered-californias-historic-first-open.html

[44] California Department of Health Care Services, *California Eligibility and Enrollment Report: Insurance Affordability Programs for October 2013 through September 2014*, http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/CA_EligibilityandEnroll_ABx1_1-Quarterly.pdf

[45] Licata, Garfield, and Arguello, 2014.

[46] Licata, Garfield, and Arguello, 2014.

[47] Licata, Garfield, and Arguello, 2014.

[48] Covered California Blog, *Spanish-Language Enrollment Application Form Now Available On Covered California Website, (*December 2013*)* http://news.coveredca.com/2013/12/spanish-language-enrollment-application.html

[49] Based on comparison of 2013 and 2014 Kaiser Survey of Low-Income Americans and the ACA.

[50] Kaiser Family Foundation analysis of 2013 Current Population Survey.

[51] Licata, Garfield, and Arguello, 2014.

[52] Licata, Garfield, and Arguello, 2014.

[53] Wilper AP, Woolhandler S, Lasser KE, McComick D, Bor DH, Himmelstein DU. Hypertension, diabetes, and elevated cholesterol among insured and uninsured US adults. *Health Affairs*. 2009;28(6):w1151-9.

[54] *Coverage Matters: Insurance and Health* Care, Committee on the Consequences of Uninsurance, Board on Health Care Services, Institute of Medicine, National Academy Press, 2001.

[55] Based on comparison of 2013 and 2014 Kaiser Survey of Low-Income Americans and the ACA.

[56] Based on comparison of 2013 and 2014 Kaiser Survey of Low-Income Americans and the ACA.

[57] Licata, Garfield, and Arguello, 2014.

[58] Based on comparison of 2013 and 2014 Kaiser Survey of Low-Income Americans and the ACA.

[59] Licata, Arguello, and Garfield, 2014.

[60] Licata, Arguello, and Garfield, 2014.

[61] Agency for Healthcare Quality and Research. *CAHPS Item Set for Addressing Health Literacy* (May 2012) https://cahps.ahrq.gov/surveys-guidance/item-sets/literacy/index.html

[62] California Department of Health Care Services, *Medi-Cal Managed Care 2013 CAHPS Survey Summary Report*, (March 2013) http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/CAHPS_Reports/CA2012-13_CAHPS_Summary_Report_F3.pdf

[63] Blue Shield of California Foundation, Langer Research Associates, *Delivering on a Promise: Advances and Opportunities in Health Care for Low-Income Californians*, (January 2015) http://www.blueshieldcafoundation.org/sites/default/files/publications/downloadable/BSCF%20Delivering%20Promise%20Full%20Report%20Web.pdf

[64] Blue Shield of California Foundation, Langer Research Associates, *Health Care in California: Leveling the Playing Field*, (November 2013) http://www.blueshieldcafoundation.org/sites/default/files/publications/downloadable/BCSF_leveling_the_playing_field.pdf

[65] Covered California, Health Plans Booklet (2014), https://www.coveredca.com/PDFs/CC-health-plans-booklet-rev4.pdf

[66] Covered California, Health Plans Booklet (2014), https://www.coveredca.com/PDFs/CC-health-plans-booklet-rev4.pdf

[67] Licata, Arguello, and Garfield, 2014.

[68] Covered California, Health Plans Booklet (2014), https://www.coveredca.com/PDFs/CC-health-plans-booklet-rev4.pdf.

[69] Burke A, Misra A, Sheingold S, 2014, Department of Health and Human Services, ASPE, Research Brief, *Premium Affordability, Competition, and Choice in the Health Insurance Marketplace* http://aspe.hhs.gov/health/reports/2014/premiums/2014mktplaceprembrf.pdf

[70] Addendum to Health Insurance Marketplace Summary Enrollment Report, October 1, 2013 - March 31, 2014, Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (HHS); May 1, 2014.

[71] Kaiser Commission on Medicaid and the Uninsured analysis based on the Council for Community and Economic Research (C2ER)'s ACCRA Cost of Living Index (COLI) for the third quarter of 2014. http://kff.org/other/state-indicator/cost-of-living-variation/

[72] Licata, Garfield, and Arguello, 2014.

[73] Licata, Garfield, and Arguello, 2014.

[74] Licata, Garfield, and Arguello, 2014

[75] Gold, J. "As California Expands Medicaid To New Beneficiaries, Many Others Are Dropped." *Kaiser Health News*. November 18, 2014.

[76] California Healthcare Foundation, *On The Path to Enrollment: Getting Californians Covered Under the ACA, (*October 2013) http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20PathEnrollmentACA.pdf

[77] Licata, Garfield, and Arguello 2014.

[78] California Healthline, *Forum Examines Residually* Uninsured (December 2014) http://www.californiahealthline.org/capitol-desk/2014/12/forum-looks-at-options-across-state-to-solve-residually-uninsured-issue

[79] California Health Line, *Californians Received $3.2B in Federal Health Subsidies Last Year*, (January 27, 2015) http://www.californiahealthline.org/articles/2015/1/27/californians-got-3-2b-in-federal-health-subsidies-last-year

[80] Dorn S and Tolbert J, *The ACA's Basic Health Program Option: Federal Requirements and State Trade-Offs*, (November 2014) http://kff.org/health-reform/report/the-acas-basic-health-program-option-federal-requirements-and-state-trade-offs/

[81] Howard, H. and C. Shearer. "State Efforts to Promote Continuity of Coverage and Care under the Affordable Care Act." *Journal of Health Politics, Policy and Law*, Vol. 38, No. 6, December 2013.

[82] Covered California Blog, *Spanish-Language Enrollment Application Form Now Available On Covered California Website, (*December 2013*)* http://news.coveredca.com/2013/12/spanish-language-enrollment-application.html

[83] Covered California, *Lessons Learned*, (October 2014) https://www.coveredca.com/PDFs/10-14-2014-Lessons-Learned-final.pdf

[84] Covered California Blog, *Covered California Partners with National Immigrant Rights Organizations to Reassure Consumers in California and Nationally That Immigration Information Is Safe, Secure and* Confidential, (December 2014) http://news.coveredca.com/2014/12/covered-california-partners-with.html

[85] Covered California Blog, *Covered California's Second Open Enrollment Yields Strong Numbers; Nearly 500,000 New Consumers Sign up for Health Plans*, (March 2015) http://news.coveredca.com/2015/03/covered-californias-second-open.html

[86] California Health Line, Jones Releases Emergency Rule Over Narrow Provider Networks, (January 6, 2015) http://www.californiahealthline.org/articles/2015/1/6/jones-issues-emergency-rule-over-narrow-provider-networks

[87] California Department of Health Care Services, *Medi-Cal 2020: Key Concepts for Renewal*, (March 2015) http://www.dhcs.ca.gov/provgovpart/Pages/1115-Waiver-Renewal-Official-Submission.aspx

[88] Department of Health and Human Services, Letter to Medi-Cal Managed Care Plans on Continuity of Care for Medi-Cal Beneficiaries Who Transition Into Medi-Cal Managed Care, (December 2014) http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-021.pdf

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THE VOICE FOR HEALTH CARE CONSUMERS

Affordable Care Act

Non-Group Health Insurance: Many Insured Americans with High Out-of-Pocket Costs Forgo Needed Health Care

SPECIAL REPORT / MAY 2015

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Executive Summary

Since its passage in 2010, the Affordable Care Act (ACA) has made tremendous progress in improving access to health insurance and health care for millions of Americans. Approximately 14.1 million previously uninsured Americans gained health insurance between the beginning of open enrollment in October 2013 and March 4, 2015. In fact, by that date, the share of Americans who were uninsured had dropped to 13.2 percent, compared to 20.3 percent at the end of 2013—the largest decrease in the number of uninsured since 1965.[1]

Some of the greatest declines in uninsured rates were for lower- and middle-income consumers,[2] including those eligible for tax credits to help pay their premiums for plans in the health insurance marketplaces. Data from the Department of Health and Human Services also show that more than 11 million people selected plans through the marketplaces, and more than 85 percent of these consumers qualified for premium tax credits.[3]

But simply having health insurance is no guarantee that consumers can afford to pay for health care. Health insurance involves different types of costs that consumers must pay out of pocket—ranging from a health plan's deductible to copayments at a doctor's office. These expenses add up, and research has shown that even nominal cost-sharing can deter people from getting needed care.[4] Unfortunately—as our study shows—for many Americans with non-group coverage, deductibles and other out-of-pocket costs are prohibitively high and are associated with many of these insured consumers forgoing needed health care.

Our study examined adults who bought private health insurance in the non-group market in 2014

We analyzed data from the Urban Institute's Health Reform Monitoring Survey (HRMS) on adults who bought private, non-group health insurance (as opposed to having insurance from an employer or a public coverage program) for themselves or their families in 2014. Our study examines the following:

- The incomes of adults who bought insurance, as well as the deductibles for those adults, grouped by three income levels: 139-249 percent of the federal poverty level, 250-399 percent of poverty, and 400 percent of poverty and higher.
- Problems that adults experienced with being able to afford health care, grouped by these income levels: 139-249 percent of poverty and 250 percent of poverty or more, and also grouped by the amount of their deductible.

Simply having health insurance is no guarantee that consumers can afford to pay for health care.

Unfortunately—as our study shows—for many Americans with non-group coverage, deductibles and other out-of-pocket costs are prohibitively high and are associated with many of these insured consumers forgoing needed health care.

The Affordable Care Act has increased access to health insurance and financial assistance for millions of Americans. But even with the new assistance that helps consumers pay their premiums and out-of-pocket health care costs, one-quarter of consumers who buy insurance on their own still have problems being able to afford needed care.

This report analyzes the portion of adults who bought non-group health insurance and who went without needed medical care because they could not afford it or who faced high deductibles. It also includes an analysis of the potential causes of these affordability issues, as well as recommendations that health insurers and state and federal governments can take to improve the affordability of consumers' out-of-pocket health care costs.

Income Levels of People Surveyed for This Report

In this report, we present findings for adults who bought insurance in the non-group market—people who bought health plans for themselves or their families (as opposed to having insurance from an employer or public coverage program). For several measures, we analyzed adults from two income groups and divided them accordingly:

- Adults with **lower to middle incomes**, who had family incomes between 139 and 249 percent of poverty (from $16,200 to $29,199 for an individual in 2014, or from $27,400 to $49,499 for a family of three). This group is eligible for two kinds of financial help in the health insurance marketplaces: They can get tax credits to lower their monthly premiums, and they qualify for cost-sharing reduction subsidies, which lower their deductibles, copayments, or total out-of-pocket expenses in marketplace plans.
- Adults with **middle incomes**, who had family incomes between 250 and 399 percent of poverty (from $29,200 to $46,699 for an individual in 2014, or from $49,500 to $79,199 for a family of three). People in this group are eligible only for premium tax credits to lower their monthly premiums.

We excluded from our sample people who had family incomes at or below 138 percent of poverty, because that group is eligible for Medicaid in many states.

Defining High Deductibles

In this report, we define plans with "*high deductibles*" as plans with deductibles of $1,500 or more per person.

The IRS defines high deductibles somewhat differently. For 2014, the IRS defined plans with high deductibles that could be used with health savings accounts as plans with deductibles of $1,250 or more for an individual and $2,500 or more for a family. In our study, $1,500 was the number that was closest to the $1,250 figure the IRS uses, which is why we chose that amount as the level for a high deductible.

We call plans with deductibles of $3,000 or more per person plans with "*exceedingly high deductibles*." However, consumers can have deductibles that are much higher: Plans that are sold to consumers in the non-group market can have deductibles that are as high as $6,600 for an individual in 2015.

Executive Summary continued ▶

The Affordable Care Act Is Making Health Insurance and Health Care More Affordable

The Affordable Care Act (ACA) is having a measurable impact on Americans' access to health insurance, particularly those with lower to middle incomes. Research has found that the number of uninsured in this country has reached historic lows since full implementation of the ACA's coverage provisions.[5] This is in large part due to the availability of new financial assistance to help lower- and middle-income individuals and families afford private, non-group insurance through the marketplaces, as well as to the expansion of Medicaid to low-income adults in 28 states plus the District of Columbia.[6]

And our own findings bear this out: The share of people with non-group insurance who have lower to middle incomes jumped by more than 10 percentage points from 2013 to 2014, a sign that people are seeking out and using the health care law's premium tax credits and other financial assistance. We also found that more individuals with non-group coverage had no deductible in 2014 compared to 2013 (the percentage nearly tripled), and that marketplace insurance is making out-of-pocket costs more affordable for many.

Report findings

Among adults who bought non-group insurance:

1 In 2014, the proportion of insured adults with lower to middle incomes increased (see Table 1).

In 2014, the first year that financial assistance was available in the marketplace to make insurance more affordable, more people who bought insurance on their own had lower to middle incomes.

The proportion of non-group adult enrollees who had lower to middle incomes increased from about one-quarter (**25.4** percent) in 2013 to more than one-third (**36.9** percent) in 2014.

2 More adults who bought non-group insurance had no deductible in 2014 than in 2013 (see Table 2).

The percent of adults with non-group insurance who had zero deductible nearly tripled, jumping from **3.6** percent in 2013 to **10.6** percent in 2014.

3 Adults who bought their insurance in the marketplace were less likely to have high deductibles or exceedingly high deductibles than those who bought their insurance outside the marketplace (see Table 3).

High deductibles: **42.8** percent of adults with non-group insurance in the marketplace reported having high deductibles of $1,500 or more per person, compared to **58.3** percent of adults with non-group insurance outside the marketplace.

Exceedingly high deductibles: **22.5** percent of adults with non-group insurance in the marketplace reported having exceedingly high deductibles of $3,000 or more per person, compared to **37.5** percent of adults with non-group insurance outside the marketplace.

However, as further discussed in the Methodology, some of the magnitude of these differences could be attributable to difficulties in how marketplace enrollees were identified in our survey data. We did more testing on questions to see if errors in survey responses could account for the change. While we could not be sure of the exact percentages of people who had no deductible in 2014, we continued to find that the increase was statistically significant, probably due to the availability of zero dollar deductible plans in the marketplace.[7]

Note: Unless otherwise noted, all of the adults referenced in our findings have incomes above 138 percent of poverty.

see tables on page 28 ▶

Executive Summary continued ▶

One-Quarter of Health Care Consumers with Non-Group Insurance Still Have Problems Affording Care

Our data also show that many Americans with non-group insurance still have problems being able to afford needed care. Just over one-quarter of adults who were insured for a full year still reported that they went without needed medical care during that year because they could not afford it. People with lower to middle incomes were more likely to forgo medical care due to affordability issues than people with higher incomes (those with incomes at or above 250 percent of poverty).

Furthermore, we found that people with high-deductible health plans were more likely than those with lower deductibles to forgo care. These high-deductible plans are common, even among those with lower to middle incomes: Our analysis found that nearly two in five lower- to middle-income adults had deductibles of $1,500 or more per person.

Report findings **Among adults who bought non-group insurance:**

4 **Just over one-quarter (25.2 percent) of adults who were insured for a full year went without needed medical care because they could not afford it** (excluding dental care, see Table 4).

The two most common types of care that adults went without were:

Tests, treatments, and follow-up care: **15.3** percent went without needed tests or follow-up care

Prescription drugs: **14.2** percent went without needed medications

5 **Adults with lower to middle incomes were the most likely to forgo needed medical care** (excluding dental care, see Table 5).

For **lower- to middle-income** adults who were insured for a full year, **32.3** percent didn't get needed medical care because they could not afford it.

For adults with **middle or higher incomes** (at or above 250 percent of poverty), a lower number—**22.2** percent—didn't get needed medical care because they could not afford it.

6 **Adults with high deductibles were more likely to forgo needed medical care** (excluding dental care, see Table 6).

For adults with deductibles of $1,500 or more per person who were insured for a full year, **29.8** percent went without needed medical care because they could not afford it.

For adults with deductibles under $1,500 per person, only **19.6** percent went without needed medical care because they could not afford it.

7 **In 2014, half (50.6 percent) of adults had high deductibles of $1,500 or more, and 30 percent had exceedingly high deductibles of $3,000 or more** (see Table 7).

Of adults with **lower to middle incomes**, **39.3** percent had high deductibles of $1,500 or more per person, and **22** percent had exceedingly high deductibles of $3,000 or more per person.

And for **middle-income** adults, **53.2** percent had high deductibles of $1,500 or more per person, and **29.9** percent had exceedingly high deductibles of $3,000 or more per person.

Note: Unless otherwise noted, all of the adults referenced in our findings have incomes above 138 percent of poverty.

see tables on page 31 ▶

Introduction

Consumers who buy health insurance in the non-group market saw many welcome changes in 2014, including several consumer protections. Many of these protections apply to insurance bought both inside and outside the health insurance marketplaces established by the Affordable Care Act (see sidebar).

But even with these changes, insured consumers may still have problems being able to afford care or understand their health plan's benefits. They may face high deductibles before their plans begin to pay for any care beyond preventive services. And after meeting their deductibles, they may still have to pay steep copayments and co-insurance until they reach their annual limit on out-of-pocket expenses. In addition, many consumers continue to struggle to understand the benefits and costs associated with their insurance.

We undertook this study to examine the portion of adults with non-group insurance who had high deductibles, difficulty affording care, and trouble understanding how to use their health insurance in 2014—the first year the marketplaces were fully operational. Using survey data collected in September 2013, September 2014, and December 2014 through the Urban Institute's quarterly Health Reform Monitoring Survey, we examined coverage, deductibles, reported problems with affording health care, and the ability to understand health insurance among adults with non-group coverage. We compared data across adults of various income levels, and, for some measures, between adults with marketplace coverage and adults with non-group coverage outside the marketplace.

Insurance Improvements for Consumers Who Buy Non-Group Coverage

Consumer protections that apply to insurance sold both inside and outside the marketplaces:

- Insurance companies can no longer deny coverage to people with pre-existing conditions or charge them higher premiums.
- Health plans must cover a more comprehensive scope of health care services and cover certain preventive services with no cost-sharing.
- There are annual limits on the most an individual or family has to pay out of pocket for covered benefits that are provided through their plan's network.
- Health plans are classified as platinum, gold, silver, or bronze based on their level of cost-sharing, which helps consumers understand how generous a plan's coverage is.

Benefits that apply only to plans sold in the marketplaces:

- Consumers with lower and middle incomes may qualify for tax credits to help pay for premiums.
- Consumers with lower to middle incomes may also qualify for cost-sharing reduction subsides that lower their out-of-pocket costs for covered services.
- Marketplace websites provide new tools to help consumers compare plans and learn about insurance.

Abridged Methodology

We contracted with the Urban Institute to analyze data from the Health Reform Monitoring Survey (HRMS) collected in September 2013, September 2014, and December 2014 regarding people who bought non-group individual or family health insurance. This quarterly survey is designed to provide timely information about implementation issues in the Affordable Care Act and about changes in insurance. The questions in the HRMS are often based on questions used in federal government surveys. More information about the survey is available online at http://hrms.urban.org/about.html.

We asked the Urban Institute to analyze data on non-elderly adults with non-group insurance (that is, insurance people bought for themselves or their families, rather than insurance people get through their employers or a public coverage program), including data on their deductibles and access to care. We limited our analysis to respondents with incomes above 138 percent of poverty for two reasons: First, this is the primary population that the Affordable Care Act is designed to help afford non-group insurance. And second, we wanted to be sure respondents were not confusing non-group insurance with Medicaid (which is available to consumers with incomes up to 138 percent of poverty in states that have expanded Medicaid under the Affordable Care Act).

We also limited our analysis of adults not getting needed care to adults who did not get needed medical care—excluding dental care. This is because health plans typically do not cover dental care for adults, and the primary focus of our analysis is assessing the problems consumers have being able to afford *covered care* due to cost-sharing. Adults' inability to afford dental care may be due to their not having any dental coverage rather than to problems with affording the cost-sharing associated with their health plan.

The Urban Institute tested all reported data for significance and reviewed this report for accuracy.
***For the full methodology**, including key assumptions and limitations, see page 24.*

I. The Affordable Care Act Is Making Health Insurance and Health Care More Affordable

Since the full implementation of the Affordable Care Act's coverage provisions, there have been landmark improvements in people's access to affordable health insurance and health care. As we noted earlier, surveys have found that the number of uninsured in this country has dipped to an historic low since the ACA was fully implemented.

Our findings also show notable improvements related to the affordability of health coverage and care for those buying insurance on their own in 2014. A greater portion of adults with non-group insurance had lower to middle incomes, and more people with non-group insurance had no deductible whatsoever in 2014. This is an encouraging sign that the affordability of both coverage and care is improving for some consumers.

People with marketplace insurance also were less likely to have high deductibles than people buying insurance on their own outside the marketplace in 2014. This underscores the enhanced value that marketplace coverage is providing to consumers, particularly those who qualify for financial assistance to help with cost-sharing in marketplace plans.

Section findings

Among adults who bought non-group insurance:

1 In 2014, the proportion of insured adults with lower to middle incomes increased (see Table 1).

In 2014, the first year that financial assistance was available in the marketplace to make insurance more affordable, more people who bought insurance on their own had lower to middle incomes.

*The proportion of non-group adult enrollees who had lower to middle incomes increased from about one-quarter (**25.4** percent) in 2013 to more than one-third (**36.9** percent) in 2014.*

2 More adults who bought non-group insurance had no deductible in 2014 than in 2013 (see Table 2).

*The percent of adults with non-group insurance who had zero deductible nearly tripled, jumping from **3.6** percent in 2013 to **10.6** percent in 2014.*

3 Adults who bought their insurance in the marketplace were less likely to have high deductibles or exceedingly high deductibles than those who bought their insurance outside the marketplace (see Table 3).

***High deductibles:** **42.8** percent of adults with non-group insurance in the marketplace reported having high deductibles of $1,500 or more per person, compared to **58.3** percent of adults with non-group insurance outside the marketplace.*

***Exceedingly high deductibles:** **22.5** percent of adults with non-group insurance in the marketplace reported having exceedingly high deductibles of $3,000 or more per person, compared to **37.5** percent of adults with non-group insurance outside the marketplace.*

However, as further discussed in the Methodology, some of the magnitude of these differences could be attributable to difficulties in how marketplace enrollees were identified in our survey data. We did more testing on questions to see if errors in survey responses could account for the change. While we could not be sure of the exact percentages of people who had no deductible in 2014, we continued to find that the increase was statistically significant, probably due to the availability of zero dollar deductible plans in the marketplace.[7]

Note: Unless otherwise noted, all of the adults referenced in our findings have incomes above 138 percent of poverty.

see tables on page 28 ▶

Financial assistance is helping lower- to middle-income adults afford insurance

The share of adults buying coverage on their own who had lower to middle incomes rose by more than 10 percentage points from 2013 to 2014. That's an important finding because people in this income group are the least likely to be able to afford the full cost of private insurance on their own. And that's precisely why the Affordable Care Act provides generous premium tax credits to this population.

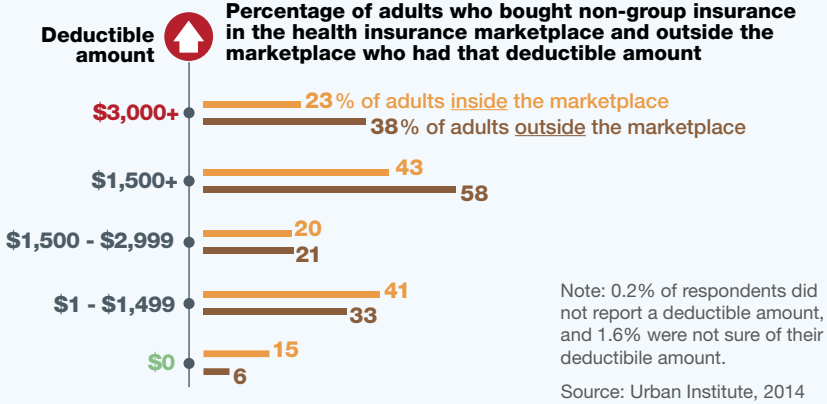
This finding is an encouraging sign that the ACA's financial assistance is truly helping more lower- to middle-income Americans afford insurance on their own.

We are hopeful that the increased proportion of non-group enrollees with lower and middle incomes is a sign that the disparity in access to coverage is closing. The Census Bureau's Current Population Survey shows that before the Affordable Care Act, people with incomes below 250 percent of poverty were less likely to have private insurance (that is, insurance either through a job or through buying non-group coverage) than people at higher income levels, and they were more likely to be uninsured.[8]

More adults have zero deductible, meaning they face one less potential barrier to care

The percent of adults with non-group insurance that had zero deductible significantly increased from 2013 to 2014, rising from 3.6 percent in 2013 to 10.6 percent in 2014. Deductibles, which require people to pay the full cost of care on their own up to a certain amount, can pose significant barriers to getting necessary care for people who can't afford to pay the full cost of care on their own.

Adults faced higher deductibles outside the marketplace



Note: 0.2% of respondents did not report a deductible amount, and 1.6% were not sure of their deductibile amount.

Source: Urban Institute, 2014

Research has shown that even nominal cost-sharing can deter people from getting needed care.[9] Given this, it is welcome news that more people buying insurance on their own do not have to worry that their deductible could make it difficult for them to be able to afford the care they need.

The increased availability of plans with no deductible may be due in part to the new cost-sharing reduction subsidies that reduce out-of-pocket costs (like deductibles) for lower- to middle-income people with marketplace insurance. We know from other data that a number of marketplace plans available to people with family incomes below 150 percent of poverty had no deductibles after cost-sharing reduction subsidies were applied.[10]

Marketplace coverage provides better value to consumers in many ways: Financial assistance that lowers premiums and cost-sharing and new tools to help consumers make informed choices about which plan to buy.

Marketplaces are making the greatest strides in improving affordability

We also found that the health insurance marketplaces are making the biggest strides in improving the affordability of cost-sharing. People buying insurance inside the marketplace were significantly less likely to have high deductibles (deductibles of $1,500 or more per person) or exceedingly high deductibles (deductibles of $3,000 or more per person) than those buying insurance outside the marketplace.

This makes sense: Marketplace coverage provides better value to consumers in many ways. Financial assistance to lower premiums and cost-sharing is available only to those with marketplace insurance. Marketplaces also include new tools consumers can use to compare coverage based on plans' out-of-pocket costs, which can help them make informed choices about which plan to buy.

II. One-Quarter of Health Care Consumers with Non-Group Insurance Still Have Problems Affording Care

Even with the historic gains made by the Affordable Care Act, many Americans with non-group insurance still have problems being able to afford needed care. Just over one-quarter of adults who were insured for a full year still went without needed medical care (excluding dental care) during that year because they could not afford it. People with lower to middle incomes were more likely to forgo medical care due to affordability issues than people with incomes above 250 percent of poverty.

Furthermore, we found that people with high-deductible health plans were more likely than those with lower deductibles to forgo care. These high-deductible plans are common, including among those with lower to middle incomes: Our analysis found that nearly two in five lower- to middle-income adults had high deductibles of $1,500 or more per person.

Section findings

Among adults who bought non-group insurance:

4 Just over one-quarter (25.2 percent) of adults who were insured for a full year went without needed medical care because they could not afford it (excluding dental care, see Table 4).

The two most common types of care that adults went without were:

*Tests, treatments, and follow-up care: **15.3** percent went without needed tests or follow-up care*

*Prescription drugs: **14.2** percent went without needed medications*

5 Adults with lower to middle incomes were the most likely to forgo needed medical care (excluding dental care, see Table 5).

*For lower- to middle-income adults who were insured for a full year, **32.3** percent didn't get needed medical care because they could not afford it.*

*For adults with middle or higher incomes (at or above 250 percent of poverty), a lower number—**22.2** percent—didn't get needed medical care because they could not afford it.*

6 Adults with high deductibles were more likely to forgo needed medical care (excluding dental care, see Table 6).

*For adults with deductibles of $1,500 or more per person who were insured for a full year, **29.8** percent went without needed medical care because they could not afford it.*

*For adults with deductibles under $1,500 per person, only **19.6** percent went without needed medical care because they could not afford it.*

7 In 2014, half (50.6 percent) of adults had high deductibles of $1,500 or more, and 30 percent had exceedingly high deductibles of $3,000 or more (see Table 7).

*Of adults with **lower to middle incomes, 39.3** percent had high deductibles of $1,500 or more per person, and **22** percent had exceedingly high deductibles of $3,000 or more per person.*

*And for **middle-income** adults, **53.2** percent had high deductibles of $1,500 or more per person, and **29.9** percent had exceedingly high deductibles of $3,000 or more per person.*

Note: Unless otherwise noted, all of the adults referenced in our findings have incomes above 138 percent of poverty.

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Even adults who were insured for a full year had to go without needed medical care because they could not afford their out-of-pocket costs for care

Overall, 25.2 percent of adults who were insured for a full year didn't get needed care (excluding dental care) during the year because they could not afford it. Medical tests, treatments, and follow-up care were the most common types of care that adults had to forgo, followed by prescription drugs. For adults who were insured for a full year, 15.3 percent did not get needed medical tests, treatment, or follow-up care because they could not afford it, and 14.1 percent did not get needed medication because they could not afford it.

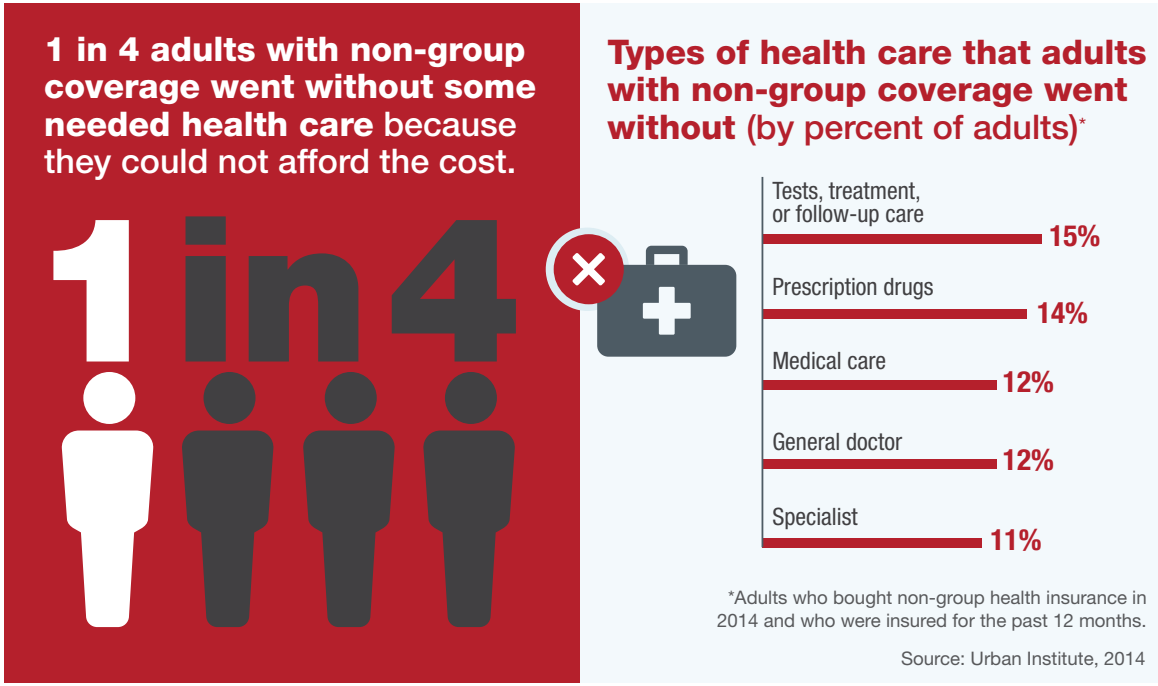
It is critically important that consumers be able to afford all of these types of care. Not getting recommended follow-up care to treat an illness or not taking needed medications can result in people facing avoidable, more serious health problems and more expensive health care costs down the road. For people with chronic conditions, consistently taking necessary medications and getting recommended tests can be vital to managing their condition.

Other research has found that insurers are designing many marketplace plans in ways that could impede access to these types of care. For example, silver marketplace plans often require that people meet a large deductible before the plan covers any care except for preventive care. Furthermore, nearly half of silver plans have a single deductible that applies to both medical and drug costs.[11]

These types of benefit designs can make being able to afford necessary prescription drugs and follow-up care more difficult for people who cannot afford to pay all or most of the cost of such care on their own.

A more consumer-friendly benefit design would have two smaller deductibles, including a small deductible for drugs and a separate deductible for other health care. Consumer-friendly plans could also be similar to many employer-based plans, which are more likely to cover some services, such as doctor visits, even before enrollees pay the full deductible.[12]

Silver marketplace plans, a popular choice with consumers, often require that people meet a large deductible before the plan covers any care except for preventive care. A more consumer-friendly benefit design would cover some services even before enrollees pay the full deductible.



Adults with lower to middle incomes have the most trouble affording some medical costs

Lower- to middle-income adults who were insured for the full year were significantly more likely than those with higher incomes to forgo needed care because they could not afford it: Nearly one-third (32.3 percent) of lower- to middle-income adults didn't get needed medical care (excluding dental care) because they could not afford it.

This population has income that would qualify it for financial assistance to reduce cost-sharing in marketplace insurance. For some, that extra help reduces their deductibles. But for others in this income group, the extra help reduces only the maximum annual out-of-pocket limit that they would face in a year.

As our findings show, even with cost-sharing assistance, some lower- to middle-income consumers still found their out-of-pocket costs for covered care to be unaffordable during the previous 12 months.

But middle- and higher-income adults also struggle to afford medical costs

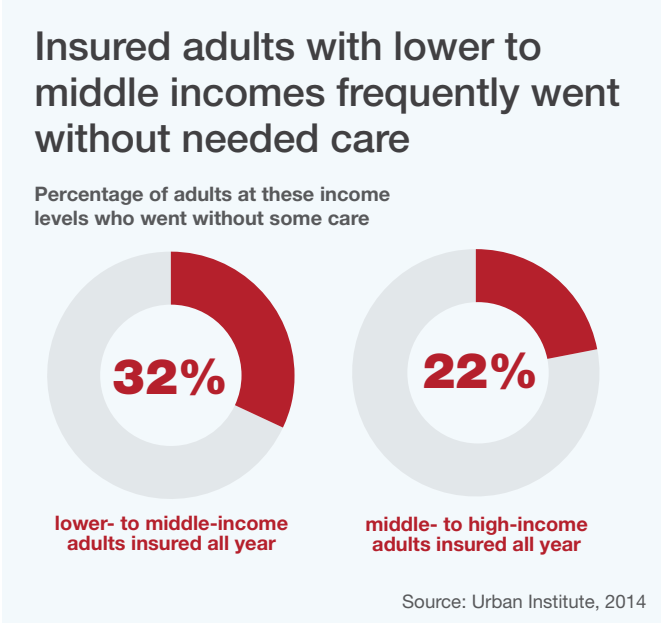
Among adults with incomes at or above 250 percent of poverty (who do not qualify for financial assistance with cost-sharing), more than one-fifth (22.2 percent) didn't get some needed care because they could not afford it.

While lower- to middle-income adults have the most difficulty with out-of-pocket costs, this finding clearly shows that many consumers with incomes at or above 250 percent of poverty also struggle to afford their cost-sharing for medical care that is covered by their plan.

High deductibles are associated with barriers to health care

Our analysis found that adults who had deductibles of $1,500 or more per person were more likely than those with lower deductibles to forgo needed care (excluding dental care) because they could not afford it.

Previous research has also found that high deductibles can create barriers that prevent consumers from getting needed care, particularly for consumers with lower incomes. Most notably, a recent Commonwealth Fund report found that people with deductibles that exceeded 5 percent of their income were more likely to delay or forgo needed care due to cost than those with lower deductibles relative to their income.[14]



A recent Commonwealth Fund report found that people with deductibles that exceeded 5 percent of their income were more likely to delay or forgo needed care due to cost than those with lower deductibles relative to their income.

Table 8. Combined Cost of Deductibles and Premiums for a Single Individual with Non-Group Health Insurance, 2014

INCOME	DEDUCTIBLE AMOUNT	DEDUCTIBLE AS A PERCENT OF INCOME	PREMIUM CONTRIBUTION AS A PERCENT OF INCOME	PREMIUM CONTRIBUTION AMOUNT	COMBINED ANNUAL COST AS A PERCENT OF INCOME	COMBINED ANNUAL AMOUNT
$29,200 MIDDLE INCOME (250% of poverty)	$1,500	5.14%	8.05%	$2,351	13.19%	$3,851
	$3,000	10.27%	8.05%	$2,351	18.32%	$5,351

Source: Families USA's estimate of the premium contribution for an adult with income at 250 percent of poverty is based on the percent of income the federal government expected consumers with this income to spend on premiums for a second least-expensive silver plan in 2014.

This means that **lower- and middle-income adults are particularly likely to forgo needed care when faced with deductibles that exceed $1,500 or, even more problematic, $3,000.** For these consumers, high and exceedingly high deductibles take up a relatively larger portion of their income compared to consumers with higher incomes (see Table 8 and the graphic on page 15).

Proponents of high deductibles argue that because high-deductible plans require consumers to pay more of their medical costs up front, these plans give consumers an incentive to use health care more wisely. However, our findings and previous research tell a different and more troubling story: High deductibles are associated with consumers having difficulty getting the care they need.

A significant number of adults have high deductibles that could be unaffordable

We also found that a substantial number of adults with lower to middle incomes still faced high deductibles (deductibles of $1,500 or more) that could be unaffordable and could prevent them from getting needed care. Among adults with lower to middle incomes, nearly two in five (39.3 percent) had deductibles that were $1,500 per person or higher. And more than one in five (22 percent) had deductibles that were $3,000 per person or higher.

Among middle-income adults, more than half (53.2 percent) had deductibles of at least $1,500 per person, and nearly one in three (29.9 percent) had exceedingly high deductibles of $3,000 or more per person.

As discussed in the previous section, our own findings and previous research suggest that deductibles of this magnitude can create problems obtaining needed care, particularly for lower- and middle-income consumers. Recent research has also found that less than half of people with private insurance who have incomes between 100 and 250 percent of poverty have financial assets that are adequate to cover a deductible of even $1,200 for an individual.[15]

It is important to note that not everyone needs enough health care that they would end up paying all of a

The Combined Cost of Premiums and Deductibles Can Eat Up a Substantial Portion of People's Income

Covering the cost of a high deductible in addition to premiums can be a substantial financial burden for lower- to middle-income consumers. These graphics illustrate the scope of problems deductibles pose for consumers.

To calculate premiums for these adults, we used the percent of income the federal government expects consumers to spend on premiums for a second least-expensive silver plan.

1 How high deductibles and premiums can add up for a middle-income individual

Middle-income individual with marketplace coverage

Annual income
middle-income adult (250% of poverty)

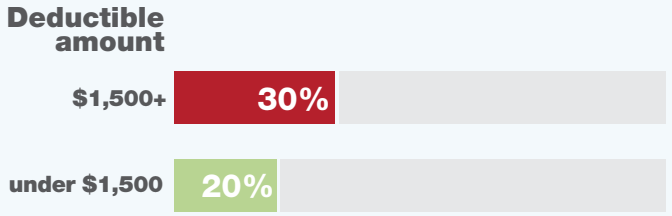
$29,200

Deductible:	$1,500 (5.14% of income)	$3,000 (10.27% of income)
+ Annual premium contribution after premium tax credits:	$2,351 (8.05% of income)	$2,351 (8.05% of income)
Individual's combined cost of deductible + annual premium:	**$3,851 (13.19% of income)**	**$5,351 (18.32% of income)**

Source: Families USA, 2014

2 Insured adults with higher deductibles are more likely to go without needed care

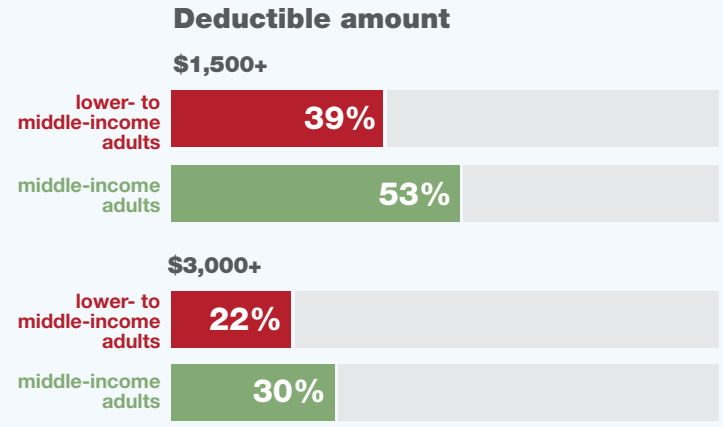
Percentage of adults at these deductible levels who went without some care



Source: Urban Institute HRMS, September and December 2014

3 Significant portions of lower- and middle-income adults face high deductibles

Percentage of adults at these income levels who had high deductibles



Source: Urban Institute HRMS, September and December 2014

$1,500 or $3,000 deductible. But lower- and middle-income adults who do have high health care costs would spend a substantial portion of their income on meeting their deductible—in addition to paying their premium—before their plan would help pay for needed care (see Table 8). For example:

- For a single adult making $29,200 (250 percent of poverty), a deductible of $1,500 plus what he or she is expected to pay in premiums for a silver plan, after premium tax credits, constitutes more than 13 percent of his or her income.
- With a $3,000 deductible, that same adult would have to pay more than 18 percent of his or her income toward premiums for a silver plan and the deductible.

The bottom line: Our findings show that too many lower- and middle-income consumers face deductibles that are likely unaffordable relative to their income and that could create barriers to them getting the care they need.

Too Many Adults Continue to Go Without Dental Care

Access to dental coverage and care is one of the most persistent problems for many adults. The Affordable Care Act made dental care a required benefit for children's insurance, but it did not extend this requirement to insurance for adults. Therefore, many adults who buy non-group insurance may still have no dental coverage. In 2008, nearly 70 percent of people who bought health insurance on their own did not have dental coverage.[13]

Without dental coverage, many adults struggle to get the dental care they need.

Our primary analysis excluded reports of forgoing needed dental care (see the Methodology on page 24). However, the Urban Institute's Health Reform Monitoring Survey does ask people whether they went without needed dental care because they could not afford it.

We examined reports of adults not getting needed dental care, and the findings were striking:

Dental care was the most common type of health care service adults went without due to affordability issues. Nearly one in four (24 percent of) adults who were insured for a full year reported not getting needed dental care during the year due to affordability issues. While those with lower to middle incomes were most likely to have trouble affording this care, even among adults with incomes at or above 250 percent of poverty, it was still the most common type of care that they had to forgo because they could not afford it (see Table 5).

This finding underscores the need to address the dental coverage gap in this country. Moving forward, it is critical that Congress requires all marketplace plans to include adult dental coverage. Without policies that expand access to affordable dental coverage to all adults, many adults will continue to be unable to afford the dental care they need.

Do high-deductible plans help consumers make better ("high-value") decisions about their health insurance?

Proponents of high-deductible plans assert that making consumers spend more to cover their medical care will induce them to seek high-value care. But this is not possible for the many consumers who do not have the tools or the basic understanding of how their health insurance works in order to make informed decisions about what care to get at what price.

Health insurance is complex. Not only is it difficult for any consumer to understand the complexities of his or her insurance and the resulting health care costs, but consumers who struggle with literacy or whose primary language is not English face even greater barriers. About 25 million Americans have limited English proficiency.[a]

Without an understanding of what they will have to pay out of pocket, consumers may buy plans that have low monthly premiums but that also have high deductibles that are difficult to afford and that don't meet their needs. And once enrolled, consumers who are uncertain about their out-of-pocket costs can experience problems with paying medical bills or may need to forgo care.

The Affordable Care Act provides new tools, such as a short "summary of benefits and coverage," that are designed to help consumers understand what care is covered by their plan and how much they may need to pay for care. However, it is still a big leap to assume that consumers are able to determine their costs.

In our study, about a quarter of survey respondents for quarters three and four of 2014 lacked the confidence that they could determine:

- whether a service was covered
- which drugs were covered or what they would cost
- the maximum they could be charged out of pocket for covered services in their health plan

And about a third of respondents were not confident that they could figure out what costs counted toward their deductible.

These findings are consistent with previous research on health insurance literacy.[b,c]

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a. U.S. Census Bureau, *2009-2013 5-Year American Community Survey*, available online at http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_13_5YR_DP02&prodType=table.

b. Kathryn Paez and Coretta Mallery, *A Little Knowledge Is a Risky Thing: Wide Gaps in What People Think They Know about Health Insurance and What They Actually Know* (Washington: American Institutes for Research, October 2014), available online at http://www.air.org/sites/default/files/Health%20Insurance%20Literacy%20brief_Oct%202014_amended.pdf.

c. Mira Norton, Liz Hamel, and Mollyann Brodie, *Assessing Americans' Familiarity with Health Insurance Terms and Concepts* (Washington: Kaiser Family Foundation, November 2014), available online at http://kff.org/health-reform/poll-finding/assessing-americans-familiarity-with-health-insurance-terms-and-concepts/.

III. Why are people still struggling with out-of-pocket costs?

The Affordable Care Act provides critical financial assistance to lower- and middle-income individuals and families to help them afford both coverage and care in the marketplace. However, our findings show that a substantial portion of people with non-group coverage, including some who may be eligible for this financial assistance, continued to have trouble being able to afford care.

There are multiple factors that are likely contributing to affordability problems in the non-group market. We discuss the three most salient factors.

In the federally facilitated marketplaces, more than three out of four people who received premium tax credits bought silver plans in 2014.

1. Premium tax credits are tied to silver plans, which often have cost-sharing that is too high for many consumers to be able to afford

Premium tax credits are designed for lower- and middle-income consumers to help them pay their monthly premiums. These tax credits are benchmarked to silver level plans: The formula for calculating the amount of tax credits is intended to assure that people who buy a typical silver plan will not have to pay more than an affordable percentage of their income on premiums.

Although consumers are allowed to use these tax credits to cover the cost of more generous (and more expensive) gold or platinum plans, most lower- to middle-income consumers cannot afford to buy these more expensive plans. This is likely one reason why silver plans are the most popular type of plan. For example, in the federally facilitated marketplaces, more than three out of four people who received premium tax credits bought silver plans in 2014.[16]

Because these tax credits are designed to help a population with lower and middle incomes, it is equally important to keep these consumers' cost-sharing amounts (deductibles and other out-of-pocket costs)

Because these tax credits are designed to help a population with lower and middle incomes, it is equally important to keep these consumers' cost-sharing amounts (deductibles and other out-of-pocket costs) low.

low. Consumers with low to middle incomes can get help with reducing their cost-sharing in a silver plan through cost-sharing reductions. This help reduces cost-sharing a great deal for people with incomes below 200 percent of poverty (about $23,500 for an individual), and it reduces cost-sharing somewhat for people with incomes up to 250 percent of poverty (about $29,200 for an individual).

But these reductions are not available to middle-income consumers. And if middle-income consumers cannot get help that reduces those high cost-sharing amounts in silver plans, these consumers can still face unaffordable deductibles and other out-of-pocket costs: The estimated average deductible of silver plans in 2014 was between $2,267 and $3,030.[17]

2. Only a portion of the lower-income consumers who are eligible for subsidies to reduce cost-sharing in silver plans receive substantial help to also reduce their deductibles

People with incomes between 100 and 250 percent of poverty qualify not just for premium tax credits, but also for cost-sharing reduction subsidies that lower the out-of-pocket costs associated with silver plans. Of this group:

- **People with incomes below 200 percent of poverty** qualify for assistance that greatly reduces their out-of-pocket maximum in silver plans, as well as the specific amounts they must pay in upfront cost-sharing for care, like deductibles, copayments, and co-insurance.
- **People with incomes between 200 and 250 percent of poverty** are eligible only for more limited assistance, which significantly reduces their out-of-pocket maximum but provides only **minor assistance** with the amounts of upfront cost-sharing.

Avalere, a public policy research firm that has conducted extensive analyses of marketplace plan offerings, has estimated that **the average deductible of silver plans offered in the marketplace to people with incomes between 200 and 250 percent of poverty, after accounting for cost-sharing reductions, was $2,342 in 2014**.[18] This shows that even some consumers who receive help with cost-sharing may still find their out-of-pocket costs for care to be unaffordable.

3. Insurers are choosing to design silver plans with upfront cost-sharing that is too high for lower- and middle-income consumers to afford

As we noted earlier, many insurers are offering silver plans that have high deductibles. In addition, many of these plans don't help pay for even basic primary care and medications before the consumer pays the full cost of his or her deductible.[19] This can make high-deductible plans particularly problematic for lower- and middle-income consumers.

Due to federal requirements that govern the way silver plans are designed, these plans must have higher cost-sharing for more extensive or complex medical care. However, **insurers do have the flexibility to design silver plans that charge low cost-sharing**

Only a portion of the lower-income consumers who are eligible for subsidies to reduce cost-sharing in silver plans receive substantial help to also reduce their deductibles.

for basic outpatient care like primary care visits, some prescription drugs, blood work, diagnostic testing, and secondary preventive services (services that help manage chronic conditions like diabetes or asthma).

The main ways insurers can do this is by exempting these types of services from the deductible (meaning that the health plan helps pay for these services even before the deductible is fully paid) and by charging low copayments for this type of care. Insurers also can design silver plans with low or no deductible.

Unfortunately, not enough insurers are taking advantage of that flexibility. This means that many lower- and middle-income consumers with silver plans may still struggle to get the basic care they need because they are not able to afford to pay the full cost of a doctor visit or medication out of pocket.

Designing Silver Health Plans that Are More Affordable for Lower- and Moderate-Income Consumers

In the health insurance marketplaces, low- and moderate-income consumers who use premium tax credits tend to buy silver plans. But recent analyses show that these types of plans typically have high deductibles. Our original research shows that it doesn't have to be this way—insurers can choose to create silver plans with upfront cost-sharing amounts that are lower than those in high-deductible plans.

Our brief, *Designing Silver Health Plans with Affordable Out-of-Pocket Costs for Lower- and Moderate-Income Consumers* (http://familiesusa.org/silver-plan-design), features:

- original research identifying existing silver plan designs that make the upfront cost for care more affordable
- policy and advocacy strategies to help advocates and policy makers effectively promote similar plan designs in other marketplaces across the country

IV. Policy Recommendations

To address the issues we outlined above, we've included five recommendations that health insurers, marketplaces, and state and federal policy makers can take up to reduce the burden of out-of-pocket costs for lower- and middle-income consumers with non-group coverage.

Health Insurers, Marketplaces, and State and Federal Policy Makers Should Improve Health Plan Offerings in the Non-Group Market

Moving forward, more health plans in the marketplaces need to have affordable cost-sharing for, at minimum, primary care, basic outpatient services, and prescription drugs. This is particularly important for plans at the silver level, given their popularity and the fact that premium tax credits are tied to the cost of silver plans. Increasing the number of plans with affordable cost-sharing for basic care is critical to ensuring that all individuals can afford the care they need to maintain their health and well-being regardless of their deductible.

There are multiple actions that health insurers, marketplaces, and state and federal policy makers can take to achieve this goal:

Health insurers should offer more plans at the silver level that have low or no cost-sharing for primary care, other outpatient services, and prescription drugs. Insurers have the flexibility to design silver plans with low or no medical deductibles. They can also offer silver plans that help pay for many outpatient services before the deductible is fully paid, including primary care, mental health visits, prescription drugs, blood work, diagnostic testing, and secondary preventive services. It is critical that more insurers take advantage of this flexibility.

Policymakers at the state and federal levels should require health insurers to sell silver plans with lower cost-sharing for primary care, other outpatient services, and prescription drugs. For example, a state could require all insurers in the state to sell at least one plan at the silver level (both inside and outside the marketplace) that exempts primary care, mental health visits, prescription drugs, and secondary preventive services from its deductible. A state-based marketplace could establish such a requirement for all insurers that sell qualified health plans in the marketplace. Or the federal government could require this of all insurers that sell qualified health plans, across all states.

More state-based marketplaces should design standardized plan offerings (plan designs that

Moving forward, more health plans in the marketplaces need to have affordable cost-sharing for, at minimum, primary care, basic outpatient services, and prescription drugs.

participating insurers are required to sell) that have lower cost-sharing for primary care, other outpatient services, and prescription drugs. Six state-based marketplaces already have standardized plan offerings, and the District of Columbia will have standardized plan offerings in the 2016 plan year.[21] Many of these states have designed standardized plans at the silver level that exempt numerous outpatient services from the deductible. These standardized plans can serve as models for other state-based marketplaces.[22]

Federal and State Lawmakers Must Strengthen the Financial Assistance for Marketplace Insurance

Even with existing financial assistance, lower- and middle-income consumers can still face unaffordable out-of-pocket costs relative to their income. Looking forward, state governments and the federal government must find ways to provide more generous financial assistance to reduce the out-of-pocket costs in marketplace insurance.

At the federal level, Congress should:

Provide cost-sharing reduction subsidies to middle-income consumers and increase the generosity of this help. Congress should expand eligibility for cost-sharing reduction subsidies to middle-income consumers with incomes above 250 percent of poverty. It should also increase the generosity of these subsidies so that they reduce consumers' upfront out-of-pocket costs more than they currently do. This will help ensure that cost-sharing is more affordable relative to consumers' income.

At the state level, lawmakers can also strengthen financial assistance:

States can also enhance financial assistance. Some states have reduced the cost-sharing for lower- to middle-income consumers with marketplace coverage by adding state funding to the funding that is available from the federal government. For example, Minnesota has established a Basic Health Program, an option available under the Affordable Care Act, using federal funds to design a plan for residents with incomes up to 200 percent of poverty that has lower cost-sharing.

See our blogs, *Tackling Affordability Barriers in the Affordable Care Act* (http://familiesusa.org/blog/2014/09/trending-tackling-affordability-barriers-affordable-care-act) and *Promoting Plans with Affordable Upfront Out-of-Pocket Costs* (http://familiesusa.org/product/designing-silver-health-plans-affordable-out-pocket-costs-lower-and-moderate-income) for more information about state strategies and standardized health plans.

Conclusion

The Affordable Care Act has made landmark achievements in expanding access to affordable coverage, and it provides substantial help with out-of-pocket costs for many lower-income consumers. However, as our findings show, many lower- and middle-income consumers who buy insurance on their own continue to face high out-of-pocket costs and have problems affording care.

Moving forward, we must build upon the foundation created by the health care law. Health insurers, marketplaces, and state and federal policymakers must take additional steps to improve the affordability of cost-sharing to ensure that all consumers can afford the care they need.

Methodology

We contracted with the Urban Institute to analyze data through the Health Reform Monitoring Survey (HRMS) concerning the population enrolled in non-group coverage in 2013 and 2014. The HRMS is a nationally-representative, quarterly survey of the nonelderly population that explores the value of cutting-edge, Internet-based survey methods to monitor the Affordable Care Act (ACA) before data from federal government surveys are available.

This analysis examines data collected from adults aged 18-64 in the September 2013, September 2014, and December 2014 waves of the HRMS who reported that they purchased coverage directly from an insurance company, including through an exchange or marketplace such as Healthcare.gov. We excluded people with incomes at or below 138 percent of poverty from the analysis to ensure that respondents were not confusing Medicaid with private insurance, and we excluded people who reported that they had coverage through an employer or the military, as well as people who had multiple coverage types if Medicare or Medicaid was the main source of their coverage.

Source of Coverage

One limitation of the HRMS survey is that respondents may have difficulty accurately reporting whether they have public or private coverage and whether they use the marketplace to purchase coverage. The survey asks two main questions to discern this information.

First, respondents are asked about the type of coverage they have.

- One of the alternatives is: "Insurance purchased directly from an insurance company (by you or another family member). This would include coverage purchased through an exchange or marketplace, such as Healthcare.gov [or the state-specific marketplace name]."
- Another option is: "Medicaid, Medical Assistance (MA), the Children's Health Insurance Program (CHIP) or any kind of state or government-sponsored assistance plan based on income or a disability. [IF THE RESPONDENT IS IN A STATE WITH STATE-SPECIFIC PROGRAM NAMES INSERT: You may know this type of coverage as [state-specific program name(s)].]"
- Respondents can select more than one coverage type, and those reporting other, non-specified coverage are asked in a follow-up question to provide a verbatim response describing what type of health insurance they have.

Second, respondents are asked:

- "As you may know, new state and federal health insurance marketplaces can be used to shop for health insurance and compare prices and benefits. These marketplaces can also be used to enroll in Medicaid, Medical Assistance or the Children's Health Insurance Program (CHIP). You may know the marketplace as Healthcare.gov [IF THE RESPONDENT IS IN A STATE WITH STATE-SPECIFIC NAMES, INSERT [or (INSERT PROGRAM NAME)]. You may have seen a website or materials with the following marketplace logo[s]. [INSERT HEALTHCARE.GOV LOGO AND RELEVANT STATE MARKETPLACE LOGO, IF ANY] Is your current coverage a health insurance plan through the marketplace?"

By eliminating from our sample the group of adults with family income at or below 138 percent of poverty who reported having a plan through the marketplace, we minimized the chances that people with Medicaid would be among our sample. Still, there may be inaccuracies in responses. For example, for people who reported income inaccurately or who lived in states with higher Medicaid income guidelines, there may still have been some confusion between the two programs. In addition, because premium

and cost-sharing subsidies are provided through the public sector, some respondents might interpret marketplace coverage as "Medicaid, Medical Assistance (MA), the Children's Health Insurance Program (CHIP) or any kind of state or government-sponsored assistance plan based on income or a disability" instead of private non-group coverage.

Income Groups

We compared the incomes of people enrolling in plans between 2013 and 2014 and the size of their deductibles. For some measures, we looked closely at two income groups: "lower- to middle-income adults" with family income between 139 and 249 percent of poverty, and "middle-income adults" with family income between 250 and 399 percent of poverty.

Beginning in 2014, lower- to middle-income adults who purchase coverage through an exchange or marketplace such as Healthcare.gov are eligible for tax credits that lower their monthly premiums and for cost-sharing reductions. Middle-income adults are not eligible for cost-sharing reductions, but they are eligible for premium tax credits if they buy plans through exchanges or marketplaces.

Affording Needed Health Care

We also examined responses to questions about the ability to afford care in the 2014 waves of the HRMS. The HRMS asks respondents whether there was any time over the past 12 months that they did not get one of the following needed medical services because they couldn't afford it: prescription drugs, medical care, an appointment with a general doctor, an appointment with a specialist, medical tests, treatment or follow-up care, dental care, mental health care or counseling, treatment of counseling for alcohol or drug abuse, medical equipment or supplies, and family planning or contraceptive prescriptions (for females only).

Dental Care

In its questions regarding whether adults did not get needed care in the past 12 months because they could not afford it, the HRMS asks whether people went without dental care because they could not afford it. We chose to exclude from our main analysis reports of not obtaining needed dental care and looked only at the proportion of adults who had problems affording other health care services besides dental care.

We did this because the primary goal of our analysis was to assess whether plans' cost-sharing was unaffordable and made it difficult for consumers to obtain necessary care. To do this, we needed to look at how often people went without *covered services* due to affordability issues.

However, adult dental care is not a required benefit that health plans must cover, so many health insurance plans simply don't cover it. This means that determining how many adults found their plan's cost-sharing to be unaffordable and did not get covered care as a result can be muddied by looking at individuals who did not get needed care, including dental care.

By excluding reports of not getting needed dental care, our analysis more accurately captured how many adults find cost-sharing for *covered services* to be unaffordable.

Health Insurance Literacy

Finally, we examined responses to questions in the 2014 waves of the HRMS that asked insured respondents to rate their confidence in figuring out which drugs and services were covered by their plan; what they would have to pay for a drug, visit, or service; which costs counted toward the plan's deductible; and the maximum they would need to pay out of pocket for services covered by the health plan in a given year.

Endnotes

1 Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Coverage and the Affordable Care Act* (Washington: Office of the Assistant Secretary for Planning and Evaluation, March 16, 2015), available online at http://aspe.hhs.gov/health/reports/2015/uninsured_change/ib_uninsured_change.pdf; Sarah Kliff, "Under Obamacare, America's Uninsured Rate Has Fallen 35 Percent," *Vox*, March 16, 2015, available online at http://www.vox.com/2015/3/16/8225253/obamacare-uninsured-medicare.

2 These are families with incomes between 139 and 400 percent of poverty. Office of the Assistant Secretary for Planning and Evaluation, op. cit.

3 Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplace 2015 Open Enrollment Period: March Enrollment Report* (Washington: Office of the Assistant Secretary for Planning and Evaluation, March 10, 2015), available online at http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf.

4 Katherine Swartz, *Cost-Sharing: Effects on Spending and Outcomes* (Princeton, NJ: The Robert Wood Johnson Foundation, December 2010), available online at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103. http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/nov/1784_collins_too_high_a_price_out_of_pocket_tb_v2.pdf.

5 Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Coverage and the Affordable Care Act*, op. cit.; Sarah Kliff, op. cit.; Katherine Grace Carman and Christine Eibner, *Changes in Health Insurance Enrollment Since 2013* (Santa Monica, CA: RAND Corporation, 2014); Sara Collins, Petra W. Rasmussen, and Michelle M. Doty, *Gaining Ground: Americans' Health Insurance Coverage and Access to Care after the Affordable Care Act's First Open Enrollment Period* (New York: The Commonwealth Fund, 2014); Sharon Long et al., *Taking Stock: Health Insurance Coverage under the ACA as of September 2014* (Washington: Urban Institute, 2015).

6 Katherine Grace Carman and Christine Eibner, op. cit.; Sara Collins, Petra W. Rasmussen, and Michelle M. Doty, op. cit.; Sharon Long et al., op. cit.

7 For example, using a more restrictive definition of marketplace enrollment, we find that only 7 percent of marketplace enrollees had a zero dollar deductible in 2014. This definition excludes respondents who reported having only public coverage when asked what type of health insurance coverage they had, but who reported having a health insurance plan through the marketplace in a follow-up question. See the Methodology for additional details.

8 Jessica Smith and Carla Medalia, *Health Insurance Coverage in the United States: 2013* (Washington: U.S. Census Bureau, September 2014), available online at http://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-250.pdf.

9 Katherine Swartz, op. cit.

10 Healthcare.gov, *QHP Landscape Individual Market Medical*, available online at https://data.healthcare.gov/dataset/QHP-Landscape-Individual-Market-Medical/b8in-sz6k, accessed on April 1, 2015.

11 Robert Wood Johnson Foundation and Breakaway Policy Strategies, *Take Two Aspirin: An Examination of Physician Visit Cost Sharing and Benefit Design in the New Health Insurance Marketplaces* (Washington: Robert Wood Johnson Foundation and Breakaway Policy Strategies, July 2014), available online at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf414722; Robert Wood Johnson Foundation and Breakaway Policy Strategies, *Eight Million and Counting: A Deeper Look at Premiums, Cost Sharing, and Benefit Design in the New Health Insurance Marketplaces* (Washington: Robert Wood Johnson Foundation and Breakaway Policy Strategies, May 2014), available online at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf412878.

12 Robert Wood Johnson Foundation and Breakaway Policy Strategies, *Take Two Aspirin: An Examination of Physician Visit Cost Sharing and Benefit Design in the New Health Insurance Marketplaces*, op. cit.

13 Barbara Bloom and Robin Cohen, *Dental Insurance for Persons under Age 65 Years with Private Health Insurance: United States, 2008* (Hyattsville, MD: National Center for Health Statistics, June 2010), available online at http://www.cdc.gov/nchs/data/databriefs/db40.pdf.

14 Sara R. Collins, Petra W. Rasmussen, Michelle M. Doty, and Sophie Beutel, *Too High a Price: Out-of-Pocket Health Care Costs in the United States: Findings from the Commonwealth Fund Health Care Affordability Tracking Survey, September-October 2014* (Washington: The Commonwealth Fund, November 2014).

15 Gary Claxton, Matthew Rae, and Nirmita Panchal, *Consumer Assets and Patient Cost Sharing* (Washington: Kaiser Family Foundation, February 2015), available online at http://kff.org/health-costs/issue-brief/consumer-assets-and-patient-cost-sharing/.

16 In the 2014 annual open enrollment period, across all federally facilitated marketplaces, 69 percent of marketplace enrollees chose a silver plan, and 76 percent of consumers who received premium tax credits chose a silver plan. Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period* (Washington: Office of the Assistant Secretary for Planning and Evaluation, May 1, 2014), available online at http://aspe.hhs.gov/health/reports/2014/marketplaceenrollment/apr2014/ib_2014apr_enrollment.pdf.

17 Estimates of the average deductible of silver plans in 2014 have varied depending on the data sources and methodology used to calculate them. Breakaway Policy Strategies' analysis of a sample of 1,208 unique silver plans sold through health insurance marketplaces in 2014 found the average individual deductible for silver plans that had a combined deductible (where medical and drug expenses count toward the same deductible) was $2,267. This analysis found that the median individual medical deductible for silver plans with a separate drug deductible was $2,500. Avalere conducted multiple analyses of silver plan offerings in 2014. Its December 2013 analysis of 207 silver marketplace plans found that the average individual medical deductible was $2,567. It did not specify whether this analysis included both combined deductibles and medical-only deductibles. A subsequent analysis by Avalere used the HHS Landscape file to analyze all silver marketplace plans across 34 states. It found that the average individual medical deductible for silver plans was $3,030. This susbequent analysis defined medical deductibles to include both combined deductibles and separate medical deductibles. Robert Wood Johnson Foundation and Breakaway Policy Strategies, *Eight Million and Counting: A Deeper Look at Premiums, Cost Sharing, and Benefit Design in the New Health Insurance Marketplaces*, op. cit.; Mathew Eyles, *Analysis: Consumer Deductibles Vary Significantly across Exchange Plans* (Washington: Avalere, December 11, 2013), available online at http://avalere.com/expertise/managed-care/insights/analysis-consumer-deductibles-vary-significantly-across-exchange-plans; Kelly Brantley, Hillary Bray, and Caroline Pearson, *Analysis of Benefit Design in Silver Plan Variations* (Washington: Avalere, June 2014), available online at http://avalere.com/expertise/managed-care/insights/avalere-analysis-cost-sharing-reductions-unevenly-applied-across-services-i.

18 Kelly Brantley, Hillary Bray, and Caroline Pearson, op. cit.

19 Robert Wood Johnson Foundation and Breakaway Policy Strategies, *Take Two Aspirin: An Examination of Physician Visit Cost Sharing and Benefit Design in the New Health Insurance Marketplaces*, op. cit.

20 For more information, see Lydia Mitts, *Designing Silver Health Plans with Affordable Out-of-Pocket Costs for Lower- and Moderate-Income Consumers* (Washington: Families USA, May 2014), available online at http://familiesusa.org/product/designing-silver-health-plans-affordable-out-pocket-costs-lower-and-moderate-income.

21 Lydia Mitts, *Standardized Health Plans: Promoting Plans with Affordable Upfront Out-of-Pocket Costs* (Washington: Families USA, December 2014), available online at http://familiesusa.org/product/standardized-health-plans-promoting-plans-affordable-upfront-out-pocket-costs.

22 For more information see, Lydia Mitts, *Designing Silver Health Plans with Affordable Out-of-Pocket Costs for Lower- and Moderate-Income Consumers*, op. cit.

Appendix

Table 1. Income of Adults with Non-Group Health Insurance, 2013 and 2014

INCOME AS A PERCENT OF POVERTY	PERCENT OF NON-GROUP INSURANCE ENROLLEES IN 2013^	PERCENT OF NON-GROUP INSURANCE ENROLLEES IN 2014
LOWER- TO MIDDLE-INCOME (139-249%)	25.4%	36.9%***
MIDDLE-INCOME (250-399%)	29.1%	25.9%
HIGH-INCOME (at or above 400%)	45.6%	37.2%***

Source: Urban Institute analysis of Health Reform Monitoring Survey data collected in September 2013 and September and December 2014.

Notes: We excluded people with incomes at or below 138 percent of poverty to eliminate possible confusion with Medicaid coverage. In many states, people with incomes up to 138 percent of poverty are eligible for Medicaid.

As more lower- to middle-income adults were able to afford marketplace insurance, they made up a bigger portion of non-group market enrollees. This does not mean that fewer middle- or higher-income adults bought coverage on their own in 2014 than previously: We do not provide data on the overall number of people with non-group insurance or the overall number of people with insurance. Analysis by HHS found that between the start of 2014 and the first two months of 2015, the number of uninsured dropped significantly among people with incomes between 139 and 400 percent of poverty. The number of people with incomes above 400 percent of poverty who were uninsured did not significantly change. Both before and after implementation of the ACA, the vast majority of people with incomes above 400 percent of poverty (about 98 percent) had health insurance.

*/**/*** Estimate differs significantly from those in the reference group, denoted by ^, at the 0.10/0.05/0.01 level, using two-tailed tests.

Table 2. Percent of Adults with Non-Group Health Insurance that Had No Deductible, 2013 and 2014

	2013^	2014
No deductible	3.6%	10.6%***

Source: Urban Institute analysis of Health Reform Monitoring Survey data collected in September 2013 and September and December 2014.

Note: There were no significant differences between 2013 and 2014 in the percentage of people that had deductibles up to $1,500, $1,500-3,000, or above $3,000.

*/**/*** Estimate differs significantly from those in the reference group, denoted by ^, at the 0.10/0.05/0.01 level, using two-tailed tests.

Table 3. Annual Deductible Per Person for Adults with Non-Group Health Insurance, by Marketplace Status, 2014

AMOUNT OF DEDUCTIBLE	INSURED IN THE MARKETPLACE^	INSURED OUTSIDE THE MARKETPLACE
No deductible	15.2%	6.0%***
Up to $1,500	40.8%	33.1%**
$1,500-2,999	20.3%	20.8%
$1,500 or more	42.8%	58.3%***
$3,000 or more	22.5%	37.5%***
Not reported	0.1%	0.3%
Not sure of amount	1.0%	2.3%

Source: Urban Institute analysis of Health Reform Monitoring Survey data collected in September and December 2014.

Notes: Definition of marketplace enrollees includes all insured respondents who reported being enrolled through the marketplace, excluding those reporting coverage through an employer or the military; those with incomes at or below 100 percent of poverty in states that had not expanded Medicaid as of December 2014; and those with incomes at or below 138 percent of poverty in states that had expanded Medicaid as of December 2014. However, we excluded all people with incomes at or below 138 percent of poverty from this analysis. We also exclude those who reported multiple coverage types if they reported that Medicaid or Medicare was their main source of coverage.

*/**/*** Estimate differs significantly from those in the reference group, denoted by ^, at the 0.10/0.05/0.01 level, using two-tailed tests.

Table 4. Percent of Adults with Non-Group Health Insurance Who Were Insured for the Past 12 Months and Who Had to Forgo Care Because They Could Not Afford It, by Type of Care, 2014

	PERCENT OF ADULTS
Any service (excluding dental)	25.2%
Tests, treatment, or follow-up care	15.3%
Prescription drugs	14.2%
Medical care	12.0%
General doctor	11.8%
Specialist	11.3%
Mental health care or counseling	5.6%
Contraceptive prescriptions (among women only)	5.0%
Medical equipment or supplies	4.4%
Treatment for alcohol or drugs	2.5%
Dental care[†]	24.0%

Source: Urban Institute analysis of Health Reform Monitoring Survey data collected in September and December 2014.

Notes: Excludes people with family income at or below 138 percent of the federal poverty level. Data are limited to people who had to forgo care at some time *in the past 12 months*.

[†]We looked at reports of adults not getting needed dental care separately from our main analysis of adults not getting needed health care because they could not afford it. This is because health plans are not required to (and typically don't) cover dental care for adults. Therefore, problems affording dental care may be due to adults not having dental coverage rather than to them having problems affording cost-sharing for that care.

Table 5. Percent of Adults with Non-Group Health Insurance Who Were Insured for the Past 12 Months and Who Had to Forgo Care Because They Could Not Afford It, by Income Level and Type of Care, 2014

	INCOME AS A PERCENT OF POVERTY	
	LOWER TO MIDDLE INCOME (139-249%)^	MIDDLE TO HIGH INCOME (AT OR ABOVE 250%)
Any service (excluding dental)	32.3%	22.2%**
Tests, treatment, or follow-up care	18.7%	13.8%
Prescription drugs	18.3%	12.5%
Medical care	14.9%	10.8%
General doctor	13.7%	11.0%
Specialist	13.4%	10.5%
Contraceptive prescriptions (among women only)	5.8%	4.5%
Mental health care or counseling	5.8%	5.5%
Medical equipment or supplies	5.4%	3.9%
Treatment for alcohol or drugs	1.3%	3.1%
Dental care†	30.3%	21.3%**

Source: Urban Institute analysis of Health Reform Monitoring Survey data collected in September and December 2014.

Notes: Excludes people with family income at or below 138 percent of the federal poverty level. Data are limited to people who had to forgo care at some time *in the past 12 months*.

†We looked at reports of adults not getting needed dental care separately from our main analysis of adults not getting needed health care because they could not afford it. This is because health plans are not required to (and typically don't) cover dental care for adults. Therefore, problems affording dental care may be due to adults not having dental coverage rather than to them having problems affording cost-sharing for that care.

*/**/*** Estimate differs significantly from those in the reference group, denoted by ^, at the 0.10/0.05/0.01 level, using two-tailed tests.

Table 6. Percent of Adults with Non-Group Health Insurance Who Were Insured for the Past 12 Months and Who Had to Forgo Medical Care Because They Could Not Afford It, by Deductible Amount and Type of Care, 2014

	DEDUCTIBLE AMOUNT (PER PERSON)			
	LESS THAN $1,500^	$1,500 OR MORE	LESS THAN $3,000^	$3,000 OR MORE
Any service (excluding dental)	19.6%	29.8%***	21.3%	33.2%***
Prescription drugs	11.9%	15.8%	12.3%	17.7%**
Tests, treatment, or follow-up care	11.5%	18.3%**	12.7%	20.5%***
General doctor	10.3%	13.1%	9.5%	16.7%*
Specialist	9.5%	12.7%*	9.5%	14.9%**
Medical care	9.4%	14.0%**	10.0%	15.9%**
Contraceptive prescriptions (among women only)	5.1%	4.7%	5.4%	3.9%
Mental health care or counseling	4.8%	6.0%	5.1%	6.3%
Medical equipment or supplies	4.2%	4.3%	3.9%	5.0%
Treatment for alcohol or drugs	3.8%	1.3%	2.8%	1.5%
Dental care†	24.7%	23.7%	24.9%	22.6%

Source: Urban Institute analysis of Health Reform Monitoring Survey data collected in September and December 2014.

Notes: Excludes people with family income at or below 138 percent of the federal poverty level. Data are limited to people who had to forgo care at some time *in the past 12 months*.

† We looked at reports of adults not getting needed dental care separately from our main analysis of adults not getting needed health care because they could not afford it. This is because health plans are not required to (and typically don't) cover dental care for adults. Therefore, problems affording dental care may be due to adults not having dental coverage rather than to them having problems affording cost-sharing for that care.

*/**/*** Estimate differs significantly from those in the reference group, denoted by ^, at the 0.10/0.05/0.01 level, using two-tailed tests.

Table 7. Annual Deductible for Adults with Non-Group Health Insurance, by Income Group, 2014

AMOUNT OF DEDUCTIBLE	INCOME GROUP (PERCENT OF POVERTY)			ALL
	LOWER- TO MIDDLE-INCOME (139-249%)^	MIDDLE-INCOME (250-399%)	HIGH-INCOME (AT OR ABOVE 400%)	
No deductible	12.1%	10.1%	9.6%	10.6%
$1-1,499	45.7%	34.9%**	29.6%***	36.9%
$1,500-2,999	17.3%	23.3%*	21.9%*	20.6%
$1,500 or more	39.3%	53.2%***	59.9%***	50.6%
$3,000 or more	22.0%	29.9%**	38.0%***	30.0%
Not reported	0.4%	0.2%	0.0%	0.2%
Not sure of amount	2.4%	1.6%	0.9%	1.6%

Source: Urban Institute analysis of Health Reform Monitoring Survey data collected in September and December 2014.

Note: Excludes people with family income at or below 138 percent of the federal poverty level.

*/**/*** Estimate differs significantly from those in the reference group, denoted by ^, at the 0.10/0.05/0.01 level, using two-tailed tests.

Table 8. Combined Cost of Deductibles and Premiums for a Single Individual with Non-Group Health Insurance, 2014

INCOME	DEDUCTIBLE AMOUNT	DEDUCTIBLE AS A PERCENT OF INCOME	PREMIUM CONTRIBUTION AS A PERCENT OF INCOME	ANNUAL PREMIUM CONTRIBUTION AMOUNT	COMBINED ANNUAL COST AS A PERCENT OF INCOME	COMBINED ANNUAL AMOUNT
$29,200 MIDDLE-INCOME (250% of poverty)	$1,500	5.14%	8.05%	$2,351	13.19%	$3,851
	$3,000	10.27%	8.05%	$2,351	18.32%	$5,351

Source: Families USA's estimate of the premium contribution for an adult with income at 250 percent of poverty is based on the percent of income the federal government expected consumers with this income to spend on premiums for a second least-expensive silver plan in 2014.

A selected list of relevant publications to date:

Standardized Health Plans: Promoting Plans with Affordable Upfront Out-of-Pocket Costs (December 2014)

Basic Health Programs: Nine Requirements for State Programs (November 2014)

Designing Silver Health Plans with Affordable Out-of-Pocket Costs for Lower- and Moderate-Income Consumers (May 2014)

For a more current list, visit:
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May 2015 | Issue Brief

Round 2 on the Legal Challenges to Contraceptive Coverage: Are Nonprofits "Substantially Burdened" by the "Accommodation"?

Laurie Sobel and Alina Salganicoff

The Affordable Care Act (ACA) requires most private health insurance plans to provide coverage for a broad range of preventive services including Food and Drug Administration (FDA) approved prescription contraceptives and services for women. Since the implementation of the ACA contraceptive coverage requirement in 2012, over 200 corporations have filed lawsuits claiming that including coverage for contraceptives or opting for an "accommodation" from the federal government violates their religious beliefs. The legal challenges have fallen into two groups: those filed by for-profit corporations and those filed by nonprofit organizations.

In the *Burwell v. Hobby Lobby* decision, the Supreme Court ruled that "closely held" for-profit corporations may be exempted from the requirement. This ruling, however, only settled part of the legal questions raised by the contraceptive coverage requirement, as there are there are other legal challenges brought by nonprofit corporations. The nonprofits are seeking an "exemption," meaning their workers would not have coverage for some or all contraceptives, rather than an "accommodation," which entitles their workers to full contraceptive coverage but releases the employer from paying for it. The Supreme Court has issued emergency orders for a religiously-affiliated nursing home, Little Sisters of the Poor[1], and a religious college, Wheaton College, that allow these nonprofits to let the government know about its objection to the contraceptive coverage, rather than directly notifying its insurer while the litigation proceeds through the lower courts.

Over 40 cases in which nonprofit organizations claim their accommodation is insufficient are still winding their way through the courts. One case is currently awaiting action by the Supreme Court. On April 15, 2015 Justice Alito issued a temporary stay to the Bishops of Pittsburgh (Zubik) and Eerie (Persico), and nonprofit Catholic Charities. This stay releases these plaintiffs from notifying HHS or their insurer of their objection to contraceptive coverage until the Supreme Court decides either to let the lower court's decision stand in favor of the government or to review this case.

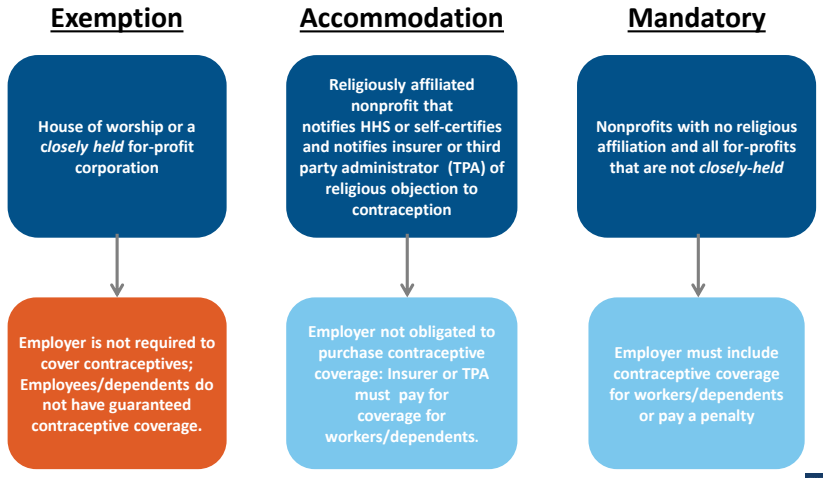
This brief explains the legal issues raised by the nonprofit litigation and discusses the impact of the *Hobby Lobby* decision on the current litigation.

WHAT ARE THE RULES THAT EMPLOYERS WITH RELIGIOUS OBJECTIONS TO CONTRACEPTION MUST FOLLOW?

As the contraceptive coverage rules have evolved through litigation and new regulations, there are three classes of employers with differing requirements. Houses of worship and "closely held" for-profit corporations can choose to be exempt from the requirement if they have religious objections (Figure 1). Workers and dependents of exempt employers do not have coverage for either some or all FDA approved contraceptive methods. While the exemption for houses of worship is part of the Obama Administration regulations, the exemption for "closely held" corporations stems from the *Hobby Lobby* decision. Forthcoming regulations will address whether "closely held" corporations with religious objections to contraception continue to qualify for an exemption or an accommodation, and this will determine whether or not women workers and dependents will have no-cost contraceptive coverage as part of their health plan.

Figure 1

Employers Objecting to Contraceptive Coverage: Exemptions and Accommodations



NOTE: This requirement applies to employers with 50+ employees unless they offer a grandfathered plan.

Religiously-affiliated nonprofits can opt out of providing contraceptive coverage by electing an accommodation, but are not eligible for an exemption. Women workers and dependents who are covered by a plan sponsored by these nonprofits have contraceptive coverage, but their employers do not have to pay for it. The accommodation was developed to release nonprofit religiously-affiliated employers that oppose birth control from the requirement of paying for contraceptive coverage, and still assure that the employees and their dependents are able to obtain full coverage for contraceptives directly from the insurer as they are entitled to under the law. This is done by requiring the insurer to bear the costs of the employees' contraceptive coverage rather than the employer.

Initially the accommodation was triggered by having the religiously-affiliated nonprofit complete an EBSA 700 form to self-certify that the organization is an eligible organization[2] and has a religious objection to providing coverage for some or all of any contraceptive services. The employer must send the completed form to its insurer or third party administrator. The back of the form has a notice to third party administrators of self-insured plans outlining their legal responsibilities. In August 2014, the Administration issued interim final regulations allowing religiously-affiliated nonprofit corporations that object to the contraceptive coverage an additional choice: either to notify their insurance company or notify the Department of Health and Human Services (HHS) about their objection. If the nonprofit notifies HHS, they must include the contact information for their insurance company. These final rules allow all religiously affiliated nonprofits to notify HHS in the

same way that the Supreme Court allowed the College of Wheaton and the Little Sisters of the Poor to notify HHS rather than notifying their insurance carrier.

Many of the nonprofits that had raised initial objections still believe that the accommodation, even with ability to notify HHS, does not satisfy their concerns. These religiously-affiliated nonprofit organizations contend that when the insurer separately contracts with an employer's workers to cover contraception at no cost, it remains part of the employer's plan and is financed by the employer. They object to notifying HHS, insurance company or their third party administrator "to provide the morally objectionable coverage and allow their health plans to be used as a vehicle to bring about a morally objectionable wrong."[3] They feel that by providing notice they will "facilitate" or "trigger" the provision of insurance coverage for contraceptive services. The Government contends that it is federal law that requires the insurance issuer or the third-party administrator to provide this coverage.

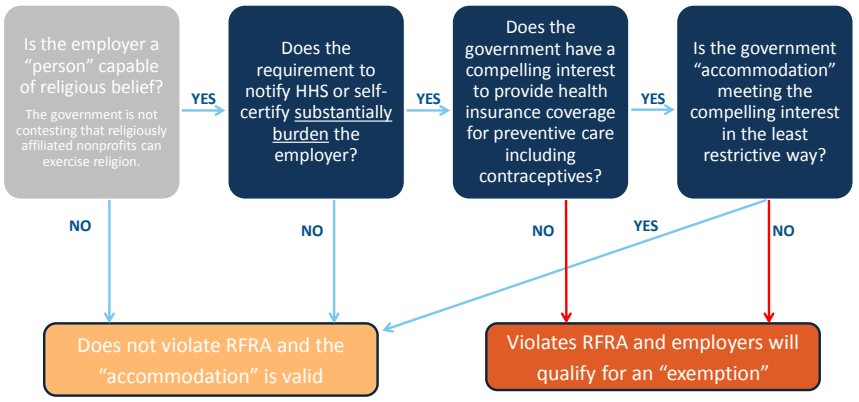
WHAT IS THE BASIS FOR THE LEGAL CHALLENGES BROUGHT BY THE NONPROFITS?

The nonprofit corporations continuing to pursue legal challenges are seeking an "exemption" from the rule, not an "accommodation." The nonprofit legal challenges involve a different question than the one raised by the for-profit challenges: Does the notice requirement to elect an "accommodation" to the contraceptive coverage requirement "substantially burden" the nonprofits' religious exercise? The employers challenging the contraceptive coverage requirement contend that they are unjustly burdened under the Religious Freedom Restoration Act (RFRA). RFRA was enacted in 1993 to protect "persons" from generally applicable laws that burden their free exercise of religion.

RFRA requires the government to show the law in question (in this case the requirement that employers notify HHS or their insurance company of their objection to including coverage for some or all contraceptive methods) furthers a "compelling interest" in the "least restrictive means" when it "substantially burdens a person's exercise of religion." The Court must consider a series of threshold questions in deciding whether the contraceptive coverage requirement is in violation of RFRA (Figure 2).

Figure 2

Legal Analysis of the Religious Freedom Restoration Act as It Applies to Religiously-Affiliated Nonprofits



In the *Burwell v. Hobby Lobby* case much of the attention was focused on the first question under the legal analysis: Can "closely held" for-profit corporations "exercise religion" under RFRA? In the nonprofit cases the focus is shifted to the second question under the RFRA analysis. The nonprofit corporations must demonstrate that the regulation, even with the accommodation, substantially burdens their exercise of religion. Just as in the cases brought by for-profit corporations, if the nonprofit corporation can show that it is substantially

burdened, then the government will then need to prove that the contraceptive coverage requirement is a "compelling interest" that is met in the "least restrictive means."

In the Court's *Hobby Lobby* ruling, Justice Alito, wrote about the accommodation as a "less restrictive means," to provide contraceptive coverage. The Court, however, did not decide whether the accommodation is lawful: "We do not decide today whether an approach of this type complies with RFRA for purposes of all religious claims. At a minimum, however, it does not impinge on the plaintiffs' religious belief that providing insurance coverage for the contraceptives at issue here violates their religion, and it serves HHS's stated interests equally well."[4]

What are the pending cases?

Since the Obama Administration issued the new regulations in August 2014, three federal courts of appeals have issued decisions denying stays to nonprofit employers. (Table 1) In February 2015, the Third Circuit Court of Appeals issued a decision in the case brought by Geneva College and the Bishops of Pittsburgh (Zubik) and Eerie (Persico), and nonprofit Catholic Charities. The court ruled that the self-certification procedure is not burdensome to the nonprofits. The Bishops and Catholic Charities then filed an emergency petition with the Supreme Court asking for a stay. On April 15, 2015 Justice Alito granted the request for a temporary stay allowing the plaintiffs to not comply with the accommodation. The Supreme Court will either let the Third Circuit Court's decision stand or take this case and decide whether requiring religiously-affiliated nonprofits to comply with the accommodation which allows their workers and dependents to receive contraceptive coverage is a substantial burden on the employers' religious beliefs. On May 18, 2015 the 3rd Circuit granted Geneva College (which did not join the emergency petition to the Supreme Court) a temporary stay pending a response and further orders by the Supreme Court in Persico and Zubik.

In another case, in November 2014, a panel of the DC Court of Appeals issued a decision in the case brought by Priests for Life, and ten other Catholic nonprofit organizations. This court also found that the accommodation offered by the government does not substantially burden the plaintiffs' religious exercise, the regulations advance compelling government interests, and the regulations are the least restrictive means for advancing those interests. In December 2014, the plaintiffs petitioned for rehearing en banc, asking the full D.C. Circuit to rehear the case. On May 20, 2015, the court denied the request for the rehearing. The plaintiffs will likely request review by the Supreme Court.

In addition, the Supreme Court has sent two cases, previously decided before the *Hobby Lobby* decision, back to the lower courts to be reconsidered in light of the *Hobby Lobby* ruling. In March 2015, the Supreme Court granted the University of Notre Dame's request to order a reconsideration of its claim based on the decision in *Burwell v. Hobby Lobby*, essentially rehearing the case. On May 19, 2015 the 7th Circuit Court of Appeals issued a decision, similar to the decisions issued by the 3rd Circuit and the DC Circuit, denying Notre Dame's request for a stay. The Court again rejected Notre Dame's argument that the accommodation requires them to be "complicit" in obtaining contraceptive coverage for their students and employees. The court stated, "It is federal law rather than the religious organization's signing and mailing the form, that requires health-care insurers, along with third-party administrators of self-insured health plans, to cover contraceptive services."[5] The Supreme Court has also ordered the 6th Circuit court of Appeals to reconsider its decision in *Michigan Catholic Charities v. Burwell* in light of *Hobby Lobby*.

Although the Supreme Court issued orders for *the Little Sisters of the Poor* and the *College of Wheaton*, allowing them to notify HHS of their objection to contraceptive coverage rather than their insurer, their cases are pending in 10th Circuit and the 7th Circuit Court of Appeals.

What's next?

In August 2014, the Administration published proposed regulations pertaining to for-profit corporations in response to the *Hobby Lobby* ruling. The Administration requested public comments on how best to define "closely held" corporations and on any additional steps the government should take to help ensure women employees and dependents have coverage of the full range of FDA-approved contraceptives without cost-sharing.

The Administration has not yet finalized the regulations pertaining to for-profit "closely held" corporations. So as of now, these corporations with sincerely held religious objects are exempt from the contraceptive coverage requirement and the women and female dependents who are insured by these employers do not have no-cost contraceptive coverage.

Depending on how the regulations are finalized, "closely held" corporations with religious objections, like Hobby Lobby, may or may not receive an exemption from the contraceptive coverage requirement. If the administration decides to require "closely held" corporations to comply with an accommodation rather than allowing an "exemption," Hobby Lobby and other similar corporations might then be required to notify their insurer or HHS so that the insurer can still provide the contraceptive coverage directly to the employees and their dependents. In this case, it is likely that the "closely held" corporations will challenge the accommodation as applied to them, contending that the accommodation still substantially burdens the corporation, in much the same way that the religiously-affiliated nonprofits have done.

The Supreme Court may ultimately have to decide whether the accommodation substantially burdens the religious exercise of both nonprofit and for-profit "closely held" corporations, whether the government has a compelling interest, and whether there is a less restrictive way of achieving the same of goal of allowing women coverage for all FDA-approved contraceptive methods without cost-sharing. The outcome of these cases will determine if the employees and dependents of these corporations will have access to no cost contraceptive coverage, as intended under the ACA.

Table 1: Selected Pending Nonprofit Cases as of May 21, 2015		
Lawsuit	Case History	Status
Zubik et. al v. Burwell	On February 11, 2015, a unanimous 3rd Circuit panel issued a decision that the accommodation does not impose a substantial burden on plaintiffs' religious exercise. The Third Circuit denied plaintiffs' petition for a rehearing en banc and request for a stay. Zubik et. al filed an emergency petition with the Supreme Court asking for a stay.	On April 15, 2015, Justice Alito issued a temporary stay allowing the plaintiffs to not comply with the accommodation while the Government submitted a response to the Court (submitted April 20, 2015). On May 21, 2015, the Solicitor General submitted a letter to the Supreme Court advising them of the recent decisions by the 7th Ciruit denying the University of Notre Dame a stay and the DC Ciruict denying Priests for Life request for an *en banc* hearing. Awaiting action by the Supreme Court.
Geneva College v. Burwell	On February 11, 2015, a unanimous 3rd Circuit panel issued a decision that the accommodation does not impose a substantial burden on plaintiffs' religious exercise. The Third Circuit denied plaintiffs' petition for a rehearing en banc and request for a stay.	On May 18, 2015 the 3rd Circuit granted Geneva College (which did not join the emergency petition to the Supreme Court) a temporary stay pending a response and further orders by the Supreme Court in Persico and Zubik.
Priests for Life v. HHS	The DC Circuit Court of Appeals panel ruled that the accommodation does not impose a substantial burden on plaintiffs' religious exercise, the regulations advance compelling government interests, and the regulations are the least restrictive means. Plaintiffs petitioned for a re-hearing *en banc* asking the full D.C. Circuit to rehear the case.	On May 20, 2015 DC Circuit Court of Appeals denied the request for an en banc hearing.
Wheaton College v. Burwell	Wheaton filed an emergency application for an injunction pending appeal with the Supreme Court. On July 3, 2014, the Supreme Court granted Wheaton's emergency application for an stay pending an appeal on the condition that it file notice with HHS that it is an organization that holds itself out as religious and has a religious objection to contraceptive coverage.	7th Circuit Court of Appeals has set a briefing schedule for the appeal.

Table 1: Selected Pending Nonprofit Cases as of May 21, 2015		
Lawsuit	Case History	Status
Little Sisters of the Poor v. Burwell	The Supreme Court granted plaintiffs' emergency application for an injunction pending appeal on the condition that they file notice with HHS that they are organizations that hold themselves out as religious and have religious objection to contraceptive coverage. Following the government's issuance of interim final rules amending the accommodation for nonprofit, the parties filed supplemental briefs addressing the impact of those rules on the case.	Oral arguments were held December 8, 2014. Awaiting decision from 10th Circuit Court of Appeals.
University of Notre Dame v. Sebelius	The 7th Circuit Court of Appeals issued a decision on February 21, 2014, denying Notre Dame a preliminary injunction. Plaintiffs asked the Supreme Court to require the 7th Circuit Court of Appeals reconsider the case in light of *Hobby Lobby*. The Supreme Court granted the request.	The 7th Circuit Court of Appeals issued a decision on May 19, 2015, denying Notre Dame a preliminary injunction. Notre Dame could ask for re-hearing *en banc,* requesting the full 7th Circuit to re-hear the case, or appeal to the Supreme Court.
Michigan Catholic Conference v. Burwell/ Catholic Diocese of Nashville v. Burwell	On June 11, 2014 a unanimous 6th Circuit panel denied plaintiffs a preliminary injunction, holding that the accommodation did not impose a substantial burden. On December 18, 2014, Plaintiffs filed a petition asking the Supreme Court to consider the case. The Supreme Court sent the case back to the 6th Circuit to re-consider in light of *Hobby Lobby*.	The 6th Circuit Court of Appeals will re-consider the case in light of *Hobby Lobby*.

ENDNOTES

[1] The case of Little Sisters of the Poor raises a new twist in the legal framework surrounding the contraception coverage requirement under the ACA. Little Sisters, a religiously affiliated nonprofit employer eligible for an accommodation, has a self-funded church plan. A church plan is a special designation under federal law that is exempt from ERISA. In the litigation, the Government has stated that it has no authority to require a third party administrator for a self-funded church plan to comply with the federal regulations. Therefore, the workers and dependents of employers with self-funded church plans that object to the coverage will not receive coverage for some or all contraceptives unless the third party administrator voluntarily decides to offer the contraceptive coverage.

[2] This "accommodation" is only available to "eligible organizations" meeting the criteria: 1) opposes providing for some or all of any contraceptive coverage on account of religious objections; 2) has nonprofit status; 3) holds itself out as a religious organization; and 4) self-certifies that it meets the first three criteria. 26 CFR § 54.9815-2713A; 29 CFR § 2590-2713A; 45 CFR § 147.31

[3] Zubik et al v. Burwell, Emergency Application to Recall and Stay Mandate or Issue Injunction Pending Resolution of Certiorari Petition, April 15, 2015, page 17

[4] *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, at 2775-76 (2014)

[5] Seventh Circuit Court of Appeals decision issued May 19, 2015, *University of Notre Dame, Plaintiff-Appellant, v. Sylvia Mathews Burwell, Secretary of U.S. Department of Health & Human Services, et al., Defendants-Appellees, and Jane Doe 3*, pages 15-16.

Topline

Kaiser Family Foundation

Survey of Non-Group Health Insurance Enrollees

May 2015

METHODOLOGY

The Kaiser Family Foundation (KFF) *Survey of Non-Group Health Insurance Enrollees* is the second in a series of surveys examining the views and experiences of people who purchase their own health insurance, including those whose coverage was purchased through a state or federal Health Insurance Marketplace and those who bought coverage outside the Marketplaces. The survey was designed and analyzed by researchers at KFF. Social Science Research Solutions (SSRS) collaborated with KFF researchers on sample design and weighting, and supervised the fieldwork. KFF paid for all costs associated with the survey.

The survey was conducted by telephone from February 18 through April 5, 2015 among a random sample of 804 adult U.S. residents who purchase their own insurance. Computer-assisted telephone interviews conducted by landline (346) and cell phone (458, including 241 who had no landline telephone) were carried out in English and Spanish by SSRS. Respondents were considered eligible for the survey if they met the following criteria:

- Between the ages of 18-64
- Currently covered by health insurance that they purchase themselves or purchased insurance that would begin in the next month
- Not covered by health insurance through an employer, COBRA, Medicare, Medicaid, a parent's plan, or the U.S. military or VA
- If purchase insurance from a college or university, the insurance covers health services received both within and outside the university setting
- If a small business owner, the health insurance they purchase is only for themselves and/or their family, and does not cover non-related employees of their business
- If purchase from a trade association, respondent pays the entire premium themselves

Because the study targeted a low-incidence population, the sample was designed to increase efficiency in reaching this group, and consisted of three parts: (1) respondents reached through random digit dialing (RDD) landline and cell phone (N=151); (2) respondents reached by re-contacting those who indicated in a previous RDD survey that they either purchased their own insurance or were uninsured (N=247); (3) respondents reached as part of the SSRS Omnibus survey (N=406), a weekly, nationally representative RDD landline and cell phone survey. All RDD landline and cell phone samples were generated by Marketing Systems Group.

A multi-stage weighting process was applied to ensure an accurate representation of the national population of non-group enrollees ages 18-64. The first stage of weighting involved corrections for sample design, including accounting for the likelihood of non-response for the re-contact sample, number of eligible household members for those reached via landline, and a correction to account for the fact that respondents with both a landline and cell phone have a higher probability of selection. In the second weighting stage, demographic adjustments were applied to account for systematic non-response along known population parameters. No reliable administrative data were available for creating demographic weighting parameters for this group, since the most recent Census figures could not account for the changing demographics of non-group insurance enrollees brought about by the ACA. Therefore, demographic benchmarks were derived by compiling a sample of all respondents ages 18-64 interviewed on the SSRS Omnibus survey during the field period (N=6,519) and weighting this sample to match the national 18-64 year-old population based on the 2014 U.S. Census Current Population Survey March Supplement parameters for age, gender, education, race/ethnicity, region, population density, marital status, and phone use. This sample was then filtered to include respondents qualifying for the current survey, and the weighted demographics of this group were used as post-stratification weighting parameters for the standard RDD and omnibus samples (including gender, age, education, race/ethnicity, marital status, income, and population density). A final adjustment was made to the full sample to control for previous insurance status (estimated based on the combined RDD and omnibus samples), to address the possibility that the criteria used in selecting the prescreened sample could affect the estimates for previous insurance status.

Weighting adjustments had a minor impact on the overall demographic distribution of the sample, with the biggest adjustments being made based on age (this is common in all telephone surveys, as younger respondents are the most difficult to reach and convince to participate). Weighted and unweighted demographics of the final sample are shown in the table below.

		Unweighted % of total	Weighted % of total
Age	18-25	9%	15%
	26-34	13	18
	35-44	14	17
	45-54	25	22
	55-64	38	26
	Refused	2	2
Gender	Male	49	48
	Female	51	52
Education	Less than high school graduate	6	7
	High school graduate	26	31
	Some college	27	29
	Graduated college	27	21
	Graduate school or more	13	9
	Technical school/other	2	2
	Refused	-	-
Race/Ethnicity	White, non-Hispanic	73	69
	Black, non-Hispanic	10	11
	Hispanic	10	12
	Other/Mixed	6	6
	Refused	1	1
Self-reported health status	Excellent	24	26
	Very good	33	33
	Good	28	27
	Fair	12	10
	Poor	4	4
	Don't know/refused	*	*

All statistical tests of significance account for the effect of weighting. The margin of sampling error (MOSE) including the design effect is plus or minus 4 percentage points for results based on the total sample. Unweighted Ns and MOSE for key subgroups are shown in the table below. For other subgroups the margin of sampling error may be higher. 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)	MOSE
Total non-group enrollees	804	±4 percentage points
ACA-compliant plans	667	±5 percentage points
Marketplace plans	494	±6 percentage points
Non-ACA-compliant plans	127	±11 percentage points

KAISER FAMILY FOUNDATION SURVEY OF NON-GROUP HEALTH INSURANCE ENROLLEES
Wave 2

NOTES FOR READING THE TOPLINE:
- Percentages may not always add up to 100 percent due to rounding
- Values less than 0.5 percent are indicated by an asterisk (*)
- "Vol." indicates a response was volunteered by the respondent, not offered as an explicit choice
- Questions are presented in the order asked; question numbers may not be sequential

MAIN QUESTIONNAIRE:
(See pages 35–38 for exact screener questions asked)

(ROTATE VERBIAGE IN PARENS)
NG-1. As you may know, a health reform bill, also known as the Affordable Care Act and sometimes referred to as Obamacare, 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?)

	4/15	5/14
Very favorable	24	25
Somewhat favorable	27	22
Somewhat unfavorable	16	13
Very unfavorable	27	30
Don't know/refused	6	9

(ROTATE Q.NG-2 AND Q.NG-3 WITH Q.NG-4 AND Q.NG-5)
NG-2. So far, would you say you and your family have personally benefited from the health reform law, or not?

	4/15	5/14
Yes, have benefited	40	34
No, have not benefited	56	62
Don't know/refused	4	4

NG-3. What would you say is the **main** way you and your family have benefited from the health reform law? Has it made it possible for someone in your family to get health coverage, lowered your health care or insurance costs, made it easier for you to get the health care you need, or have you benefitted in some other way?

Based on total who say they have benefitted from the health reform law; n = 325

	4/15
Allowed someone in your family to get or keep health coverage	34
Lowered your health care insurance costs	32
Made it easier for you to the health care you need	29
Improved coverage, general (Vol.)	1
Preventive services benefit/free checkups/women's health/birth control (Vol.)	*
Health reform will help - general (Vol.)	*
Able to get coverage for preexisting condition (Vol.)	*
Medical loss ratio/insurance must give me a rebate or credit (Vol.)	*
Peace of mind/financial protection (Vol.)	*
Able to quit/change jobs/retire early (Vol.)	*
Have you benefitted in some other way	2
Don't know/refused	1

NG-2/NG-3. Combo Table based on total

	4/15
Have benefitted from the health reform law	40
Allowed someone in your family to get or keep health coverage	14
Lowered your health care insurance costs	13
Made it easier for you to the health care you need	11
Preventive services benefit/free checkups/women's health/birth control (Vol.)	*
Health reform will help, general (Vol.)	*
Able to get coverage for preexisting condition (Vol.)	*
Medical loss ratio/insurance must give me a rebate or credit (Vol.)	*
Improved coverage, general (Vol.)	*
Peace of mind/financial protection (Vol.)	*
Able to quit/change jobs/retire early (Vol.)	*
Have you benefitted in some other way	1
Don't know/refused	*
Have not benefited from the health reform law	56
Don't know/refused	4

(ROTATE Q.2 AND Q.3 WITH Q.4 AND Q.5)
NG-4. So far, would you say you and your family have been negatively affected by the health reform law, or not?

	4/15	5/14
Yes, negatively affected	33	29
No, not negatively affected	64	66
Don't know/refused	3	5

NG-5. What would you say is the **main** way you and your family have been negatively affected by the health reform law? Has it caused someone in your family to lose their insurance, increased your health care or insurance costs, made it more difficult for you to get the health care you need, or have you been negatively affected in some other way?

Based on total who say they have been negatively affected by the health reform law; n = 278

	4/15
Increased your health care or insurance costs	64
Made it more difficult to get the health care you need	13
Caused someone in your family to lose their insurance	10
Opposed to individual mandate/fines/forced coverage (Vol.)	3
Can't see the doctor I want/less choice of doctors (Vol.)	3
Taxes/having to pay for other people's coverage (Vol.)	1
Cut to benefits/less options/choices, general (Vol.)	1
Lost job/hours cut/declining income/bad for business (Vol.)	1
Insurance plan changed, general (Vol.)	*
Don't qualify for government help/haven't been helped by it (Vol.)	-
Privacy concerns (Vol.)	-
Website/enrollment problems (Vol.)	-
Have you been negatively affected in some other way	3
Don't know/refused	*

NG-4/NG-5. Combo Table based on total

	4/15
Have been negatively affected by the health reform law	33
Increased your health care or insurance costs	21
Made it more difficult to get the health care you need	4
Caused someone in your family to lose their health insurance	3
Opposed to individual mandate/fines/forced coverage (Vol.)	1
Can't see the doctor I want/less choice of doctors (Vol.)	1
Taxes/having to pay for other people's coverage (Vol.)	*
Cut to benefits/less options/choices (general) (Vol.)	*
Lost job/hours cut/declining income/bad for business (Vol.)	*
Insurance plan changed (general) (Vol.)	*
Don't qualify for government help/haven't been helped by it (Vol.)	-
Privacy concerns (Vol.)	-
Website/enrollment problems (Vol.)	-
Have been negatively affected in some other way	1
Don't know/refused why negatively affected	*
Have not been negatively affected by the health reform law	64
Don't know/refused	3

NG-9. How would you rate your overall health insurance coverage – excellent, good, not so good or poor?

	4/15	5/14
Excellent	18	23
Good	57	53
Not so good	13	10
Poor	7	8
Just got my plan/too soon to tell (vol.)	3	NA
Don't know/refused	2	6

NG-10. In general, do you feel well-protected by your health insurance plan, or do you feel vulnerable to high medical bills?

	4/15	5/14
Feel well-protected by your health insurance plan	58	60
Feel vulnerable to high medical bills	37	34
Just got my plan/too soon to tell (vol.)	2	NA
Don't know/refused	3	5

NG-11. Would you say your health insurance is an excellent value, good value, only a fair value or a poor value for what you pay for it? (INTERVIEWER NOTE: IF RESPONDENT SAYS IT'S A "FAIR VALUE" (NOT "ONLY FAIR"), REPEAT ANSWER CHOICES TO MAKE SURE THEY'VE HEARD THEM ALL)

	4/15	5/14
Excellent value	13	19
Good value	41	37
Only a fair value	25	23
Poor value	18	16
Don't pay directly/don't know how much it costs (vol.)	*	2
Just got my plan/too soon to tell (vol.)	1	NA
Don't know/refused	1	3

(SCRAMBLE ITEMS a-g)
NG-12. Thinking about your CURRENT health insurance plan, how satisfied are you with each of the following? What about (INSERT)? (READ 1ST TIME, THEN AS NECESSARY: Are you very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?)[1] [INTERVIEWER NOTE: IF R SAYS "I HAVE NO COPAY" OR "THERE IS NO DEDUCTIBLE" ASK IF THEY ARE SATISFIED WITH THE FACT THAT THERE IS NO COPAY OR DEDUCTIBLE]

a. The premium you have to pay each month for your health insurance coverage

	4/15	5/14
Very satisfied	26	30
Somewhat satisfied	32	34
Somewhat dissatisfied	17	13
Very dissatisfied	21	19
Just got plan/too soon to tell (vol.)	1	NA
Don't know/refused	3	3

b. Your annual deductible, that is the amount you have to pay yourself before insurance will start paying any part of your medical bills

	4/15	5/14
Very satisfied	22	27
Somewhat satisfied	35	35
Somewhat dissatisfied	19	16
Very dissatisfied	20	17
Just got plan/too soon to tell (vol.)	1	NA
Don't know/refused	2	5

c. The copay, or amount you have to pay out of your own pocket when you visit a doctor

	4/15	5/14
Very satisfied	31	36
Somewhat satisfied	42	36
Somewhat dissatisfied	13	14
Very dissatisfied	10	10
Just got plan/too soon to tell (vol.)	3	NA
Don't know/refused	2	5

d. The amount you have to pay out of your own pocket when you fill a prescription

	4/15	5/14
Very satisfied	31	33
Somewhat satisfied	37	36
Somewhat dissatisfied	13	9
Very dissatisfied	11	14
Just got plan/too soon to tell (vol.)	5	NA
Don't know/refused	3	8

e. The choice of primary care doctors available under your plan

	4/15	5/14
Very satisfied	45	45
Somewhat satisfied	34	36
Somewhat dissatisfied	9	7
Very dissatisfied	7	7
Just got plan/too soon to tell (vol.)	3	NA
Don't know/refused	2	4

[1] 2014 trend wording was "Are you very satisfied, somewhat satisfied, somewhat unsatisfied, or very unsatisfied?"

f. The choice of hospitals available under your plan

	4/15	5/14
Very satisfied	42	43
Somewhat satisfied	35	37
Somewhat dissatisfied	8	7
Very dissatisfied	6	5
Just got plan/too soon to tell (vol.)	3	NA
Don't know/refused	6	7

g. The choice of specialists, such as cardiologists and orthopedists, available under your plan

	4/15	5/14
Very satisfied	31	35
Somewhat satisfied	34	35
Somewhat dissatisfied	9	8
Very dissatisfied	6	7
Just got plan/too soon to tell (vol.)	8	NA
Don't know/refused	12	15

(ROTATE 1-4/4-1)
NG-13. How easy or difficult is it for you to afford to pay the cost of your health insurance each month?

	4/15	5/14
Very easy	22	24
Somewhat easy	31	33
Somewhat difficult	31	28
Very difficult	14	12
Don't pay directly/cost is zero/haven't paid first premium yet (vol.)	1	2
Don't know/refused	1	2

NG-14. How well do you feel you understand what health care services your plan covers and what it doesn't? Would you say you understand it very well, somewhat well, not too well, or not well at all?

	4/15	5/14
Very well	28	35
Somewhat well	47	40
Not too well	16	15
Not well at all	7	8
Don't know/refused	1	1

NG-15. How well do you feel you understand how much you would have to pay when you visit a doctor or health care provider? Would you say you understand it very well, somewhat well, not too well, or not well at all?

	4/15	5/14
Very well	45	47
Somewhat well	38	36
Not too well	10	11
Not well at all	6	5
Don't know/refused	*	2

NG-16. How worried are you, if at all, that you won't be able to afford the health care services you need?

	4/15	5/14
Very worried	19	30
Somewhat worried	37	28
Not too worried	28	21
Not at all worried	15	20
Don't know/refused	*	*

NG-17. Suppose you had an unexpected medical bill, and the amount NOT covered by your insurance came to $500. Based on your current financial situation, how would you pay the bill? Would you…?

	4/15
Pay the bill right away by cash or check	30
Put it on a credit card and pay it off in full at the next statement	14
Put it on a credit card and pay it off over time	26
Borrow money from a bank, a payday lender, or friends or family to pay the bill	8
Would not be able to pay the bill at all	13
Arrange a payment plan with provider/monthly installments (Vol.)	6
Something else (Vol.)	1
Don't know/refused	3

NG-18. Now suppose you had an unexpected medical bill, and the amount not covered by your insurance came to $1500. Based on your current financial situation, would you…? (READ LIST IN ORDER)

Based on total who would be able to pay an unexpected medical bill of $500 or dk/ref; n = 696

	4/15
Pay the bill right away by cash or check	19
Put it on a credit card and pay it off in full at the next statement	11
Put it on a credit card and pay it off over time	36
Borrow money from a bank, a payday lender, or friends or family to pay the bill	11
Would not be able to pay the bill at all	12
Arrange a payment plan with provider/monthly installments (Vol.)	7
Something else (Vol.)	1
Don't know/refused	3

NG17/NG-18. Combo table based on total

	4/15
Would pay $1500 bill right away by cash or check	16
Would pay $1500 bill by putting it on a credit card and paying in full at the next statement	10
Would pay $1500 bill by putting it on a credit card and paying it off over time	32
Would pay $1500 bill by borrowing money	9
Would arrange a payment plan with provider/monthly installments (Vol.)	6
Would pay $1500 bill some other way (Vol.)	1
Would not be able to pay bill at all (NET)	23
Would not be able to pay unexpected medical bill of $500 at all	13
Would not be able to pay unexpected medical bill of $1500 at all	10
Don't' know/Refused	3

NG-19. Did you purchase your current health insurance 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?

	4/15	5/14
Directly from an insurance company	23	28
From healthcare.gov (or STATE SPECIFIC MARKETPLACE NAME)	46	43
Through an insurance agent or broker	27	29
Somewhere else (Vol.)	2	NA
Don't know/refused	2	--

NG-20. 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?

Based on total who did not buy current plan through marketplace; n = 430

	4/15
Marketplace plan	25
Non-marketplace plan	26
Not sure	47
Don't know/refused	3

NG-19/NG-20. Combo Table based on total

	4/15
Marketplace plan	59
Non-marketplace plan	14
Not sure if marketplace plan/Don't know/refused	27

NG-21. How long have you been covered by your CURRENT health insurance plan? Is this a new plan that started in 2015, or a plan that you had for all or part of 2014 and renewed in 2015?

Based on total who are currently covered; n = 775

	4/15
New as of 2015	40
Had plan for all or part of 2014 and renewed	59
Don't know/refused	1

NG-21a. Did you have this same insurance plan for all twelve months of 2014, or did your coverage under this plan begin some time after January 2014?

Based on total who have a renewed 2014 plan; n = 459

	4/15
Had same plan for all 12 months of 2014	61
Coverage under this plan began some time after January 2014	38
Don't know/refused	1

NG-21b. Do you happen to remember in which month of 2014 your current coverage began?

Based on total who did not have plan for all 12 months of 2014; n = 186

	4/15
January	9
February	7
March	15
April	9
May	13
June	6
July	2
August	7
September	5
October	5
November	2
December	4
Don't know/refused	16

NG-21/21a/21b. Combo table based on total

	4/15
Have a renewed 2014 plan	56
Had same plan for all 12 months of 2014	34
Coverage under this plan began some time after January 2014/dk/ref	22
Began in January	2
Began in February	2
Began in March	3
Began in April	2
Began in May	3
Began in June	1
Began in July	*
Began in August	1
Began in September	1
Began in October	1
Began in November	1
Began in December	1
Don't know/refused when began	4
Plan is new as of 2015	39
New plan – coverage hasn't started yet	4
Don't know/refused	1

NG-21c. Did you also have this same insurance plan for all or part of 2013, or did your coverage under this plan first begin in January 2014?

Based on total who had plan for all 12 months of 2014 and plan is not Marketplace plan; n = 148

	4/15
Had current plan for all or part of 2013	86
Coverage under current plan first began in January 2014	12
Don't know/refused	1

Insurance combo table based on total

	4/15
ACA compliant, new plan as of 2015	43
ACA compliant, renewed 2014 plan	40
Non-ACA compliant, pre 2014 plan	16
Undetermined	1

NG-22. What kind of health coverage, if any, did you have immediately before you signed up for your current plan? Were you covered by a DIFFERENT plan you purchased yourself, were you covered by an employer, by COBRA, did you have Medicaid or other public coverage, or were you uninsured? [IF NECESSARY: We're asking about your insurance status immediately before you began coverage under your current plan.]

Based on total who had new plan as of 2015 or had plan only part of 2014; n = 494

	4/15
Covered by a different plan you purchased yourself	27
Covered by an employer	15
Covered by COBRA	4
Had Medicaid or other public coverage	4
Was uninsured	46
Covered through/by a family member (Vol.)	2
Had coverage from some other source (Vol.)	1
Don't know/refused	1

NG-23. Did you purchase your 2014 health insurance 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? (ENTER ONE ONLY)

Based on total who had new plan as of 2015 and were previously covered by non-group plan; n = 117

	4/15
Directly from an insurance company	34
From healthcare.gov (or [INSERT STATE SPECIFIC MARKETPLACE]	31
Through an insurance agent or broker	26
Somewhere else (Vol.)	3
Don't know/refused	5

NG-24. Regardless of how you purchased your plan in 2014, do you know if it was a marketplace or [healthcare.gov/INSERT STATE SPECIFIC MARKETPLACE NAME] plan, was it NOT a marketplace or [healthcare.gov/INSERT STATE SPECIFIC MARKETPLACE NAME] plan , or are you not sure?

Asked of total who were covered by a different non-group plan in 2014 and did not buy previous plan through marketplace (sample size insufficient to report)

NG-25. Thinking about your PREVIOUS plan, did your coverage under that plan take effect BEFORE January 1, 2014 or did it take effect ON or AFTER January 1, 2014?

Asked of total who were previously covered by a non-group plan that was not purchased through a marketplace (sample size insufficient to report)

(RANDOMIZE, ALWAYS ASK ITEM A FIRST; IF ITEM a = YES, SKIP ITEMS b THROUGH f)
NG-27. I'm going to read you some reasons people give for changing health plans. For each, please tell me if this is a reason why you switched to a different health plan this year, or not. (First/next), (READ ITEM).

Based on total who were covered by a non-group plan in 2014 and switched to a new plan in 2015; n = 117

a. The plan you had last year was cancelled

	4/15
Yes, reason	47
No, not a reason	53
Don't know/refused	1

Based on total who were covered by a non-group plan in 2014 and switched to a new plan in 2015; n = 117

b. You wanted to be eligible for government financial help

	4/15
Yes, reason	6
No, not a reason	11
Not asked (answered yes to "The plan you had last year was cancelled")	47
Not asked (did not switch from non-Marketplace to Marketplace plan)	37

Based on total who were covered by a non-group plan in 2014 and switched to a new plan in 2015; n = 117

c. Your or your family's health needs changed

	4/15
Yes, reason	4
No, not a reason	49
Not asked (answered yes to "The plan you had last year was cancelled")	47

Based on total who were covered by a non-group plan in 2014 and switched to a new plan in 2015; n = 117

d. You wanted a plan with more choice of providers or one that covered a specific provider

	4/15
Yes, reason	8
No, not a reason	45
Don't know/refused	*
Not asked (answered yes to "The plan you had last year was cancelled")	47

Based on total who were covered by a non-group plan in 2014 and switched to a new plan in 2015; n = 117

e. You found a plan with a lower monthly premium than what you would have paid to renew your previous plan

	4/15
Yes, reason	37
No, not a reason	16
Not asked (answered yes to "The plan you had last year was cancelled")	47

Based on total who were covered by a non-group plan in 2014 and switched to a new plan in 2015; n = 117

f. You wanted a plan with a lower annual deductible

	4/15
Yes, reason	22
No, not a reason	31
Not asked (answered yes to "The plan you had last year was cancelled")	47

NG-28. Is there another reason I haven't mentioned why you switched to a different health plan this year?

Based on total covered by non-group plan in 2014 and switched to new plan in 2015; n = 117

	4/15
Cost/financial reasons	9
Better coverage	5
Moved out of state/personal/family reasons	*
Other reason	3
No other reason	35
Don't know/refused	1
Not asked (answered yes to "The plan you had last year was cancelled")	47

(ROTATE WORDING IN PARENS)

NG-29. Do you think your current plan offers you (more) choice or (less) choice of doctors and hospitals than the plan you had last year, or is it about the same?

Based on total covered by non-group plan in 2014 and switched to new plan in 2015; n = 117

	4/15
More choice	9
Less choice	24
About the same amount of choice	60
Don't know/refused	7

NG-30.Do you think you will have to change any of the doctors you see as a result of switching health plans, or not?

Based on total covered by non-group plan in 2014 and switched to new plan in 2015; n = 117

	4/15
Yes, will have to change doctors	31
No, will not have to change doctors	63
Don't know/refused	6

NG-31. Was your coverage automatically renewed for 2015 or did you take action to re-enroll in the same plan?

Based on total who renewed 2014 plan; n = 459

	4/15
Automatically renewed	59
Took action to re-enroll	39
Don't know/refused	2

(ROTATE 1-4/4-1)
NG-32. How easy or difficult was it for you to renew your health plan? Was it very easy, somewhat easy, somewhat difficult, or very difficult?

Based on total who renewed 2014 plan; n = 459

	4/15
Very easy	61
Somewhat easy	23
Somewhat difficult	9
Very difficult	5
Don't know/refused	2

NG-33. When you renewed your health plan this year, did you shop around or look at other options first, or did you decide to renew your current plan without shopping around?

Based on total who renewed 2014 plan; n = 459

	4/15
Shopped around	29
Did not shop around	70
Don't know/refused	1

(ROTATE WORDING IN PARENTHESES)
NG-39. When shopping for a health plan this year, do you think you had (too many) or (too few) plans to choose from, or was the number of choices about right?

Based on total who have a new plan as of 2015 or who have a renewed plan and shopped around before renewing; n = 493

	4/15
Too many	10
Too few	28
About right	59
Don't know/refused	3

NG-33a. What is the **main** reason you did not shop around before renewing your current health plan? (OPEN END)

Based on total who renewed 2014 plan and did not shop around before renewing; n = 307

	4/15
No computer/not internet access	1
Convenience of staying with plan/did not want to shop	13
Satisfaction with existing plan/no reason to change	37
Have preexisting conditions/health problems	1
Don't think you could afford other plans/like cost of current plan	8
Too busy/did not have time	8
No other options/limited options	2
Shopped around before/made a good decision last time/haven't had plan that long	6
Didn't want to have to change doctors/providers	2
Too confusing/complicated	3
Other	9
No reason	9
Don't know/refused	2

NG-34. What is the main reason you decided to renew with your current plan after shopping or looking at other options? (OPEN END)

Based on total who renewed 2014 plan and did shop around before renewing; n = 148

	4/15
Plan I had was good/couldn't find anything better (general)	38
Low cost (general)/premium	32
No/few other options	6
Convenience/ease of staying with the same plan	5
Didn't want to change doctors/providers	4
Age/specific health needs/issues covered	3
Low deductible	2
Other	9
No reason	-
Don't know/refused	1

NG-35. Did someone help you [enroll in health insurance/renew your health plan for 2015] or did you complete the [enrollment/renewal] process on your own?[2]

	4/15	5/14
Someone helped you (enroll/renew)	41	49
Completed the (enrollment/renewal) process on your own	52	49
Auto-renewed (vol.)	6	NA
Don't know/refused	1	1

[2] 2014 question wording was "Did someone help you enroll in health insurance or did you complete the enrollment process on your own?"

NG-36. Who was that person? Was it a family member or friend, a representative from (the federal health insurance exchange/[INSERT STATE EXCHANGE NAME]), a health insurance broker or agent, a community or county health worker, a health plan representative, or someone else?

Based on total who had someone help them (enroll in/renew) health insurance; n = 319

	4/15	5/14
A health insurance broker or agent	33	34
Family member or friend	29	22
A representative from (the federal health insurance exchange/STATE SPECIFIC NAME)	19	26
A health plan representative	12	NA
A community or county health worker	3	9
Someone else	3	8
Don't know/refused	2	1

Note: Total may add up to more than 100% because multiple responses accepted

NG-35/NG-36. Combo table based on total

	4/15	5/14
Someone helped you (enroll in/renew) health insurance	41	49
A health insurance broker/agent	13	17
Family member/friend	12	11
A representative from the federal health insurance exchange	8	13
A health plan representative	5	NA
A community/county health worker	1	5
Someone else	1	4
Don't know/Refused	1	--
Completed the (enrollment/renewal) process on your own	52	49
Auto-renewed	6	
Don't know/refused	1	1

(ROTATE 1-4/4-1)
NG-38. Thinking about when you signed up for your current health plan, how easy or difficult was it for you to (INSERT)?

Items a, b, & d based on total who do not have a pre-2014 plan; n = 677

	Very easy	Somewhat easy	Somewhat difficult	Very difficult	Not applicable (VOL)	Don't know/ refused
a. Compare the copays and deductibles you would have to pay when you use health services						
4/15	30	36	21	8	3	2
5/14	32	37	18	9	2	2
b. Compare the monthly premium you would have to pay for coverage						
4/15	39	35	17	7	2	1
5/14	38	35	16	7	2	2
d. Compare the doctors, hospitals, and other health care providers you could see under each plan						
4/15	27	31	23	12	4	3
5/14	28	36	21	9	3	3

Items c & e based on total who have a Marketplace plan; n = 494

	Very easy	Somewhat easy	Somewhat difficult	Very difficult	Not applicable (VOL)	Don't know/ refused
c. Figure out if your income qualifies you for financial assistance						
4/15	33	34	19	7	4	3
5/14	33	31	16	13	4	4
e. Set up an account with the health insurance marketplace (healthcare.gov/STATE MARKETPLACE NAME)						
4/15	30	29	23	12	5	2
5/14	32	27	19	14	3	5

(SCRAMBLE ITEMS a-e)
NG-40. Please tell me how important each of the following factors was in choosing your current health plan over the other choices available. What about (INSERT)? [READ FIRST TIME, THEN AS NECESSARY: Was this extremely important, very important, somewhat important, or not too important in your choice of plans?]

	Extremely important	Very important	Somewhat important	Not too important at all	Not important at all (VOL)	Don't know/ refused
a. The monthly premium costs	37	44	13	4	*	1
b. The deductibles and copays you have to pay when you use services	31	43	20	5	*	1
c. The choice of doctors and hospitals available	27	35	26	10	1	1
d. The range of benefits or a specific benefit covered	24	38	26	11	*	2
e. Recommendations from friends or family	8	14	22	51	3	2

NG-41. To the best of your knowledge, is your current health plan a bronze, silver, gold or platinum plan?

Based on total who do not have pre-2014 plans; n = 677

	4/15	5/14[3]
Bronze	23	21
Silver	36	29
Gold	9	7
Platinum	6	7
Catastrophic (vol)	-	--
None of these (vol)	3	4
Don't know/refused	24	31

NG-42. And do you happen to remember if the plan you had LAST year was a bronze, silver, gold, or platinum plan?

Asked of total who were covered by a different Marketplace plan in 2014 (sample size insufficient to report)

[3] 2014 question was asked of those with Marketplace plans only.

NG-43. Thinking about your CURRENT health plan, approximately how much do you pay per month for your health insurance premium, that is the amount you pay to be covered by health insurance?

(INTERVIEWER NOTES: IF RESPONDENT SAYS THEY'RE GETTING A GOVERNMENT SUBSIDY OR TAX CREDIT, SAY "We're interested in knowing the amount of the premium you are responsible for paying yourself, even if that doesn't represent the total cost of coverage." IF RESPONDENT ASKS IF WE WANT TO KNOW THEIR TOTAL HEALTH CARE COSTS, SAY "We're interested in knowing just the amount you pay for your insurance, not including the health care costs you pay directly out of your own pocket when you get health care or pay a prescription." IF RESPONDENT IS UNABLE TO GIVE A MONTHLY AMOUNT BUT CAN PROVIDE A YEARLY OR QUARTERLY AMOUNT, ENTER MONTHLY OR YEARLY)

(ASK IF Q.NG-43=$0 OR Q.NG-43>$2,000/MONTH OR Q.NG-43>$6,000/QUARTER OR Q.NG-43>$24,000/YEAR): Just to confirm, you said your health plan premium, that is the amount you pay for your health insurance coverage is (INSERT AMOUNT FROM Q.NG-43) per (month/quarter/year). Is that correct?

	4/15	5/14
$1-$200	40	36
$201-$500	27	21
$501+	19	15
Less than $1 per month	4	6
Don't know/refused	10	22

NG-45. Is the amount you pay for coverage just for yourself, or does it also include coverage for other members of your family?

	4/15	5/14
Just for self	57	58
Other members of your family	42	40
Don't know/refused	1	1

NG-46. How many people, including yourself, are covered by this health care plan?

Based on total who say amount paid for coverage includes other family members; n = 314

	4/15	5/14
2	58	46
3	19	22
4	14	24
5	6	3
6	2	2
7	1	--
8+	*	1
Don't know/refused	*	3

NG-47. How many of those people are children under age 19?

Based on total who say amount paid for coverage includes other family members; n = 314

	4/15	5/14
None	58	50
1	23	28
2	13	20
3	4	1
4	2	--
5	*	--
6	*	1
7	-	--
8+	-	--
Don't know/refused	*	*

NG-48. As far as you know, are you personally getting financial help from the government, such as a premium tax credit or premium assistance, to help pay your monthly premium for health insurance, or not?

Based on total with Marketplace plans; n = 494

	4/15	5/14[4]
Yes, getting financial assistance	59	46
No, not getting financial assistance	37	48
Don't know/refused	4	4

NG-49.As far as you know, is the amount you pay for your health plan based on your income, or is it not based on your income?

Based on total with Marketplace plans who say they are not getting financial assistance or dk/ref; n = 207

	4/15
Yes, based on income	53
No, not based on income	39
Don't know/refused	8

NG-48/NG-49. Combo table based on total with Marketplace plans; n = 494

	4/15
Getting financial assistance or premium based on income	81
Getting financial assistance	59
Amount you pay is based on income	22
Not getting financial assistance/not based on income	16
Don't know/refused	3

[4] 2014 question was asked of all respondents; 2014 percentage shown in table is based on Marketplace enrollees only.

NG-50. Have you received a form, known as form 1095-A or the Health Insurance Marketplace Statement that contains information about your health insurance coverage needed to file your 2014 taxes, have you not received this form, or are you not sure?

Based on total with Marketplace plans in 2014; n = 303

	4/15
Yes	50
No	22
Not sure	25
Don't know/refused	2

NG-50a. Did this form show that you received a premium tax credit or that the government paid a portion of your health insurance costs in 2014, or not?

Based on total with Marketplace coverage in 2014 and received form 1095-A; n = 156

	4/15
Yes	71
No	16
Don't know/refused	13

NG-50/NG-50a. Combo table based on total who had Marketplace coverage in 2014; n = 303

	4/15
Received form 1095-A	50
Showed that you received premium tax credit	36
Did not show that you received premium tax credit	8
Don't know/refused	6
Did not receive from 1095-A	22
Not sure if received form	25
Don't know/refused	2

NG-51. Have you filed your federal income taxes yet for 2014?

	4/15
Yes	41
No	56
Don't file/not required to file taxes (vol.)	2
Don't know/refused	1

NG-52. [Do you plan to/Did you] file your taxes yourself, either on paper or using computer software, or [do you plan to/did you] use a professional tax preparer to complete your tax forms?

Based on total except those who say they do not file/are not required to file taxes; n = 787

	4/15
File yourself	31
File by professional tax preparer	66
Don't file/not required to file taxes (vol.)	2
Don't know/refused	2

NG-51/NG-52. Combo table based on total

	4/15
File/required to file income taxes	98
Filed/plan to file taxes yourself	30
Filed/plan to file taxes by professional tax preparer	64
Did not file/not required to file taxes (vol.)	2
Don't know/refused	2
Don't file/not required to file taxes (vol.)	2

NG-53. Did your monthly income increase or decrease at any point in 2014, or was your income pretty much the same each month in 2014? (INTERVIEWER NOTE: If R says "changes every month" ASK FOLLOW-UP) (FOLLOW-UP: Was that a big change or just a small change?)

Based on total who had Marketplace coverage in 2014 or 2015; n = 497

	4/15
Big change in monthly income	20
Small change in monthly income	19
Income was pretty much the same each month	56
Don't know/refused	5

NG-53a. In 2014, did you have a change in your family status, like a marriage, divorce, new child, or a change in the number of tax dependents, or did your family status stay the same throughout the year?

Based on total who had Marketplace coverage in 2014 or 2015; n = 497

	4/15
Changed	8
Stayed the same	92
Don't know/refused	*

NG-54. Did you inform the health insurance marketplace (healthcare.gov/INSERT STATE-SPECIFIC NAME) of any changes to your income or family status in 2014?

Based on total who had Marketplace coverage in 2014 and experience a change in income or family status; n = 136

	4/15
Yes	52
No	45
Don't know/refused	4

NG-53/NG-53a/NG-54. Combo table based on total who had Marketplace coverage in 2014 or 2015

	4/15
Experienced a change in income or family status in 2014	44
Informed health insurance marketplace of changes	13
Did not inform health insurance marketplace of changes	11
Don't know/refused	1
Did not experience a change in income or family status in 2014/dk/ref	56

NG-55. As far as you know, when someone gets financial help from the government to pay their health insurance premium, is it possible they would end up owing money to the government if their income or family size changes during the year, or not?

Based on total who had Marketplace coverage in 2014 or 2015; n = 497

	4/15
Yes	54
No	19
Don't know/refused	27

NG-56. Thinking about your CURRENT insurance plan, I'd like to ask about your annual deductible for medical care, that is the amount you have to pay yourself before your insurance plan will start paying any of your medical bills. Is your annual deductible LESS than $1,500 a year , or is it $1,500 a year or more? (IF NECESSARY: If your plan has separate deductibles for services received from providers inside and outside the plan's network, please answer based on the in-network deductible.) [IF NECESSARY: If your plan has separate deductibles for different types of services, please think about the deductible that applies to most services.]

	4/15
Less than $1500	36
$1500 or more	47
$0/No deductible	3
Don't know/refused	13

NG-57.Is that a FAMILY deductible, meaning you must spend that amount on your entire family's medical care before the insurance company begins to pay, or is it a PER PERSON deductible, meaning that you must spend that amount on care for any one person before the insurance company will begin to pay for that person's care?

Based on total who pay an annual deductible and say amount paid for coverage includes other family members; n = 277

	4/15
Family deductible	49
Per person deductible	40
Don't know/refused	11

NG-58. Still thinking about your CURRENT insurance plan, is your annual deductible LESS than $3,000 a year, or is it $3,000 a year or more? (IF NECESSARY: If your plan has separate deductibles for services received from providers inside and outside the plan's network, please answer based on the in-network deductible.) [IF NECESSARY: If your plan has separate deductibles for different types of services, please think about the deductible that applies to most services.]

Asked of total who pay a family deductible and deductible is $1500 or more (sample size insufficient to report)

Deductible combo table based on total

	4/15
High-deductible ($1500 or more individual/$3000 or more family)	40
Not high-deductible (less than $1500 individual/less than $3000 family)	43
Undetermined	17

NG-59. Was there a time over the past twelve months when you [or another family member covered by your plan] needed medical care, but did not get it because of the cost, or not?

	4/15
Yes, there was	17
No, there was not	81
Don't know/refused	2

NG-60. Was there a time over the past twelve months, when you [or another family member covered by your plan] DID NOT fill a prescription for a medicine because of the cost, or not?

	4/15
Yes, there was	20
No, there was not	79
Don't know/refused	1

(SCRAMBLE a-e)
NG-61. I'm going to read you a list of problems some people experience with their health insurance plan. Please tell me if you have had any of these problems in the past twelve months, or not. How about (INSERT)?

	Yes, have	No, have not	Not applicable/ haven't used services yet (VOL)	Don't know/ refused
a. You were surprised to find out that your plan would not pay anything for care you (or a family member) received, that you thought was covered	18	76	4	1
b. Your plan paid less than you expected for a bill you received from a doctor, hospital, or lab	26	67	5	2
c. You reached the limit on the number of visits or services your insurance company would pay for treatment of a specific illness or injury	6	87	5	2
d. A particular doctor you wanted to see was not covered by your plan	19	76	4	1
e. A particular hospital you wanted to visit was not covered by your plan	8	86	5	1

(IF COVERED BY A DIFFERENT PLAN FOR AT LEAST PART OF 2014, ASK IMMEDIATELY AFTER EACH YES TO ANY OF THE ABOVE): Was that under your CURRENT health plan or a previous health plan?

NG-61a/62a. You were surprised to find out that your plan would not pay anything for care you (or a family member) received, that you thought was covered

Combo table based on total

	4/15
Yes had a problem	18
Current plan (including those who've had same plan for >12 months)	15
Previous plan	3
Both (Vol.)	*
Don't know/refused if current/previous plan	*
Did not have a problem	76
Not applicable/haven't used services yet	4
Don't know/refused	1

NG-61b/62b. Your plan paid less than you expected for a bill you received from a doctor, hospital, or lab

Combo table based on total

	4/15
Yes had a problem	26
Current plan (including those who've had same plan for >12 months)	21
Previous plan	4
Both (Vol.)	1
Don't know/refused if current/previous plan	*
Did not have a problem	67
Not applicable/haven't used services yet	5
Don't know/refused	2

NG-61c/62c. You reached the limit on the number of visits or services your insurance company would pay for treatment of a specific illness or injury

Combo table based on total

	4/15
Yes had a problem	6
Current plan (including those who've had same plan for >12 months)	5
Previous plan	1
Both (Vol.)	*
Don't know/refused if current/previous plan	*
Did not have a problem	87
Not applicable/haven't used services yet	5
Don't know/refused	2

NG-61d/62d. A particular doctor you wanted to see was not covered by your plan

Combo table based on total

	4/15
Yes had a problem	19
Current plan (including those who've had same plan for >12 months)	17
Previous plan	2
Both (Vol.)	1
Don't know/refused if current/previous plan	-
Did not have a problem	76
Not applicable/haven't used services yet	4
Don't know/refused	1

NG-61e/62e. A particular hospital you wanted to visit was not covered by your plan

Combo table based on total

	4/15
Yes had a problem	8
Current plan (including those who've had same plan for >12 months)	7
Previous plan	1
Both (Vol.)	*
Don't know/refused if current/previous plan	*
Did not have a problem	86
Not applicable/haven't used services yet	5
Don't know/refused	1

NG-63. In the past 12 months, have you [or another family member covered by your plan] had any problems paying medical bills, or not?

	4/15
Yes, have	19
No, have not	79
Not applicable/haven't used services yet	1
Don't know/refused	1

DEMOGRAPHICS:

S14. Interviewer: record gender. If unclear ask: What is your gender?

	4/15	5/14
Male	48	50
Female	52	50

Z-7. What is your age?
Z-7a. Could you please tell me if you are ...?

	4/15	5/14
18-29	25	29
30-49	38	35
50-64	37	35
Refused	-	*

D1. In general, would you say your health is excellent, very good, good, fair, or poor?

	4/15	5/14
Excellent	26	24
Very good	33	31
Good	27	30
Fair	10	11
Poor	4	3
Don't know/refused	*	1

D2. Does any disability, handicap, or chronic disease keep you from participating fully in work, school, housework, or other activities?

	4/15	5/14
Yes	14	14
No	85	85
Don't know/refused	*	1

Z-2. Are you: (READ LIST)

	4/15	5/14
Single, that is never married	27	34
Single, living with a partner	8	9
Married	48	40
Separated	2	2
Widowed	3	3
Divorced	11	11
Refused	*	1

Z-4. Currently, are you yourself employed full-time, part-time, or not at all? (INTERVIEWER NOTE: If respondent asks to define "full-time" please define as 30 or more hours per week)

	4/15	5/14
Full-time	48	46
Part-time	22	23
Not employed	29	31
Retired	7	7
A homemaker	8	6
A student	6	7
Temporarily unemployed	6	9
Disabled/handicapped	2	2
Other	1	1
Refused	*	--

D6. Are you self-employed, or do you work for someone else? (IF R SAYS THEY HAVE MULTIPLE JOBS: "Thinking about the job you spend the most time at…")

Based on total who are employed; n = 554

	4/15	5/14
Self-employed	40	35
Work for someone else	59	64
Don't know/refused	1	1

Z-4/D6. Combo table based on total

	3/29/30	5/14
Employed	70	69
Self-employed	28	24
Work for someone else	42	44
Not employed	29	31
Refused	*	--

D6a. Does your employer or union offer a health plan to at least some of its employees? (IF NECESSARY: Does the employer offer to pay all or some of employees' health insurance costs?)

Based on total who are employed full-time and work for someone else; n = 189

	4/15
Yes	39
No	60
Don't know/refused	1

Z-4/D6/D6a. Combo table based on total

	4/15
Employed full-time for someone else	26
Employer offers a health to at least some of its employees	10
Employer does not offer a health plan	15
Don't know/refused	*
Employed part-time for someone else	16
Self-employed	28
Not employed	29
Don't know/refused employment status	1

D6b. Which of the following is the main reason why you don't participate in this health plan? Is it because… (READ IN ORDER)

Asked of total who are employed for someone else and employer offers coverage (sample size insufficient to report)

D6a/D6b. Combo table based on total who are employed full-time for someone else

	4/15
Employer offers a health plan to at least some of its employees	39
You are not eligible to participate	6
You're not currently eligible, but will be after a waiting period	5
It's less expensive to buy your own coverage than to pay your portion for your employer's plan	16
You're not happy with the plan your employer offers	9
Some other reason I haven't mentioned	2
Don't know/refused	2
Employer does not offer a health plan	60
Don't know/refused	1

D4d. Including all its locations and worksites, about how many people are employed by the company or organization you work for? Just stop me when I get to the right category. Are there fewer than 50 employees, 50 to 100 employees, or more than 100 employees? [IF NECESSARY: Just your best guess.]

Based on total who are employed full-time for someone else; n = 189

	4/15
Fewer than 50 employees	53
50 to 100 employees	8
More than 100 employees	35
Don't know/refused	3

D6b/D4d. Combo table based on total

	4/15
Employed full-time for someone else	26
Company has fewer than 50 employees	14
Company has 50 to 100 employees	2
Company has more than 100 employees	9
Don't know/refused	1
Employed part-time for someone else	16
Self-employed	28
Not employed	29
Don't know/refused employment status	1

Z-11a. Generally speaking, do you usually think of yourself as: NOTE: If respondent gives answer such as: "conservative, liberal, vote for best man" Probe: Would that be Republican, Democrat, or independent?

	4/15	5/14
A Republican	23	17
A Democrat	30	34
An independent	40	40
Other	1	1
None/no affiliation	*	*
Don't know/refused	6	7

(PN: ROTATE ITEMS IN PARENS IN SAME ORDER AS D8)
D10. Do you LEAN more towards the (Republican Party) or the (Democratic Party)?

Based on total who are do not consider themselves Republicans or Democrats; n = 353

	4/15	5/14
Republican	21	21
Democratic	30	30
Independent/don't lean to either party	30	23
Other party	2	1
Don't know/refused	17	12

Z-11a/D10. Leaned Party Table based on total

	4/15	5/14
Republican	23	17
Lean Republican	10	10
Independent/don't lean	14	12
Lean Democrat	14	15
Democrat	30	34
Other	1	7
Don't know/refused	8	6

(ROTATE 1-5/5-1)
D4. Generally speaking, would you describe your political views as…?

	4/15	5/14
Very conservative	15	13
Somewhat conservative	25	21
Moderate	25	27
Somewhat liberal	17	20
Very liberal	11	13
Don't know/refused	7	6

Z-8 What is the last grade of school you completed? (DO NOT READ LIST)

	4/15	5/14
Less than high school graduate	7	8
High school graduate	31	32
Some college	29	25
Graduated college	21	20
Graduate school or more	9	11
Technical school/other	2	3
Refused	-	1

Z-10. Are you of Hispanic origin or background?

	4/15	5/14
Yes	12	13
No	88	87
Don't know/refused	*	*

CO-1. Were you born in the United States, the island of Puerto Rico, or in another country?

Asked of total Hispanics (sample size insufficient to report)

Z-10/CO-1 Combo Table based on total

	4/15	5/14
Hispanic	12	13
Born in the United States	6	8
Born in Puerto Rico	1	--
Born in another country	4	5
Non-Hispanic	88	87
Don't know/refused	*	*

Z-11. Do you consider yourself white, black or African American, Asian, Native American, Pacific Islander, mixed race or some other race? (IF RESPONDENT SAYS HISPANIC ASK: Do you consider yourself a white Hispanic or a black Hispanic?) (INTERVIEWER NOTE: CODE AS WHITE (1) OR BLACK (2). IF RESPONDENTS REFUSED TO PICK WHITE OR BLACK HISPANIC, RECORD HISPANIC AS "OTHER,"

	4/15	5/14
White	75	70
Black or African American	12	15
Asian/Chinese/Japanese	3	4
Native American/American Indian/Alaska Native	1	1
Native Hawaiian and Other Pacific Islander	-	*
Mixed	4	5
Hispanic/Latino	1	3
Other	1	1
Don't know/refused	2	2

Race Summary Table based on total

	4/15	5/14
White non-Hispanic	69	63
Black non-Hispanic	11	13
Hispanic	12	13
Asian	3	4
Native American	1	1
Native Hawaiian	-	*
Mixed	2	4
Other	*	*
Don't know/refused	1	2

D17. How many dependent children do you have, if any? [INTERVIEWER NOTE: If respondent asks to clarify what "dependent children" means, say "Any child who is dependent on you for support, or who you claim as a dependent on your tax return"]

	4/15	5/14
1	16	15
2	13	13
3	5	3
4	2	1
5	1	*
6	*	*
7	*	*
8+	64	65
Don't know/refused	*	1

If family size could not be calculated from previous questions, the following questions were asked:

D18. Besides yourself, how many people are in your family, meaning your spouse and any dependent children? [INTERVIEWER NOTE: If respondent asks to clarify what "dependent children" means, say "Any child who is dependent on you for support, or who you claim as a dependent on your tax return"]

D19. Does anyone else, such as a parent, claim you as a dependent on their tax return?

D20. Is the parent or person who claims you as a dependent married, or not? (INTERVIEWER NOTE: If R says their parents are married but not to each other, code as "1: Married") (INTERVIEWER NOTE: If the R is not claimed by their parent, ask about the person claiming them as a dependent)

D21. Besides yourself, how many other dependent children (do/does) your (parents/parent) have? (INTERVIEWER NOTE: If the R is not claimed by their parent, ask about the person claiming them as a dependent)

FAMILYSIZE VARIABLE CALCULATED AS FOLLOWS:
IF Q.Z-2=3: FamilySize= {2+D17}
IF Q.Z-2=1-2 OR 4-6: FamilySize= {1+ D17}
IF Q.D18=(0-16): FamilySize = {1 +D18}
IF Q.D18=D,R: FamilySize = {2}
IF Q.D19=1: FamilySize = {1+ ("2" IF Q.D20=1 OR "1" IF Q.D20=2, D, R) +(Q.D21 OR "0" IF Q.D21=DD OR RR)}
IF Q.D19=2: FamilySize = {1}
IF Q.D19=D, R: FamilySize = {2}

	100%	AMT1 (138%)	AMT2 (250%)	AMT3 (400%)
FamilySize	**Poverty guideline**			
1	$11,670	$16,000	$29,000	$47,000
2	$15,730	$22,000	$39,000	$63,000
3	$19,790	$27,000	$49,000	$79,000
4	$23,850	$33,000	$60,000	$95,000
5	$27,910	$39,000	$70,000	$112,000
6	$31,970	$44,000	$80,000	$128,000
7	$36,030	$50,000	$90,000	$144,000
8	$40,090	$55,000	$100,000	$160,000
9	$44,150	$61,000	$110,000	$177,000
10	$48,210	$67,000	$121,000	$193,000
11	$52,270	$72,000	$131,000	$209,000
12	$56,330	$78,000	$141,000	$225,000

(IF FAMILYSIZE=1, INSERT FIRST VERBIAGE IN PARENS "PERSONAL" AND DO NOT INSERT BRACKETS)
(IF MARRIED OR HAS CHILDREN OR IS A DEPENDENT (Z-2=3 OR D17=1+ OR D18=1+ OR D17=1), INSERT SECOND VERIBIAGE IN PARENS "FAMILY" AND INSERT BRACKETS)
(IN BRACKETS: INSERT "AND your spouse" IF married [Q.Z-2=3], INSERT "and your dependent children" if any dependent children [Q.D17=1+], INSERT "AND your spouse and/or any dependent children" [Q.D18=1-17, R], [PN: INSERT "AND your {parents/parent}" if claimed [D19=1], INSERT "AND any other dependent children of your {parents/parent}" if parents have other children [D21=1+], INSERT "AND your {parents/parent} AND/OR any other dependent children of your {parents/parent}" IF don't know [D21=D, R OR D21=D, R] (INSERT FIRST VERBIAGE IN "{}" IF D20=1; INSERT SECOND VERBIAGE IN "{}" IF D20=2, D, R)

D22. To help us describe the people who took part in our study, it would be helpful to know which category best describes your (personal/family) income last year before taxes. [Family income only includes income from you yourself, (AND your spouse), (and your dependent children) (AND your spouse and/or any dependent children), (AND your {parents/parent}), (AND any other dependent children of your {parents/parent}), (AND/OR any other dependent children of your {parents/parent})]. Was your total (personal/family) income in 2014 from all sources, and before taxes, less than (AMOUNT 1), at least (AMOUNT 1) but less than (AMOUNT 3) or (AMOUNT 3) or more? [INTERVIEWER: IF RESPONDENT REFUSES: Your responses are strictly confidential and are not attached to any identifying information. It is important for us to know this information to help us describe people who took part in our study.] [INTERVIEWER: IF RESPONDENT SAYS THEY ARE NOT SURE, PROBE: Can you estimate?]
D22a. Is that less than (AMOUNT 2) or (AMOUNT 2) or more? (INTERVIEWER NOTE: PLEASE READ NUMBER AMOUNTS SLOWLY AND CAREFULLY)[5]

	4/15	5/14
Less than (138%)	29	32
At least (138%) but less than (400%)	42	37
Less than (250%)	23	21
(250%) or more	17	15
More than 138% (unspecified)	1	1
(400%) or more	22	20
Don't know/refused	8	11

REGION

	4/15	5/14
Northeast	12	17
North Central	20	24
South	44	34
West	24	26

[5] In order to group people according to income as a percentage of the federal poverty level (FPL), which is tied to an individual's income as well as the size of their family, respondents were first asked a series of questions to determine their family size. These results were then used to plug different dollar values into a question about last year's family income. Self-reported income on the survey was lower than we expected for this group. Research has shown that respondents tend to under-report their income in surveys (see, for example, Moore et. al "Income Measurement Error in Surveys: A Review," available at http://beta.census.gov/srd/papers/pdf/sm97-05.pdf). The fact that respondents were asked about their income in the previous year may also be a factor in the lower-than-expected self-reported values. Since this group includes many people who are self-employed or own a small business, their incomes are likely to fluctuate more than people with employer coverage, so prior year's income may not necessarily match up with current income.

SCREENER

HH3. Confirm ages 18-64

S1. (Thinking about how you get your health insurance/And just to confirm): I am going to read a few common types of health insurance. For each one, please tell me "yes" if you currently have it and "no" if you don't. How about [INSERT]?

[PN: DO NOT SCRAMBLE. ONCE RESPONDENT SAYS YES TO ANY ITEM FOLLOW THE INSTRUCTIONS BELOW]

[INTERVIEWER: IF AT ANY POINT RESPONDENT SAYS "I DON'T HAVE ANY HEALTH INSURANCE": CONFIRM "DO YOU MEAN YOU HAVE NO HEALTH INSURANCE AT ALL"?" IF YES, THAN ENTER CODE 3]

1 Yes, currently have it
2 No, do not have it
3 You do not have any kind of health insurance
D (DO NOT READ) Don't know
R (DO NOT READ) Refused/prefer not to answer

a. A health plan you get through an employer or union, or through a family member's employer or union
b. [State Medicaid Plan Name], also called Medicaid
c. Medicare
d. A military health care plan, such as TRI-CARE, CHAMPUS, or CHAMP-VA
e. A plan you purchased yourself either from an insurance company or a state or federal marketplace like healthcare.gov or [IF STATE MARKETPLACE: INSERT STATE-SPECIFIC NAME]
f. (IF 18-25) A plan through one of your parents
g. Some other kind of insurance I haven't already mentioned (SPECIFY):_____

[IF S1a OR S1b OR S1c OR S1d=1 OR S1f = 1 TERM AS T.S1]
[IF S1e=1 GO TO S10]

[ASK S2 IF ALL ITEM S1a THROUGH S1g = 2,D,R OR IF ANY ITEM S1a THRU S1g=3]

S2. Have you signed up for or purchased health insurance coverage that will begin in the next month, either through an insurance company or a state or federal marketplace like healthcare.gov or [IF STATE MARKETPLACE: INSERT STATE-SPECIFIC NAME]? INTERVIEWER NOTE: IF RESPONDENT SAYS THEY STARTED THE PROCESS OF SIGNING UP BUT HAVEN'T COMPLETED IT, CODE AS 2. IF THEY SAY THEY HAVE SIGNED UP FOR COVERAGE BUT HAVEN'T PAID THEIR FIRST PREMIUM YET, CODE AS 1.]

1 Yes
2 No
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(IF S2=1 GO TO S11)
(IF S2=2, D, OR R, TERMINATE)

[ASK S3 IF S1g=1]:

S3. Is that a plan you purchased directly from an insurance company, through a health insurance broker, or from a state or federal health insurance marketplace like healthcare.gov or [IF STATE MARKETPLACE: INSERT STATE-SPECIFIC NAME], or not?

1 Yes
2 No
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK S4 IF S3 = 2 or D or R)

S4. Is it a plan purchased through a trade association, or not?

1 Yes
2 No
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(IF Q.S4 = 2 OR D OR R, TERMINATE)

(ASK Q.S5 IF Q.S4 = 1)

S5. Do you pay the entire premium yourself, or not?

1 Yes
2 No
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(IF Q.S5 = 2 OR D OR R, TERMINATE)

(ASK Q.S10 IF Q.S1e = 1 OR Q.S3 = 1 OR Q.S5 = 1)

S10. Do you purchase your health insurance coverage from a college or university where you or your spouse are enrolled as a student?

1 Yes
2 No
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

[ASK Q.S10a IF Q.S10=1]

S10a. Does your insurance cover health services received outside the university setting, or is it only good for services received on the college or university campus?

1 Covers health services received outside the university setting
2 Only good for services received on the college or university campus
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(IF Q.S10a = 2 OR D OR R, TERMINATE AS TQS10a)
(IF Q.S10a = 1, GO TO Q.S14)

(ASK Q.S11 IF Q.S2 = 1 OR Q.S10 = 2, D, OR R OR Q.S10a = 1)

S11. Are you or your spouse a small business owner, or not?

1 Yes
2 No
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(ASK Q.S11a IF Q.S11 = 1)

S11a. Is the health insurance that you purchase for yourself part of a plan that also covers non-related employees of your business, or is the plan just for yourself and your family?

1 Also covers non-related employees of your business
2 Just for yourself and your family
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(IF Q.S11a = 1 OR D OR R, TERMINATE)

(ASK Q.S12 IF Q.S11 = 2, D, OR R OR Q.S11a = 2)

S12. Is the health insurance that you purchase yourself an extension of coverage that you previously got through an employer, commonly called COBRA?

1 Yes
2 No
D (DO NOT READ) Don't know
R (DO NOT READ) Refused

(IF Q.S12 = 1 OR D OR R, TERMINATE)

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NATIONAL ACADEMY OF SOCIAL INSURANCE

Active Purchasing for Health Insurance Exchanges: An Analysis of Options

By Sabrina Corlette and JoAnn Volk

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Executive Summary

State-based health insurance exchanges are a critical component of the Patient Protection and Affordable Care Act's (ACA) provisions to expand access to coverage to millions of Americans. In addition to being the gateway for people to purchase subsidized health insurance, exchanges are expected to help organize insurance markets and promote more effective competition among health plans. There is, however, disagreement among policy-makers over whether and how exchanges should be able to act on behalf of individual and small group buyers to demand higher-quality products at more affordable prices. Some policy-makers believe that the exchanges must be "active purchasers," empowered to selectively contract with carriers, set tougher participation criteria than the federal standards and/or negotiate price discounts in order to effectively serve consumers. Others believe the best way to serve consumers is to have the exchange provide the broadest possible array of plans (a "Travelocity" approach).

In our research we found that active purchasing is not just one activity and it doesn't just involve determining whether plans should be in or out of an exchange. Rather, it can encompass a wide range of activities to leverage higher-quality, more affordable insurance for individuals and small businesses.

We also assess environmental factors in the states that would support – or undermine – the range of active purchasing activities in which an exchange may wish to engage. We conclude that even in states with the least hospitable environments for active purchasing efforts, there will be some important activities that the exchange leadership can undertake on behalf of enrollees. Selected findings include the following:

- The ACA requires states to authorize their exchanges to take on a number of activities that go beyond the role of a passive clearinghouse. At a minimum, each exchange must have the authority to exercise its own judgment of whether a health plan's participation is "in the interests of" consumers and employers in the exchange.
- The ACA permits exchanges to take on a wide range of activities to promote the availability of high-quality, affordable insurance products. These include, but are not limited to:
  - Setting additional certification criteria that reflect the state's goals for such things as population health, plan quality, access to providers, delivery system reform and transparency;

  - Using a selective contracting process to negotiate better prices and higher-quality from plans;
  - Managing product choices and setting parameters for cost-sharing;
  - Leveraging quality improvement and delivery system reforms by encouraging participating health plans to implement strategies to promote the delivery of better coordinated, more efficient health care services;
  - Aligning with other large purchasers in the state, such as large employer coalitions, the Medicaid agency and/or the state government employee benefits agency to send consistent purchasing signals to health insurance carriers and providers;
  - Recruiting new insurance carriers, particularly in states with highly concentrated insurance markets. Such an approach could also include providing technical assistance to regional, home-grown or Medicaid carriers to help them become exchange participants; and
  - Leveraging consumer decision-making through better information and web-based decision tools.
- There are environmental factors that could support – or undermine – active purchasing in the states. Each state will face a different calculus in whether and how to pursue active purchasing for its exchange, depending on such factors as market concentration, market rules, the number and health status of exchange enrollees and the exchange's ability to recruit and maintain a leadership and staff free from conflicts of interest and with the requisite expertise.
- Exchanges that sit in highly concentrated insurance markets are limited in how selective they can be, but they can pursue other strategies to improve value for enrollees. Exchanges need an appealing mix of health plan offerings to attract and sustain enrollment, particularly for small employers and unsubsidized individuals. While an exchange in a concentrated market may have limited leverage to negotiate price discounts, they could work to recruit new market entrants or encourage smaller carriers that may be able to expand market share through an exchange. They can also focus on promoting better consumer decision-making and encouraging competition based on value. The exchange could also collaborate with other large purchasers to align purchasing strategies.
- The size of the exchange impacts its ability to exercise leverage. Even though the exchange will be the exclusive source of coverage for most individuals eligible for federal premium and cost-sharing subsidies, in many states it will represent a relatively small share of the total commercial market. And small businesses and individuals will have alternative options in the outside market. In addition, states that establish Basic Health Plans may draw from the exchange a significant proportion of its subsidy-eligible enrollees. As a result, it is important not to overestimate the exchange's leverage to negotiate with carriers.
- The rules for the market outside the exchange are critical to successful active purchasing. If the exchange cannot capture a large enough share of the healthy participants in the commercial market, the whole notion of being an active purchaser is largely moot – it will not be able to attract a sufficient number of carriers with which to negotiate. The exchange will also need to worry about adverse selection among plans within the exchange. Officials involved in existing exchanges report that "carriers' confidence in risk adjustment is critical."
- Being an effective active purchaser requires resources, data-driven knowledge of the markets and the expertise to negotiate with carriers. Active purchasing cannot be done effectively without an infrastructure to do it. However, some states may face challenges assembling a board of directors with sufficient expertise that is also free from conflicts of interests. Others may find it similarly difficult to recruit and retain a staff that can perform the necessary duties. And maintaining the necessary personnel will require raising revenue, which in many cases will be accompanied by political pressure to demonstrate that the public investment is worth it.

- Negotiating price discounts from carriers will likely prove challenging for many exchanges. The fact that the exchange is not the sole distribution channel for insurance products could limit its leverage to negotiate prices with carriers. This is in part because the ACA requires that prices for the same products be the same inside and outside the exchange, meaning that any price discount negotiated by the exchange would have to be implemented in the outside market as well. For most carriers, the exchange won't be a big enough book of business to justify such across-the-board rate reductions. Most importantly, however, negotiating price discounts year-to-year with carriers does nothing to tackle the long-term problem for consumers and small businesses: the runaway growth in the costs of health care.
- Exchanges may have the greatest potential to improve value by incentivizing health plans and, in turn, providers to deliver higher-quality care, more efficiently. By consolidating individuals and small groups and potentially partnering with other large purchasers to align purchasing strategies, the exchange can encourage long-term delivery system reforms that can help improve the quality of care and mitigate the unsustainable trend in health care inflation.

Introduction

State-based health insurance exchanges are a critical component of the Patient Protection and Affordable Care Act's (ACA) provisions to expand access to coverage to millions of Americans. In addition to being the gateway for people to purchase subsidized health insurance, exchanges are expected to help organize insurance markets and promote more effective competition among health plans. There is, however, disagreement among policy-makers over whether and how exchanges should take on a more active role in promoting a reformed marketplace.

To be sustainable, exchanges will have to take on a minimum set of activities, not the least of which will be monitoring risk among plans within the exchange and closely tracking prices and products in the outside market. They will need to make sure the consumer shopping experience is as simple and streamlined as possible, including helping people enroll – and re-enroll – in the program most appropriate for them, whether it is Medicaid, CHIP, another state program or premium subsidies through the exchange. They'll need to run an effective Navigator program and work with insurance brokers and community groups to reach potential customers, educate them about their new rights and responsibilities under the law, sign them up for coverage and effectively respond to complaints. All of these activities suggest an exchange that is active in shaping the marketplace, rather than a passive conduit of information between buyers and sellers. However, these activities are just a necessary prerequisite for an exchange to be an active purchaser. As an active purchaser, an exchange not only needs to be a market organizer, it must be able and willing to act on behalf of individual and small group buyers to demand higher-quality products at more affordable prices.

Whether and how state exchanges should be active purchasers have been focal points of debate as states consider legislation to establish exchanges under the ACA. Many believe that the exchange must be empowered to selectively contract with carriers, set tougher participation criteria than the federal standards and/or negotiate price discounts in order to effectively serve consumers. Other stakeholders believe the best way to serve consumers is to have the exchange provide the broadest possible array of plans (the "Travelocity" approach).

Through a review of primary and secondary source materials and interviews with officials currently or formerly responsible for running purchasing exchanges or groups that service individuals, employees and small businesses, we assess existing efforts to provide value-oriented products to subscribers. We conclude that active purchasing is not just one activity. Rather, it can encompass a wide range of activities to leverage higher-quality, more affordable health insurance for individuals and small businesses.

From our review of existing exchanges and augmented by interviews with national health policy experts, we discuss environmental factors in the states that would support – or undermine – the range of active purchasing activities in which an exchange may wish to engage. All of the active purchasing activities we identify will not work in all states. By the same token, even in states that have the least conducive environments for active purchasing efforts, there will be some important activities the exchange leadership can undertake to deliver better quality, affordable products to their enrollees. The findings in the paper are the authors' alone and should not be attributed to any individuals or groups with whom we consulted.

What it Means to be an Active Purchaser

The notion of a market sponsor that is also an active purchaser has a long history, with roots in the concept of managed competition. As articulated in 1993 by Alain Enthoven, managed competition involves "intelligent, active collective purchasing agents" acting on behalf of enrollees and "connotes the ability to use judgment to achieve goals…to be able to negotiate." And it uses "rules for competition…to reward…those health plans that do the best job of improving quality, cutting cost and satisfying patients."[1]

Health insurance exchanges build on Enthoven's vision. They could be empowered to act on behalf of consumers and small business owners in a number of ways that would drive value. In its initial guidance to states about insurance exchanges, the Department of Health and Human Services (HHS) has interpreted the law to allow a state to empower its exchange to be an active purchaser, "using market leverage and the tools of managed competition to negotiate product offerings with insurers," much like a large employer would. And while HHS notes that a state can operate its exchange as a "clearinghouse that is open to all qualified insurers," the law sets boundaries on how open that clearinghouse can be.[2]

Minimum Requirements Under the ACA

Whether or not a state chooses to empower its exchange to be an active purchaser, the ACA requires exchanges to take on a number of activities that go well beyond the role of a passive clearinghouse. For example, exchanges cannot take "any willing plan." To participate, plans must not only provide the federally prescribed essential benefits package[3] and offer products that meet minimum cost-sharing and actuarial value standards, they must satisfy a set of certification criteria. These criteria include, for example:

- **Marketing standards.** Plans cannot use marketing or benefit design to discourage sicker people from enrolling.
- **Network adequacy.** Plans must provide a sufficient choice of providers and notify consumers about the availability of in-network and out-of-network providers. Plans must also include within their networks essential community providers that serve low-income, medically underserved individuals.
- **Accreditation.** Plans must be accredited based on clinical quality measures and patient experience ratings, including their performance on consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals and other factors.
- **Quality improvement.** Plans must implement a quality improvement strategy that includes implementing quality reporting, case management, care coordination, prevention of hospital readmissions, activities to improve patient safety and activities to reduce health disparities.
- **Standardization.** Plans must use a uniform enrollment form and standardized format for summarizing the benefits in their products.
- **Transparency.** Plans must provide to enrollees and prospective enrollees information on their performance on quality metrics. They must also report to HHS their performance on pediatric quality measures.[4]

In addition to these criteria, the exchange must determine that each plan's participation is "in the interests of" consumers and employers in the exchange.[5] This federal standard is subjective and the leadership of state exchanges could implement it in a myriad of ways. But at a minimum, it means that if the exchange leadership decides a plan's participation is not in the interests of consumers and business owners, it can reject it. And presumably, no state legislature could take away the exchange's ability to make that kind of subjective judgment without falling out of compliance with the ACA. Indeed, HHS's January 2011 Funding Opportunity Announcement (FOA) for exchange planning and implementation makes clear that, to be certified as compliant (and avoid a federally established exchange), exchanges must have "the capacity and authority to take all actions necessary to meet Federal standards, *including the discretion to determine whether health plans offered through the Exchange are in the interests of qualified individuals and qualified employers*"[6] (emphasis added).

Similarly, while the ACA does not mandate that exchanges engage in price negotiations with carriers, it encourages exchanges to monitor rates inside and outside the exchange. At a minimum, all exchanges must review plans' requested premium increases before they go into effect and take the information they receive in that process into consideration when deciding whether to accept or reject a plan in the exchange.[7] The law also requires exchanges to take into account any recommendations from the state department of insurance (DOI) on whether to exclude a health plan because of a "pattern or practice of excessive or unjustified rate increases."[8] The ACA also sets some limits on exchanges' ability to regulate the market. It prohibits exchanges from excluding a health plan through "the imposition of premium price controls."[9] The law does not define what a "premium price control" is, but presumably it means that

the exchange cannot dictate the price a plan can charge for a particular package of benefits.

Once plans are selected to participate, the ACA supports the exchange continuing to take an active role in managing the products it offers. For example, exchanges must assign each product with a rating based on relative quality and price.[10] HHS is tasked with developing the rating methodology and the exchange must post each rating on its web portal, along with information on the level of enrollee satisfaction in each health plan.[11] The exchange must also display on its web portal health plans' product offerings within prescribed benefit levels, based on actuarial value (i.e. Bronze, Silver, Gold and Platinum).[12] For most states, this implies that the exchange will have to exert some effort to make sure issuers are actually in compliance with the actuarial value standard. For example, the exchange may want to ensure that a plan claiming a Silver level designation actually has the requisite combination of benefits and cost-sharing to achieve the required 70% actuarial value.[13]

In addition, because the ACA empowers exchanges to re-certify and de-certify qualified health plans, the exchange will need to monitor the plans' marketing standards, network adequacy requirements and other certification criteria on an ongoing basis to ensure that they are living up to their obligations.[14] The law assists exchanges in this role by requiring qualified health plans to submit to the exchange, HHS and the state's DOI an array of business practice data, including data on rating practices, claims payment policies and practices, enrollment and disenrollment, denied claims and cost-sharing for out-of-network care. Plans must also submit "periodic financial disclosures" to the exchange.[15] HHS will presumably issue regulations with guidance to states on the depth and scope of data that plans will need to make available, but exchanges will be able to make use of such disclosures to assess plans' fitness to remain in the exchange on an ongoing basis.

Active Purchasing: A Wide Range of Activities

The federal law sets a floor, but state exchanges that wish to take on the role of active purchaser can take on a much wider array of activities to try to promote access to more affordable, higher-quality insurance products for consumers and small businesses. The broad wording of the ACA's provision requiring exchanges to consider "the interests of" participating individuals and employers gives them considerable discretion to decide what activities to pursue, within the context of local market conditions, stakeholder interests and its resources and capacity.

Examples of Active Purchasing

- Additional certification criteria
- Selective contracting
- Negotiation on price/quality
- Limiting the number of products
- Setting standards for cost-sharing
- Piloting new delivery system and reimbursement strategies
- Aligning with other state purchasers (i.e., Medicaid, state employee plans)
- Recruiting and assisting new market entrants
- Use of web-based decision tools to drive value-oriented decisions by consumers

Additional Certification Criteria

While the ACA lays out minimum federal standards for participation in the exchanges, states have considerable flexibility to add to those standards with criteria that reflect the state's goals for such things as population health, plan quality, access to providers, delivery system reform and transparency. For example, the exchange could require participating plans to engage in specific efforts to promote interoperable health IT in clinical settings, implement strategies to ensure continuity of care for individuals whose income changes cause them to gain or lose eligibility for public programs or coordinate with state public health officials on emerging public health challenges.[16] However, because additional certification criteria could add to plans' costs and are not required of plans in the outside market, the exchange will need to be mindful of any effect on premiums in the exchange.

Exchanges could also require participating plans to provide benefits in addition to those required by federal

law in the essential benefits package. Such additional benefits could reflect existing state benefit mandates that were not included in the federal package; or they could be added over time in response to emerging consumer needs, scientific advancement and changes in the evidence base. However, such benefits could add to the premium, and the ACA requires states to defray any premium costs above those associated with the federally defined essential benefit package.[17]

Selective Contracting and Price Negotiation

Many stakeholders and advocates view the ability of the exchange to selectively contract with health insurance carriers to be the lynchpin of active purchasing. In a competitive health insurance marketplace, with multiple plans seeking access to exchange enrollees, the authority to limit the number of plans could give an exchange leverage to negotiate better prices and quality.

To the extent an exchange is able to selectively contract with health plans, the process would involve two steps: first, an initial certification that a plan is eligible to participate in the exchange because it meets the necessary ACA criteria, as well as any additional criteria the exchange may impose. Second, certified plans would be allowed to bid for exchange business and plans would be chosen based on their bids. That bidding could take place through a formal "Request for Proposals" (RFP) process in which the lowest bidders would win. It might also involve less formal negotiations between the exchange and carriers.

Case Studies of Active Purchasing – On the Ground Efforts to Promote Value in Insurance Coverage

With the exception of large employer-purchasers like California Public Employees' Retirement System (CalPERS), and the Massachusetts Connector Authority, we were unable to find many examples of existing insurance exchanges that take on the activities that connote active purchasing. And those that do engage in these activities have unique characteristics and environments that make their efforts more feasible. CalPERS, for example, has a largely "captive" population of state government employers. The Massachusetts Connector was created in a relatively competitive insurance market, with a foundation of market rules that ensured a level playing field. It also created a separate marketplace for subsidized individuals and, at least initially, limited access to that market to Medicaid Managed Care Organizations (MCOs). In this paper we include short case studies of existing "exchanges," each of which falls along a continuum of what it means to be an active purchaser.

Massachusetts' Connector Authority

The Connector began enrolling individuals in 2006, just months after enactment of the law that created the exchange. The Connector is administered by a quasi-public agency and operates two exchanges: Commonwealth Care (CommCare) as the marketplace for individuals eligible for subsidies and Commonwealth Choice (CommChoice) as the marketplace for unsubsidized individuals and small businesses. The Connector covers 220,000 individuals, of which 40,000 are individuals in CommChoice and 4,500 are enrolled through small business.[22]

The Massachusetts Connector has been able to use selective contracting in CommCare, largely because it serves a captive population: subsidies for those under 300 percent of the federal poverty level (FPL) are only available through CommCare. It has structured the bidding and enrollment process to encourage the lowest-possible bids, resulting in an annual rate of increase in premiums of under 5 percent – about half the rate of growth in commercial health insurance.[23] With CommCare, noted a former official, "We have the same tools any large employer has."[24] In addition, when CommCare opened to new plans, the Connector worked hard to recruit a national carrier, Centene, to offer coverage with tighter provider networks in both CommCare and CommChoice. Because Centene's product offerings (called Celticare) had a lower cost structure, the Connector leveraged those to garner lower bids from the original participating plans.[25]

While CommChoice's population is not "captive," in that unsubsidized individuals and small businesses have similar products available to them in the outside market, the Connector has undertaken active purchasing functions in CommChoice. However, its efforts to push plans on its quality and efficiency goals must be balanced with the need to offer an attractive and affordable mix of plan offerings. Carriers must gain the Connector "Seal of Approval" to participate and the Connector staff has used market research to require plans to limit the number of products offered and standardize cost sharing. However, like the other exchanges examined in this report, the Connector does not negotiate on price, since it has limited leverage to do so. As one board member put it: "With CommChoice we're largely just a price taker."[26] However, the Connector has effectively used the standardization of benefits and "guarantee" of quality products to drive consumer shopping that is based primarily on value.[27]

Large employers that engage in active purchasing, such as the California Public Employees' Retirement System (CalPERS), use the contracting process extensively to extract the best possible value from participating plans. For example, CalPERS incorporates into their contracts metrics to assess their plans' financial performance and customer service and actively encourages their plans to implement delivery system and care management reforms that will improve outcomes and reduce health care costs.[18] CalPERS also reserves the right to audit plans' calculations of rates. As Priya Mathur, Chair of the CalPERS Health Committee noted, "We do that because we want the best rate possible and because we don't feel we can just accept what their black box process says their rate should be."[19]

Non-employer based exchanges that offer possible models of selective contracting include the Massachusetts Connector and the law creating the California exchange, which requires the exchange board to selectively contract with carriers "so as to provide health care coverage choices that offer the optimal combination of choice, value, quality and service."[20]

Since its first year of operation in 2007, the Massachusetts Connector has used its authority to select participating plans to obtain premium discounts from carriers. In its subsidized market, Commonwealth Care, officials report that the average annual rate of increase in premiums per covered person has been held under 5% – about half the rate of growth in commercial health insurance. Although it also selectively contracts in its unsubsidized market, the Connector has had less leverage with carriers because it is not the sole distribution channel for insurance products. Coupled with the fact that rates for the same products have to be the same in the Connector and the outside markets, the Connector is simply not big enough to demand big price discounts in the unsubsidized market.[21]

Managing Product Choices and Setting Parameters for Cost Sharing

An active purchaser exchange might not only manage the number and quality of participating carriers, but also manage the number and type of products they offer. For states with concentrated insurance markets, it may be more desirable to allow all qualified carriers to participate but limit their product offerings. As noted above, the ACA requires plans to offer products with at least the essential benefits package at specified actuarial value levels (Bronze, Silver, Gold and Platinum); it does not require any further standardization of cost-sharing. Thus, participating carriers could offer potentially hundreds of products at each actuarial value, with different permutations of cost-sharing and additional benefits.

Many experts believe there are considerable advantages to greater benefit standardization. Research has shown that too much choice among health insurance products can be confusing to consumers and lead them to purchase products that do not best meet their needs.[28] In Massachusetts, focus groups of consumers enrolled in coverage through the Connector indicated that the degree of product choice initially offered was overwhelming.[29] In the Medicare Advantage (MA) program, which provides private coverage to Medicare beneficiaries, the Centers for Medicare and Medicaid Services (CMS) has noted that in many areas the plethora of plan options has resulted in beneficiary confusion and difficulty in choosing a plan that meets their needs.[30] In 2012, CMS will approve only Medicare D plans that are "substantially different from those currently on the market by the same insurer."[31]

Limiting the number of available benefit designs can also narrow carriers' ability to use benefit design to select favorable risk. Research has shown that plans can use flexibility to adjust cost-sharing for certain services to attract the healthiest enrollees and deter sicker ones. For example, in Medicare Advantage, some plans imposed higher co-payment charges for days in the hospital and costly treatments like chemotherapy than in traditional Medicare.[32] CMS became concerned about the resulting adverse selection and has moved to standardize cost-sharing.[33]

For both reasons – to help consumers make better choices more easily and to limit carriers' opportunities for risk selection – the Massachusetts Connector has limited carriers to offering only a certain number of products at each benefit level (three at the Bronze level, two at the Silver level and one at the Gold level). It has also moved to standardize deductibles and co-payments for certain clinical services.[34] HealthPass New York's exchange actively structures benefits,[35] as does Washington's new Health Insurance Partnership (HIP), a federally subsidized small business exchange.[36]

Washington Health Insurance Partnership

The Washington state Health Insurance Partnership (HIP) opened to enrollment in January, providing subsidized coverage options to small, low-wage firms. The program targets small firms (up to 50 employees) where half the employees earn less than 200 percent of the federal poverty level (FPL) and the firm does not offer coverage. These firms either cannot afford to contribute the share of premium required in the small group market (between 75 and 100 percent) or their low-wage employees cannot afford their share of the premium.[39] HIP allows employers to contribute as little as 40 percent of the premium and subsidizes between 60 and 90 percent of the worker's share based on household income. Currently, small firms use a broker to select and enroll in a plan, but the law requires HIP to allow employees to choose their coverage beginning in 2013.

The program is administered by the state agency that also administers the state employee and Basic Health Plan (BHP) offerings. By law, the HIP Board selects products offered in the small group market that fit within four categories: comprehensive, mid-range, a Health Savings Account (HSA) eligible high-deductible plan and a catastrophic plan. The board has engaged in some standardization of benefits by defining the deductibles that correspond to those four levels of coverage. After some debate, the board decided to include a catastrophic plan option (with deductibles of $5,000) to give employers that previously did not offer health insurance a low-cost option; however, no enrollees have chosen this plan to date. Plan administrators speculate this is because employers are able to choose more comprehensive coverage for their workers because of the employee subsidy and the reduced contribution requirement for employers. HIP intends to monitor enrollment in each of its plan levels to better understand the products to which employers are gravitating.[40]

HIP views itself as an "organizer" because they are required by statute to choose products already available in the small group market. However, they do carry out one of the key activities of active purchasing: the board has a selection process for participating carriers that asks the carriers to submit appropriate products for the target population with benefit values calculated against a benchmark plan (the state's self-funded health plan). The plans were then ordered according to the four categories, from comprehensive to catastrophic, based on the actuarial value of each plan. The goal was to establish groups or "tiers" of plans in each category and to minimize the amount of variation in the actuarial value within each category.[41]

HIP officials believe the program will be successful because of a number of factors. First, they largely serve a captive audience, since the employee subsidies and reduced employer contribution rate are limited to products sold by HIP. Second, HIP credits the first year's limited enrollment and the uniformity of market rules governing plans operating inside and outside as key to the program's partnership with carriers willing to participate.[42] HIP may take on a more active role as enrollment grows, including instituting a requirement that carriers offer products in all four tiers. And the HIP board has created a risk adjustment subcommittee to consider implementing risk adjustment when "employee choice" is implemented in 2013.

Currently, 52 individuals are enrolled through 14 small businesses. Enrollment is limited by available federal funding, which was originally expected to last for three years and allow for up to 4,000 subsidized lives. However, the FY2010 federal budget put in jeopardy future funding for the program after August 31, 2011. Program administrators are awaiting further word on the status of future funding.

However, exchanges should approach benefit standardization with some caution. Setting cost-sharing parameters up front could meet resistance from carriers who may have to create whole new products, rather than offer existing ones. The exchange will also want to ensure that a more limited array of products is in line with – and keeps up with – consumer preferences. For example, the Massachusetts Connector did not require greater standardization until it had clear evidence of consumer demand for a narrower set of products as well as data on the products to which consumers were gravitating.[37] In addition, to the extent an exchange promotes standardized benefit designs, it will need to be sensitive to the impact on potential innovations that could benefit consumers and promote value, such as "value based" cost-sharing ("VBID") or provider tiering based on quality and efficiency.[38]

Leveraging Quality Improvement and Delivery System Reforms

Many policy experts and administrators of employer and government purchasing programs believe that the long-term benefits of health insurance exchanges lie not in their ability to negotiate rates with health plans in the short-term, but rather to help align incentives among purchasers and payers to encourage long-term, systemic changes in the way health care is paid for and delivered.[43] As Priya Mathur of CalPERS noted, "Just negotiating on price with an insurance company is not sufficient. Active purchasing is an opportunity to get at what's underlying

the trend. You have to get down to the provider and the member level."[44]

While some large employers have acted to drive delivery system and payment reforms at the provider level through their contracts with health plans, individual and small group purchasers have been absent from those efforts because they haven't had the infrastructure, capacity or market leverage to participate. At the same time, many insurance markets are experiencing a wave of consolidation among hospital and physician groups, giving those groups greater leverage to raise prices.[45] As a result, some health plans may actually welcome an exchange that is active in this area. An official with one health plan put it this way: "For those of us who are negotiating with providers, we might like to see an exchange putting requirements on plans that give us leverage in those negotiations."[46]

For example, CalPERS is moving to implement initiatives with its participating health plans that will drive delivery system reform at the provider level. It recently announced the results of a pilot to develop Affordable Care Organizations (ACOs) in partnership with one of its participating health plans, Blue Shield of California. Launched in January 2010, CalPERS reports the program is showing positive health outcomes (i.e., reduced hospital readmissions) and has generated an estimated $15.5 million in cost savings.[47]

The grocery chain Safeway, a self-insured purchaser, is also working to lower its costs and improve health outcomes. For example, while the company imposes no cost-sharing for colonoscopies in order to encourage at-risk employees to undergo the screening, they discovered that providers were charging widely disparate rates for the same exact procedure, with no discernable difference in quality. In the San Francisco Bay Area alone, the cost of a colonoscopy ranged from $880 to $8,650. Safeway now uses "reference pricing" for colonoscopy and other services, letting employees know that it would pay up to $1,500 for the procedure; employees who go to higher-priced providers must pay the difference.[48] The goal of the program is to change consumer behavior by encouraging employees to obtain preventive services from lower-cost providers. It may also have the effect of encouraging providers to charge prices for their services that are more in line with their costs.

States may consider whether their exchange could act as catalysts for quality improvement and delivery system change in the market just as purchasers like CalPERS and Safeway do. The ACA plants seeds for this by requiring exchange plans to report to HHS and their enrollees about their programs to improve health outcomes, reduce hospital readmissions, implement patient safety and error reduction programs, promote prevention and wellness and reduce health disparities.[49] Further, to participate in the exchange, plans must be accredited by an entity such as the National Committee for Quality Assurance (NCQA), which accredits health plans based on quality performance and patient experience. Other requirements for participating plans include: implementing provider payment strategies to improve quality and patient safety, requiring participating hospitals to implement patient safety systems and use discharge planning for patients and including in their networks only those doctors and other providers who implement certain quality improvement mechanisms.[50]

An exchange could aggregate the purchasing power of individuals and small groups to encourage more coordinated and efficient care. Building on the example of purchasers such as CalPERS and Safeway, exchanges might encourage plans to implement new reimbursement strategies and value-oriented benefit designs to improve health outcomes and perhaps also reduce the long-term trend in health care costs. Such initiatives might best evolve as part of a long-term strategy, in cooperation with other purchasers and with input from providers and consumers.

Alignment with Other State Purchasers

Policy experts have expressed the concern that, as envisioned under the ACA, exchanges may not have a sufficient proportion of the commercial insurance market to leverage change in the behavior of plans or providers.[54] An exchange might gain sufficient leverage in a number of ways, such as aligning purchasing strategies with large employer coalitions, state government employee benefit agencies and/or state Medicaid and CHIP programs. Such an effort does not mean combining risk pools, but rather it would require the exchange leadership to coordinate purchasing initiatives with these entities so that all are sending consistent signals to carriers and providers.

For example, many purchasers are interested in promoting "medical homes," primary care physician practices that agree to take on accountability for the full range of patients' health needs, usually for a fixed per-member per-month payment. There is evidence that medical homes have the potential to improve patient care while reducing spending.[55] However, many physician practice groups are reluctant to undertake the necessary IT and workforce investments required to achieve a medical home designation if only a small percentage of their patient population would be enrolled. To the extent large purchasers in the state all require carriers to implement medical homes, this could greatly expand the number of patients involved, encouraging primary care physician groups to form medical homes and specialists to cooperate with medical home protocols. Similarly, many providers complain about the plethora of carriers' "pay for performance" (P4P) programs, each with a different set of quality measures and different payment structure. If all carriers were essentially implementing the P4P programs with aligned measures and types of incentives, providers might be more likely to participate.

Recruiting New Market Entrants

Exchanges that sit in concentrated insurance markets, where one or two carriers dominate the individual and small group markets, may find an active purchasing role more challenging. While the ACA attempts to encourage new competition through the creation of multi-state insurance plans[56] and health insurance cooperatives,[57] these programs have yet to be developed and it is too soon to assess whether they will be successful. In a highly concentrated market, an exchange might work to recruit new carriers to the state or assist home-grown regional carriers or Medicaid plans to meet requirements for offering products through the exchange. Such efforts could involve technical assistance or using a request for proposals (RFP) process to entice new entrants. In states with high-quality regional carriers with integrated or local networks, exchanges need to be careful about requirements that might inadvertently prevent them from participating. For example, a requirement that participating carriers offer coverage state-wide could limit competition without offsetting advantages.[58]

The Massachusetts Connector worked in 2009 (for FY2010) to recruit Centene, a national for-profit carrier, to enter the state and offer products in both the subsidized and unsubsidized markets. It was the first major new market entrant in the state in decades.[59] In subsequent rounds of contracting, Centene's low premiums encouraged other carriers to compete on price. The Connector also worked with a Medicaid managed care organization (MCO) to obtain a commercial license, enabling it to become the eighth plan offering the Commonwealth Choice product.[60]

California Public Employees' Retirement System (CalPERS)

CalPERS is the second largest public purchaser of coverage in the nation after the federal government. Administered by the state of California, it purchases health benefits for more than 1,100 local and government agencies and school employers. It offers three health maintenance organization (HMO) products offered through two carriers and three self-funded preferred provider organization (PPO) products.[51]

CalPERS views itself as an employer purchaser, aligning with other employer purchasing groups and functions like an active purchaser exchange. CalPERS uses purchasing on behalf of 1.3 million beneficiaries to drive better value from the plans with which it contracts. The board decided in 2002 to modify the contracting process to strengthen its purchasing clout. In that year, the board moved from an "any willing plan" process to multi-year, performance-based contracts with carriers.[52] The number of carriers was narrowed in order to concentrate CalPERS purchasing power "at a time when providers in California were consolidating their power."[53] The remaining carriers each got a bigger share of the total enrollment and had greater incentive to partner with CalPERS on value based purchasing. The contracting process now incorporates performance metrics – both financial and customer service – as well as auditing in their contracts with insurers. Their purchasing approach is to "actively manage the trend" in health care costs, with contract terms that vary by plan depending on the goals they're pursuing with the plan. For example, they have partnered with participating plans to do disease management and pilot an ACO.

Participating employers are set in statute and have the option to purchase coverage outside of CalPERS. However, the population enrolled in CalPERS is relatively stable and largely captive. In response to some groups leaving to take "teaser rates" from plans operating in the outside market, CalPERS instituted a five-year-lock out period on any employer that leaves CalPERS, which has substantially reduced the number of employers leaving CalPERS.

Leveraging Consumer Decision-Making

Active purchasing also involves changing consumer behavior. Exchanges will have new transparency rules and web portals to help consumers make more informed and value-based comparisons of health plan products.

The notion of "plan chooser software" is not new; it has been used for years by large employers and on-line brokers such as ehealthinsurance.com and has been implemented in both the Utah and Massachusetts exchanges. What is more innovative is the idea that such software can be used strategically to empower consumers to make more value-oriented decisions. As one expert noted, most consumers shop for plans based on only two dimensions: price and provider.[61] These two dimensions tell consumers very little about plan benefits, customer service or provider quality, limiting their ability to choose plans that align with all of their needs.

Many exchange planners are thinking about ways to use the web to guide consumers in new ways, "designing for the future, not where consumers are now."[62] The ACA encourages exchanges to use their websites to provide an unprecedented amount of information to consumers about health insurance products, such as a standardized summary of benefit form, proposed or approved premium increases, actuarial value, the medical loss ratio (MLR) and performance based on price and quality. Exchanges might provide this information with graphics, simplified language and navigation to allow consumers to prioritize according to their preferences and make informed choices.

Exchanges can take the comparative display of information further by giving a special designation (i.e., "Top Value" or "Exchange Select") to plans that submit the lowest-price bids, have consistently high MLRs, and/or score high on quality and customer satisfaction metrics. They might additionally program the plan chooser software so that these plans are the first that appear when consumers conduct a search.[63]

The Massachusetts Connector has effectively used the web to guide consumers to plans with lower cost structures. Because plan offerings are standardized and each has received the Connector's approval, consumers are able to make apples-to-apples comparisons and choose lower-priced plans with confidence that they are still getting a quality product. As a result, plans with lower cost structures (i.e., with tighter networks and/or lower marketing budgets) have a greater market share in Commonwealth Choice than they do in the outside market.[64] At the same time, the Connector continues to offer plans with wider networks for consumers that prefer less restricted access to providers.

Factors that Could Support – or Undermine – Active Purchasing in the States

States' decisions about whether and how to pursue an active purchasing strategy for their exchange will hinge on a wide range of factors and each state will face a different calculus, depending on such environmental factors as market concentration, market rules, the number and risk profile of exchange enrollees and the exchange's ability to develop and maintain leadership and staff with the requisite expertise.

States that decide to pursue active purchasing may do so in any number of ways. Some may conclude that direct "price negotiation" with carriers will not work well in their markets, but will build a web portal that allows apples-to-apples comparisons and strongly encourages consumers to select plans that offer the best value. Some states may decide that the best thing they can do to promote competition is to recruit new market entrants or provide technical assistance to help home-grown, regional plans participate in the exchange. Others may conclude that the best way to make insurance coverage more affordable in the long term is to partner with participating health plans to drive delivery system reform at the provider level. Other states might have a political leadership that rejects any effort to organize or reform their insurance markets. Below we discuss a range of environmental factors that could either support or undermine the exchange's success as an active purchaser.

Connecticut Business and Industry Association

The Connecticut Business and Industry Association (CBIA) sponsors Health Connections, which began in 1995 with the goal of providing its member small businesses (3 to 100 employees) with one place to shop among a choice of health plans. Employees choose their own plan (an "employee choice" model) and enroll in coverage with the help of a broker. Enrollment to date is 6,000 businesses covering 85,000 lives.

CBIA does not engage in what might be traditionally considered "active purchasing." However, it plays an active role in selecting products to offer in the exchange. According to CBIA officials, exchange staff actively monitor what consumers are buying and work with brokers to identify attractive products. Sometimes those products are already available in the small group market and sometimes they ask carriers to develop new products for CBIA. Recently, two carriers pulled out of the small group market, leaving just two carriers participating in CBIA's exchange. A concentrated market, a CBIA official said, presents a challenge for any exchange because it means the exchange's "attractiveness…is minimized."[65] In other words, as a market organizer, an exchange operating in a concentrated market will be hampered because there are fewer options to organize.

However, CBIA's leadership believes it continues to provide an appealing alternative for small businesses, for two primary reasons. First, employers can make a defined contribution to their employees' coverage and their employees can choose among the health plan options (the "employee choice" model). Those employees choosing more expensive coverage must pay the difference.[66]

Second, CBIA provides a full suite of services to small employers that don't have their own human resources department. For example, CBIA provides member businesses with other insurance products (e.g., long-term disability and life insurance) and administration of COBRA coverage, Section 125 plans, Health Reimbursement Accounts and Health Savings Accounts. This feature gives the exchange an advantage when competing with the outside small group market.

Market Concentration

Nearly all health insurance markets in the U.S. are highly concentrated; in 48 percent of metropolitan statistical areas, just one insurer holds at least half of the market.[67] In general, that large insurer (as well as its closest competitor) will be a "must have" plan in the state exchange, if the exchange is to attract unsubsidized individuals and small businesses. For some states, these large carriers may be the only ones with networks that reach statewide. Equally important, at least initially, is that consumers and small business owners see these brand name plans when they shop for coverage. If an exchange fails to attract a sufficient mix of insurance products that consumers want to buy, it could stumble out of the gate, failing to attract sufficient enrollment.

Nothing in the ACA requires plans to participate in the exchanges and plans will make pragmatic business decisions about whether to participate. Many health insurance carriers may dislike the head-to-head nature of competition in an exchange and prefer instead to use traditional distribution channels for their products. As Elliot Wicks noted in a 2002 brief for the Commonwealth Fund:

> *Health plans have often been hostile to the purchasing co-op model for several reasons. First, they are understandably wary of the model because it gives their customers bargaining clout. Second, they do not like the individual-choice feature of co-ops because it provides enrollees with a ready way of switching to a different health plan during every open enrollment period. Third, they believe that their chances of getting and keeping all of the employees in an employer group – which brings in more revenue and helps spread risk – are much better when they market to that group outside of the purchasing co-op.*[68]

Past efforts to operate exchanges have largely failed because plans chose not to participate or, in some cases, actively worked to undermine the exchange.[69] However, the ACA's market reforms that go into effect in 2014, including the responsibility to purchase insurance, the elimination of health status underwriting and premium subsidies will create a very different competitive environment than has existed in the past. As a result, some carriers may see opportunities to expand their market shares within a structure of individual choice, and exchanges should seek to partner constructively with these carriers.

If an exchange wishes to contract selectively with plans or negotiate with them on price and quality, it needs to attract a reasonable mix of carriers with products that consumers and small business owners want to buy. If the exchange sits in a market that is highly concentrated, this approach to active purchasing will likely be unsuccessful. An

exchange in this environment may want to approach active purchasing as a long-term strategy. As Professor Timothy S. Jost of Washington and Lee University School of Law notes in an interview for the Commonwealth Fund, "Exchanges may want to start out as less selective and gradually move toward a more active purchasing model."[70]

In addition, an exchange in a concentrated market can work to recruit new market entrants or provide encouragement to smaller carriers that might be able to expand market share within the exchange. If it can't be a successful price negotiator, it can focus its efforts to promote better consumer decision-making and encourage competition based on price and quality. It can also collaborate with other large purchasers in the market such as employer coalitions, the state Medicaid agency and the state government employee plan to align purchasing strategies and send consistent signals regarding quality improvement and delivery system reform to carriers and providers.

Size and Risk Profile of The Exchange

The larger the exchange becomes, the more likely it can exercise leverage in the marketplace. Even though it will be the exclusive source of coverage for individuals eligible for federal premium and cost-sharing subsidies and will therefore constitute a large share of the individual market, in most states, exchanges will have a relatively small share of the total commercial market (including employer coverage). As one expert noted, in many ways an exchange that actively purchases on behalf of its enrollees would play the same role a large employer plays in soliciting bids to provide coverage to its workers.[71] Yet a growing number of large employers feel that they have little real leverage in an increasingly concentrated insurance market.[72] And the individuals and small businesses that the exchange may wish to serve will have alternative options in the outside market.

It is helpful to think about the potential population for a state exchange in three categories:

- **Subsidy-eligible individuals and families.** These individuals, with incomes up to 400 percent of FPL, can access federal premium and cost-sharing subsidies only through the exchange. This population represents a greater proportion of the market in some states than others. For example, 76 percent of Mississippi residents have incomes below 400 percent of FPL compared to 52 percent in Connecticut.[73] This will largely be a "captive population" (with possible exceptions discussed below) that many health plans might be eager to serve.
- **Self-pay individuals and families.** Individuals with incomes over 400 percent of FPL may sign up for coverage through insurance exchanges, but they are not eligible for subsidies. The exchange will need to provide an adequate mix of affordable plan choices to incentivize them to participate.
- **Small businesses.** Small businesses with up to 50 employees are eligible to enroll through an exchange, with a state option to expand their small group market to up to 100 employees. Beginning in 2017, states can allow large employers to participate. Eligible small businesses (with no more than 25 employees and average wages under $50,000) can access premium tax credits through the exchange for two years. This may give some employers a modest, temporary incentive to purchase through exchanges. However, as it will with self-pay individuals, the exchange will need to demonstrate that it can add value to the options currently available in the outside small group market.

For subsidy-eligible individuals, those at the higher end of the income scale will not necessarily be a captive population for the exchange. The generosity of the federal subsidies drops off considerably between 250-400% of poverty (see Table 1). Depending on how states regulate their non-group markets outside the exchange, these individuals might find products outside the exchange that are more affordable to them, even though they would lose access to subsidies.

Table 1. Maximum Nongroup Premiums Based on Income

Income	Maximum Household Premium Payment
Up to 133% of poverty	2% of income
133-150% of poverty	3-4% of income
150-200% of poverty	4-6.3% of income
200-250% of poverty	6.3-8.05% of income
250-300% of poverty	8.05-9.5% of income
350-400% of poverty	9.5% of income

A state's decision to establish a "Basic Health Plan" (BHP) for the lowest-income individuals eligible for subsidies in the exchange could also reduce enrollment

in the exchange and impact its ability to be an active purchaser. Authorized under the ACA and pitched to states as a "more affordable alternative to health insurance Exchanges," the BHP program gives the states the option to enroll low-income individuals between 133-200 percent of FPL in a Medicaid-like plan.[74] If a state establishes a BHP, the federal government would provide 95 percent of the premium subsidy that it would have spent on those individuals if they were enrolled in the exchange. If states leverage Medicaid provider discounts for the BHP program, they will likely be able to set premiums lower than exchange premiums and roll the extra federal subsidy into a richer benefit package or higher provider rates. One estimate indicates that states could access an extra $1,000 per enrollee if they establish a BHP instead of enrolling low-income individuals in the exchange.[75]

However, BHPs could pull a significant percentage of what would otherwise be a "captive" population for state insurance exchanges. The Urban Institute has estimated that, in an average state, a BHP would reduce the percentage of the population enrolled in the average exchange from 16 to 14 percent of all residents.[76] While this is a small total reduction, the BHP would significantly lower the number of "captive" individuals in the exchange – i.e., those eligible for substantial federal premium and cost-sharing subsidies. As noted in the chart above, once an individual approaches the 250 percent FPL threshold, the generosity of his or her subsidy diminishes considerably. This makes it more likely, in a state that allows a looser regulatory environment outside the exchange, that young and healthy individuals at the higher end of the income range will find a cheaper product in the outside market. However, while the BHP may result in the exchange having a smaller proportion of the commercial market than it might have otherwise, the exchange could increase its market leverage by aligning purchasing strategies with the BHP. And states may have greater financial incentives to pursue cost management in the BHP than they would in an exchange because they will be able to retain any savings that result.

Market Rules

The insurance rules for the individual and small group markets outside of the exchange will have a critical impact on the ability to be an active purchaser.

The primary challenge – and responsibility – of the exchange is to protect itself against adverse selection. As Professor Jost notes, "The single most important reason why some exchanges have not succeeded in the past is that they became the victims of adverse selection – they were unable to capture a large enough share of the healthy participants in the insurance market."[77] Indeed, if its survival is at stake, the whole notion of an exchange being an active purchaser is largely moot – it will not be able to attract a sufficient number of plans with which to selectively contract or negotiate. Existing exchanges that have to compete with an outside market, such as HealthPass New York, CBIA and the Massachusetts Connector, identify the equality of the inside/outside market rules as essential to their sustainability.[78]

For states establishing exchanges under the ACA, the law allows for small but potentially meaningful differences in the market rules. For example, all plans in the exchange must meet certain network adequacy standards. If a state allows plans in the outside market to operate with less robust networks, those plans could sell their products more cheaply and attract healthier enrollees than exchange plans with equivalent benefits. Similarly, exchange plans are forbidden from using marketing practices that discourage higher-risk people from enrolling. If the state allows plans in the outside market to use marketing strategies that discourage sicker people, it could result in adverse selection against the exchange. States will need to use their licensing and regulatory authority to ensure a level playing field on these and other market rules if they want a successful and sustainable exchange.

Exchanges also need to worry about adverse selection among plans within the exchange. According to Bill Kramer, an executive with the Pacific Business Group on Health (which operated California's failed small business exchange, PacAdvantage): "Insurance companies are obsessed with avoiding bad risk." One lesson from PacAdvantage is that "if plans felt they were being selected against, they bailed out."[79] This is for good reason: as soon as a carrier starts to take on sicker enrollees than its peers, the resulting higher claims (and thus, premiums) can trigger an adverse selection "spiral" that often cannot be reversed. Officials involved with existing exchanges such as HealthPass New York and

HealthPass New York

HealthPass began in 1999 with $1 million in seed money from the Mayor's office and the goal of giving small business greater access to coverage and stemming the tide of working uninsured. Sponsored by the Northeast Business Group on Health, HealthPass allows employees of participating employers to choose their own plan with a defined contribution from their employer. Almost half of the employers who buy coverage through HealthPass had no prior insurance and about one-fourth of the employees were previously uninsured.[83] Enrollment has been growing. HealthPass covers 4,000 employers with 17,000 employees, for a total of 33,000 covered lives.

HealthPass representatives say the program is a microcosm of the outside marketplace, acting as an organizer that selects certain products for offer within the exchange. The program offers between 20 and 30 benefit options across four categories of products: in network providers only, in- and out-of-network provider options, a "cost-sharing" plan (i.e., more cost-sharing for most services other than preventive services) and HSA-eligible high deductible plans. For the first 18 months the program operated, they used standardized plans based on co-payment amount, but carriers said they couldn't sustain that model and wanted to offer products based on what they thought would sell. In response, HealthPass moved to the current four groupings of coverage.[84] Program representatives note the products they offer have lower MLRs than those offered in the outside market, suggesting the exchange is attracting employees with relatively lower claims costs. This, in turn, has made their exchange more attractive as a distribution channel for the carriers.

HealthPass, like CBIA, must compete with the outside small group market for business and so concentrates on providing as many support services as possible – many of those same services offered by CBIA – in order to relieve employers of the burden of administering the program and not disadvantage them in the labor market when competing with large employers that offer services and benefits beyond health coverage.[85]

the Massachusetts Connector indicated that "carriers' confidence in risk adjustment is critical."[80]

The ACA gives the states some tools to boost such confidence, through requirements that they implement a risk adjustment program among carriers and a temporary reinsurance program. If the exchange can demonstrate to carriers that it has an average risk profile that mirrors the rest of the market and is effectively managing risk among its product offerings, carriers may say, "I can't *not* bid on this business."[81] Officials with HealthPass New York's exchange attribute their success in attracting carriers in large part to the health of its population relative to the outside market.[82]

State Resources

Being an active purchaser can be resource-intensive. To do it well requires sitting down with plans, one-on-one, early and often to discuss goals, priorities, requirements and areas of mutual interest. It requires staff time, market research and ongoing outreach to stakeholders. It requires a staff and leadership with the knowledge and expertise to go toe-to-toe with the carriers. It requires careful monitoring of consumer demands and managing a portfolio of products to meet consumers' needs.

For some states, assembling a board of directors with sufficient expertise that is also free from conflicts of interest could be a challenge. It may be similarly difficult to recruit, develop and retain a director and staff that can perform the necessary duties. For states that choose to house their exchange within the executive branch or require the exchange to meet the same personnel and procurement standards as state government agencies, pay scales and civil service rules may hinder their ability to attract individuals with the requisite experience. States that house their exchange in a non-profit outside the government structure could face challenges coordinating with other state agencies on purchasing strategies. Other states simply might not want to operate an exchange that requires a large operating budget.

One thing is clear: active purchasing cannot be done effectively without an infrastructure to do it. Those with on-the-ground experience with purchasing groups consistently emphasize the need to have a dedicated staff focused on the responsibilities of being an active purchaser. For example, when one large purchaser moved to standardize benefits offered to its employees, the chair of its benefits committee found that plans would try to skirt the new requirements in their policy's "fine print." He emphasized, "You have to stay on top of these things."[86]

Exchanges that do have the necessary personnel will require an adequate operating budget. Many states are considering an assessment on carriers or subscribers to support their exchange.[87] These assessments will add to the costs of insurance. As a result, exchanges will likely

come under political pressure to demonstrate that they are effectively managing the market and moderating premium increases. They will need to prove that the public investment in them is worth it.

Impact of Environment On One Form of Active Purchasing: Price Negotiation

Using the exchange to negotiate price discounts from carriers is an appealing concept, but will be challenging for many states to execute. And some may not want to – with only federal dollars at risk, some states may not want to pursue active purchasing at all.

But even for states that do wish to negotiate on price, the fact that the exchange is not the sole distribution channel for insurance products marketed to self-pay individuals and small employers could limit its leverage to negotiate prices with carriers. Because the ACA requires that prices for the same products be the same inside and outside the exchange, any price discount the exchange negotiates with a carrier will have to apply to that product market-wide. While the exchange might have a large population, for most carriers it won't be a large enough book of business to justify also discounting their rates in the outside market. The Massachusetts Connector has encountered this problem with its unsubsidized exchange (Commonwealth Choice), whose roughly 40,000 enrollees (about half the individual market) represent a small book of business for participating carriers. As a result, the Connector has had little leverage to garner price reductions from plans. "With CommChoice we're largely just a price taker," one Connector board member told us.[88]

That said, because the media and political spotlight will be on exchanges, particularly in the early years, a state may want to use its bully pulpit to encourage lower bids. For example, when carriers in Massachusetts submitted initial bids to the Connector in 2007, the Governor asked them to "sharpen their pencils," and they returned with lower bids – although they achieved those lower bids largely by raising the cost-sharing in their benefit design.[89]

In any event, such efforts to push prices lower must honestly take into account plans' underlying costs and need for solvency. If they don't, plans will need to increase premiums by an even greater amount in the next bidding cycle or shift more costs to consumers.

Health policy experts on the NASI study panel on exchanges flag another challenge of price negotiation: the ability of plans to change their rates during the course of the year.[90] In other words, a negotiated rate, to go into effect when people sign up during the next year's open enrollment period, could be meaningless if carriers can adjust their rates monthly or quarterly outside of open enrollment. And if the exchange negotiates a rate guarantee throughout the year, but the state doesn't impose the same requirement on plans in the outside market, plans bidding for exchange business would be placed at a disadvantage.[91]

But perhaps most importantly, simply negotiating premium discounts with plans year-to-year does nothing to tackle the long-term problem for consumers and small businesses: the runaway growth in the costs of health care. This is where an insurance exchange might have a dramatic impact. By consolidating individuals and small groups and potentially partnering with other large purchasers (i.e., state government employee purchasers, Medicaid and self-insured employers in the state) to align purchasing strategies, the exchange can incentivize health plans and, in turn, providers to deliver higher-quality care, more efficiently.

Concluding Comments

Our analysis gives rise to several findings. First, all states will have to empower their exchanges to take on a minimal level of "active purchasing" in order to meet the ACA's requirements. At a minimum, they must have discretion to exclude a plan if it is not in the interest of enrollees.

Second, active purchasing is not just one activity but rather connotes a range of activities that involve an ability and willingness to act on behalf of individual and small group buyers and set rules for competition that encourage higher-quality, efficiency and consumer satisfaction.

Third, the most aggressive conception of active purchasing – the notion that an exchange will selectively contract with and negotiate price discounts with carriers – will face environmental and operational challenges in

many states. These may include heavily concentrated markets, inadequate size relative to the outside market, adverse selection, and a lack of the necessary infrastructure to take on the job. Exchanges can be effective in negotiating high-quality, lower-cost coverage, but it requires health plans that want to participate, a sufficient number of healthy enrollees, a regulatory environment that provides a level playing field and a leadership and staff with expertise and market savvy.

Finally, exchanges may have the greatest potential to improve value by incentivizing health plans and, in turn, providers to deliver higher-quality care, more efficiently. By consolidating individuals and small groups, potentially partnering with other large purchasers to align purchasing strategies and encouraging value-oriented consumer shopping, the exchange can encourage long-term delivery system reforms that can help improve quality and tackle the long-term challenge of unsustainable health care costs.

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Endnotes

1 Alain Enthoven, "The History and Principles of Managed Competition," *Health Affairs* 12 Supp. (1993) 24-48.

2 HHS, "Initial Guidance to States on Exchanges," Nov. 18, 2010, http://cciio.cms.gov/resources/files/guidance_to_states_on_exchanges.html.

3 The essential benefit package will be defined in regulation, but must include, at a minimum, the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness and chronic disease management services; pediatric services, including oral and vision care. ACA § 1302(b).

4 ACA § 1311(c)(1).

5 ACA § 1311(e)(1)(B).

6 HHS, Funding Opportunity Announcement, "Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges," at 46, Jan. 20, 2011, http://cciio.cms.gov/resources/fundingopportunities/foa_exchange_establishment.pdf.

7 ACA § 1311(e)(2).

8 Id., see also § 1003, adding new § 2794 to the Public Health Service Act (PHSA).

9 ACA § 1311(e)(1)(B).

10 ACA § 1311(c)(3).

11 ACA § 1311(c)(4).

12 ACA § 1311(d)(4).

13 Some states may choose to delegate this responsibility to their Department of Insurance.

14 Similarly, some states may choose to delegate these responsibilities to their Department of Insurance.

15 ACA §1311(e)(3).

16 In its draft 2010 report on establishing an exchange in Wisconsin, former Governor Doyle's Office of Health Reform included a number of such certification criteria in addition to those specified in the ACA. Wisconsin Office of Health Care Reform, "Wisconsin Health Insurance Exchange: A 2010 Report," unpublished draft, Dec. 2010.

17 ACA § 1311(d)(3)(B).

18 Telephone interview with Priya Mathur, Chair of the CalPERS Health Committee, Apr. 20, 2011.

19 Id.

20 Cal. Gov. Code §§ 100505, 10053(c) (2011).

21 Corlette, S., Alker, J., Touschner, J., Volk, J., "The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned," Mar. 2011, http://ihcrp.georgetown.edu/pdfs/Mass%20Utah%20Exchanges%20Lessons%20Learned.pdf.

22 Ibid.

23 Ibid.

24 Telephone interview with Jon Kingsdale, Wakely Consulting Group, Apr. 22, 2011.

25 Ibid.

26 Telephone communication with Nancy Turnbull, Connector Board Member, Apr. 29, 2011.

27 Op. Cit., "The Massachusetts and Utah Health Exchanges: Lessons Learned," Mar. 2011.

28 See, e.g., S. Seth-Iyengar and M.R. Lepper, "When Choice is Demotivating: Can One Desire Too Much of a Good Thing?" *Journal of Personality and Social Psychology,* Dec. 2000 79(6):995-1006; S. Seth-Iyengar, G. Huberman and W. Jiang, "How Much Choice is Too Much? Contributions to 401(k) Retirement Plans," in *Pension Design and Structure: New Lessons from Behavioral Finance* (O.S. Mitchell and S. Utkus, eds.) (New York: Oxford University Press, 2004), pp. 83-95.

29 Op. Cit. "The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned," Mar. 2011.

30 CMS. 2012 Final Call Letter to Medicare Advantage Organizations, Prescription Drug Plan Sponsors and Interested Parties, Apr. 4, 2011, http://www.cms.gov/MedicareAdvtgSpecRateStats/AD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=descending&itemID=CMS1246529&intNumPerPage=10.

31 Ibid. at 122-123.

32 Edwin Park, "Informing the Debate about Medicare Advantage Overpayments," Center on Budget and Policy Priorities, May 13, 2008.

33 Op. Cit., CMS, 2012 Final Call Letter to Medicare Advantage Organizations.

34 Massachusetts Connector Board Meeting Minutes, Jan. 13, 2011, https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/2011/2011-2-10/2%2520-%2520Minutes%25201.13.11.pdf.

35 Telephone interview with Shawn Nowicki, Mark Kessler, Jonah Morrison of HealthPass New York, Apr. 8, 2011.

36 Telephone interview with Beth Walter, HIP Program Director, Apr. 11, 2011.

37 Telephone interview with Glen Shor, Executive Director of the Massachusetts Connector Authority, Jan. 24, 2011.

38 "Value-Based Insurance Design" (VBID) is a new approach to benefit design in which cost-sharing for services is explicitly linked to the evidence of value for that service. See Niteesh K. Choudhry, et. al., "Assessing the Evidence for Value-Based Insurance Design," *Health Affairs*, 29, no. 11 (2010) 1988-1994. "Provider tiering" is a practice of managing a plan's provider network by establishing differential cost-sharing for providers based on their performance on quality and/or efficiency measures. See James C. Robinson, "Hospital Tiers in Health Insurance: Balancing Consumer Choice with Financial Motives," *Health Affairs* (2003), http://content.healthaffairs.org/content/early/2003/03/19/hlthaff.w3.135.full.pdf.

39 Op. Cit., interview with Beth Walter.

40 Ibid.

41 Ibid.

42 Ibid.

43 Op. Cit., interview with Priya Mathur and interviews with Alain Enthoven, Marriner S. Eccles Professor of Public and Private Management, Emeritus, Stanford University, Apr. 7, 2011; Jason Helgerson, New York State Medicaid Director and former Wisconsin Medicaid Director, Apr. 22, 2011; Bill Kramer, Executive Director of National Health Policy, Pacific Business Group on Health, Apr. 13, 2011.

Endnotes

44 Op. Cit., interview with Priya Mathur.

45 See, e.g., Massachusetts Attorney General Preliminary Report, "Investigation of Health Care Cost Trends and Cost Drivers," Jan. 29, 2010, http://www.mass.gov/Cago/docs/healthcare/Investigation_HCCT&CD.pdf; Robert Berenson, et. al.,"Unchecked Provider Clout in California Foreshadows Challenges to Health Reform," *Health Affairs*, 29, no. 4 (2010): 699-705.

46 Telephone interview with Michael Johnson, Blue Shield of California, Apr. 15, 2011.

47 California HealthLine, "CalPERS Seeing Savings, Positive Outcomes from New ACO Pilot Program," Apr. 13, 2011, http://www.californiahealthline.org/articles/2011/4/13/calpers-seeing-savings-positive-outcomes-from-new-aco-pilot-program.aspx.

48 James C. Robinson, "Applying Value-Based Insurance Design to High Cost Health Services," *Health Affairs*, 29, no.11 (2010):2009-2016.

49 ACA § 1311(g)(1).

50 ACA § 1311(c).

51 CalPERS, "Facts at a Glance: Health, April 2011" Accessed at http://www.calpers.ca.gov/eip-docs/about/facts/health.pdf.

52 Staff Analysis, Health Benefit Committee, CalPERS, December 17, 2002.

53 Op. Cit., interview with Priya Mathur.

54 Telephone interview with David Riemer, Director, Community Advocates Public Policy Institute, Apr. 5, 2011.

55 Patient-Centered Primary Care Collaborative, "The Patient-Centered Medical Home: A Purchaser Guide," http://www.pcpcc.net/files/PurchasersGuide/PCPCC_Purchaser_Guide.pdf.

56 ACA § 1334.

57 ACA § 1322.

58 Op. Cit., interview with Jason Helgerson.

59 Op. Cit., "The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned."

60 Op. Cit., interview with Jon Kingsdale.

61 Telephone interview with Abby Block, Booz Allen Hamilton, Apr. 13, 2011.

62 Op. Cit., interview with Bill Kramer.

63 The former Wisconsin Office of Health Reform recommended pursuing this approach in its December 2010 draft white paper. Op. Cit., Wisconsin Office of Health Reform, "Wisconsin Health Insurance Exchange: A 2010 Report."

64 Op. Cit., "The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned."

65 Telephone Interview with Phil Vogel, Sr. Vice President, CBIA Service Corporation, April 11, 2011.

66 Ibid.

67 AMA, "New AMA Study Finds Lack of Competition Among Health Insurers," Feb. 1, 2011, http://www.ama-assn.org/ama/pub/news/news/competition-health-insurers.page.

68 Wicks, E., "Health Insurance Purchasing Cooperatives," The Commonwealth Fund, Nov. 2002, http://www.commonwealthfund.org/usr_doc/wicks_coops.pdf.

69 Id., See also, California HealthCare Foundation Issue Brief, "Building a National Insurance Exchange: Lessons from California," Jul. 2009, http://www.chcf.org/~/media/Files/PDF/B/PDF%20BuildingANationalInsuranceExchange.pdf.

70 Sharon Silow-Carroll, Diana Rodin Dehner, T. and Bern, J., "Health Insurance Exchanges: State Roles in Selecting Health Plans and Avoiding Adverse Selection," The Commonwealth Fund, Feb./Mar. 2011, http://www.commonwealthfund.org/Content/Newsletters/States-in-Action/2011/Mar/February-March-2011/Feature/Feature.aspx.

71 Telephone interview with Rick Curtis, Institute for Health Policy Solutions, Apr. 5, 2011.

72 Op. Cit., interview with Bill Kramer.

73 Kaiser Family Foundation, "Individual State Health Profiles," http://www.statehealthfacts.org/profile.jsp, accessed Apr. 28, 2011.

74 McKinsey & Company, "The basic health plan – an emerging option for states," Mar. 24, 2011, http://healthreform.mckinsey.com/en/Insights/Reform_Center_Health_Intelligence/The_Basic_Health_Plan.aspx.

75 Id.

76 Stan Dorn, "The Basic Health Program Option Under Federal Health Reform: Issues for Consumers and States," Urban Institute, Mar. 1, 2011, http://www.urban.org/publications/412322.html.

77 Timothy Stoltzfus Jost, "Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues," The Commonwealth Fund, Jul. 2010, http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Jul/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx.

78 Op. Cit., interviews with Shawn Nowicki, HealthPass NY and Phil Vogel, CBIA.

79 Id.

80 Op. Cit., interview with Shawn Nowicki, Mark Kessler and Jonah Morrison, HealthPass NY, Apr. 8, 2011; Op. Cit., interview with Jon Kingsdale.

81 Op. Cit., interview with David Riemer.

82 Op. Cit., interview with Shawn Nowicki, et.al.

83 Shawn Nowicki, HealthPass New York, "SHOP Exchanges: A Small Business Benefit," presented at Families USA 2011 conference, January 2011.

84 Op.Cit., interview with Shawn Nowicki et. al.

85 Ibid.

86 Op. Cit., interview with Alain Enthoven.

87 See, e.g., National Association of Insurance Commissioners Draft White Paper, "Financing the Exchange," Mar. 7, 2011, http://www.naic.org/documents/committees_b_exchanges_exposures_financing_the_exchange.pdf.

88 Telephone communication with Nancy Turnbull, Connector Board Member, Apr. 29, 2011.

89 Telephone interview with Massachusetts health plan representatives, Jan. 25, 2011.

90 "Designing an Exchange: A Toolkit for State Policymakers," The National Academy of Social Insurance, Jan. 2011, http://www.nasi.org/research/2011/designing-exchange-toolkit-state-policymakers.

91 Op. Cit., Interview with Jon Kingsdale.

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MISSED OPPORTUNITIES:

THE CONSEQUENCES OF STATE DECISIONS NOT TO EXPAND MEDICAID

Updated June 2015

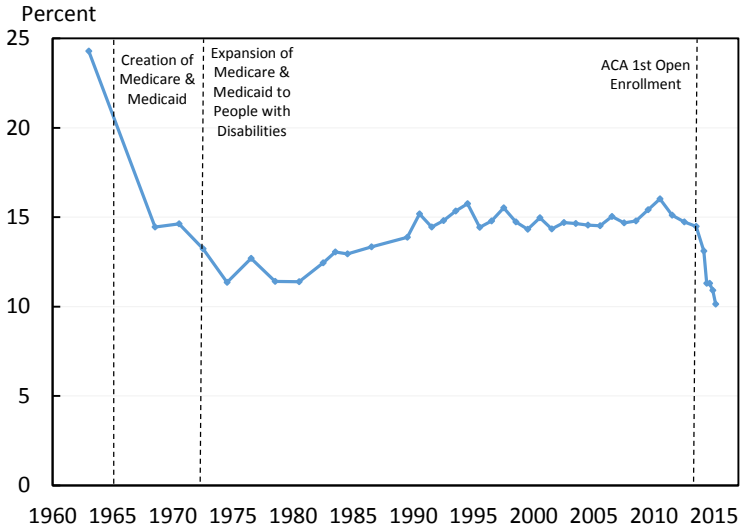
Contents

Executive Summary

The Affordable Care Act has dramatically expanded access to high-quality, affordable health insurance coverage. Since the law's major coverage provisions took effect at the start of 2014, the Nation has seen the sharpest reduction in the uninsured rate since the decade following the creation of Medicare and Medicaid in 1965, and, as depicted in Figure 1, the Nation's uninsured rate now stands at its lowest level ever. Combining these recent gains with earlier gains after the law's provision allowing young adults to remain on a parent's plan until age 26 took effect, more than 16 million Americans had gained health insurance coverage as of early 2015 (ASPE 2015).

One important way in which the Affordable Care Act is expanding coverage is by providing financial support to States that opt to expand Medicaid eligibility to all non-elderly individuals with incomes below 138 percent of the Federal Poverty Level. To date, 28 States and the District of Columbia have seized this opportunity. But 22 States—including many of the States that would benefit most—have not yet expanded Medicaid (although Montana has passed legislation to expand Medicaid and is working with the Centers for Medicare and Medicaid Services to determine the structure of its expansion). These 22 States have seen sharply slower progress in reducing the number of uninsured over the last year and a half, and researchers at the Urban Institute estimate that, if these States do not change course, 4.3 million of their citizens will be deprived of health insurance coverage in 2016.

Figure 1: Percent of Population Without Health Insurance



Source: CEA analysis of National Health Interview Survey, Cohen et al. (2009), Klemm (2000), and CMS (2009) through 2014:Q3; Gallup-Healthways Well-Being Index used to extrapolate through 2015:Q1. Note: Data are generally either annual or bi-annual through 2015:Q1 and quarterly thereafter. See CEA (2014a) for details.

This analysis uses the best evidence from the economics and health policy literatures to quantify several important consequences of States' decisions not to expand Medicaid. That evidence, which is based primarily on careful analysis of the effects of past policy decisions, is necessarily an imperfect guide to the future, and the actual effects of Medicaid expansion under the Affordable Care Act could be larger or smaller than the estimates presented herein. But this evidence leaves no doubt that the consequences of States' decisions are far-reaching, with major implications for the health of their citizens and their economies.

Direct Benefits of Expanded Insurance Coverage for the Newly Insured

One direct consequence of States' decisions not to expand Medicaid is that millions of their uninsured citizens will not experience the improved access to health care, better health outcomes, and greater financial security that come with insurance coverage.

Improved Access to Care

Having health insurance improves access to health care. This analysis estimates that if the States that have not yet expanded Medicaid did so:

- *1.0 million more people would have a usual source of clinic care.*

  Having health insurance increases the likelihood that individuals have a usual source of clinic care, like a primary care physician's office. If the 22 States that have not yet expanded Medicaid did so, an additional 1.0 million people would have a usual source of clinic care once expanded coverage was fully in effect. States that have already expanded Medicaid will achieve this outcome for 1.0 million people.

- *491,000 more people would receive all needed care in a year.*

  Having health insurance increases the probability that individuals report receiving "all needed care" over the prior year. If the 22 States that have not yet expanded Medicaid did so, an additional 491,000 people would receive "all needed care" over a given year once expanded coverage was fully in effect. States that have already expanded Medicaid will achieve this outcome for 478,000 people.

- *Hundreds of thousands more people would receive recommended preventive care each year.*

  Having health insurance increases the probability of receiving several types of recommended and potentially life-saving preventive care, including:

  - Cholesterol-level screenings: If the 22 States that have not yet expanded Medicaid did so, then each year an additional 626,000 people would receive cholesterol-level screenings once expanded coverage was fully in effect. States that have already expanded Medicaid will achieve this outcome for 609,000 people.

- Mammograms: If the 22 States that have not yet expanded Medicaid did so, then each year an additional 163,000 women between the ages of 50 and 64 would receive mammograms once expanded coverage was fully in effect. States that have already expanded Medicaid will achieve this outcome for 155,000 women in this age group.

- Papanicolaou tests ("pap smears"): If the 22 States that have not yet expanded Medicaid did so, then each year an additional 262,000 women would receive pap smears once expanded coverage was fully in effect. States that have already expanded Medicaid will achieve this outcome for 252,000 women.

➢ *Millions of people would be better able to obtain other needed medical care.*

Having health insurance also increases receipt of other types of medical care. For example, if the 22 States that have not yet expanded Medicaid did so, they would enable an additional 11.6 million physician office visits each year once expanded coverage was fully in effect. States that have already expanded Medicaid will enable an additional 11.3 million physician office visits each year.

Better Health and Longer Lives

By improving access to needed care, having health insurance improves mental and physical health. This analysis estimates that if the States that have not yet expanded Medicaid did so:

➢ *572,000 additional people would report being in excellent, very good, or good health.*

Having health insurance improves the likelihood that an individual assesses himself or herself to be in good health. This analysis estimates that if the 22 States that have not yet expanded Medicaid did so, 572,000 additional people would report being in excellent, very good, or good health once expanded coverage was fully in effect. States that have already expanded Medicaid will achieve this outcome for 556,000 people.

➢ *393,000 fewer people would experience symptoms of depression.*

Having health insurance improves mental health. This analysis estimates that if the 22 States that have not yet expanded Medicaid did so, there would be 393,000 fewer people experiencing symptoms of depression once expanded coverage was fully in effect. States that have already expanded Medicaid will reduce the number of people experiencing symptoms of depression by 382,000.

➢ *5,200 fewer people would die each year.*

Having health insurance reduces the risk of death. This analysis estimates that if the 22 States that have not yet expanded Medicaid did so, 5,200 deaths would be avoided annually once expanded coverage was fully in effect. States that have already expanded Medicaid will avoid 5,000 deaths per year.

Greater Financial Security

Having health insurance provides protection from financial hardship due to sickness. This analysis estimates that if the States that have not yet expanded Medicaid did so:

- *193,000 fewer people will face catastrophic out-of-pocket medical costs in a typical year.*

  Having health insurance dramatically reduces the risk that individuals face catastrophic out-of-pocket medical costs. If the 22 States that have not yet expanded Medicaid did so, 193,000 fewer people would face catastrophic medical costs (defined as costs in excess of 30 percent of income) each year once expanded coverage was fully in effect. States that have already expanded Medicaid will eliminate catastrophic medical costs for 187,000 people each year.

- *611,000 fewer people will have trouble paying other bills due to the burden of medical costs.*

  Having health insurance reduces individuals' risk of having to borrow money to pay bills or skip a payment entirely in order to pay medical bills. If the 22 States that have not yet expanded Medicaid did so, 611,000 fewer people would report this type of financial strain over the course of a year once expanded coverage was fully in effect. States that have already expanded Medicaid will achieve this outcome for 594,000 people each year.

Benefits of Expanding Medicaid for State Economies

States' decisions to expand Medicaid will also generate substantial benefits for their economies by increasing their citizens' standard of living, improving the resilience of their economies in the face of economic shocks, and increasing the long-term productivity of their workforces.

Higher Standard of Living

By expanding Medicaid, States can pull billions in additional Federal funding into their economies every year. This analysis estimates that if the 22 States that have not yet expanded Medicaid did so, States would receive an additional $29 billion in net Federal spending in 2016 if expanded coverage was fully in effect. States that have already expanded Medicaid will receive an additional $37 billion in net Federal spending in that year.

These additional Federal dollars will increase the overall standard of living for States' citizens by increasing low-income individuals' ability to access care, relieving cash-strapped families of high out-of-pocket costs, and reducing uncompensated care. Notably, if the 22 States that have not yet expanded Medicaid did so, uncompensated care costs would be $4.5 billion lower in 2016 if expanded coverage was fully in effect. States that have already expanded Medicaid will reduce uncompensated care by $4.4 billion in that year.

Greater Macroeconomic Resilience

Improved access to care and financial security for the newly insured combined with a reduced burden of uncompensated care for others in the State will help boost demand for medical and non-medical goods and services throughout States' economies. This increase in demand is likely

currently accelerating the recovery from the Great Recession in States that have already expanded their Medicaid programs. Looking ahead, State Medicaid expansions will safeguard access to health care and cushion household budgets in the face of the job and income losses that occur during future recessions, helping reduce the severity of future downturns while better protecting families from their consequences.

Healthier, More Productive Workers

By improving workers' access to care and their physical and mental health, Medicaid expansions will help people live longer, healthier lives. Recent research implies that these improvements in workers' health may improve those workers' productivity in the long run, boosting States' long-run economic performance.

The remainder of this report provides more detail on States' option to expand Medicaid under the Affordable Care Act, discusses the effects of States' choices for their uninsured citizens and their economies, presents the methodology used to quantify those effects, and provides tables and figures with State-by-State detail.

I. Background on States' Option to Expand Medicaid Under the Affordable Care Act

Medicaid is a program jointly funded by the Federal government and the States that provides health insurance to eligible low-income people. Each State operates its own Medicaid program and has considerable flexibility in determining eligibility criteria. The Affordable Care Act (ACA) gives States the option to expand their Medicaid programs to all non-elderly individuals in families with incomes below 133 percent of the Federal Poverty Level (FPL). Program rules provide for an additional five percent "income disregard," bringing the effective eligibility threshold to 138 percent of FPL: $16,243 for a single adult or $33,465 for a family of four in 2015.

This expansion benefits a wide swath of low-income adults. Prior to the Affordable Care Act's Medicaid expansion, the median eligibility level for working parents was only 61 percent of the FPL, and, in nearly all States, non-disabled adults without children were not eligible at all (Heberlein et al. 2013). Children at these income levels are eligible for Medicaid or the Children's Health Insurance Program regardless of whether their State expands their Medicaid program. As depicted in Figure 2, as of June 4, 2015, 28 States and the District of Columbia had taken advantage of this option to expand Medicaid. One state, Montana, has not yet expanded the program, but has indicated its intention to do so and is working with the Centers for Medicare and Medicaid Services to determine the structure of its expansion.

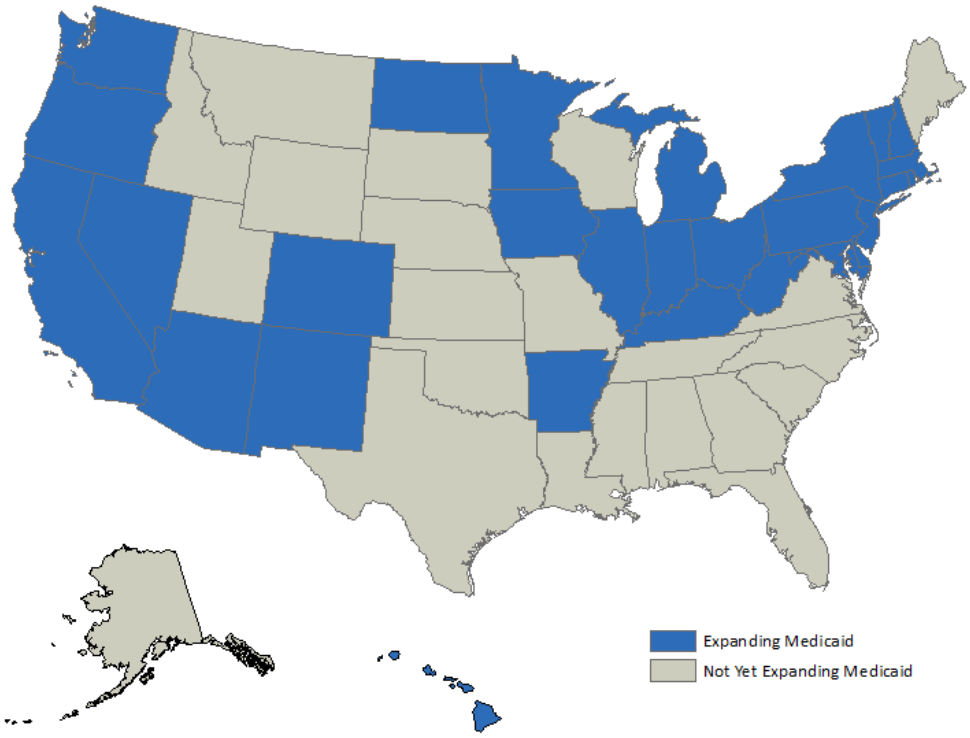
The Federal government will cover the vast majority of the costs of expanding Medicaid eligibility under the Affordable Care Act. Through 2016, the Federal government will pay 100 percent of the costs of covering newly eligible individuals, falling gradually to 90 percent in 2020 and subsequent years. This is a considerably larger Federal contribution than for eligibility categories in existence before the Affordable Care Act, for which program costs are shared between the Federal government and the States according to a formula that targets additional assistance to lower-income States, with the Federal share ranging between 50 percent and 74 percent in fiscal year 2015.[1]

States electing to expand their Medicaid programs are likely to realize large savings in other areas of their budgets that offset even the modest increase in State Medicaid spending after 2016. Researchers at the Urban Institute have estimated that, if all States expanded Medicaid, reductions in uncompensated care currently financed by State governments would more than offset any additional Medicaid costs, generating $10 billion in savings over ten years for all States, although the net impact will vary by State (Holahan, Buettgens, and Dorn 2013). That analysis also omits other potential State savings, including reduced costs to States of providing mental health services that would now be covered by Medicaid. Related research has concluded that these other savings may be substantial (Buettgens et al. 2011).

[1] Coverage provided through the Children's Health Insurance Program is eligible for a higher matching rate. The Federal share for CHIP coverage ranged between 65 to 82 percent in fiscal year 2015.

Medicaid is an important component of the Affordable Care Act's overall approach to expanding health insurance coverage. Individuals with incomes under 100 percent of the FPL are not eligible for tax credits and cost-sharing assistance through the Health Insurance Marketplaces and, as a consequence, will generally not have access to affordable health insurance coverage if their State does not expand Medicaid. Furthermore, Medicaid typically offers lower out-of-pocket costs than Marketplace coverage, so expanding Medicaid will lower the cost of coverage for individuals in families with incomes above 100 percent and below 138 percent of the FPL.

Figure 2. States Expanding and Not Yet Expanding Medicaid



II. Methodology for Estimating the Effects of States' Decisions to Expand Medicaid

To estimate the consequences of State decisions to expand Medicaid, this analysis proceeds in two steps. First, we obtained estimates of States' Medicaid expansion decisions on insurance coverage and the amount of Federal funding entering State economies; these estimates were either taken directly from or derived from publications by the Urban Institute and the Congressional Budget Office. Second, we used research on the effects of past policy decisions to translate those direct effects into impacts on the ultimate outcomes of interest: access to care, financial security, health and well-being, and the performance of States' economies.

The available research literature unambiguously demonstrates that State decisions to expand Medicaid will have large effects in all of these areas, effects that are reflected in the estimates reported in this analysis. Nevertheless, it is important to keep in mind that, while all of the studies this report draws upon are rigorous, all research has limitations. Statistical analyses are subject to imperfections that can cause estimates to systematically overstate or understate the effects of the policy changes studied, as well as sampling errors reflecting limited sample sizes. In addition, the effects of past policy changes may not be a perfect guide to the effects of future policy changes. As a consequence, while the estimates presented in this analysis represent the best available estimates of the effects of expanding Medicaid, the actual effects could turn out to be larger or smaller than the estimates presented in this report.

The remainder of this section describes our methodology in greater detail.

Effects on Insurance Coverage

The most direct consequence of a State's decision to expand Medicaid is to increase insurance coverage in that State. Because the other benefits of expanding Medicaid flow from this basic effect, estimates of how expanding Medicaid affects insurance coverage are a crucial input into the rest of the analyses undertaken in this report.

This report relies upon published estimates from the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), which provide State-by-State estimates of how each State's decision about whether to expand Medicaid would affect the number of uninsured individuals in that State (Holahan et al. 2012; Holahan, Buettgens, and Dorn 2013; Buettgens, Holahan, and Recht 2015). The HIPSM national estimates of how the Affordable Care Act will affect insurance coverage are broadly similar to those produced by other analysts, including the Congressional Budget Office (CBO 2012a) and the RAND Corporation (Eibner et al. 2010).

The most recent published HIPSM estimates include only States that have not yet expanded their Medicaid programs (Buettgens, Holahan, and Recht 2015).[2] For those States, we have used the most recent estimates. For States not included in these most recent estimates, we

[2] These estimates also exclude Montana, which the authors categorize as an expansion state.

have adjusted the estimates reported in Holahan, Buettgens, and Dorn (2013) based on the average revision for States that appear in both sets of estimates.[3] Throughout, we focus on the HIPSM estimates for 2016 because these should provide a reasonable guide of the long-run effects of Medicaid expansion on insurance coverage, after the initial "ramp-up." Consistent with that, this analysis refers to these HIPSM estimates for 2016 as reflecting the effects of expanded Medicaid coverage "when fully in effect." The detailed State-by-State estimates are reported in Table 1.

Actual experience has borne out model-based predictions that State Medicaid expansions would substantially increase insurance coverage. In particular, survey data have shown faster declines in the uninsured rate in expansion States than in non-expansion States since the Affordable Care Act's main coverage provisions took effect (Long et al. 2015; ASPE 2015; CDC 2015a).

The differences between these two sets of States are particularly striking among adults with incomes below 138 percent of the FPL, the population directly affected by States' Medicaid expansion decisions. Figure 3 depicts how coverage gains in this income group differ between expansion and non-expansion States using data from three different surveys (Long et al. 2015; ASPE 2015; CDC 2015b). Although the precise estimates differ across surveys due to differences in timing, income measurement, sampling error, and other factors, all three surveys show dramatically larger coverage gains in Medicaid expansion States. (This group of low-income adults has seen substantial increases in insurance coverage even in non-expansion States, primarily because uninsured individuals in these States with incomes between 100 and 138 percent of the FPL are typically eligible for subsidized Marketplace coverage.)

[3] Specifically, we have calculated an "adjustment ratio." The numerator of this ratio is the aggregate reduction in the number of uninsured estimated by the authors if all States included in the current report expand Medicaid (except that we exclude Wisconsin, for which the underlying policy assumptions appear to have changed between the two sets of estimates). The denominator of this ratio is the same quantity, calculated for the same set of states, but using the older HIPSM estimates. For the States for which up-to-date estimates are not available, we obtained adjusted estimates by multiplying the old HIPSM estimates by the adjustment ratio.

Figure 3: Change in Uninsured Rate for Non-Elderly Adults with Incomes < 138% FPL, Expansion v. Non-Expansion States

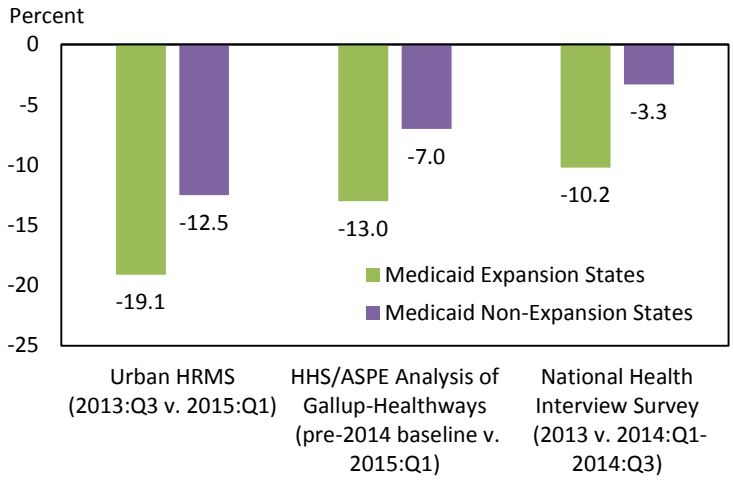


Table 1. Projected Increase in Number of People with Insurance Coverage if State Expands Medicaid	
	Increase in Number of People with Insurance Coverage in 2016
Not Yet Expanding Medicaid	**4,299,000**
Alabama	177,000
Alaska	17,000
Florida	750,000
Georgia	389,000
Idaho	59,000
Kansas	77,000
Louisiana	193,000
Maine	40,000
Mississippi	139,000
Missouri	191,000
Montana*	32,000
Nebraska	42,000
North Carolina	313,000
Oklahoma	127,000
South Carolina	160,000
South Dakota	25,000
Tennessee	179,000
Texas	1,107,000
Utah	68,000
Virginia	179,000
Wisconsin	21,000
Wyoming	14,000
Expanding Medicaid	**4,178,000**
Arizona	44,000
Arkansas	122,000
California	1,188,000
Colorado	132,000
Connecticut	72,000
Delaware	6,000
District of Columbia	16,000
Hawaii	33,000
Illinois	340,000
Indiana	224,000
Iowa	17,000
Kentucky	151,000
Maryland	115,000
Massachusetts	2,000
Michigan	181,000
Minnesota	36,000
Nevada	90,000
New Hampshire	22,000
New Jersey	194,000
New Mexico	82,000
New York	143,000
North Dakota	18,000
Ohio	381,000
Oregon	159,000
Pennsylvania	261,000
Rhode Island	22,000
Vermont	3,000
Washington	55,000
West Virginia	68,000

Source: Urban Institute; CEA calculations.

* Montana has not yet expanded Medicaid but has indicated its intention to do so and is working with the Centers for Medicare and Medicaid Services to determine the structure of its expansion.

Effects on Access to and Use of Medical Care

Perhaps the most obvious purpose of the Medicaid program is to ensure that enrollees have access to and receive needed medical care. To quantify the improvement in access to medical care that will result from States' decisions to expand Medicaid, this analysis relies upon estimates from the Oregon Health Insurance Experiment (Finkelstein et al. 2012; Baicker et al. 2013a; Baicker et al. 2013b; Taubman et al. 2014). The Oregon Health Insurance Experiment (OHIE) arose from the State of Oregon's decision in early 2008 to reopen enrollment under an earlier Medicaid expansion that had extended coverage to uninsured adults with incomes under 100 percent of the FPL. Because the State could not accommodate all interested applicants, it allocated the opportunity to enroll in Medicaid by lottery.

The State of Oregon's decision to allocate Medicaid coverage by lottery created a unique research opportunity. By comparing individuals who won the lottery to individuals who lost the lottery, it is possible to isolate the causal effect of having or not having Medicaid coverage, without the concern that the comparison is confounded by unobserved differences between those who do and do not have Medicaid coverage. Randomized research designs of this kind are considered the "gold standard" in social science research, and the OHIE is unique in using such a design to study the effects of having health insurance.

An additional important advantage of the OHIE for the current analysis is that the population that gained coverage in the Medicaid expansion studied in the OHIE—low-income, uninsured adults—is quite similar to the group that will gain health insurance coverage if States expand Medicaid under the Affordable Care Act. This increases the confidence that the results of the OHIE can be extrapolated to the Affordable Care Act's Medicaid expansion.

Of course, as noted at the outset, no study based on past policy changes in a specific environment applies perfectly to a future policy change in a different environment. Oregon's health care system differs from other States' health care systems in some ways, including the availability of medical providers (Huang and Finegold 2013), and other States' low-income populations do not look precisely like Oregon's. In addition, the OHIE can only speak to results over a follow-up period of approximately two years, but the effects of insurance coverage could differ over longer periods. Finally, the effects of larger-scale coverage expansions could differ from the effects of the smaller-scale expansion examined in the OHIE. Nevertheless, the OHIE clearly provides the best available estimates for quantifying many potential effects of States' decisions to expand Medicaid under the Affordable Care Act.

The OHIE found that Medicaid coverage significantly improves enrollees' access to medical care. Specifically, based on in-person interviews two years after the coverage lottery, the authors estimate that those enrolled in Medicaid were more likely to:

- *Receive all needed care.*

  Medicaid coverage increased the probability that individuals reported receiving all needed medical care over the prior 12 months by 11.4 percentage points, relative to a baseline rate of 61.0 percent in the control group.[4]

- *Have a usual source of clinic care.*

  Medicaid coverage increased the probability that individuals reported having a usual source of clinic care (e.g. a primary care physician) by 23.8 percentage points, relative to a baseline probability of 46.1 percent in the control group.[5]

- *Receive recommended preventive care.*

  Medicaid coverage dramatically increased receipt of several important types of recommended preventive care that have been clinically demonstrated to improve health outcomes:

  - Cholesterol-level screenings: Medicaid coverage increased the probability that an individual received a cholesterol-level screening in the last 12 months by 14.6 percentage points, relative to a baseline probability of 27.2 in the control group.

  - Mammograms: Medicaid coverage increased the probability that women ages and 50 and older received a mammogram in the last 12 months by 29.7 percentage points, relative to a baseline probability of 28.9 percent in the control group.

  - Papanicolaou tests ("pap smears"): Medicaid coverage increased the probability that a woman had received a pap smear in the last 12 months by 14.4 percentage points,

[4] Many individuals in the control group reported receiving all needed care because no care was necessary or because they were able to access care through other sources (including, for individuals who ultimately qualified for Medicaid through other eligibility pathways, Medicaid itself). Similarly, individuals with Medicaid coverage may report not receiving all needed care for a variety of reasons, including scheduling or transportation difficulties or challenges in identifying a suitable provider.

[5] In other work based on the OHIE, the authors find that Medicaid increases emergency room utilization (Taubman et al. 2014). This finding is not inconsistent with the increase in the probability that individuals had a usual source of clinic care; Medicaid may simultaneously increase access to primary care and make individuals more willing to make use of emergency rooms by protecting them from the high out-of-pocket costs that can come with such a visit. In addition, the finding that Medicaid increases emergency room utilization could change when looking over longer time periods (as enrollees build stronger relationships with their primary care physicians) or as a result of efforts to reform the health care delivery system, including efforts set in motion by the Affordable Care Act.

relative to a baseline probability of 44.9 percent in the control group.[6]

- *Receive other types of medical care.*

  Medicaid coverage also increased receipt of other categories of medical care. Medicaid coverage made possible an additional 2.7 office visits over the course of a year, relative to 5.5 visits in the control group. Similarly, Medicaid increased the number of prescription medications an individual was currently taking by 0.7 prescriptions, relative to 1.8 prescriptions in the control group.

While the OHIE is uniquely well-suited to the current analysis in light of its randomized design and focus on a population that is very similar to the population that will gain coverage if more states elect to expand Medicaid, the finding that having health insurance or more generous health insurance increases access to health care services has been convincingly demonstrated in many health care settings. High-quality studies arriving at similar conclusions include the well-known RAND Health Insurance Experiment (Newhouse 1993), studies of past Medicaid expansions (e.g. Sommers, Baicker, and Epstein 2012), studies of the effect of gaining Medicare eligibility at age 65 (e.g. McWilliams et al. 2007; Card et al. 2009), and a recent study of Massachusetts health reform (Sommers, Long, and Baicker 2014).

To translate the OHIE estimates into the number of additional individuals estimated to have specified type of health care experience in each State, the relevant point estimates were simply multiplied by the HIPSM estimates of the number of individuals who would gain coverage in that State if the State expands Medicaid coverage.[7] Several of the preventive care estimates apply only to particular age and gender subgroups; we estimated the share of new Medicaid

[6] Approximately half of States' Medicaid programs have undertaken "family planning expansions" under which they offer Medicaid coverage for family planning and related services, including pap smears, to some individuals who are not eligible for full Medicaid benefits (Guttmacher Institute 2014). In almost all such States, women who would gain eligibility for full Medicaid benefits if their State expands Medicaid under the Affordable Care Act could already have obtained coverage for pap smears via the State's family planning expansion.
Oregon had a family planning expansion in place during the OHIE under which eligibility extended up to 185 percent of the FPL (Sonfield, Alrich, and Benson Gold 2008); the State has since extended eligibility through 250 percent of the FPL (Guttmacher Institute 2014). The OHIE nevertheless found that gaining full Medicaid coverage increased pap smear utilization, perhaps because accessing such care is easier in the context of coverage for a comprehensive set of health care services. This suggests that expanding eligibility for full Medicaid benefits will increase pap smear utilization even in States with a family planning expansion in place. Expanding eligibility for full Medicaid benefits might be expected to have a larger effect in States without a family planning expansion, in which case the estimates in this report will understate the increases in those States. Similarly, State and local health departments provide certain screening services funded through federal grant programs or other sources. As with family planning expansions, the existence of such programs should not affect the conclusion that expanding eligibility for Medicaid would increase utilization of these services.

[7] The results presented by the OHIE reflect the effect of ever being on Medicaid during the study period, so not all individuals were enrolled in Medicaid for the full period over which the change in utilization was measured. The effect of continuous Medicaid enrollment on the outcomes examined in this report would likely be larger, so these estimates are somewhat conservative.

enrollees who fall in the relevant subgroups using the American Community Survey and the methodology described in Appendix A and then scaled down the HIPSM estimates accordingly.

The resulting State-by-State estimates of the increase in receipt of medical care are reported in Table 2 (preventive care) and Table 3 (other utilization measures). Figure 4 maps the State-level estimates of the increase in the annual number of cholesterol-level screenings if each State expands Medicaid.

Figure 4. Projected Annual Number of Additional Cholesterol-Level Screenings if Each State Decides to Expand Medicaid

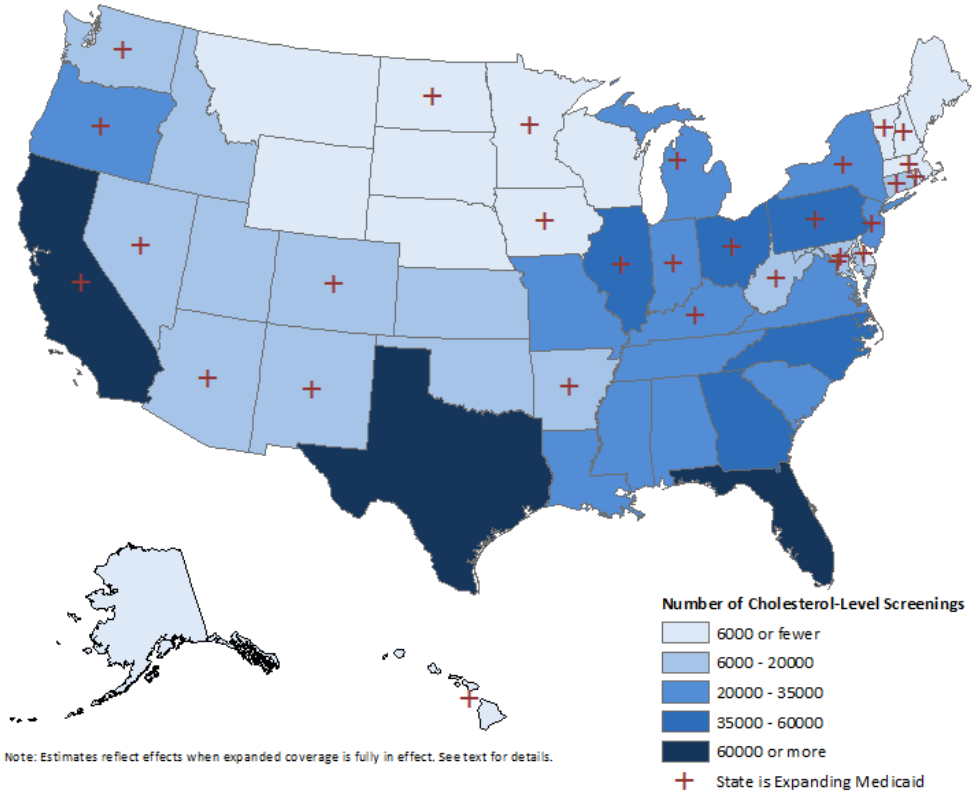


Table 2. Projected Increase in People Receiving Preventive Care if State Expands Medicaid

	Cholesterol-Level Screening in Past 12 Months	Mammogram in Past 12 Months	Papanicolaou Smear in Past 12 Months
Not Yet Expanding Medicaid	**626,400**	**163,400**	**262,400**
Alabama	25,800	7,000	10,700
Alaska	2,500	600	1,000
Florida	109,300	31,200	46,100
Georgia	56,700	13,900	23,500
Idaho	8,600	2,500	3,600
Kansas	11,200	2,400	4,400
Louisiana	28,100	7,600	11,600
Maine	5,800	1,900	2,500
Mississippi	20,300	5,200	8,200
Missouri	27,800	7,100	11,300
Montana*	4,700	1,300	2,000
Nebraska	6,100	1,400	2,600
North Carolina	45,600	11,500	19,100
Oklahoma	18,500	5,000	7,500
South Carolina	23,300	6,500	9,700
South Dakota	3,600	900	1,500
Tennessee	26,100	7,300	10,700
Texas	161,300	40,400	68,900
Utah	9,900	1,800	4,100
Virginia	26,100	6,800	11,100
Wisconsin	3,100	700	1,200
Wyoming	2,000	600	1,000
Expanding Medicaid	**608,800**	**154,500**	**251,500**
Arizona	6,400	2,200	2,700
Arkansas	17,800	4,800	7,300
California	173,100	42,100	74,200
Colorado	19,200	4,400	7,700
Connecticut	10,500	2,700	4,300
Delaware	900	300	400
District of Columbia	2,400	300	1,100
Hawaii	4,900	1,400	1,900
Illinois	49,600	12,600	20,300
Indiana	32,600	7,700	13,000
Iowa	2,500	600	1,000
Kentucky	22,000	5,600	8,800
Maryland	16,800	4,000	7,000
Massachusetts	200	100	100
Michigan	26,400	6,000	10,200
Minnesota	5,200	1,100	2,200
Nevada	13,100	3,700	5,500
New Hampshire	3,200	1,000	1,400
New Jersey	28,300	7,300	12,000
New Mexico	12,000	3,100	4,700
New York	20,800	7,100	8,800
North Dakota	2,600	600	1,100
Ohio	55,500	14,900	22,300
Oregon	23,200	6,000	9,700
Pennsylvania	38,000	9,500	15,100
Rhode Island	3,200	700	1,400
Vermont	500	<100	<100
Washington	8,000	1,900	3,300
West Virginia	10,000	2,800	4,000

Sources: Urban Institute; American Community Survey, 2010-2012; CEA calculations.

Note: Estimates reflect effects when expanded coverage is fully in effect. See text for details on the methodology. Numbers may not sum due to rounding. Mammogram estimates reflect mammograms received by women 50 and older only.

* Montana has not yet expanded Medicaid but has indicated its intention to do so and is working with the Centers for Medicare and Medicaid Services to determine the structure of its expansion.

Table 3. Projected Effects on Access to Care if State Expands Medicaid			
	Additional People with a Usual Source of Clinic Care	Additional People Receiving All Needed Care in Past 12 Months	Number of Additional Physician Visits Each Year
Not Yet Expanding Medicaid	**1,021,000**	**491,000**	**11,609,000**
Alabama	42,000	20,000	478,000
Alaska	4,000	2,000	46,000
Florida	178,000	86,000	2,025,000
Georgia	92,000	44,000	1,050,000
Idaho	14,000	7,000	159,000
Kansas	18,000	9,000	208,000
Louisiana	46,000	22,000	521,000
Maine	10,000	5,000	108,000
Mississippi	33,000	16,000	375,000
Missouri	45,000	22,000	516,000
Montana*	8,000	4,000	88,000
Nebraska	10,000	5,000	113,000
North Carolina	74,000	36,000	845,000
Oklahoma	30,000	15,000	343,000
South Carolina	38,000	18,000	432,000
South Dakota	6,000	3,000	68,000
Tennessee	43,000	20,000	483,000
Texas	263,000	127,000	2,989,000
Utah	16,000	8,000	184,000
Virginia	43,000	20,000	483,000
Wisconsin	5,000	2,000	57,000
Wyoming	3,000	2,000	38,000
Expanding Medicaid	**992,000**	**478,000**	**11,282,000**
Arizona	10,000	5,000	118,000
Arkansas	29,000	14,000	330,000
California	282,000	136,000	3,208,000
Colorado	31,000	15,000	355,000
Connecticut	17,000	8,000	194,000
Delaware	1,000	1,000	16,000
District of Columbia	4,000	2,000	44,000
Hawaii	8,000	4,000	90,000
Illinois	81,000	39,000	919,000
Indiana	53,000	26,000	605,000
Iowa	4,000	2,000	46,000
Kentucky	36,000	17,000	409,000
Maryland	27,000	13,000	312,000
Massachusetts	<1000	<1000	5,000
Michigan	43,000	21,000	489,000
Minnesota	9,000	4,000	97,000
Nevada	21,000	10,000	242,000
New Hampshire	5,000	3,000	60,000
New Jersey	46,000	22,000	524,000
New Mexico	19,000	9,000	222,000
New York	34,000	16,000	385,000
North Dakota	4,000	2,000	48,000
Ohio	91,000	44,000	1,029,000
Oregon	38,000	18,000	429,000
Pennsylvania	62,000	30,000	704,000
Rhode Island	5,000	3,000	60,000
Vermont	1,000	<1000	9,000
Washington	13,000	6,000	148,000
West Virginia	16,000	8,000	185,000

Sources: Urban Institute; CEA calculations.

Note: Estimates reflect effects when expanded coverage is fully in effect. See text for details on the methodology. Numbers may not sum due to rounding.

* Montana has not yet expanded Medicaid but has indicated its intention to do so and is working with the Centers for Medicare and Medicaid Services to determine the structure of its expansion.

Effects on Health Outcomes

Medicaid also seeks to improve enrollees' health. The findings above showing that Medicaid increases receipt of recommended medical care—care for which there is a strong clinical evidence base demonstrating its effectiveness in improving health—justifies a strong presumption that Medicaid does indeed improve enrollees' health. Nevertheless, direct evidence that health insurance improves health is desirable.

To quantify effects on mental health, this analysis turns once more to the OHIE. The OHIE asked respondents to complete a standard eight-question questionnaire regarding the presence and intensity of several symptoms of depression. The authors categorized individuals as having "screened positive" for depression if the summary score generated from the questionnaire fell above a specified threshold that had been shown in prior research to be highly predictive of depression (as measured by a clinical evaluation). They found that Medicaid coverage reduced the probability that an individual screened positive for depression by 9.2 percentage points, relative to a 30.0 percent baseline probability in the control group.[8] Medicaid coverage also generated improvements in self-reported mental health, as measured using a standard three-question battery on the effect of mental health on quality of life.

The OHIE's estimate that Medicaid reduced the probability of screening positive for depression was translated into a reduction in the number of people experiencing symptoms of depression by multiplying the OHIE point estimate by the HIPSM estimates of the number of individuals who will gain coverage in each State if that state expands its Medicaid program. The resulting State-by-State estimates of are reported in Table 4.

Turning to physical health, the OHIE provides clear evidence that individuals receiving Medicaid perceived themselves to be in better health. In results through approximately two years of follow-up, Medicaid coverage increased the share of individuals reporting that their health had remained the same or improved over the prior year by 7.8 percentage points, relative to a baseline probability of 80.4 percent in the control group. In earlier results through slightly more than one year of follow-up, Medicaid also increased the probability that an individual reported that his or her health was good, very good, or excellent by 13.3 percentage points, relative to a baseline probability of 54.8 percent in the control group.

[8] As discussed below, this analysis does not use the OHIE to quantify the effects of Medicaid on physical health, as the relevant estimates are imprecise and not statistically different from zero. One concern with using only the results from the OHIE that happen to be statistically significant is that, as the number of health outcomes under consideration rises, the probability that one will be statistically significant purely by chance rises as well, even if, in truth, Medicaid has no effect on any of these outcomes. In this case, focusing on the statistically significant estimates and disregarding the others can be misleading, a problem statisticians and econometricians refer to as the problem of "multiple comparisons."
One way of addressing this problem is to set a higher threshold for statistical significance when evaluating the results of multiple statistical tests. Using a standard method for computing that higher threshold (known as the "Bonferroni method") while taking into account that the study also examined effects on high blood pressure, cholesterol levels, and blood sugar control, the p-value for the estimated effect of Medicaid coverage on depression remains below 10 percent. This indicates that the OHIE's depression results are still unlikely to have arisen by chance, even after accounting for multiple comparisons.

To translate the OHIE estimate of the effect of Medicaid on the number of individuals reporting that they are in good, very good, or excellent health into an estimate of the number of additional people who would assess their health in this way if each State expanded Medicaid, we multiplied the OHIE point estimate by the number of people who will gain coverage if each State expands its Medicaid program. The resulting State-by-State estimates are reported in Table 4.

The limited sample size of the OHIE makes it more difficult to reach firm conclusions about the effect of Medicaid on objective measures of physical health since the OHIE estimates were generally imprecise. The OHIE did attempt to measure the effect of Medicaid coverage on several physical health outcomes, including the incidence of high blood pressure, high cholesterol, and poor control of blood sugar. The study's *point estimates* (roughly speaking, a point estimate is the most likely single value in light of a study's data) showed some improvement in each of these domains. For example, the study's point estimate was that Medicaid reduced the incidence of elevated blood pressure by 1.3 percentage points, relative to a baseline incidence of 16.3 percent in the control group; the point estimates for the other measured dimensions of physical health were, in proportional terms, similar or larger. In early results, the OHIE also reported a point estimate suggesting that Medicaid reduced mortality over a follow-up period of slightly more than one year. These point estimates would generally be clinically meaningful if they exactly reflected reality (Frakt 2013a; Frakt 2013b).

However, the OHIE's sample size was (by necessity) limited, so the precision with which these changes in health outcomes could be measured was also limited. As a result, these estimated improvements in physical health fell far short of statistical significance, and it is impossible to determine with any confidence whether the point estimates described above arose because Medicaid actually generated improvements in physical health or if Medicaid actually has negligible effects on physical health, and these estimates were simply obtained by chance. For example, while the study's point estimate was that Medicaid reduced the incidence of high blood pressure by 1.3 percentage points, a 95 percent confidence interval around that estimate stretches from a 7.2 percentage point reduction in incidence to a 4.5 percentage point increase in incidence. Closely related, it may not have been reasonable to expect the OHIE to find statistically significant improvements in physical health stemming from Medicaid coverage. To be reliably detected by the OHIE, the effects of Medicaid on physical health would have had to be quite large, often larger than what seems medically plausible (Frakt 2013a; Frakt 2013b; Richardson, Carroll, and Frakt 2013; Mulligan 2013).

In light of the limitations of the OHIE for learning about the effects of Medicaid on objective physical health outcomes, CEA has instead drawn upon a parallel literature that uses "quasi-experiments" created by past policy changes to study how Medicaid coverage affects a health outcome of particular interest: the risk of death. The disadvantage of relying on quasi-experimental research is that it is more vulnerable to unobserved confounding factors than research using a randomized research design. However, these quasi-experimental studies have the important advantage that they can often draw on much larger samples and, thus, deliver much more precise estimates.

Two recent quasi-experimental studies are particularly relevant since they examine insurance expansions that primarily affect low- or moderate-income adults, like State Medicaid expansions under the Affordable Care Act. Sommers, Long, and Baicker (2014) study the mortality effects of Massachusetts health reform, which primarily affected adults with incomes similar to or modestly higher than those affected by the Affordable Care Act's Medicaid expansion. They compare mortality trends in Massachusetts counties to mortality trends in demographically similar counties in the rest of the country. They find that the mortality rate for Massachusetts adults fell by 2.9 percent from the years before to the years after reform relative to the comparison group. The authors document that mortality followed similar trends in Massachusetts counties and comparison counties before reform, that the mortality gains were concentrated in counties with lower incomes and lower insurance coverage rates prior to reform, and that the improvements were primarily in causes of death believed to be avoidable with better health care; all of these findings are consistent with the interpretation that the observed decline in mortality in Massachusetts was caused by the expansion of insurance coverage. On the basis of their estimates, the authors conclude that one death was avoided annually for every 830 adults who gained health insurance under Massachusetts health reform. Notably, this estimate falls well within the wide 95 percent confidence interval for the corresponding OHIE estimate.

Sommers, Baicker, and Epstein (2012) examine pre-ACA expansions of Medicaid coverage to low-income adults in Arizona, New York, and Maine. Much like Sommers, Long, and Baicker, the authors estimate how these Medicaid expansions affected the risk of death by comparing mortality trends in the three expansion states to mortality trends in neighboring states. They find that the mortality rate for adults fell by 6.1 percent in the expansion states relative to non-expanding States in the years around the reform. They document that mortality trends were similar in expansion and non-expansion states before reform and that the mortality gains were concentrated in lower-income counties, consistent with the interpretation that the fall in mortality in the expansion states was caused by expanded insurance coverage. On the basis of their estimates, the authors calculate that one death was avoided annually for every 176 adults who gained health insurance under these Medicaid expansions. This estimate is also not statistically different from the imprecise corresponding OHIE estimate.

These are not the only quasi-experimental studies examining the link between health insurance status and the risk of death, although they are the two that are most relevant to evaluating the consequences of States' Medicaid expansion decisions. Levy and Meltzer (2008) undertake a careful review of the quasi-experimental literature and conclude that the balance of the evidence demonstrates that expanding access to health insurance coverage improves health for specific well-studied populations. Other recent research has bolstered the case that health insurance reduces mortality. Meyer and Wherry (2012) examine past Medicaid expansions affecting children and find that those coverage expansions substantially reduced mortality later in life for the affected socioeconomic groups. Brown et al. (2015) also study Medicaid expansions affecting children and find evidence of reduced mortality later in life. Card, Dobkin, and Maestas (2009) document a discrete reduction in mortality for patients arriving at the

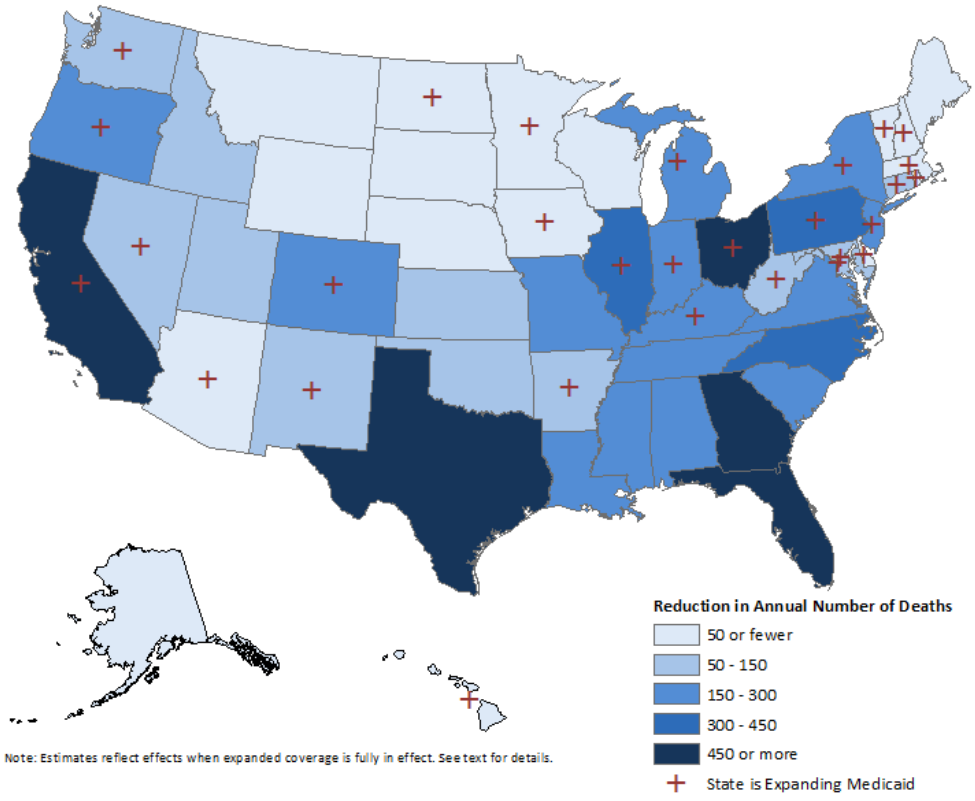
hospital with “non-deferrable” conditions at age 65, coinciding with the beginning of eligibility for Medicare.

This evidence base justifies confidence that State Medicaid expansions under the Affordable Care Act will reduce mortality. Of course, as with the other outcomes investigated in this analysis, meaningful uncertainty remains about the magnitude of these effects. The Sommers, Long, and Baicker and Sommers, Baicker, and Epstein studies, like all studies, are subject to a variety of sampling and non-sampling errors. Furthermore, effects could differ across areas due to subtle differences in the affected populations or differences in the health care systems of the affected areas, in which case these estimates could be an imperfect guide to effects nationwide.[9] Thus, the mortality effects of State Medicaid expansions could be larger or smaller than the Sommers, Long, and Baicker and Sommers, Baicker, and Epstein estimates imply.

In light of this uncertainty and in the interest of being conservative, this analysis relies upon the smaller estimate reported by Sommers, Long, and Baicker to estimate the number of deaths that could be avoided if States elect to expand Medicaid. To translate this point estimate into a number of avoided deaths at the State level, the point estimate is applied directly to the HIPSM estimates of the number of individuals who will gain coverage if each State expands its Medicaid program. The resulting State-by-State estimates of the reduction in the annual number of deaths are reported in Table 4. Figure 5 maps the State-by-State estimates.

[9] These studies found relatively constant effects on mortality rates over the first few years following the expansion of coverage, but these effects could change over longer periods of time. For example, certain types of care could have larger effects on mortality if provided on a sustained basis over many years. On the other hand, effects on mortality could be smaller over the longer run if individuals whose lives are saved during the initial years of expanded coverage are more likely to die from other causes in subsequent years.

Figure 5. Reduction in Annual Number of Deaths if Each State Decides to Expand Medicaid



Note: Estimates reflect effects when expanded coverage is fully in effect. See text for details.

Table 4. Projected Effects on Health Outcomes if State Expands Medicaid			
	Reduction in Number of People Experiencing Symptoms of Depression	Additional People Reporting Good, Very Good, or Excellent Health	Reduction in Annual Number of Deaths
Not Yet Expanding Medicaid	**393,000**	**572,000**	**5,180**
Alabama	16,000	24,000	210
Alaska	2,000	2,000	20
Florida	69,000	100,000	900
Georgia	36,000	52,000	470
Idaho	5,000	8,000	70
Kansas	7,000	10,000	90
Louisiana	18,000	26,000	230
Maine	4,000	5,000	50
Mississippi	13,000	18,000	170
Missouri	17,000	25,000	230
Montana*	3,000	4,000	40
Nebraska	4,000	6,000	50
North Carolina	29,000	42,000	380
Oklahoma	12,000	17,000	150
South Carolina	15,000	21,000	190
South Dakota	2,000	3,000	30
Tennessee	16,000	24,000	220
Texas	101,000	147,000	1,330
Utah	6,000	9,000	80
Virginia	16,000	24,000	220
Wisconsin	2,000	3,000	30
Wyoming	1,000	2,000	20
Expanding Medicaid	**382,000**	**556,000**	**5,030**
Arizona	4,000	6,000	50
Arkansas	11,000	16,000	150
California	109,000	158,000	1,430
Colorado	12,000	18,000	160
Connecticut	7,000	10,000	90
Delaware	1,000	1,000	10
District of Columbia	1,000	2,000	20
Hawaii	3,000	4,000	40
Illinois	31,000	45,000	410
Indiana	20,000	30,000	270
Iowa	2,000	2,000	20
Kentucky	14,000	20,000	180
Maryland	11,000	15,000	140
Massachusetts	<1000	<1000	<10
Michigan	17,000	24,000	220
Minnesota	3,000	5,000	40
Nevada	8,000	12,000	110
New Hampshire	2,000	3,000	30
New Jersey	18,000	26,000	230
New Mexico	8,000	11,000	100
New York	13,000	19,000	170
North Dakota	2,000	2,000	20
Ohio	35,000	51,000	460
Oregon	15,000	21,000	190
Pennsylvania	24,000	35,000	310
Rhode Island	2,000	3,000	30
Vermont	<1000	<1000	<10
Washington	5,000	7,000	70
West Virginia	6,000	9,000	80

Sources: Urban Institute; CEA calculations.

Note: Estimates reflect effects when expanded coverage is fully in effect. See text for details on the methodology. Numbers may not sum due to rounding.

* Montana has not yet expanded Medicaid but has indicated its intention to do so and is working with the Centers for Medicare and Medicaid Services to determine the structure of its expansion.

Effects on Financial Security

While one important goal of the Medicaid program is to ensure that enrollees have access to medical care and thereby improve health outcomes, an equally important goal is to protect families from large out-of-pocket medical costs and ensure that illness does not threaten families' ability to meet other important needs. To quantify the improvements in financial security resulting from State decisions to expand Medicaid under the Affordable Care Act, this analysis turns once again to the OHIE, which found that Medicaid coverage significantly improved financial security.

This analysis focuses on two specific outcomes measured in the OHIE, which were measured using in-person interviews two years after the coverage lottery:

- *Catastrophic out-of-pocket costs.*

  Medicaid coverage nearly eliminated the risk of facing catastrophic out-of-pocket medical costs (defined in the study as out-of-pocket spending in excess of 30 percent of household income) during the prior year. Specifically, being enrolled in Medicaid reduced the probability of experiencing such an outcome by 4.5 percentage points, relative to a baseline risk of 5.5 percent in the control group.

- *Trouble paying bills due to medical expenses.*

  Medicaid coverage dramatically reduced the risk that an individual reported having borrowed money or skipped paying other bills due to medical expenses during the prior year. Specifically, being enrolled in Medicaid reduced the probability of experiencing such an outcome by 14.2 percentage points, relative to a baseline risk of 24.4 percent in the control group.

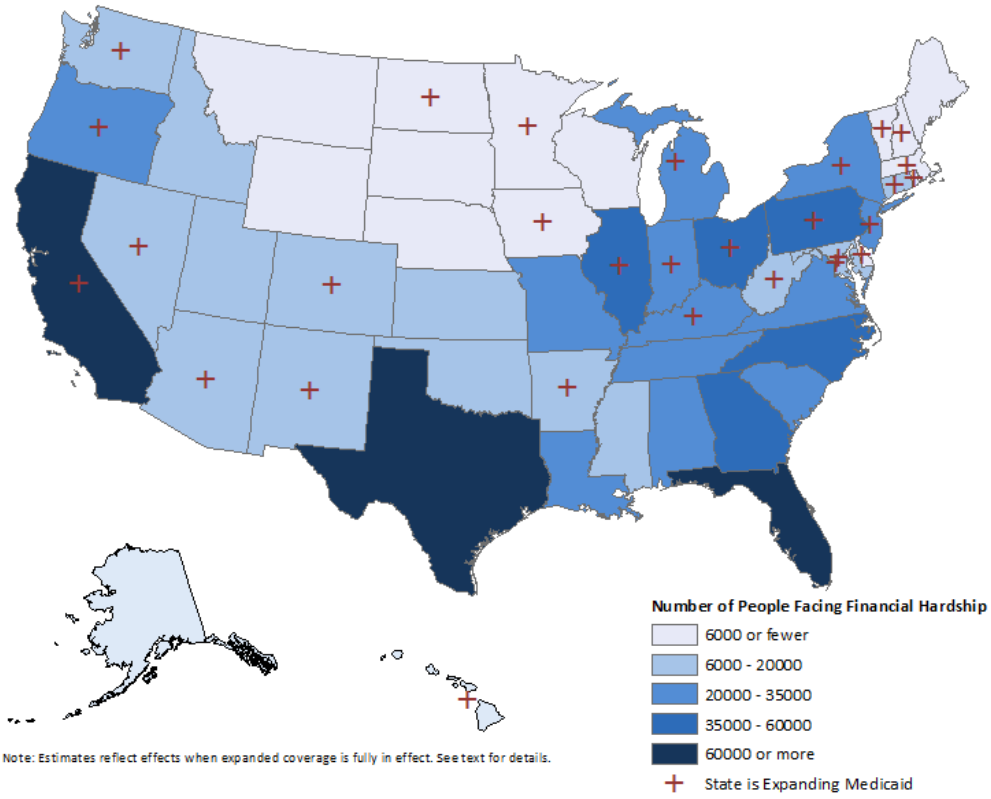
The OHIE also found that Medicaid coverage reduced the average amount of out-of-pocket spending and the probability of having any medical debt. In addition, in earlier work using credit report data, the OHIE investigators documented a large reduction in the probability of having had a medical bill sent to a collection agency over slightly more than one year of follow-up.

As with the health care utilization results discussed in the last subsection, the finding that health insurance improves financial security is not unique to the OHIE. Finkelstein and McKnight (2008) demonstrate that the introduction of Medicare in 1965 led to sharp reductions in seniors' exposure to large out-of-pocket medical costs. Gross and Notowidigdo (2011) examine Medicaid expansions during the 1990s and early 2000s and find that those expansions significantly reduced the risk of consumer bankruptcy.[10]

[10] Using credit report data, the OHIE found no evidence of a reduction in the risk of bankruptcy over a follow-up period extending slightly more than one year from the date that lottery winners gained coverage, despite finding large improvements on other measures of financial strain. This difference in results could reflect the much longer follow-up period available to Gross and Notowidigdo. Alternatively, it could reflect differences in the types of Medicaid expansions under study; the expansions studied by Gross and Notowidigdo primarily affected children,

To translate the OHIE estimates into the number of individuals estimated to avoid these negative financial outcomes in each State, the OHIE point estimate was multiplied by the HIPSM estimates of the number of individuals estimated to gain coverage in that State if the State expands Medicaid coverage. The resulting State-by-State estimates of the reduction in the number of individuals facing adverse financial outcomes due to high out-of-pocket medical costs are reported in Table 5. Figure 6 maps the State-level estimates of the reduction in the number of individuals borrowing money or skipping payments on other bills due to medical expenses if each State expands Medicaid.

Figure 6. Projected Annual Reduction in the Number of Individuals Borrowing Money or Skipping Payments Due to Medical Expenses if Each State Decides to Expand Medicaid



while the expansion studied in the OHIE affected adults. The limited sample size available in the OHIE does not appear to explain the difference in results, as the difference between the estimate reported by the OHIE and the estimate reported by Gross and Notowidigdo approaches standard thresholds for statistical significance.

Table 5. Projected Reduction in Number of People Facing Financial Hardship if State Expands Medicaid		
	People with Catastrophic Out-of-Pocket Costs in a Typical Year	People Borrowing to Pay Bills or Skipping Payments Due to Medical Bills
Not Yet Expanding Medicaid	**192,600**	**611,400**
Alabama	7,900	25,200
Alaska	800	2,400
Florida	33,600	106,700
Georgia	17,400	55,300
Idaho	2,600	8,400
Kansas	3,400	10,900
Louisiana	8,600	27,400
Maine	1,800	5,700
Mississippi	6,200	19,800
Missouri	8,600	27,200
Montana	1,500	4,600
Nebraska	1,900	6,000
North Carolina	14,000	44,500
Oklahoma	5,700	18,100
South Carolina	7,200	22,800
South Dakota	1,100	3,600
Tennessee	8,000	25,500
Texas	49,600	157,400
Utah	3,000	9,700
Virginia	8,000	25,500
Wisconsin	900	3,000
Wyoming	600	2,000
Expanding Medicaid	**187,200**	**594,200**
Arizona	2,000	6,200
Arkansas	5,500	17,400
California	53,200	169,000
Colorado	5,900	18,700
Connecticut	3,200	10,200
Delaware	300	900
District of Columbia	700	2,300
Hawaii	1,500	4,700
Illinois	15,200	48,400
Indiana	10,000	31,800
Iowa	800	2,400
Kentucky	6,800	21,500
Maryland	5,200	16,400
Massachusetts	100	200
Michigan	8,100	25,800
Minnesota	1,600	5,100
Nevada	4,000	12,800
New Hampshire	1,000	3,200
New Jersey	8,700	27,600
New Mexico	3,700	11,700
New York	6,400	20,300
North Dakota	800	2,600
Ohio	17,100	54,200
Oregon	7,100	22,600
Pennsylvania	11,700	37,100
Rhode Island	1,000	3,200
Vermont	200	500
Washington	2,500	7,800
West Virginia	3,100	9,700

Sources: Urban Institute; CEA calculations.

Note: Estimates reflect effects when expanded coverage is fully in effect. See text for details on the methodology. Numbers may not sum due to rounding. Catastrophic medical costs defined as medical costs exceeding 30 percent of income.

* Montana has not yet expanded Medicaid but has indicated its intention to do so and is working with the Centers for Medicare and Medicaid Services to determine the structure of its expansion.

Effects on State Economies

States' decisions will also have important benefits for the performance of their economies. States that expand Medicaid will receive substantial additional Federal funding, boosting their citizens' overall standard of living through the improvements in access to care and financial security described above and through reductions in uncompensated care costs. These additional Federal funds are also boosting demand for goods and services throughout States' economies today, which is likely increasing employment and economic activity today in States that have expanded the program; State decisions to expand Medicaid will similarly improve States' ability to weather economic shocks in the future. Finally, recent research suggests that access to health insurance coverage can have substantial benefits for workers' health, with potentially significant effects on their productivity over the long term. Each of these benefits for States' economies is discussed in greater detail below.

Higher Standard of Living

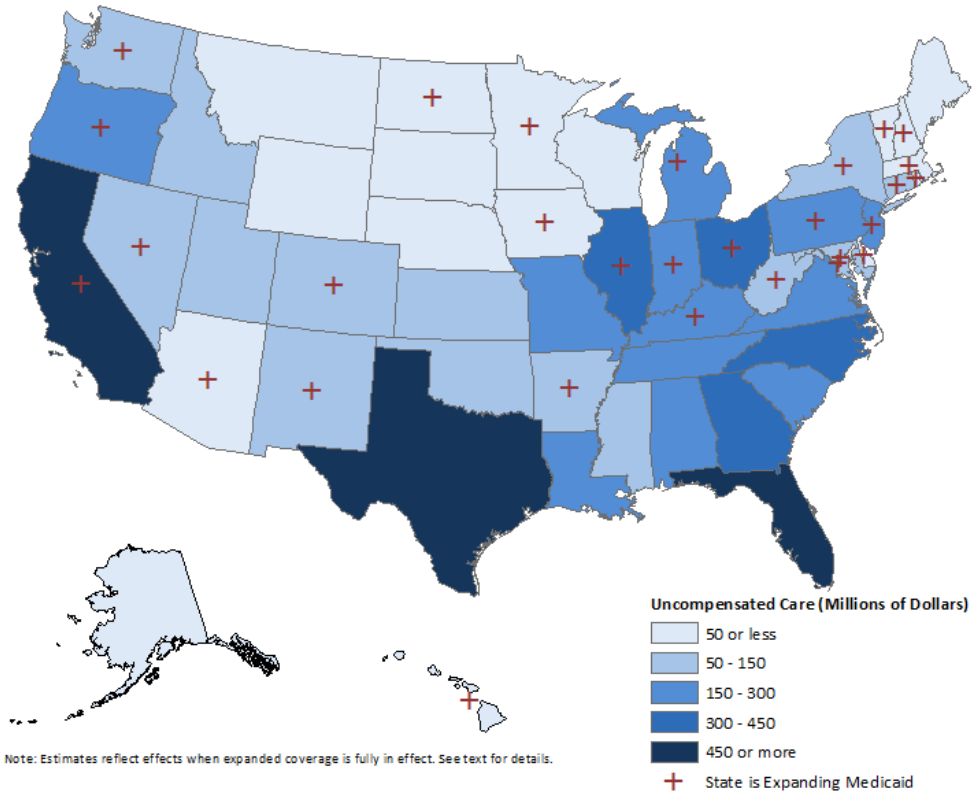
State decisions to expand Medicaid will draw substantial additional Federal funding into their economies, which will boost the overall standard of living of their citizens. In detail, when a State elects to expand its Medicaid program, the Federal government finances additional payments to medical providers in the State in exchange for providing medical services to the new Medicaid enrollees. These additional Medicaid outlays are only partially offset by reduced Federal spending on premium tax credits and cost-sharing assistance for individuals with incomes between 100 and 138 percent of the FPL who switch from receiving coverage through the Marketplaces to receiving coverage through Medicaid.

CEA has used projections by the Congressional Budget Office and Urban Institute to estimate the additional Federal outlays each State would have triggered if it had expanded Medicaid by January 1, 2014; the detailed methodology is presented in Appendix B. On the basis of this methodology, CEA estimates that if the 22 States that have not yet expanded Medicaid did so, they would receive an additional $29 billion in Federal outlays during 2016 if expansion were fully in effect in that year and similar amounts in subsequent years. States that have already expanded Medicaid will generate additional Federal outlays of $37 billion during 2016. State-by-State estimates of the additional Federal outlays resulting from each State's decision to expand Medicaid are reported in Table 6.

The additional Federal dollars States capture by expanding Medicaid will boost their citizens' standards of living in two ways. First, the bulk of these dollars will directly boost the standard of living of the newly insured by enabling them to receive additional health care and by reducing their out-of-pocket costs, making it easier to meet other pressing needs. Second, the rest of these dollars will compensate providers for care that was previously provided without payment, typically referred to as "uncompensated care." In turn, those funds will be available to the entities that were previously bearing the cost of that uncompensated care: some combination of State and local governments, privately-insured individuals, and medical providers, increasing those entities' ability to purchase other valued goods and services.

To estimate the magnitude of the reductions in uncompensated care, CEA built on estimates by Coughlin et al. (2014). Coughlin et al. use the Medical Expenditure Panel Survey to estimate uncompensated care costs per uninsured individual. Coughlin et al. estimate that, in 2013, each non-elderly person who was uninsured for the full year received $1,005 in care for which the provider received no payment.[11] To translate this estimate from Coughlin et al. into an estimate of the effect of a State's decision to expand Medicaid on the amount of uncompensated care in the state, this $1,005 figure (updated to 2016 dollars using Congressional Budget Office projections of the Consumer Price Index; CBO 2014b) was multiplied by the number of people who will gain coverage if each State expands its Medicaid program. The resulting State-by-State estimates are reported in Table 6 and are mapped in Figure 7.

Figure 7. Projected Annual Reduction in Uncompensated Care in 2016 if Each State Decides to Expand Medicaid



[11] This $1,005 figure corresponds to what Coughlin et al. call the amount of "implicitly subsidized" care. The authors estimate that total uncompensated care for each full-year-uninsured individual was $1,702 in 2013. This larger amount includes care that was paid for through non-health insurance sources linked to an individual patient's care, including worker's compensation, automobile and homeowners' insurance, and care provided directly by Federal, State, and local governments. Those additional amounts are not relevant to the current analysis. In addition, neither amount nets out funding (e.g., Disproportionate Share Hospital payments) that are intended to offset uncompensated care costs but are not linked to any particular uninsured patient's care.

Table 6. Projected Effects on Federal Spending and Uncompensated Care if State Expands Medicaid		
	Net Increase in Federal Spending in 2016 (Millions of Dollars; Calendar Year)	Reduction in Uncompensated Care in 2016 (Millions of Dollars; Calendar Year)
Not Yet Expanding Medicaid	**28,990**	**4,540**
Alabama	1,240	190
Alaska	90	20
Florida	5,900	790
Georgia	2,850	410
Idaho	300	60
Kansas	300	80
Louisiana	1,070	200
Maine	430	40
Mississippi	1,380	150
Missouri	1,370	200
Montana*	140	30
Nebraska	200	40
North Carolina	3,670	330
Oklahoma	770	130
South Carolina	1,250	170
South Dakota	190	30
Tennessee	1,770	190
Texas	5,440	1,170
Utah	240	70
Virginia	1,240	190
Wisconsin	280	20
Wyoming	110	10
Expanding Medicaid	**37,050**	**4,410**
Arizona	570	50
Arkansas	1,060	130
California	5,790	1,250
Colorado	870	140
Connecticut	710	80
Delaware	170	10
District of Columbia	60	20
Hawaii	280	40
Illinois	1,760	360
Indiana	1,170	240
Iowa	270	20
Kentucky	1,640	160
Maryland	1,330	120
Massachusetts	670	<10
Michigan	1,460	190
Minnesota	400	40
Nevada	500	90
New Hampshire	210	20
New Jersey	1,490	200
New Mexico	190	90
New York	5,210	150
North Dakota	220	20
Ohio	5,030	400
Oregon	740	170
Pennsylvania	3,350	280
Rhode Island	270	20
Vermont	110	<10
Washington	680	60
West Virginia	840	70

Sources:Urban Institute; CEA calculations.

Note: See text for details on the methodology. Numbers may not sum due to rounding.

* Montana has not yet expanded Medicaid but has indicated its intention to do so and is working with the Centers for Medicare and Medicaid Services to determine the structure of its expansion.

Greater Macroeconomic Resilience

The Federal dollars that flow into a State as a result of its decision to expand Medicaid also increase demand for goods and services throughout its economy. In particular, the increase in access to medical care for the newly insured boosts demand for medical goods and services, while the increased financial security for the newly insured and the reduction in the burden of uncompensated care for other members of the State's economy increases demand for a wide variety of other types of goods and services.

Over the period since January 2014, the higher demand generated by State Medicaid expansions has likely translated into higher employment and overall economic activity for States that have elected to expand their Medicaid programs since the U.S. economy has been operating well below full employment due to the aftereffects of the Great Recession. In an earlier version of this report, CEA used a standard "multiplier" analysis to estimate the potential increases in employment and overall economic activity if States had expanded their Medicaid programs as of January 2014 and found that these gains were likely to be quite substantial (CEA 2014b).

However, the current window for State Medicaid expansion decisions to boost overall employment and output is likely closing. Since December 2013, the U.S. economy has added 3.9 million jobs and the unemployment rate has fallen by 1.3 percentage points. The unemployment rate now stands at 5.4 percent, only modestly above many analysts' estimate of the level that corresponds to "full employment." While other labor market measures suggest more "slack" remains and make clear that the U.S. economy is still not fully healed from the Great Recession, it is equally clear that the economy is far closer to fully employing its productive resources than was the case in December 2013. When the amount of slack in the economy is limited, the effect of the increase in demand created by State Medicaid expansions will become smaller and eventually disappear entirely since increases in demand in one sector will mostly tend to reallocate resources away from other sectors, rather than increase total production.

While the current window for State Medicaid expansions to provide a needed boost to aggregate demand may be closing, this is unlikely to be the last time that State Medicaid expansions (and the Affordable Care Act as a whole) help stabilize States' economies—and the economy of the Nation as a whole—in the face of economic headwinds. Recent discussions of macroeconomic policy have suggested that changes in the United States economy have increased the likelihood that monetary policy will be constrained by the zero lower bound in future recessions, raising the likelihood that fiscal policy will have to play an important role in combatting recessions in the future (Summers 2014; Teulings and Baldwin 2014). That makes improvements in the United States' system of automatic stabilizers—programs that automatically expand during hard times and contract during good ones—particularly valuable.

While expanding Medicaid under the Affordable Care Act is not normally thought of as a way of improving the Nation's system of automatic stabilizers, it is just that. Expanded availability of

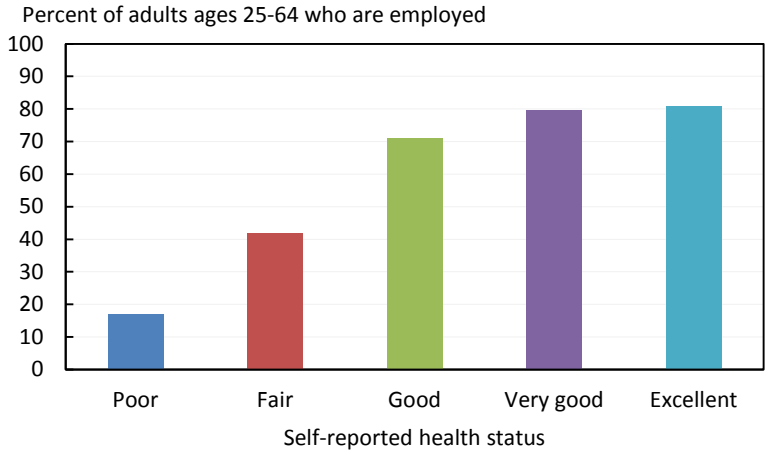
coverage through Medicaid will help safeguard access to health care and cushion household budgets in the face of the job and income losses that occur during a recession. Expanding Medicaid will thus help households smooth consumption and will expand aggregate demand when it would otherwise be impaired, reducing the severity of future recessions while better protecting families from their consequences.[12] Furthermore, because the expansion is almost entirely Federally funded, States can achieve these benefits without substantially reducing other spending or increasing taxes in the face of a downturn. Thus, States that elect to expand their Medicaid programs are likely to be better protected from the economic consequences of the next downturn, whenever it arrives.

Healthier, More Productive Workers

In addition to helping ensure that State economies make full use of their productive resources at times of weak aggregate demand, States' Medicaid expansion decisions may also change the productive capacity of their workforces over the longer-run by affecting workers' productivity and labor supply decisions.

Medicaid expansion could affect workers' productivity and labor supply decisions through at least two channels. First, by improving workers' access to care and their physical and—possibly particularly important—mental health, Medicaid expansions will help people live longer, healthier lives. In light of the strong cross-sectional correlation between better health and employment documented in Figure 8, it is intuitively plausible that these workers will miss fewer days of work, be less likely to become disabled, spend more years in the workforce, and be more productive while on the job.

Figure 8: Employment Rates by Health Status



Source: Current Population Survey, Annual Social and Economic Supplment, 2014; CEA calculations.

On the other hand, access to coverage through Medicaid would likely cause some workers to reduce their labor supply, either because having Medicaid coverage eliminate the need to work

[12] The Affordable Care Act's tax credits and cost-sharing assistance for eligible individuals purchasing through the Marketplaces will play a similar role for higher-income families, with similar macroeconomic benefits.

in order to obtain health insurance or because Medicaid causes individuals to choose to work less in order to avoid losing access to Medicaid coverage.[13] Reductions in labor supply driven by the desire to retain access to Medicaid coverage generally reduce economic efficiency. By contrast, reductions in labor supply driven by the availability of health insurance outside the workplace can improve economic efficiency if they permit workers to choose to pursue a higher-value alternative activity like caring for children or other family members, pursuing additional education, or starting a business. Some reductions in this category are commonly described as reflecting reductions in "job lock" or "employment lock."

The best available evidence suggests that the net effects of Medicaid expansion on the labor supply of workers like those affected by Medicaid expansion under the Affordable Care Act are small in the short-run. The highest-quality evidence once again comes from the OHIE, which concluded that Medicaid enrollment had small and statistically insignificant effects on labor supply over a period of slightly more than one year after coverage began (Baicker et al. 2014).[14]

However, recent research suggests that effects on workers' productivity may become important over the long run. These papers have examined the consequences of prior expansions of insurance coverage to children through Medicaid or the Children's Health Insurance Program (CHIP). Because many of these program expansions are now decades old, it is increasingly feasible to study how expanding access to health insurance through these programs has affected beneficiaries' outcomes as adults. While these studies do not apply directly to the population affected by State Medicaid expansions under the Affordable Care Act (which primarily target adults), this research compellingly establishes that access to insurance coverage at a point in time can have important benefits for labor market outcomes much later in life, benefits that appear to be mediated at least in part through durable improvements in health.

In particular, two recent studies have used variation in Medicaid/CHIP eligibility rules across states and over time to examine how Medicaid eligibility in childhood affects education and

[13] Other portions of the Affordable Care Act's coverage expansion could drive increases in labor supply. For example, for individuals who were eligible for Medicaid before the Affordable Care Act, expanded Medicaid eligibility and the availability of Marketplace coverage means that they can now increase their labor supply without worrying that they will lose their health insurance coverage.

[14] Some recent non-randomized quasi-experimental studies have found different results. Dague, DeLeire, and Leininger (2014) study an episode in which a portion of Wisconsin's Medicaid program was closed to new enrollment and conclude that Medicaid enrollment drove modest reductions in labor supply. Garthwaite, Gross, and Notowidigdo (2014) study a large-scale disenrollment from Tennessee's TennCare program in the mid-2000s and estimate much larger effects on labor supply. The reasons for these differing results are not well understood. They could arise because the effects of Medicaid actually differed in the settings studied by the various authors; notably, the population studied by Garthwaite, Gross, and Notowidigdo is somewhat higher income than the population affected by the Affordable Care Act's Medicaid expansion. On the other hand, the differences could reflect purely statistical factors. The quasi-experimental estimates could be contaminated by unobserved differences between those who do and do not enroll in Medicaid that the authors are unable to fully control for, which provides a good reason to place more weight on the OHIE estimates. The Garthwaite, Gross, and Notowidigdo estimate is also considerably less precise than the other two estimates, suggesting that their very large estimate may be, to some extent, a statistical fluke.

labor-market outcomes in adulthood. The first of these studies concludes that eligibility for Medicaid/CHIP coverage in childhood substantially increases children's probability of completing high school and college (Cohodes et al. 2014). The second study finds similar evidence of improvements in educational attainment plus direct evidence of increased earnings in early adulthood, at least for women. It also finds evidence that both men and women pay more in income and payroll taxes in their young adult years, potentially offsetting a substantial fraction of the cost of providing Medicaid/CHIP coverage to children (Brown et al. 2015).

The mechanism behind these long-run benefits is unclear, but a pair of complementary studies suggest that long-lasting improvements in health status may be playing an important role. These studies use a feature of Federal Medicaid eligibility rules that caused children born in October 1983 or later to be more likely to qualify for Medicaid coverage during their pre-teen and early-teen years than children born before October 1983 (Meyer and Wherry 2012; Wherry et al. 2015). The authors find that, in the socioeconomic groups most affected by the discontinuity in coverage eligibility, children born on the October 1983 side of the eligibility threshold experience lower mortality in their late teen years and are substantially less likely to be hospitalized as adults. These findings imply that access to Medicaid coverage in childhood generated durable improvements in health.

Conclusion

This report documents the far-reaching benefits that States that have already expanded Medicaid under the Affordable Care Act are receiving, and the benefits that States that have not yet expanded the program could achieve if they elected to do so. In particular, this analysis shows that by expanding their Medicaid programs, States can improve access to essential medical care, reduce financial hardship, improve their citizens' physical and mental health, and claim billions of dollars in Federal funding that could raise their citizens' standard of living and make their economies more resilient in the future. The Administration hopes that more States will decide to take advantage of these opportunities in the months and years ahead and stands ready to work with States to make these opportunities a reality.

References

(ASPE) Assistant Secretary for Planning and Evaluation, Department of Health and Human Services. 2015. "Health Insurance Coverage and the Affordable Care Act." http://www.aspe.hhs.gov/health/reports/2015/uninsured_change/ib_uninsured_change.pdf.

Baicker, Katherine, et al. 2013. "The Oregon Experiment – Medicaid's Effects on Clinical Outcomes." *New England Journal of Medicine* 368, no. 18: 1713-1722.

_____. 2014. "The Impact of Medicaid on Labor Force Activity and Program Participation: Evidence from the Oregon Health Insurance Experiment." *American Economic Review*, 104(5): 322-28.

Black, Lindsey I. and Robin A. Cohen. 2015. "Insurance Status by State Medicaid Expansion Status: Early Release of Estimates From the National Health Interview Survey, 2013–September 2014." http://www.cdc.gov/nchs/data/nhis/health_insurance/MedExAUER.pdf.

Brown, David, Amanda Kowalski, and Ithai Lurie. 2015. "Medicaid as an Investment in Children: What is the Long-Term Impact on Tax Receipts?" Working Paper 20835. Cambridge, MA: National Bureau of Economic Research.

Buettgens, Matthew, John Holahan, and Hannah Recht. 2015. "Medicaid Expansion, Health Coverage, and Spending: An Update for the 21 States That Have Not Expanded Eligibility." http://kff.org/medicaid/issue-brief/medicaid-expansion-health-coverage-and-spending-an-update-for-the-21-states-that-have-not-expanded-eligibility/.

Card, David, Carlos Dobkin, Nicole Maestas. 2009. "Does Medicare Save Lives?" *The Quarterly Journal of Economics* 124, no 2: 597-636.

(CBO) Congressional Budget Office. 2012a. "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision." http://www.cbo.gov/publication/43472.

_____. 2012b. "Updated Budget Projections: Fiscal Years 2012 to 2022." http://www.cbo.gov/publication/43119.

_____. 2014a. "The Budget and Economic Outlook: 2014 to 2024." http://www.cbo.gov/publication/45010.

_____. 2014b. "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014." http://www.cbo.gov/publication/45231.

_____. 2015. "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, March 2015." https://www.cbo.gov/publication/43900.

(CEA) Council of Economic Advisers. 2014. "Methodological Appendix: Methods Used to Construct a Consistent Historical Time Series of Health Insurance Coverage."

_____. 2014. "Missed Opportunities: The Consequences of State Decisions Not To Expand Medicaid."

(CMS) Centers for Medicare & Medicaid Services. 2009. "Medicare Enrollment: National Trends 1966-2008." https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/downloads/HI08.pdf.

_____. 2014. “Medicaid & CHIP: April 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report.” http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/April-2014-Enrollment-Report.pdf.

Cohen, Robin A., Diane M. Makuc, Amy B. Bernstein, Linda T. Bilheimer, and Eve Powell-Griner. 2009. “Health Insurance Coverage Trends, 1959-2007: Estimates from the National Health Interview Survey.” National Health Statistics Reports, 17. National Center for Health Statistics. http://www.cdc.gov/nchs/data/nhsr/nhsr017.pdf.

Cohen Ross, Donna, et al. 2009. “A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009, Data Tables.” http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8028_t.pdf.

Cohodes, Sarah, Daniel Grossman, Samuel Kleiner, and Michael F. Lovenheim. 2014. “The Effect of Child Health Insurance Access on Schooling: Evidence from Public Health Insurance Expansions.” Working Paper 20178. Cambridge, MA: National Bureau of Economic Research.

Coughlin, Teresa A., et al. 2014. “An Estimated $84.9 Billion in Uncompensated Care Was Provided in 2013; ACA Payment Cuts Could Challenge Providers.” *Health Affairs* 33, no 5: 807-814.

Dague, Laura, and Thomas DeLeire, and Lindsey Leininger. 2014. “The Effect of Public Insurance Coverage for Childless Adults on Labor Supply.” Working Paper 20111. Cambridge, MA: National Bureau of Economic Research.

Eibner, Christine, et al. 2010. “Establishing State Health Insurance Exchanges: Implications for Health Insurance Enrollment, Spending, and Small Businesses.” http://www.rand.org/content/dam/rand/pubs/technical_reports/2010/RAND_TR825.pdf.

Finkelstein, Amy and Robin McKnight. 2008. “What did Medicare Do? The Initial Impact of Medicare on Mortality and Out of Pocket Medical Spending.” *Journal of Public Economics* 92, no. 7: 1644-1668.

Finkelstein, Amy, et al. 2012. “The Oregon Health Insurance Experiment: Evidence from the First Year.” *The Quarterly Journal of Economics* 127, no 3: 1057-1106.

Frakt, Austin. 2013a. “My Reply to Jim Manzi.” http://theincidentaleconomist.com/wordpress/my-reply-to-jim-manzi/.

_____. 2013b. “The Oregon Medicaid Study and Cholesterol.” http://theincidentaleconomist.com/wordpress/the-oregon-medicaid-study-and-cholesterol/.

Garthwaite, Craig, Tal Gross, and Matthew Notowidigdo. 2014. “Public Health Insurance, Labor Supply, and Employment Lock.” *Quarterly Journal of Economics* 129, no. 2: 653-696.

Guttmacher Institute. 2014. “Medicaid Family Planning Eligibility Expansions.” http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf.

Gross, Tal and Matthew J. Notowidigdo. 2011. “Health insurance and the consumer bankruptcy decision: Evidence from expansions of Medicaid.” *Journal of Public Economics* 95, no 7-8: 767-778.

Heberlein, Martha et al. 2013. "Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-sharing Policies in Medicaid and CHIP, 2012-2013." http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8401.pdf.

Holahan, John, Matthew Buettgens, Stan Dorn. 2013. "The Cost of Not Expanding Medicaid." http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8457-the-cost-of-not-expanding-medicaid4.pdf.

Holahan, John, et al. 2012. "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis." http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384.pdf.

Huang, Elbert S. and Kenneth Finegold. 2013. "Seven Million Americans Live in Areas Where Demand for Primary Care May Exceed Supply by More than 10 Percent." *Health Affairs* 32, no. 3: 614-621.

(KFF) Kaiser Family Foundation. 2009. "Expanding Health Coverage for Low-Income Adults: Filling the Gaps in Medicaid Eligibility." http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7900.pdf.

_____.2010. "Expanding Medicaid to Low-Income Childless Adults Under Health Reform: Key Lessons from State Experiences." http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8087.pdf.

Kenney, Genevieve M., et al. 2012. "Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Coverage?" http://www.urban.org/UploadedPDF/412630-opting-in-medicaid.pdf.

Klemm, John D. 2000. "Medicaid Spending: A Brief History." Health Care Financing Review 22(1): 105-112.

Levy, Helen and David Meltzer. 2008. "The Impact of Health Insurance on Health." *Annual Review of Public Health* 29, 399-409.

Long, Sharon K., et al. 2015. "Taking Stock: Gains in Health Insurance Coverage under the ACA as of March 2015." http://hrms.urban.org/briefs/Gains-in-Health-Insurance-Coverage-under-the-ACA-as-of-March-2015.html.

McWilliams, Michael J. et al. 2007. "Use of Health Services by Previously Uninsured Medicare Beneficiaries." *New England Journal of Medicine* 357, no. 2: 143-153.

Meyer, Bruce D. and Wherry, Laura R. 2012. "Saving Teens: Using a Policy Discontinuity to Estimate the Effects of Medicaid Eligibility." Working Paper 18309. Cambridge, MA: National Bureau of Economic Research.

Mulligan, Casey B. 2013. "The Perils of Significant Misunderstandings in Evaluating Medicaid." *The New York Times*. http://mobile.nytimes.com/blogs/economix/2013/06/26/the-perils-of-significant-misunderstandings-in-evaluating-medicaid/.

Newhouse, Joseph P. 1993. *Free for All? Lessons from the RAND Health Insurance Experiment*. Harvard University Press.

Richardson, Sam, Aaron Carroll, Austin Frakt. 2013. "More Medicaid Study Power Calculations." http://theincidentaleconomist.com/wordpress/more-medicaid-study-power-calculations-our-rejected-nejm-letter/.

Ruggles, Steven, et al. 2010. "Integrated Public Use Microdata Series: Version 5.0 [Machine-readable database]." Minneapolis: University of Minnesota.

Sommers, Benjamin D., Katherine Baicker, and Arnold M. Epstein. 2012. "Mortality and Access to Care among Adults after State Medicaid Expansions." *The New England Journal of Medicine* 367, no. 11: 1025-1034.

Sommers, Benjamin D., Sharon K. Long, and Katherine Baicker. 2014. "Changes in Mortality after Massachusetts Health Care Reform: A Quasi-Experimental Study." *Annals of Internal Medicine* 160, no. 9: 585-593.

Sonfield, Adam, Casey Alrich, and Rachel Benson Gold. 2008. "State Government Innovation in the Design and Implementation of Medicaid Family Planning Expansions." http://www.guttmacher.org/pubs/2008/03/28/StateMFPEpractices.pdf.

Summers, Lawrence. 2014. "U.S. Economic Prospects: Secular Stagnation, Hysteresis, and the Zero Lower Bound." Business Economics, vol. 49, no. 2, pp. 65-73. February.

Taubman, Sarah L., et al. 2014. "Medicaid Increases Emergency-Department Use: Evidence from Oregon's Health Insurance Experiment." *Science* 343: 263-268.

Teulings, Coen, and Richard Baldwin, eds. 2014. Secular Stagnation: Facts, Causes and Cures. London: Centre for Economic Policy Research.

Wherry, Laura, Sarah Miller, Robert Kaestner, and Bruce Meyer. 2015. "Childhood Medicaid Coverage and Later Life Health Care Utilization." Working Paper 20929. Cambridge, MA: National Bureau of Economic Research.

Appendix A: Estimating the Age and Gender Mix of Individuals Who Would Gain Coverage if Their State Expands Medicaid

Several of the OHIE estimates of the effect of Medicaid on receipt of preventive care apply only to particular age or gender subgroups. Unfortunately, the published HIPSM estimates of the increase in insurance coverage arising from States' decisions to expand Medicaid do not detail the ages and genders of the individuals who would gain coverage. To address this issue, CEA estimated the share of new Medicaid enrollees who fall in the relevant subgroups using the Census Bureau's American Community Survey (ACS), a large household survey that collects information on income, insurance status, state of residence, and other relevant family characteristics.[15]

In detail, this was done in two steps. First, CEA identified individuals likely to gain coverage through Medicaid if their State expanded the program using the following criteria; namely, individuals who: (1) are adults age 19 to 64 with family income under 138 percent of the FPL; (2) were not eligible for Medicaid under pre-ACA State Medicaid income eligibility criteria;[16] (3) do not report being enrolled in Medicaid;[17] and (4) do not report being enrolled in employer-sponsored coverage. Among that group, it is straightforward to estimate the share of potential new enrollees falling in each age-gender subgroup of interest. These shares can then be applied to the State-level HIPSM estimates to obtain the increase in insurance in each relevant age-gender subgroup as a result of each State's decision to expand Medicaid.

In implementing this approach, income is defined as total cash income minus Supplemental Security Income and means-tested cash assistance (e.g. Temporary Assistance for Needy Families), a definition that closely matches modified adjusted gross income (MAGI), the income definition used to assess eligibility for Medicaid under the Affordable Care Act. Due to data limitations, certain other types of income that are not included in MAGI (e.g. child support) could not be excluded from the income measure used, but any resulting biases are likely to be small. Families units were defined using an algorithm for defining "health insurance units" (HIUs) developed by State Health Access Data Assistance Center (SHADAC). A description of this algorithm and programs for implementing it are available from the SHADAC website.[18]

It is important to note that this approach has certain limitations. First, Medicaid coverage is only available to citizens and certain legal residents, and this approach makes no attempt to account for the fact that the ACS includes ineligible non-citizens. Second, the method used to

[15] This analysis uses the IPUMS-USA pre-processed extracts of the ACS for years 2010-2012 (Ruggles et al. 2010).

[16] Information on pre-ACA eligibility criteria are obtained from various reports produced by the Kaiser Family Foundation (Cohen Ross, et al. 2009; KFF 2009; KFF 2010). Pre-ACA eligibility criteria as those in effect in 2009; this approach is consistent with HIPSM, which also uses treats pre-ACA eligibility criteria as those in effect in 2009 (Holahan et al. 2012).

[17] This provides a crude way of excluding individuals who were eligible for Medicaid before the Affordable Care Act as a result via more expansive eligibility criteria that are applicable only to specific groups, like those with disabilities. These more detailed eligibility criteria are challenging to model in survey data.

[18] See http://www.shadac.org/publications/defining-family-studies-health-insurance-coverage.

model pre-ACA Medicaid eligibility rules is somewhat crude, and more sophisticated methods might give better results. Notably, however, Kenney et al. (2012) handle both of these issues in more sophisticated ways and arrive at broadly similar estimates of the share of potential new enrollees falling in specified age and gender groups. Finally, individuals' propensity to actually enroll in Medicaid coverage may differ across age and gender groups; failing to account for these differing enrollment propensities could cause this approach to overstate or understate the number of individuals gaining coverage in each of these groups.

Appendix B: Estimating Effects on Federal Outlays if States Expand Medicaid

The most important input into analyzing how State decisions to expand Medicaid affect total employment and overall economic activity is how each State's decision affects Federal outlays. CEA estimated these amounts in two steps. First, estimates from the Congressional Budget Office (CBO) were used to estimate the total change in Federal outlays if all states expanded Medicaid relative to if no states expanded the program. Second, CEA distributed that national total across States using HIPSM estimates. This appendix describes each step in greater detail.

Focusing first on the national totals, the net change in Federal outlays if all states elect to expand Medicaid consists of two components: (1) an increase in Federal outlays reflecting additional spending on Medicaid coverage; and (2) a reduction in Federal costs to provide premium tax credits and cost-sharing assistance. The second, offsetting, component reflects the fact that some individuals in families with incomes between 100 and 138 percent of the FPL will receive coverage through Medicaid if their State does expand the program and would instead obtain coverage through the Marketplace if their states does not expand Medicaid. CEA used CBO estimates to estimate the size of each of these two components in a scenario in which all States expanded Medicaid, relative to a scenario in which no States expanded Medicaid.

To estimate the direct effect on Federal Medicaid outlays, the starting point was CBO's March 2012 estimates of the effect of the Affordable Care Act's coverage expansion on Federal Medicaid spending (CBO 2012a). Because these estimates pre-date the Supreme Court's decision in *NFIB v. Sebelius*, they implicitly reflect the increase in Federal Medicaid outlays if all States expand the program.[19] CEA then adjusted these amounts to reflect changes in CBO's assumptions regarding per-enrollee Medicaid costs since CBO's March 2012 baseline.[20]

To estimate the offsetting savings on premium tax credits and cost-sharing assistance, CEA used CBO's estimate of how the Supreme Court's decision in *NFIB v. Sebelius* affected the costs of these programs (CBO 2012b). CBO estimated that the Supreme Court decision caused a $28 billion increase in Marketplace subsidy costs in fiscal year 2022. CBO also indicated that they assumed that two-thirds of the overall expansion population would live in States that declined

[19] In principle, these estimates also include Federal spending associated with previously eligible individuals who would newly enroll in Medicaid even if their State failed to expand the program, perhaps due to enhanced outreach associated with the Marketplaces. In practice, the number of such individuals is likely to be relatively small, so including them is unlikely to significantly affect the results of this analysis.

[20] Specifically, CEA used the percent change in CBO's projection of per-enrollee costs for children from CBO's March 2012 baseline to its April 2014 baseline (CBO 2014b). While cost trends for children may differ slightly from those for adults, the changes in CBO's reported per-enrollee costs for adults incorporate changes in the composition of the Medicaid population caused by changes in States' decisions about whether or not to expand Medicaid. As such, they cannot be used to adjust for changes in underlying per-enrollee costs across different vintages of CBO's projections. We did not adjust for changes in these costs from CBO's April 2014 to its March 2015 baseline since CBO changed the basis on which it reports per-enrollee costs between these reports, but CBO's narrative discussion of changes in its cost projections over this period suggests that adjusting for any such changes would have only a small effect on the results.

to expand the Medicaid program for individuals between 100 and 138 percent of the FPL. This estimate implies that, if all States declined to expand the program, the reduction in premium tax credit and cost-sharing assistance costs would be 50 percent larger than the $28 billion referenced above, so CEA scaled up the $28 billion estimate accordingly. CEA then projected this fiscal year 2022 estimate back to the present by assuming it would grow in proportion to total Marketplace subsidy costs reported in CBO's March 2012 baseline. Finally, similar to the Medicaid estimates, the resulting stream of costs was adjusted for changes in CBO's projections of per-enrollee subsidy costs since CBO's March 2012 baseline.[21,22]

To distribute these national amounts across states, CEA relied upon estimates from the Urban Institute's HIPSM (described in the main text). Specifically, incremental Medicaid outlays were distributed across States using HIPSM's State-by-State estimates of the incremental Medicaid outlays in 2016 if each State elects to expand coverage. The offsetting savings on premium tax credits and cost-sharing assistance were distributed using the State-specific difference between the increase in Medicaid enrollment and the increase in overall insurance coverage that occurs if that State expends Medicaid (once again, using estimates for 2016); this difference approximates the number of individuals who would switch from receiving coverage through the Marketplace to receiving coverage through Medicaid if the State expanded Medicaid.[23]

[21] CBO's per-enrollee subsidy estimates are for calendar years, while the outlay estimates are for fiscal years. In making this adjustment, CEA used an appropriate blend of the calendar year per-enrollee estimates to adjust each fiscal year estimate.

[22] Specifically, CEA used the percent change in CBO's projection of per-enrollee costs for children from CBO's March 2012 baseline to its March 2015 baseline (CBO 2015). The overall change in per-enrollee subsidy costs from CBO's March 2012 baseline to its March 2015 baseline may differ from the change in per-enrollee costs for a given enrollee with income between 100 and 138 percent of FPL, for several reasons. First, premium tax credit covers a larger share of the total premium for this group than for the average enrollee, and these individuals receive cost-sharing assistance, unlike some higher-income enrollees. In addition, some of the change in per-enrollee costs from CBO's March 2012 baseline to its April 2014 baseline may reflect compositional changes if individuals who were switched from Medicaid to the Marketplaces by the Supreme Court Decision differ from the typical Marketplace enrollee. The effect of these imperfections on the overall results of this analysis are small.

[23] This difference may also reflect some offsetting reduction in the number of individuals enrolled in employer coverage, but it appears that the reduction in Marketplace coverage is the primary component. In any case, the State-level outlay estimates are relatively insensitive to the precise method used to distribute the offsetting tax credit and cost-sharing assistance costs.

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DATAWATCH

Trends In Health Insurance Enrollment, 2013–15

We examined insurance transitions between September 2013 and February 2015, before and after the Affordable Care Act's coverage-related provisions took effect in 2014. We found that 22.8 million people gained coverage and that 5.9 million people lost coverage, for a net increase of 16.9 million people with insurance.

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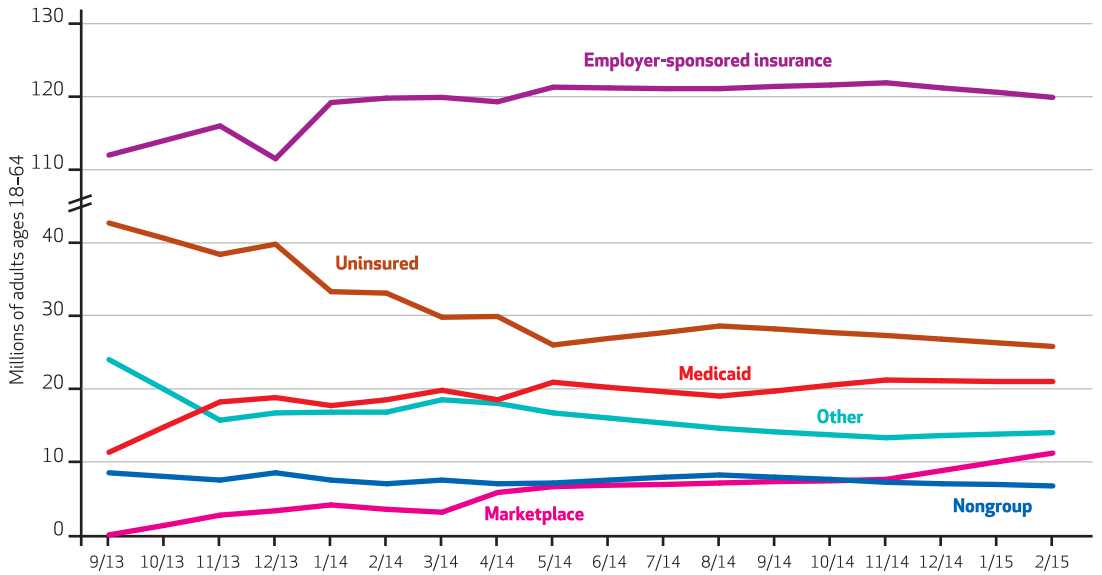
There is by now substantial evidence that approximately ten million people gained health insurance coverage following the first Affordable Care Act (ACA) open enrollment period, which occurred between October 2013 and April 2014.[1–3] Despite these gains, roughly 16 percent of the US population remained uninsured.[1] Policy makers and the Congressional Budget Office anticipated that rates of insurance coverage would continue to increase following subsequent open enrollment periods. In this analysis we investigated changes in insurance coverage following the ACA's second open enrollment period, which occurred between November 2014 and February 2015. We used longitudinal data from the RAND Health Reform Opinion Study, which enabled us to estimate transitions across types of insurance coverage. Our study focused on adults ages 18–64, the group most likely to have been affected by ACA's coverage expansions.

Exhibit 1 shows changes in insurance coverage between September 2013 and February 2015. The number of adults without insurance fell by 16.9 million, and most of this decline occurred between September 2013 and May 2014. Simultaneously, we found increased enrollment in employer-sponsored insurance, Medicaid, and the ACA's Marketplaces. By the end of February 2015, we estimate that there were 11.2 million Marketplace enrollees, a number close to the federal

EXHIBIT 1

Trends In Insurance Coverage Among US Adults Ages 18–64, By Type Of Coverage, September 2013–February 2015



SOURCE Authors' analysis. **NOTE** Because of the difference in the size of the population covered by employer-sponsored coverage relative to that of the other insured groups, the *y* axis is compressed between 40 million and 110 million.

government's reported 11.7 million enrollees as of February 22, 2015.[4] We estimate that 9.6 million people enrolled newly in Medicaid, a figure that is also close to the federal government's tally of 10.8 million additional Medicaid and Children's Health Insurance Program (CHIP) enrollees as of December 2014.[5]

While the net change in insurance was positive, we estimate that there were declines in enrollment in nongroup plans and in "other" coverage, such as non-Medicaid public coverage.

These estimates provide a first look at how the ACA has affected health insurance enrollment, with a particular focus on insurance transitions. Many of our estimates were close to those reported by the administration and by other early look surveys. However, an important limitation of these data is that our survey had a low cumulative response rate. This may have led to bias in our estimates. Surveys with higher response rates such as those conducted by the federal government are typically available only with a substantial lag. The data we collected provide a timely estimate of the effects of the ACA.

Study Data And Methods

DATA SOURCE We tracked insurance transitions using the RAND Health Reform Opinion Study, a longitudinal survey that followed a cohort of people from September 2013 through February 2015. By focusing on this time period, we were able to follow people starting immediately before the ACA's first open enrollment period and track how their insurance changed through the end of the ACA's second open enrollment period.

This ongoing survey is conducted using the RAND American Life Panel, a nationally representative panel of people who regularly participate in surveys. Invited to participate were 2,953 panel members ages 18–64 recruited using probability sampling methods. We focused our analysis on 1,589 invited participants who responded in both September 2013 and February 2015 and provided information about their source of insurance. We conducted twelve surveys during the period. The response rate among those invited to participate ranged from 60 percent to 70 percent. Following previous work in the American Life Panel, we estimate that the cumulative response rate among all people invited to participate in the panel was 9 percent.[6] As in other rapid-turnaround surveys, our cumulative response rate was much lower than the response rate for government surveys.

METHODS We used sample weights to make our September 2013 sample representative of the population, benchmarking key demographic characteristics to the 2013 Current Population Survey (CPS), a national survey conducted by the Census Bureau and the Bureau of Labor Statistics.[7] Furthermore, we adjusted our weights to address nonresponse to the 2015 survey among those responding in 2013 by dividing by the propensity of response to the 2015 survey among those who responded to the 2013 survey. More detailed information about the methods is available in the online Appendix.[8]

LIMITATIONS These data provide a unique opportunity to study insurance transitions since September 2013. However, there were some limitations. First, the sample contained only 1,589 observations, which reduced the precision of our estimates. Second, some respondents may have incorrectly reported the type of insurance coverage they had. In particular, Medicaid and nongroup coverage were difficult to measure in survey data because of confusion among consumers over the names of these programs. Furthermore, people may have had difficulty distinguishing Marketplace coverage from Medicaid and other nongroup coverage as a result of confusion over the definition of "Marketplace" and because qualified applicants may have been directed to Medicaid through a Marketplace website.[9]

Third, as previously mentioned, the response rate for our survey, around 9 percent, was low. Nonresponse especially in web-based surveys may bias estimates of enrollment in web-based Marketplaces. Despite weighting to match the CPS as closely as possible, this low response rate may indicate that the results were not nationally representative. Fourth, one concern with panel data was that participation in later waves may be influenced by the variables of interest—in this case, that insurance choices may influence the decision to participate in later waves of the survey. To address this concern, our survey weights adjusted for nonresponse associated with factors that are observable in our data. A strength of the longitudinal approach is that it avoids recall bias that might occur when respondents are asked to retrospectively report about prior insurance coverage.

Study Results

In November 2013 and December 2013, respondents were asked about their expected insurance coverage for 2014. In later surveys, respondents were asked about current coverage. The percentage of respondents with insurance coverage grew consistently from November 2013 through May 2014 (Exhibit 1). Among those purchasing insurance on the Marketplaces, we observed the most growth in April and May 2014, consistent with the surge in enrollment reported by the

Department of Health and Human Services. We observed additional growth during the second open enrollment period.

We estimate that between September 2013 and February 2015, on net, enrollment in Medicaid increased by 9.6 million; in Marketplace plans, 11.2 million; and in employer-sponsored insurance, 8.0 million (Exhibit 2). (A fuller version of Exhibit 2 with confidence intervals is available in Appendix Exhibit A2.)[8] The confidence intervals are large, in large part because of the small sample size. See the Appendix for ranges for each estimate.[8] The Medicaid enrollment increases were driven by both people becoming newly insured and people switching from one type of insurance to another. Coverage through nongroup policies and other sources (such as Medicare, military insurance, and other state policies) declined by 1.9 million and 10.0 million, respectively. Those losing coverage became uninsured or switched to another type of plan. A number of factors contributed to the large decrease in other coverage, but we lacked the information needed to definitively parse out the causes. One contributing factor may have been the elimination of state safety-net programs that coincided with the increase in Medicaid eligibility. In total, a net 16.9 million additional people became insured during the study period; the number of uninsured people declined from 42.7 million in September 2013 to 25.8 million in February 2015.

Of the 42.7 million who were uninsured in 2013, 22.8 million gained insurance and 19.9 million remained uninsured. Of 155.8 million who were insured in 2013, 5.9 million lost insurance (Exhibit 3). (A fuller version of Exhibit 3 with confidence intervals is available in Appendix Exhibit A3.)[8] The number of people gaining insurance was more than three times as large as the number losing coverage. A total of 149.9 million people were consistently insured in both time periods.

Transitions in health insurance coverage occur for many reasons; with the exception of Marketplace enrollment, which could not have occurred before the ACA, we cannot distinguish between changes caused by the ACA and changes caused by other factors. Among those gaining coverage, most (9.6 million) enrolled in employer plans, followed by Medicaid (6.5 million), the Marketplaces (4.1 million), other insurance sources (1.5 million), and nongroup plans (1.2 million) (Exhibit 4). (A fuller version of Exhibit 4 with confidence intervals is available in Appendix Exhibit A4.)[8] Among those starting out with insurance, 2.4 million people transitioned from employer coverage to uninsured status, 0.6 million transitioned from Medicaid to uninsured status, and 2.3 million transitioned from other sources of coverage to uninsured status. Despite concerns about plan cancellations, only 600,000 people starting out with nongroup coverage became uninsured. Of the 155.8 million people with insurance in September 2013, 80 percent experienced no changes in the source of their insurance during the study period. Among those who were uninsured at baseline, 47 percent remained uninsured at follow-up.

Of the 11.2 million people estimated to have Marketplace coverage in 2015, 4.1 million (37 percent) were uninsured in September 2013. Of the estimated 12.6 million new enrollees in Medicaid, 6.5 million (52 percent) were uninsured in September 2013 (Exhibit 4).

EXHIBIT 2

Net Changes In Insurance Coverage Among US Adults Ages 18–64 (Millions), 2013 And 2015

	Number of people		
Type of coverage	**2013**	**2015**	**Difference**
Insured			
Employer	111.9	119.9	8.0***
Medicaid	11.3	21.0	9.6****
Nongroup	8.5	6.7	−1.9*
Marketplace	—[a]	11.2	11.2****
Other	24.1	14.0	−10.0****
Subtotal	155.8	172.7	16.9****
Uninsured	42.7	25.8	−16.9****

SOURCE Authors' analysis of survey data. **NOTE** A bootstrap methodology was used to identify statistical significance, accounting for the correlation in behavior over time. [a]Marketplaces did not exist in 2013. *$p<0.10$ ***$p<0.01$ ****$p<0.001$

Discussion

Our results suggest that insurance coverage has continued to increase since the ACA's major provisions took effect. We estimate that 22.8 million people became newly insured and that 5.9 million lost coverage, for a net increase of 16.9 million with insurance as of February 2015. The net

EXHIBIT 3

Transitions In Insurance Coverage Among US Adults Ages 18–64 (Millions), September 2013 To February 2015

	Coverage in 2015		
Coverage in 2013	**Uninsured**	**Insured**	**2013 totals**
Uninsured	19.9[a]	22.8[b]	**42.7**
Insured	5.9[b]	149.9[a]	**155.8**
2015 totals	**25.8**	**172.7**	**198.5[c]**

SOURCE Authors' analysis of survey data. [a]No change from 2013 to 2015 (that is, people who experienced no transition). [b]Number of transitions from 2013 to 2015. [c]Weighted to the same population totals in 2013 and 2015, using characteristics of adults ages 18–64 from the 2013 Current Population Survey. As a result, changes in population size attributable to death, aging, and migration are excluded.

EXHIBIT 4

Transitions Across Insurance Categories Among US Adults Ages 18–64 (Millions), September 2013 To February 2015

	Source of coverage in 2015						
Source of coverage in 2013	**None**	**ESI**	**Medicaid**	**Nongroup**	**Marketplace**	**Other**	**2013 totals**
None	19.9[a]	9.6	6.5	1.2	4.1	1.5	**42.7**
ESI	2.4	102.3[a]	1.1	1.1	3.6	1.4	**111.9**
Medicaid	0.6	1.1	8.4[a]	0.03	0.6	0.6	**11.3**
Nongroup	0.6	2.0	0.1	4.1[a]	1.6	0.1	**8.5**
Other	2.3	4.9	4.9	0.2	1.3	10.4[a]	**24.1**
2015 totals	**25.8**	**119.9**	**21.0**	**6.7**	**11.2**	**14.0**	**198.5[b]**

SOURCE Authors' analysis of survey data. **NOTE** ESI is employer-sponsored insurance. [a]No change from 2013 to 2015 (that is, people who experienced no transition). [b]Weighted to the same population totals in 2013 and 2015, using characteristics of eighteen- to sixty-four-year-olds from the 2013 Current Population Survey. As a result, changes in population size attributable to death, aging, and migration are excluded.

increase in insurance that we observed is slightly higher than a recent estimate from the federal government, which found 14.1 million newly insured adults since 2013.[10] However, given the large confidence intervals in both surveys, we cannot reject the hypothesis that our estimates are equivalent.

Among the 22.8 million people who gained insurance, most enrolled in employer-sponsored insurance, followed by Medicaid and the Marketplaces. Employer coverage is by far the largest source of insurance among Americans younger than age sixty-five, and the ACA creates new incentives for people to take up employer policies. Specifically, while the ACA mandates that most people must enroll in insurance, people are ineligible for Marketplace subsidies if they have an affordable offer of coverage from their employer. Gains in employer coverage were also found following Massachusetts's health reform.[11,12] However, other nationally representative surveys did not show an increase in employer coverage between 2013 and 2014.[13,14] It is possible that the increases in employer coverage that we observed were idiosyncratic to our small sample, rather than a true representation of changes in coverage at the population level.

While the vast majority of those previously insured experienced no change in their source of coverage, 5.9 million people lost coverage over the period studied, and 24.6 million moved from one source of coverage to another. Transitions in health insurance coverage are common in the United States and occur for a variety of reasons, including job changes and family transitions.[15] Recent estimates suggest that the share of people losing coverage between 2013 and 2014 was no higher than the share of people who lost coverage in prior years.[16]

One concern frequently cited by public officials and the media was that people may have lost individual market coverage as a result of plan cancellations. We found that the vast majority of those with individual market insurance in 2013 remained insured in 2015, which suggests that even among those who had their individual market policies canceled, most found coverage through an alternative source. Others who had their policies canceled may have become eligible for the ACA's tax credits, potentially making Marketplace plans more affordable than their previous nongroup policies.

80%

Saw no change

Of the 155.8 million people with insurance in September 2013, 80 percent saw no changes in the source of their insurance during the study period.

Conclusion

The ACA has greatly expanded health insurance coverage in the United States with little change in the source of coverage for those who were insured before the major provisions of the law took effect. Furthermore, the law has expanded coverage using all parts of the health insurance system, including employer-sponsored insurance, Medicaid, and the newly created Marketplaces. While these data have limitations, especially due to the low response rate, they provide an early look at how the ACA has affected insurance enrollment. ■

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NOTES

1 Sommers BD, Musco T, Finegold K, Gunja MZ, Burke A, McDowell AM. Health reform and changes in health insurance coverage in 2014. N Engl J Med. 2014;371(9):867–74.

2 Collins SR, Rasmussen PW, Doty MM. Gaining ground: Americans' health insurance coverage and access to care after the Affordable Care Act's first open enrollment period [Internet]. New York (NY): Commonwealth Fund; 2014 Jul [cited 2015 Apr 14]. Available from: http://www.commonwealthfund.org/publications/issue-briefs/2014/jul/health-coverage-access-aca

3 Long SK, Karpman M, Shartzer A, Wissoker D, Kenney GM, Zuckerman S, et al. Taking stock: health insurance coverage under the ACA as of September 2014 [Internet]. Washington (DC): Urban Institute; 2014 Dec 3 [cited 2015 Apr 14]. Available from: http://hrms.urban.org/briefs/health-insurance-coverage-under-the-aca-as-of-september-2014.html

4 Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Health insurance Marketplaces 2015 open enrollment period: March enrollment report [Internet]. Washington (DC): HHS; 2015 Mar 10 [cited 2015 Apr 14]. Available from: http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Mar2015/ib_2015mar_enrollment.pdf

5 Centers for Medicare and Medicaid Services. Medicaid and CHIP: December 2014 monthly applications, eligibility determinations, and enrollment report [Internet]. Baltimore (MD): CMS; 2015 Feb 23 [cited 2015 Apr 14]. Available from: http://medicaid.gov/medicaid-chip-program-information/program-information/downloads/december-2014-enrollment-report.pdf

6 Gutsche TL, Kapteyn A, Meijer E, Weerman B. The RAND Continuous 2012 Presidential Election Poll. Public Opin Q. 2014;78(S1):233–54.

7 Census Bureau. State and county quickfacts [Internet]. Washington (DC): Census Bureau; 2014 Mar [cited 2015 Apr 14]. Available from: http://quickfacts.census.gov/qfd/states/00000.html

8 To access the Appendix, click on the Appendix link in the box to the right of the article online.

9 Pascale J, Rodean J, Leeman J, Cosenza C, Schoua-Glusberg A. Preparing to measure health coverage in federal surveys post-reform: lessons from Massachusetts. Inquiry. 2013;50(2):106–23.

10 Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Health insurance coverage and the Affordable Care Act [Internet]. Washington (DC): HHS; 2015 Mar 16 [cited 2015 Apr 14]. Available from: http://aspe.hhs.gov/health/reports/2015/uninsured_change/ib_uninsured_change.pdf

11 Long SK, Stockley K. Sustaining health reform in a recession: an update on Massachusetts as of fall 2009. Health Aff (Millwood). 2010;29(6):1234–41.

12 Kenney GM, Long SK, Luque A. Health reform in Massachusetts cut the uninsurance rate among children in half. Health Aff (Millwood). 2010;29(6):1242–7.

13 Henry J. Kaiser Family Foundation. 2014 Employer Health Benefits Survey [Internet]. Menlo Park (CA): KFF; 2014 Sep 10 [cited 2015 Apr 14]. Available from: http://ehbs.kff.org/

14 Blavin F, Shartzer A, Long SK, Holahan J. An early look at changes in employer-sponsored insurance under the Affordable Care Act. Health Aff (Millwood). 2015;34(1):1170–7.

15 Graves JA, Swartz K. Understanding state variation in health insurance dynamics can help tailor enrollment strategies for ACA expansion. Health Aff (Millwood). 2013;32(10):1832–40.

16 Vistnes J, Cohen SB. Transitions in health insurance coverage over time, 2012–2014 (selected intervals): estimates for the US civilian noninstitutionalized adult population under age 65. Rockville (MD): Agency for Healthcare Research and Quality; 2015 Feb. Statistical Brief no. 467.