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More U.S. Companies Switch To High Deductible Health Plans

by **JOHN YDSTIE**

February 18, 2014 5:00 AM

Listen to the Story

Morning Edition **4 min 28 sec**

Over-all health care cost increases have slowed dramatically, but consumers may not notice it. Many face higher deductibles, co-pays and out-of-pocket maximums as employers' insurance plans try to encourage them to pay more attention to health care costs. One big problem is health care price information is often not available.

RENEE MONTAGNE, HOST:

It's MORNING EDITION, from NPR News. I'm Renee Montagne.

DAVID GREENE, HOST:

And I'm David Greene. Good morning.

The cost of health care in this country seems to be coming under control. Health care spending, while still on the rise, has increased at historically low levels the last few years, which makes you wonder: Why aren't we feeling it?

Some of you've probably noticed it's costing more to go to the doctor these days and also, more to fill out a prescription. Out-of-pocket costs - co-pays and deductibles - have been going up rapidly.

NPR's John Ydstie looks at why that is, and what could change it.

JOHN YDSTIE, BYLINE: Jenny Miers and her husband felt the sting of higher out-of-pocket medical costs when they adopted a 3-month-old baby girl last June. Shortly after they got her home, she developed a fever,

which they suspected was caused by a urinary tract infection. So they took her to the emergency room.

JENNY MIERS: And they did a quick check on her, confirmed that that's what it was; so we thought we were in the clear and that we were going to go home with, you know, the little, pink antibiotic, and we were good to go. But we were told pretty quickly, no, you're being admitted.

YDSTIE: Hospital protocol required that the baby stay in the hospital for at least 48 hours, to make sure the fever wasn't caused by something else. In the end, the baby was fine, but Miers and her husband felt some pain in their pocketbook.

MIERS: We currently owe 7- or $8,000.

YDSTIE: That's almost $3,000 more than she would have paid under her old policy with its lower out-of-pocket cap. Miers' company recently doubled the deductibles and out-of-pocket maximum on her policy. The out-of-pocket max is now $10,000. That's made her more aware of the costs.

MIERS: We're paying a lot more, and we're going to question everything that you're putting in front of us to make sure that, you know, it was necessary.

YDSTIE: Getting people to act like price-sensitive consumers is the point, says Tom Mangan, CEO of UBA - United Benefits Advisors - based in Chicago. He says there's been a big shift by employers to higher deductible, higher co-pay plans, and away from HMO-type plans with very low out-of-pocket costs.

TOM MANGAN: If structured properly and communicated properly, they are effective in holding down costs. And their trend is significantly below that of low-deductible, low co-pay plans because people actually think about what a prescription costs.

YDSTIE: But Jenny Miers said her experience with her sick child demonstrates it's very hard to get good information on prices in the health care system.

MIERS: Everything is quite confusing out there, even with getting the itemized bill and trying to understand what we're looking at.

YDSTIE: Mangan, whose firm UBA advises companies on health care options, says this is a problem with high-deductible programs.

MANGAN: We've raised the cost, but we didn't provide the information that was promised. It's coming. We are working with a company called Castlight. And with a smartphone, you can type in information on this is my condition, this is the provider I want to see; and it will actually tell you what the quality outcomes are and the pricing.

YDSTIE: Leah Binder is CEO of The Leapfrog Group, a nonprofit that represents businesses that purchase health benefits for their employees. She says companies are rapidly moving to high-deductible plans.

LINDA BINDER: This is a tsunami of change. Five years ago, about zero people had a high-deductible health plan and now, it's 1 in 5 American workers.

YDSTIE: Binder says consumers may have a hard time getting transparent pricing information during the transition, partly because health care pricing is arcane and even bizarre.

BINDER: It's quite difficult. We don't have the right kind of transparency. But I don't see a solution to that, unless we have somebody driving a market. When consumers are demanding things, they tend to get them.

YDSTIE: Binder expects a rapid shift to more transparent pricing. She points to a new Massachusetts law that requires health care providers to give prices for treatments within 24 hours of a request. She also says the high out-of-pocket costs in many Obamacare policies will add to the pressure for pricing transparency.

In the short-term, Binder says, consumers may pay a bit more for their health care. But in the long run, she believes consumers will pay less than they would have, as health care responds more to market forces.

John Ydstie, NPR News, Washington.

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The Commonwealth Fund Blog

Coverage Opportunities and Obstacles for Hispanics Under the ACA

February 13, 2014

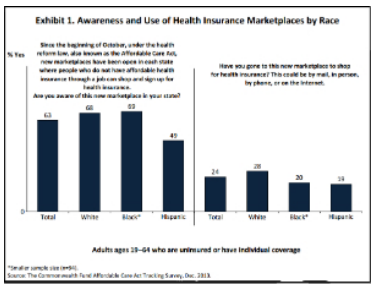
Tags: state health insurance exchanges safety net Medicaid


By Michelle M. Doty and David Blumenthal, M.D.

The Hispanic community—a group whose vote is highly valued by both political parties—stands to benefit significantly from the Affordable Care Act (ACA). At least a third of all Hispanics under the age of 65, or 15.3 million people, lack health insurance. According to RAND estimates, 5.4 million of these individuals will gain coverage by 2016 because of the ACA.

Even more uninsured Hispanics could gain coverage, but the numbers depend on whether states act to expand Medicaid and whether Hispanics take advantage of new state and federal insurance marketplaces. So far, 26 states and the District of Columbia have decided to expand eligibility for Medicaid, including two states with large Hispanic populations, New York and California. Yet, Florida and Texas, home to an estimated 14 million Hispanic residents, are among those states that haven't expanded Medicaid.

Hispanic adults have a number of important new coverage opportunities. Adults with incomes below 138 percent of poverty are eligible to enroll in Medicaid if their state opts to expand their Medicaid program. Adults with incomes above 138 percent of poverty are eligible to buy subsidized coverage in state and federal exchanges if they do not have affordable job-based coverage. Although undocumented immigrants are ineligible for Medicaid or participation in state and federal marketplaces, because of the ACA, legal immigrants are now eligible for Medicaid or subsidized private coverage depending on what state they live in and how long they have been residing in the United States.[1]



One potential obstacle to realizing the promise of the ACA for Hispanics is their general lack of awareness of the law and its provisions. According to The Commonwealth Fund Marketplace Survey conducted three months into the first open-enrollment period, only 49 percent of Hispanics who were potentially eligible for marketplace coverage were aware of the marketplace in their state, compared with nearly seven of 10 whites and blacks (Exhibit 1). Only 19 percent of Hispanic, 20 percent of black, and 28 percent of white adults who were potentially eligible for coverage had gone to the marketplace by the end of December 2013 to shop for health insurance.

Although the proportion of people who visited the marketplaces within the first three months of open enrollment was low, the survey found that the vast majority of potentially eligible Hispanics (73%) were likely to go or return to their state marketplace by March 31, 2014, to enroll in a health plan. But targeted outreach and assistance is still needed to increase awareness and enrollment among Hispanics. In recognition of this need, the U.S. Department of Health and Human Services has begun an outreach plan in English and Spanish appealing to mothers in the Hispanic community to encourage them and their family members to enroll.

If Hispanics do take advantage of the ACA's new insurance options in large numbers, and millions more have access to health care and insurance, then any major changes in the law would have significant consequences for the Hispanic community. The Hispanic vote could then become a major factor in the continuing political battle over the future of the ACA.

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[1] In states that are expanding Medicaid, legal immigrants who have been in the United States for five years or more and have incomes below 138 percent of poverty are eligible to enroll in Medicaid. And those immigrants who have the same income or lower but have lived in the U.S. for less than five years can buy subsidized coverage through the marketplace if they do not have affordable coverage through an employer. This is an important new opportunity for people legally present in the United States who previously had to wait five years to gain access to affordable health insurance. In states that do not expand their Medicaid programs, people with incomes between 100 percent and 400 percent of poverty are eligible for subsidized private plans. But in those states, U.S. citizens and legal residents with income under 100 percent of poverty are not eligible for subsidized private coverage while lawfully residing immigrants are. See L. Ku, "New Opportunities to Increase Legal Immigrants' Health Insurance Coverage," *The Commonwealth Fund Blog*, Dec. 13, 2013.

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ASPE
RESEARCH BRIEF

ELIGIBLE UNINSURED LATINOS: 8 IN 10 COULD RECEIVE HEALTH INSURANCE MARKETPLACE TAX CREDITS, MEDICAID OR CHIP

February 11, 2014
By Emily R. Gee

Under the Affordable Care Act, 10.2 million eligible uninsured Latinos gained access to new options for health care coverage on January 1, 2014.[1] Eight in ten, or 8.1 million, of these eligible uninsured Latinos may qualify either for tax credits to purchase coverage in the Health Insurance Marketplace (3.9 million) or for Medicaid or the Children's Health Insurance Program (CHIP) (4.2 million). If all states were to expand Medicaid, 95 percent of all eligible uninsured Latinos would be eligible for Marketplace tax credits, Medicaid, or CHIP.

Of the 41.3 million uninsured nonelderly U.S. citizens and others lawfully residing in the United States (a group referred to as "eligible uninsured" in this brief), 10.2 million people or one in four (25 percent) are Latino. Latinos are uninsured at a much higher rate than the U.S. population overall; 16 percent of all nonelderly U.S. citizens and others lawfully residing are uninsured, while the comparable proportion among eligible Latinos is 24 percent.

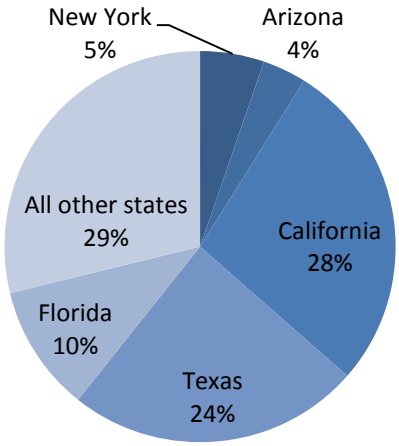
Location – More than half of the nation's 10.2 million eligible uninsured Latinos live in California or Texas. The five states with the greatest number of eligible uninsured Latinos are:

- California 2.8 million (28 percent of all eligible uninsured Latinos),
- Texas 2.5 million (24 percent),
- Florida 1.1 million (10 percent),
- New York 0.5 million (5 percent), and
- Arizona 0.4 million (4 percent).

[1] ASPE tabulations from the CY 2011 American Community Survey Public Use Microdata Sample (ACS PUMS) are adjusted to exclude estimated undocumented persons based on ASPE's TRIM3 microsimulation model. All references to eligible uninsured in this brief use these tabulations. See the methodology section for more information. For more information about eligibility to purchase coverage in the Marketplace, see https://www.healthcare.gov/immigration-status-and-the-marketplace/. The estimates contained in this brief do not take into account certain Marketplace coverage and Medicaid/CHIP eligibility requirements, such as those relating to other minimum essential coverage or tax filing requirements, and thus the populations described in this brief should be construed as "potentially" eligible, subject to these other requirements. Also, the statutory threshold for Medicaid expansion set by the Affordable Care Act is 133 percent of the FPL, not 138 percent of the FPL. This brief refers throughout to 138 percent of the FPL, which is the effective threshold including the 5 percent statutory disregard.

The greater Los Angeles, Houston, New York, and Dallas metropolitan areas are home to one-quarter (25 percent) of eligible uninsured Latinos (see Table 4). Approximately 18 percent of all eligible uninsured Latinos live outside a metropolitan area.[2]

Figure 1: Distribution of Eligible Uninsured Latinos by State, 2011



Demographic Characteristics of Eligible Uninsured Latinos

Gender — More men than women are uninsured in the United States. This is also the case for Latinos. Among the Latino eligible uninsured, less than half, or 45 percent (4.6 million), are Latinas.

Age — Young adults are a disproportionately large share of the uninsured relative to their share of the general population. They are the age group most likely to be without health insurance coverage in the U.S.[3] The same is true among young Latinos: young adults ages 18 to 35 account for nearly half (4.6 million; 46 percent) of the Latino eligible uninsured but only 30 percent of the eligible Latino population overall. Of the 4.6 million eligible uninsured Latinos ages 18 to 35, 1.9 million (42 percent) are women and 2.7 million (58 percent) are men.

Employment — The vast majority (73 percent) of eligible uninsured Americans live in households with at least one full-time worker. Similarly, nearly eight in ten (79 percent) eligible uninsured Latinos have at least one full-time worker in the family.

[2] ASPE determined the metropolitan status of households in the ACS PUMS based on the household's public use microdata area (PUMA) of residence. If fewer than 50 percent of all residents within a PUMA reside in metropolitan areas, that entire PUMA is classified as non-metropolitan (i.e., "rural"); otherwise, the PUMA is considered metropolitan. PUMAs are Census-designated geographic areas which contain at least 100,000 residents in one or more neighboring counties within a single state.

[3] For the most up to date information on the demographic characteristics of the uninsured, including by age and gender, see a summary of the Census Bureau's Current Population Survey released in September 2013 at http://aspe.hhs.gov/health/reports/2013/CPSIssueBrief/ib_cps.cfm.

Education — About one-third (35 percent) of eligible uninsured Latinos did not earn a high school diploma, more than half (58 percent) have a high school diploma, and an additional 7 percent hold a college degree. Among all eligible uninsured Americans nationwide (41.3 million), 20 percent do not have a high school diploma, 68 percent have a high school diploma, and 12 percent hold a college degree.

Language — A majority (63 percent) of eligible uninsured Latinos report that they speak English as a first language or at least "very well" as a second language. About one-third (37 percent) of eligible uninsured Latinos rely on Spanish, and 27 percent live in a household without an English-speaking adult present.

Income — About 42 percent (4.2 million) of eligible uninsured Latinos have family incomes[4] below 100 percent of the Federal Poverty Level (FPL), and nearly half of these people (2 million) live in states not expanding Medicaid. This means that nearly one in five uninsured Latinos may not gain access to affordable coverage through Medicaid in 2014 because their state declined to take this federally funded option.

Approximately 5.7 million eligible uninsured Latinos have family incomes at or below 138 percent of the FPL, the threshold for qualifying for Medicaid in expansion states. Of these 5.7 million, 3 million live in Medicaid expansion states.[5]

[4] For family income, a "family" is based on the "health insurance unit" (HIU), which includes adults, their spouses, and their dependent children (ages 0-18, plus full-time students under age 23), using ASPE analysis of the ACS PUMS data.

[5] Our analysis assumes that the following 25 states plus the District of Columbia expand their Medicaid programs: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Rhode Island, Vermont, Washington, and West Virginia.

Table 1: Distribution of Eligible Uninsured Latinos by Family Income

	Medicaid Expansion States	Non-Expansion States	All States[6]
Number of States	26	25	51
All Eligible Latinos[7]	25,461,000	16,374,000	41,835,000
Eligible *Uninsured* Latinos	5,465,000	4,703,000	10,168,000
By Family Income as Percent of the Federal Poverty Level (FPL)	**Medicaid Expansion States**	**Non-Expansion States**	**All States**
100% FPL or Less	2,267,000	1,958,000	4,224,000
101% to 138% FPL	782,000	661,000	1,443,000
139% to 400% FPL	2,126,000	1,838,000	3,964,000
Above 400% FPL	290,000	246,000	536,000

Latinos and the Marketplace

Each state has a Health Insurance Marketplace where consumers can shop for and purchase health insurance coverage. In states that are expanding Medicaid, individuals and families with household incomes from 138 to 400 percent of the FPL may be eligible for tax credits to make health insurance even more affordable. In states that do not expand Medicaid, those with family incomes between 100 and 400 percent of FPL may qualify for tax credits.

Of the 4.4 million uninsured Latinos eligible to purchase Marketplace plans, 3.9 million—or nearly 9 in 10 (88 percent)—may qualify for a premium tax credit for Marketplace coverage (see Table 2).[8] The estimated 4.4 million Marketplace-eligible uninsured include 2.1 million eligible uninsured Latino adults (ages 19 and older) in Medicaid expansion states with incomes above 138 percent of the FPL, 2.3 million eligible uninsured in the remaining 25 non-expansion states with incomes above 100 percent of the FPL, and 234,000 eligible uninsured Latino children from all states with family incomes above 250 percent of the FPL.[9]

[6] The sum of expansion and non-expansion state estimates may not equal the stated total for all states due to rounding.
[7] Estimates in this row are for all nonelderly (ages 0 to 64) Latinos who are U.S. citizens or lawfully residing in the United States.
[8] We define Marketplace-tax-credit-eligible individuals in this analysis as uninsured U.S. citizens and others lawfully residing in the area served by the Marketplace who are adults (ages 19 to 64) with family incomes above 138 percent to 400 percent of the FPL in Medicaid expansion states and above 100 percent to 400 percent of the FPL in non-expansion states or who are children (ages 0 to18) with incomes 250 percent to 400 percent of the FPL.
[9] We make the simplifying assumption in this analysis that all children with incomes below 250 percent of the FPL would be eligible for Medicaid/CHIP rather than the Marketplace.

Table 5 contains examples of premiums before and after tax credits are applied.

Latinos and Medicaid

Many uninsured Latinos may be eligible for coverage through Medicaid or the Children's Health Insurance Program (CHIP) at little or no cost. About 2.4 million eligible uninsured Latinos adults (30 percent of all eligible uninsured Latinos) who reside in states expanding their Medicaid programs may be eligible for Medicaid coverage. Additionally, approximately 1.8 million eligible uninsured Latino children ages 0 to 18 have family incomes at or below 250 percent of FPL and may be eligible for coverage under Medicaid/CHIP (see Table 2).

More than 1.5 million Latino adults live in states that are not expanding Medicaid and have family incomes below 100 percent of the FPL. If all states were to expand Medicaid, 95 percent of all eligible uninsured Latinos would be eligible for Marketplace tax credits, Medicaid, or CHIP.

Table 2: Number and Percentage of Eligible Uninsured Latinos Who May Qualify for Marketplace Tax Credits, Medicaid, or CHIP[10]

	Medicaid Expansion States	**Non-Expansion States**	**All States[11]**
Eligible uninsured Latinos	5,465,000 *53.7%*	4,703,000 *46.3%*	10,168,000 *100.0%*
Uninsured Latinos who may be eligible for Marketplace	2,141,000 *21.1%*	2,264,000 *22.3%*	4,405,000 *43.3%*
Eligible uninsured Latinos who may qualify for Marketplace Premium Tax Credits	1,851,000 *18.2%*	2,018,000 *19.8%*	3,869,000 *38.1%*
Eligible uninsured Latinos who may qualify for Medicaid (age 19 to 64)	2,445,000 *24.0%*	N/A[12]	2,445,000 *24.0%*
Eligible uninsured Latinos who may qualify for or Medicaid/CHIP (age 0 to 18)	878,000 *8.6%*	892,000 *8.8%*	1,771,000 *17.4%*

[10] Percentages in Table 2 are a proportion of all eligible uninsured Latinos (10.2 million).
[11] The sum of expansion and non-expansion state estimates may not equal the stated total for all states due to rounding.
[12] In non-expansion states, some eligible uninsured may currently qualify for Medicaid and are not enrolled, and such individuals are not included in our analysis. For expansion states, our estimate of the eligible uninsured who may qualify for Medicaid includes both the current and the newly eligible.

Latinos by Location

By State — As noted earlier, eligible uninsured Latinos are generally concentrated in 5 states—more than half live in California, Texas, Florida, New York, and Arizona. Table 3 shows the number of eligible Latinos and those who are uninsured in all 50 states and the District of Columbia.

Table 3: Number of Eligible Uninsured Latinos by State

State	Total Eligible Latino Population	Eligible Uninsured Latinos	Percent of Eligible Latinos Who Are Uninsured	Eligible Uninsured Latinos as Percent of U.S. Total
Alabama	118,000	32,000	27.5%	0.3%
Alaska	39,000	7,000	17.4%	0.1%
Arizona	1,610,000	367,000	22.8%	3.6%
Arkansas	150,000	38,000	25.6%	0.4%
California	11,837,000	2,802,000	23.7%	27.6%
Colorado	867,000	181,000	20.9%	1.8%
Connecticut	412,000	59,000	14.3%	0.6%
Delaware	58,000	9,000	14.8%	0.1%
District of Columbia	44,000	6,000	12.9%	0.1%
Florida	3,412,000	1,063,000	31.2%	10.5%
Georgia	606,000	173,000	28.5%	1.7%
Hawaii	116,000	10,000	8.4%	0.1%
Idaho	142,000	29,000	20.6%	0.3%
Illinois	1,657,000	316,000	19.1%	3.1%
Indiana	308,000	72,000	23.3%	0.7%
Iowa	117,000	19,000	16.2%	0.2%
Kansas	241,000	52,000	21.4%	0.5%
Kentucky	97,000	18,000	18.8%	0.2%
Louisiana	145,000	47,000	32.4%	0.5%
Maine	13,000	2,000	15.5%	0.0%
Maryland	338,000	57,000	16.7%	0.6%
Massachusetts	573,000	48,000	8.4%	0.5%
Michigan	390,000	63,000	16.1%	0.6%
Minnesota	197,000	40,000	20.1%	0.4%
Mississippi	56,000	16,000	27.8%	0.2%
Missouri	172,000	43,000	24.8%	0.4%
Montana	28,000	7,000	26.5%	0.1%
Nebraska	135,000	30,000	21.9%	0.3%
Nevada	551,000	158,000	28.6%	1.6%
New Hampshire	33,000	6,000	18.4%	0.1%

State	Total Eligible Latino Population	Eligible Uninsured Latinos	Percent of Eligible Latinos Who Are Uninsured	Eligible Uninsured Latinos as Percent of U.S. Total
New Jersey	1,261,000	277,000	22.0%	2.7%
New Mexico	816,000	181,000	22.2%	1.8%
New York	2,940,000	539,000	18.3%	5.3%
North Carolina	560,000	138,000	24.7%	1.4%
North Dakota	14,000	3,000	24.4%	0.0%
Ohio	298,000	53,000	17.8%	0.5%
Oklahoma	268,000	69,000	25.7%	0.7%
Oregon	352,000	66,000	18.6%	0.6%
Pennsylvania	656,000	114,000	17.4%	1.1%
Rhode Island	112,000	17,000	15.6%	0.2%
South Carolina	163,000	43,000	26.5%	0.4%
South Dakota	19,000	5,000	24.7%	0.0%
Tennessee	210,000	62,000	29.6%	0.6%
Texas	7,984,000	2,465,000	30.9%	24.2%
Utah	276,000	86,000	31.2%	0.8%
Vermont	7,000	1,000	9.1%	0.0%
Virginia	460,000	80,000	17.4%	0.8%
Washington	627,000	135,000	21.6%	1.3%
West Virginia	19,000	3,000	15.2%	0.0%
Wisconsin	283,000	52,000	18.4%	0.5%
Wyoming	44,000	10,000	22.2%	0.1%
United States	*41,835,000*	*10,168,000*	*24.3%*	*100.0%*

By Metropolitan Area — Eligible uninsured Latinos are concentrated in certain metropolitan areas as shown in Table 4, which lists the top 20 metropolitan statistical areas by the number of eligible uninsured Latinos. Nearly six in ten of the nation's eligible uninsured Latinos live in one of these 20 metropolitan areas.

Table 4: Top 20 Metropolitan Statistical Areas by Number of Eligible Uninsured Latinos

Rank	Metropolitan Statistical Area (MSA)	Eligible Uninsured Latinos in MSA	Eligible Uninsured Latinos in State	MSA Eligible Uninsured Latinos as Percent of State Total	MSA Eligible Uninsured Latinos as Percent of U.S. Total
1	Los Angeles-Long Beach, CA	1,211,000	2,802,000	43.2%	11.9%
2	Houston-Brazoria, TX	541,000	2,465,000	22.0%	5.3%
3	New York-Northeastern NJ, NY portion only	484,000	539,000	89.8%	4.8%
4	Dallas-Fort Worth, TX	456,000	2,465,000	18.5%	4.5%
5	Riverside-San Bernardino, CA	434,000	2,802,000	15.5%	4.3%
6	Miami-Hialeah, FL	394,000	1,063,000	37.0%	3.9%
7	Chicago, IL	288,000	316,000	91.1%	2.8%
8	San Antonio, TX	235,000	2,465,000	9.5%	2.3%
9	Phoenix, AZ	221,000	367,000	60.3%	2.2%
10	New York-Northeastern NJ, NJ portion only	215,000	277,000	77.5%	2.1%
11	McAllen-Edinburg-Pharr-Mission, TX	207,000	2,465,000	8.4%	2.0%
12	San Diego, CA	203,000	2,802,000	7.2%	2.0%
13	San Francisco-Oakland-Vallejo, CA	161,000	2,802,000	5.7%	1.6%
14	El Paso, TX	157,000	2,465,000	6.4%	1.5%
15	Orlando, FL	134,000	1,063,000	12.6%	1.3%
16	Las Vegas, NV	118,000	158,000	75.1%	1.2%
17	Atlanta, GA	109,000	173,000	63.1%	1.1%
18	Denver-Boulder, CO	107,000	181,000	59.2%	1.1%
19	Fort Lauderdale-Hollywood-Pompano Beach, FL	105,000	1,063,000	9.8%	1.0%
20	Austin, TX	104,000	2,465,000	4.2%	1.0%
TOTAL	*Top 20 MSAs (and respective 10 states)*[13]	*5,883,000*	*8,340,000*	*70.5%*	*57.9%*

[13] The 10-state total is based on the 10 states corresponding to the top 20 MSAs listed in the table, not the 10 states by greatest number of eligible uninsured Latinos.

Table 5: Examples of Marketplace Monthly Premiums after Tax Credit

This table includes premiums for two illustrative groups, a single 27-year-old and a family of four, in major metropolitan areas in selected states with large eligible uninsured Latino populations. For example, in Maricopa County, Arizona, which includes the city of Phoenix, a 27-year-old with income of $25,000 could purchase a bronze plan for as little as $123 per month after the tax credit. If a city spans more than one county, the premiums below are for the county which covers a larger area of the city.

		Premium for a 27-Year-Old			**27-Year-Old with an Income of $25,000**			**Family of Four with an Income of $50,000[14]**		
City, State	**County**	Lowest Bronze	Lowest Silver	Lowest Catastrophic	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Lowest Bronze After Tax Credit	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Lowest Bronze After Tax Credit[15]
Phoenix, AZ	Maricopa	$139	$159	$105	$161	$145	$123	$545	$282	$207
Tucson, AZ	Pima	$119	$136	$90	$138	$138	$119	$467	$282	$218
Los Angeles, CA[16]	L.A. (north)	$153	$182	$122	$207	$145	$92	$698	$282	$102
	L.A. (south)	$172	$198	$148	$212	$145	$105	$717	$282	$147
San Diego, CA	San Diego	$182	$221	$136	$253	$145	$74	$853	$282	$42
San Francisco, CA	San Francisco	$182	$251	$169	$306	$145	$21	$1,033	$282	$0
Denver, CO	Denver	$153	$201	$139	$205	$145	$92	$694	$282	$104
Fort Lauderdale, FL	Broward	$128	$174	$86	$199	$145	$74	$674	$282	$41
Miami, FL	Miami-Dade	$163	$202	$109	$221	$145	$87	$746	$282	$86
Orlando, FL	Orange	$182	$207	$141	$225	$145	$102	$761	$282	$136

[14] For the purposes of this analysis, a family of four is defined as two 30-year-old adults and two children under age 21.
[15] Net of tax credits, bronze premiums for a family of four may be below those for a single individual and may be as low as 0. This occurs because the tax credit is calculated as the difference between the cost of the second lowest cost silver plan premium and the maximum payment amount determined by income. Because premiums for older individuals and families are higher than those for younger individuals, tax credits are larger for older individuals and families. Therefore, using tax credits to purchase a bronze plan may yield lower bronze premiums for older individuals and families than for younger individuals.
[16] Los Angeles County is split into two rating areas for Marketplace premiums.

City, State	County	Premium for a 27-Year-Old			27-Year-Old with an Income of $25,000			Family of Four with an Income of $50,000[14]		
		Lowest Bronze	Lowest Silver	Lowest Catastrophic	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Lowest Bronze After Tax Credit	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Lowest Bronze After Tax Credit[15]
Tampa, FL	Hillsborough	$167	$189	$129	$199	$145	$113	$673	$282	$173
Atlanta, GA	Fulton	$166	$188	$127	$205	$145	$105	$694	$282	$148
Chicago, IL	Cook	$125	$172	$141	$174	$145	$96	$586	$282	$117
Detroit, MI	Wayne	$138	$156	$105	$184	$145	$99	$621	$282	$126
Newark, NJ	Essex	$230	$253	$186	$260	$145	$114	$880	$282	$178
Albuquerque, NM	Bernalillo	$126	$155	$110	$159	$145	$112	$538	$282	$170
Las Vegas, NV	Clark	$150	$194	$155	$195	$145	$99	$660	$282	$128
New York, NY	New York	$308	$359	$184	$390	$145	$63	$1,112	$282	$49
Philadelphia, PA	Philadelphia	$195	$210	$171	$246	$145	$94	$831	$282	$109
Dallas, TX	Dallas	$153	$217	$173	$223	$145	$74	$754	$282	$44
El Paso, TX	El Paso	$119	$169	$155	$174	$145	$90	$588	$282	$96
Houston, TX	Houston	$133	$169	$109	$189	$145	$89	$638	$282	$94
McAllen, TX	Hidalgo	$109	$153	$98	$155	$145	$99	$523	$282	$128
San Antonio, TX	Bexar	$138	$168	$109	$196	$145	$87	$663	$282	$87

Methodological Overview and Study Limitations

This analysis is based on ASPE analysis of the 2011 American Community Survey Public Use Microdata Sample (ACS PUMS), the best source for obtaining information about the current characteristics of the uninsured population at the state level and for smaller demographic groups. ASPE tabulations from the ACS PUMS have been adjusted to exclude estimated undocumented persons based on ASPE's TRIM3 microsimulation model (http://trim.urban.org).[17]

The smallest geographic unit defined in the ACS PUMS is the Census-defined public-use microdata area (PUMA). To obtain metropolitan area estimates, we assigned PUMAs to metropolitan statistical areas based on a crosswalk created from the University of Minnesota's Integrated Public Use Microdata Series.[18]

Our methodology for examples of plan premiums is described in detail in an earlier ASPE brief titled "Health Insurance Marketplace Premiums for 2014." The full text is available online at http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/ib_marketplace_premiums.cfm. Plan data for Federally-facilitated Marketplaces were downloaded on January 2, 2014 from https://www.healthcare.gov/health-plan-information/, and State-based Marketplace premiums were obtained from state sources in fall 2013.

For family incomes used to estimate Marketplace and Medicaid eligibility, the "family" is defined as the "health insurance unit" (HIU). HIUs include adults plus their spouses and dependent children (ages 0 to 18, plus full-time students under age 23) living in the household, based on ASPE analysis of the ACS PUMS data.

The estimate of uninsured Medicaid-eligible adults is the number of adults age 19 older who have family (HIU) incomes below 138 percent of the FPL and live in one of the 25 Medicaid expansion states or the District of Columbia. Although the statutory threshold for Medicaid expansion set by the Affordable Care Act is 133 percent of the FPL, this brief uses 138 percent of the FPL, which is the effective threshold when the 5 percent statutory disregard is included.

We made the simplifying assumption that children in families with incomes at or below 250 percent of FPL are eligible for CHIP, and children in families with incomes between 250 percent and 400 percent of the FPL are eligible for Marketplace coverage with premium tax credits. We recognize that states have different maximum income standards for CHIP eligibility.

[17] The adjustment methodology is based on imputations of immigrant legal status in ASPE's TRIM3 microsimulation model (http://trim.urban.org/), according to methods initially developed by Jeffrey Passel and Rebecca Clark.

[18] The Integrated Public Use Microdata Series (Version 5.0) was developed by Steven Ruggles, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek at the University of Minnesota. Available online: https://usa.ipums.org/usa/index.shtml.

YOUNG ADULT PARTICIPATION IN THE HEALTH INSURANCE MARKETPLACES JUST HOW IMPORTANT IS IT?

FEBRUARY 2014

Sara R. Collins

The Commonwealth Fund, among the first private foundations started by a woman philanthropist—Anna M. Harkness—was established in 1918 with the broad charge to enhance the common good.

The mission of The Commonwealth Fund is to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.

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Abstract: The participation of young adults in the health insurance marketplaces has received considerable attention. At issue is whether men and women ages 19 to 34—a group uninsured at disproportionately high rates but generally healthier than older adults—will enroll in marketplace health plans at a rate high enough to ensure the marketplaces' success. The conclusion of health insurance actuaries, health plan representatives, researchers, and federal officials invited to participate in a Commonwealth Fund meeting on the topic is that while young adult participation is important for the stability of the marketplaces and 2015 premiums, it was, and will continue to be, one of many factors that affects premiums. There is no single "right" rate of young adult participation that will guarantee success. In fact, health plan actuaries view health status for all age groups as being more important in their pricing decisions.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the author and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. To learn more about new publications when they become available, visit the Fund's website and register to receive email alerts. Commonwealth Fund pub. 1732.

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ACKNOWLEDGMENTS

The author thanks John Bertko, Ed Cymerys, and Cori Uccello, for their review of the draft; Sharon Arnold, Linda Blumberg, Gary Claxton, Michael Cohen, Nancy Delew, Chrissy Eibner, Geoffrey Sandler, and Jeff Wu for helpful comments and insights; Cathy Schoen, Don Moulds, Rachel Nuzum, Tracy Garber, Petra Rasmussen, and Jordan Kizla for helpful comments and meeting notes; and Chris Hollander, Paul Frame, and Suzanne Augustyn for editorial support and design.

Editorial support was provided by Chris Hollander.

EXECUTIVE SUMMARY

The participation of young adults in the Affordable Care Act's health insurance marketplaces has received considerable attention in the policy community and the media over the past few months. At issue is whether men and women ages 19 to 34—a group that historically has been uninsured at disproportionately high rates but is generally healthier than older adults—will enroll in marketplace health plans at a rate high enough to ensure that the marketplaces are a success.

There is little consensus, however, as to the level of young adult participation that is necessary to achieve balance in state individual market risk pools, or how important that is compared with the health status of enrollees irrespective of age. If participation by young adults is less than what insurers expected when they set premiums for 2014, what are the implications for the stability of the marketplaces and insurance premiums in 2015? In late January 2014, The Commonwealth Fund invited a group of health insurance actuaries, health plan representatives, researchers, and federal officials to discuss these and related issues. (See participant list.) This report provides an analysis of the meeting discussion. It is not intended to broadly represent the views of other experts or those of the insurance industry overall.

Young Adult Participation Less Important Than Health Status of Overall Enrollment Pool

Actuaries and researchers both agreed that while the participation of young adults in the marketplaces is important for stability of the marketplaces and 2015 premiums, it was, and will continue to be, *one of many different factors* that affects premiums of marketplace plans. In fact, young adult participation is not even the most important factor: health plan actuaries view health status—which determines what the likely use of heath care services will be—for all age groups as being more important in their pricing decisions.

In setting premiums, some health plans develop their own projections of young adult enrollment based on modeling of expected behavior under the health reform law's coverage provisions and the individual mandate to have coverage. This means that insurers' gains or losses for 2014 and the effect on 2015 premiums depend on how actual experience differs from what insurers expected. In other words, there is no single right percentage for young adult participation.

The young adult enrollment rate is less important than health status of all enrollees because carriers can still price an individual's policy based on his or her age within the law's three-to-one age bands. In other words, carriers can charge older adults as much as three times what they charge younger adults. While this gives less room for pricing variation than most states allowed prior to 2014, insurers can nevertheless still make adjustments to premiums based on age. Thus, even if enrollment among young adults is less than projected, it will potentially have less of an effect on insurers' gains or losses, according to the meeting participants, than will enrollment that turns out to be less healthy than expected. This is because insurers can no longer charge people premiums based on their health.

Health plans will need to file premiums in the second quarter of 2014 for the 2015 plan year that starts next January. Because open enrollment in the individual market and marketplaces ends on March 31, health plans will have, at most, three months of claims experience on which to base their premiums. To the extent that plan actuaries project that their 2014 premiums are less than adequate for 2014 enrollment, they will likely make an adjustment to their assumptions about plan risk pools in 2015 in order to ensure that 2015 premiums are at a sustainable level.

Several Factors Will Limit Insurers' Losses and Premium Rate Increases

Meeting participants were in agreement, however, that several factors would 1) limit losses and/or 2) temper premium increases in 2015. Factors that might limit losses include the ability to price based on age, and the Affordable Care Act's risk-sharing programs, which limit high-cost claims and offset insurer losses. In addition, a majority of enrollment in large insurance plans that comply with the law's standards may well consist of existing customers, if those customers choose to stay with their carriers. This group's health status is known

to carriers, and, since its members were previously charged premiums based on their health (before the law's 2014 reforms went into effect), they tend to be healthier than average.

The degree to which premiums increase this year is expected to be tempered, among other factors, by the health reform law's premium rate review provision, which requires health plans to justify premium increases of 10 percent or more, and the medical loss ratio requirement. This latter provision requires that plans spend a set percentage of their premiums on medical care, as opposed to profits and administrative expenses. Competition in less-concentrated markets may also temper price increases.

Health policy analysts conclude that lower-than-projected enrollment of young adults may be one of many factors that lead carriers to adjust their premiums to levels that are considered adequate, but it will not be the most important factor. Nor will lower enrollment among young adults, even in the extreme, lead to a so-called premium death spiral and market failure.

In 2014, premiums for the marketplace plans came in lower than what had been projected by the Congressional Budget Office. According to the actuaries in the Commonwealth Fund meeting, this outcome largely reflected the extensive offering of narrow provider networks, the restructuring of provider payment, and benefit design. While some degree of uncertainty will continue in health plan rate-setting into 2015, actuaries and researchers predict a gradual stabilization of the marketplaces and greater certainty among health plans when setting premiums in 2016 and beyond. While some health plans may see increasingly narrow provider networks to restrain premiums in plans this year, orher plans may view narrow networks as only one step in a long-term strategy of more fundamental changes to care delivery, including the spread of accountable care organizations.

INTRODUCTION

The participation of young adults in the Affordable Care Act's health insurance marketplaces has received considerable attention in the policy community and the media over the past few months. At issue is whether men and women ages 19 to 34—a group that historically has been uninsured at disproportionately high rates but is generally healthier than older adults—will enroll in marketplace health plans at a rate high enough to ensure that the marketplaces are a success.

There is little consensus, however, regarding the level of young adult participation that is necessary to achieve balance in state individual market risk pools, or how the relative importance of young adult enrollment to the success of the marketplaces compares with that of health status across all age groups. If the participation of young adults is less than what insurers expected when they set premiums for 2014, what are the implications for premiums in 2015 and for the very stability of the marketplaces themselves?

In January 2014, The Commonwealth Fund invited a group of health insurance actuaries, health plan representatives, researchers, and federal officials to discuss issues related to young adult participation, including:

- insurers' expectations for young adult participation in the marketplaces at the time they set plan premiums for 2014;
- how various rates of young adult participation will likely affect the financial experience of health plans in 2014 as well as insurance premiums in 2015;
- the significance of enrollee age versus health status for well-balanced risk pools;
- the effects of the Affordable Care Act's risk-sharing provisions;
- whether key conditions have changed since 2014 premium rates were set, and what the impacts are likely to be; and
- the expectations for enrollment, marketplace risk pools, and premium growth in 2016 and beyond.

This report provides an analysis of the discussion that took place. It is not intended to represent the views of the insurance industry or experts not present at the meeting.

HOW DID MARKETPLACE PLANS SET PREMIUMS FOR 2014, AND HOW IMPORTANT WAS YOUNG ADULT PARTICIPATION?

In 2013, when health insurance actuaries set 2014 premiums for marketplace plans, they faced significant uncertainty stemming from the many new variables that could potentially affect medical claims in 2014. The participation rate of young adults was only one of many interrelated factors they were considering. Other factors included:

- the Affordable Care Act's prohibition on underwriting, or setting premiums, based on health status;
- limits on what insurers may charge older adults relative to younger adults by a three-to-one ratio;
- the law's single risk pool provision, whereby new enrollees from both inside and outside the marketplaces are combined in a plan's existing pool for the purpose of setting premiums;
- the new minimum benefit standards;
- new standardized cost-sharing tiers based on a plan's actuarial value (bronze, silver, gold, and platinum), and the catastrophic plan option (for adults under age 30 and people who cannot find a plan that costs less than 8 percent of their income);
- narrow provider network products created by insurers and uncertainty about their effects; and
- the effect of the law's reinsurance program, which defrays the cost of high claims for insurers in the individual market, and the risk corridor program, which protects against large losses in the marketplaces.

Projections of Young Adult Enrollment

Some health plans such as Aetna develop their own projections of young adult enrollment based on modeling of expected behavior under the health reform law's coverage provisions and the individual mandate, according to Geoffrey Sandler, Senior Actuary, Health Policy, Aetna/Coventry. This means that insurers' gains or losses for 2014, as well as the effect on 2015 premiums, depend on how actual experience differs from what insurers expected. In other words, there is no single right percentage for young adult participation.

Some of the actuaries who participated in the Commonwealth Fund meeting expect that the first people to enroll, not only in the first year but over the next few years, will be older and sicker. They anticipate that as time goes on and the size of the penalty for not having health insurance rises, younger and healthier people will gradually enroll. Depending on the insurance carrier, premiums were set based on assumptions like these and others.

For example, according to one plan actuary's 2014 projections by age—though not necessarily representative of industry projections—enrollment of 19-to-34-year-olds in marketplace plans would account for about 29 percent of total enrollees under age 65. Enrollment for this age group was expected to account for 25 percent of enrollment in plans sold by the insurer outside the marketplaces. Thus, while some analyses and media reports have compared the enrollment rate for young adults to their share of the overall population that is eligible for marketplace plans (a commonly cited statistic is 40 percent of the eligible population), the more relevant benchmarks are the projected participation rates used by actuaries to set this year's premiums.

Limits on Insurers' Ability to Charge Older Adults Higher Premiums

Health plan actuaries and researchers at the meeting noted that the higher-than-expected number of older enrollees will be mitigated by the fact that insurers can, to a certain extent, price an individual's policy based on their age: carriers can charge older adults as much as three times the amount they charge younger adults. Although some actuaries pointed out that this three-to-one ratio is lower than what they were able to charge in most states prior to 2014, as well as lower than the expected actual cost difference across the entire age spectrum, the ability to charge older adults more—however limited that may be—is viewed as diminishing the adverse effects of higher-than-expected enrollment for this age group.

Inability to Charge People Based on Health Status

In contrast to age, health status can no longer be used in setting insurance premiums. Plan actuaries view the health status of new enrollees this year as the "big unknown." Ed Cymerys, former chief actuary of Blue Shield of California, said that uncertainty regarding the health status of their ultimate enrollment pool contributed to projections of claims costs that varied by as much as 25 percent higher or lower. Indeed, to the extent that enrollment is older and healthier, health plans actually are poised to do better, since premiums for older adults are higher. Health status, not age, is viewed as *the* critical factor for balancing the risk pool at any age level.

Single Risk Pool

Under the Affordable Care Act, premiums must now reflect the health risk of a single risk pool in a state; that is, health plan premiums are set to reflect the combined membership in plans that meet the health law's standards both inside and outside the marketplaces. Plans sold inside and outside the marketplaces must meet the same standards and are sold at the same bronze, silver, gold, and platinum benefit levels. Premiums for those plans are set for the full market, as health plans can no longer segment risk. This means that the health status of people who enroll in plans outside the marketplaces will also have an effect on overall premiums.

In addition, insurers that previously sold plans in the individual market will have members in 2014 who were enrolled in their plans prior to 2014. Some enrollment may be in grandfathered plans and thus would not be included in the single risk pool. And some

people may choose plans offered by another carrier, either directly or through the marketplaces. Yet, there was agreement among actuaries that the share of new enrollment for existing insurers will be small for many insurers that are not new entrants. For larger insurers, existing enrollment might comprise 75 percent or more of their overall enrollment. Because individuals in this pool were previously subject to underwriting, they tend to be healthier on average, and, importantly, their medical claims experience is known. This will mitigate the effects of new enrollment on overall premiums for larger insurers in markets where enrollees stay with their current carrier.

The Affordable Care Act's Risk-Sharing Provisions

Because of the considerable uncertainty surrounding the health status of enrollees in the new marketplace risk pools, Congress wrote three risk-sharing provisions into the Affordable Care Act. As Cori Uccello of the American Academy of Actuaries has pointed out, these provisions—the reinsurance program, the risk corridor program, and the risk adjustment program—were designed to 1) help ensure that carriers would be willing to sell health plans in the marketplaces even though they lost their ability to underwrite on health, and 2) decrease the incentive to avoid insuring potentially high-cost enrollees.[1] The reinsurance program limits exposure to expensive medical claims of individuals enrolled in plans both inside and outside the marketplaces. The risk corridor program limits losses as well as gains realized by plans sold through the marketplaces. Both programs are temporary; they phase out in three years, by which time it is expected that enrollment in marketplaces and health plans' certainty about their risk pools will both be greater. The risk adjustment program is permanent. (See sidebar on how these programs work.)

Reinsurance program. Meeting participants view the reinsurance program as a substantial source of funding that will considerably offset claims costs in 2014, and it was a factor in how health plans set 2014 premiums. Health plan actuaries said that the program reduced projected health care costs by 10 percent to 15 percent of their entire block of individual market business for 2014. The federal government's recent proposed changes reducing the threshold amount to $45,0000 mean that claims costs will be lowered by more than was recognized in the original pricing of 2014 premiums.

However, since the overall amount of reinsurance dollars is capped at the total amount of insurer fees collected this year, or $10 billion, there is some uncertainty about reimbursement amounts, since total payouts cannot exceed collected fees. Plan actuaries also expressed concern that the overall reinsurance pool will fall to $6 billion in 2015 and $4 billion in 2016, before phasing out altogether. This phase-out will place upward pressure on premiums in those years, though the enrollment of healthier people in 2015 and 2016 would temper this. Still, there was strong agreement that this provision of the law was a critical factor in calculating premiums this year and will continue to be important for stabilizing premiums over the next two years.

Risk corridor program. Risk corridors are designed to narrow losses and gains for insurers selling plans in the marketplaces as they gain knowledge of the health status of their enrollees. Some actuaries view this program as particularly important for new entrants to the market, and of lesser importance to large insurers. Unlike the reinsurance program, the risk corridor program is not budget-neutral: the federal government could end up paying more than it receives from health plans. However, the Congressional Budget Office is now projecting that, over the 2015–2024 budget period, risk corridor payments from the federal government to health insurers will total $8 billion, and the corresponding collections from insurers will amount to $16 billion, yielding net federal savings of $8 billion.[2] The experience in rolling out the Medicare Part D prescription drug program was similar: the government collected more in payments from health plans than they paid to plans, for a net gain of $2.74 billion.[3]

The Affordable Care Act's Risk-Sharing Programs

Reinsurance: Effective from 2014 to 2016, the reinsurance program aims to stabilize premiums in the individual insurance market during the first three years of the law's market reforms, which ban insurers from underwriting on the basis of health.[4] Under proposed rules, nongrandfathered plans sold in the individual market that experience claims costs in excess of $45,000 per individual are eligible for payments worth 80 percent of costs for expenses incurred between $45,000 and $250,000. For 2015, the federal government has proposed increasing the claims threshold to $70,000 and will also decrease the share of reimbursement.

The reinsurance program is funded through fees assessed on all health plans in the United States, including employer self-insured plans, at an amount of $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016. The program is budget-neutral: the federal government will lower payments if there is a potential that they will exceed collected fees.

Risk Corridors: The risk corridor program was designed specifically to address the uncertainty about the enrollee medical spending that insurers face when they set premiums for health plans sold through the marketplaces in 2014 through 2016. The program limits both gains and losses of insurers selling qualified health plans in the marketplaces. If an insurer's claims are much more than they expected when premiums were set, the insurer receives a payment from the federal government; if claims are much lower than expected, the insurer makes a payment. If claims are greater than 3 percent over expected claims, insurers receive a payment equal to 50 percent of the loss between 3 percent and 8 percent. If they are greater than 8 percent, they receive 80 percent of the excess loss above 8 percent. Conversely, if a plan's claims are less than 3 percent lower than expected, the plan makes a payment to the government equal to 50 percent of gains between 3 percent and 8 percent below; if they are less than 8 percent, they would make a payment of 80 percent of gains over 8 percent. The program is temporary, since premium pricing will become less uncertain as insurers acquire more knowledge of their enrollees' health status.

Risk Adjustment: The risk adjustment program is a permanent program intended to remove incentives for insurance carriers to design plans to attract the healthiest enrollees. Under the program, plans in the individual and small-group markets either receive payments from other plans in the market, if their actuarial risk (the health risk of their enrollees) is greater relative to the market average, or make payments to other plans, if their actuarial risk is less than the market average. Risk adjustment payments also flow across benefit tiers—that is, if bronze plans have enrollees with below-average actuarial risk, they might make payments to gold or platinum plans if they have enrollees with above-average actuarial risk.

HOW MIGHT VARYING RATES OF YOUNG ADULT PARTICIPATION AFFECT PLANS' FINANCIAL EXPERIENCE IN 2014 AND THEIR PREMIUMS IN 2015?

In the second quarter of 2014, just after open enrollment ends on March 31, health plans will have to file their premiums for the 2015 plan year that starts next January. The most important task for insurers will be to ascertain whether their 2014 premiums are likely to adequately cover their medical claims for the year, and whether they need to adjust the assumptions underlying their rates for 2015. Insurers will have demographic information about enrollment, including age, but there was general agreement that many more moving parts will factor into decisions about 2015 premiums than just the participation of young adults. These additional variables include the health status of their membership and the effect of regulatory and other changes since they set their 2014 rates.

Health Status of Risk Pools

The health status of their 2014 risk pools was the biggest unknown factor when insurers set 2014 premiums and, to some degree, it will continue to be uncertain as they set 2015 rates. This is because insurers will have at most three months of claims experience to judge the health status of their pools, with even less claims data for individuals enrolling toward the end of the period. Plans will also face uncertainty about the risk status of their competitors' enrollees who make up the rest of the statewide risk pool.

There was some disagreement about the adequacy of 2014 claims experience to set premiums for 2015. Recalling the rollout of the Medicare Part D program, one actuary said that insurers had had access to early claims data that allowed them to make informed decisions about their pricing for the following year. Some actuaries were less confident in their ability to assess experience based on early claims, noting that it may take longer to develop credible claims experience with medical records. Going into 2015, they said, there would be ongoing uncertainty about the health status of enrollees in marketplace plans.

Additional uncertainty exists regarding both the number and health status of people who might join plans during special enrollment periods after March 31. People can apply for health insurance after the open enrollment period under special circumstances, for example, when they lose coverage upon loss of a job or following a divorce. Based on experience, however, there was some consensus that this would be a group of people with a risk profile similar to that of the rest of the pool.

Changes in the Environment Since Insurers Set 2014 Rates

Adding to uncertainty about the health status of marketplace enrollment are changes in regulations and unexpected developments that occurred since carriers set their rates in 2014. These include the Obama administration's one-year allowance to let people with cancelled policies keep them at the discretion of state insurance commissioners, and lower-than-expected enrollment as a result of problems with the marketplace websites operated by the federal government and some of the states. Changes like these would affect the assumptions insurers make about the composition of their risk pools in 2015, as well as how many people in their plans they could spread fixed administrative costs over.

Renewals of health plans not compliant with minimum benefit standards. In November, the Obama administration decided to allow people whose coverage was cancelled to have their plans reinstated, even if these plans did not meet the Affordable Care Act's minimum benefit standards.[5] But the administration left it to each state's insurance commissioner, and health plans, to decide whether to pursue the practice. Several states had already allowed carriers to renew existing policies prior to the policy change.[6] If the people who keep their plans are healthier than average (since they were all underwritten based on health for pre-2014 coverage), their removal from the pool of people with policies that meet the law's benefit standards will lower that pool's health profile.

There is some disagreement about the likely impact of this change. While some actuaries saw this as removing healthy people from their pools, they expected the decision to have a rather limited effect, because 21 states have decided not to allow plans to extend policies, or have limited the ability of health plans to do so.[7] Still, actuaries view this as an uncertainty that could play into rate-setting in 2015.

Slow ramp-up of enrollment caused by marketplace website problems. A larger uncertainty is the total enrollment effect of technical problems with both state and federal marketplace websites. There is general concern that the difficult rollout period has slowed enrollment, particularly among people who are healthy. Health plans at the meeting reported seeing lower overall enrollment than they had projected for this point in time and larger shares of older enrollees than projected.

For example, Blue Shield of California had assumed that a high percentage of people eligible for a subsidy would sign up, noted Ed Cymerys, its former chief actuary, since the subsidy enables people to pay

only a little for a substantial benefit. But the technical glitches and complexity of signing up for the subsidy postponed the enrollment of eligible healthy people, who likely had less patience than individuals with big medical bills looming. Said Cymerys, "An individual's 'cost' is their premium, plus their time and aggravation, compared to the expected bills that the coverage would pay for."

The health plan actuary who provided projections of enrollment in the individual market, both inside and outside the marketplaces, also provided data on applications received by the beginning of January. By the beginning of January, of all applicants in marketplace plans, 25 percent were ages 19 to 34, while 23 percent were in that age range in plans outside the marketplaces. Both of these figures are close to projections. But older adults comprised 46 percent of marketplace plan applicants, higher than the projected share of 24 percent. So by January, this particular plan was seeing its enrollment skewed toward older enrollees, even though young adults were participating at expected rates.

Health plans differ in their expectations for enrollment by the end of March. Some doubt that enrollment will catch up to their projections, leading to an exacerbation of any adverse selection (causing the risk pool to skew toward poorer health risks) and an increase in administrative costs per enrollee. Others are more optimistic: they expect a second enrollment wave in March as the website issues are resolved and people, healthy men and women in particular, learn how to navigate the enrollment process and enroll in greater numbers as the March 31 deadline for coverage approaches.

Factors That Will Limit Losses and Rising Premiums in 2015

To the extent that health plan actuaries believe that their 2014 prices are less than adequate for their 2014 risk pools, they will likely make an adjustment to the assumptions about their 2015 risk pools underlying their 2015 rates. Meeting participants noted that publicly traded insurance companies will be under significant pressure from Wall Street to make adjustments to their 2015 assumptions if their 2014 pricing appears to be lower than costs in 2014. There was consensus among participants in the meeting that, if necessary, health plans are likely to make corrections in their assumptions to move to an adequate level of pricing in 2015.

There was agreement, however, that several mitigating factors would limit losses and/or limit the degree of premium increases. Factors that are expected to limit losses include:

- Only modest restrictions on the ability of health plans to price based on age.
- The health reform law's reinsurance and risk corridor programs, which lower claims costs and offset insurer losses in the first three years of the rollout.
- The single risk pool for plans with large enrollment in the individual market prior to 2014. To the extent that their members remain with them rather than shop and switch to a new plan, a majority of their enrollment may be existing members who were previously underwritten, and thus healthier, and whose claims experience is known.
- The extension of the law's Pre-Existing Condition Insurance Plan program to March 2014. Because enrollees in this program have higher medical costs, health plans will have substantially lower potential claims costs in 2014—on the order of $100 million, according to one actuary.

The degree of increase in 2015 premiums is expected to be tempered by:

- The Affordable Care Act's premium rate review provision, which requires health plans to justify premium increases of 10 percent or more.
- The law's medical loss ratio requirement, which requires that plans spend a set percentage of their premiums on medical care, as opposed to profits and administrative expenses.
- Continuing competition in less-concentrated insurance markets, though there is not an expectation of many new entrants to markets this year.

Effect of competition on premiums. Linda Blumberg and John Holahan of the Urban Institute and others have suggested that competition in less-concentrated insurance markets has been one of several factors that have kept premiums low this year, relative to Congressional Budget Office projections, in many states, and moreover will help limit premium increases in 2015.[8] Some meeting participants noted that Wall Street and shareholders will likely place pressure on publicly traded insurance companies to price products in ways that ensure costs are covered, and to revise assumptions about risk pools as quickly as possible. Both factors will likely be at play this year.

A related issue is the uncertainty carriers have regarding the health risk of their enrollees compared with the rest of the market. Under the risk adjustment program, health plans with risk greater than the market average receive payments from health plans with below-average risk. If the whole market experiences higher risk this year, the reinsurance and risk corridor programs would subsidize higher claims costs and offset losses. These programs thus also factor into insurers' views of their enrollment relative to the rest of the market and into pricing decisions.

Projections of Health Policy Researchers

Consistent with the view of actuaries, health policy analysts conclude that lower-than-projected enrollment of young adults may be one of many factors that lead carriers to adjust assumptions about their 2015 risk pools, but it will not be the most important factor. Even extremely low enrollment is not expected to lead to a so-called death spiral, where premiums increase so much that enrollment dries up and markets fail.

Using RAND's COMPARE model, Christine Eibner and colleagues Evan Saltzman and Amado Cordova estimated that 18-to-34-year-olds would comprise about 31 percent of total enrollment in 2015 inside and outside the marketplaces. Premium tax credits provide an incentive for relatively healthy people to enroll. In terms of premiums, Eibner argues that what is most important is how spending compares with what carriers are allowed to charge people based on their age. At any age, someone who is healthy and whose spending is less than the age rating allowed by the law is considered a "good risk." Eibner finds that young adults are somewhat more likely to be good risks than older adults. And for any given spending level, a healthy older person is preferable to a younger person, because the older person can be charged a higher premium.

Eibner finds that if the actual enrollment of young adults were to be 8 percentage points below what RAND COMPARE predicts, premiums might increase by 4 percent to 5 percent. However, although the COMPARE model accounts for the law's risk adjustment and reinsurance programs, it does not account for the risk corridor program. Therefore, estimates of premium change attributable to reduced enrollment of young adults would likely be lower if risk corridors were included in the calculations. Eibner found no evidence of a premium death spiral, even at very low levels of enrollment for this age group.

In a recent analysis, Larry Levitt, Gary Claxton, and Anthony Damico of the Kaiser Family Foundation estimated that young adults ages 18 to 34 comprise about 40 percent of the population that is potentially eligible for enrollment in the individual market, both inside and outside the marketplaces.[9] The researchers then conducted an exercise to determine the degree to which premiums might vary if enrollment were expected to be proportional to the potentially eligible population, but fell below that. In other words, if a health plan had set premiums assuming that enrollment of this age group would be about 40 percent of total enrollment, and enrollment ended up being somewhat less, what might be the effect on premiums in the following year as the plan revised its assumptions about its risk pool? The authors predict that if young adult enrollment ends up at 33 percent of enrollment, health care expenses, plus overhead and profits, might exceed premium revenues by 1.1 percent. If enrollment were to be about 25 percent of total enrollment, the authors predict that costs would be 2.4 percent higher than revenues. Insurers generally set their premiums to realize a 3 percent to 4 percent profit margin. Carriers thus might be expected to raise rates by 1 percent to

2 percent in 2015 to reflect revised enrollment assumptions, even in the extreme case. The researchers conclude that such increases would constitute an adjustment, rather than a death spiral.

EXPECTATIONS FOR ENROLLMENT, RISK POOLS, AND PREMIUM GROWTH IN 2016 AND BEYOND

While some degree of uncertainty will continue in health plan rate-setting into 2015, actuaries and heath policy researchers at the Commonwealth Fund meeting predicted a gradual stabilization of the marketplaces and greater certainty among plans in setting premiums for 2016 and beyond, after the first full year of claims experience is analyzed. One actuary noted that this was a multiyear process, and that it will take a few years for the market to reach new equilibriums, as the mandate penalties increase and insurers get new claims data. Linda Blumberg pointed out that while the troubled rollout of the marketplaces may have undermined enrollment in the first two months, the number of people enrolled has continued to climb now that many of those initial problems have been resolved. Enrollment will climb further as information about plan options and financial assistance is more widely disseminated, she said. Moreover, the tax associated with not having health insurance rises over the next few years, increasing the incentive for people to enroll.

Matthew Buettgens of the Urban Institute pointed out that people will gain information about insurance options through the tax-filing process: many tax software companies now include at least some Affordable Care Act subsidy eligibility information and enrollment assistance in their products. This will help boost enrollment by the end of March this year and during next year's open enrollment period, which starts in November.

In 2014, premiums for marketplace plans in most states came in lower than projected by the Congressional Budget Office. According to health plan actuaries at the meeting, this largely reflected the extensive use of narrow provider networks, the restructuring of provider payment, and benefit design. Some health plans may see increasingly narrow networks as a mechanism to lower premiums. For other plans, the use of narrow networks may be a starting point to forming accountable care organizations and other more fundamental delivery system reforms. According to one actuary, much of the low-hanging fruit has already been picked this year to achieve competitive premiums, and going forward it was going to be more challenging to look for new alternatives to address the underlying rate of medical cost inflation. But his health plan was committed to such a strategy as a means of ensuring that it will be a player in the market for the long run.

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Early State Experiences with the First Open Enrollment under the Affordable Care Act

A Maximizing Enrollment Brief

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January 2014

A product of the
Maximizing Enrollment Program

NATIONAL ACADEMY for STATE HEALTH POLICY

Robert Wood Johnson Foundation

Maximizing Enrollment is a national program of the Robert Wood Johnson Foundation with technical assistance and direction provided by the National Academy for State Health Policy.

About Maximizing Enrollment

Maximizing Enrollment has worked intensively with eight states to improve eligibility and enrollment systems, policies and procedures. This report examines how states pursued programmatic change by bringing together three key strategies: providing leadership to achieve culture change, improving data analysis to target and track policy changes, and focusing on coordination across the various state and local entities administer eligibility systems.

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Acknowledgements

The authors wish to thank the many state officials whose work and reflections informed this brief. In particular, we would like to thank state officials from Illinois, South Carolina, and Washington who shared their experiences on a Maximizing Enrollment Webinar, *State Experiences with ACA Open Enrollment: Early Successes and Lessons*. We would also like to acknowledge the leadership of the Maximizing Enrollment program, Alice Weiss, Maureen Hensley-Quinn, and Catherine Hess at the National Academy for State Health Policy (NASHP), for their guidance and editorial review and Nicole Dunifon for her technical support. Finally, we would like to thank Lori Grubstein and Andrew Hyman at the Robert Wood Johnson Foundation for their continued guidance of the Maximizing Enrollment national program.

Introduction

The Affordable Care Act (ACA) brought significant change to the United States' health insurance landscape with the goals of expanding insurance coverage, streamlining enrollment processes, and increasing access to care. The ACA's foundation is the expansion of coverage to an estimated 14 million previously uninsured Americans with the creation of health insurance marketplaces and the expansion of Medicaid for populations that historically have been ineligible for coverage.[1] To achieve the law's goals, states have developed and implemented streamlined eligibility and enrollment systems and innovative partnerships and policy solutions. States have taken varied approaches to implementing the ACA, particularly in deciding whether to expand Medicaid or to establish a state-based marketplace (SBM), federally-facilitated marketplace (FFM), or a federal-state partnership marketplace (SPM). Despite differences, all states had to build new integrated information technology systems, implement procedures to transfer data among and between state and federal agencies, adopt new income counting methodology, and establish new consumer assistance entities and processes for eligibility staff. Many of these changes had to be implemented by October 1, 2013, with the beginning of the first open enrollment period for health insurance marketplaces, which ends March 31, 2014. This brief describes state experiences from the first three months of the first open enrollment under the ACA. While many states experienced well-publicized challenges during this time, state officials worked to address issues and many employed an array of strategies and workarounds to help consumers apply for and enroll in coverage.

This brief describes components of a number of states' experiences with implementing enrollment systems in the areas of: (1) consumer education and assistance, (2) application and enrollment, and (3) Medicaid and open enrollment. Each of these areas is discussed in turn, highlighting state descriptions of challenges encountered and workaround strategies or solutions developed. In most cases, this brief reflects the *earliest* state experiences. Information was obtained from discussions among senior-level state officials at a number of National Academy for State Health Policy (NASHP) convenings during the first month of open enrollment and was supplemented by publicly available data. Between then and the issuance of this brief, states have made many changes, and taken steps to address challenges and improve the enrollment experience. These changes are important to ensuring that eligible individuals enroll in coverage and that ongoing improvements to state eligibility and enrollment operations occur. However, the early state experiences described in this brief help to document the evolution of health reform in the states and may prove instructive for states at different stages of ACA implementation as well as for planning for the next open enrollment period.

Consumer Education and Assistance

Under the ACA, all states had to implement significant changes to their eligibility and enrollment policies and systems, regardless of the state's choice to host a health insurance marketplace or expand Medicaid. To ensure the success of these changes, many states were challenged to develop and disseminate information that was straightforward for consumers while accurately conveying the complex changes to coverage and consumer assistance options. Although states faced challenges in coordinating their messaging and assistance efforts and managing a high volume of consumer queries, many worked to construct creative and cohesive strategies for assisting and relaying complex state-specific information to the public. The following sections discuss state strategies including media outreach, messaging to existing enrollees, call center operations, and the introduction of new consumer assistance entities.

Media Campaigns. Some states used statewide media and commercial advertising to reach the many individuals newly eligible for coverage through the ACA. For example, Washington's extensive marketing campaign for its state-based Health Benefit Exchange garnered significant earned media and national recognition. Washington's media strategy included memorable TV advertising, a mobile enrollment tour, innovative community partnerships, and a cohesive "Coverage is Here" brand, which was incorporated into all marketing efforts. Washington also specifically targeted the young invincible population—young adults between ages 18 to 29—who are a crucial demographic for health plans wanting to keep costs balanced. Washington created advertisements featuring images and ideas that resonate with this demographic, such as a young person snowboarding and highlighting the launch of a smart phone application. The state also engaged Death Cab for Cutie, a band originally from Washington that has gained national recognition, to increase awareness of new coverage options and encourage enrollment. Washington's media efforts also underscore the importance of flexibility—when the state experienced initial challenges with the debut of its web portal it chose to suspend some of its TV advertising in order to keep from advertising for coverage options that were temporarily unavailable. The state received positive feedback through a consumer brand perception survey and its success is also seen through its early enrollment numbers.[2] While most SBM states participated in similar marketing and branding activities, not all states, particularly FFM states, were as actively engaged as Washington in media campaigns.

Informing Existing Enrollees. In addition to reaching out to newly eligible consumers, some states proactively communicated with individuals who were already enrolled in Medicaid or the Children's Health Insurance Program (CHIP) to help them understand how the ACA affects their coverage. These messaging efforts informed current enrollees that, while the ACA makes significant changes to the way some individuals receive health insurance coverage, for many individuals already enrolled in Medicaid or CHIP, nothing would change. Some states expressed concern that individuals already enrolled may not realize that their coverage would remain the same. To help ease this concern, some states sent targeted information to these individuals. In Montana, the Medicaid agency sent flyers to current Medicaid enrollees explaining that the state would be making major changes to its Medicaid systems as part of the ACA and, while enrollees may experience hiccups, nothing should fundamentally change with their coverage. Similarly, Vermont also targeted existing Medicaid enrollees, advising them that their coverage would remain the same and that no immediate action was required in order to retain it. However, one state official in Vermont reported that these notices actually spurred some individuals to call the call center with concerns about their existing Medicaid coverage.

Managing Call Center Operations. States debuted their new integrated enrollment processes on October 1, 2013 and for many, higher than anticipated volume, website glitches, and challenges coordinating state and federal call centers significantly affected call center operations. Many states faced higher than expected call volume, receiving calls ranging from questions about coverage options and difficulty with downed websites, to those seeking to apply for coverage over the phone. Some states with FFMs also found it challenging to coordinate their state call center efforts with the federal call center. In these states, consumers who were determined ineligible for Medicaid by state call centers were referred to the FFM call center, only to have the FFM refer them back to the state. To address this issue, the federal call center worked to better train its staff about eligibility nuances, particularly around Medicaid, and relay appropriate information to consumers.

Some call centers were inundated with high consumer demand. In Washington, after launching the online application and during the first few weeks of open enrollment, the state received 4-6 times more calls than had been anticipated and experienced wait times as high as 23 minutes. To address these challenges, Washington doubled the number of customer service representatives as of mid-December 2013 and made additional resources available to help triage calls. Washington also continues to work on fixing underlying systems issues, particularly with the marketplace web portal,

which the state cites as a key driver of the high call center volume.[3] Oklahoma call centers experienced lengthier phone calls from individuals who had more questions than usual. Oklahoma increased the number of trained Medicaid call staff prior to open enrollment, which helped manage demand. While lengthy calls persisted, wait time was not an issue for Oklahoma early in the enrollment period.

In anticipation of high but unpredictable demand, Illinois, a partnership-model marketplace state, reorganized its call center infrastructure as part of its cohesive "Get Covered Illinois" strategy. The state advertised a single "Get Covered" call center phone number to initially screen callers and direct them to either the federal marketplace call center or the state's Medicaid call center, depending on their likely eligibility. Both the "Get Covered" and Medicaid call centers were well-staffed and consumers experienced wait times of less than one minute. Illinois' call center restructuring allowed the state flexibility to manage caseworker time and caseload, which has been integral to the success of its call center operations thus far. The center is able to re-orient staff between the "Get Covered" call center, which performs the key steps of screening and triaging calls, and the Medicaid call center based on where volume is highest.[4]

Consumer Assistance. Consumer assistance has been a key component of states' efforts to ensure that the adoption of the marketplace and other new eligibility and enrollment processes are successful. To aid states in helping consumers, the ACA created and funds several new assistance entities, including navigators, Certified Application Counselors, and In-Person Assisters. Most states have adopted a combination of these assister entities, and have had to quickly determine how these new entities will coordinate with existing assistance entities, such as application assisters at Federally Qualified Health Centers (FQHCs) or local health clinics.[5]

To ensure that the many consumer assistance entities in the state were coordinated, Washington formed strong community-based partnerships. The state enlisted ten lead organizations including public health districts, non-profits, and foundations throughout the state, which then subcontracted with other organizations. As of early December, the 10 lead organizations were working with 100 community-based organizations, 1,400 in-person assisters, and 2,000 agents and brokers, giving Washington a broad and community-focused consumer assistance model.[6]

Some states with additional state certification requirements for navigators and other consumer assistance entities found it challenging to meet the demand for consumer assistance in the early weeks of implementation due to delays in navigators and assisters receiving these required state certifications. For example, it was reported that in one state even after the start of the open enrollment period, many FQHC workers who already had completed assister training were still awaiting finalized privacy agreements and identification numbers from the state. Without necessary documentation of completion of the required training, these assisters had to cancel appointments with consumers. Similarly, in another state, two weeks into open enrollment, many navigators were still waiting to complete training, receive state-issued licenses or computer log-in information, or undergo background checks.[7] Despite the delays in some states, all states were able to employ existing consumer assistance workers, particularly at county and local levels, to help answer questions and enroll individuals and families into coverage.

Application and Enrollment

A major component of the ACA is its vision for streamlined application and enrollment processes, which has necessitated systemic changes for state eligibility and enrollment systems and eligibility workers. This vision for seamlessness means that states must be able to process applications, make eligibility determinations, and enroll individuals into Medicaid, CHIP, or the marketplace whether they apply online, by phone, by mail, or in-person. To achieve this "no wrong door" vision, states upgraded, replaced, and integrated eligibility system technology, implemented a simplified eligibility standard based on modified adjusted gross income (MAGI), and built and debuted online web portals that allow consumers to browse plans and purchase one that best suits their needs. States also had to decide whether to implement CMS approved targeted enrollment strategies; whether to use an expanded flat file transfer for individual account transfers or wait for the online system functionality to be ready; how to implement identity proofing; and how to report performance indicators. During the early enrollment period states experienced various challenges with the application experience and with achieving a seamless enrollment process. These challenges and examples of state strategies to address them are discussed in the following sections.

Online Applications. The ability to compare plans, purchase, and enroll through an online marketplace website is one of the core components of the ACA's transformation of an individual's enrollment experience. However, early in the open enrollment period, state and federal marketplace websites experienced well-documented technological difficulties, which delayed many marketplaces' capacity to deliver on the promise of this transformation.[8,9] The federal marketplace website, HealthCare.gov, faced significant technological challenges beginning with its debut on October 1, 2013, with the site down 60 percent of the time for the first few weeks.[10] Since then, the Department of Health and Human Services (HHS) has made significant upgrades and improvements in capacity, and as of December 1, 2013, consumers in the 36 states relying on the federal marketplace were able to more successfully shop for plans, with the website loading quicker and with fewer errors.[11]

Some SBM states also faced troubles with their online marketplace portals but many found workarounds and continued to process applications even when websites were down. Statistics from Covered California, California's health insurance marketplace show that by the end of November the marketplace had made significant improvement in processing applications and enrolling individuals in coverage, overcoming a rollout that had experienced some technical glitches. The marketplace's executive director, Peter Lee, reported that Covered California enrolled 79,981 people as of November 19, 2013 in marketplace health plans, more than doubling October's enrollment of 30,830 in less than three weeks.[12] Similarly, the Washington Health Benefit Exchange web portal experienced several brief periods of outage within the first week of its opening. However, by establishing extra server connections the state was able to relieve bottlenecks and enrolled more than 100,000 individuals in November.[13,14]

Phone, In-Person, and Paper Applications. In addition to developing an online portal for applying for and enrolling in health coverage, states were expected to create a "no wrong door" experience—whereby individuals could apply for marketplace, Medicaid, or CHIP coverage by phone, on paper, or in-person and be seamlessly enrolled in the appropriate coverage program. To help compensate for the difficulties with online applications, many states leveraged these alternative application methods.

For example, Oregon's state-based marketplace portal, Cover Oregon, experienced significant technical troubles during the early enrollment period. As of mid-January, Oregon was unable to enroll consumers into the marketplace using the online portal, and was accepting only paper applications. The state has taken steps to address technical issues with the online marketplace portal, but these

fixes have taken longer than anticipated and despite hiring additional workers to process paper applications, the state experienced a large backlog of applications.[15,16] When websites were briefly down in Michigan, New Jersey, and Washington these states also turned to paper applications as a workaround.[17] Although processing paper applications is a time consuming process, states made progress in enrolling individuals in coverage using this method while their web-based portals were offline. New Jersey, an FFM state, enlisted the aid of federally certified marketplace navigators to help enroll individuals using paper applications when HealthCare.gov was unable to enroll individuals online. Navigators in the state also directed applicants who appeared to be Medicaid-eligible to apply using the state's Medicaid website, rather than the federal website, HealthCare.gov. In Montana, the state recommended that consumers apply for coverage over the phone. Although call center wait times were high, individuals could file applications by phone more quickly than they could online. Washington hired additional eligibility workers and extended office hours in order to handle the larger than anticipated volume of paper applications.[18]

During the early enrollment period, in-person applications were less common than telephone or paper applications. A few states were concerned that local offices might be inundated with people walking in without appointments but this problem did not materialize. In New Jersey, state officials placed freestanding computers in the lobbies of social services offices in order to facilitate individuals applying in-person online rather than using paper to allow for more efficient processing.

Targeted Enrollment Strategies. CMS issued guidance in May 2013, providing states with the option to implement five time-limited targeted enrollment strategies designed to facilitate the enrollment of eligible individuals in Medicaid and relieve administrative burden during the early years of ACA implementation. Among the five strategies was the early adoption of MAGI-based eligibility determinations, which CMS approved in the District of Columbia and 15 states: Colorado, Hawaii, Illinois, Kansas, Louisiana, Missouri, Nevada, New Jersey, Oklahoma, Oregon, Pennsylvania, South Carolina, Virginia, Washington, and West Virginia.[19] This optional targeted enrollment strategy permitted states to adopt MAGI-based eligibility determination rules for *all* eligibility determinations in advance of January 1, 2014, thus avoiding having to operate two sets of eligibility rules for those eligible for Medicaid or CHIP during the marketplace open enrollment period beginning October 1, 2013. States like Virginia implemented early MAGI without much trouble, but other states experienced some technological programming challenges.

CMS' May 2013 guidance also offered states the option to use income data from the Supplemental Nutrition Assistance Program (SNAP) to identify and enroll Medicaid-eligible individuals, many of whom are newly eligible for coverage in 2014. Five states—Arkansas, Illinois, New Jersey, Oregon, and West Virginia—sent letters to SNAP recipients informing them of their opportunity to opt into Medicaid coverage. Using this option, West Virginia successfully enrolled more than 58,000 children and adults in Medicaid and CHIP and Arkansas enrolled 63,465 individuals in Medicaid and 3,000 children in CHIP.[20,21]

Identity Proofing. Identity proofing is a process by which the marketplaces and Medicaid and CHIP state agencies verify an individual's identity. After being verified, the individual can consent to the use of certain federal and state data to make an eligibility determination for coverage in the marketplace, Medicaid, or CHIP.[22] CMS is providing a remote identity proofing (RIDP) service to marketplace, Medicaid, and CHIP agencies through the federal data services hub. Some states, including South Carolina, were initially concerned that the RIDP service would only work for a small subset of individuals in the state. However, a state official in South Carolina reported that RIDP worked successfully during the early enrollment period—most individuals referred for identity proofing moved through the system and obtained a final assessment. In addition, from October to November 2013, South Carolina saw improvement in the RIDP process in the form of a reduced error rate, from 8.1 to

4.7 percent. A state official in South Carolina shared that the early success of RIDP is a good indicator that moving populations towards online applications will be successful in the state.[23]

South Carolina's experience with identity proofing is an example of how RIDP can be useful for states. However, there also have been reports of challenges with identity proofing in multiple states.[24,25] Even in South Carolina, 18.9 percent of individuals applying for coverage were unable to use identity proofing due to a lack of credit history, suggesting that perhaps at its best, identity proofing may be an imperfect tool.[26] An official from one state said that preparing for RIDP was a challenge because the state had not anticipated the level of intensity and resources required to implement it, and had not budgeted accordingly. Another state experienced issues with identify proofing certain populations, namely minors, but was working with CMS to address this.

Account Transfers. As part of the "no wrong door" approach to coverage under the ACA, all states have to coordinate and electronically transfer applicant accounts to ensure eligibility determination for the appropriate insurance affordability program. To facilitate this coordination, Medicaid agencies in FFM or SPM states chose to receive either an initial assessment of Medicaid eligibility or to accept a final Medicaid eligibility determination for individuals who apply through the marketplace. The account transfer is intended to effectuate the seamless "no wrong door" enrollment process by preventing applicants from having to provide the same information more than once for eligibility determinations once they apply for a single health insurance affordability program. However, due to the technological challenges experienced during this first enrollment period, CMS delayed account transfers, which were slated to begin October 1, 2013. This delay meant that states with FFMs were not initially able to enroll individuals either determined or assessed to be eligible for Medicaid or CHIP.

The delay in the account transfers was a concern for many states with FFMs. One state official shared that the delay created messaging challenges in her state, which is not expanding Medicaid. Having to convey what coverage and/or financial subsidies are available to whom, along with changes to coverage programs, and the delayed enrollment timeframes made developing an easily understood message challenging. To work around the challenge of the delayed account transfers, Illinois implemented strategies to minimize the need for transferring applications from one program to another. The state did this by helping individuals seeking coverage to apply directly with the coverage program for which they were most likely eligible. For those calling the "Get Covered" call center, the eligibility screen facilitated this. Consumers in Illinois were informed that they can submit applications for coverage through both the state call center for Medicaid and the FFM website or call center. Messaging around these strategies was complex, but the state wanted to prevent applicants from having to wait for an eligibility determination until the account transfer issues were addressed.

In November 2013, CMS issued guidance providing states with a time-limited option to enroll individuals in Medicaid or CHIP based on an expanded flat file transfer from the FFM. The flat file is not a full electronic account for an individual but does contain sufficient data for states to identify an individual and the FFM's determination or assessment of Medicaid or CHIP eligibility. CMS originally intended for states to use the flat file to simply anticipate staff workload and consumer demand in advance of full account transfer functionality.[27] In January 2014, CMS augmented the personal data that could be transferred as part of the expanded flat file transfer to include both income and gender data, making this information more usable for state processing needs. Once the full electronic account transfer is operational, state application and enrollment processing will occur as originally intended. For states, the option to enroll eligible individuals into coverage based on the flat file transfer must be weighed against the opportunity cost for doing so. For example, states may need to consider what, if any, programming changes need to occur for eligibility and enrollment systems to enroll individuals based on the flat file.

One important consideration for FFM and SPM states is whether they chose to have the FFM assess or determine eligibility for Medicaid. Determination states allow the marketplace to make full MAGI-based eligibility determinations for Medicaid, which are accepted by the state. Assessment states accept only an initial assessment of Medicaid eligibility by the marketplace—applicant files are electronically transferred from the marketplace to the state Medicaid agency in order to conduct an eligibility review and any necessary additional verifications.[28] For FFM determination states, enrollment based on the flat file is complete and will be valid for the full 12-month Medicaid enrollment period. By contrast, for FFM assessment states, enrollment based on the flat file only lasts for 90 days, after which time the state will have to do a new determination.[29] Once the account transfer is available, these states will need to complete processing cases using the full data set. This likely means that assessment states taking up the flat file enrollment option will have to process enrollments twice.

Performance Indicators. In October 2013, states began reporting on a set of 12 eligibility and enrollment performance indicators including enrollment, call center volume, wait times, and call abandonment rates.[30] CMS requested that states provide three months (July, August, and September 2013) of baseline data for the performance indicators, and established a schedule for the weekly and monthly reporting of the performance indicators. Some states were unsure about the usefulness of the baseline data, but reported it as best they could. Other states were unable to report the baseline on some measures because they did not collect that data. For example, some states historically have not collected data on processing time and had to provide instruction to state employees on how to calculate this measure. Some states indicated that in addition to the performance indicator data requested by CMS, they are collecting and analyzing other data such as how long it takes to complete an application (Alabama), complaints from consumers (Rhode Island), and consumer satisfaction (New Jersey) to help assess the state's overall performance during the first open enrollment period. Early analyses of the eligibility and enrollment performance indicator data and associated processes for reporting, analyzing, and interpreting the data find that the indicators mark a significant improvement in timely and high-quality data reporting for Medicaid and CHIP, which has historically been inconsistent.[31]

Medicaid and Open Enrollment

The open enrollment period, which runs from October 1, 2013 through March 31, 2014, has been a critical time for establishing enrollment through the new health insurance marketplaces, but it has also meant a boost in Medicaid enrollment. Although enrollment in Medicaid can occur at any time during the year, this first ever open enrollment period for the marketplaces coincided with significant state and national attention on enrollment, efforts to simplify enrollment processes in Medicaid, and the ACA's "no wrong door" approach, all of which helped to increase enrollment.

All states experienced an increase in Medicaid enrollment during the early open enrollment period—states expanding Medicaid experienced a 15.5 percent increase in the number of applications received in October and states not expanding Medicaid experienced a 4.1 percent increase. A total of 3.9 million individuals were determined eligible for Medicaid and CHIP as of the end of November 2013.[32] The HHS Assistant Secretary for Planning and Evaluation reported that from October 1 to November 30, 268,974 individuals were determined or assessed to be eligible for Medicaid or CHIP by the FFM itself.[33] While many states, particularly those expanding Medicaid, expected an increase in the number of Medicaid eligible individuals, non-expansion states made different assumptions about how many eligible but not enrolled individuals would enter the program. For example, South Carolina projected a 16 percent increase in its Medicaid enrollment, whereas three states (Louisiana, Maine, and Wisconsin) projected a decrease in Medicaid enrollment for FY 2014.[34]

During the first months of open enrollment, Medicaid enrollment outpaced enrollment in qualified health plans (QHPs) and some states experienced an increase in enrollment among those who were previously eligible for Medicaid but not enrolled. For example, in the first week of October, Washington enrolled 5,946 newly eligible individuals—adults with incomes up to 133 percent of the federal poverty level who are newly eligible under the state's Medicaid eligibility expansion—into Medicaid coverage effective January 1, 2014. Washington also enrolled an additional 2,594 individuals who were eligible for immediate Medicaid coverage based on pre-2014 eligibility standards.[35] By the end of October, the state had enrolled a total of 55,367 individuals—about 54 percent were enrolled in Medicaid coverage beginning January 1, 2014, 34 percent were immediately enrolled in Medicaid coverage, and 13 percent enrolled in a QHP in the marketplace.[36] Kentucky had a similar experience with Medicaid enrollment far outpacing marketplace enrollment during the early open enrollment period. As of January 2, 2014, a total of 123,543 individuals had enrolled in coverage, of which 73 percent had enrolled in Medicaid and 27 percent had enrolled in a QHP.[37] The increases in Medicaid enrollment will have implications for state program staffing, strategies to ensure access to providers, and budgets, which will have to be addressed in 2014 and future years.

Conclusion

With the introduction of health insurance marketplaces and the expansion of Medicaid, the ACA expands health insurance coverage options to millions of uninsured individuals, and makes significant changes to how states structure and operate their eligibility and enrollment processes. Given the substantial scope and volume of changes states undertook in preparation for open enrollment, it is not surprising that some states experienced challenges in the early months. Many of the challenges in states have been well-publicized. However, despite the difficulties and glitches, many states rose to the occasion, implementing backup strategies, adjusting approaches, and redistributing resources so that as many of their consumers seeking health insurance coverage could obtain it. As 2013 year-end enrollment data demonstrate, state adjustment strategies helped to promote enrollment for 3.9 million individuals eligible for Medicaid and CHIP and 2.2 million individuals eligible for marketplace coverage.

States have already identified a number of challenges and issues that will warrant attention in the coming months and future open enrollment periods. Ensuring strong and effective communication and coordination with state and federal partners, including call centers, federally certified navigators, and other consumer assistance entities will be critical to success. Building on the lessons learned during this first marketplace open enrollment period—such as anticipating periods of high demand and implementing effective strategies for responding—could help states ensure smooth and efficient open enrollment periods in upcoming years.

State and federal agencies also will want to ensure that the technical tools they are relying on to support enrollment are both functional and effective. While investments have been made to make tools such as the federal remote identity proofing service as effective as possible, South Carolina's experience is an early indication that there are limitations to RIDP's effectiveness for certain individuals. To maximize the integrity of the enrollment process, consideration of alternative methods for identity proofing may be warranted. The reporting of performance measures provides an important opportunity to enable data-driven analysis of the enrollment experience. Over time, with greater state experience with collecting the measures and improved consistency in reporting, there should be opportunities to assess the effectiveness of state enrollment processes and identify areas for improvement.

Since the earliest weeks of the open enrollment period, states have made many systems and operational improvements, and as data are now showing, enrolling millions of consumers into coverage. Despite the rapidly changing landscape, the early experiences of states can offer useful perspectives for understanding current and future approaches for implementing new coverage options and streamlined eligibility systems.

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STATE HEALTH POLICY

Briefing

A PUBLICATION OF THE NATIONAL ACADEMY FOR STATE HEALTH POLICY

JANUARY 2014

Shared Responsibility in Consumer Assistance: Examples from Federally Facilitated and Partnership Marketplace States

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State Health Policy Briefing provides an overview and analysis of emerging issues and developments in state health policy.

Many states that are utilizing a Federally Facilitated Marketplace (FFM) or that established a marketplace in partnership with the federal government (SPM) are working to minimize the potential for consumer confusion by coordinating with federal systems and building on their historical experience to regulate and deliver health insurance to their residents. This brief explores ways in which states are sharing the responsibility of consumer assistance with the federal marketplace in three key areas: marketing and advertising initiatives, the work of navigators and other in-person assisters, and the development of a system for eligibility decision appeals. This brief provides specific examples of states utilizing the FFM or those partnering with it for consumer assistance, and illustrates some of the ways that FFM and SPM states can work with their existing consumer assistance structures and with the federal government to help consumers find their way in a new coverage landscape.

Robert Wood Johnson Foundation

NATIONAL ACADEMY for STATE HEALTH POLICY

Introduction

With the Affordable Care Act (ACA), the federal government took an active role in assuring consumers access to affordable health insurance. But the ACA relies heavily on existing state and private systems that predate it. Today, the federal and state governments—and various agencies within a state—share responsibility for Medicaid, the Children's Health Insurance Program (CHIP), and marketplaces. In this first year of implementation, these agencies must work together to conduct consumer outreach and education, provide enrollment support, and consider eligibility determination appeals so that consumers have a smooth experience applying for health coverage. Many states that are utilizing a Federally Facilitated Marketplace (FFM) or that established a marketplace in partnership with the federal government (SPM) are working to minimize the potential for consumer confusion by coordinating with federal systems and building on their historical experience to regulate and deliver health insurance to their residents.

This brief explores ways in which states are sharing the responsibility of consumer assistance with the federal marketplace in three key areas. The first section discusses coordination between states and the FFM or SPM on marketing and advertising initiatives. States have devised ways to share the responsibility with the federal government for getting the word out about new health insurance options. Some states utilizing or partnering with the FFM have developed their own marketing strategies to raise awareness of new insurance affordability program (IAP) options by expanding their public websites to provide information on the law, or developing state-specific branding for use in mass media and online advertising.

Next, the brief explores how states are coordinating the work of navigators and other in-person assisters in FFM and SPM states. State Medicaid, CHIP, and insurance departments offer walk-in assistance and operate long-established call centers to answer consumers' questions and work with individuals as their circumstances change. Some FFM and SPM states are coordinating these existing consumer assistance functions with new federal assisters by cross-training staff or by referring consumers to the new marketplace consumer assistance entities.

The brief's final section focuses on how state Medicaid agencies in FFM and SPM states are coordinating with the federal government to develop a system for consumers who wish to appeal decisions about their eligibility for insurance affordability programs (IAP). States are connecting their systems with federal systems to ease documentation burdens for these consumers.

Each of the three sections includes examples from states utilizing the FFM or those partnering with it for consumer assistance. These examples illustrate some of the ways that FFM and SPM states can work with their existing consumer assistance structures and with the federal government to help consumers find their way in a new coverage landscape.

Marketing and Advertising

Research shows that the very people most likely to benefit from health insurance marketplaces are those least likely to know about the marketplaces and the plans sold there.[1] People who have been denied insurance in the past, or who have been unable to afford insurance, are skeptical that any available, affordable coverage will also be high-quality coverage.[2] Thus, there is a need for marketing and public information to allay these concerns by presenting the facts about marketplaces and health insurance plans and options available. The federal government, as well as some of the states that are hosting an FFM or SPM, launched marketing and advertising campaigns to inform the public about these marketplaces. The federal government and some state governments have also established websites and call centers to respond to consumer inquiries.

Federal Marketing and Advertising of the FFM

The federal government has marketed health insurance marketplaces via a website and through television, radio, and print advertisements.[3] In August 2013, the federal government relaunched an updated HealthCare.gov, the official consumer site for the FFM, with new information about the federal marketplace and subsidies. The federal government also contracted with the public relations firm Webber Shandwick to develop radio and television ads that raise consumer awareness of federal marketplaces.[4] The Department of Health and Human Services (HHS) allocated 12 million dollars in television advertisements that ran across 12 FFM states beginning September 30, 2013. The number of states and the cost of the campaign are expected to grow during the first open enrollment season.[5] Federal marketing of the FFM also includes partnerships with sports franchises and celebrity personalities, with the latter targeted toward younger populations.[6,7]

The FFM Website and Call Center

The federal marketplace website, www.healthcare.gov, provides information about marketplaces and allows for open enrollment, which began October 1, 2013. The website includes a live chat feature available 24 hours a day, seven days a week. The website also lists a toll free number to a continually staffed call center. The Centers for Medicare & Medicaid Services (CMS) is responsible for the operation of the call center, which serves customers using the FFM and SPM. Call center representatives provide general information and answer questions related to consumer eligibility, plan

comparisons, and enrollment. Where possible, call center representatives also help consumers enroll in plans or provide referrals to local in-person assistance programs.[8]

State Marketing and Advertising Options

In addition to federal marketing and advertising of the FFM, states have options to advertise FFMs and SPMs. With approval from the Department of Health and Human Services, states may conduct activities to promote the FFM and SPM. These activities may include state-branded consumer assistance websites as well as earned and paid media.[9] Communications experts recommend tailoring marketing and advertising messages to specific target audiences and aligning messages promoted through media with those delivered individually (e.g., by enrollment agencies and other state agencies that interact with target audiences).[10]

State Case Study – A State Marketing and Advertising Campaign

In **Arkansas**, an SPM state, a variety of methods have been used to market and advertise the marketplace. The state's early advertising campaign, branded "Get in," included a broad media approach using television and radio advertisements, grassroots-level print media in over 120 small town newspapers, and billboard covers on high traffic roads. Initial television advertisements that ran through September 30, 2013 used a "Get informed" message as the first step in the "Get in" campaign.[11] In an effort to reach consumers of varying demographics and geographic areas, the state used social media, including Facebook, and advertised on popular online services like Hulu and Pandora. The state also planned advertising of the SPM at venues such as the Arkansas State Fair, local festivals, and events like the "Race for the Cure." These efforts were designed to be particularly effective in reaching rural Arkansans. Finally, the state produced bus wraps delivering the "Get in" message to an urban audience.

State Website and Call Center Options

CMS is allowing states to create state-branded consumer assistance websites that link to the FFM website. States can also customize their residents' experience of the federal marketplace website. While the name of the federal marketplace and the federal marketplace website URL will remain constant across states, states have the option to include state-specific icons, such as a flag or seal, on the state-specific sections of the federal marketplace website.[12]

Although consumers in FFM and SPM states will use the federal call center for enrollment and any other questions, some states have negotiated with the federal government to establish telephone resource centers to help triage consumers.[13] This option may be appealing, since states already run call centers through their Medicaid programs and departments of insurance to help consumers with enrollment and health insurance questions. A telephone resource center can provide a single phone number for consumers, who can then be routed to the appropriate state or federal call center to meet their needs.

State Case Study – State-branded Marketplace Website

In **Arkansas**, the state tailored the look and branding of the FFM's online portal and the state's in-person assistance (IPA) website. The process started with convening focus groups to determine consumer preferences in terminology. Based on consumer feedback, the state chose the branding: "Arkansas Health Connector, Your Guide to Health Insurance." Arkansas is using this branding for its entire marketplace outreach and education program. The state also changed the name of the state insurance department division overseeing this work to align with the branding. The state's Arkansas Health Connector website links directly to the federal marketplace portal.

State Case Study – State Resource Center

As an SPM state, **Illinois** secured approval to run a telephone resource center.[14] The resource center serves as a "front line" resource to answer consumers' basic questions regarding the marketplace. The resource center can route consumers' calls to one of four call centers: 1) the call center for the state Medicaid office; 2) the state Department of Insurance; 3) the federally-staffed SPM call center; or 4) the federally-staffed Small Business Health Options Program (SHOP) call center. The resource center does not provide eligibility determinations for Medicaid or the SPM. Instead, staff administers screening

questions to assess whether callers are likely to be newly Medicaid eligible, eligible for a marketplace plan, or if they have insurance and require further consultation. The resource center also assists callers with locating consumer assisters in their areas. The resource center helps the Medicaid and SPM call centers to focus on their primary responsibilities of eligibility and enrollment. Illinois expects the resource center to improve the consumer experience by reducing the number of consumers who start at the "wrong" call center (state Medicaid versus SPM).

State Case Studies – State Consumer Assistance Websites

In federal marketplace states where the state has not assumed consumer assistance functions, state insurance departments and insurance commissions have developed websites for consumers, with general information about the Affordable Care Act (ACA) and health insurance available through the federal marketplace.

- **Kansas** – The state insurance department developed the website, www.insureks.org, with the tagline: "Get the facts. Get informed. Get insured." The website links to the federal marketplace portal for Kansas, and includes information about insurance rates and plans. Website visitors can search a database for in-person assistance by geographic area and can use an online calculator to estimate their monthly premium payments and available tax credits in the marketplace. Through an interactive tutorial narrated by an animated character named "Alex," website visitors can learn about health care changes under the ACA, tailored to their individual circumstances. The tutorial utilizes software developed by the multimedia company Jellyvision Lab and is accessible in both English and Spanish. Finally, the website includes additional resources in the form of video and print materials, and embeds the state insurance department's Twitter page, providing real-time updates.
- **Montana** – The state insurance commission developed the website, montanahealthanswers.com, to assist Montanans' understanding of health insurance under the ACA. The website includes general information about the marketplace, insurance benefits, Medicare and Medicaid, and a list of contacts for navigators, Certified Application Counselors (CACs) and registered Montana Insurance Agents, known as Certified Exchange Producers. The website also includes information directed to employers and to specific populations such as tribal members, farmers, and ranchers. Website visitors can submit questions to the insurance commission, and receive answers within five business days. The website also lists upcoming public informational meetings led by the state's Commissioner of Insurance and Securities.
- **South Carolina** – The state insurance department has expanded its website, www.doi.sc.gov, to include sections on the ACA and the federal marketplace in South Carolina. Website visitors can access information targeted to small businesses, learn about key provisions of the law that take effect immediately, and link to webinars, slide decks, and brochures in English and Spanish that support consumers' understanding of the ACA and the FFM. The website also includes a summary chart of approved qualified health plans by metal level in the individual and small group market available as of January 1, 2014.

Navigators and Other In-person Assistance

Marketing and advertising help raise consumer awareness of IAPs, but individuals may need assistance to complete the application process and follow through to enrollment. HHS is sharing consumer research with states for their use in outreach and education, and has encouraged states to use this information to develop their own outreach efforts. States are developing ways to link their historical in-person assistance programs to new programs established through the ACA.

Navigators and other in-person assistance programs are integral to achieving the ACA's goals of increasing coverage and offering "no wrong door" entry to insurance coverage. Consumer assistance programs funded by the ACA include: navigators, IPAs, Certified Application Counselors (CACs), agents and brokers,

and federally qualified health centers (FQHCs). The consumer assistance landscape will vary slightly depending on which marketplace model the state has chosen.[15] All State-based Marketplaces utilize navigators and CACs and some may have an IPA program, although it is optional. SPMs that perform consumer assistance functions also engage navigators, IPAs, and CACs. FFMs have only a navigator and a CAC program; there is no federal IPA program. The federal government stipulates training requirements for in-person consumer assisters.[16] States also have the option to create additional certification requirements for these consumer assistance programs. States can work with and through the various types of assisters to help ensure consumers are enrolled in appropriate health coverage.

Consumer Assistance Options by Marketplace Model

Exchange Models	Navigators	IPAs	CACs	Health Centers	Agents and Brokers
SBM	SBMs award navigator grants.	SBMs can choose to have IPAs.	SBMs certify CACs.	The Health Resources and Services Administration (HRSA) awarded outreach grants to over 1,000 federally qualified health centers (FQHCs) in all states.	SBMs decide the role of brokers.
Consumer Assistance Partnership[17]	The federal government awards navigator grants.	SPMs award IPA grants.	The federal government certifies CACs.		The FFM requires agent/broker registration.
FFM		Not available.			

Table adapted from Enroll America Fact Sheet

Program Landscape in FFM and SPM States

Navigators

Navigators are established in the ACA and have specific statutory and regulatory requirements related to their functions and conflicts of interest. Navigator duties include: public education, maintaining expertise in eligibility and enrollment, providing information in a manner that is fair, impartial and culturally and linguistically appropriate, facilitating Qualified Health Plan (QHP) selection, and making appropriate referrals to other agencies.[18] Navigators in FFM and SPM states may not be a health insurance issuer or a subsidiary of an issuer, or an association that lobbies on behalf of the insurance industry, and may not receive compensation from issuers for enrolling individuals in QHPs.[19] Navigator programs in both FFM and SPM states are federally funded and federally selected. Navigators in FFM and SPM states are required to complete certification training online and annual recertification is required.[20,21] In 2013, CMS awarded navigator grants to 105 organizations in 33 states, totaling $67 million dollars.[22]

In-person Assisters (IPAs)

In-person assisters perform many of the same functions as navigators and are held to the same conflict of interest requirements as navigators. They are similarly required to complete training, receive certification, and comply with specific cultural and linguistic accessibility requirements. The FFM does not have IPAs; only SPMs that have

assumed consumer assistance functions are required to establish this program (SBMs may choose to utilize IPAs). States are responsible for selecting and compensating IPAs, but distinct from navigators, states may use federal marketplace establishment grant funding to pay IPAs.

State Case Studies – Navigators and IPAs

In SPM and FFM states, navigators and CACs are federally selected and funded, and some of these states are working creatively with these entities to ensure that consumers have the information and assistance they need when applying for new coverage. Illinois developed state-specific training to help navigators understand the state landscape, while Kansas and Nebraska are providing consumers with information about their options and where they can find in-person assistance.

- **Illinois: State-specific requirements and training** – The state partnered with the University of Illinois at Chicago School of Public Health (UIC) to develop state-specific training for IPAs in Illinois. In conjunction with UIC, the state developed a three-day training schedule: one day of online training, followed by two days of in-person training. The online training focuses on roles, responsibilities, ethics, and an ACA overview, while the in-person training focuses on state-specific programs and issues. The curriculum includes information on the ACA for assister organizations that may be new to health care. Navigators and assisters are required to complete the training; CACs are required to complete a modified online training of about six hours.

  Illinois has also integrated federal navigators into activities and processes with their in-person assisters by distributing relevant policy guidance and outreach tools to navigators, including them in weekly webinars with state assister grantees, and assigning regional outreach coordinators employed by the state to IPAs and navigators to monitor activity and ensure that their needs are being met.

- **Kansas: Online tools for consumers and assisters** – Kansas has developed a state-specific website, www.insureks.org, to provide consumers in the state with information on how the marketplace works, what premiums they might pay, tax credits for which they might be eligible, and where they can find in-person assistance.

  The Kansas Insurance Department is a part of the Kansas Marketplace Consortium led by the Kansas Association for the Medically Underserved, a navigator grant awardee.[23] Through this partnership and by partnering with issuers, the department has developed a directory of navigators, brokers and CACs that are available to Kansans. The website allows users to search by zip code or to see all assister organizations sorted by city. The site also has a tax credit calculator that incorporates the actual cost of the second lowest cost silver plan, adjusted for age and region. The tool is helpful not only to consumers, but also to agents/brokers and navigators. The state has also held in-person assistance events around the state to educate consumers, with navigator and issuer participation at some of the events. Finally, the state has developed a statewide calendar of navigator-led events that is updated weekly.

- **Nebraska: Online information and tools to link consumers with assisters** – Nebraska has developed an informational website, www.nehealthinsuranceinfo.gov, including information about the marketplace, a glossary of terms, frequently asked questions (FAQs), and details about options for individuals and small businesses under the ACA. Nebraska requires navigators and other consumer assistance entities receiving federal money for enrollment assistance activities to register with the state. The resulting registration database has allowed the Department of Insurance to create a list of approved navigators in the state, including names and addresses, so that consumers are able to easily find assistance.[24] The state also plans to provide a list of FFM-certified brokers available once HHS releases that information.

Certified Application Counselors (CACs)

Certified Application Counselors are a volunteer role designed to help provide consumers with information about their coverage options and with applying for coverage.[25] CACs are not required to perform outreach and are not held to the same strict cultural and linguistic accessibility requirements as federal navigators

and IPAs. They must complete training, disclose any potential conflicts of interest, act in the "best interest" of applicants, and comply with privacy and security requirements.[26] In FFM states, CACs will be limited to providers, community health centers, hospitals, and social service agencies, are unpaid, and are certified by CMS. There is no limit to the number of organizations that can be designated as CACs.[27]

Agents and Brokers

Agents and brokers will continue their traditional roles in helping consumers select and enroll in private insurance plans. In SPM and FFM states, agents and brokers must complete training and register with the FFM in order to sell QHPs in the FFM. The federal marketplace will not pay commissions; agents and brokers will continue to receive commission from issuers.[28] Brokers are also not required to display all QHPs when assisting consumers, but must adhere to all state laws, regulations, and marketplace requirements.

Community Health Centers

The Health Resources and Services Administration (HRSA) awarded outreach and enrollment grants to more than 1,100 FQHCs across the country to enroll uninsured consumers. The funding will allow health centers to expand their existing outreach and enrollment activities, as well as to facilitate enrollment of eligible patients and service area residents into Medicaid, CHIP, or the marketplace.[29] The grants total $208 million dollars and include all 50 states, Washington, D.C., Puerto Rico, and four additional territories.[30] There are training requirements for health center staff that conduct outreach and assess program eligibility: in FFMs and SPMs, health center grantees must apply for CAC designation and must ensure that employees complete the CAC training.[31]

Additional State Requirements

Navigators must comply with all state licensure requirements, as long as those requirements do not interfere with the provisions of the ACA.[32] Navigators also cannot be required to be licensed brokers as a condition of being navigators. The Commonwealth Fund has identified 17 states (14 FFM states and three SPM states) that established rules for navigators.[33] These additional requirements include provisions for training and licensure, registration and reporting requirements, financial requirements, and restrictions on the type of advice navigators can provide to consumers. Some states are also requiring licensure of IPAs and/or CACs. Some of these requirements are being challenged in the court system, and it remains to be seen how courts will interpret the requirement that these state laws not prevent the application of the ACA.[34]

Appeals of Eligibility Determination for Medicaid and Advanced Premium Tax Credits

Under the ACA, individuals have a right to appeal determinations of eligibility for Medicaid and Advanced Premium Tax Credits (APTC). If a consumer believes that he is eligible for Medicaid or for an Advanced Premium Tax Credit but was denied eligibility, he can file an appeal to be given a "second look" at his application. The right to appeal a determination of eligibility is not an addition to the rights of applicants, but the ACA established new regulations to make the process seamless between Medicaid and marketplaces. Individuals also have a right to appeal a decision about determination of an individual exemption from the mandate to carry health insurance,[35] but this brief does not discuss these appeals, nor does it discuss appeals based on categorical Medicaid eligibility such as aged, blind, or disabled. It only discusses appeals of Modified Adjusted Gross Income (MAGI)-based eligibility, which includes income rules, as well as non-financial eligibility rules such as immigration status.[36]

Appeals of Medicaid Eligibility Decisions

Medicaid agencies have long been required to have an appeals process in place. The new marketplaces must also have an appeals process. Medicaid and marketplaces are required to coordinate appeals to make sure that the process is fair and minimally burdensome for consumers.[37] In all states, including states with an FFM, the state Medicaid agency decided how Medicaid appeals would be handled. States could choose from three options. States may opt to: 1) process all appeals within the Medicaid agency; 2) delegate all appeals to the marketplace; or 3) delegate all appeals to a third-party state agency.

Many state Medicaid agencies have chosen the agency that makes the original eligibility determination to also handle any appeals of Medicaid eligibility. States that choose to delegate appeals must do so through a written, formal process that specifies roles and establishes operational protocols and oversight responsibilities.[38] Regardless of the agency chosen to handle appeals, application information must be shared across all agencies involved in the initial application and any appeal. Applicants cannot be asked to produce any documents that they have already submitted as part of their application.[39] Even when a state Medicaid agency delegates authority to hear appeals to the marketplace (state or federal), in most cases,[40] individual consumers maintain the right to request an appeal directly through the Medicaid agency.

Administration of Appeals by the State Medicaid Agency

In states that chose this option, the Medicaid agency will hear appeals for all consumers appealing eligibility determinations for Medicaid. Individuals must be allowed to file their appeal through telephone, mail, in person, or by email; states can opt to also allow filing through a website.[41] During 2014, states may use a paper-based process if necessary, but after this first year, states must process appeals electronically.[42] A consumer must file an appeal within 90 days or within the time frame established for Medicaid, but this cannot be less than 30 days.[43]

State Medicaid agencies may choose to adopt an informal resolution process to remedy issues before resorting to formal appeals.[44] In this process, appeals staff and consumers can work to determine the accuracy of supporting documents, submit updated documents, and review the case.[45] If the consumer is not satisfied with the result of the informal resolution, the case will then continue through the formal appeals process.

State Case Study - Medicaid Agency Hears Appeals

New Hampshire is a partnership marketplace state (SPM) that has decided to process appeals within the Medicaid agency. New Hampshire is an assessment state, relying on the FFM to assess, but not make the final determination, of Medicaid eligibility. Historically, appeals for all New Hampshire State benefit programs, such as Medicaid and the Supplemental Nutrition Assistance Program (SNAP), are heard by the Administrative Appeals Unit of the state Department of Health and Human Services (HHS). New Hampshire decided to keep this system of hearing appeals through HHS and to make no significant changes to the appeals process.

Delegation of Medicaid Appeals to the FFM

States that are using the FFM to determine (rather than assess) eligibility for Medicaid may choose to delegate appeals to the FFM. In this case, HHS will hear appeals for both Medicaid and APTC eligibility determinations. States officially select this option using the state's rulemaking process to establish a Medicaid regulation.[46] For consumers who have their appeals heard by the HHS appeals entity, seeking an informal resolution is a required first step.[47] If the consumer is not satisfied with the informal resolution, he may continue through the formal resolution process.

Importantly, individuals in states that delegate appeals to HHS maintain their right to have a Medicaid appeal heard by the state Medicaid agency. A consumer who chooses to appeal directly to the Medicaid agency may subsequently appeal to HHS. Alternately, if they appeal to HHS and are not happy with the result, they may choose to have a fair hearing with the Medicaid agency. If the consumer does not choose to use the Medicaid agency, the HHS decision stands but is subject to Medicaid legal review.[48]

State Case Study – Delegation of Appeals to FFM

Montana, which uses the FFM to determine, rather than only assess Medicaid eligibility, opted to delegate appeals to the federal marketplace. Since the FFM will be determining eligibility, the state Medicaid agency felt that the FFM is in the best position to show what data were used to determine a person's eligibility for Medicaid and thus best suited to process appeals.

Delegation of Medicaid Appeals to a Third-party State Agency

State Medicaid agencies may choose to delegate Medicaid appeals to a third-party state agency using authority in the Intergovernmental Cooperation Act of 1968 (ICA).[49] The ICA waiver option has existed for decades, however the ACA added new requirements that states must follow, including using a written agreement that outlines the Medicaid agency's oversight

responsibilities. In states that delegate to a third party agency using the ICA waiver process, a consumer may appeal only to this third party agency. The consumer has no right to appeal through the Medicaid agency.[50]

State Case Study – Delegation of Appeals to Third-party State Agency

Illinois is a partnership marketplace state (SPM) that has elected to have the marketplace assess Medicaid eligibility, leaving the state to complete the final eligibility determination. The Medicaid agency, the Department of Healthcare and Family Services (HFS), will handle Medicaid appeals for most of the consumers who have applied only for Medical assistance. HFS' sister agency, the Department of Human Services (DHS), will handle Medicaid appeals that also involve applications for SNAP, Temporary Assistance for Needy Families (TANF) or other support programs, and appeals involving disability determinations. The division of appeals function reflects how original determinations of eligibility are made: appeals by consumers whose applications are processed by HFS will be heard by HFS, while appeals by consumers whose applications are processed by DHS, including all who apply for multiple HHS benefit programs, will be heard by DHS.

The delegation of eligibility determinations and appeals to DHS was set up prior to the enactment of the ACA. The state is now working with CMS to formalize this relationship in the federally-required state plan amendment governing administration of the Medicaid program in Illinois under the ACA. The Medicaid agency will retain oversight and monitoring duties, which will include random audits, case reviews, and reports.

State Medicaid Agency Involvement in Appeals of APTC Eligibility Decisions

If an individual has been found Medicaid-ineligible and subsequently files an appeal of APTC eligibility or cost-sharing, that appeal triggers an appeal of the Medicaid eligibility decision, avoiding the need for a person to submit appeals requests to different agencies.[51] In FFM states, the marketplace will notify the Medicaid agency of the appeal using an electronic interface, but how the two agencies will work together to resolve the appeal was still being worked out at the time of this writing.

The ACA's "no wrong door" policy requires Medicaid agencies and marketplaces to work together to ensure every consumer is enrolled in the correct IAP. The goal of a seamless enrollment experience for consumers extends to the eligibility determination appeals process. State Medicaid agencies have generally chosen to send Medicaid appeals to the agency that first determined eligibility. Similarly, since the FFM is determining eligibility for Advanced Premium Tax Credits, many states appear to be leaving APTC appeals to the federal government. In both cases, Medicaid agencies and marketplaces must share information to correctly and efficiently resolve appeals. It is a bit unclear how the transfer of information for APTC appeals is being implemented in FFM states at this time. As consumers file appeals and agencies gain experience in sharing information to review eligibility determinations, the mechanics of APTC appeals in FFM states should become clearer.

Conclusion

As ACA implementation unfolds during 2014 and beyond, states will continue to play a key role in providing education, outreach, and assistance to consumers selecting, enrolling in, and transitioning between IAPs. The state examples included here show that even states not running their own marketplaces can still play a big role in the success of their residents applying for and enrolling in health coverage.

After the first open enrollment period ends, consumer assistance will continue to be an important function for both federal and state governments. Additional marketing and outreach is also needed to ensure all consumers are aware of their options for IAPs. Some consumers will need in-person assistance when life or family circumstances change their eligibility for IAPs, or when making IAP decisions. And when eligibility determinations are complex, consumers will rely on a streamlined appeals process to ensure they are enrolled in the appropriate IAP. As IAPs serve a broader group of Americans, the federal and state governments will need to work together to educate consumers, update in-person assister training, and assure smooth data transfer between federal and state systems. States will likely refine and improve the ways they are working with the federal government as the provisions of the ACA are fully implemented.

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Acknowledgments:
The writing of this brief was supported by the Robert Wood Johnson Foundation. Under the umbrella of RWJF's State Health Reform Assistance Network (*State Network*), the National Academy for State Health Policy (NASHP) has provided complementary analysis to benefit states beyond *State Network*, with a focus on addressing state roles in Federally Facilitated Marketplaces. The authors would like to thank Katie Baudouin and Kaitlin Sheedy, Policy Specialists at NASHP, for their editing of the brief; Catherine Hess, Managing Director at NASHP, for her review; Christina Miller, Policy Specialist at NASHP, for her insights into the experience of FFM states; and Sarabeth Zemel, Program Manager at NASHP, for her regulatory analysis. The authors also gratefully acknowledge all of the state officials who willingly shared their experiences and contributed to the examples provided in this brief.

Citation:
Rachel Dolan, Jacqueline LeGrand, Julien Nagarajan, and Katharine Witgert, *Shared Responsibility in Consumer Assistance: Examples from Federally Facilitated and Partnership Marketplace States*, 2014 (Portland, ME: National Academy for State Health Policy).

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