Reports and Research

Table of Contents

May 22, 2014 Board Meeting

- *Drivers of 2015 Health Insurance Premium Changes* – **American Academy of Actuaries**
  May, 2014

- *Eight Million and Counting: A Deeper Look at Premiums, Cost Sharing and Benefit Design in the New Health Insurance Marketplaces* – **Breakaway Policy and Robert Wood Johnson Foundation**
  May, 2014

- *Health Reform: Designing a Marketplace: A State-by-State Comparison of Marketplace Implementation* – **Center on Budget and Policy Priorities**
  May, 2014

- *Insurance Cancellations in Context: Stability of Coverage in the Nongroup Market Prior to Health Reform* – **Health Affairs**
  May, 2014

- *Realizing Health Reform's Potential: The Federal Medical Loss Ratio Rule: Implications for Consumers in Year 2* – **The Commonwealth Fund**
  May, 2014

- *What to Expect for 2015 ACA Premiums: An Actuary Opens the Black Box* – **National Institute for Health Care Management**
  May, 2014

- *Why Not Just Eliminate the Employer Mandate* – **Robert Wood Johnson Foundation and Urban Institute**
  May, 2014

- *Individual Market: Insights into Consumer Behavior at the End of Open Enrollment* – **McKinsey Center for U.S. Health System Reform**
  May 8, 2014

- *Did California Just Save 2300 Lives by Expanding Obamacare? Let's do the Math* – **California Healthline**
  May 7, 2014

- *Exchange Enrollment Outpaces Expectations in 22 States* – **Avalere**
  May 6, 2014

- *New State-Based Marketplaces Unlikely in 2015, but Technology Challenges Create More Shades of Gray* – **The Center on Health Insurance Reforms (Georgetown University Health Policy Institute)**
  May 2, 2014

- *Health Insurance Exchange Compare: Benefit Design and Cost Sharing Information for Health Plans in all 50 States* – **Robert Wood Johnson Foundation**
  May 1, 2014

- *Measuring Marketplace Enrollment Relative to Enrollment Projections: Update* – **Urban Institute**
  May 1, 2014

- *Deciphering the Data: State-Based Marketplaces Spend Heavily to Help Enroll Consumers* – **Leonard Davis Institute of Health Economics (University of Pennsylvania) and Robert Wood Johnson Foundation**
  April, 2014

- *Exchange Consumer Experience Analysis* – **Avalere**
  April, 2014

- *Improving Integration of Dental Health Benefits in Health Insurance Marketplaces* – **National Academy for State Health Policy**
  April, 2014

- *Measuring Changes in Insurance Coverage Under the Affordable Care Act* – **The Henry J. Kaiser Family Foundation**
  April, 2014

- *Small Businesses and Health Reform: Results from a Survey of Five States* – **Mathematica Policy Research**
  April, 2014

- *The Best Evidence Suggests the Effects of the ACA on Employment Will be Small: Timely Analysis of Immediate Health Policy Issues* – **Urban Institute**
  April, 2014

- *Aiming Higher: Results from a Scorecard on State Health System Performance, 2014* – **The Commonwealth Fund**
  April 30, 2014

- *Reform Update: States that did not Expand Medicaid May See Higher Premiums, Industry Experts Say* – **Modern Healthcare**
  April 22, 2014

- *Deadlines for the HHS Secretary and Other Federal Entities in the Patient Protection and Affordable Care Act Through March 23, 2013: Addendum to CRS Congressional Distribution Memorandum Dated April 5, 2011 (Memorandum)* – **Congressional Research Service**
  April 21, 2014

- *Looking at Costs and Risks, Many Skip Health Insurance* – **The New York Times**
  April 21, 2014

- *ACAView: Measuring the Impact of Health Care Reform: Metrics that Assess the ACA's Impact on Providers, Patients and Physicians* – **Robert Wood Johnson Foundation**
  March, 2014

- *Covered California* – **Government Technology Magazine**
  March, 2014

American Academy *of* Actuaries

ISSUE BRIEF

MAY 2014

Key Points

- Much of the uncertainty regarding the health spending by plan enrollees that existed when insurers submitted their 2014 rates remains for 2015.
- How 2015 premiums change from 2014 will depend on how assumptions regarding the composition of the risk pool differ from those assumed for 2014.
- Other major drivers of 2015 premium changes include the reduction of reinsurance program funds and the underlying growth in health care costs.

Additional Resources

- How Will Premiums Change under the ACA? (May 2013).

Drivers of 2015 Health Insurance Premium Changes

The Affordable Care Act's (ACA) 2014 open enrollment period for the individual health insurance market ended on March 31 and health insurers are already developing premium rates for the 2015 plan year. Insurers must submit their 2015 premiums to state and federal regulators this spring, with final approval decisions by the fall. Open enrollment for 2015 will begin November 15.

This brief outlines factors underlying premium rate setting generally and then highlights the major drivers behind why 2015 premiums could differ from those in 2014. It focuses on the individual market, but considerations for the small group market are similar.

Premiums Reflect Many Factors

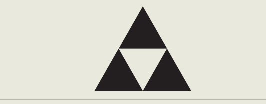
Actuaries develop premiums based on projected medical claims and administrative costs for a pool of individuals or groups with insurance.

Who is covered—the composition of the risk pool

Pooling risks allows the costs of the less healthy to be subsidized by the healthy. In general, the larger the risk pool, the more predictable and stable premiums can be. But, the composition of the risk pool is also important. Although the ACA prohibits insurers from charging different premiums to individuals based on their health status, premium levels reflect the health status of an insurer's risk pool as a whole. If a risk pool disproportionately attracts those with higher expected claims, premiums will be higher. If a risk pool disproportionately avoids those with higher expected claims or can offset those with higher claims by enrolling a large share of

The American Academy of Actuaries is an 18,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

©2014 The American Academy of Actuaries.
All Rights Reserved.



American Academy *of* Actuaries
Objective. Independent. Effective.™

1850 M Street NW, Suite 300, Washington, DC 20036
Tel 202 223 8196, Fax 202 872 1948
www.actuary.org

Mary Downs, Executive Director
Charity Sack, Director of Communications
Craig Hanna, Director of Public Policy
Cori Uccello, Senior Health Fellow
Heather Jerbi, Assistant Director of Public Policy

lower-cost individuals, premiums will be lower.

Projected medical costs

The majority of premium dollars goes to medical claims, which reflect unit costs (e.g., the price for a given health care service), utilization, the mix and intensity of services, and plan design.

Other premium components

Premiums must cover administrative costs, including those related to product development, enrollment, claims processing, and regulatory compliance. They also must cover taxes, assessments, and fees, as well as profit (or, for not-for-profit insurers, a contribution to surplus).

Laws and regulations

Laws and regulations can affect the composition of risk pools, projected medical spending, and the amount of taxes, assessments, and fees that need to be included in premiums.

Major Drivers of 2015 Premium Changes

Composition of the risk pool and how it compares to what was projected

Premiums for 2015 will reflect insurer expectations regarding the composition of the enrollee risk pool, including the distribution of enrollees by age, gender, and health status. How 2015 premiums change from 2014 will depend on how assumptions regarding the composition of the 2015 risk pool differ from those assumed for 2014.

When calculating 2014 premiums, insurers made assumptions regarding the characteristics of individuals obtaining coverage—in terms of demographics, health status, prior health insurance status, etc.—and what their medical spending would be. There was much uncertainty regarding these assumptions because insurers had only limited experience data on individuals who would be newly insured in the post-reform market.

Although insurers now have information regarding the age and gender of their 2014 enrollees, they still will have only limited information on enrollee health status when 2015 premiums need to be determined, in light of the reporting lag between when health care services are provided and when claims are processed by insurers. Practitioners are observing that while some insurers are seeing 2014 enrollee demographics fairly similar to what they projected, others are seeing an older-than-expected enrollee population. In general, higher-cost individuals are more likely to enroll early during the open enrollment period and in the first year of the program. Lower-cost individuals are more likely to enroll later during the open enrollment period and perhaps in later years as the individual mandate penalty increases. Insurers will need to make assumptions regarding the extent to which the increase in the mandate penalty and overall awareness of the program increases enrollment in 2015 beyond that in 2014.

In addition, because the ACA risk adjustment program shifts funds among insurers depending on the relative health status of an insurer's population to that of the entire market, insurers need to consider not only the risk profile of enrollees in their own plans, but also the risk profile of enrollees in the market as a whole.

Other factors also will affect the composition of the 2015 risk pool and its impact on premiums, including:

The primary drafters of this publication are the Academy's Senior Health Fellow Cori E. Uccello, MAAA, FSA, FCA, MPP, and Shari Westerfield, MAAA, FSA.
Members of the Health Practice Council include: David A. Shea Jr., MAAA, FSA, vice president; Karl Madrecki, MAAA, ASA, vice-chairperson; Michael S. Abroe, MAAA, FSA; Rowen B. Bell, MAAA, FSA; Karen Bender, MAAA, ASA, FCA; Kristi Bohn, MAAA, FSA, EA; April S. Choi, MAAA, FSA; Jennifer L. Gillespie, MAAA, FSA; Audrey L. Halvorson, MAAA, FSA; Warren R. Jones, MAAA, ASA; Laurel A. Kastrup, MAAA, FSA; Darrell D. Knapp, MAAA, FSA; Mita Lodh, MAAA, FSA, FCA; Catherine M. Murphy-Barron, MAAA, FSA; Nancy F. Nelson, MAAA, FSA; Michael E. Nordstrom, MAAA, ASA; Donna C. Novak, MAAA, ASA, FCA; Jeffrey P. Petertil, MAAA, ASA, FCA; Geoffrey C. Sandler, MAAA, FSA; John J. Schubert, MAAA, ASA, FCA; Sudha Shenoy, MAAA, FSA, CERA; P.J. Eric Stallard, MAAA, ASA, FCA; Michael J. Thompson, MAAA, FSA; Cori E. Uccello, MAAA, FSA, FCA, MPP; Shari A. Westerfield, MAAA, FSA; Thomas F. Wildsmith, MAAA, FSA; and Dale H. Yamamoto, MAAA, FSA, FCA, EA.

- **Single risk pool requirement.** The ACA requires that insurers use a single risk pool when developing rates. That is, experience inside and outside the health insurance marketplaces (aka exchanges) must be combined when determining premiums. Premiums for 2015 will reflect demographics and health status factors of enrollees both inside and outside of the marketplace, as was true for 2014.
- **Transitional policy for non-ACA-compliant plans.** For states that adopted the transitional policy that allowed non-ACA-compliant plans to be renewed, the risk profile of 2014 ACA-compliant plans might be worse than insurers projected. This would occur if lower-cost individuals retain their prior coverage and higher-cost people move to new coverage. The transitional policy was instituted after 2014 premiums were finalized, meaning insurers were not able to incorporate this policy into their premiums. For most states, the transitional policy for 2015 is known in advance and can be incorporated into assumptions regarding the composition of the 2015 risk pool. The impact on premiums could be greatest in states that had large, heavily-underwritten individual markets in place prior to 2014.
- **State-by-state variations.** Health insurance enrollment, and the composition of that enrollment, is often presented on a national basis. However, health insurance premiums are set at the state level (with regional variations allowed within a state) and will reflect state- and insurer-specific experience. For instance, enrollment volume and the composition of the risk pools could be worse than projected in states with ineffective outreach efforts and/or technical problems with the marketplaces. Insurers will incorporate that experience into their 2015 premium assumptions to the extent they expect such trends to continue. Insurers also will incorporate information on whether the state adopted the transitional policy for non-ACA-compliant plans and whether states are allowing that policy to continue through 2015.

Importantly, if actual experience regarding the risk profile of 2014 enrollees differs from assumptions and losses occur in 2014, insurers cannot recoup past losses through higher premiums for 2015. Instead, assumptions for 2015 will be reset incorporating available 2014 experience. As noted above, however, insurers will have only a few months of incomplete experience data prior to filing their 2015 rates.

Reduction of reinsurance program funds

The ACA transitional reinsurance program provides for payments to plans when they have enrollees with especially high claims, thereby offsetting a portion of the costs of higher-cost enrollees in the individual market. This reduces the risk to insurers, allowing them to offer premiums lower than they otherwise would be. Funding for the reinsurance program comes from contributions from all health plans, including not only plans in the individual market, but also those in the small and large group markets, as well as self-insured plans. These contributions are then used to make payments to ACA-compliant plans in the individual market.

For the 2014 plan year, $10 billion will be collected from health insurers and used to pay plans in the individual market when an individual's claims exceed $45,000. Insurers will be reimbursed for 80 percent of these individuals' health claims between $45,000 and $250,000. For the 2015 plan year, the amount collected for the reinsurance program will decrease to $6 billion, and it is anticipated that insurers will be reimbursed for 50 percent of an individual's health claims between $70,000 and $250,000. For the 2016 plan year, collections are scheduled to decrease further, to $4 billion. No further collections are scheduled.

The reduced reinsurance funds available for 2015 and 2016, coupled with a potential in-

crease in enrollment in the individual market, will reduce the per enrollee reinsurance subsidy. By providing less of an offset to premiums, the reduction in reinsurance funds will result in an increase in premiums. Reinsurance program payments for 2014 generally reduced projected net claim costs by about 10 to 14 percent.[1] For 2015, projected reinsurance program payments will likely reduce net claims by about 6 to 8 percent, due to the reduction in total reinsurance funds. This lower reduction in claims translates to about a 4 to 7 percent increase in projected claims, due only to the reduction in the reinsurance program and not factoring in any other factors such as medical trend or risk pool changes.

Underlying growth in health care costs

The increase in costs of medical services, referred to as medical trend, reflects not only the increase in per-unit costs of services, but also increases in health care utilization and intensity. In recent years, health spending growth has been low relative to historical levels. There is, however, some uncertainty regarding the causes of these trends and whether they will continue. The recent economic downturn and slow recovery have contributed to the slowdown. More structural changes to the health care payment and delivery system also may have contributed to slower health spending growth, through for instance a greater focus on cost-effective care or a slowdown in new medical technology. Premiums for 2015 will reflect assumptions regarding the extent to which the recent slowdown will persist.

Other Drivers

Changes in provider networks

In 2014, many insurers shifted to narrower provider networks to keep premiums affordable. Narrower networks can give insurers more leverage to negotiate lower provider payment rates, and they also can be used to direct enrollees to more cost-effective and high-quality providers. Broadening provider networks could put upward pressure on premium increases.

Changes in provider reimbursement structures

Any increased negotiating power among providers could put upward pressure on premium increases. On the other hand, insurers could pursue changes in provider reimbursement structures that move from paying providers based on volume to paying based on value. For example, accountable care organization structures offer incentives to provide cost-effective and high-quality care. Such efforts could put downward pressure on premium increases.

Benefit package changes

Changes to benefit packages (e.g., through changes in cost-sharing requirements or benefits covered) can affect claim costs and therefore premiums. This can occur even if a plan's metal level remains unchanged.

Risk margin changes

Insurers build risk margins into the premiums to reflect the level of uncertainty regarding the costs of providing coverage. These margins provide a cushion in case costs are greater than projected. Greater levels of uncertainty typically result in higher risk margins and higher premiums. Changes to the level of uncertainty regarding claim costs or other aspects of ACA provisions can cause changes to the risk margins. For instance, the ACA risk corridor program will now be implemented on a budget neutral basis. This could increase the risk of insurer losses if premiums are set too low. As a result, insurers

---

[1] Originally, the reinsurance program was scheduled to reimburse 80 percent of health claims between $60,000 and $250,000. Premiums filed for 2014 reflected these reinsurance program parameters. Subsequently, the reinsurance attachment point was lowered from $60,000 to $45,000. Further pro rata changes to these parameters are possible if total reinsurance funds collected differ from the total claims submitted for reimbursement.

could increase their risk margin to reflect the additional risk associated with pricing uncertainty.

Market competition

Market forces and product positioning also can affect premium levels and premium increases. Insurers might withstand short-term losses in order to achieve long-term goals. Due to the ACA's uniform rating rules and transparency requirements imposed by regulators, premiums are much easier to compare than before the ACA, and some insurers lowered their premiums after they were able to see competitors' premiums.

Changes in administrative costs

Any changes in administrative costs also will affect premiums. For instance, changes can result from increased costs associated with ACA implementation or from spreading fixed costs over a different than projected enrollment base.

Increase in the health insurer fee

In 2014, the ACA health insurer fee is scheduled to collect $8 billion from health insurers. The fee will increase to $11.3 billion in 2015 and gradually further to $14.3 billion in 2018, after which it will be indexed to the rate of premium growth. The fee is allocated to insurers based on their prior year's premium revenue as a share of total market premium revenue. In general, insurers pass along the fee to enrollees through an increase to the premium. The effect on premiums will depend on the number of enrollees over which the fee is spread—a greater number of enrollees will translate to the fee being a smaller addition to the premium. The increase in health insurer fee collections from 2014 to 2015 will, in most cases, lead to a small increase in 2015 premiums relative to 2014. Certain insurers may see larger increases, however, such as CO-OPs that did not write business in 2013 and therefore were not subject to the fee in 2014.

Changes in geographic regions

Within a state, health insurance premiums are allowed to vary across geographic regions established by the state according to federal criteria. Changes in the number of geographic regions in the state or how those regions are defined could cause premium changes that would vary across areas. For instance, assuming no other changes, if a lower-cost region and a higher-cost region are combined into one region for premium rating purposes, individuals in the lower-cost area would see premium increases, and individuals in the higher-cost areas would see premium reductions.

Summary

The 2015 health insurance premium rate filing process is underway, as insurers are preparing and submitting their premiums to state and federal regulators for review. Much of the uncertainty regarding the health spending by plan enrollees that existed when insurers submitted their 2014 rates remains for 2015. Although insurers have information on enrollee demographics, only limited information will be available on enrollee health status and health spending.

How 2015 premiums differ from those in 2014 will depend on many factors. Key drivers include how the composition of the risk pools for 2014 compares to what was projected (to the extent this is identifiable), the reduction of funds available through the temporary reinsurance program, and the underlying growth in health costs. How enrollment differs from expected will vary by insurer and by state, with larger premium increases possible in states that adopted the transition policy allowing non-ACA-compliant plans to be renewed.

Other factors potentially contributing to rate changes include any modifications to: provider networks, provider reimbursement structures, benefit packages, risk margins, administrative costs, or geographic region definitions. The increase in the health insurance fee could put upward pressure on premiums if it is not offset by a commensurate increase in enrollment. Insurers also incorporate market considerations when determining 2015 premiums.

Eight Million and Counting:
A Deeper Look at Premiums, Cost Sharing and Benefit Design in the New Health Insurance Marketplaces

Monitoring the ACA's Health Insurance Marketplaces | May 2014

SUMMARY OF FINDINGS

In partnership with the Robert Wood Johnson Foundation (RWJF), Breakaway Policy Strategies has compiled and is making available to the public in open source a comprehensive dataset (HIX Compare) containing (1) premium information for all 7,027 Silver plans being sold through the new Affordable Care Act (ACA) health insurance exchanges (Exchanges) and (2) benefit design and cost sharing requirements for all 1,208 unique* Silver Exchange plans. HIX Compare is being released as part of RWJF's Reform by the Numbers initiative to make available timely and unique data about the impact of health reform.

Breakaway believes that HIX Compare will serve as a valuable resource to researchers, consumers and other health care stakeholders seeking to better understand the nature of health coverage offered through the ACA's Exchanges. In this report, for example, Breakaway has used HIX Compare to analyze premiums, deductibles and limits on out-of-pocket expenses under Exchange plans. Specific findings included:

- Exchange plan premiums vary widely between states and among rating areas within states. Across all Silver plans, the national average premium is $265 per month for a 27 year-old individual, $435 per month for a 50 year-old individual, and $878 for a family of four. The lowest and highest plan premiums are found in Minnesota and Virginia, respectively. Most premiums fall below the national average for self-only coverage under employer-sponsored insurance (ESI) plans, which was $491 per month in 2013, though Silver plans' actuarial value is about 15 percentage points below the average premium available through ESI plans.
- Many Exchange plans subject health care services such as primary care physician (PCP) visits and prescription drugs to a deductible, a benefit design feature which is not as common in ESI plans.
- Of the 1,208 unique Silver plans analyzed, approximately half (641) offer combined deductibles under which medical and prescription drug expenses accumulate to a single deductible. The average combined deductible for those plans is $2,267.
- Among the 1,208 unique plans, 1,150 had a combined out-of-pocket maximum (OOP Max), meaning that medical and prescription drug expenses accumulate to the same OOP Max.

**A unique plan is a plan with a specific benefit design offered by a particular insurer. Unique plans may be offered across multiple rating areas. Benefits and cost sharing remain constant but premiums may vary across areas.*

Implementation of the Affordable Care Act (ACA) has brought about a wave of changes to the way that health care coverage is provided in our country, affecting everything from the cost of health insurance to the way that insurers manage risk and cover certain health benefits. In addition to new regulations and consumer protections, the state-based health insurance marketplaces (Exchanges) through which much coverage is being sold stand to broadly influence how Americans obtain health insurance and the nature of the coverage in which they enroll/purchase.

To better understand the types of health insurance coverage available to consumers through the Exchanges, Breakaway Policy Strategies (Breakaway) partnered with the Robert Wood Johnson Foundation (RWJF) to compile and make available to researchers, health care stakeholders and the general public a comprehensive dataset (HIX Compare) detailing benefit design, premium and cost sharing information for the 7,027 Silver-level health plans being offered in the health insurance marketplaces of all 50 states plus the District of Columbia. Specifically, HIX Compare includes the following information:

- Premiums
- Deductibles
- Out-of-Pocket Maximums
- Copayments/Coinsurance for:
    - Primary Care Physician (PCP) Visits
    - Specialist Visits
    - Inpatient Hospital Stays
    - Emergency Room Services
    - Ambulatory Services
    - Prescription Drugs

Given the potential implications of the Exchange plans for the health insurance market as a whole, as noted above, Breakaway and RWJF are making HIX Compare available to researchers, consumers and other health care stakeholders in open source. HIX Compare data will be made available in an Excel format so that it is readily accessible to consumers and other health care stakeholders. HIX Compare will also be posted in .txt format for easy use in most statistical packages. This version will be coded to reflect 305 variables associated with various types of plan benefit design and cost sharing features. By providing HIX Compare in this format, we hope to provide researchers with a comprehensive source of information on Exchange plans to enable them to conduct their own market analyses. In addition, Breakaway intends to update HIX Compare on an annual basis so that researchers and others can examine emerging and historical trends in Exchange health coverage through longitudinal data.

One month after the Exchanges launched, in November 2013, Breakaway and RWJF issued a joint report, *Looking Beyond Technical Glitches: A Preliminary Analysis of Premiums and Cost Sharing in the New Health Insurance Marketplaces* (Report I), the first in a series called "Monitoring the ACA's Health Insurance Marketplaces." In that report, we provided a snapshot of averages and ranges of premiums and deductibles associated with the second-lowest cost Silver plans (SLCSPs) across 96 rating areas in 15 states, 11 state-based exchanges (SBEs) and four federally facilitated exchanges (FFEs)[1]. Report I also provided the averages and ranges of copayment and coinsurance amounts applicable to in-network PCP and specialist visits.

In this more in-depth report, we analyze data for all 7,027 Silver-level plans and cost sharing data for all 1,208 unique Silver plans in the more than 500 rating areas[2] across all 50 states (plus the District of Columbia), focusing on premiums, deductibles and out-of-pocket maximums. Future reports will take a closer look at:

- Cost sharing for PCP and specialist physician visits, prescription drugs and hospital services;

- Discrepancies between the cost sharing information in the summaries of benefits and coverage (SBCs) published by insurance carriers and the information in the individual market landscape file posted by the Centers for Medicare & Medicaid Services (CMS Data); and

- Differences in average premiums, deductibles and physician visit cost sharing between states with standardized benefits and a number of states with non-standardized benefits.

Beyond the ACA Exchanges

Implications for Employer-Sponsored Insurance and Private Exchanges

On April 17, the Obama administration announced that 8 million people had signed up for health insurance coverage through the Exchanges. The announcement came just days after the Congressional Budget Office (CBO) released its latest report on the budgetary effects of the ACA's insurance coverage provisions in which CBO estimated that six million individuals will have insurance coverage through the Exchanges in 2014. (See Figure 1.) The discrepancy between the two figures may be attributable, at least in part, to the fact that CBO's estimate, unlike the Administration's, is an average for 2014 that accounts for variations in exchange plan enrollment throughout the year—such as increases during special enrollment periods and drops in exchange plan coverage from individuals who later shift to Medicaid or employer plans. CBO's estimate also does not include individuals who fail to pay their initial plan premiums or lose coverage at any point in 2014 for not continuing premium

payments. In contrast, the Administration's current enrollment numbers include both individuals who have paid their premiums and those who have not.

Whether the actual number of enrollees turns out to be 6 or 8 million individuals, it is a small population compared to the roughly 149 million people covered in the employer-sponsored insurance (ESI) market.[3] CBO estimates, however, that enrollment in Exchange plans will increase substantially in 2015 and 2016, and then gradually increase and level off from 2017 to 2024. In fact, in its latest report, CBO estimates a more rapid increase in enrollment in 2016 and 2017 than previously projected. In addition, the cost sharing and benefit designs of the new Exchange plans, which have the government's seal of approval as having met ACA requirements, may influence cost sharing and benefit design in ESI (including ESI offered through new private exchange markets) over time.

Data Sources

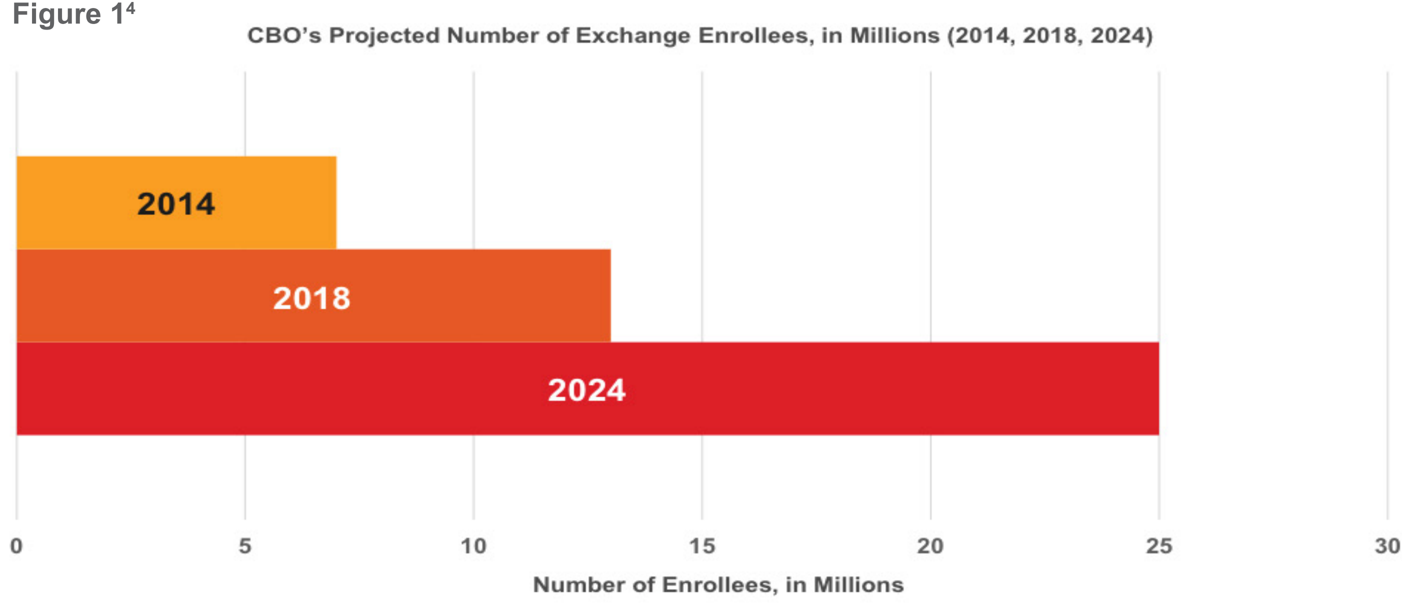
From October 1, 2013 through January 1, 2014, Breakaway collected premium and in- and out-of-network cost sharing information for: a 27 year-old individual, a 50 year-old individual, a single parent with two children and a family of four. For SBEs, Breakaway obtained all benefit design and cost sharing data from the state health insurance Exchange websites. In cases where information was not available through the state Exchange website, Breakaway obtained the necessary data directly from SBCs posted on the insurance carriers' websites (SBC Data). If a carrier did not post the SBC for a plan(s), Breakaway used other plan information posted by the carrier. Where information in the SBC conflicted with other plan information posted by the carrier, Breakaway utilized the information provided in the SBC.

For FFEs and partnership exchanges, Breakaway obtained all premium and cost sharing information from the individual market landscape file posted by CMS.[5]

In the course of compiling the data, Breakaway found that some cost sharing information varied by source. Specifically, Breakaway observed that the CMS Data and SBC Data sometimes contain conflicting information on deductibles, prescription drug cost sharing, and other variables. To better understand the magnitude of these discrepancies, Breakaway reviewed 25 percent of all of the unique Silver plans in each of the 50 states, plus the District of Columbia. To ensure that a sufficient number of issuers were accounted for in the sample, we supplemented the sample to include at least one plan offering from each distinct issuer in each state. Breakaway also included a mix of plan types in its comparative analysis (i.e., HMO, PPO, HSA). This methodology yielded a sample of 344 Silver-level plans. This review revealed that approximately 40 percent of the plans studied have at least one discrepancy between the CMS Data and the SBC Data. Given the potential implications of these inconsistencies for consumers and other stakeholders, Breakaway is continuing to study their scope.

When the cost sharing information provided on an Exchange or carrier website was incomplete or unclear, Breakaway made an effort to obtain the information by contacting the carrier directly. If the carrier was unable to clarify or provide the information, the data was not included in the analysis. In the limited cases where insurance premiums were not available through the state Exchange website or carrier website, Breakaway did not include the plans in HIX Compare.

Figure 1[4]



It should be noted that the premiums and cost sharing figures reported here do not reflect the premium tax credits[6] or cost sharing reductions (CSRs) for which many enrollees are eligible. According to one recent analysis,[7] as of the end of February, 83 percent of Exchange plan enrollees were eligible for premium subsidies, with 21 percent of those eligible actually applying for assistance. While total and average subsidies were found to vary by state, the analysis estimated that 3.5 million people had qualified for a total of about $10.0 billion in annual premium subsidies, an average of about $2,890 per person. To date, there are no comprehensive statistics on the total number of Exchange plan enrollees eligible for CSRs but at least two states have looked at the percentage of enrollees in their Exchanges who are eligible for subsidies and CSRs (all individuals eligible for CSRs also are eligible for premium subsidies). In its December 2013 Enrollment Report, NY State of Health reported that 50 percent of its enrollees (75,516 individuals) were eligible for subsidies and CSRs.[8] In its February 2014 Enrollment Report, Washington Health Plan Finder reported that 58 percent of Exchange enrollees (60,352 individuals) were eligible for CSRs.[9]

Exchange Plan Premiums

As we noted in our initial report, premiums vary from state to state and among rating areas within individual states. Across all 7,027 Silver plans, the national average premium is $265 per month for a 27 year-old individual, $435 per month for a 50 year-old individual, and $878 for a family of four. Under many plans, the family deductible is roughly twice the amount of the individual deductible. The lowest and highest plan premiums are found in Minnesota and Virginia, respectively. For a 27 year-old individual, premiums range from a low of $126 in Minnesota to a high of $1,858 in Virginia. For a 50 year-old, premiums range from a low of $215 in Minnesota to a high of $3,167 in Virginia. For a family of four, premiums range from a low of $452 in Pennsylvania to a high of $1,848 in Colorado.[10] (See Figure 2.) While these variations across and within states are important for understanding overall cost patterns, it should be noted that individual consumers are selecting from among plans within a given rating area, where the range and average will be based on local circumstances.

The national average and ranges of premiums for a 27 year-old individual and 50 year-old individual, as well as the averages and ranges for the ten states with the highest expected Exchange enrollment are shown in Figure 3, on the next page. As was expected, most premiums fall below the national average of self-only coverage under ESI plans, which was $491 per month in 2013. (See Figure 3.)

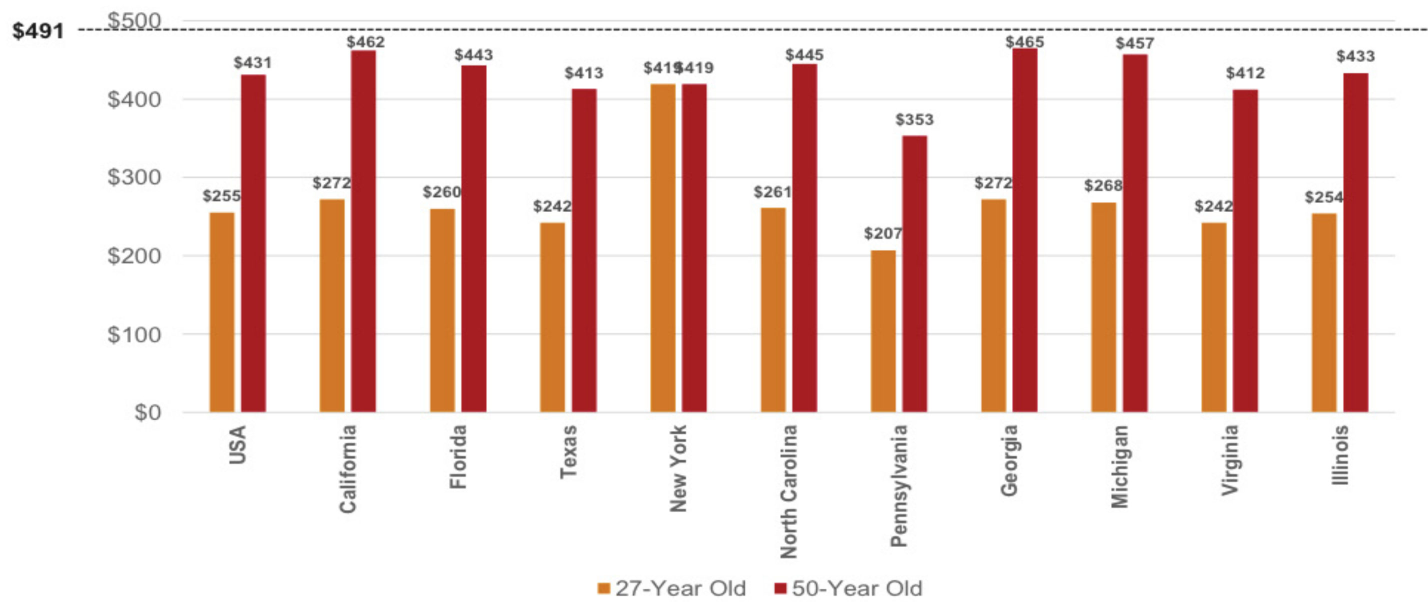
In this report, we make some comparisons between the premiums and cost sharing requirements of Exchange plans and ESI plans. Many of the new Exchange plan enrollees previously were uninsured or were insured through the individual market, not through ESI plans. The pre-ACA individual market looked fundamentally different from the ACA Exchanges. According to one study, more than half of the plans sold through the individual market would not have

Figure 2[11,12]

Premium Ranges and Averages Across the Nation and the Top 10 States by Expected Exchange Enrollment

	Lowest Premium		Highest Premium		Average Premium	
State	*27 Year Old*	*50 Year Old*	*27 Year Old*	*50 Year Old*	*27 Year Old*	*50 Year Old*
USA	$126 (MN)	$215 (MN)	$1,858 (VA)	$3,167 (VA)	$265	$435
California	$184	$313	$394	$672	$272	$462
Florida	$167	$285	$395	$674	$261	$445
Texas	$153	$260	$354	$602	$240	$410
New York	$270	$270	$553	$553	$416	$416
North Carolina	$215	$367	$322	$549	$262	$447
Pennsylvania	$134	$228	$355	$606	$224	$382
Georgia	$188	$321	$410	$699	$273	$465
Michigan	$156	$266	$395	$674	$266	$454
Virginia	$188	$321	$1,858	$3,167	$528	$899
Illinois	$157	$268	$334	$570	$257	$438

Figure 3



satisfied ACA requirements.[13] Although most new enrollees were not previously covered by ESI plans, we do believe that comparisons between the Exchange marketplace and ESI marketplace help provide some important context for our findings. Moreover, the ESI figures are relevant because there is likely to be more crossover between the two markets in the coming years. As this crossover continues to occur, and as benefit design and cost sharing features of Exchange plans possibly migrate into the ESI market, the comparisons become even more relevant.

Exchange Plan Deductibles

To be offered through the Exchanges, plans must provide all ten categories of essential health benefits (EHB) and have an actuarial value sufficient to satisfy one of the metal levels established by the ACA. To meet these requirements while still keeping premiums low enough to attract enrollees, some insurers have, among other things, increased cost sharing, including copayments, coinsurance and deductibles. Deductibles take on a new significance in Exchange plans. As will be examined in future reports, many Exchange plans subject health care services such as PCP visits and prescription drugs to the deductible, a benefit design feature which is less common in ESI plans.[14] In addition, as detailed below, Exchange plan deductibles are relatively high as compared to ESI plan deductibles. Accordingly, even some individuals who qualify for CSRs may find it difficult to afford the amounts that they will have to pay out-of-pocket before their Exchange plans begin to pay benefits.

Figure 4

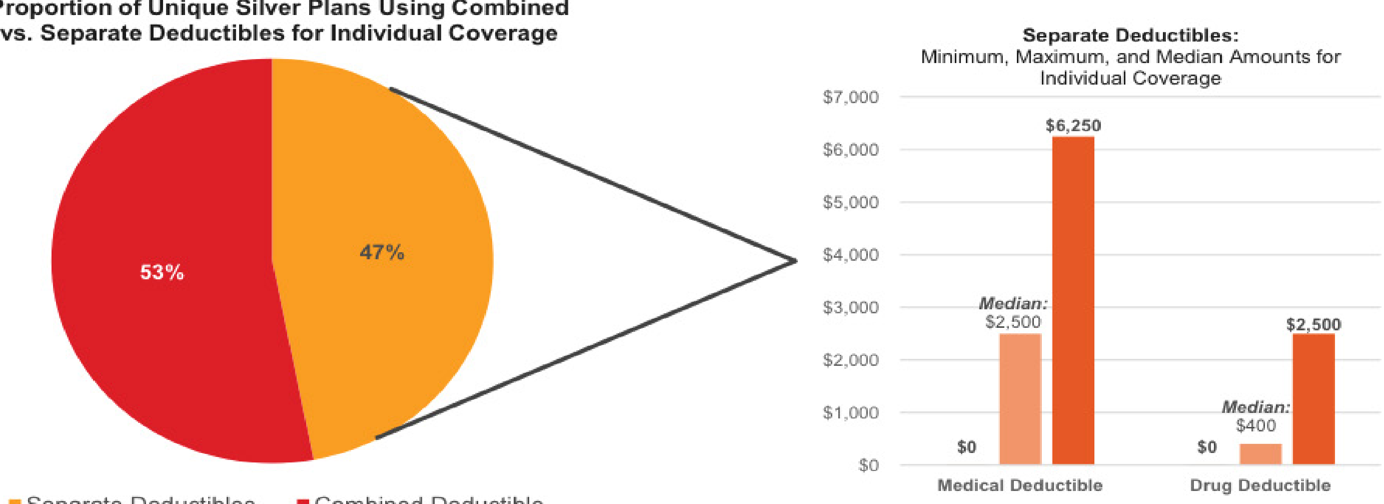
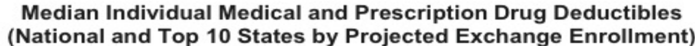
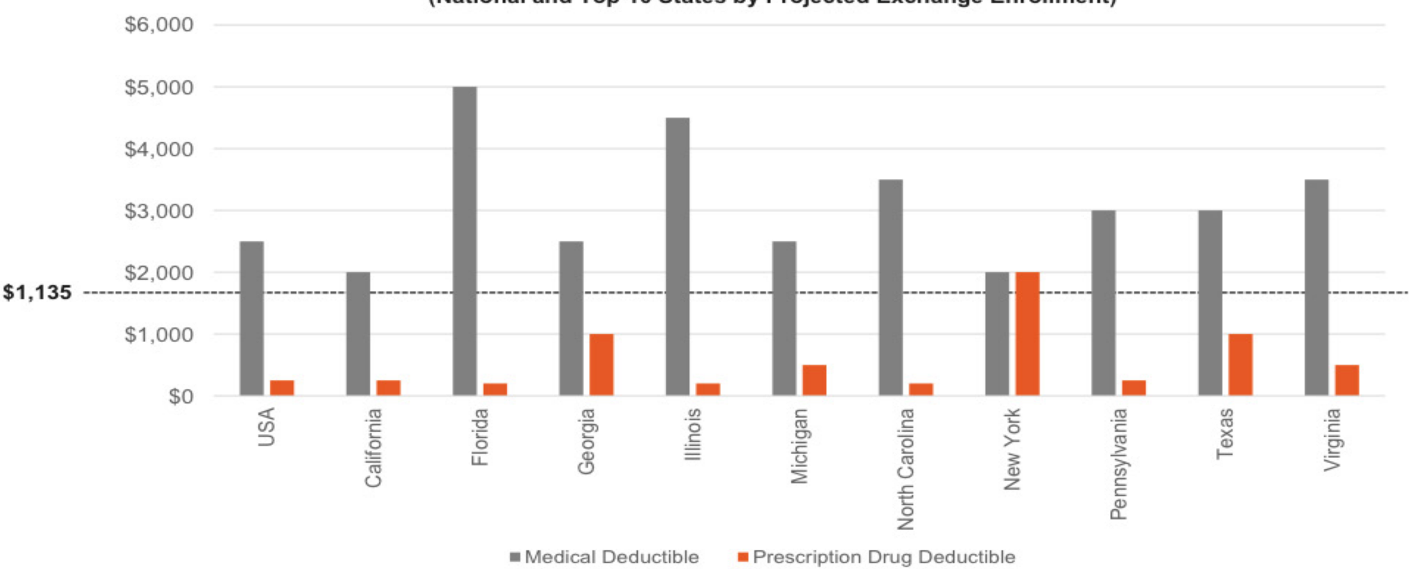


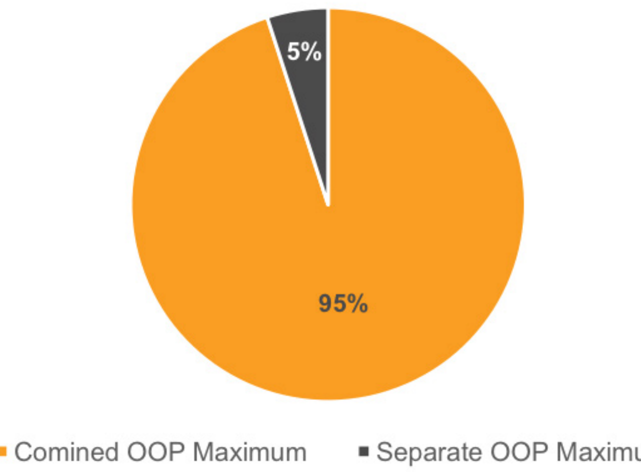
Figure 5





Of the 1,208 unique Silver plans analyzed, approximately half (641) offer *combined deductibles* under which medical and prescription drug expenses accumulate to a single deductible. The average combined deductible for those plans is $2,267 for a 27 year-old individual. The other approximately half of plans (567) have two *separate deductibles*, a medical deductible towards which expenses for medical services accumulate and a drug deductible towards which expenses for prescription drugs accumulate. (See Figure 4.) Among the plans having separate medical and prescription drug deductibles, separate medical deductibles range from $0 to $6,250, with the median amount being $2,500, approximately twice the amount of the average separate medical deductible for ESI plans ($1,135). Separate prescription drug deductibles range from $0 to $2,500, with a median of $400. (See Figure 5.) Figure 6 below, shows the median individual medical and prescription drug deductibles nationwide as well as for the ten states having the highest expected Exchange enrollment.

Figure 6

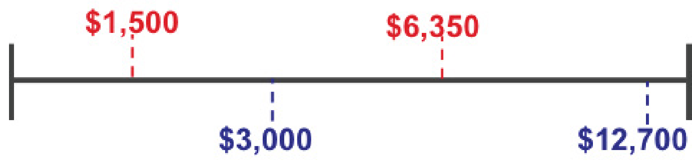


Out-of-Pocket Maximums

The ACA limits the amount that plans can require people to pay out-of-pocket each year for *in-network* deductibles, copayments and coinsurance on covered services to $6,350 for individuals ($12,700 for a family). Among the 1,208 unique

Figure 7

Combined OOP Maximums:
Range for Individual and Family Coverage



Separate OOP Maximums:
Range for Medical and Drug OOP Maximums

plans, 1,150 had a *combined out-of-pocket maximum* (OOP Max), meaning that medical and prescription drug expenses accumulate to the same OOP Max. (See Figure 6.) The OOP Max for those plans ranges from $1,500 to $6,350, with a median of $6,350 for individuals. The range for combined OOP Max for families is $3,000 to $12,700, with a median of $12,700.

The remaining plans had *separate limits on out-of-pocket medical expenses and prescription drug expenses*. For those plans, the OOP Max on medical expenses ranged from a low of $1,500 to a high of $6,350, with the median also being $6,350. The OOP Max on prescription drug expenses ranged from a low of $950 to a high of $2,350, with a median of $1,500. (See Figure 7.)

Looking Back—and Ahead

Prior to the launch of the Exchanges, most of the attention regarding the new insurance marketplaces centered on premiums. In Report I, we emphasized that premiums alone do not provide consumers with a complete picture of their potential out-of-pocket costs and that consumers should look beyond premiums and also consider other cost sharing requirements in determining which Exchange plan best meets their needs.

Our more exhaustive review of the cost sharing requirements in over 1,200 unique Silver plans underscores the importance of examining Exchange plan details beyond premiums. It also shows that cost sharing under the new Exchange plans varies, in some cases considerably, from cost sharing under traditional ESI plans.

Recognizing that evaluating and comparing Exchange plans would be somewhat of a challenge, Breakaway and RWJF believe it is important to make HIX Compare available in open source. By providing HIX Compare in this format, we hope to provide researchers with a comprehensive source of information on Exchange plans to enable them to conduct their own market analyses. In addition, Breakaway intends to update HIX Compare on an annual basis so that researchers and others can examine emerging and historical trends in Exchange health coverage through longitudinal data.

The applicability, use and amount of deductibles in Exchange plans may be particularly important for consumers and other stakeholders to understand. In addition to being relatively high as compared to the ESI market, deductibles under Exchange plans are being applied to products and services not generally subject to the deductible in ESI plans, such as prescription drugs and physician visits. This could further complicate enrollees' task of evaluating plans' cost sharing provisions, as they will not only have to consider the amount of deductibles but also the way they are applied. Application of deductibles, and other cost sharing requirements will be examined in future reports.

Using HIX Compare, Breakaway is currently examining cost sharing requirements for specific benefits under Exchange plans and will be releasing additional reports in the coming weeks and months.

About Breakaway Policy Strategies

Breakaway Policy Strategies is a health policy firm that provides research, analysis, practical advice and strategic solutions to a wide range of health care stakeholders. Breakaway's health care experts offer creative, sophisticated guidance to help hospitals, health plans, physicians, employers, consumers, patients, government agencies, biopharmaceutical and device companies, foundations and investors successfully navigate the transformative changes taking place in the American health care system. Learn more at www.breakawaypolicy.com.

About the Robert Wood Johnson Foundation

For more than 40 years the Robert Wood Johnson Foundation has worked to improve the health and health care of all Americans. We are striving to build a national culture of health that will enable all Americans to live longer, healthier lives now and for generations to come. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.

Notes

1. For the first report, Breakaway chose to examine premiums and cost sharing for SLCSPs since the SLCSP in an individual's rating area is used as the benchmark for determining the amount of his or her premium tax credit.

2. The ACA requires that each state have a set number of geographic rating areas that all issuers in the state must use to set their rates. CCIIO, Market Rating Reforms, State Specific Geographic Rating Areas, http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-gra.html.

3. Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2013 Annual Survey, http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20131.pdf, citing Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, The Uninsured: A Primer: Key Facts About Americans Without Health Insurance, October 2012, http://www.kff.org/uninsured/issue-brief/the-uninsured-a-primer/.

4. Congressional Budget Office. "Effects of the Affordable Care Act on Health Insurance Coverage." April 2014. http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf.

5. QHP Landscape – Individual Market Medical, https://data.healthcare.gov/dataset/QHP-Landscape-Individual-Market-Medical/b8in-sz6k.

6. Premium tax credits are determined by calculating the maximum percentage of income that an individual must pay toward health insurance, which is based on a sliding scale for people earning up to 400 percent of the federal poverty level (FPL)—$45,960 for an individual and $94,200 for a family of four in 2013. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2013 Federal Poverty Guidelines. That amount is then subtracted from the second lowest cost Silver plan (SLCSP) in the individual's rating area.

7. Kaiser Family Foundation, Issue Brief, "How Much Financial Assistance Are People Receiving Under the Affordable Care Act?" March 27, 2014, http://kaiserfamilyfoundation.files.wordpress.com/2014/03/8569-how-much-financial-assistance-are-people-receiving-under-the-affordable-care-act1.pdf.

8. NY State of Health: The Official Health Plan Marketplace, December 2013 Enrollment Report, http://info.nystateofhealth.ny.gov/sites/default/files/December%202013%20Enrollment%20Report_Jan%2013%202014.pdf.

9. Washington Health Plan Finder, Health Coverage Enrollment Report, February 2014, http://wahbexchange.org/files/1813/9568/0206/February_Data_Report_FINAL.pdf.

10. The extremely high premiums listed for Virginia are not necessarily representative of the entire Exchange plan marketplace in that state. Rather, they most likely are associated with plans having a rider covering bariatric surgery. Virginia does not mandate coverage of bariatric surgery but does require that bariatric treatment be offered as an option for consumers. Kaiser Health News, "Why Some Virginia Health Plans Cost So Much," October 13, 2013, http://www.kaiserhealthnews.org/stories/2013/october/13/why-some-virginia-health-plans-cost-so-much.aspx.

11. The state of New York still requires full community rating which explains why the premiums for a 27 year-old individual and 50 year-old individual are identical.

12. Top 10 states by expected exchange enrollment based on Kaiser Family Foundation analysis of state marketplace statistics. March 2014. http://kff.org/health-reform/state-indicator/state-marketplace-statistics/.

13. Health Affairs, "More Than Half Of Individual Health Plans Offer Coverage That Falls Short Of What Can Be Sold Through Exchanges As Of 2014," May 2012, http://content.healthaffairs.org/content/early/2012/05/22/hlthaff.2011.1082.

14. The majority of workers covered by ESI plans having a deductible do not have to meet that deductible before certain services, such as physician office visits or prescription drugs, are covered. Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2013 Annual Survey, http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20131.pdf.

Health Reform: Designing a Marketplace
A state-by-state comparison of Marketplace Implementation

The Affordable Care Act (ACA) creates a Health Insurance Marketplace (Marketplace) in every state, which offers individuals and small businesses the opportunity to shop from an array of affordable, comprehensive health insurance plans. A state can either create and operate the Marketplace itself as a State-based Marketplace (SBM), partner with the federal government under a State Partnership Marketplace (SPM), or defer to the U.S. Department of Health and Human Services to manage a Federally-facilitated Marketplace (FFM) in the state.

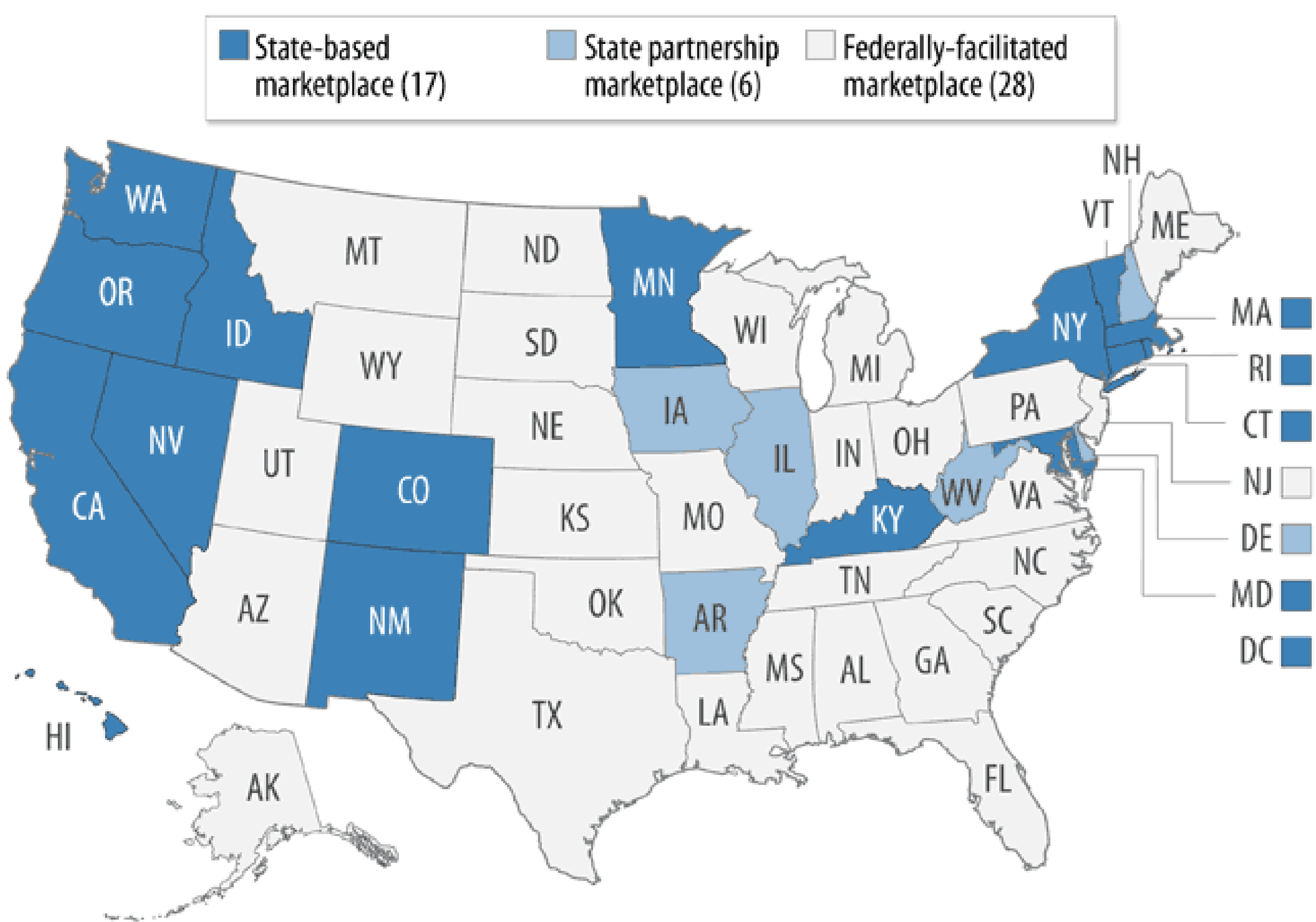
Table of Contents

(click here to view the detailed full list of Marketplace design questions)

- Eligibility and Enrollment
- Consumer Assistance
- Brokers
- Plan Management
- Plan Offerings
- SHOP

In 2014, 16 states and the District of Columbia have established a State-based Marketplace for both individuals and small businesses, six states have a State Partnership Marketplace, and one state is administering a State-based SHOP Marketplace just for small businesses (with an FFM serving individuals).

The ACA provides states with significant flexibility in the design and structure of their Marketplace; hundreds of policy and operational decisions had to be addressed during the Marketplace implementation process. **CBPP has evaluated SBM and SPM states across a number of these Marketplace design questions and compiled the information in this interactive tool.**



How to use this tool

Marketplace design information available for each state is displayed in the online database. Users may first wish to explore the entire list of questions via the link provided in the Table of Contents before navigating the database to become familiar with the various Marketplace design measures. A version of the Table of Contents is also provided in the left-hand tab on the database page which allows users to jump to a specific design question in any category. Scrolling to the right or left allows you to compare responses to a specific design question across all states, or you can select a particular state from the drop-down menu and compare its responses to all other states. Users can also download the data into an Excel spreadsheet. Unless otherwise indicated, all information applies to the 2014 plan year.

Note: this resource will be updated periodically to reflect new information as it becomes available. If information appears out-of-date or inaccurate for a given state, please contact Dave Chandra, chandra@cbpp.org.

Sources

Information on State-based Marketplaces and State Partnership Marketplaces was obtained from the following sources:

State-based Marketplace Board meeting notes and minutes;
Public resources and materials available online from State-based Marketplaces and State Partnership Marketplaces;
The Center on Health Insurance Reform, Georgetown University Health Policy Institute;
The Commonwealth Foundation;
Kaiser Family Foundation;

State Health Reform Assistance Network (SHRAN);
KidsWell;
Conversations with health care advocacy organizations in State-based Marketplace and State Partnership Marketplace states; and
Conversations with representatives of the Marketplace, Department of Insurance, Department of Health, Medicaid agency, or Governor's Office in State-based Marketplace and State Partnership Marketplace states.

Acknowledgements

We would like to thank the following agencies and individuals for their assistance in reviewing and verifying our Marketplace findings for their states:

Arkansas Insurance Department
Delaware Department of Health and Social Services
Connect for Health Colorado
Cover Oregon
Covered California
HealthSource RI
Maryland Health Connection
Massachusetts Health Connector
MNsure
Nevada Health Link
New Mexico Health Insurance Exchange
Utah Governor's Office of Economic Development
Vermont Health Connect
West Virginia Office of the Insurance Commissioner

Ellen Andrews, Connecticut Health Policy (Connecticut)
Elisabeth R. Benjamin, Community Service Society of New York (New York)
Kyle Brittingham, Community Service Society of New York (New York)
Suzanne Curry, Health Care for All (Massachusetts)
Jim Duffett, Campaign for Better Healthcare (Illinois)
Lynn Etkins, Legal Aid Center of Southern Nevada (Nevada)
Sarah Greenfield, Take Action Minnesota (Minnesota)
Debra Judy, Colorado Health Initiative (Colorado)
Lisa Kaplan Howe, New Hampshire Voices for Health (New Hampshire)
Linda Katz, Economic Progress Institute (Rhode Island)
Trinka Kerr, Vermont Legal Aid (Vermont)
George Lyford, Colorado Center on Law and Policy (Colorado)
Sireesha Manne, New Mexico Center on Law and Poverty (New Mexico)
Claire McAndrew, Families USA (District of Columbia)
Teresa Mosqueda, Washington State Labor Council (Washington)
Jesse Ellis O'Brien, Oregon State Public Interest Research Group (Oregon)
Anna Odegaard, SEIU Healthcare Minnesota (Minnesota)
Jillian Phillips, Campaign for Better Healthcare (Illinois)
Leni Preston, Maryland Women's Coalition for Health Care Reform (Maryland)
Elaine Saly, Families USA (District of Columbia)
Julie Silas, West Coast Office of Consumers Union (California)
Jason Stevenson, Utah Health Policy Project (Utah)

Cara Stewart, Kentucky Equal Justice Center (Kentucky)
Anna Strong, Arkansas Advocates for Children and Families (Arkansas)
Donna Sutton Fay, Vermont Campaign for Health care Security Education Fund (Vermont)
Anthony Wright, Health Access California (California)
Jill Zorn, Universal Health Care Foundation of Connecticut (Connecticut)

We would also like to appreciate the extensive data collection, analysis, and website development efforts of the following CBPP staff and interns:

Samuel Abbott
Kelsey Bogue
Valerie Caplan
Kyle Hayes
Nick Kasprak
Edward Bremner
Altelisha Taylor

About | Areas of Research | Policy Basics | Experts | Donate | Press Room | Jobs | RSS | Contact Us | Privacy Policy

Center on Budget and Policy Priorities | 820 First Street, NE, Suite 510 | Washington, DC 20002 | Ph: 202-408-1080 | Fax: 202-408-1056 | center@cbpp.org

Contact the web team with questions or comments about the site.
Copyright © 2008 - 2014 Center on Budget and Policy Priorities. All rights reserved.

Created by Matrix Group International, Inc.

By Benjamin D. Sommers

DOI: 10.1377/hlthaff.2014.0005
HEALTH AFFAIRS 33,
NO. 5 (2014): –
©2014 Project HOPE—
The People-to-People Health
Foundation, Inc.

Insurance Cancellations In Context: Stability Of Coverage In The Nongroup Market Prior To Health Reform

Benjamin D. Sommers
(bsommers@hsph.harvard.edu)
is an assistant professor of health policy and economics at the Harvard School of Public Health and an assistant professor of medicine at Brigham and Women's Hospital and Harvard Medical School, in Boston, Massachusetts.

ABSTRACT Recent cancellations of nongroup health insurance plans generated much policy debate and raised concerns that the Affordable Care Act (ACA) may increase the number of uninsured Americans in the short term. This article provides evidence on the stability of nongroup coverage using US census data for the period 2008–11, before ACA provisions took effect. The principal findings are threefold. First, this market was characterized by high turnover: Only 42 percent of people with nongroup coverage at the outset of the study period retained that coverage after twelve months. Second, 80 percent of people experiencing coverage changes acquired other insurance within a year, most commonly from an employer. Third, turnover varied across groups, with stable coverage more common for whites and self-employed people than for other groups. Turnover was particularly high among adults ages 19–35, with only 21 percent of young adults retaining continuous nongroup coverage for two years. Given estimates from 2012 that 10.8 million people were covered in this market, these results suggest that 6.2 million people leave nongroup coverage annually. This suggests that the nongroup market was characterized by frequent disruptions in coverage before the ACA and that the effects of the recent cancellations are not necessarily out of the norm. These results can serve as a useful pre-ACA baseline with which to evaluate the law's long-term impact on the stability of nongroup coverage.

When the open enrollment period for the Affordable Care Act's insurance Marketplaces began in October 2013, the media were filled with reports of Americans receiving cancellation notices from their health insurance plans.[1] An Associated Press report claimed that as many as 4.7 million people might have been affected.[2] The plans in question were private coverage that was not employment based—often referred to as nongroup or individual health insurance.

The provisions in the Affordable Care Act (ACA) that were linked to these cancellations were new minimum coverage standards in the nongroup market that became binding on all nongrandfathered plans in 2014. These standards include the elimination of annual limits for coverage and mandated coverage of essential health benefits.[3] Insurers with plans that had been altered since 2010 (thereby losing grandfathered status) and that did not meet these standards began notifying customers in the fall of 2013 that their plans were being cancelled for 2014. The ensuing political firestorm led to President Barack Obama's announcing in November 2013 that insurance companies could temporarily continue to offer these plans and that

Downloaded from content.healthaffairs.org by Health Affairs on May 16, 2014
by KATHERINE MARCELLUS

enrollees would not be subject to the individual insurance mandate in 2014.[4,5] This announcement shifted to insurers and state insurance regulators the responsibility for deciding whether the plans could be offered for another year.

The debate about these insurance cancellations suffered from a lack of clear evidence about the number of cancellation notifications that were sent out,[6] what would happen to people who lost coverage, and how these changes of coverage in the nongroup market differed from the market's baseline level of plan turnover.

Previous research has shown that health insurance in the United States is characterized by frequent changes in people's source of coverage, which means that millions of Americans experience transitions in insurance each year or periods without any coverage at all.[7–9] Previous analyses have examined these dynamics for people covered by Medicaid,[10] the Children's Health Insurance Program (CHIP),[11] and private insurance (most of which is employer based).[12] However, pre-ACA coverage stability in the nongroup health insurance market has been studied only in individual states,[13] not with nationally representative data.

In addition, the evidence base for a range of issues in the nongroup health insurance market —such as coverage quality, stability, and prevalence—is far less substantial than is the case with other sources of coverage.[14] This is because of a lack of standardized reporting, confusion among beneficiaries about their coverage, and varying estimates of coverage rates according to the data source used.[15]

If most people who participate in the nongroup market do so only for short periods of time, then the 2013 cancellations may have little long-term impact on rates of coverage and may not produce dynamics that differ significantly from the norm for this market. However, if coverage in the nongroup market is generally stable over time, the cancellations may cause many people to lose coverage. As a result, it is possible that the ACA could reduce the number of Americans with health insurance, at least in the short term.

The objectives of this analysis were threefold: The first aim was to provide context for interpreting the recent insurance cancellations by describing the stability of coverage in the nongroup health insurance market using 2008–11 US census data, before the implementation of most of the ACA's provisions. The second aim was to identify which people were most likely to experience changes in nongroup coverage over time. The third was to provide a useful pre-ACA baseline for evaluations of the law's long-term impact on coverage continuity in the nongroup market.

Study Data And Methods

DATA SOURCE The primary data source for this analysis was the Census Bureau's Survey of Income and Program Participation (SIPP), a nationally representative household survey that follows people over time and includes detailed information on their demographic characteristics, income, and health insurance coverage. Each household in SIPP is surveyed every four months.

The most recent panel of the survey began in May 2008. This analysis focuses on respondents' coverage during the ensuing three years. The first twenty-four-month period is of particular interest, since this was before the insurance regulations in the ACA began to take effect, in late 2010.

DATA ANALYSIS The sample was limited to respondents ages 0–64 who reported having a privately purchased insurance plan that was not obtained from an employer (past or present) or a union. To focus on people who had their primary health insurance from a nongroup plan, the sample excluded respondents who also reported having simultaneous coverage from an employer, Medicaid, Medicare, or the military. The sample consisted of 4,199 respondents with nongroup coverage in their first month in the survey.

Insurance status was assessed using data for the first month of each survey wave. The outcome variable was the percentage of respondents who reported consistent nongroup health insurance at subsequent four-month intervals, until thirty-six months. In other words, a person with nongroup coverage at zero and twelve months but not at eight months would not be considered to have stable coverage at twelve months because of the gap.

Secondary outcomes were alternative coverage status for those respondents who did not have nongroup coverage after twelve months. The categories of alternative coverage were employer-sponsored insurance, public insurance (Medicare, Medicaid, or both), other insurance, and no insurance.

There has been significant interest in the age distribution of participants in the nongroup market and the new ACA health insurance Marketplaces. Therefore, I also analyzed nongroup coverage over time separately for younger and older adults (ages 19–35 and 36–64, respectively).

A multivariate model was then used to identify predictors of coverage stability in the nongroup market. The outcome for this analysis was the presence or absence of stable nongroup coverage after twelve months. Covariates were age (0–18, 19–35, and 36–64 years), sex, marital status, race and ethnicity, level of education (for children,

Downloaded from content.healthaffairs.org by *Health Affairs* on May 16, 2014
by KATHERINE MARCELLUS

The evidence base for a range of issues in the nongroup market is far less substantial than is the case with other sources of coverage.

the highest level of education attained by any adult in the household), family income as a percentage of the federal poverty level, self-employment status (defined as a respondent's owning his or her own business), and census region. All covariates were based on the respondent's first month in the survey.

The outcome was modeled using a logistic regression for the binary variable of stable twelve-month nongroup coverage, and odds ratios were also converted into predicted probabilities for ease of interpretation. Twelve months was the period chosen as the basis for this analysis because policy discussions commonly use annual time frames, such as the ACA's annual open enrollment periods.

Finally, I conducted several sensitivity analyses using alternative samples, as discussed below. Some of these samples were created by excluding respondents who were potentially eligible for Medicaid, including in the nongroup coverage category those who reported having "other insurance," or limiting the sample to new spells of nongroup coverage (that is, examining only people who did not have nongroup coverage in the first month of the survey but who subsequently signed up for it).

All analyses were conducted with the statistical software Stata, version 12.0. Analyses accounted for SIPP's survey design and used nationally representative survey weights from the first wave of the sample. Sensitivity analyses used the one-, two-, and three-year longitudinal survey weights, as discussed in the next section and in the notes to online Appendix Exhibit 2.[16]

LIMITATIONS As is the case with all surveys, SIPP relies on self-reported data. To the extent that people misreport their source of coverage, this could bias the results of this analysis. Previous research suggests that some people who report having nongroup coverage in fact have Medicaid.[15] Other people may report having "other coverage" without specifically identifying that coverage as a plan purchased directly from an insurance company.

Fortunately, the results presented below were largely unchanged in several sensitivity analyses. One alternative analysis excluded from the sample all adults with incomes below 150 percent of poverty and all children with family incomes below 250 percent of poverty, which should have removed most people who might be eligible for Medicaid or CHIP. A second alternative analysis tested a more expansive definition of nongroup coverage, which included "other insurance" reported in SIPP. The findings of these analyses are presented in the Appendix.[16]

The survey source, SIPP, has additional limitations that may affect this analysis. First, the survey exhibits so-called seam bias, which occurs when respondents are less likely to report changes in status (for example, related to income or insurance) within a given four-month wave of the survey and are more likely to report such changes between waves. Versions of SIPP since 2001 have reduced this bias to some extent.[17] In any case, because of the seam bias, this analysis focused on coverage estimates in four-month increments (once per wave) instead of focusing on month-to-month changes, which may be less accurate.

Second, like all longitudinal surveys, SIPP suffers from attrition, as households are lost to follow-up over time. This analysis presents estimates at each point in time based on the respondents who had complete data from the start of the survey through that point. As a result, the sample contained more respondents at twelve months than at later points in time.

Although SIPP includes longitudinal survey weights designed to account for this attrition, the weights are not a perfect solution. Respondents who dropped out of the sample likely differed significantly from those who remained, in terms of their continuity of coverage over time, even after observable demographic features are accounted for. In particular, it is probable that respondents who left the survey were more likely to have experienced disruptions in life circumstances and insurance coverage than those who were able to be contacted and to complete the survey over longer periods of time.

Thus, if attrition bias affected the results, it probably led to underestimates in coverage turnover, especially over longer time periods. The approach used here—estimating coverage continuity using the full sample present at each point in time, even if some members of the sample subsequently leave the survey—helps avoid some of this selective bias over shorter time periods

Downloaded from content.healthaffairs.org by Health Affairs on May 16, 2014
by KATHERINE MARCELLUS

but cannot eliminate it entirely. The Appendix[16] presents sensitivity analyses with alternative approaches using SIPP's longitudinal survey weights.

Finally, this analysis was able to identify only respondents who changed their source of coverage from nongroup to another category (employer-sponsored, public insurance, or no insurance). It could not identify changes from one nongroup insurance plan to another. Data on respondents who changed coverage in this way are critically important for analyses of plan cancellations. To the extent that some of the respondents who reported having ongoing coverage in the nongroup market changed nongroup plans, this analysis may significantly underestimate the extent of plan turnover in the nongroup market before the passage of the ACA.

EXHIBIT 1

Descriptive Statistics For The Study Sample—People Ages 0–64 Enrolled In Nongroup Insurance, 2008

Characteristic	Percent	95% CI
Age (years)		
0–18	22.8	20.9, 24.7
19–35	26.0	24.2, 27.9
36–64	51.2	49.1, 53.2
Male	43.3	41.8, 44.8
Married	48.0	46.7, 49.3
Race		
White	86.5	84.9, 88.1
Black	5.3	4.3, 6.4
Asian	5.6	4.7, 6.5
Other	2.6	1.9, 3.3
Latino ethnicity	7.1	5.7, 8.5
Family income (% of FPL)		
<138	24.8	22.7, 26.8
138–400	39.9	37.8, 42.1
>400	35.2	32.7, 37.7
Education[a]		
Less than high school diploma	5.7	2.1, 9.3
High school graduate	42.6	40.1, 45.1
At least some college	51.5	48.9, 54.2
Self-employed	27.2	25.4, 29.1
Census region		
West	27.1	24.3, 29.8
Midwest	25.4	21.9, 28.9
South	36.2	33.4, 39.0
Northeast	11.4	9.8, 12.9

SOURCE Author's analysis of data from the 2008 Survey of Income and Program Participation (SIPP). **NOTES** The sample consists of all survey respondents ages 0–64 who reported having nongroup health insurance coverage in the first month of the survey, and no other form of health insurance (Medicare, Medicaid, employer-sponsored insurance, or military health coverage) at that time. FPL is federal poverty level. [a]Education for children (ages 0–18) is based on the highest level of education attained by any adult in their household.

Study Results

The nongroup market contains a wide age range of beneficiaries, with half of the respondents in the sample ages 36–64 (Exhibit 1). The majority of respondents had family incomes at or below the ACA's cutoff for subsidized coverage (400 percent of poverty), but more than one-third had higher incomes. Roughly one-quarter were self-employed. The largest portion of the sample was from Southern states, and the smallest was from the Northeast.

Coverage in the nongroup market was often short-lived (Exhibit 2). Over one-third of those in the sample no longer had nongroup insurance after four months. After one year, only 42 percent had experienced stable nongroup coverage; after two years, just 27 percent had. Respondents ages 19–35 experienced much more turnover in coverage than older adults (those ages 36–64): Only one-third of younger adults maintained stable nongroup insurance for at least twelve months, compared to nearly half of older adults.

The majority of the respondents who experienced a coverage change had acquired other insurance at twelve months. Fifty percent had employer-sponsored insurance, 20 percent had regained nongroup coverage, 6 percent had Medicare or Medicaid, and 4 percent had other coverage. The remaining 20 percent were uninsured a year into the study period.

Groups experiencing more stable nongroup coverage over time included older adults, whites, self-employed people, and respondents living in the West or Midwest (Exhibit 3). Groups with higher turnover included children, younger adults, blacks, Latinos, and people living in the Northeast.

The results were quite similar in the sensitivity analysis that excluded lower-income adults and children who might be eligible for Medicaid or CHIP (Appendix Exhibit 1).[16] Coverage stability in the nongroup market was slightly worse (2–3 percentage points at each time interval) when respondents who reported having "other insurance" were added to those who reported having nongroup coverage. These results suggest that several potential forms of classification error in the SIPP data had minimal impact on the overall findings.

Estimates of coverage stability were dramatically lower if the sample was limited to those who began a new period of nongroup coverage in the second wave of the study: Only 21 percent of the limited sample had stable coverage at twelve months, compared to 42 percent in the full sample (see Appendix Exhibit 1).[16] This is consistent with results from studies of similar policy phenomena, such as the duration of unemployment

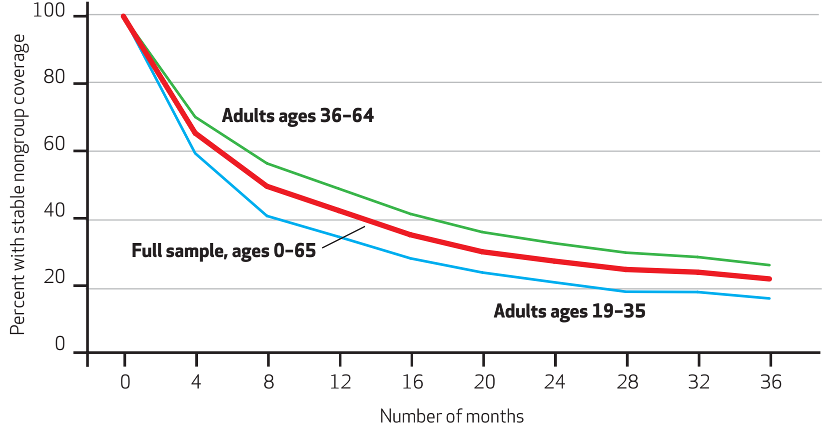
Downloaded from content.healthaffairs.org by Health Affairs on May 16, 2014
by KATHERINE MARCELLUS

spells.[18] Focusing on a cross-section at a point in time typically captures a higher share of long spells of coverage or unemployment, compared to studying only new periods of either phenomenon. The analysis and discussion in this article focus primarily on the full sample of all people in nongroup plans, since this sample provides the best estimate of how many people experience coverage changes each year. This estimate is arguably more relevant to the current policy debate than estimates based on the percentage of episodes of nongroup enrollment (as opposed to people) experiencing such coverage disruptions.

Using SIPP's one- and two-year longitudinal weights produced results that were nearly identical to the baseline estimates (Appendix Exhibit 2).[16] Using the three-year longitudinal weights led to estimates of coverage continuity that were roughly 1 percentage point higher for the first twenty-four months. This provides evidence of selective attrition earlier in the survey among respondents with less stable coverage.

EXHIBIT 2

Percentage Of Nonelderly People With Stable Nongroup Health Insurance Over Time, By Age Group, 2008



SOURCE Author's analysis of data from the 2008 Survey of Income and Program Participation (SIPP). **NOTES** The sample consists of 4,199 survey respondents ages 0–64 who reported having nongroup health insurance coverage in the first month of the survey, and no other form of health insurance (Medicare, Medicaid, employer-sponsored insurance, or military health coverage) at that time. At each time point after zero months, the sample consists of all people who responded to health insurance questions about that period and all prior time periods. This resulted in a sample size of 3,133 at twelve months, 2,508 at twenty-four months, and 2,100 at thirty-six months.

Discussion

This analysis of nationally representative data from the period 2008–11 shows that the nongroup health insurance market was characterized by frequent disruptions in coverage over time, even before the ACA affected the ability of companies to continue offering existing plans to consumers. In fact, fewer than half of all nonelderly people with nongroup coverage at the beginning of the study period still had that coverage a year later. The majority of those who left nongroup coverage had switched to employer coverage, and smaller shares had acquired public insurance, become uninsured, or moved out of and then back into nongroup coverage.

These results are consistent with prior evidence suggesting that the nongroup market can provide transitional coverage for many people,[7] particularly those who are between jobs or waiting for benefits from a new employer to start. However, administrative data from a 2005 analysis of California's nongroup market indicated somewhat more stable coverage in the nongroup market, with roughly 60 percent of people maintaining continuous coverage for twelve months,[13] compared to 42 percent in this study.

These differences may reflect the limitations of self-reported data versus administrative data. However, they also likely indicate differences in coverage continuity between nationally representative estimates and data from a single state. As Exhibit 3 shows, there is significant variation across regions.

The Congressional Research Service has estimated that 10.8 million people had nongroup coverage in 2012.[6] According to my estimates for the sample population, this suggests that 6.2 million Americans typically leave nongroup coverage each year. Presumably some of them do so voluntarily, because they qualify for Medicaid or start a new job with employer-sponsored coverage. Others lose coverage through inability to afford increased premiums, loss of income, or changes in health status that affect eligibility for nongroup insurance.

In this context, reports that recent cancellations of coverage may affect as many as 4.7 million adults (though precise estimates are lacking)[6] are likely capturing a great deal of the normal turnover in this market. The findings presented here also suggest that overall coverage rates in the United States are unlikely to fall as a result of these cancellations: Most people who left nongroup coverage in this study acquired other insurance within twelve months, even before the ACA offered increased coverage via the Medicaid expansion and tax credits for Marketplace insurance.

Of course, the ACA's regulations are presumably leading some people to lose nongroup coverage that they would prefer to keep. The results of this study indicate that certain subsets of people—in particular, those who are older than thirty-five, white, or self-employed—with nongroup insurance are likely to retain that coverage for three years or more. For some people who were

6.2 million

Americans

According to estimates from the sample population, 6.2 million Americans leave nongroup coverage each year.

Downloaded from content.healthaffairs.org by Health Affairs on May 16, 2014
by KATHERINE MARCELLUS

EXHIBIT 3

Demographic Predictors Of Stable Nongroup Health Insurance Coverage Over A Twelve-Month Period

Characteristic	Odds ratio	95% CI	Predicted probability of stable nongroup coverage at 12 months (%)
Age (years)			
0–18	0.62***	0.46, 0.84	37.0
19–35	0.56***	0.46, 0.68	34.6
36–64	Ref	—[a]	48.0
Male	0.91	0.78, 1.06	41.2
Married	0.92	0.74, 1.14	41.2
Race			
White	Ref	—[a]	43.5
Black	0.47***	0.28, 0.80	27.4
Asian	0.84	0.52, 1.36	39.5
Other	0.55*	0.30, 1.02	30.1
Latino ethnicity	0.34***	0.16, 0.69	21.6
Family income (% of FPL)			
<138	1.16	0.84, 1.59	45.5
138–400	0.93	0.71, 1.23	40.5
>400	Ref	—[a]	42.1
Education[b]			
Less than high school diploma	0.64*	0.38, 1.06	33.7
High school graduate	0.91	0.73, 1.14	41.7
At least some college	Ref	—[a]	43.8
Self-employed	1.28**	1.04, 1.57	46.3
Region			
West	1.98***	1.22, 3.20	50.6
Midwest	1.46*	0.95, 2.26	43.4
South	1.15	0.73, 1.81	38.0
Northeast	Ref	—[a]	34.8

SOURCE Author's analysis of data from the 2008 Survey of Income and Program Participation. **NOTES** The sample ($N = 3133$) contains all people ages 0–64 who reported having nongroup health insurance coverage in the first month of the survey, reported having no other form of health insurance (Medicare, Medicaid, employer-sponsored insurance, or military health coverage) at that time, and reported their health insurance status twelve months later. The outcome variable was whether an respondent reported having stable nongroup coverage during the ensuing twelve months. Analyses used survey-weighted multivariate logistic regression, with predicted probabilities to quantify absolute changes in risk. CI is confidence interval. FPL is federal poverty level. [a]Not applicable. [b]Education for children (ages 0–18) is based on the highest level of education attained by any adult in their household. *$p < 0.10$ **$p < 0.05$ ***$p < 0.01$

covered by nongrandfathered plans, cancellations related to the ACA represent an unwanted change in coverage options that may be quite disruptive.

However, the ACA creates a range of new coverage alternatives via Medicaid and the Marketplaces. In addition, most insurance companies that are issuing cancellations are making efforts to enroll into alternative plans those customers receiving cancellation notices.[19] Notably, 65 percent of the sample in this study had incomes below 400 percent of poverty. This suggests that many, if not most, of those who received cancellation notifications are now likely to be eligible for subsidized coverage that may be less expensive than their previous insurance.

This study's findings are also relevant to the issue of premium "sticker shock"—which occurs when a person has to pay significantly more than in the past to remain covered by a plan—in the nongroup market. Some policy makers have expressed concern that the market reforms in the ACA are leading to significantly higher premiums for many healthy young adults (particularly men)[20] and may lead people to drop their current coverage.

In this context, it is notable how rapid coverage turnover was among adults ages 19–35 in this study. Even before the ACA was implemented, nearly 80 percent of these adults experienced a change in coverage within two years. Undoubtedly, some adults in this age range with nongroup coverage will experience premium increases due to the ACA. However, most of them will qualify for lower premiums due to tax credits,[21] and many of them will experience even larger declines in total out-of-pocket spending because of reduced cost-sharing require-

Downloaded from content.healthaffairs.org by Health Affairs on May 16, 2014
by KATHERINE MARCELLUS

Recent plan cancellations may not have an impact that is markedly different from the normal turnover in this market.

ments. Thus, true "sticker shock" is the exception rather than the rule for younger adults in this rapidly changing market.

This study's findings also are relevant to how the Obama administration has responded to the tumult over insurance cancellations. As noted above, the president announced that insurance companies could continue offering previously cancelled plans to existing customers for one year, and that beneficiaries would not be subject to the individual insurance mandate in the ACA.

Two potential limitations in the White House's approach to this issue are that some state insurance regulators have declined to allow insurers to continue offering these plans, and that even if insurers do still offer the plans, this may only push the problem a year down the road, after which it will recur. The administration's proposed solution has been rejected by several liberal states, including New York and Massachusetts.[4] However, the multivariate analysis in this study demonstrated that nongroup coverage in the Northeast is already much more prone to turnover than such coverage in other parts of the country. This means that following the president's proposal may be less critical to maintaining coverage in these states, compared to states without as much turnover in their nongroup markets.

Furthermore, concerns that this problem will simply recur in a year may be overstated. This study's findings indicate that fewer than half of people with nongroup insurance today will still have that coverage in a year, with the majority of them likely to have obtained employer-provided insurance in the meantime. This latter issue may be moot, however, as the White House has more recently proposed extending this remedy for three years in total.[22]

One additional policy consideration is that states that elect to follow the president's proposal could find that people interested in continuing coverage under previously cancelled plans may be disproportionately older. In this study, long-term coverage in nongroup plans was most common for adults older than thirty-five. This may imply higher-than-expected costs and premiums, given the disproportionately older risk pool.

Conclusion

An analysis of nongroup coverage patterns from 2008–11 shows that this market was characterized by high turnover even before the ACA's reforms were implemented. Thus, recent plan cancellations may not have an impact that is markedly different from the normal turnover in this market. This analysis can also provide a nationally representative estimate of baseline coverage stability in this market. It remains to be seen whether the ACA will succeed in both expanding coverage and making that coverage more stable over time, especially since many people previously covered by nongroup insurance will transition into health insurance Marketplaces. ■

Benjamin Sommers serves part time as an adviser in the Office of the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services (HHS). This article does not represent the views of HHS. [*Published online April 23, 2014.*]

Downloaded from content.healthaffairs.org by *Health Affairs* on May 16, 2014
by KATHERINE MARCELLUS

NOTES

1 Gorman A, Appleby J. Thousands of consumers get insurance cancellation notices due to health law changes. Kaiser Health News [serial on the Internet]. 2013 Oct 21 [cited 2014 Mar 25]. Available from: http://www.kaiserhealthnews.org/stories/2013/october/21/cancellation-notices-health-insurance.aspx
2 Associated Press. Policy notifications and current status, by state. Yahoo! News [serial on the Internet]. 2013 Dec 26 [cited 2014 Mar 25]. Available from: http://news.yahoo.com/policy-notifications-current-status-state-204701399.html
3 Kaiser Family Foundation. Summary of the Affordable Care Act [Internet]. Menlo Park (CA): KFF; 2013 Apr 23 [cited 2014 Mar 25]. Available from: http://kaiserfamilyfoundation.files.wordpress.com/2011/04/8061-021.pdf
4 Ollove M, Vestal C. Q&A: insurance cancellation controversy explained. USA Today. 2013 Nov 222.
5 Parker A, Pear R. Obama moves to avert cancellation of insurance. New York Times. 2013 Nov 14.
6 Fernandez B, Mach AL. Cancellation of nongroup health insurance policies [Internet]. Washington (DC): Congressional Research Service; 2013 Nov 19 [cited 2014 Mar 25]. Available from: http://www.fas.org/sgp/crs/misc/R43314.pdf
7 Short PF, Graefe DR. Battery-powered health insurance? Stability in coverage of the uninsured. Health Aff (Millwood). 2003;22(6):244–55.
8 Graves JA, Swartz K. Understanding state variation in health insurance dynamics can help tailor enrollment strategies for ACA expansion. Health Aff (Millwood). 2013;32(10):1832–40.
9 Swartz K. Dynamics of people without health insurance. Don't let the numbers fool you. JAMA. 1994; 271(1):64–6.
10 Sommers BD. Loss of health insurance among non-elderly adults in Medicaid. J Gen Intern Med. 2009; 24(1):1–7.
11 Hill I, Lutzky AW. Is there a hole in the bucket? Understanding SCHIP retention [Internet]. Washington (DC): Urban Institute; 2003 May [cited 2014 Mar 26]. (Occasional Paper No. 67). Available from: http://www.urban.org/UploadedPDF/310792_OP-67.pdf
12 Cutler DM, Gelber AM. Changes in the incidence and duration of periods without insurance. N Engl J Med. 2009;360(17):1740–8.
13 Marquis MS, Buntin MB, Escarce JJ, Kapur K, Louis TA. Is the individual market more than a bridge market? An analysis of disenrollment decisions. Inquiry. 2005–6;42(4):381–96.
14 Pauly MV, Nichols L. The nongroup insurance market: short on facts, long on opinions and policy disputes. Health Aff (Millwood). 2002;21:w325–44. DOI: 10.1377/hlthaff.w2.325.
15 Cantor JC, Monheit AC, Brownlee S, Schneider C. The adequacy of household survey data for evaluating the nongroup health insurance market. Health Serv Res. 2007; 42(4):1739–57.
16 To access the Appendix, click on the Appendix link in the box to the right of the article online.
17 Moore JC. Seam bias in the 2004 SIPP panel: much improved, but much bias still remains [Internet]. Washington (DC): Census Bureau; 2008 Feb 25 [cited 2014 Mar 26]. Available from: https://www.census.gov/srd/papers/pdf/rsm2008-03.pdf
18 Kiefer NM, Lundberg SJ, Neumann GR. How long is a spell of unemployment? Illusions and biases in the use of CPS data. J Bus Econ Stat. 1985;3(2):118–28.
19 House of Representatives, Committee on Energy and Commerce, Minority Staff. Debunking Republican claims about coverage losses under the Affordable Care Act [Internet]. Washington (DC): House of Representatives; 2013 Dec [cited 2014 Mar 26]. Available from: http://democrats.energycommerce.house.gov/sites/default/files/documents/ACA-Coverage-Statistics-2013-12-31.pdf
20 House of Representatives, Committee on Energy and Commerce, Majority Staff. The price of Obamacare's broken promises: young adults and middle class families set to endure higher premiums and unaffordable coverage [Internet]. Washington (DC): House of Representatives; 2013 Mar [cited 2014 Mar 26]. Available from: http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/analysis/20130305PremiumReport.pdf
21 Collins SR, Nicholson JL. Rite of passage: young adults and the Affordable Care Act of 2010 [Internet]. New York (NY): Commonwealth Fund; 2010 May [cited 2014 Mar 26]. (Issue Brief). Available from: http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/May/1404_Collins_rite_of_passage_2010_v3.pdf
22 Zaldivar A. Obama administration announces two-year extensions for canceled health plans. PBS Newshour [serial on the Internet]. 2014 Mar 5 [cited 2014 Apr 2]. Available from: http://www.pbs.org/newshour/rundown/obama-administration-announces-two-year-extensions-canceled-health-plans/

Downloaded from content.healthaffairs.org by *Health Affairs* on May 16, 2014
by KATHERINE MARCELLUS

MAY 2014

Realizing Health Reform's Potential

The Federal Medical Loss Ratio Rule: Implications for Consumers in Year 2

Michael J. McCue and Mark A. Hall

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

For more information about this study, please contact:

Michael J. McCue, D.B.A.
Professor
Virginia Commonwealth University
mccue@vcu.edu

To learn more about new publications when they become available, visit the Fund's website and register to receive email alerts.

Commonwealth Fund pub. 1744
Vol. 8

Abstract: For the past two years, the Affordable Care Act has required health insurers to pay out a minimum percentage of premiums in the form of medical claims or quality improvement expenses—known as a medical loss ratio (MLR). Insurers with MLRs below the minimum must rebate the difference to consumers. This issue brief finds that total rebates for 2012 were $513 million, half the amount paid out in 2011, indicating greater compliance with the MLR rule. Spending on quality improvement remained low, at less than 1 percent of premiums. Insurers continued to reduce their administrative and sales costs, such as brokers' fees, without increasing profit margins, for a total reduction in overhead of $1.4 billion. In the first two years under this regulation, total consumer benefits related to the medical loss ratio—both rebates and reduced overhead—amounted to more than $3 billion.

OVERVIEW

One of the consumer protections afforded by the Affordable Care Act (ACA) is the regulation of health insurers' "medical loss ratios," or MLRs. An MLR is a key financial measure that shows the percentage of premium dollars a health insurer pays out for medical care and quality improvement expenses, as opposed to the portion allocated to overhead in the form of profits, administrative costs, and sales expenses. For instance, if an insurer uses 80 cents of every premium dollar to pay its customers' medical claims and carry out activities to improve the quality of care, it has a medical loss ratio of 80 percent.

To reduce overhead and, ultimately, the cost of insurance to consumers and the government, the ACA sets minimum MLRs for insurers. Starting January 1, 2011, insurers offering comprehensive major medical policies were required to maintain an MLR of at least 80 percent in the individual and small-group markets and at least 85 percent in the large-group market.[1] Insurers that pay out less than these percentages on medical care and quality improvement must rebate the difference to their members.

Any major new regulation of an industry requires a period of adjustment, and often some measure of disruption or dislocation can be expected. A year ago, we reported that health insurers that failed to meet the MLR requirements paid out over $1 billion in rebates to consumers in 2012.[2] In addition, insurers reduced administrative costs and profits by over $350 million, in part to reduce the rebates they might owe. Insurers reported spending less than 1 percent of their premium revenues on improving the quality of care.[3]

This issue brief revisits these measures a year later to determine whether there has been an impact of similar magnitude in the MLR regulation's second year. We find that rebates in year 2 dropped by half, to $513 million, indicating greater compliance with the minimum MLR standard. Insurer spending on quality improvement remained low, at less than 1 percent of premiums. However, insurers continued to reduce their administrative and sales costs, such as brokers' fees, without increasing profit margins, for a total reduction in overhead of $1.4 billion. This is on top of the $350 million of reduced overhead seen in 2011. It is not known exactly how much of the reduced overhead can be attributed to the new MLR regulation rather than to market competition, but it seems fair to conclude that total consumer benefits related to the MLR have amounted to more than $3 billion in the first two years (consisting of $1.5 billion in rebates and $1.75 billion in reduced overhead).

Data for this brief come mainly from insurers' MLR filings with the Centers for Medicare and Medicaid Services (CMS) for 2011 and 2012. Using these data, each section of this report draws on a different sample of insurers: all reporting insurers, or insurers with "credible" actuarial experience (defined as having at least 1,000 members in each market segment). (For more, see "About This Study," below.)

CONSUMER REBATES

Overall, the amount that insurers paid in consumer rebates dropped by half from 2011 to 2012, from $1.1 billion to $513 million dollars (Exhibit 1). This total reflects both a reduction in the percentage of insurers owing rebates and in the size of rebates they owed. The pattern varied somewhat by market segment, but in general, there was a greater drop in the size of rebates than in the percentage of insurers that paid rebates (Exhibit 2).

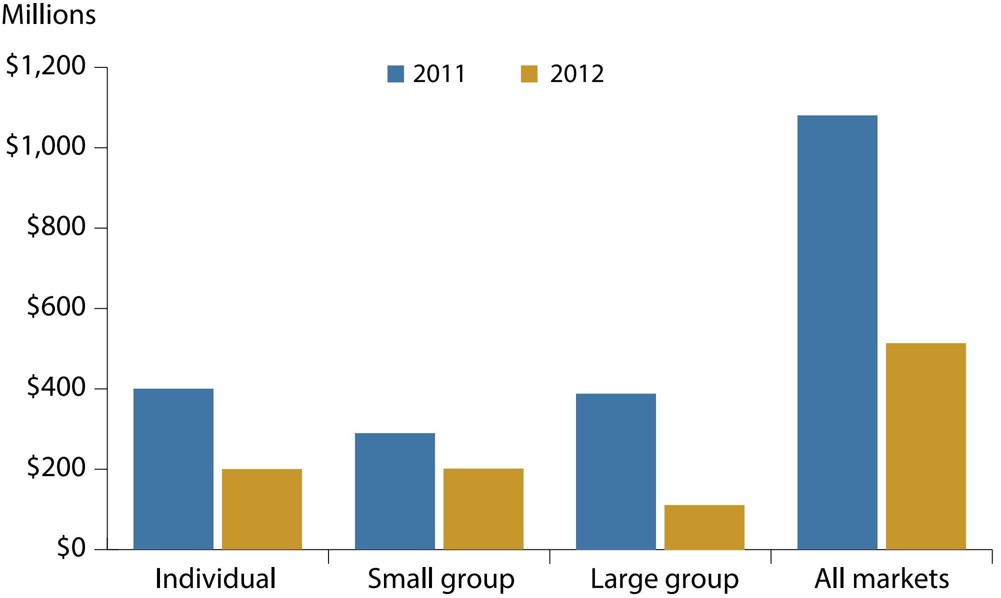
In the individual market, the median adjusted MLR[4] among insurers increased 2 percentage points,

About This Study

Study data were collected from the Centers for Medicare and Medicaid Services (CMS) as of August 1, 2013, for 2012 data and November 26, 2012, for 2011 data. Data were collected from health insurers in 50 states and the District of Columbia, but not from the territories. The key financial measures are referenced from insurers' National Association of Insurance Commissioners Supplemental Health Care Exhibit. In calculating financial measures, we included all insurers regardless of size, but we excluded those with negative or zero values for premium earned or medical claims. For the individual market, this produced a sample of 1,904 insurers in 2011 and 1,635 in 2012; for the small-group market, there were 1,030 insurers in 2011 and 950 in 2012; and for large-group insurers, 907 in 2011 and 852 in 2012.

CMS requires only insurers with "credible" actuarial experience to calculate MLRs and pay rebates. Actuarial credibility for this purpose requires at least 1,000 members in the particular market segment in a state. In 2011, this number was based on only a year of experience. In 2012, however, insurers were required to determine credibility based on two years' of experience combined, so more insurers became credible and thus subject to the MLR rule in 2012 than in 2011. Because of this change in measuring credibility, when we counted the number of active insurers, we did not use the CMS credibility rule. Instead, we counted insurers that had at least 1,000 members in a single year.

Exhibit 1. Consumer Rebates in the Individual, Small-Group, and Large-Group Markets



Source: Authors' analysis of CMS rebate data.

from 82.5 percent to 84.5 percent, between 2011 and 2012. Overall, individual market insurers paid $200 million in rebates in 2012, about half the amount they rebated the year before and less than 1 percent of their premium.

In the group markets, the median adjusted MLR increased less than 1 percentage point for both small- and large-group insurance. For the small-group market, this resulted in a smaller decline in rebates than for large groups. Total small-group rebates dropped 30 percent from 2011 to 2012, from $289 million to $201 million, whereas total large-group rebates dropped 71 percent, from $388 million to $111 million.

We also observed whether MLRs and the percentage and size of rebates differed among insurers according to their corporate characteristics. In 2012, as in 2011, insurers had lower median MLRs in most market segments, and thus were more likely to owe rebates, if they were for-profit, publicly traded, or not sponsored by health care providers (Exhibit 3).

Exhibit 2. Medical Loss Ratios and Rebates by Market Segment, 2012 and 2011

	Individual		Small Group		Large Group	
	2011 n=548	2012 n=655	2011 n=562	2012 n=622	2011 n=587	2012 n=663
Median adjusted MLR	82.5%	84.5%	84.6%	85.3%	89.2%	89.6%
Percentage of credible insurers owing rebate	38%	32%	20%	18%	18%	15%
Median rebate per member	$108	$95	$116	$86	$99	$57
Total rebate paid (in millions)	$399.5	$200.4	$289.1	$201.4	$388.2	$111.3
Rebate as a percentage of premium	1.39%	0.72%	0.38%	0.28%	0.192%	0.06%

Insurers with actuarial "credibility" are those with enough enrollment to be subject to the MLR rule. Adjusted MLRs are defined in note 4 on page 8.
Source: Authors' analysis of CMS medical loss ratio and rebate data.

Exhibit 3. 2012 MLR and Rebate by Corporate Type

Individual Market	Median Adjusted MLR	Percentage Owing Rebate
Non-publicly traded n=325	88%	28%
Publicly traded n=330	82%	36%
Not-for-profit n=117	93%	10%
For-profit n=538	83%	37%
Provider-sponsored n=40	98%	10%
Non-provider-sponsored n=615	84%	34%
Small-Group Market		
Non-publicly traded n=325	87%	14%
Publicly traded n=297	84%	22%
Not-for-profit n=156	87%	10%
For-profit n=466	85%	21%
Provider-sponsored n=60	92%	3%
Non-provider-sponsored n=562	85%	19%
Large-Group Market		
Non-publicly traded n=314	92%	10%
Publicly traded n=349	88%	20%
Not-for-profit n=171	92%	2%
For-profit n=492	89%	20%
Provider-sponsored n=68	93%	2%
Non-provider-sponsored n=595	89%	17%

Source: Authors' analysis of CMS medical loss ratio and rebate data.

Insurers' Financial Performance

We next analyzed how key financial performance measures for insurers changed from 2011 to 2012. Last year, we reported that between 2010 and 2011, the first year of the MLR rule, administrative costs decreased nationally in each fully insured market segment. The biggest decrease—more than $785 million—occurred in the large-group (fully insured) market, with reductions of about $200 million in both the small-group and individual markets.[5] For the large-group and small-group markets, this $975 million combined reduction in administrative costs coincided with increases in profits of more than $1 billion. In the individual market, profit margins declined by $351 million, which was more than administrative costs.

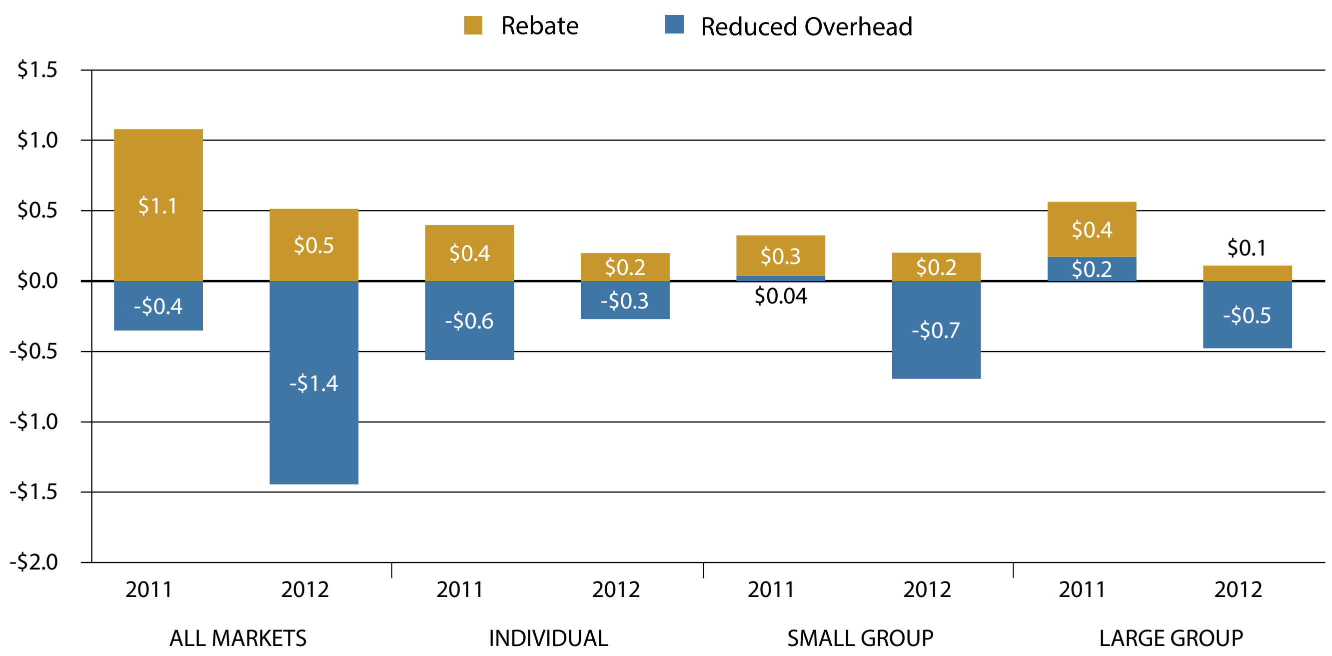
As shown in Exhibits 4 and 5, similar trends continued and increased in the MLR rule's second year. The overall MLR for the industry (unadjusted for quality expenses or other factors) increased by half a percentage point, which means that premium amounts devoted to overhead (profits plus administrative and sales costs) decreased by $1.4 billion. The lowered overhead—while not entirely attributable to the MLR rule—represents a significant benefit for consumers.

Quality Expense and Overhead Components

Exhibit 5 presents components of insurers' expenses that are of particular interest for public policy. The Affordable Care Act's MLR rule regards expenses for quality improvement (for definition, see glossary on page 7) as being part of medical claims rather than part of administrative expenses. In 2012, these quality improvement expenses remained just under 1 percent of premiums.[6]

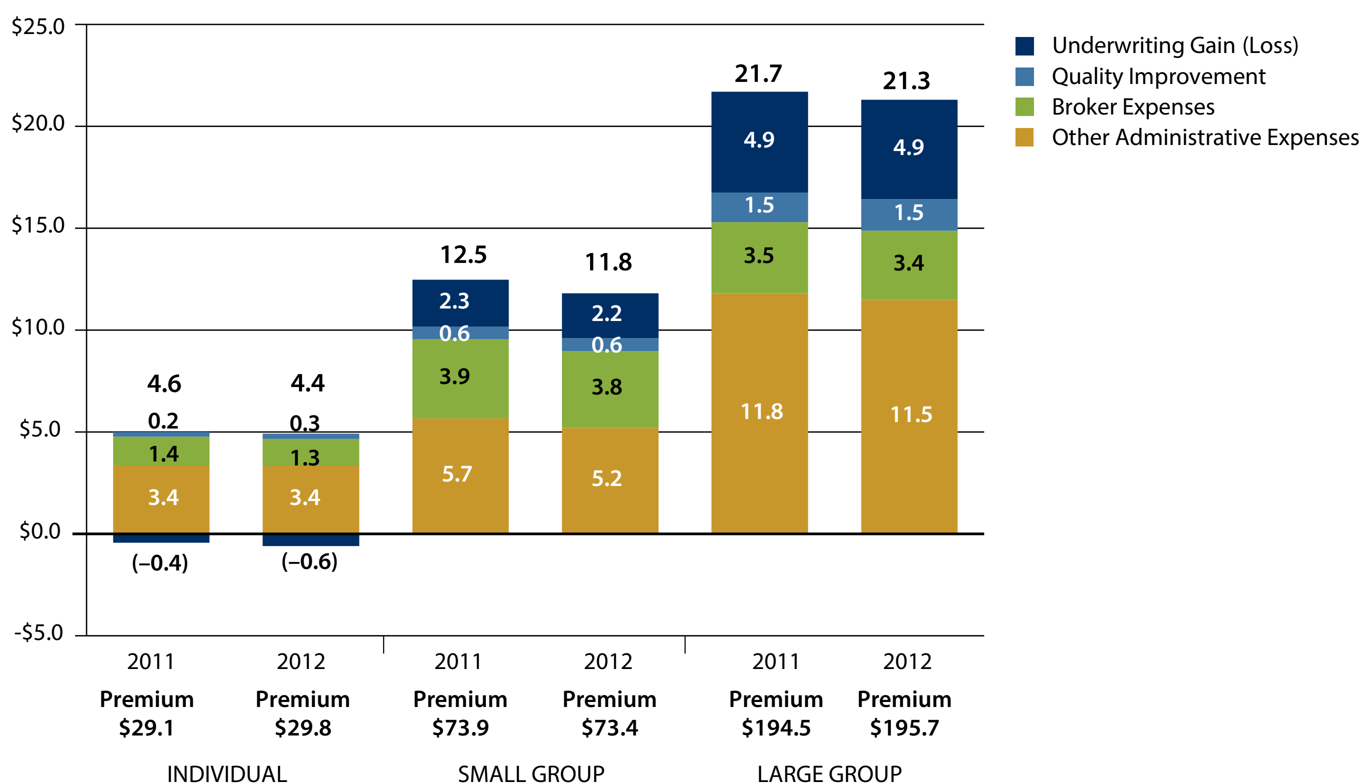
We also focus on insurers' expenses for brokers as a component of administrative costs. This issue is significant because of the concern that increasing MLRs will cause insurers to reduce the role of—or compensation for—independent brokers. Broker expenses, which amount to about 3 percent of

Exhibit 4. Insurance Rebates and Overhead Reductions, 2011 and 2012, by Market (in billions)



Note: Overhead consists of profits plus administrative and sales costs.
Source: Authors' analysis of NAIC and CMS medical loss ratio and rebate data.

Exhibit 5. Components of Insurance Overhead and Quality Improvement Spending, by Market (in billions)



Source: Authors' analysis of CMS medical loss ratio data.

Exhibit 6. Number of Credible Insurers with 1,000 or More Members, by Market

Insurers

	2011	2012
Individual	549	488
Small group	563	530
Large group	587	592

Source: Authors' analysis of CMS medical loss ratio and rebate data.

premiums, dropped by almost $300 million across all three markets in 2012. However, that amounts to only 3.5 percent of total broker expense.

Finally, insurers' total profits (also known as underwriting gain) for all markets declined by over $300 million, which is only 0.1 percent of premiums. Individual insurance continued to show a small loss, while group insurance had underwriting gains of 2.5 percent to 3 percent.

Number of Insurers

When the Affordable Care Act was enacted, some critics predicted it would cause an exodus of insurers from the market.[7] To assess this concern, we measured changes in the number of active insurers, either inside or outside the new marketplaces. In this analysis, we only included insurers with 1,000 or more members in a market segment.

In 2012, there was a modest contraction but still a substantial number of insurers actively competing (Exhibit 6). Throughout the country, there were roughly 500 insurers in each market segment (individual, small-group, and large-group). These numbers reflect modest decreases from 2011 in the individual and small-group markets, where the number of insurers with at least 1,000 members declined 11 percent and 6 percent, respectively.[8]

Some degree of market consolidation is to be expected. The number of insurers has declined steadily for more than a decade as the industry consolidates either through acquisition and merger or because smaller insurers have difficulty competing.[9] Therefore, a modest reduction in the number of insurers does not appear to be strongly related to the Affordable Care Act. Perhaps some insurers have left because their business model depended on the type of close medical underwriting that the ACA now prohibits. However, the ACA's subsidized insurance marketplaces are credited with bringing a significant number of new insurers into the individual market.[10]

CONCLUSION

The new federal regulation of health insurers' medical loss ratios continues to provide substantial consumer benefits in its second year of operation. Although total rebates to consumers dropped by half, from over $1 billion to $513 million for 2012, this results from insurers' greater compliance with the MLR rule. To meet the new minimums, insurers also reduced their administrative costs without substantially increasing profits,

producing a net reduction in overhead of $350 million in 2011 and $1.4 billion in 2012. The combined effect of both $1.5 billion in rebates and $1.75 billion in reduced overhead amounts to more than $3 billion of consumer benefit related to the MLR rule in the first two years. However, insurer spending on quality improvement has remained low, at less than 1 percent of premium, even though the new law allows insurers to count these expenses toward meeting their required minimums.

These consumer gains have not come at the cost of substantially reduced competition or choice among insurers. Although there was a modest reduction in the number of insurers with 1,000 or more members, this appears to continue a decade-long trend of consolidation. Despite this reduction, roughly 500 insurers appear to remain active in both the individual and the group markets across all states. On balance, federal regulation of MLRs appears to be producing significant consumer benefits without causing any substantial harm to the insurance markets.

GLOSSARY OF FINANCIAL MEASURES

Premium earned is net adjusted premium earned after accounting for reinsurance.

Medical expense is net incurred medical claims after accounting for reinsurance. This is a gross measure that does not fully account for several adjustments that insurers are permitted to make in calculating whether they comply with the MLR rule or owe a rebate.

Quality improvement costs are all expenses related to improving quality of care activities and include the following activities: improving health outcomes, preventing hospital readmissions, improving patient safety and reducing medical errors, increasing wellness and promotion, and incurring health information technology expenses for improving quality of care. Total quality of care is included along with medical expenses in the numerator of the MLR for purposes of calculating rebates owed under the federal regulation.

Overhead refers to the component of premium that is not spent on medical costs or improving quality of care. It equates simply to the sum of administrative and sales costs plus profit margin.

- ***Agent and broker expenses*** are usually reported as part of administrative expenses, but here we separate out this element.
- ***Other administrative costs*** are all administrative expenses other than those for agent and broker fees. Included are internal sales expenses, claims adjustment costs, and salary and benefit expenses, as well as all other general corporate overhead costs.
- ***Profit margin*** is also known as the underwriting gain or loss. It is calculated by subtracting medical and quality improvement expenses and administrative and sales costs from net premium earned. As such, it does not include profit or loss from investments or taxes on investments. A negative profit margin indicates that medical and administrative costs exceeded premiums.

Notes

1 The small-group market consists of employers with 50 or fewer workers.

2 M. J. McCue and M. A. Hall, *Insurers' Responses to Regulation of Medical Loss Ratios* (New York: The Commonwealth Fund, Dec. 2012).

3 M A. Hall and M. J. McCue, *Insurers' Medical Loss Ratios and Quality Improvement Spending in 2011* (New York: The Commonwealth Fund, Mar. 2013).

4 In calculating the MLR for rebate purposes, the federal rule allows insurers to make various adjustments. Insurers with fewer than 75,000 members and those that have high deductibles (i.e., greater than $2,500) may increase their calculated MLR under a formula that takes into account greater actuarial predictability for smaller pools and lower claims for high-deductible plans.

5 McCue and Hall, *Insurers' Responses*, 2012. In data not shown, insurers reported a somewhat lower proportion of quality expense being devoted to health outcomes (44% in 2012 vs. 51% in 2011) but a somewhat increased proportion being devoted to wellness and health promotion (17% in 2012 vs. 13% in 2011). It is difficult to interpret how meaningful these changes are in how insurers allocate quality expenses.

6 Ibid.

7 For instance, R. Epstein, "Unmanageable Competition," *Forbes,* Nov. 24, 2009.

8 In this snapshot, we did not investigate whether these enrollment drops were large or miniscule for each insurer or whether these insurers remained somewhat active in the market or withdrew entirely. Also, note that some changes in insurer counts, both increases and decreases, can occur simply because an insurance holding company with various subsidiaries either consolidates or increases the number of subsidiaries. Also, since 2012, new insurers have entered the individual market in several states as part of their new insurance exchanges. See C. Cox, G. Claxton, L. Levitt et al., *An Early Look at Premiums and Insurer Participation in Health Insurance Marketplaces, 2014* (Menlo Park, Calif.: Kaiser Family Foundation, Sept. 2013). Therefore, our coarse measure does not perfectly reflect the level of effective competition in a state. Nevertheless, it gives a rough indicator of any major changes nationally.

9 J. C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs,* Nov. 2004 25(6):11–24; American Medical Association, *Competition in Health Insurance* (various years); D. Andrew Austin and T. L. Hungerford, *The Market Structure of the Health Insurance Industry* (Washington, D.C.: Congressional Research Service, 2009).

10 McKinsey Center for U.S. Health System Reform, *Emerging Exchange Dynamics: Temporary Turbulence or Sustainable Market Disruption?* (New York: McKinsey and Company, 2013); J. Holahan et al., *Insurer Participation and Competition in Health Insurance Exchanges* (Urban Institute, 2013), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf406939.

About the Authors

Michael J. McCue, D.B.A., is the R. Timothy Stack Professor in the Department of Health Administration in the School of Allied Health Professions at Virginia Commonwealth University. He received his doctorate in business administration from the University of Kentucky with a concentration in corporate finance and has conducted several funded studies with Robert E. Hurley, Ph.D., on the financial performance of publicly traded Medicaid health plans.

Mark A. Hall, J.D., is the Fred D. & Elizabeth L. Turnage Professor of Law and Public Health at Wake Forest University. One of the nation's leading scholars of health care law and policy and bioethics, he is currently engaged in research in the areas of health insurance regulation and reform, consumer-driven health care, and safety-net access for the uninsured. Hall regularly consults with government officials, foundations, and think tanks about health care public policy issues.

Editorial support was provided by Deborah Lorber.

THE
COMMONWEALTH
FUND

Expert Voices

In Health Care Policy

WHAT TO EXPECT FOR 2015 ACA PREMIUMS: AN ACTUARY OPENS THE BLACK BOX

John Bertko, FSA, Retired Senior Actuary, Center for Consumer Information and Insurance Oversight, CMS

May 2014

The Affordable Care Act (ACA) greatly changed how health insurers set premiums in the individual market starting in 2014. In spite of the uncertainty introduced by these changes, premiums for this year generally emerged better than expected, and CBO and JCT have lowered their estimate of average 2014 premiums in the exchanges by about 15 percent.[1] Time will tell whether these premiums end up being too low, too high, or right on the mark for the population enrolled. While early enrollment snags in many exchanges fueled concerns about adverse selection and a possible spike in premiums for 2015, the late enrollment surge seems to have mitigated some of this concern.[2]

Well before the full 2014 experience is known, however, insurers must set their prices for 2015. Initial rate filings are already underway, and negotiations with regulators and exchange managers over the summer will determine final rates. In this essay, I describe the myriad factors that will be on the minds of health plan actuaries as they develop premiums, highlighting factors that will be more – or less – predictable and assessing their likely influence on future rates. This assessment is from a national perspective; individual state experiences will differ significantly based on whether they allowed insurers to extend non-ACA compliant policies beyond 2013 and their overall success in enrolling a large and balanced risk pool in exchange plans. Pricing updates also will vary across markets within a state and even within markets, depending on the characteristics of the local market and the insurers offering products.

REMEMBER THE SINGLE RISK POOL

Under ACA rules an insurer must price for the individual market using a single risk pool that includes all of its enrollees in ACA-compliant policies, whether purchased on or off the exchange. Enrollees in catastrophic plans are excluded, as are those remaining in pre-2014 non-compliant products via grandfathering, early renewal or the extension of these products first permitted in November 2013. It is the exclusion of this latter group, largely expected to be better risks, that leads to concerns about worsening risk pools in states allowing such transitions. However, many off-exchange enrollees will be healthier people who were previously underwritten and "retained" by their insurer, offsetting some of the pressure for higher premiums based on exchange enrollment alone.

KNOWABLE FACTORS

Some factors affecting insurers' 2015 premiums can be projected with a fair amount of certainty. As always, actuaries will begin by using prior-period adjudicated claims to compute "trend" – that is, the rates at which cost per service, service use per enrollee, and intensity of service use have been changing for all of their privately insured enrollees. This factor will point to increasing premiums. They must then project this trend forward to the 2015 rating period by assessing whether utilization patterns of the 2014 enrollees differ from those underlying the trend (such as due to the new, very expensive drug for Hepatitis C) and developing expectations about whether the 2015 enrollees will look like the 2014 pool.

Insurers now assessing their 2014 enrollees will face data shortcomings but will not be completely in the dark. Many carriers will have claims for their pre-ACA enrollees who stayed with them in 2014 by moving into ACA-compliant products on or off the exchange. Actuaries at several insurers have told me they expect these enrollees to comprise up to three-quarters of their single risk pool – providing very significant insights for future pricing as well as a large share of enrollees expected to be healthier, on average. Similarly, insurers will know the risk profile of any enrollees continuing in their non-compliant plans and can estimate the impact of excluding them from the pricing pool.

Enrollees who are new to the insurer in 2014 pose more of a projection challenge. Insurers will know their age and gender but will have very limited data from medical claims in time for rate filing, even for people who signed up early enough to start using services in January 2014. Projecting forward from a short period with limited data can be misleading particularly if early enrollees quickly generate claims due to higher-than-average health needs while later enrollees are healthier and not represented in

the claims. To gather additional information, many insurers are administering Health Risk Assessments to new enrollees. They are also poring over prescription drug claims, which are available in near real time, to help fill in the risk profile for all of their enrollees. Insights gleaned from these sources may impact rates in either direction, depending on the risk profile that emerges.

Insurers must also consider the "pent-up demand" that is expected as previously uninsured enrollees take advantage of their new coverage. Most actuaries priced for this higher utilization when they set 2014 premiums, but they are likely to project a smaller impact from this factor for 2015. Consumers with these high initial needs would have obtained services early in 2014 and there should be disproportionately fewer enrollees with unmet health needs in 2015, assuming those with the most pressing needs enrolled in 2014.

Finally, actuaries can easily account for new parameters in the transitional re-insurance program that will cause fewer claims to qualify for protective payments next year. As this protection is eased, there will be upward pressure on premiums.

FACTORS THAT ARE HARDER TO ESTIMATE

Accounting for the other two components of the ACA's premium stabilization protections – risk adjustment and risk corridors – will be more difficult in the pricing decisions now being made. For risk adjustment, the flow of funds between plans will depend on how each plan's risk score stacks up relative to the average risk score for all plans in the market, but this latter score will not be known until early 2015. A plan whose current assessment of its own enrollees suggests that it has attracted higher risks still cannot count on compensation under risk adjustment next year if all plans in the market attracted similarly less healthy members in 2014.

Likewise, payments and collections under the risk corridors will not occur until mid-2015 for 2014 plan experience. Recent changes to the risk corridor formula provide additional protection to plans for higher-than-expected administrative costs related to the transitional policy and exchange rollout problems and are intended to avert premium spikes. However, the application of budget neutrality to the risk corridor program introduces new uncertainty that may prompt insurers to price this risk into their premiums.[3]

Another unknown is how large the enrollment pool will be next year. Most actuaries expect higher take-up rates among the uninsured as the individual mandate penalty rises appreciably. Continuing improvement in exchange functionality and more public awareness of coverage options should also bolster enrollment. A larger pool will help to moderate premium increases by diluting the impact of high cost enrollees.

> "The outlook for 2015 premiums is still very cloudy… there will be significant variation across states… rates will depend on much more than simply the mix of enrollees attracted to the exchanges."

Much of the "surprise" of the lower-than-expected premiums seen in 2014 has been attributed to the use of narrower provider networks for which insurers have been able to negotiate the most favorable rates. A big question going forward is whether these narrow networks will persist. Will insurers determine that they can continue to achieve premium savings and attract enrollees using this strategy? Or will consumer and provider backlash, and perhaps more stringent regulations about network adequacy and inclusion, force a retreat? Answers to these questions will affect premiums for 2015 and beyond.

Various industry fees and taxes are expected to increase premiums on net, but the magnitude of the impact is hard to predict, particularly for any given insurer. For example, the size of any assessments imposed by states next year to support their exchanges will be determined by still-unknown 2015 exchange enrollment figures. Insurers also will not have all information needed to estimate their share of the $11.3 billion health insurer tax to be collected for 2015. Furthermore, the health insurance and medical device taxes may be passed on entirely to consumers or partially absorbed by insurers, manufacturers and providers trying to retain or increase their competitive positions.

The effects of competition and new entrants are probably the biggest unknowns for 2015 pricing, as insurers jockey for market position. While most large national insurers chose to stay mainly on the sidelines in 2014, some like United HealthCare appear poised to enter additional markets next year. Might new entrants price more aggressively believing that the higher-risk 2014 enrollees will "stick" with their 2014 insurance plans? Or will they anticipate attracting their share of risky enrollees during open enrollment and temper their pricing accordingly? And what about some of the CO-OPs and other start-ups that attracted significant market share this year through low premiums: will they be able to maintain similar pricing in 2015? All carriers offering individual coverage will be sizing up the competitive environment in specific local markets and factoring this assessment into their pricing strategies.

CONCLUSION

The outlook for 2015 premiums is still very cloudy at this point. In all markets, important factors such as trend, lower transitional reinsurance payments and industry fees point to higher premiums. Conversely, the single risk pool and the expected influx of brand-new consumers with fewer immediate health needs should help to mitigate premium increases. For many other factors, considerable uncertainty remains about how things will play out.

Importantly, there will be significant variation across states based on the degree to which they allowed insurers to extend non-ACA compliant policies beyond 2013. My calculations and conversations with others in the industry suggest that the smaller and less healthy risk pools in states that delayed transition to ACA compliance will lead to premium increases that are at least 10 percent larger than in other states.

Predicting rates is not a simple exercise for plan actuaries and is even more difficult for outside prognosticators operating with less data. Clearly, 2015 rates will depend on much more than simply the mix of enrollees attracted to the exchanges. And wherever the 2015 rates settle after the regulatory reviews this summer, it will be yet another year (or even longer) before we know if the 2015 pricing was on the mark. By that time, plans will be pricing for 2016.

ENDNOTES

1 Congressional Budget Office, "The Budget and Economic Outlook: 2014 to 2024," February 2014. http://www.cbo.gov/publication/45010 (accessed February 5, 2014).

2 Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. "Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period." May 1, 2014. http://tinyurl.com/o639hcr (accessed May 2, 2014).

3 American Academy of Actuaries. Comments on Exchange and Insurance Market Standards for 2015 and Beyond – Proposed Rule. April 21, 2014. http://tinyurl.com/k5x2x6y (accessed May 2, 2014).

Why Not Just Eliminate the Employer Mandate?

Linda J. Blumberg, John Holahan, and Matthew Buettgens

Timely Analysis of Immediate Health Policy Issues

MAY 2014

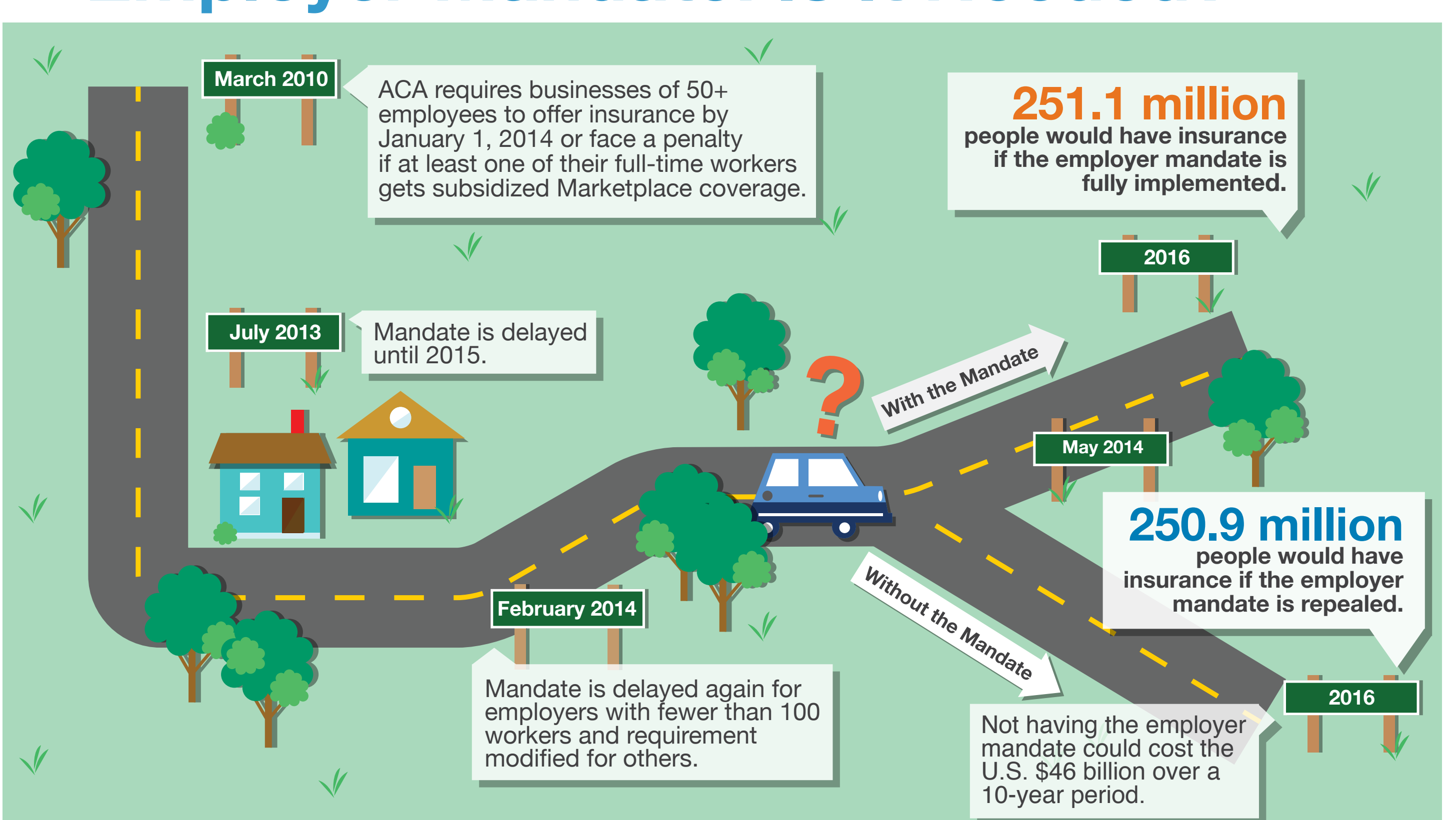
In-Brief

Controversy over the Affordable Care Act's employer mandate continues. The requirement's implications for coverage are small, and yet the negative labor market effects of keeping it in place could harm some low-wage workers.

Under the law, employers of 50 or more workers are subject to a penalty if at least one of their full-time workers obtains a Marketplace subsidy. Employees offered coverage deemed affordable and adequate are prohibited from obtaining subsidies, as are their family members, and employers can avoid penalties by offering coverage to at least 95 percent of workers. However, the Administration has delayed the requirements until 2016 for employers of 50-99, for larger employers until 2015, and softened requirements for that first year. Yet there are anecdotal reports of employers changing labor practices even though penalties have yet to be implemented.

Our analyses as well as that of others find that eliminating the employer mandate will not reduce insurance coverage significantly, contrary to its supporters' expectations. Eliminating it will remove labor market distortions that have troubled employer groups and which would harm some workers. However, new revenue sources will be required to replace that anticipated to be raised by the employer mandate.

Employer Mandate: Is It Needed?



The Employer Mandate and Business Opposition to the ACA

The ACA's employer penalties will increase costs for some employers because they must newly provide coverage or pay penalties. This has contributed to vocal opposition to the ACA from business groups. These responses may also influence decisions by employers related to the number of workers they employ and the hours each works. The most frequent claim is that employers will move to more of a part-time workforce. For example, several large firms recently announced that they would be reducing hours for part-time workers to less than 30 (Land's End, Regal Entertainment, Wendy's, and SeaWorld).[1] In a different response, Trader Joe's and Target stopped providing coverage to part-time workers (those typically working fewer than 30 hours per week), believing most would be better off with subsidized coverage in Marketplaces. These claims have taken a toll on the perception of the law, but the actual size of changes in the workforce and whether they are sustainable in strong labor markets is unclear.

Those working 30 to 39 hours per week who do not already have access to employer based insurance and who fall within the income range making them eligible for Marketplace-based subsidies compose 1.8 percent the workforce (2.3 million people).[2] Some firms could also shift a segment of their full-time workforce to part-time status—under 30 hours per week. However, there are problems with a reliance upon a part-time workforce. Moving to more of a part-time workforce means employing larger numbers of workers to do the same jobs, which will lead to increased costs from administrative expenses and nonhealth benefits and lost efficiency from employing more workers to do a job than is necessary. There are also turnover costs and hiring difficulties when workers do not obtain their desired number of hours. Although a small share of the workforce may be affected by these types of changes in hours, the lost income for those who do experience such changes will likely be problematic.

Another claim is that small firms will avoid increasing the number of workers they hire beyond 49. The decision to hire more than 49 workers will be based on many factors, of which health insurance costs are only one. Firms look at the longer-term gains of expanding their workforce and thus their productive capacity; they do not simply look at the marginal cost of adding the 50th employee. All of these concerns provide disincentives to change employer approaches to workforce decisions, somewhat counterbalancing the incentives in the ACA's provisions.

However, even if the ACA's labor market effects are modest, there will undoubtedly be some distortions created. Creating arbitrary thresholds (e.g., potential penalties for firms of 50 or more workers not providing coverage for employees typically working 30 or more hours per week) for financial requirements will change the employment decisions in some firms, and at least some workers will be adversely affected by them.

And, as is the case when employers begin to make contributions to worker health insurance coverage, penalties imposed on employers for not providing coverage to their workers may initially affect employers' bottom lines. But over time, these costs are likely to be passed back to their workers in the form of reduced wages. This transition can take an indeterminate amount of time, though in the interim these costs can affect employers' profits.[3] In the long run, the costs tend to be absorbed by the workers.

Employers with 50 or more workers not offering coverage pre-ACA are the same employers that are highly likely to not offer in the future, therefore incurring the ACA's penalties. Because the nonoffering firms are much more likely to be firms dominated by low-wage workers (Table 1 shows the substantial differences in offer rates by employer size and worker wages), low-wage employees will bear the greatest brunt of the penalties imposed.

Table 1. 2012 Distribution of Employers of 50 or More Workers, by Size, Share of Low Wage Workers, and Offer Status

	Employer Size			
	Total 50+ Workers	50-99 Workers	100-999 Workers	1,000+ Workers
Number of Employers				
Total	1,668,613	218,619	450,402	999,592
Low-wage	656,874	72,760	166,748	417,366
Higher-wage	1,011,739	145,859	283,654	582,226
Number Not Offering ESI				
Total	68,843	37,207	26,551	5,086
Low-wage	48,609	26,094	19,176	3,339
Higher-wage	20,235	11,113	7,375	1,747
Share Not Offering ESI				
Total	4.1%	17.0%	5.9%	0.5%
Low wage	7.4%	35.9%	11.5%	0.8%
Higher-wage	2.0%	7.6%	2.6%	0.3%

Source: Authors' calculations based on Medical Expenditure Panel Survey–Insurance Component data, 2012.

Notes: A low-wage worker is defined as a worker earning at or below the 25th percentile for all hourly wages in the US, based on data from the Bureau of Labor Statistics. In 2012, workers earning at or below $11.50 per hour were deemed low-wage workers. A low-wage firm is defined as having 50 percent or more of its workers low-wage. Counts are numbers of establishments by firm size.

Therefore, using employer penalties as a tool for financing reform tends to be a regressive approach.

Eliminating the employer responsibility requirements should substantially diminish employer opposition to the ACA. In fact, without that burden, employers may play more of a role promoting the expansion of coverage under the law.

Why Employers Will Generally Continue Providing Coverage without a Mandate

Most employers would not drop coverage if the penalties were eliminated. About two thirds of American workers now have offers of employer coverage when there is no mandate to do so.[4] Why do employers provide health insurance coverage voluntarily? One major reason lies in the tax benefits. Workers benefit from receiving employer health insurance contributions—nontaxable compensation—in lieu of salary. The alternative would be giving individuals a higher salary, which would be taxable income, and those workers would then have to purchase coverage in the individual market. These tax benefits to individuals increase as incomes increase, thus incentives to offer coverage are greater for employers with a higher-paid workforce than a less well paid one. Individuals also benefit from employers providing coverage because of efficiencies in administration. Human resource offices develop expertise in assisting with the choice of insurance. Businesses also provide natural risk-pooling (i.e., individuals come together because of their skill and work interests, not to obtain health insurance); this reduces risk to insurers and lowers premiums. It is also argued that firms provide coverage to enhance employee loyalty.

The ACA has components that, alone, would lead to both increases and decreases in the number of employers offering health insurance. The penalties on employers will increase the likelihood that some employers will offer coverage, although most firms that do not offer coverage today (e.g., those with fewer than 50 workers) are not subject to penalties. The presence of the Small Business Health Options Program (SHOP) may make insurance easier for employers to purchase, reduce premiums, and provide broader choice of insurance plans for employees, although this program has gotten off to a slow start in most states. There are also small business tax credits which, though limited to the smallest, lowest-wage employers, may induce more employer-based coverage. Finally, the individual mandate is likely to cause employees, particularly those not eligible for income-related subsidies, to seek to have their employers provide health insurance coverage.

On the other hand, firms with large numbers of low-wage workers may become less likely to offer. For such firms, workers may benefit more from premium tax credits than they do from the tax benefits from employer-based coverage. The employer penalty can make the difference in the employer's coverage decision if the value of the premium tax credits to the firm's workers exceeds the value of the employer-based tax benefits by less than the size of the penalty. Firms with extremely low-wage workers (those with family incomes below 138 percent of the federal poverty level) will benefit from having their workers enroll in Medicaid (employers do not incur any penalties from their workers enrolling in Medicaid).[5] These low-wage firms were far less likely to offer coverage before the ACA and some will drop coverage whether there is an employer penalty or not, simply because subsidies for those without an affordable offer of insurance and expanded Medicaid eligibility make dropping coverage more likely.

On balance, the individual mandate and tax benefits will keep most employers offering coverage regardless of the penalty. And those that drop because of the ACA will have done so because of other provisions in the law (e.g., the Medicaid expansion and income-related subsidies). Few employers will decide to no longer offer coverage simply because penalties are eliminated.

Coverage Impacts of Eliminating the Mandate

Our analysis using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), taking all of the law's coverage-related provisions into account, indicates that there will be little change in the number of employers offering coverage and the number of workers obtaining employer-based coverage under the ACA if the employer mandate were eliminated (compared to it being fully implemented). Table 2 shows the key results—overall, coverage is changed very little. The number with employer coverage falls by 500,000, a relative decrease of just 0.3 percent. Other forms of coverage (i.e. nongroup and Medicaid) change more modestly, increasing by 300,000 and 100,000 people respectively. The number of uninsured increases by about 200,000 people, a relative increase of about 0.6 percent.

In comparison, the Congressional Budget Office's (CBO) estimates of the effect of a one-year delay in the employer requirement were that employer coverage would fall by 1.0 million people;[6] this is higher than our estimate but still 0.6 percent of the expected level with the employer mandate. The CBO model is based on a different data set than HIPSM and implicitly assumes more employers will drop insurance coverage under the ACA than is computed by HIPSM. Nevertheless, both of these different models show very small coverage effects from eliminating the employer responsibility requirement. By CBO's estimate, about half of the extra 1 million not obtaining employer coverage would gain Medicaid or nongroup coverage and the number of uninsured would increase by 0.5 million. CBO suggests that the effects would be larger if the mandate was permanently delayed, but they did not provide such an estimate.[7]

These projections of small coverage effects of the employer penalty are consistent with the evidence of reform in Massachusetts. In 2006, Massachusetts passed comprehensive health insurance reform legislation, expanding Medicaid eligibility, providing subsidized private nongroup insurance coverage for the low-income population without affordable access to employer based coverage, and instituting an individual mandate to obtain coverage. The Massachusetts

Table 2. The Impact of Eliminating the Employer Mandate on Insurance Coverage (in Millions)

	ACA With Employer Mandate		ACA Without Employer Mandate	
	N	%	N	%
Insured	***251.1***	***90.6%***	***250.9***	***90.6%***
Employer	160.9	58.1%	160.4	57.9%
Non-Group (Non-Marketplace)	3.5	1.3%	3.5	1.3%
Non-Group (Marketplace)	20.6	7.4%	20.9	7.5%
Medicaid/CHIP	58.3	21.0%	58.4	21.1%
Other (Including Medicare)	7.7	2.8%	7.7	2.8%
Uninsured	***26.0***	***9.4%***	***26.2***	***9.4%***
Total	***277.1***	***100.0%***	***277.1***	***100.0%***

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2014.
Note: The ACA is simulated as if fully implemented in 2016.

reforms served as a model for many of the coverage components in the ACA. However, the Massachusetts law provided more generous financial subsidies for the purchase of private insurance to those residents below 300 percent of the federal poverty level than does the ACA,[8] and the state's employer penalties were considerably smaller than those in the ACA.[9] In fact, at a maximum of $295 per worker per year, the employer penalties in Massachusetts were sufficiently small to be considered irrelevant by many. While the subsidized nongroup coverage was more attractive for the low-income population and the penalties for employers not offering coverage were smaller than the ACA, there is no evidence that the state's reforms decreased the rate of employer offers or the rate of employer-based coverage. According to the Medical Expenditure Panel Survey-Insurance Component, the share of employers offering insurance coverage to their workers increased from 63.3 percent in 2005 to 64.6 percent in 2011, a period during which the offer rate in the US overall fell from 56.3 percent to 51.0 percent.[10] In addition, the share of the state's adults with employer-sponsored insurance rose to 63.6 percent in 2012 from 61.0 percent in 2006.[11]

Revenues

Ending the employer responsibility requirement would eliminate the federal revenues from penalty payments that employers would pay under current law. Our simulation estimates show that this would amount to just under $4 billion in 2016. Slight increases in Medicaid and Marketplace subsidies when the employer requirement is eliminated mean that net government cost would be about $4.3 billion higher per year absent the requirement, or about $46 billion between 2014 and 2023. The CBO estimates were $130 billion between 2014 and 2023.[12] Even though HIPSM estimates show that the federal revenue effects of the employer requirement are significantly smaller than those estimated by CBO given the different models, data, and behavioral assumptions, eliminating the requirement necessitates replacing revenues in the amount estimated by CBO, the official legislative scorekeeper. CBO's recent report[13] lists many options for raising revenue, including increasing income and payroll tax rates and broadening tax bases. CBO also suggests a number of health care–related options, including increasing the payroll tax for Medicare hospital insurance, raising taxes on alcoholic beverages and cigarettes, and reducing the tax preference for employer-based insurance. However, changing the tax preference, which can yield large sums of revenue, is a complicated option because it can have significant interactive effects with employer decisions to offer insurance (i.e., as the tax preference is reduced, the likelihood that employers will offer coverage to their workers decreases).

Reaching political agreement on new sources of revenue is never an easy task; however, the policy tradeoffs are straightforward. Concerns over labor market distortions and employer financial burdens related to the ACA's employer penalties can be eliminated with little relative impact on overall insurance coverage or the distribution of that coverage; the cost is agreeing upon an alternative source of $130 billion in federal revenue over 10 years.

CONCLUSION

In summary, eliminating the employer mandate would eliminate labor market distortions in the law, lessen opposition to the law from employers, and have little effect on coverage. Alternative sources of revenue would have to be found to compensate for the federal loss of penalties. Both the elimination of the mandate and creating a new source of revenue to replace it will require legislation. Current legislation before Congress proposes to move the employer requirement from employers of 50 or more workers to employers of 100 or more. While this approach would help those firms between 50 and 99 employees and decrease the exposure to adverse incentives within that group, it shifts the threshold where labor market effects could take place to a different point and does not address the concerns of large, low-wage firms. The individual mandate, together with the Medicaid expansion and income related subsidies, is, as we have shown elsewhere,[14] critical to expanding coverage under the ACA; the employer mandate is not.

Notes

1. Rocco M. "With Eye to ObamaCare, Companies Move to Cut Workers' Hours." *Fox Business*, Wednesday, September 11, 2013. http://www.foxbusiness.com/industries/2013/09/11/with-eye-on-obamacare-companies-move-to-cut-workers-hours/.
2. UC Berkeley Labor Center. "Which Workers Are More At Risk of Reduced Work Hours under the Affordable Care Act?" Berkeley: University of California Berkeley Labor Center, 2013. http://laborcenter.berkeley.edu/healthcare/reduced_work_hours13.pdf.
3. Garrett B and Chernew M. "Health Insurance and Labor Markets: Concepts, Open Questions, and Data Needs." *Inquiry*, 45(1): 30–57, 2008.
4. Medical Expenditure Panel Survey, Insurance Component, 2012. Eighty-five percent of workers are in firms that offer coverage (http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2012/tib2.pdf) and 78 percent of workers in offering firms are eligible for coverage (http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2012/tib2a.pdf).
5. 26 U.S.C. § 4980H(a)(2) and 26 U.S.C. § 4980H(b)(1)(B) (2010).
6. Congressional Budget Office. "Analysis of the Administration's Announced Delay of Certain Requirements Under the Affordable Care Act." July 30, 2013. http://www.cbo.gov/sites/default/files/cbofiles/attachments/44465-ACA.pdf
7. Rand estimates an even smaller effect on coverage of eliminating the employer mandate, noting that 300,000 fewer people would have access to employer insurance and nearly all of them would get coverage from another source. See Price CC and Saltzman E. "Delaying the Employer Mandate: Small Change in the Short Term, Big Cost in the Long Run." Santa Monica, CA: Rand Corporation, 2013. http://www.rand.org/content/dam/rand/pubs/research_reports/RR400/RR411/RAND_RR411.pdf.
8. Commonwealth of Massachusetts, Executive Office of Health and Human Services and the Commonwealth Health Connector. "Update on ACA Subsidized Coverage Configuration." Boston: Commonwealth of Massachusetts, Executive Office of Health and Human Services, 2013.
9. Blavin F, Blumberg LJ, Buettgens M, and Roth J. "Massachusetts under the Affordable Care Act: Employer-Related Issues and Policy Options." Boston: Blue Cross Blue Shield of Massachusetts Foundation, 2012. http://www.urban.org/UploadedPDF/1001626-Massachusetts-Under-the-Affordable-Care-Act-Employer-Related-Issues-and-Policy-Options.pdf.
10. Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2005 and 2011 Medical Expenditure Panel Survey-Insurance Component (http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2005/tiia2.pdf and http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2011/tiia2.pdf).
11. Long SK and Fogel A. "Health Insurance Coverage and Health Care Access, Use, and Affordability in Massachusetts: An Update as of Fall 2012." Boston: Blue Cross Blue Shield of Massachusetts Foundation, 2014. http://bluecrossmafoundation.org/sites/default/files/download/publication/MHRS_2012%20Full%20Report.pdf.
12. Rand estimated that the revenue from the employer penalty would total $149.2 billion over the 2014 to 2023 time period. See Price and Saltzman "Delaying the Employer Mandate."
13. Congressional Budget Office. *Congressional Budget Office Choices for Deficit Reductions: An Update.*
14. Blumberg LJ and Holahan J. "Delaying the Individual Mandate Would Disrupt Overall Implementation of the Affordable Care Act." Washington, DC: Urban Institute, 2013.

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

ABOUT THE AUTHORS & ACKNOWLEDGMENTS

Linda Blumberg is a senior fellow, John Holahan is an Institute fellow, and Matthew Buettgens is a senior research associate at the Urban Institute's Health Policy Center. The authors appreciate the comments and suggestions of Larry Levitt, Genevieve Kenney, and Steve Zuckerman. The authors are grateful to the Robert Wood Johnson Foundation for supporting this research.

ABOUT THE URBAN INSTITUTE

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic and governance problems facing the nation. For more information, visit *http://www.urban.org*. Follow the Urban Institute on Twitter *www.urban.org/twitter* or Facebook *www.urban.org/facebook*. More information specific to the Urban Institute's Health Policy Center, its staff, and its recent research can be found at *www.healthpolicycenter.org*.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to health and health care, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, measurable and timely change. For more than 40 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit *www.rwjf.org*. Follow the Foundation on Twitter *www.rwjf.org/twitter* or Facebook *www.rwjf.org/facebook*.

McKinsey&Company

McKinsey Center for U.S. Health System Reform

Individual market: Insights into consumer behavior at the end of open enrollment

As the Affordable Care Act's (ACA's) first individual market open enrollment period (OEP) came to a close in April, we conducted our fifth national online survey to discern insights into how the 2014 individual market has evolved. We conducted the first four surveys between November 2013 and February 2014 and the fifth survey between April 7 and April 16, 2014.

The surveys have focused on both the intentions consumers expressed and the actions they reported taking during the 2014 OEP (especially their reports about how they shopped for, and evaluated, various plans and whether they decided to enroll or go uninsured). The surveys also explored consumers' awareness of the ACA's requirements and provisions (including potential subsidies and penalties) and other factors influencing their actions. Each survey included consumers reporting that they enrolled in healthcare coverage for 2014 (either on or off an exchange or by renewing an existing plan), those reporting that they shopped but did not enroll, and those reporting that they did not shop for health insurance during OEP.

All findings in this Intelligence Brief reflect the rapidly evolving individual insurance marketplace through April 16, 2014. As we discuss in the Appendix, these findings cannot be directly compared to publicly reported exchange enrollment data.[1] Furthermore, we have based our findings on how respondents described their behavior, attitudes, and demographics, and the descriptions may naturally include some subjectivity. Nevertheless, the size of our sample – 2,874 respondents eligible for qualified health plans (QHPs) in April; 9,533 in total across the five surveys – and the answers they gave to the detailed questions we posed provide useful insights into the individual market's evolution.

The key findings from our April survey confirm some of our earlier observations and provide an indication of how consumers may behave in the future:

---

[1] Our findings cannot be directly compared to publicly reported exchange enrollment data because our surveys covered the entire individual market, not just the federal and state exchanges. Furthermore, our survey was conducted only in English, and thus its findings cannot be compared against studies that included questions in Spanish or other languages.

- Enrollment continued to grow – at the time of our April survey, 90 percent of the respondents who indicated that they had previously had coverage, and 13 percent of those who were previously uninsured,[2] reported that they had enrolled in a plan. Of all respondents who reported having selected a new ACA plan at the time of the April survey (either on or off the exchanges), 26 percent reported being previously uninsured. This percentage is similar to the one we found in our February survey (27 percent).

- Eighty-seven percent of all respondents who reported having selected a new 2014 ACA indicated that they had already paid their first premium. Reported payment rates were higher among those previously insured and those aged 30 or older. A slightly lower percentage of respondents (80 percent) reported that they definitely intend to pay future 2014 premiums[3]; that intention was lower among those previously uninsured than among those previously insured (71 percent vs. 83 percent).

- A higher percentage of those previously uninsured reported having shopped for a plan in our April survey than in our February survey (61 percent vs. 44 percent); however, the conversion rate – the percentage who said they had purchased a plan after shopping for one – remained much lower among the previously uninsured than among the previously insured (for example, 21 percent vs. 84 percent in April, and 23 percent vs. 71 percent in February).

- As in earlier surveys, perceived affordability was the reason most often given for not enrolling by both previously insured and previously uninsured respondents. About 90 percent of all those citing perceived affordability challenges were subsidy-eligible, and among these subsidy-eligible respondents, awareness of the subsidies has remained low. (For example, 66 percent of the April respondents and 65 percent of the February respondents who were subsidy-eligible and who reported that they had shopped but did not enroll because of affordability concerns were unaware of their eligibility). Among previously uninsured, subsidy-eligible respondents, those who indicated that they were aware of the subsidies were almost three times as likely to have reported enrolling as those who were unaware.

---

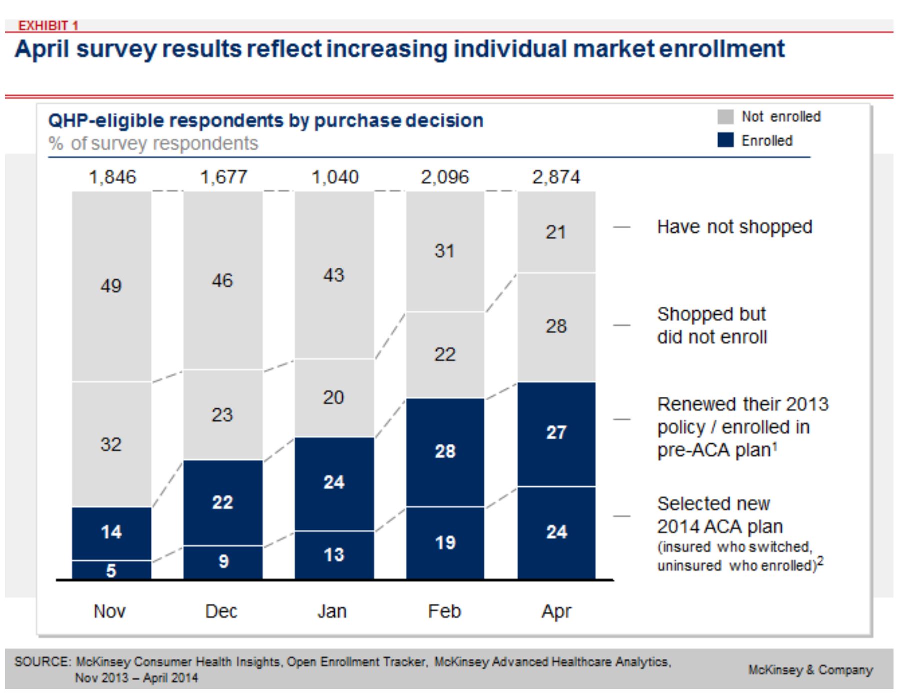
[2] Our surveys measured whether individuals were covered *prior* to the time of application (as defined by the answer they gave to the question: "Which of the following best describes your primary insurance coverage in 2013? For most of the year I was covered by ….," with those we defined as being previously uninsured answering "I did not have health insurance, I was uninsured.") Several other publicly reported OEP enrollment surveys (e.g., those from the Department of Health and Human Services, Gallup, and the New York State of Health Marketplace) measured whether individuals *currently* had health insurance at the time of their application. Our approach yields a lower estimate of the previously uninsured, because it distinguishes individuals who were uninsured for the majority of 2013 from those who only very recently became uninsured as a result of a plan cancellation. The latter group is categorized as previously insured in our survey. See the Appendix for a more detailed comparison with other publicly reported surveys.

[3] Respondents who answered the question "Are you planning to pay your health insurance premiums for the remainder of 2014?" by selecting "I will definitely make all payments" were categorized as intending to pay.

- Of those reporting that they remained without coverage after the 2014 OEP, 23 percent indicated that they intend to purchase coverage in 2015. Among those who reported having purchased coverage for 2014, 50 percent indicated that they plan to enroll in 2015. Close to half (48 percent) of all respondents not planning to enroll in 2015 were unaware of the penalty for lack of coverage. After they were informed about the penalty, the percentage of respondents reporting that they planned to enroll in 2015 rose by 6 points among those currently uninsured (to 29 percent) and by 5 points among those currently insured (to 55 percent).

Enrollment growth continued, but the percentage of newly enrolled who were previously uninsured did not further increase

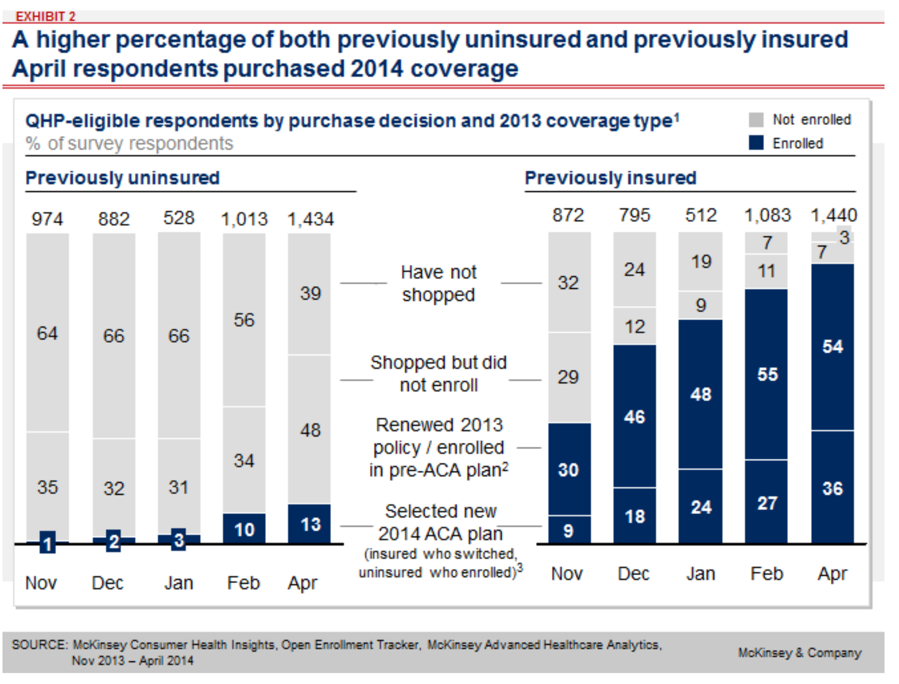
Reported enrollment rates increased steadily across our five surveys *(Exhibit 1).* Of the 2,874 QHP-eligible respondents in April's survey, 51 percent indicated they had enrolled in an individual plan, just under half of whom said they had enrolled in an ACA plan.



1 Includes previously insured whose policies were automatically renewed or who decided to renew existing policies with their current carrier, and those enrolling in a pre-ACA policy with effective date prior to Jan 1
2 Includes previously insured who switched from one carrier to another or who changed policies but stayed with the same carrier and also previously uninsured who enrolled. Policies could be selected on- or off-exchange. Includes those who had paid their first premium and those who had not yet done so

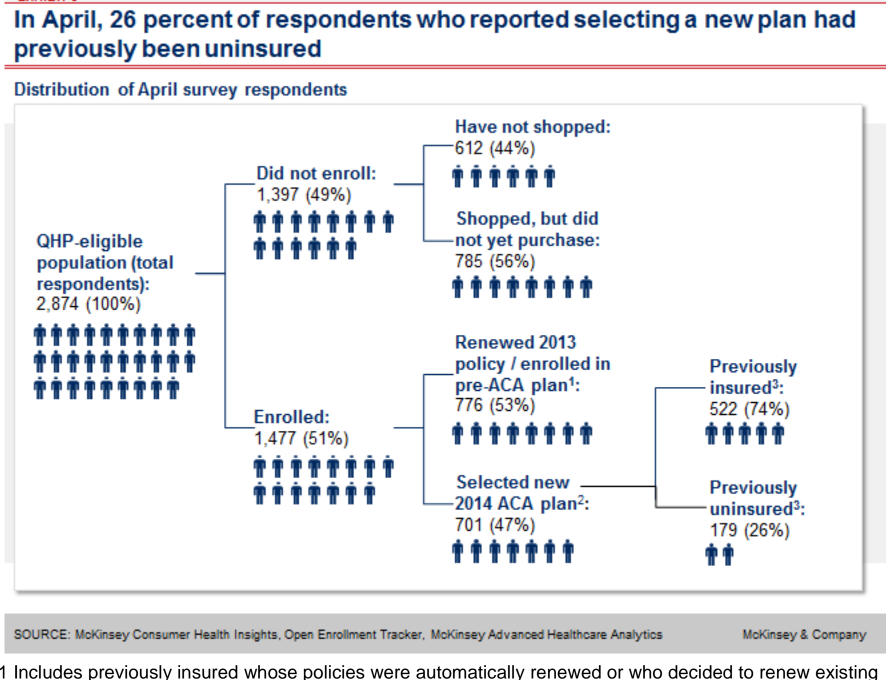
Between November and April, enrollment rates rose steadily among both previously uninsured and previously insured respondents (*Exhibit 2)*. In all of the surveys, however, enrollment rates remained much lower among those previously uninsured than among those previously insured (13 percent vs. 90 percent in our April survey, for example). Of all

previously insured respondents who reported having enrolled in a 2014 plan, 60 percent indicated that they had renewed their 2013 policy or selected a pre-ACA policy prior to January 1st.



1 Self-reported in response to: "Which of the following best describes your primary insurance coverage in 2013? For most of the year I was covered by:"
2 Includes previously insured whose policies were automatically renewed or who decided to renew existing policies with their current carrier, and those enrolling in a pre-ACA policy with effective date prior to Jan 1
3 Includes previously insured who switched from one carrier to another or who changed policies but stayed with the same carrier and also previously uninsured who enrolled. Policies could be selected on- or off-exchange. Includes those who had paid their first premium and those who had not yet done so

Between February and April, the rate of enrollment growth among those reporting having purchased new plans – on or off the exchanges – was consistent across coverage types (previously insured and previously uninsured). Accordingly, the coverage mix of those enrolling in 2014 plans remained steady. Among the April respondents who selected a new 2014 product, 26 percent had been previously uninsured (*Exhibit 3*). The corresponding figure in our February survey was 27 percent. These rates exceed those in our earlier surveys (11 percent in November, December, and January).



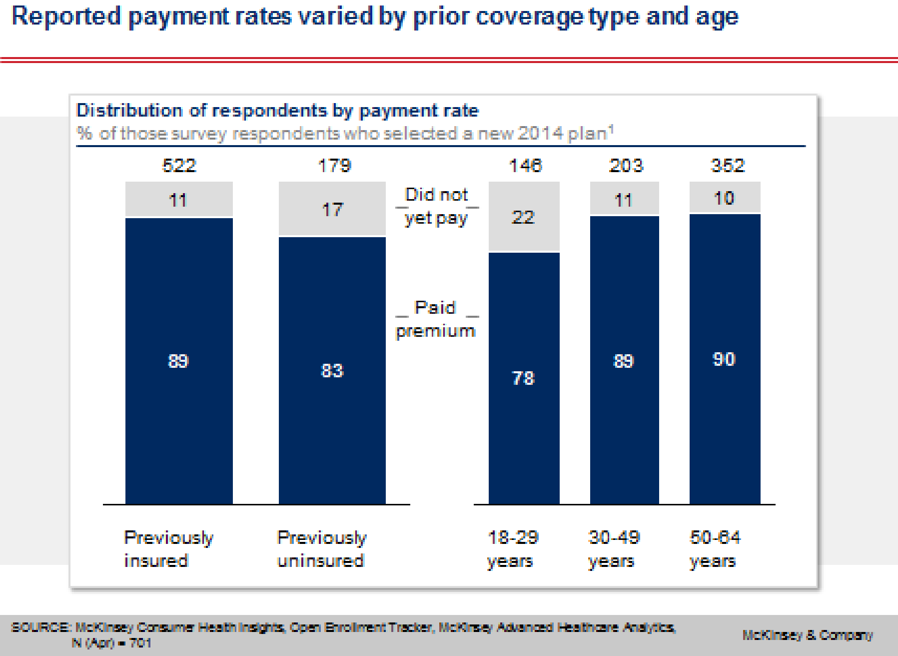
1 Includes previously insured whose policies were automatically renewed or who decided to renew existing policies with their current carrier, and those enrolling in a pre-ACA policy with effective date prior to Jan 1
2 Includes previously insured who switched from one carrier to another or who changed policies but stayed with the same carrier and also previously uninsured who enrolled. Policies could be selected on- or off-exchange. Includes those who had paid their premium and those who had not yet done so
3 Self-reported in response to: "Which of the following best describes your primary insurance coverage in 2013? For most of the year I was covered by:"

Reported payment rates are high overall, particularly among older respondents and those previously insured

Among the April respondents reporting having purchased a new 2014 ACA plan, 87 percent indicated that they had already paid their first premium, up from 77 percent in February.[4] However, reported payment rates varied by age: 78 percent among 18- to 29-year olds, compared with about 90 percent among older respondents (those aged 30 to 64). Reported payment rates also varied by previous coverage type, but to a lesser degree: 89 percent among those previously insured, compared with 83 percent among those previously uninsured (*Exhibit 4*).

---

[4] These numbers do not distinguish between different effective dates for the start of 2014 coverage; consumers have 30 days from their effective date until premium for coverage is due.

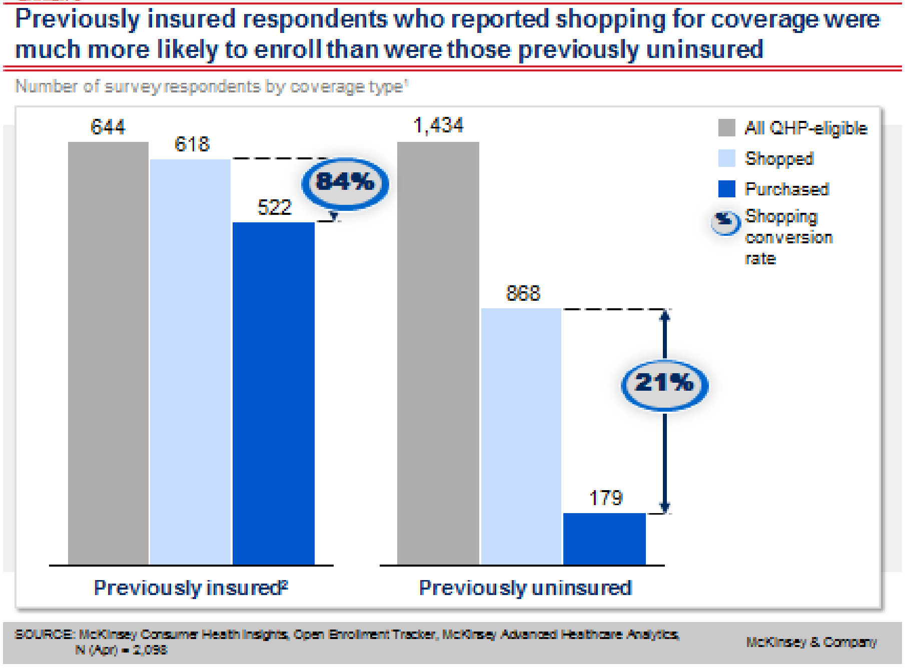


1 Does not distinguish between different effective dates for start of 2014 coverage; consumers have 30 days from their effective date until premium for coverage is due

When we asked the respondents who indicated having purchased a new 2014 ACA plan about their intention to pay future premiums for the remainder of this year, 80 percent reported that they "will definitely make all payments." This rate also varied by coverage type (83 percent of those previously insured, compared with 71 percent of those previously uninsured). The intention to pay future premiums was similar in all age groups (about 80 percent).

Although more previously uninsured respondents shopped for plans, their conversion rate remained low, often because of perceived affordability

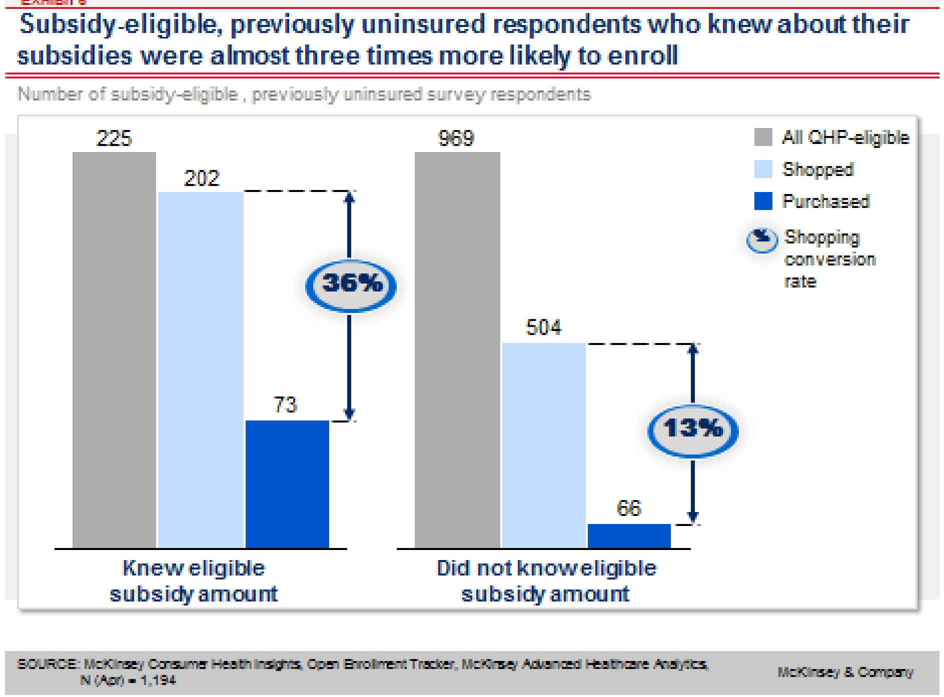
Between our February and April surveys, the percentage of previously uninsured respondents reporting having shopped for coverage rose from 44 percent to 61 percent (see *Exhibit 2*). However, only 21 percent of the previously uninsured respondents in our April survey who indicated that they had shopped for coverage reported enrolling in a plan *(Exhibit 5)*. This conversion rate is much lower than the conversion rate reported by previously insured respondents in all of our surveys. In April, it was 84 percent.



1 Self-reported in response to: "Which of the following best describes your primary insurance coverage in 2013? For most of the year I was covered by:"
2 Does not include previously insured who renewed their 2013 policy or enrolled in a pre-ACA plan

In our April survey, 72 percent of the respondents who reported that they shopped but did not buy were both previously uninsured and subsidy-eligible. Perceived affordability remained the most common reason for exiting the purchase process; it was cited by 59 percent of all April respondents who reported shopping but not enrolling and by 64 percent of the subsidy-eligible respondents who reported that behavior. Eighty-eight percent of all those citing perceived affordability challenges were subsidy-eligible. Consistent with our February findings, most of the subsidy-eligible respondents (66 percent) who cited perceived affordability as the reason they stopped shopping were aware of neither their eligibility nor the amount for which they were eligible.

Nevertheless, both factors appear to be strong contributors to enrollment. For example, previously uninsured, subsidy-eligible shoppers who indicated that they knew their subsidy amounts were almost three times as likely to report having enrolled as those who did not *(Exhibit 6)*. Consistent with this finding, 71 percent of the respondents who reported shopping but not enrolling indicated that they would be more likely to enroll if they had more information about the cost of different plans (including subsidy eligibility, net-of-subsidy premium amounts, out-of-pocket maximums, and expected out-of-pocket total cost).



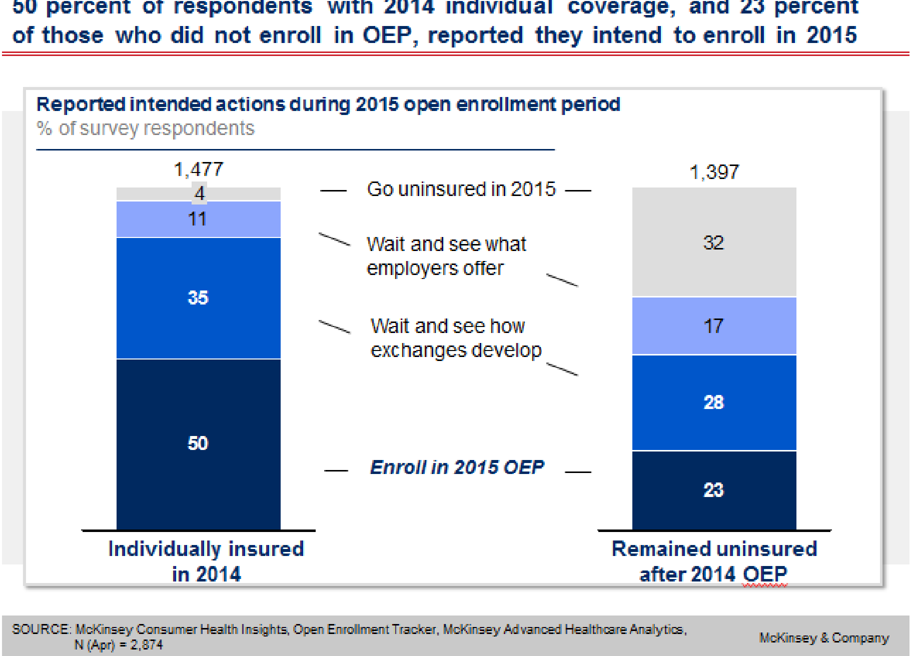
Perceived affordability was also the reason offered most often for not enrolling among those reporting that they had not even shopped for coverage; it was cited by 71 percent of all respondents in this group and by 75 percent of the subsidy-eligible individuals in this group. Ninety percent of those citing perceived affordability challenges who did not shop were subsidy-eligible. Seventy-nine percent of the subsidy-eligible respondents who cited perceived affordability as the reason they did not shop were unaware of their eligibility or the amount of subsidy for which they were eligible.

Concerns about affordability were common even among those previously insured. Fifty percent of the respondents in this group who reported shopping but not enrolling, and 66 percent of those who had not shopped, cited affordability as the reason.

Most currently uninsured and half of the currently insured reported that they do not yet plan to enroll in 2015; penalty awareness raised these numbers slightly

Forty-nine percent of the respondents in our April survey – 87 percent of the previously uninsured and 10 percent of the previously insured – indicated that they did not enroll during the 2014 OEP. Of these respondents, 23 percent reported their intention to purchase coverage in 2015 *(Exhibit 7)*. An additional 45 percent reported planning to wait and see how the exchanges evolved and what employers would be offering before making a decision; 32 percent reported planning to remain uninsured.

Among the respondents reporting enrollment in a 2014 plan, 50 percent indicated their intention to enroll again in 2015; only 4 percent reported planning to let their insurance lapse in 2015. The remainder reported they would wait and see what happens.



Close to half (48 percent) of all respondents not planning to enroll in 2015 were unaware of the penalty for lack of coverage (60 percent of those currently uninsured and 31 percent of those currently insured). After they were informed about the penalty, their intended purchase behavior changed somewhat: the percentage of respondents reporting that they planned to enroll in 2015 rose by 6 points among those currently uninsured (to 29 percent) and by 5 points among those currently insured (to 55 percent). Two reasons were offered most often by those who did not intend to enroll despite awareness of the penalty: 49 percent believed the penalty would be less than the cost of health insurance, and 24 percent did not think they needed health insurance.

Fifty-nine percent of the respondents not intending to enroll in the 2015 OEP indicated that additional tools and information would be "extremely helpful" during the enrollment process, potentially increasing their likelihood to enroll. Examples of the types of information include an understanding of expected out-of-pocket cost (45 percent), an understanding of subsidy eligibility (38 percent), and learning what benefits are covered under different plans (38 percent).

□ □ □

The preliminary findings presented in this Intelligence Brief provide a perspective on the emerging individual market through April 16th. These findings are directional indicators only, based on publicly reported enrollment data and our own national online consumer survey.

Amit Bhardwaj, Erica Coe, Jenny Cordina, Ruchira Saha

The authors would like to thank Ananya Banerjee and Jason Leung for their support.

Appendix

Survey overview

Through a collaboration of McKinsey Advanced Healthcare Analytics (MAHA) and the McKinsey Center for U.S. Health System Reform, we are regularly surveying a national sample of QHP-eligible uninsured, individually insured, or previously group-insured consumers throughout the individual market's OEP. This research is independently funded by McKinsey & Company without contribution from any third party. The objective is to understand the shopping and purchasing behavior of consumers who are eligible to purchase individual coverage on the ACA exchanges or elsewhere. These surveys therefore provide snapshots of enrollment over time.

To date, we have completed five rounds of surveys:

- Nov. 25 to Dec. 6, 2013: sample size of 1,846
- Dec. 16 to Dec. 20, 2013: sample size of 1,677
- Jan. 6 to Jan. 10, 2014: sample size of 1,040
- Feb. 4 to Feb. 13, 2014: sample size of 2,096
- Apr. 7 to Apr. 16, 2014: sample size of 2,874

Methodology

Each round of the survey was designed and analyzed by McKinsey teams. The surveys were administered online in English by a third-party vendor.

We used the following characteristics to focus on the consumer segments eligible to purchase individual coverage on the ACA exchanges or elsewhere:

- Ages 18 to 64
- Non-Medicaid eligible (income above 100 percent FPL in states with no Medicaid expansion and above 138 percent FPL in states with expansion)
- Primary 2013 coverage (by self-report) was no insurance, individual insurance, or group insurance that did not continue into 2014 (whether by participant's choice or employer discontinuation)

Weighting: Each response was weighted separately (using 2012 population data) for the previously uninsured, individually insured, and group-insured segments, using the following factors:

- Age
- Gender
- Geography

- Household size
- Income

In addition, responses were weighted across reported primary 2013 coverage using 2012 population data for insurance coverage status.

Summary of survey questions in Intelligence Brief

Current actions and channel usage: Which of the following describe your actions relating to healthcare coverage since October 1, 2013 (this open enrollment period)?

- I have not shopped for 2014 health insurance anywhere (e.g., online, with an agent, calling someone)
- I shopped but have not selected / paid for health insurance for 2014
- My 2013 existing health insurance policy was automatically renewed by my health insurer for 2014 (I will not be receiving government subsidy)
- I shopped for health insurance, but decided to renew my 2013 existing health insurance policy with my health insurer for 2014 (I will not be receiving government subsidy)
- I shopped and selected a new health insurance product for 2014 (either with the same insurance company or with a different company), but have not paid for the new health insurance (8 options provided to describe actions respondents took)
- I shopped and selected and paid for new health insurance for 2014 (either with the same insurance company or with a different company) (8 options provided to describe actions respondents took)

Reasons for not completing selection / purchase: I shopped but have not selected or paid for any health insurance, because … (11 options provided to describe reasons, including perceived lack of affordability and other reasons).

Intended purchasing action: Do you plan to purchase individual health insurance either on or off the Public Health Exchange during the next open enrollment period (Nov-Feb) for health coverage in 2015? (4 options provided to describe actions).

Current payment status: Of all respondents who said that they enrolled in new 2014 ACA plan, whether they paid their first month premium was determined by their answer to the above "Current actions and channel usage" question. (See last two options, i.e., "I shopped and selected … but have not paid" and "I shopped and selected and paid….")

Future payment intentions: Are you planning to pay your health insurance premiums for the remainder of 2014? (5 options)

Additional topics included in survey research

Healthcare attitude, including attitudes towards health insurance coverage, perceived importance of health insurance compared to other financial considerations, and loyalty to payors / providers

Utilization experience, including frequency and type of 2014 plan healthcare service use to date and experience when attempting to access services, and indicators of 2013 health status

Awareness of ACA, including awareness and understanding of different aspects of legislation (e.g., channels for gaining awareness, OEP timing, presence / amount of penalty, mental health parity) and impact on 2014 and 2015 intended purchase action

Shopping experience, including triggers for shopping, channels for information gathering and purchasing, influencers on purchase decisions and factors most important in purchase decision, shopping experience (e.g., length of time, number of interactions, clarity of information)

Purchase details, including features of products purchased (price, network breadth, HMO/PPO, brand) by key consumer demographics and trade-offs considered (awareness / consideration of payor brand, price point, network breadth)

Caveats

Four important points help clarify how these survey findings should be interpreted.

- Some of the respondents purchased coverage through channels other than the online exchanges. Furthermore, the respondents to our surveys included consumers who renewed or purchased insurance policies through brokers or directly from carriers. As a result, the numbers in our survey cannot be directly compared to the publicly reported exchange enrollment numbers. More details about the differences in methodology used by the Department of Health and Human Services (HHS) and other organizations can be found in the Issue Brief "Health insurance marketplace: Summary enrollment report for the annual open enrollment report" published by HHS.[5]
- Our survey was conducted only in English. Thus, it does not reflect the behavior or attitudes of those people who would have preferred a survey in Spanish or another language.
- The respondents' previous insurance coverage (uninsured or insured) was defined by their answers to the question: "Which of the following best describes your primary insurance coverage in 2013? For most of the year I was covered by …." Respondents were categorized as *previously uninsured* if the answer they selected was "I did not have health insurance, I was uninsured."

---

[5] http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf

- Categorization of the respondents' purchasing behavior was also based on self-report. Those categorized as having *renewed their 2013 policy* or *enrolled in a pre-ACA plan* include respondents who were automatically renewed by their 2013 insurer, elected to renew their pre-ACA policy, or enrolled in a pre-ACA policy with an effective date prior to January 1, 2014. Those categorized as having *selected a new 2014 ACA plan* include previously insured respondents who switched from one carrier to another or who switched policies but stayed with the same carrier, as well as previously uninsured respondents who enrolled in a 2014 plan (either on or off the exchanges).

Glossary

Shop for health coverage: Includes activities such as gathering information about insurance products, comparing different products, and getting quotes

Renew 2013 policy: Previously individually insured respondents whose policies were automatically renewed or who decided to renew existing policies with their current insurer

Enroll in pre-ACA policy: Respondents who enrolled in a pre-ACA policy for 2014 coverage with an effective date prior to January 1st

Select new 2014 ACA policy: Respondents who are either previously insured who switched policies (either switching from one carrier to another, or switching policies but staying with the same carrier), or previously uninsured who enrolled. Refers to policies that are either QHPs (either an on-exchange plan or an off-exchange plan that is identical to an on-exchange plan), or ACA plans (off-exchange only plan that complies with all ACA rules but is not sold on the exchange so never received QHP-certification). Includes those who paid their premium and those who had not yet paid at the time of the survey

Enroll in health coverage: Having health coverage for 2014, either through renewal or purchase of a new health plan

Previous insurance: Based on self-reported response to this question: "Which of the following best describes your 2013 primary insurance coverage? For most of the year, I was covered by:"

- "I did not have health insurance, I was uninsured" (respondents categorized as uninsured)
- "Insurance purchased by me or my spouse / partner (i.e., not through employer)", or "My employer, my spouse / partner's employer, my parents, or my school, however, I will NOT continue this in 2014" (respondents categorized as previously insured)

Subsidy-eligible: Based on self-reported household size and total annual household income. Using each of these factors, we calculated each respondent's federal poverty level (FPL). For respondents in non-Medicaid expansion states, they were identified as subsidy-eligible if their income falls between 100-400 percent of the federal poverty level (FPL). For respondents in Medicaid expansion states, they were identified as subsidy-eligible if their income falls between 138-400 percent FPL.

Obtaining previous Intelligence Briefs

Previous Intelligence Briefs on exchange dynamics can be obtained online at: healthcare.mckinsey.com/reform

- "Individual market enrollment: Updated view" (March 2014)
- "Exchange product benefit design: Consumer responsibility and value consciousness" (February 2014)
- "Individual market enrollment: Early assessments and observations" (January 2014)
- "Hospital networks: Configurations on the exchanges and their impact on premiums" (December 2013)
- "Exchanges go live: Early trends in exchange dynamics" (October 2013)
- "Emerging exchange dynamics: Temporary turbulence or sustainable market disruption?" (September 2013)

Updated as of May 8, 2014

Copyright © 2014 McKinsey & Company

Any use of this material without specific permission of McKinsey & Company is strictly prohibited.

A SERVICE OF THE CALIFORNIA HEALTHCARE FOUNDATION

Did California Just Save 2,300 Lives by Expanding Obamacare? Let's Do The Math.

by Dan Diamond, California Healthline Contributing Editor

Wednesday, May 7, 2014

"Road to Reform" last week posed the question if the Affordable Care Act was improving our health.

We may not have the answer yet -- but we do have some new insight.

A major study on the effects of having health insurance went live on Monday. And the results ended up being both relevant and groundbreaking: Mortality noticeably fell in Massachusetts after the state expanded health coverage.

As noted last week, no researchers have ever been able to make a firm connection between giving people health coverage and seeing health outcomes subsequently get better.

But based on this new study, it seems that "expanding insurance substantially improves the well-being of people who get it," Harvard's Katherine Baicker told the *New York Times*.

So by extension, it *appears* that the Affordable Care Act is making health care somewhat better, too.

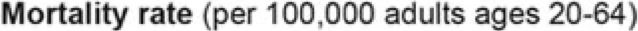
How the Study Worked

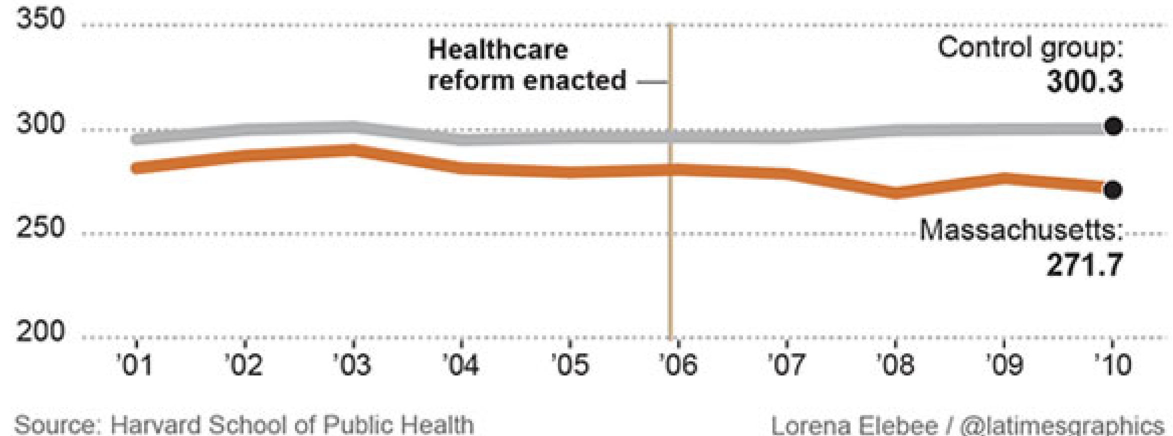
Baicker and her co-authors -- Ben Sommers, a Harvard professor and the study's lead author, and Sharon Long of the Urban Institute -- took a look at how mortality in counties in Massachusetts compared with control counties in other states with similar economic conditions.

One specific focus was whether mortality changed when patients with conditions like cancer and heart disease -- afflictions that could, in theory, be inflected by health coverage.

Here's what the researchers found: Four years after Massachusetts expanded health insurance coverage, the death rate among non-elderly adults had fallen by nearly 3%. The decline was even steeper -- 4.5% -- among patients with conditions considered "amenable" to health care.

For a visual comparison of that decline, see the chart from the *Los Angeles Times* below:





Since the study's publication in *Annals of Internal Medicine*, the researchers have confidently proclaimed that health coverage does more than keep people healthier -- it saves lives.

But they're still cautious about drawing broad inferences.

"Nationally, you have to be careful [when trying] to extrapolate from one state," Sommers said in an interview, noting the many differences between Massachusetts and other states -- everything from the range in residents' financial situations to whether state officials support the idea of public coverage expansion.

That hasn't stopped other researchers from getting animated about the findings, or openly conjecturing about the implications. Their excitement is chiefly because the *Annals* study is a rare confirmation of what many had long suspected (but couldn't prove) -- that giving people health insurance ends up making them healthier.

The research and policy communities also are enthusiastic because the study changes the tone of debate over health reform, contends Austin Frakt, a health economist and *New York Times* contributor. (Frakt wrote the editorial accompanying the new study.)

That's largely because the findings from Massachusetts put real numbers around a potential impact of coverage expansion: For every 830 people who received coverage, one death was prevented, the authors say.

So rather than ask whether "does health insurance improve health," we can now focus on the more productive conversation of "how much to spend to save a life," Frakt posted on Twitter.

What Might it Mean for California?

The new data could help quantify the impact of a state's decision to expand coverage under Obamacare.

That's particularly true in a state like California -- where millions have obtained coverage through the law, but one sticking point is that many of those people may have been previously insured.

Acknowledging the many caveats of trying to export findings from one state to another, how effective *might* the ACA be at

helping save lives in California? Specifically, if the state saw mortality gains comparable to Massachusetts?

To figure it out, we'll rely on data provided by Covered California; takeaways from the new *Annals* study; and estimates that Ken Jacobs, chair of the Labor Center at UC-Berkeley and one of the creators of the CalSIM model, shared with my colleague David Gorn.

Let's start by examining the number of **privately insured.**

- *The top-line number:* There were almost 1.41 million new sign-ups through the insurance exchange, Covered California has reported.
- *The conversion factor:* Jacobs suggests that about 39% of these new sign-ups will end up having been previously uninsured.
- *The final math:* 39% of 1.41 million is about 548,000. But because only 85% of them may end up paying the first month's premium, that reduces the estimate of newly insured, qualified health plan-holding customers to about 465,800.

Meanwhile, **California's Medicaid numbers** are a little easier to figure out.

- *The top-line number:* There were 1.93 million new Medi-Cal enrollees through the exchange and the Low-Income Health Program.
- *The conversion factor:* Jacobs said that "we would expect 75% of newly eligible Medi-Cal enrollees to have been previously uninsured."
- *The final math:* 75% of 1.93 million is 1.45 million.

Taken together, that's a little bit more than 1.91 million people who are presumably newly insured. And applying the Massachusetts calculation -- one saved life for every 830 who get coverage -- translates to a little more than 2,300 lives saved every year in California, thanks to the ACA.

But that figure may only be scratching the surface.

California had more than 7 million uninsured residents in 2012; while that number could fall by about 6 million through 2017, Rachel Dornhelm writes for KQED's "State of Health," it isn't vanishing right away.

"We really think that enrollment in ACA is a three-year process rather than get everyone enrolled the first year," Gerald Kominski, professor of health policy and management and director of the UCLA Center for Health Policy Research, told Dornhelm.

If California continues to achieve its coverage goals, and the Massachusetts conversion holds true, the state would end up saving more than 7,200 lives a year thanks to Obamacare.

Key Caveats

Some critics have pointed out that it's far too simplistic to take the state-specific results of one state and apply them to another.

Writing on Twitter, economist Stephen Parente of the University of Minnesota has called it an "apples and oranges" comparison.

Nor should we expect that getting the uninsured to sign up for coverage means that they'll immediately start receiving care. The huge crunch of new enrollees in California means that Medi-Cal has been plagued by troubles, with a backlog of

900,000 pending applications as of last week. There's also a logistical problem facing current enrollees: "The renewal form is really a mess," Elizabeth Landsberg of the Western Center on Law and Poverty told *California Healthline*. That could hamper renewals and lead some to lose coverage, too.

The crunch of newly insured Americans also presents a different kind of challenge: There might not be sufficient provider access to cope with the demand of patients, leading to wait lists that cancel out some of the positive effects of having insurance.

Still, the Massachusetts study suggests these are better short-term problems to wrestle with than the long-term problem of lacking coverage. Especially because the full effects of health coverage expansion may not be revealed for some time.

As Tom Liu writes at the Advisory Board's *Daily Briefing*, it may eventually turn out that "being uninsured" was one of the top 5 causes of preventable deaths. (The Advisory Board Company produces *California Healthline* for the California HealthCare Foundation.)

Around the nation

Here's what other stories are making news on the road to reform.

The looming uncompensated-care burden: Writing at the *Washington Post*'s "WonkBlog," Jason Millman notes that providers deliver as much as $85 billion in uncompensated care today, and that's not going away with coverage expansion.

Why didn't Latinos sign up for Obamacare? *National Journal*'s Clara Ritger goes deeper into the mostly logistical reasons behind the reluctance.

More than 80% of exchange customers have paid their first month's premium: That's according to insurers' testimony presented at Wednesday's House hearing on Obamacare enrollment, Alex Wayne reports for *Bloomberg*.

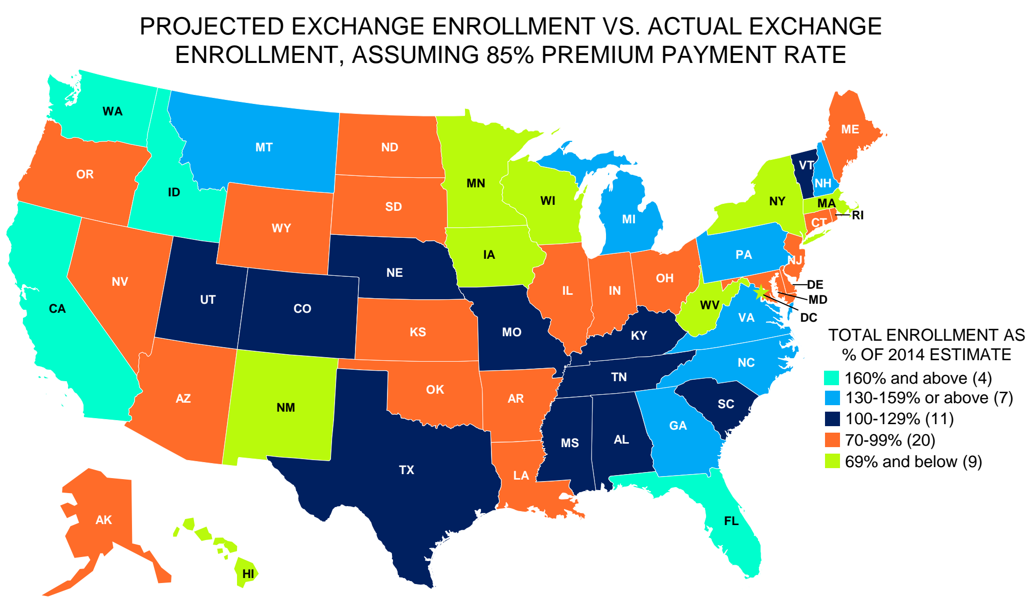
© 1998 - 2014. All Rights Reserved. California Healthline is published daily
for the **California HealthCare Foundation** by **The Advisory Board Company**.

Exchange Enrollment Outpaces Expectations in 22 States

Analysis assumes 85 percent of enrollees pay first month's premium

A new analysis from Avalere Health finds that exchange enrollment meets or exceeds expectations in 22 states (44%), even after accounting for any attrition due to nonpayment of premiums. Assuming 15 percent of enrollees do not take the final enrollment step and pay their premiums, over 6.8 million people who enrolled through April 19 will have coverage effective as of May 1.

"The large uptick in enrollment in March and early April brought many states over the finish line in terms of projected enrollment for 2014," said Caroline Pearson, Vice President at Avalere. "Even after accounting for potential non-payment, enrollment exceeds 100 percent of projections in nearly half of states."



Avalere's analysis compares exchange participation at the end of open enrollment to state projections based on the Congressional Budget Office (CBO) estimate that 6 million people would enroll in exchanges. Florida, California, and Idaho lead in enrollment compared to expectations, while Hawaii and the District of Columbia lag behind with less than 50 percent of expected enrollees paying their first month's premium.

"Once again, the data paint a diverse and complex picture. Enrollment significantly beat expectations in some states but fell short in others," said Elizabeth Carpenter, Director at Avalere. "Regional variation is a key feature of the current exchange marketplace, and it could impact carrier decisions to participate in some markets in 2015."

1350 Connecticut Avenue, NW | Suite 900 | Washington, DC 20036 | Tel 202.207.1300 | Fax 202.467.4455

© Avalere Health LLC www.avalerehealth.net

State	Projected 2014 Enrollment	Actual Enrollment, through April 19	Enrollment, % of Projected	Estimated Enrollment After Premium Attrition	Attrition Enrollment, % of Projected[3]	State Rank
Alabama	76,700	97,900	128%	83,200	109%	16
Alaska	15,700	12,900	82%	11,000	70%	41
Arizona	111,500	120,100	108%	102,100	92%	25
Arkansas[1]	48,500	43,400	90%	36,900	76%	38
California	641,500	1,405,100	219%	1,194,300	186%	2
Colorado	85,800	127,200	148%	108,100	126%	12
Connecticut	77,900	79,200	102%	67,300	86%	31
Dist. Of Col.	22,500	10,700	48%	9,100	40%	51
Delaware	12,300	14,100	114%	12,000	97%	23
Florida	421,300	983,800	234%	836,200	199%	1
Georgia	180,500	316,500	175%	269,100	149%	8
Hawaii	15,800	8,600	54%	7,300	46%	50
Idaho	35,000	76,100	217%	64,700	185%	3
Illinois	193,100	217,500	113%	184,900	96%	24
Indiana	127,700	132,400	104%	112,600	88%	30
Iowa[1]	43,000	29,200	68%	24,800	58%	45
Kansas	54,700	57,000	104%	48,500	89%	27
Kentucky	65,800	82,700	126%	70,300	107%	19
Louisiana	97,800	101,800	104%	86,500	88%	29
Maine	44,400	44,300	100%	37,600	85%	33
Maryland	81,000	67,800	84%	57,600	71%	40
Massachusetts	49,000	31,700	65%	26,900	55%	49
Michigan	151,100	272,500	180%	231,700	153%	6
Minnesota	75,500	50,500	67%	42,900	57%	47
Mississippi	52,100	61,500	118%	52,300	100%	22
Missouri	120,200	152,300	127%	129,500	108%	18
Montana	23,100	36,600	158%	31,100	135%	11
Nebraska	35,700	43,000	120%	36,500	102%	21
Nevada	44,600	45,400	102%	38,600	86%	32
New Hampshire	24,300	40,300	166%	34,200	141%	9

New Jersey	185,800	161,800	87%	137,500	74%	39
New Mexico	39,700	32,100	81%	27,300	69%	43
New York	643,100	370,500	58%	314,900	49%	48
North Carolina	197,700	357,600	181%	303,900	154%	5
North Dakota	11,700	10,600	91%	9,000	77%	36
Ohio	171,900	154,700	90%	131,500	76%	37
Oklahoma	73,100	69,200	95%	58,800	80%	35
Oregon	67,400	70,200	104%	59,700	89%	28
Pennsylvania[1]	180,000	318,100	177%	270,400	150%	7
Rhode Island	29,700	28,500	96%	24,200	82%	34
South Carolina	95,800	118,300	124%	100,600	105%	20
South Dakota	16,000	13,100	82%	11,100	70%	42
Tennessee	115,300	151,400	131%	128,600	112%	15
Texas	577,300	733,800	127%	623,700	108%	17
Utah	61,000	84,600	139%	71,900	118%	14
Vermont	26,600	38,000	143%	32,300	122%	13
Virginia	134,800	216,400	161%	183,900	136%	10
Washington[2]	98,900	163,200	165%	163,200	165%	4
West Virginia	27,800	19,900	71%	16,900	61%	44
Wisconsin	207,300	139,800	67%	118,800	57%	46
Wyoming	11,300	12,000	106%	10,200	90%	26
Total	**6,000,000**	**8,025,500**		**6,821,700**		

[1]*Note: These estimates do not include Medicaid beneficiaries who may be enrolled in exchange plans via "premium assistance" models in Arkansas, Iowa, and Pennsylvania.*
[2]*Washington reported only enrollees who made their first month premium payment*
[3]*Assumes 85 percent of individuals who enroll pay first month's premium based on public comments by health insurers participating in the exchange, which have indicated that 80 to 90 percent of applicants are paying premiums.*

Methodology:

Avalere's analysis incorporates the HHS enrollment figures released on May 1, 2014, as well as updated state-specific tracking from publicly-available resources in Colorado, Minnesota, and Oregon. Enrollment projections are based on Avalere's projections for enrollment distribution by state at the end of 2014 applied to the CBO's February enrollment projection of 6 million. This

approach assumes smooth implementation across states; that is, eligible populations take up coverage at similar rates across states.

Since enactment of the Affordable Care Act (ACA), Avalere has developed and continually refined an enrollment model that projects coverage over ten years at the state level. The model accounts for state decisions about whether to expand Medicaid. In addition to enrollment reports from the federal government, Avalere utilizes a range of data sources to account for local population demographics and experience. Such sources include data from the Congressional Budget Office (CBO), Centers for Medicare & Medicaid Services (CMS) on Medicaid Managed Care Enrollment Report and Medicare Enrollment, the Census Bureau's American Community Survey (ACS) and Current Population Survey (CPS), and the Urban Institute. Avalere also evaluates past program launches including the Medicare Part D Program and the Massachusetts exchange, known as the Health Connector.

For exchanges specifically, our model primarily examines local coverage and demographic information for the exchange-eligible population, which primarily includes the uninsured and non-group markets pre-2014. We also include some other modest shifts such as those out of employer coverage and those in states that previously had more generous Medicaid programs, planning to roll back eligibility to 138% of poverty and move these lives into the exchanges. Avalere assumes that seven states—Connecticut, Maine, New Jersey, New York, Rhode Island, Vermont, and Wisconsin—are shifting higher-income, adult Medicaid beneficiaries out of their Medicaid programs and into exchange coverage. It is unclear how quickly these states are making this transition, which could make the enrollment projections for these states appear higher than expected.

Avalere assumes 85 percent of people who choose a health plan will effectuate coverage by paying their first month's premium, based on public comments by health insurers participating in the exchange which have indicated that 80 to 90 percent of applicants are paying premiums.

New State-Based Marketplaces Unlikely in 2015, but Technology Challenges Create More Shades of Gray

Posted on **May 2, 2014** by **CHIR Faculty**

Like Share Share Tweet Share

By Sarah Dash and Amy Thomas

The options for states to take part in the Affordable Care Act's health insurance marketplaces have evolved over time. While the law initially contemplated only two models—state-based or federal marketplaces—political and practical circumstances ultimately led to the creation of multiple avenues through which states could establish marketplaces in 2014 and take on responsibilities for running various marketplace functions.

The U.S. Department of Health and Human Services (HHS) recently released the 2015 marketplace models for states. Moving forward, states may continue to move between different marketplace models. In doing so, they will consider a number of factors, including the likelihood of obtaining legal authority to run a state-based marketplace, funding availability, desire to maximize state regulatory oversight, and their technological capabilities. To transition from a federally run to a state-based or state-partnership marketplace, states must meet key deadlines this spring and establishment grants cannot be awarded after January 1, 2015. Conversely, states choosing to relinquish marketplace operation to the federal government must notify HHS at least 12 months in advance.

In their latest blog post for the Commonwealth Fund, Sarah Dash and Amy Thomas dig into which states are transitioning to state-based marketplaces – and which states are looking at alternative models, from SHOP-only to potential regional marketplaces. Read about their findings here.

Related posts:

1. Under Pressure: An Update on Restrictive State Insurance Marketplace Consumer Assistance Laws
2. Helping People Select Insurance Coverage: A Tale of Two Programs
3. Helping Consumers Understand their Coverage Options, from Coast to Coast

4. Last Call for State-Based Health Insurance Marketplaces

This entry was posted in **State of the States** and tagged **aca implementation**, **affordable care act**, **federally facilitated marketplace**, **health insurance marketplace**, **SHOP**, **state-based marketplace** by **CHIR Faculty**. Bookmark the **permalink [http://chirblog.org/new-state-based-marketplaces-unlikely-in-2015/]** .

Health Insurance Exchange Compare

Benefit design and cost sharing information for health plans in all 50 states

May 1, 2014 | Publisher: Robert Wood Johnson Foundation | Publication: Reform by the Numbers

Author(s): Breakaway Policy Strategies

Data on marketplace plans from every state.

The Health Insurance Exchange (HIX) Compare dataset provides information on benefit design and cost sharing for health plans offered in all 50 states and the District of Columbia. Specifically, the dataset includes data on premiums, network composition, deductibles, out-of-pocket limits, and copayment and coinsurance amounts.

This data, updated May 1, 2014, was collected from state and federal government-sponsored exchange websites, and will provide perspective on consumer choice and affordability under the ACA.

The HIX Compare dataset is a collaboration between Breakaway Policy Strategies and the Robert Wood Johnson Foundation. Breakaway Policy Strategies is a health policy firm based in Washington, D.C. that provides strategic advice, research and analysis to a range of health care stakeholders. In addition to providing the publicly available dataset, Breakaway Policy Strategies will provide reports and briefs that highlight key findings and implications from their data.

Note: If you are using the HIX Compare dataset for research purposes please cite the data set as follows: Breakaway Policy Strategies. (2014): HIX Compare Dataset. http://www.rwjf.org/en/research-publications/find-rwjf-research/2014/03/breakaway-policy-dataset.html.

If you have any questions regarding the HIX Compare dataset please contact Gina Boscarino at gboscarino@breakawaypolicy.com.

Our mission: to improve the health and health care of all Americans.

© 2001–2014 Robert Wood Johnson Foundation. All Rights Reserved.

Health Policy Center

Independent research for better health policy and better health

Measuring Marketplace Enrollment Relative to Enrollment Projections: Update

Linda J. Blumberg, John Holahan, Genevieve M. Kenney, Matthew Buettgens, Nathaniel Anderson, Hannah Recht, and Stephen Zuckerman

May 1, 2014

This brief updates information provided in early April that assesses how reported Affordable Care Act (ACA) marketplace enrollment compares to 2014 enrollment totals projected by the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), using the Congressional Budget's Office's (CBO) initial marketplace projection of 7 million for 2014. The earlier brief drew on enrollment data as of March 1, 2014. The tabulations presented here cover enrollment during the initial open enrollment period that ended on March 31, 2014 and enrollment through April 19, 2014 during the special enrollment period based on information released May 1, 2014 by the United States Department of Health and Human Services. This period accounted for people who were "in line" because had started their applications by March 31, 2014, as well as those who experienced a qualifying life event or a complex situation related to applying for coverage in the Marketplaces. It is important to note that the final enrollment totals for 2014 will likely differ from these numbers for two reasons. On the one hand, some people will not pay their premiums and as such will not be covered by Marketplace plans during 2014. On the other hand, others will enroll in Marketplace plans after April 2014 because of special enrollment periods.

AT A GLANCE:

- As of April 19, 2014, the Affordable Care Act's (ACA) Health Insurance Marketplaces had enrolled 115 percent of 2014 projected nationwide enrollment of subsidized and unsubsidized individuals, as derived from the Urban Institute's Health Insurance Policy Simulation Model (Table 1). On May 1, 2014, the Department of Health and Human Services released a report indicating that enrollment had surpassed 8 million nationally, exceeding CBO projections for the year. By April 19, 2014, 26 states had exceeded 2014 Marketplace enrollment projections for their state.
- Marketplace enrollment grew from 61 percent of projected enrollment as of March 1, 2014 to 115 percent of projected enrollment as of April 19, 2014 (Figure 1).
- State-Based Marketplaces (SBMs) and Federally Facilitated Marketplaces (FFMs) had both exceeded Marketplace projections for 2014 by April 19: SBMs had enrolled 121 percent of the enrollment projected to occur by December 31, 2014, compared to 113 percent for FFMs (Table1). The gap relative to projected enrollment between these two groups closed considerably between March 1 and April 19, 2014.
- Within SBM and FFM categories, enrollment relative to projections varies tremendously across states (Figure 1).
- As of April 19, Marketplaces had enrolled 46 percent of projected 2016 enrollment and 25 percent of the entire target population (pre-reform nongroup insurance enrollees and uninsured individuals ineligible for public insurance or affordable employer-based coverage; Table 1).

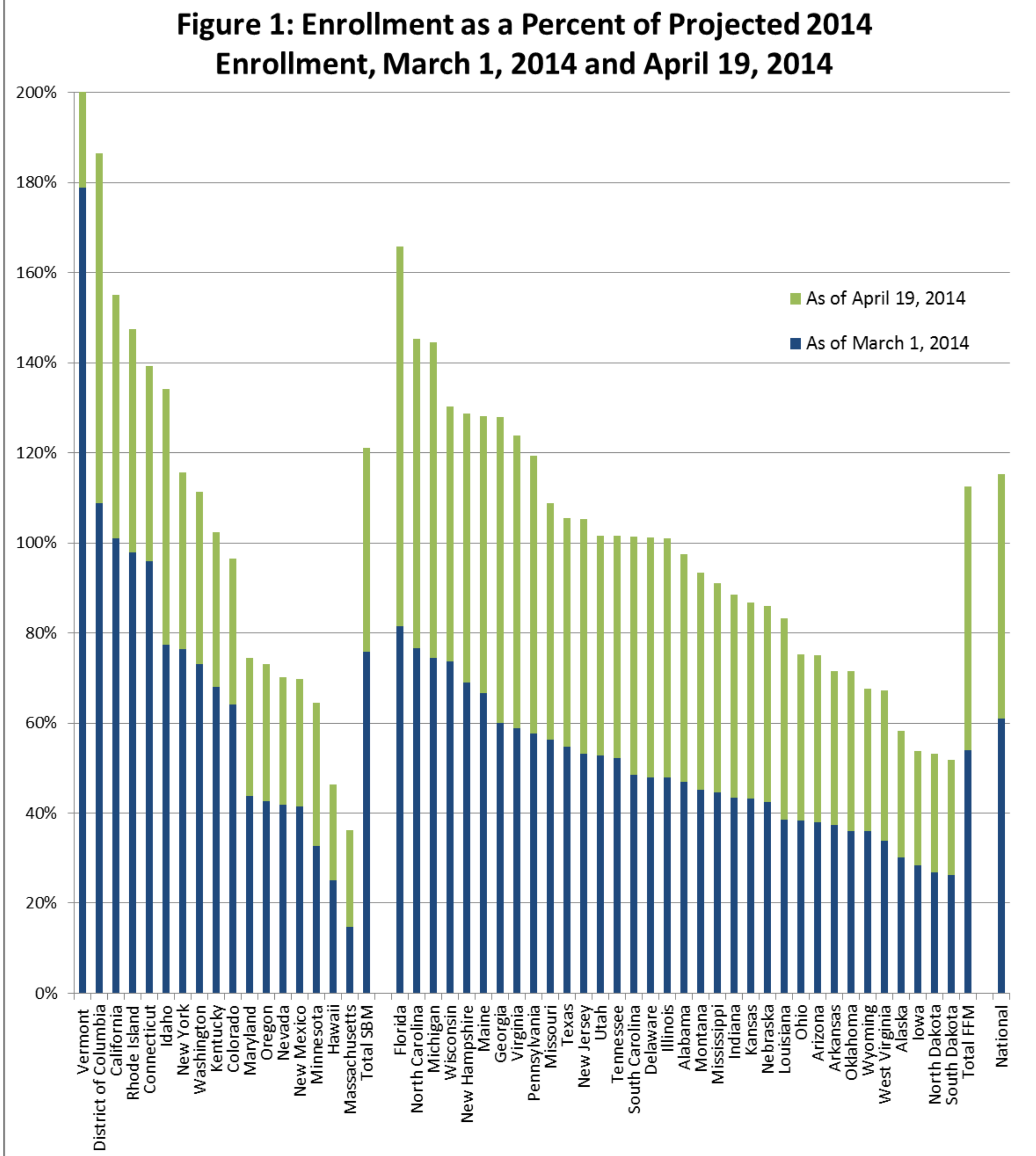
Table 1: Marketplace Enrollment Progress, by Marketplace Type

Current Enrollment as of April 19, 2014

State	(1) Projected 2014 Marketplace Enrollment	(2) Total Marketplace Target Population for 2016	(3) Projected 2016 Marketplace Enrollment	(4) Latest Marketplace Enrollment Data	**(5 = 4/1) Current Enrollment as a Percent of Projected 2014 Enrollment**	**(6 = 4/2) Current Enrollment as a Percent of the Total Target Population**	**(7 = 4/3) Current Enrollment as a Percent of Projected 2016 Enrollment**
Vermont	14,000	52,000	35,000	38,048	**279.9%**	**73.5%**	**109.8%**
District of Columbia	6,000	31,000	19,000	10,714	**186.5%**	**34.2%**	**56.7%**
California	906,000	3,332,000	2,357,000	1,405,102	**155.1%**	**42.2%**	**59.6%**
Rhode Island	19,000	75,000	48,000	28,485	**147.5%**	**38.2%**	**58.9%**
Connecticut	57,000	241,000	162,000	79,192	**139.2%**	**32.8%**	**48.9%**
Idaho	57,000	267,000	142,000	76,061	**134.1%**	**28.5%**	**53.7%**
New York	321,000	1,295,000	811,000	370,451	**115.6%**	**28.6%**	**45.7%**
Washington	147,000	572,000	373,000	163,207	**111.3%**	**28.5%**	**43.7%**
Kentucky	81,000	307,000	196,000	82,747	**102.4%**	**26.9%**	**42.3%**
Colorado	130,000	497,000	351,000	125,402	**96.4%**	**25.3%**	**35.7%**
Maryland	91,000	397,000	250,000	67,757	**74.4%**	**17.1%**	**27.2%**
Oregon	94,000	350,000	232,000	68,308	**73.0%**	**19.5%**	**29.4%**
Nevada	65,000	242,000	156,000	45,390	**70.1%**	**18.8%**	**29.1%**
New Mexico	46,000	171,000	112,000	32,062	**69.8%**	**18.8%**	**28.7%**
Minnesota	75,000	331,000	223,000	48,495	**64.5%**	**14.7%**	**21.8%**
Hawaii	19,000	86,000	47,000	8,592	**46.3%**	**10.0%**	**18.2%**
Massachusetts	88,000	396,000	255,000	31,695	**36.1%**	**8.0%**	**12.4%**
Total SBM	***2,213,000***	***8,640,000***	***5,769,000***	***2,682,000***	*121.2%*	*31.0%*	*46.5%*
Florida	594,000	3,177,000	1,437,000	983,775	**165.7%**	**31.0%**	**68.5%**
North Carolina	246,000	1,304,000	615,000	357,584	**145.3%**	**27.4%**	**58.2%**
Michigan	189,000	781,000	467,000	272,539	**144.5%**	**34.9%**	**58.4%**
Wisconsin	107,000	444,000	269,000	139,815	**130.3%**	**31.5%**	**52.0%**
New Hampshire	31,000	157,000	79,000	40,262	**128.8%**	**25.6%**	**50.8%**
Maine	35,000	157,000	82,000	44,258	**128.1%**	**28.1%**	**53.9%**
Georgia	247,000	1,445,000	608,000	316,543	**127.9%**	**21.9%**	**52.1%**
Virginia	175,000	941,000	451,000	216,356	**123.9%**	**23.0%**	**48.0%**
Pennsylvania	267,000	1,439,000	677,000	318,077	**119.3%**	**22.1%**	**47.0%**
Missouri	140,000	785,000	349,000	152,335	**108.8%**	**19.4%**	**43.7%**
Texas	696,000	3,831,000	1,683,000	733,757	**105.4%**	**19.2%**	**43.6%**
New Jersey	154,000	603,000	396,000	161,775	**105.3%**	**26.8%**	**40.9%**
Utah	83,000	384,000	208,000	84,601	**101.6%**	**22.0%**	**40.7%**
Tennessee	149,000	832,000	378,000	151,352	**101.6%**	**18.2%**	**40.0%**
South Carolina	117,000	657,000	283,000	118,324	**101.3%**	**18.0%**	**41.9%**
Delaware	14,000	60,000	34,000	14,087	**101.2%**	**23.4%**	**40.9%**
Illinois	215,000	897,000	566,000	217,492	**101.0%**	**24.2%**	**38.5%**
Alabama	100,000	637,000	252,000	97,870	**97.4%**	**15.4%**	**38.9%**
Montana	39,000	190,000	98,000	36,584	**93.3%**	**19.3%**	**37.4%**
Mississippi	68,000	417,000	162,000	61,494	**91.1%**	**14.8%**	**37.9%**
Indiana	150,000	856,000	369,000	132,423	**88.5%**	**15.5%**	**35.9%**
Kansas	66,000	352,000	169,000	57,013	**86.7%**	**16.2%**	**33.8%**
Nebraska	50,000	244,000	136,000	42,975	**85.9%**	**17.6%**	**31.5%**
Louisiana	122,000	735,000	305,000	101,778	**83.3%**	**13.8%**	**33.3%**
Ohio	205,000	796,000	498,000	154,668	**75.3%**	**19.4%**	**31.1%**
Arizona	160,000	559,000	391,000	120,071	**75.0%**	**21.5%**	**30.7%**
Arkansas	61,000	218,000	147,000	43,446	**71.5%**	**19.9%**	**29.5%**
Oklahoma	97,000	520,000	235,000	69,221	**71.5%**	**13.3%**	**29.5%**
Wyoming	18,000	84,000	45,000	11,970	**67.5%**	**14.2%**	**26.5%**
West Virginia	30,000	118,000	68,000	19,856	**67.3%**	**16.8%**	**29.1%**
Alaska	22,000	105,000	51,000	12,890	**58.2%**	**12.3%**	**25.5%**
Iowa	54,000	218,000	145,000	29,163	**53.8%**	**13.4%**	**20.1%**
North Dakota	20,000	73,000	54,000	10,597	**53.1%**	**14.5%**	**19.8%**
South Dakota	25,000	125,000	66,000	13,104	**51.9%**	**10.5%**	**19.8%**
Total FFM	***4,745,000***	***24,142,000***	***11,773,000***	***5,338,000***	*112.5%*	*22.1%*	*45.3%*
National	**6,958,000**	**32,781,000**	**17,542,000**	**8,020,000**	**115.3%**	**24.5%**	**45.7%**

Source: Urban Institute projections based on the 2014 Health Insurance Policy Simulation Model using data from the American Community Survey (HIPSM-ACS 2014); Enrollment data is as of April 19, 2014 from the United States Department of Health and Human Services

Note: The Marketplace target population for 2016 consists of three groups: those eligible for subsidies, those currently with nongroup coverage but who are ineligible for subsidies or Medicaid/CHIP, and those currently uninsured who do not have access to employer coverage and who are ineligible for subsidies or Medicaid/CHIP; Enrollment numbers for Hawaii, Massachusetts, Minnesota, and Washington may be undercounted (see Appendix E for more details); SBM= State-Based Marketplace; FFM= Federally Facilitated Marketplace.



Source: Urban Institute projections based on the 2014 Health Insurance Policy Simulation Model using data from the American Community Survey (HIPSM-ACS 2014); Enrollment data is as of March 1, 2014 and April 19, 2014 from HHS (http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Mar2014/ib_2014mar_enrollment.pdf; http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf).
Notes: Vermont has a current enrollment that is more than twice greater than projected 2014 enrollment (279.9%); Enrollment numbers for Hawaii, Massachusetts, Minnesota, and Washington A may be undercounted (see http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf Appendix E for more details); SBM= State-Based Marketplace; FFM= Federally Facilitated Marketplace

Copyright© April 2014. The Urban Institute. Permission is granted for reproduction of this file, with attribution to the Urban Institute.

About the Authors and Acknowledgements

Linda Blumberg is a senior fellow, John Holahan is an Institute Fellow, Genevieve Kenney is a co-director and a senior fellow, Matthew Buettgens is a senior research associate, Nathaniel Anderson and Hannah Recht are research assistants, and Stephen Zuckerman is a co-director and a senior fellow at the Urban Institute's Health Policy Center. This study was funded by the Robert Wood Johnson Foundation. The authors are grateful to Bowen Garrett and Lisa Clemans-Cope for their input into revisions of the Health Insurance Policy Simulation Model (HIPSM).

About the Robert Wood Johnson Foundation

For more than 40 years the Robert Wood Johnson Foundation has worked to improve the health and health care of all Americans. We are striving to build a national culture of health that will enable all Americans to live longer, healthier lives now and for generations to come. For more information, visit **www.rwjf.org**. Follow the Foundation on Twitter **www.rwjf.org/twitter** or Facebook **www.rwjf.org/facebook**.

About the Urban Institute

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic and governance problems facing the nation. For more information, visit **www.urban.org**. Follow the Urban Institute on Twitter **www.urban.org/twitter** or Facebook **www.urban.org/facebook**. More information specific to the Urban Institute's Health Policy Center, its staff, and its recent research can be found at **www.healthpolicycenter.org.**

APRIL 2014

Deciphering the Data: State-Based Marketplaces Spent Heavily to Help Enroll Consumers

In-Brief

The Affordable Care Act required that consumers have access to in-person or on-call assistance to understand their choices and "navigate" the complexities of the new health insurance marketplaces. One consequence of each state's decision about whether to run its own marketplace is an extreme variation in the time-limited funding available for consumer assistance programs. This Data Brief looks at the types of assistance available and the level of funding for each state in the first year of marketplace operations, and analyzes the components of that variation.

BACKGROUND

Recognizing that health insurance is a complex product and that consumers would need help understanding their options and navigating a health insurance marketplace, the Affordable Care Act and subsequent regulations created a number of consumer assistance programs. This was especially important given that a key target population was the uninsured, many of whom were unfamiliar with the basics of health insurance.

Here we focus on programs that trained or certified people and organizations to directly assist consumers in enrolling in the marketplaces. The assister programs had outreach responsibilities, but are distinct from the broader education and outreach efforts conducted by public and private groups (for example, Enroll America).

The assister programs were intended to operate at the state level with funds going directly to community centers or other entities already operating within the state. States with a state-based marketplace (SBM) took on the role of funding and selecting Navigator organizations, while the federal government took on this role in states with a federally facilitated marketplace (FFM). The partnership states could decide whether to take on consumer assistance functions or rely on the federal government.

Consumer assistance programs fall within three categories: Navigators, In-Person Assisters (IPAs) and Certified Application Counselors (CACs). While the duties of Navigators and other in-person assisters are fairly straightforward, with three types of marketplaces and three categories of programs, the scope and implementation of consumer assistance varies considerably across states.

As initially conceived in the ACA, "**Navigators**" would be funded and trained to conduct outreach and facilitate enrollment in the new marketplaces. The ACA also specified standards to ensure Navigators are qualified, free of conflicts of interest, and providers of fair and impartial information and services. A wide range of entities could run a Navigator program, such as community non-profit groups, trade, industry, and professional organizations, ranching and fishing associations, chambers of commerce, and unions. This broad array of potentially qualified entities reflects the recognition that the success of Navigators would depend on the extent to which they are trusted by the people using the marketplaces.

In the 29 FFM states, as well as two partnership states, the federal government distributed $67 million in Navigator funding, using a specific formula based on the number of uninsured residents under age 65. Each state received a minimum of $600,000, with the remainder allocated by the state's share of the number of uninsured in FFM and partnership states. A total of 105 organizations received one-year, non-renewable Navigator grants in August 2013.

The ACA required that SBM Navigator programs be funded by revenues generated by the operations of the marketplace. States could not pay Navigators from their federal Exchange Establishment block grants (although the grants could be used for training and administrative expenses). As a result, the SBM states had a timing problem in funding their Navigator programs: they needed to conduct outreach and enrollment before their marketplaces started generating revenues to become self-sustaining. Thus, the Department of Health and Human Services (DHHS) created a similar, optional "**In-Person Assister (IPA)**" program that states could fund through the federal block grants,

which totaled more than $3 billion. The 16 SBM states and DC could decide how much to spend on IPAs and how to disburse the funds through September 2015. The five partnership states with consumer assistance functions were required to have IPA programs. Other than funding streams, there was little difference, in training or duties, between the Navigators and the IPAs.

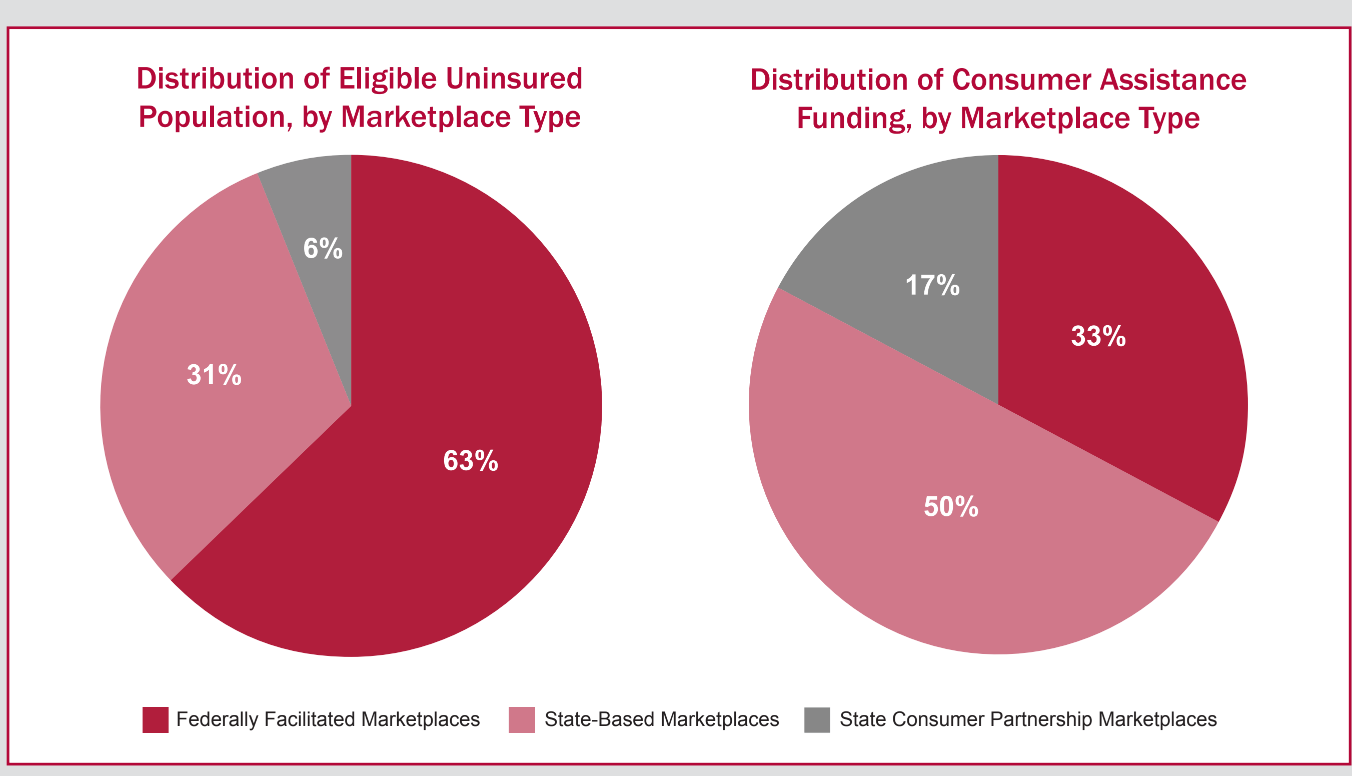
By rule, all marketplaces were required to have a third type of assister, called "**Certified Application Counselors (CACs)**." Many states have existing CAC organizations that help people enroll in Medicaid. CACs have similar functions to Navigators and IPAs, but have less stringent training requirements. Unlike Navigators and IPAs, they are not required to conduct consumer education and outreach activities. CACs were not funded by these consumer assistance programs. However, they could receive funding through other state or federal programs, such as Medicaid, and thus, funding varied by state.

In July 2013 the federal government awarded $150 million to fund consumer assistance in community health centers, allocated proportionately among federally-qualified health centers in each state. More than 1100 centers received funds, at a base funding level of $55,000, and an additional amount allocated by the grantees' proportion of uninsured patients. In FFM and partnership states, health centers receiving this funding were required to become designated CAC organizations; SBM states had the option of imposing this requirement on health centers in those states.

The ACA specifically foresaw a role for licensed insurance agents and brokers in enrolling consumers in the marketplaces. In FFM and partnership states, agents and brokers could register and receive marketplace-specific training; SBM states had the option of adding state-specific requirements for agent and broker participation in the marketplace. Although agents and brokers played a large role in some marketplaces, we were unable to measure the scope of these activities, and confine our analysis to the three consumer assistance programs.

WHAT WE DID

We gathered data from various sources on state-level funding of consumer assistance programs and rates of uninsurance. The source of Navigator-specific funding for FFM and partnership states was the Centers for Medicare & Medicaid Services (CMS). SBM spending on IPAs/Navigators came from September 2013 data from the Kaiser Family Foundation (KFF). We also reviewed public documents and websites to update IPA information on states that had not yet funded their programs when KFF gathered its data. We obtained data on Community Health Center funding for consumer assistance from the Health Resources and Services Administration (HRSA), and the size of the eligible uninsured population under 65 in each state from CMS, who derived estimates from the Census Bureau's American Community Survey. Using these data, we calculated aggregate and per-uninsured funding levels. We looked at aggregate funding by type of marketplace, as well as the breakdown of funding by funding source. HIX 2.0, a database of exchange information, is a one-stop-shop for all the data we used for this brief. We relied on the HIX 2.0 for its delineation of marketplace types to ascertain the consumer assistance responsibilities of the partnership states. For these purposes, we included the two partnership states not running their own



consumer assistance programs (Iowa and Michigan) in the FFM category.

WHAT WE FOUND

By comparing consumer assistance funds to the uninsured, we found consumer assistance funds to be more concentrated in SBM states. SBMs accounted for 50% of total consumer assistance funds, although they have just 31% of all uninsured. In contrast, 63% of the uninsured live in FFM states, which accounted for 33% of the funding. The five partnership states in charge of consumer assistance functions were home to just 6% of the uninsured, but garnered 17% of the funding.

We then calculated the total consumer assistance funds per uninsured by marketplace type and found that states that run their own marketplaces, on average, spent much more on consumer assistance than states that opted to defer to the federal government to run their marketplace ($17.15 per uninsured for SBMs vs. $5.42 per uninsured for FFMs). The highest spending was in the five partnership states responsible for consumer assistance ($31.53 per uninsured).

The differences by marketplace type correspond to the differences in funding eligibility. The five partnership states with consumer assistance functions were the only ones with access to all three funding streams: federal Navigator funding, IPA funding from exchange establishment grants, and community health center funding. As a result, they had, on average, the highest per-uninsured funding levels. The FFMs were not able to draw on exchange grants for the more generous IPA funding and the SBMs were not eligible for the less generous federal Navigator funding. Looking at the components of funding, we can see the importance of the community health center funding in the FFM states, where it accounted for 57%, compared to 26% in SBM states and 15% in partnership states.

Consumer Assistance Funding Per Eligible Uninsured, by Marketplace Type

Marketplace Type	Total per uninsured
Federally Facilitated Marketplaces	$5.42
State Consumer Partnership Marketplaces	$31.53
State-Based Marketplaces	$17.15

Legend: CHC Funds; Navigator Funds; IPA/State Funds. Y-axis: 0–35.

On a state level, we found relatively small variations in FFM funding for consumer assistance, ranging from $4.24 per uninsured in Georgia to $17.22 per uninsured in Alaska. This is not surprising, given that the FFM funds (beyond certain minimums) were allocated based on the number of uninsured.

Much larger differences exist in SBM and partnership states, because these states had great discretion as to how much from the large pool of Exchange Establishment grants they would devote to consumer assistance. SBM states ranged from a per-uninsured low of $6.18 for Nevada to highs of $87.86 in Hawaii and $163.93 in DC. The highest per-insured spenders have small uninsured populations, which suggests that fixed costs in launching these programs might explain some of the differences.

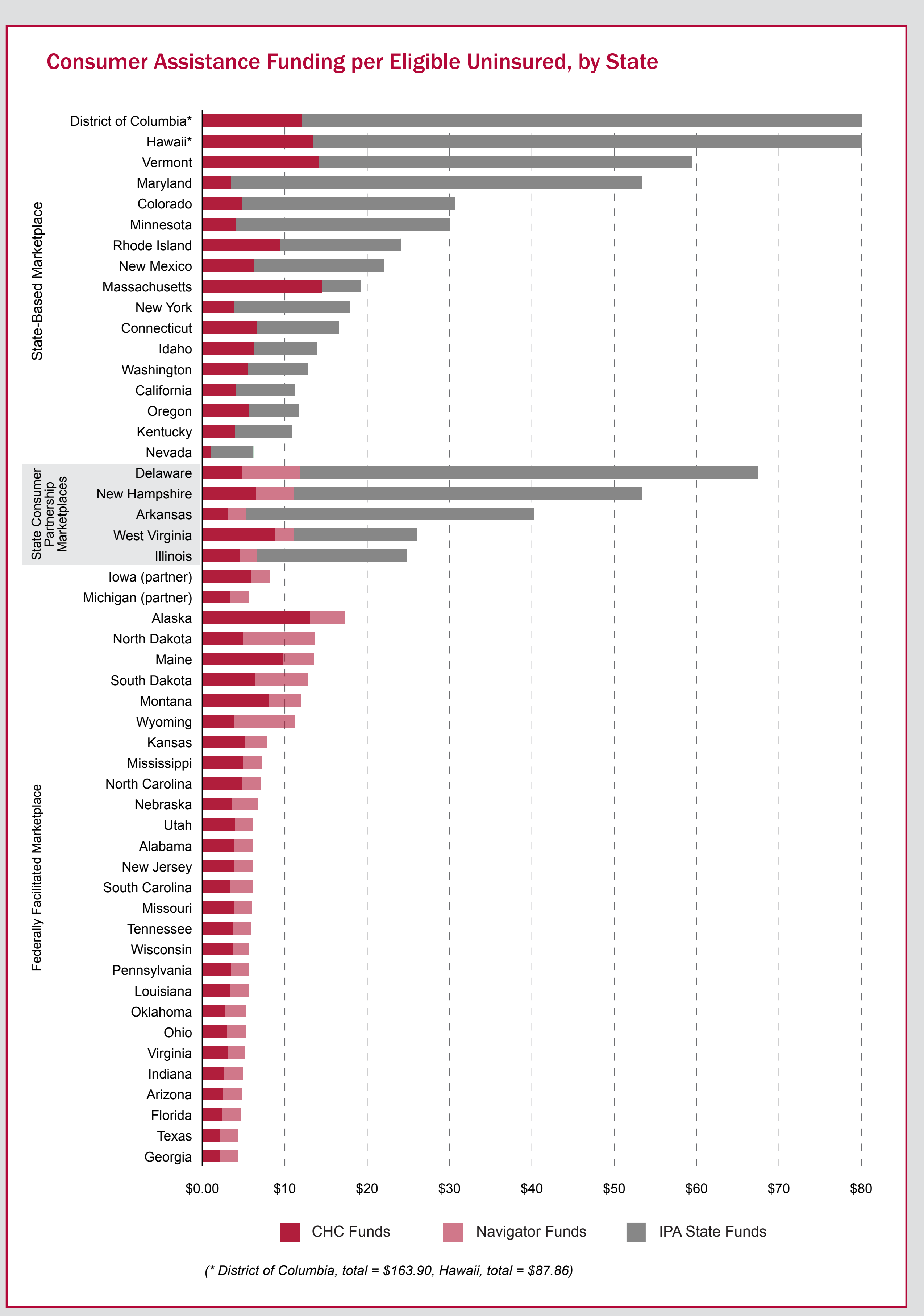
The five partnership states with consumer assistance functions were higher on average than the SBMs even though the range between the highest and lowest partnership states was much less than for SBMs. Funding ranged from $25.76 per uninsured in Illinois to $67.39 in Delaware.

WHAT DOES IT MEAN?

This analysis reveals extreme differences in the amount of funding available to states to help consumers enroll in the new marketplaces. Enrollment data to date suggests wide variations in how successful states were in enrolling their eligible populations in private plans, with SBMs and partnership states, in general, having more success than FFMs. It is still too early to tell how much of this success can be ascribed to the greater levels of consumer assistance available to the SBMs and partnership states as they were launching their marketplaces.

Many other factors could be at play here. Our analysis does not account for marketplace funds spent on broad marketing campaigns or call centers, nor does it account for insurer initiatives to enroll new customers. For example, some states and insurers used enrollment buses and enrollment telethons.

The effectiveness of the Navigators themselves might have differed from state to state, especially in states that create barriers to assister programs. Many states passed laws to restrict activities of consumer assistance programs, sometimes requiring assisters to


Consumer Assistance Funding per Eligible Uninsured, by State
State-Based Marketplace
District of Columbia*
Hawaii*
Vermont
Maryland
Colorado
Minnesota
Rhode Island
New Mexico
Massachusetts
New York
Connecticut
Idaho
Washington
California
Oregon
Kentucky
Nevada
State Consumer Partnership Marketplaces
Delaware
New Hampshire
Arkansas
West Virginia
Illinois
Federally Facilitated Marketplace
Iowa (partner)
Michigan (partner)
Alaska
North Dakota
Maine
South Dakota
Montana
Wyoming
Kansas
Mississippi
North Carolina
Nebraska
Utah
Alabama
New Jersey
South Carolina
Missouri
Tennessee
Wisconsin
Pennsylvania
Louisiana
Oklahoma
Ohio
Virginia
Indiana
Arizona
Florida
Texas
Georgia
$0.00
$10
$20
$30
$40
$50
$60
$70
$80
CHC Funds
Navigator Funds
IPA State Funds
(* District of Columbia, total = $163.90, Hawaii, total = $87.86)

obtain credentials beyond federal requirements. A number of these laws have been overturned in federal courts.

It is also unclear how the variation in consumer assistance funding interacted with each state's decision whether or not to expand Medicaid. The combination of funding for community health centers and extensive use of CACs might have been especially helpful in reaching and enrolling the uninsured in states that expanded Medicaid.

This natural variation in first-year funding provides an excellent opportunity to study, both qualitatively and quantitatively, the outcomes of one of the largest outreach and consumer assistance efforts the United States has ever undertaken. Such research could give us insights into the most effective use of resources, both public and private, financial and non-financial, as states prepare for subsequent open enrollment periods in the health insurance marketplaces. These insights will be critical as these large pools of resources for consumer assistance run out and are replaced next year by much smaller amounts generated by marketplace revenues.

The future funding of consumer assistance is uncertain. Two funding streams—the federal Navigator and IPA grants—account for nearly two-thirds of the funding we report here and are scheduled to run out at the end of the year. The establishment grants that SBM states used to fund IPA programs will not be awarded beyond 2014. The FFM Navigator grants were one-time only, and subsequent funding beyond revenues raised by each marketplace is unclear. Going forward, it is likely that community health centers will continue to be central in consumer assistance efforts. For 2014, the Department of Health and Human Services (DHHS) awarded $58 million in one-time funding to community health centers for outreach and enrollment assistance (not included in our present analysis). For FY 2015, it has stated its commitment to outreach and enrollment as an ongoing health center activity, and anticipates annualizing its July 2013 funding amounts into each center's base funding.

About the Authors

This Data Brief was written by Daniel E. Polsky, PhD, MPP, Janet Weiner, MPH, Christopher Colameco, and Nora Becker.

About The Leonard Davis Institute of Health Economics

The Leonard Davis Institute of Health Economics (LDI) is the University of Pennsylvania's center for research, policy analysis, and education on the medical, economic, and social issues that influence how health care is organized, financed, managed, and delivered. LDI, founded in 1967, is one of the first university programs to successfully cultivate collaborative multidisciplinary scholarship. It is a cooperative venture among Penn's health professions, business, and communications schools (Medicine, Wharton, Nursing, Dental Medicine, Law School, and Annenberg School for Communication) and the Children's Hospital of Philadelphia, with linkages to other Penn schools, including Arts & Sciences, Education, Social Policy and Practice, and Veterinary Medicine.

About the Robert Wood Johnson Foundation

For more than 40 years the Robert Wood Johnson Foundation has worked to improve the health and health care of all Americans. We are striving to build a national culture of health that will enable all Americans to live longer, healthier lives now and for generations to come. For more information, visit *www.rwjf.org*. Follow the Foundation on Twitter at *www.rwjf.org/twitter* or on Facebook at *www.rwjf.org/facebook*.

Exchange Consumer Experience Analysis

April 2014
avalerehealth.net

This analysis was funded by Pfizer, Inc. Avalere maintained editorial control over the content.

Goal of Analysis, Methodology, and Limitations

Goal of Analysis

- To provide a snapshot view of the consumer experience in selecting a health insurance plan on the healthcare marketplaces (or exchanges) for the 2014 plan year

Methodology

- Avalere analyzed the exchange websites that enable consumers to shop and compare individual insurance plans
  - Avalere reviewed plans sold in the Federally-Facilitated Marketplace (FFM) on Healthcare.gov and the other state-based exchanges (SBEs)
- We gauged the consumer experience on several factors:
  - The ease of accessing formularies and provider directories
  - The order of plans listed on websites, and
  - The availability of out-of-pocket calculators and drug look up tools
- Avalere assessed access to formularies and provider directories by devising a scoring methodology specific to this information
- For each SBE website, Avalere analyzed five plans: the two lowest-priced Bronze and Silver plans and the lowest-priced Gold plan
- For the FFM website, we analyzed five plans in the top five states by projected enrollment
  - Avalere selected the most populous counties in each state for the analysis

Limitations

- Avalere could not access exchange websites for Hawaii, Kentucky, or Vermont
- Once formularies and provider directories were accessed, Avalere did not assess the accuracy of the content or ease of use.
- Additionally, Avalere could not review various cost-sharing and premium subsidy information given the requirement to create an account with personalized information

Methodology for Formulary and Provider Directory Scores

- Avalere evaluated the consumer experience of navigating websites to find plan formulary and provider directory information
- To determine a score for each analyzed plan, Avalere assigned points based on the following:
  - Number of clicks to access the information
    - Avalere started the counting of clicks at the point of viewing the list of plan options for a given exchange website
  - Location of the information (assigned a score based on Table 1)
- From there, Avalere added the two numbers to get a total score for each plan
- The scores fall into five different categories (outlined in Table 2)
- For example, a formulary directly linked from an exchange website that took 2 clicks to access would receive a score of Very Accessible (0 for exchange location plus 2 for the clicks)

TABLE 1. LOCATION OF BENEFIT INFORMATION

Category	Description	Score
Exchange	Direct link from exchange website	0
Plan's Formulary/Provider Page	Webpage dedicated to drug coverage and provider information information	1
Product Page	Webpage outlining product information	2
Plan's Home Page	Plan's overall home page	4
Not Available	No formulary / directory information available	-

TABLE 2. OVERALL SCORE

Degree of Accessibility	Score Range
Very Accessible	1-2
Moderately Accessible	3-4
Difficult	5-6
Very Difficult	7-11
No formulary / directory information available	-

Key Findings

In almost half of exchange plans, it is difficult or impossible for enrollees to determine what drugs are covered by the plan

- In 48% of exchange plans analyzed, formularies are difficult, extremely difficult, or impossible to access
  - 38% of plans had no formulary data available, presenting significant obstacles to consumers
- Formularies are very or moderately accessible in 52% of exchange plans
  - Of these accessible plans, 80% have a direct link from the exchange website to the applicable formulary on the plan's website
  - Notably, Nevada has formulary information about every plan included in a drug lookup tool on the exchange website

Locating provider directories is somewhat easier compared to locating formularies

- Over 75% of plans offer very or moderately accessible access to provider network directories
- Close to half of exchange websites offer a provider lookup tool on the actual exchange website

Most exchanges by default list plans by premium price

- Some websites offer the functionality of sorting by features other than price (e.g., metal level, carrier, benefit design feature)
- California offers consumers an out-of-pocket calculator to help gauge expected costs by exchange plan

Healthcare.gov offered better drug transparency compared to some state exchanges

- Formulary data was more accessible on Healthcare.gov than in half of state exchanges
- Healthcare.gov will further improve drug coverage transparency by requiring plans to submit direct links to formularies in 2015

Formulary Information Is Difficult or Impossible to Access in Almost Half of Exchange Plans

DRUG FORMULARY ACCESSIBILITY, BY PLAN*

- Very Accessible, 31%
- Moderately Accessible, 21%
- Difficult, 7%
- Very Difficult, 4%
- Formulary Not Available, 38%

N=85 Plans

DIRECT FORMULARY LINKS

80% of very/ moderately accessible plans had direct links to formularies**

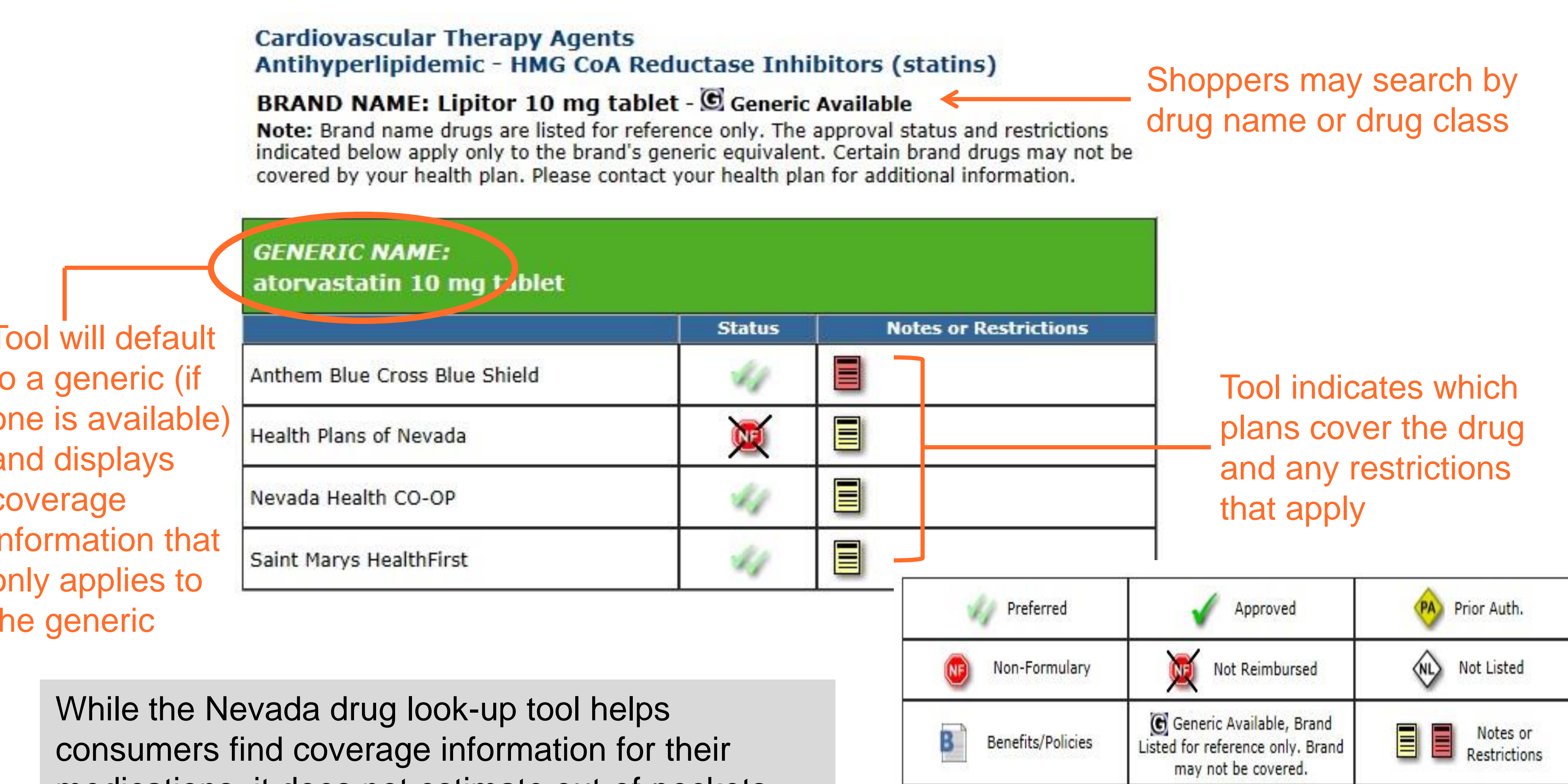
NV

FEATURED STATE: Nevada allows consumers to enter drug information and see which plans cover their medications and what restrictions apply.

*Numbers may not sum to 100% due to rounding.
** This shows those plans deemed either very or moderately accessible that have a direct link to a PDF or html formulary from an exchange website; that is, consumers do not need to take any further steps to identify and select the formulary once linked to the issuer's website. Also note that this includes all plans analyzed.

Drug Look-Up Tools Are Rare Among Exchange Websites; While an Exception, Nevada's Tool Has Limitations

Nevada is the only website to include a look-up tool; it offers consumers the ability to shop for plans based on coverage of medications, but some limitations apply



While the Nevada drug look-up tool helps consumers find coverage information for their medications, it does not estimate out-of-pockets costs for the drug

Coverage Information Provided by the Nevada Tool May Cause Confusion

- While the tool includes a legend for the symbols related to drug coverage, there is still a lack of clarity around the difference among *Non-Formulary / Not Reimbursed / Not Listed* and *Preferred* and *Approved*

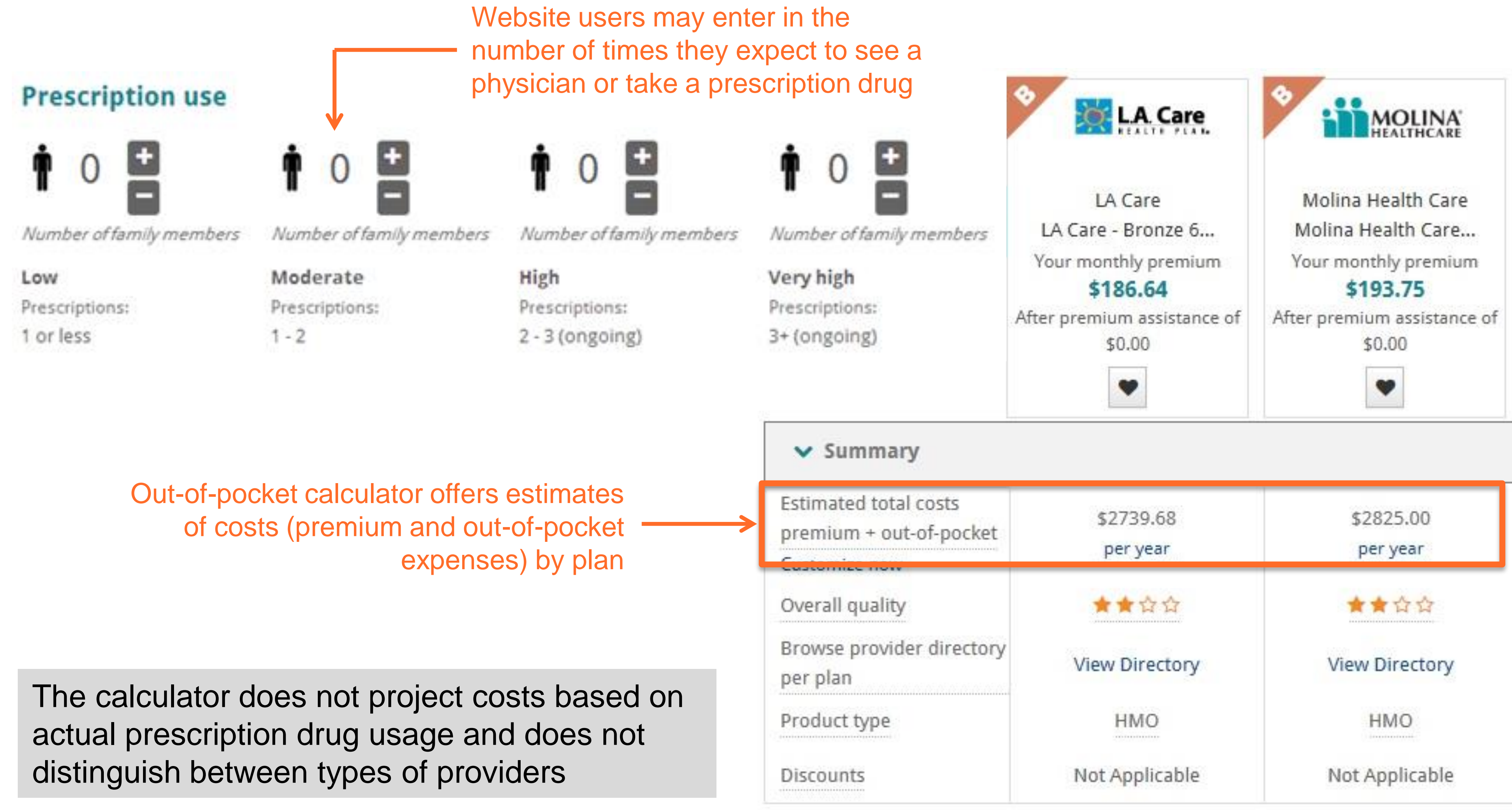
Status	Symbol(s)	Interpretation
Preferred		Preferred over all other drugs in the same therapeutic category.
Approved		Approved for reimbursement without any restrictions.
Prior Authorization	PA	Reimbursement will be allowed only when the claim has been submitted to plan officials by a prescriber for review prior to the issuance of a prescription.
Non-Formulary	NF	The Plan lists this drug as not on the formulary. Please click on the B icon to review the Plan's Benefits/Policies regarding non formulary drugs.
Not Reimbursed	NF	This drug is not reimbursed by the plan.
Not Listed	NL	No information available for this drug. It may or may not be reimbursable.
Benefits/Policies	B	Click the icon to view the Plan's Benefits/Policies.
Generic Available	G	The G symbol indicates that the drug name it appears after is available as a generic equivalent. Health insurance providers almost always require that a generic be used if it is available.
Notes or Restrictions		Click the icon to view the Plan's notes or restrictions.

Tool does not clearly differentiate between preferred and approved

Similar confusion surrounds non-formulary, not reimbursed, and not listed

California Has an Out-of-Pocket Calculator to Help Project Annual Costs

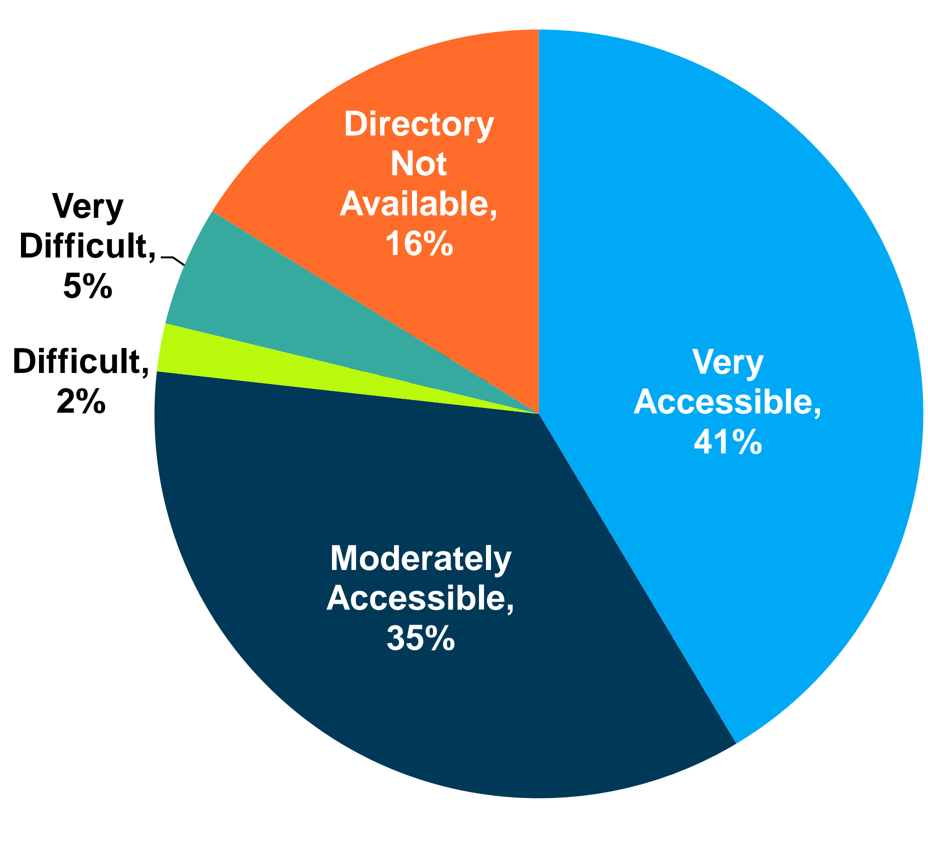
- The OOP Calculator seeks to project yearly out-of-pocket costs for prospective enrollees by plan



The calculator does not project costs based on actual prescription drug usage and does not distinguish between types of providers

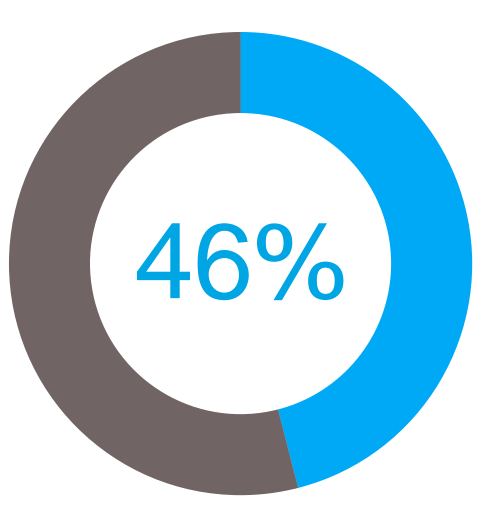
Majority of Plans Have Very or Moderately Accessible Provider Directories; Yet, Over 15 Percent Have No Provider Directories

PROVIDER DIRECTORY ACCESSIBILITY, BY PLAN*



N=85 Plans

PERCENTAGE OF EXCHANGE WEBSITES WITH PROVIDER LOOKUP TOOLS



N= 13 Websites

FEATURED STATES:

- Some state websites, such as Washington and Massachusetts, allowed users to easily enter provider information to see which plans covered certain providers.
- Minnesota's provider tool was inoperable for certain periods

*Numbers may not sum to 100% due to rounding.

Exchange Websites Present a Variety of Options for Sorting or Searching Plan Options

The primary default for the arrangement of plan options is by premium price (lowest to highest).

FUNCTIONALITY OF SORTING OR SEARCHING FOR PLAN OPTIONS ON FEDERAL AND STATE WEBSITES

Option	# of Analyzed Exchange Websites
Premium by Price	13
Metal Level	12
Search by Issuer	10
Deductible	6
Search by Provider	6
Quality Rating*	4
Plan Type	3
OOP Max	2
Annual Costs**	1
Plan Name	1
Cost Sharing For Select Services	1

* Four states allow users to sort by some type of quality rating: CT (using NCQA), NY, OR, and NV.

** Includes premiums and OOP expenses.

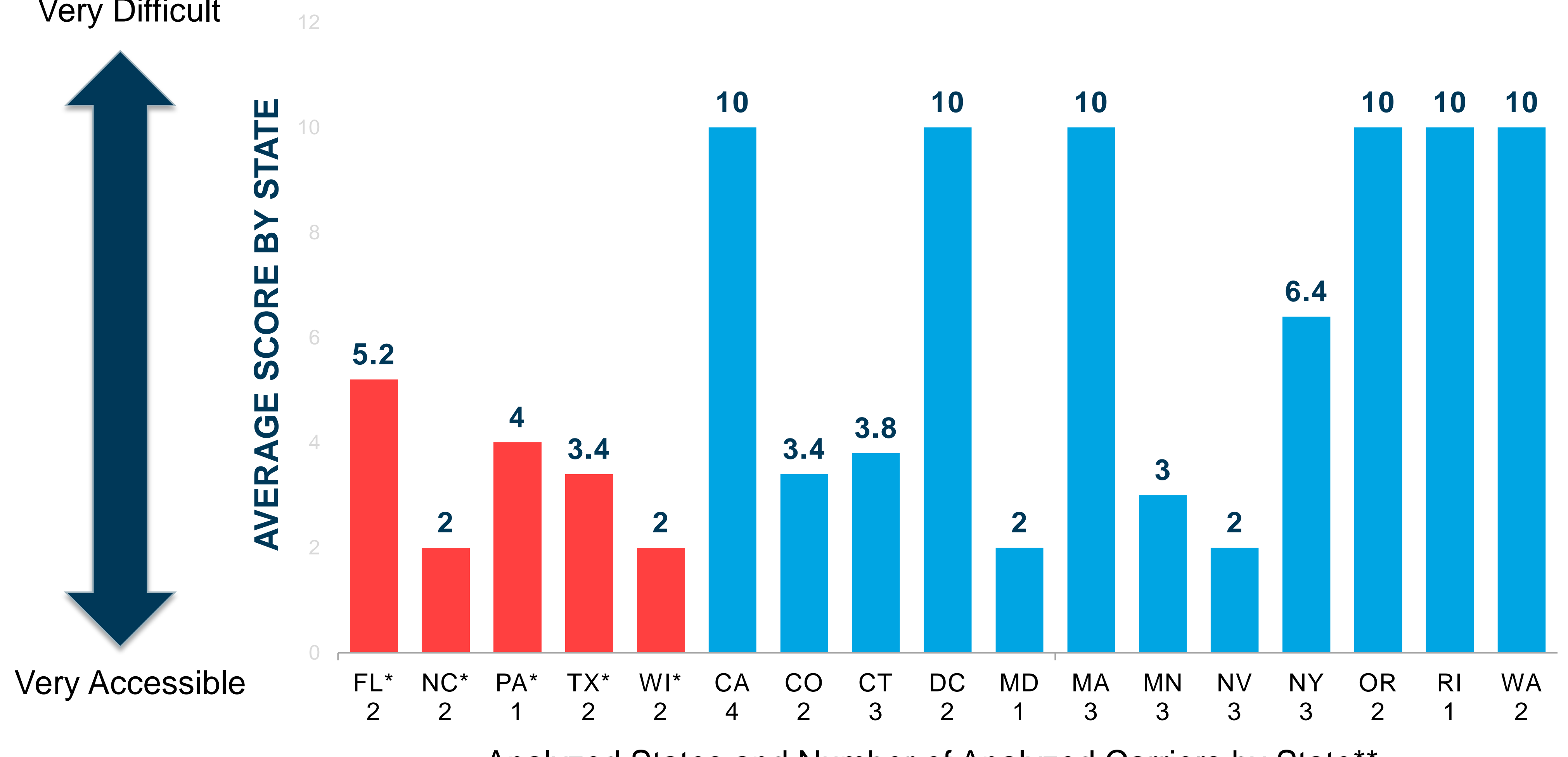
Please note that Avalere analyzed 13 total exchange websites: FFM and 12 SBE websites.

State Specific Findings

Both the Exchange and Plan Websites Impact Consumer Access to Plan Information

- Transparency around exchange plan benefit information is a critical component in allowing consumers to make an informed decision when selecting a plan option for 2014
- The ease of accessing critical information related to plan coverage of prescription drugs and provider plan networks is generally driven by two factors:
  - Ease of use of the exchange website
  - How directly plans link important benefit information from the exchange website
- Some exchange websites may not offer any links to formularies or even provider directories
  - However, even in states with websites that do offer links, links may redirect to plans' home pages, which may require extensive consumer navigation
- To enhance transparency for 2015, policy solutions would need to focus both on improving the ease of use of exchange websites and ensuring plans adequately link important information and documents such as formularies and provider directories
  - Already, the federal government will require plans operating in the federal exchange for 2015 to have direct links to plan formularies

Formulary Accessibility: Average Scores of Analyzed Plans by State



Methodological note: In order to quantify a state average, Avalere graded plans with no available formularies with a score of "10"

* Analyzed Federally-Facilitated Marketplace states. FFM states also denoted in red.

** Note that, in each state, we analyzed a total of five plans offered by the number of different carriers shown below each state on the graph.

Formulary Accessibility: Analyzed Plan Scores by State

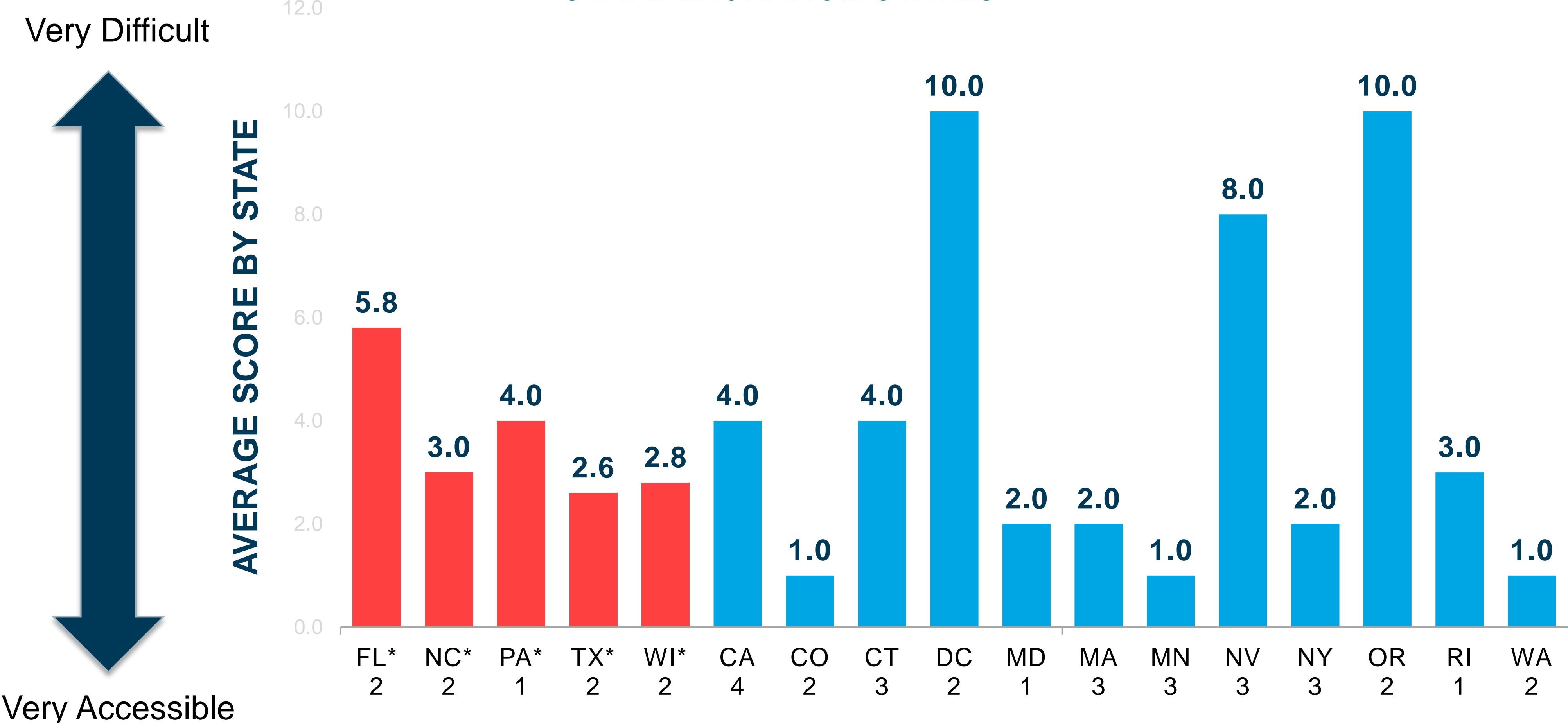
NUMBER OF PLANS BY FORMULARY ACCESSIBILITY SCORE, BY STATE

State (# of Carriers)	Link to Formulary Information Available	Very Accessible	Moderately Accessible	Difficult	Very Difficult
Florida (2)	Yes	3	-	-	2
North Carolina (2)	Yes	5	-	-	-
Pennsylvania (1)	Yes	-	5	-	-
Texas (2)	Yes	1	4	-	-
Wisconsin (2)	Yes	5	-	-	-
California (4)	No	-	-	-	5
Colorado (2)	Yes	2	-	3	-
Connecticut (3)	Yes	-	4	-	1
DC (2)	No	-	-	-	5
Maryland (1)	Yes	5	-	-	-
Massachusetts (3)	No	-	-	-	5
Minnesota (3)	Yes	-	5	-	-
Nevada (3)	Yes	5	-	-	-
New York (3)	Yes	-	-	3	2
Oregon (2)	No	-	-	-	5
Rhode Island (1)	No	-	-	-	5
Washington (2)	No	-	-	-	5

Avalere assumed that in cases where the plan had no available formulary, the plan received a score of "10." Therefore, the plan was considered to be in the Very Difficult category.

Red = FFM states analyzed. Blue = state-based exchanges analyzed.
Please note the number in parentheses represent number of carriers analyzed in state.

Provider Directory Accessibility: Average Scores of Analyzed Plans by State



Methodological note: In order to quantify a state average, Avalere graded plans with no available directories with a score of "10"

* Analyzed Federally-Facilitated Marketplace states. FFM states also denoted in red.

** Note that, in each state, we analyzed a total of five plans offered by the number of different carriers shown below each state on the graph.

Provider Directory Accessibility: Analyzed Plan Scores by State

NUMBER OF PLANS BY PROVIDER DIRECTORY ACCESSIBILITY SCORE, BY STATE

State (# of Carriers)	Link to Provider Directory Available	Very Accessible	Moderately Accessible	Difficult	Very Difficult
Florida (2)	Yes	-	3	-	2
North Carolina (2)	Yes	-	5	-	-
Pennsylvania (1)	Yes	-	5	-	-
Texas (2)	Yes	1	4	-	-
Wisconsin (2)	Yes	1	4	-	-
California (4)	Yes	3	-	-	2
Colorado (2)	Yes	5	-	-	-
Connecticut (3)	Yes	-	4	1	-
DC (2)	No	-	-	-	5
Maryland (1)	Yes	5	-	-	-
Massachusetts (3)	Yes	5	-	-	-
Minnesota (3)	Yes	5	-	-	-
Nevada (3)	Yes	-	-	1	4
New York (3)	Yes	5	-	-	-
Oregon (2)	No	-	-	-	5
Rhode Island (1)	Yes	-	5	-	-
Washington (2)	Yes	5	-	-	-

Avalere assumed that in cases where the plan had no available directory, the plan received a score of “10.” Therefore, the plan was considered to be in the Very Difficult category.

Red = FFM states analyzed. Blue = state-based exchanges analyzed.
Please note the number in parentheses represent number of carriers analyzed in state.

NATIONAL ACADEMY
for STATE HEALTH POLICY®

Improving Integration of Dental Health Benefits in Health Insurance Marketplaces

Andrew Snyder
Keerti Kanchinadam
Catherine Hess
Rachel Dolan

April 2014

Copyright © 2014 National Academy for State Health Policy. For reprint permission, please contact NASHP at (207) 874-6524.

This publication is available on the web at: www.nashp.org

About the National Academy for State Health Policy

The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers. We are dedicated to helping states achieve excellence in health policy and practice. A non-profit and non-partisan organization, NASHP provides a forum for constructive work across branches and agencies of state government on critical health issues.

To accomplish our mission we:

- Convene state leaders to solve problems and share solutions
- Conduct policy analyses and research
- Disseminate information on state policies and programs
- Provide technical assistance to states

The responsibility for health care and health care policy does not reside in a single state agency or department. At NASHP, we provide a unique forum for productive interchange across all lines of authority, including executive offices and the legislative branch.

We work across a broad range of health policy topics including:

- Affordable Care Act and State Health Care Reform
- Coverage and Access
- Medicaid
- Quality, Cost, and Health System Performance
- Long Term and Chronic Care
- Quality and Patient Safety
- Population and Public Health
- Insurance Coverage and Cost Containment

Our strengths and capabilities include:

- Active participation by a large number of volunteer state officials
- Developing consensus reports through active involvement in discussions among people with disparate political views
- Planning and executing large and small conferences and meetings with substantial user input in defining the agenda
- Distilling the literature in language useable and useful for practitioners
- Identifying and describing emerging and promising practices
- Developing leadership capacity within states by enabling communication within and across states

For more information about NASHP and its work, visit www.nashp.org

Portland, Maine Office:
10 Free Street, 2nd Floor
Portland, ME 04101
Phone: [207] 874-6524

Washington, DC Office:
1233 20th Street, NW, Suite 303
Washington, DC 20036
Phone: [202] 903-0101

Follow us @nashphealth on Twitter

Table of Contents

Acknowledgements **1**

Executive Summary **2**

Introduction **5**

The Dental Coverage Landscape **7**
Public Coverage Programs 7
Private Coverage 8

Dental Coverage under the Affordable Care Act **9**
Essential Health Benefits and the Marketplace 9
Offering Pediatric Dental Benefits in the Marketplace 10
Offering Adult Dental Benefits in the Marketplace 12
Dental Benefits Outside the Marketplace 13
Policy Options for Addressing Issues with Dental Benefit Structure under the ACA 14

Affordability of Dental Benefits in the Marketplace **15**
Premiums 15
Advanced Premium Tax Credits 15
Cost Sharing 16
Annual Limits on Consumer Out-of-Pocket Costs 16
Policy Options for Addressing Issues with Affordability 18

The Consumer Experience of Dental Benefits **19**
Purchasing Pediatric Dental Benefits 19
Purchasing Adult Dental Benefits 20
Consumer Assistance for Dental Benefits 21
Policy Options for Addressing Issues with Consumer Experience 21

Conclusion **23**

Appendix A. Expert Meeting Participant List **25**

Appendix B. Summary of Federal Guidance Related to Dental Benefits **26**

Appendix C. Individual Marketplace Pediatric Dental Benefit Decisions for 2014 **29**

Endnotes **31**

Acknowledgements

This report benefited greatly from input and feedback from a number of individuals. The authors would like to thank the state marketplace leaders, dental experts, and health policy experts listed in Appendix A for participating in the January 2014 meeting convened by the National Academy for State Health Policy (NASHP) and for reviewing and providing thoughtful input on this report. The conclusions in the report are NASHP's and do not necessarily reflect the views of all expert meeting participants. The authors also wish to thank NASHP Executive Director, Alan Weil, and marketplace officials from Washington and California for their thoughtful review of this report. The expert meeting and this report were made possible with support from the DentaQuest Foundation.

Executive Summary

The Affordable Care Act (ACA) includes pediatric dental services as one of ten essential health benefits that health plans in the small group and individual markets must cover. This is an important step forward in ensuring that all children have dental coverage and it builds on progress made in Medicaid and the Children's Health Insurance Program. While adult dental services are not required as an essential health benefit, marketplaces may offer an opportunity for adults to also gain dental coverage.

However, the way that the ACA structures dental coverage has created a number of implementation challenges to ensuring dental coverage for children and offering it for adults. These challenges include:

- **Benefit design.** The ACA allows marketplaces to offer dental benefits in three ways: (1) "embedded" in a Qualified Health Plan; (2) as a "stand-alone" product offered by a dental plan; or (3) as a "bundled" product that pairs a medical and a dental policy. Stand-alone products make up most of the existing commercial market for dental coverage and they specialize in designing dental plans and maintaining dental provider networks. Plans that embed dental benefits, however, include a range of consumer protections that don't apply to stand-alone dental products. Most marketplaces offered both embedded and stand-alone dental products in the 2014 plan year, though a few state-based marketplaces such as Connecticut's offered only embedded pediatric coverage, and states like Nevada, Washington, and California offered only stand-alone products in the individual market.
- **Affordability.** Federal regulations were written such that several key affordability protections do not apply to the purchase of stand-alone dental products. Stand-alone dental products are not included in the calculation of Advanced Premium Tax Credits (APTC)—which help individuals under 400 percent of the Federal Poverty Level purchase marketplace coverage. Cost-sharing reductions—which help mitigate out-of-pocket spending—are also not applicable to stand-alone dental products. Dental products may also have a separate out-of-pocket maximum stacked on top of the out-of-pocket spending limit for a medical plan. Action related to affordability is occurring at the state and federal levels, but some concerns remain. In March 2014, the Centers for Medicare & Medicaid Services issued a final rule lowering the dental out-of-pocket for plan year 2015 to $350 for one child and $700 for two or more children. A 2013 law in California caps out-of-pocket spending across medical and dental benefits at a single level beginning in plan year 2015.
- **Consumer experience.** While marketplaces are required to allow the offer of stand-alone pediatric dental products, there is no federal requirement that individuals must purchase dental benefits for their children. This, combined with affordability concerns and website designs that may not highlight dental information, could result in families opting not to purchase dental coverage for their children. Kentucky, Nevada, and Washington all instituted requirements to purchase pediatric dental coverage in their state-based marketplaces. Some stakeholder groups have also developed dental-specific training information for consumer assistors that states are incorporating.
- **Adult benefits.** The ACA only includes dental services for children, and not adults, in the required essential health benefits. This creates a variety of inconsistencies and technical issues between coverage inside and outside the marketplace. Several states, however, are offering adults the option of purchasing unsubsidized dental coverage through their marketplaces. This is a potentially promising way to reduce high levels of dental uninsurance among adults.

The National Academy for State Health Policy convened an expert meeting in January 2014 to identify potential policy solutions that state and federal policymakers could consider to improve how dental benefits are provided in future years. Experts identified a range of actions that can be taken through legislation, regulation, plan design, website design, and monitoring strategies to track and improve the provision of dental benefits. These actions, which are a compilation of suggestions made by experts and do not represent an effort to gain consensus, include:

Benefit design

- Evaluate 2014 experience with embedded and stand-alone dental offerings to determine how many children enrolled in dental coverage, which benefit design approach worked best for consumers, and whether dental products offered in 2014 met the marketplace's goals.
- Examine ways that marketplaces could solicit and offer stand-alone dental products to provide coverage for individuals without dental insurance, including adults inside and outside the marketplace, or families with employer-sponsored medical insurance but no dental coverage.
- Monitor patterns in service utilization and premium payment among adults to determine if those gaining dental coverage through the marketplace are keeping it through the year.
- Explore options to encourage issuers to offer embedded pediatric dental products.
- Consider state legislation or regulation to apply insurance reforms (e.g. guaranteed issue, medical loss ratio) to stand-alone dental products.
- Consider plan certification requirements that extend consumer protections including age and geographic rating factors and guaranteed rates to stand-alone dental products.
- Develop a state approach to essential health benefits for adults that promotes consistency between plans purchased inside and outside the marketplaces.
- At the federal level, consider expanding the ten essential health benefit categories to include adult dental.

Affordability

- Revisit federal APTC guidelines to include the cost of dental benefits in the calculation of APTC for all who purchase pediatric dental benefits.
- Revisit preventive services guidelines to exempt routine preventive dental services from cost-sharing.
- Monitor the effect of any changes to dental out-of-pocket maximums on dental product premiums and consumers' uptake of coverage.
- Plan ways to ensure that affordability protections extend to children covered in the marketplaces, especially any children who move from CHIP to the marketplace should CHIP funding not be extended beyond FFY 2015.
- In states offering embedded pediatric dental benefits, consider implementing a "protective" dental deductible and/or out-of-pocket maximum inside the overall cost-sharing limits.

Consumer experience

- Provide dental training for navigators and other consumer assistance entities to ensure they understand the specifics of dental benefits in their state's marketplace.

- Utilize feedback from navigators and other consumer assistance entities to address consumer concerns and improve the provision of dental benefits.
- Monitor uptake, purchasing demographics, and any issues with access to care among the newly insured, in order to identify issues and create targeted solutions. Provide periodic data reports to stakeholders.
- Develop relationships with other state entities that have expertise with oral health programs—including Medicaid, CHIP, Title V, and state dental directors—to partner around efforts to monitor uptake of dental insurance, measure access to care, and conduct dental-specific outreach.
- Require more robust and standardized benefit, premium, and cost-sharing information to enable comparisons of dental coverage between plans.
- Ensure that marketplace websites are designed to display clear information and messaging about dental products and options; highlighting the use of the Summary of Benefits and Coverage form to identify whether dental is included in a medical plan or not.
- Design websites to present adults shopping for Qualified Health Plans (and potentially Medicaid) with the option to purchase dental coverage prior to checkout.
- At the state level, require families with children to purchase pediatric dental in a state offering stand-alone dental products.

The inclusion of a policy on this list does not imply that all participating in the expert meeting agreed with the option. It is also important to note that it is still early in ACA implementation, and there may not be data available to determine which options would work best.

While implementation of dental benefits is only a small part of the work that state and federal officials must do to implement ACA, maintaining good oral health is important to every person's ability to eat, learn, work, and interact with others, so it is important that this coverage work as intended.

Introduction

Oral health is an important but often overlooked part of health and health care. Dental disease remains a common childhood chronic disease—42 percent of children ages 2 to 11 have dental caries (tooth decay)—and left untreated, dental decay and disease can have negative results on child growth, development, and school attendance.[1] For adults, poor oral health and missing teeth can affect an individual's ability to eat nutritious food, as well as get and keep employment.[2] Good oral health requires regular dental visits with routine opportunities for prevention, early diagnosis, and treatment. Dental insurance is positively associated with greater access to dental care. In 2010, 57 percent of individuals with private dental coverage and 33 percent with Medicaid coverage had a dental visit, compared to 18 percent of uninsured individuals.[3] The availability of dental insurance is also a top factor motivating enrollment into Medicaid and CHIP. In 2011, 68 percent of low-income parents surveyed chose access to dental care as a top reason for enrolling their child in coverage.[4]

The Affordable Care Act (ACA) brings significant change to the entire health insurance landscape, including dental insurance. The major ACA provision impacting dental insurance is the requirement that health plans in the small and individual market both inside and outside of the health insurance marketplace offer pediatric dental benefits as part of a core package of items and services, known as essential health benefits (EHB). It is estimated that nearly 4 million children will gain coverage through the marketplaces under the ACA, and these children are also envisioned to gain dental coverage.[5] This coverage builds on the foundation of dental coverage in Medicaid and the Children's Health Insurance Program (CHIP), which each require states to provide dental coverage to enrolled children.

The ACA and subsequent federal guidance treat pediatric dental benefits differently from the other EHB categories, creating unique challenges in implementing the vision of a guaranteed pediatric dental benefit. Federal policy allows marketplaces to offer stand-alone dental products separately from medical coverage. These stand-alone products are not included in calculations for financial assistance, so purchasing separate dental coverage may be an additional cost for marketplace enrollees. Moreover, while marketplaces must offer pediatric dental coverage as part of EHB, there is no federal requirement for individuals shopping on the marketplace to purchase such coverage. Taken together, these federal provisions may mean that some families will choose to forgo "essential" pediatric dental coverage. For adults, while the ACA does not include adult dental coverage as an essential benefit, there are several important policy nuances that have arisen, particularly around individuals who are purchasing coverage outside of the state and federal marketplaces.

To discuss the benefits and challenges of various policy approaches to implementing dental benefits in the marketplace, the National Academy for State Health Policy (NASHP) convened a January 2014 meeting of state marketplace leaders, dental experts, and health policy experts (meeting participants are listed in Appendix A). Meeting participants examined current federal and state approaches and identified key issues and potential policy solutions to addressing these challenges in future years.

This report synthesizes materials compiled for the meeting with key themes and findings from the discussion to describe major issues and identify policy solutions for improving the integration of dental benefits in marketplaces. Meeting participants identified a broad variety of actions that can be taken to address concerns about affordability and uptake of dental benefits—not only state and federal legislative or regulatory changes, but also decisions about plan design, changes to IT systems, consumer assistance

training, and monitoring strategies. This report includes all policy suggestions offered and discusses the pros and cons as identified by meeting participants. However, the conclusions drawn are NASHP's and do not necessarily reflect the views of all expert meeting participants. It is also important to note that it is early in the ACA implementation process and in many cases data indicating best policy options are not yet available. We hope that focusing attention on this specific but important policy area will help state and federal officials as they work to realize the ACA's vision for health care coverage, improved health outcomes, and lowered costs in future years.

The Dental Coverage Landscape

Dental care service delivery, coverage, and financing systems have traditionally been separate from the medical care system. (A notable milestone was the enactment of Medicare in 1965, which more closely tied medical care to health insurance, but did not include dental coverage.) While there have been notable gains for children over the last ten years, coverage and access to dental care for adults lags behind. Consumers are two to three times more likely to be without dental insurance than medical insurance.[6] This separation contributes to some of the policy issues that arise under the ACA.

Public Coverage Programs

Medicaid and CHIP are critical sources of dental coverage for children in families with low incomes. Medicaid provides health coverage for 28 million children and 20 million adults, and these numbers will grow in light of the ACA's expansion of the program.[7] By including pediatric services, including dental services, as part of the essential health benefit provision, the ACA builds on the comprehensive benefits and guarantees of dental coverage that exist in Medicaid and CHIP.

Since 1967, Medicaid has required that enrolled children under the age of 21 receive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, which include medically necessary preventive, restorative, and emergency dental services. Medicaid-enrolled children are exempt from most out-of-pocket cost-sharing. Limited access to dental providers and low utilization of dental services have been perennial problems for state Medicaid programs, though there has been progress in the past decade. From 2007 to 2011, almost half of all states attained at least a 10 percentage point increase in the proportion of children enrolled in Medicaid who received a preventive dental service.[8] States have worked to improve this performance through strategies that have included increasing payment rates to dentists, contracting with specialized dental benefit administrators, providing targeted outreach to families, and focusing on better integration of medical and dental care.[9,10]

About eight million children in families with income too high to qualify for Medicaid and who cannot afford private coverage receive coverage through CHIP.[11] Dental coverage for children in CHIP was an optional benefit for the first 12 years of the program (although most states opted to include it), and became a federal requirement in 2009 under the Children's Health Insurance Program Reauthorization Act (CHIPRA). Prior to CHIPRA, states that operated stand-alone CHIP programs (rather than expansions of their Medicaid programs) were able to tailor CHIP dental coverage to look more like private dental coverage, with more substantial cost-sharing and annual benefit limits. CHIPRA required all state CHIP programs to either offer a state-defined dental benefit package that includes all services required by the CHIPRA statute or choose one of three dental benchmark plans also outlined in the law. While CHIP has been largely successful in covering children, funding is currently authorized only through September 30, 2015. If CHIP funding is not extended, more than five million children may transition into the marketplace.[12] Many of these children may go from having a guarantee of dental coverage to a situation where families can opt not to purchase dental coverage, as discussed in more detail in this report.

While there has been progress for children's dental coverage through Medicaid and CHIP, dental services are an optional benefit for adults. Many states currently provide only a limited adult dental benefit, and often only to a subset of adult enrollees. In 2012, eight states did not include any adult dental coverage in Medicaid, and 17 states provided emergency dental coverage only. Only 11 states provided comprehensive dental benefits to all adults.[13] Some states extend dental coverage to Medicaid- or CHIP-

enrolled pregnant women as a "pregnancy-related service." The ACA's expansion of Medicaid to adults without children does not change the optional status of dental benefits for adults.

Access to dental coverage is also limited for adults enrolled in Medicare since dental services are not covered in traditional Medicare. A limited number of Medicare Advantage plans include dental care, but by and large, the 12.7 million individuals in the program do not have dental coverage.[14]

Private Coverage

Individuals who receive health benefits through employment or who purchase coverage through the individual market are less likely to carry dental insurance than medical insurance. For instance, in 2012, only 54 percent of firms offering health benefits to their employees offered or contributed to a dental insurance benefit.[15] When dental benefits are offered, they are typically delivered through a "stand-alone dental policy" – a limited-scope insurance product, often administered by a specialized vendor focused only on dental benefits. These stand-alone policies are either purchased separately from medical benefits or as a rider to medical coverage. The National Association of Dental Plans (NADP) reports that 99 percent of dental plans in 2014 are sold as separate products.[16] Dental insurance products typically have tiered cost-sharing—for preventive services, like examinations and cleanings, the plans typically pay 100 percent of the charge; for restorative services (such as fillings), plans typically pay 80 percent, with 20 percent coinsurance by the patient; and for more complex services (such as crowns), plans typically pay 50 percent with 50 percent coinsurance. Products typically have an annual maximum benefit of $1000-$2000 which, NADP estimates, fewer than 5 percent of individuals reach in a given year.[17] Meeting participants noted that with this cost-sharing structure, commercial plans have traditionally aimed to emphasize prevention and early diagnosis of dental health issues.

Dental Coverage under the Affordable Care Act

The ACA makes substantial changes in public and private coverage and how they work together, and also contains provisions to improve care and outcomes. The ACA's changes include a number of provisions related to oral health or dental care, such as provisions supporting dental public health programs, oral health education campaigns, and improvements to the information collected about oral health in national epidemiological surveys. The most significant dental coverage-related provision is that pediatric dental benefits are required as part of a set of 10 essential health benefits that all non-grandfathered small group and individual insurance plans offered inside and outside the marketplace must generally offer. The marketplaces are online organizations where individuals can purchase coverage, with subsidies available for applicants between 100 and 400 percent of the Federal Poverty Level (FPL). The following sections briefly review the ACA's essential health benefit provision and describe how dental insurance products are being offered both inside and outside the marketplace. (See Appendix B for a summary of federal guidance related to dental benefits.)

Essential Health Benefits and the Marketplace

The ACA requires that health insurance plans sold to individuals and small businesses provide a minimum package of services in ten categories, called "essential health benefits" (EHB). Beginning in 2014, EHB are applicable to most individual and small group health plans sold both inside and outside the marketplace; plans for certain new groups of Medicaid enrollees; and Basic Health Program plans.[18] As defined by the law, the ten EHB categories are: (1) ambulatory patient services, (2) emergency services (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.[19] The final category mandates dental services for children; dental services for adults are not included as part of EHB. Federal cost-sharing subsidies that are available to lower-income individuals in the marketplace are only applicable to benefits under a state's EHB package and not to additional benefits—such as adult dental—offered by plans. The ACA also requires states to cover the costs of state-mandated benefits that exceed EHB requirements.[20]

The ACA directed the Secretary of Health and Human Services to more specifically define the scope of benefits to be covered under EHB. Rather than establishing a new national standard, the Center for Consumer Information and Insurance Oversight issued a bulletin in December 2011 allowing each state flexibility to define its own EHB by selecting from a number of possible "benchmarks" and supplementing benefits as needed to cover essential benefits.[21] These policies were finalized in a February 2013 rule.[22] In order to define EHB, states chose from one of the following federally-defined "benchmark plans": (1) the three largest small group market plans in the state (2) the three largest state employee health plans (3) the three largest federal employee health plans or (4) the state's largest commercial non-Medicaid HMO plan. The default benchmark plan for states that opted not to select one was the largest small-group plan in the state. This benchmark approach allows states a path to keep from paying for state-mandated benefits that exceed EHB—if a state chooses a benchmark plan that is subject to state mandates, such as a small group market plan, those state mandates (enacted prior to 2012) would be included as part of the state's EHB package.[23] Most states (43, including DC) chose or defaulted to a small group plan in their states.[24] EHB-benchmark plans, selected by states in 2012, will remain in place for coverage years 2014 and 2015. The Centers for Medicare & Medicaid Services (CMS) has indicated that it will re-evaluate this method for defining EHB for 2016.[25]

If a selected benchmark plan does not include one or more of the 10 categories of benefits, the state must supplement the plan with the missing categories using another benchmark option. Pediatric dental services, along with habilitative and vision services, are benefits most frequently missing from state benchmark plans. Therefore, federal guidance outlined options for supplementing these required benefits—states could select or default to the Federal Employee Dental and Vision Insurance Program (FEDVIP) or choose the state's separate CHIP program.[26] Both options generally include a broad base of dental benefits but there is some variation from state to state with coverage for medically necessary orthodontia—for instance, Arkansas, Colorado, Michigan, and Utah chose CHIP supplemental benchmarks that do not cover medically necessary orthodontia.[27] Twenty-five states and the District of Columbia chose FEDVIP to supplemental their benchmark plan and 24 states chose CHIP dental benefits. One state, Utah, went with the dental benefit that was already included in its benchmark plan, the catastrophic plan for state employees known as Utah Basic Plus, which covers routine exams, cleanings, x-rays, and dental sealants but not restorative treatments like fillings, crowns, and root canals.[28,29] Benchmark decisions determine the scope of services that will be included and not the cost-sharing structure, which is largely driven by actuarial value standards. The next section will describe how state and federally-facilitated marketplaces have translated the benchmark standards into offerings that consumers can purchase.

Offering Pediatric Dental Benefits in the Marketplace

The ACA includes some provisions specific to dental coverage that create unique complexity in how these benefits are packaged and delivered to consumers. The ACA requires marketplaces to allow carriers the option to offer pediatric dental coverage as a separate policy.[30] In addition, qualified health plans (QHPs) are not required to include pediatric dental benefits if at least one stand-alone pediatric dental policy is offered in a marketplace.[31] Due to these provisions, states have opted to solicit plans meeting the pediatric dental requirement in three ways—as a benefit embedded in a medical health plan, as a bundled package of medical and dental plans, or as a stand-alone dental product. The structure of pediatric dental benefits in the marketplace has important implications for how accessible and affordable these benefits will be for families. Due to IT system limitations and differences under the ACA in how consumer protections and federal subsidies apply, each benefit structure differs in important ways:

1) **Embedded Benefit:** Medical QHP issuers can choose to include, or "embed," pediatric dental benefits to create a comprehensive single plan. Medical QHP issuers can contract with a dental issuer to offer the pediatric dental benefit, but in an embedded benefit, the medical issuer assumes all risks and liabilities of covering the dental benefit under one contract.[32] This is similar to prescription drug coverage, which is frequently administered through a specialized third party administrator.[33,34] In an embedded QHP, the pediatric dental benefit appears to consumers like any other benefit covered in the plan and is included under a single premium. An embedded QHP must comply with all market reform and rating rules, such as guaranteed availability, a ban on lifetime and annual limits, dependent coverage up to age 26, limits on out-of-pocket maximums, medical loss ratio, and limits on allowable rating factors.[35] QHPs, including those that embed pediatric dental benefits, are required to meet actuarial value levels corresponding to metal tiers: platinum (90 percent), gold (80 percent), silver (70 percent), or bronze (60 percent). With an embedded dental benefit, pediatric dental spending typically counts toward a single shared deductible and out-of-pocket maximum for medical and dental care. In addition, cost-sharing reductions (discussed further in the next section) will be available to eligible families purchasing a comprehensive QHP.

Meeting participants acknowledged that embedded plans are simpler for states to administer and may be more affordable for consumers. However, they also identified some concerns with embedding pediatric dental benefits. A main concern is that families of children with high needs for dental care, but low needs for other medical care, may be disadvantaged by a single shared deductible and out-of-pocket spending limit, which could require substantial out-of-pocket spending before insurance would begin paying dental claims. Meeting participants also discussed whether embedding pediatric dental into all QHPs unfairly passes on the cost of pediatric dental benefits to individuals without children. However, Connecticut shared that the state has not received any pushback from consumers to its approach to embedded plans and consumers seem pleased to have one less thing to worry about. In addition, an American Dental Association analysis of a sample of plans in 25 federally-facilitated marketplace states calculated the average monthly cost of dental benefits embedded in a silver plan to be relatively low, at $5.11.[36]

2) **Stand-Alone Dental Policy:** The ACA allows dental benefits to be sold separately from medical benefits in the marketplaces as certified stand-alone dental policies. To be certified, stand-alone dental policies must offer pediatric dental services as included in the state's chosen dental benchmark and must abide by applicable QHP certification standards including ensuring a provider network that is sufficient in number, type, and geographic distribution of providers. In addition, pediatric dental benefits offered in a stand-alone dental policy must be offered without annual and lifetime limits.[37]

   However, many provisions of the ACA applicable to medical QHPs were modified or deemed inapplicable to stand-alone dental plans. For example, federal guidance established a separate approach for calculating actuarial value for stand-alone dental plans, categorizing plans as "high" (85 percent) or "low" (70 percent) for 2014.[38] In addition, dental benefits provided through a stand-alone dental plan are considered "excepted benefits" under section 2791(c) of the Public Health Service Act, and therefore are not subject to many consumer protections that do apply to embedded plans. Stand-alone dental policies are not subject to ACA requirements related to medical loss ratio requirements, protection against denials for pre-existing conditions, fair insurance premiums based only on age and geography, and guaranteed premium rates.[39] However, meeting participants noted that commercial dental products typically have not exercised denials of coverage for preexisting conditions, or used rating based on health status. Stand-alone dental plans can also have a separate out-of-pocket limit on cost sharing, which is stacked on top of the limit established in the ACA for medical plans. Finally, federal guidance does not allow federal cost-sharing reductions to apply to these plans.[40]

   Federal guidance does not preclude states from opting to apply market reforms to stand-alone dental policies and some states have already taken action to apply these protections. States can use marketplace application processes to extend age and geographic rating standards to stand-alone dental products or to guarantee rates. California's marketplace chose to apply nearly all consumer protections to stand-alone dental policies via contract requirements in 2014.[41] In February 2014, a bill was also introduced in California that would apply medical loss ratios to dental issuers.[42,43] The federally-facilitated marketplace requires stand-alone dental plans to publicly display whether their rates are guaranteed or not, which could help provide transparency for the consumer and may help incentivize stand-alone dental plans to hold rates steady.[44] The National Association of Dental Plans reports that in 2014, all stand-alone dental policies on the federally-facilitated marketplace guaranteed their rates.

3) **Bundled Benefit:** A QHP that does not include the pediatric dental EHB may contract with a separately licensed dental issuer to sell the two distinct policies together as a package. In this case,

individuals cannot mix and match different medical QHPs with different stand-alone dental policies, nor can they enroll in one product without the other. While the enrollee would pay a single combined premium, the dental issuer and medical issuer would each assume the risks and liabilities associated with providing coverage under its plan only—differentiating a bundled benefit from an embedded one.[45] While offering a full set of benefits like embedded policies, bundled dental policies are treated like stand-alone dental products with regard to out-of-pocket limits on cost sharing and market reform rules, and face many of the same challenges. Bundled benefits are not being offered in any marketplace in plan year 2014. The federally-facilitated marketplace, operating in 35 states, decided not to allow bundled benefits in 2014 because it did not yet have the IT capacity to list dental and medical deductibles and out-of-pocket maximums separately.[46] Some states with state-based marketplaces also chose to not offer bundled benefits, while other state-based marketplace states solicited bundled benefit plans and simply did not receive any submissions from issuers.

For 2014, most marketplaces, including in states with a federally-facilitated marketplace, solicited for both stand-alone dental plans and embedded plans. Across all states operating a federally-facilitated or partnership marketplace, 34 percent of QHPs embed pediatric dental benefits. The prevalence of embedded plans varies greatly by state—Alabama and West Virginia have embedded pediatric dental in nearly all QHPs, whereas less than five percent of QHPs embed pediatric dental in Texas and Iowa.[47] For plan year 2014, California and Washington decided to only allow the offer of stand-alone products. However, California plans to offer embedded dental products side by side with stand-alone dental policies beginning in plan year 2015 (see text box on page 18).[48] While some states solicited for bundled plans, no state is offering this type of plan in 2014. Connecticut is the only state requiring all issuers participating in the marketplace to embed pediatric dental benefits in medical QHPs that they offer.[49] (In 2014, Connecticut did not offer stand-alone dental products directly on their marketplace due to IT systems limitations. The state is soliciting stand-alone pediatric and family dental products for the 2015 plan year, but is not permitting medical QHPs to be offered via the marketplace without embedded pediatric dental. [50] Dental plans have raised concerns about how this requirement comports with ACA provisions related to stand-alone dental policies.[51]) Several states have indicated that they are reconsidering their plan solicitations for 2015 due to a variety of reasons, including increased IT capabilities or stakeholder pressure. A full summary of 2014 state decisions regarding pediatric dental offerings in the marketplace can be found in Appendix C.

Offering Adult Dental Benefits in the Marketplace

Adult dental benefits are not part of EHB and therefore there is no federal requirement that QHP issuers offer these benefits in the marketplace. However, carriers can choose to offer dental products for adults. Adult dental benefits can be included as part of a family stand-alone dental policy or embedded within a medical policy. The difference is that all stand-alone dental plans must include the pediatric dental benefit—even if the policy is intended for adults—but a QHP could offer embedded adult dental without including pediatric dental coverage. (Note that if a marketplace doesn't include stand-alone policies, then all QHPs would be required to embed pediatric dental.)

Many marketplaces in states represented at the meeting offered stand-alone family dental products that include adult and pediatric coverage. Regardless of the structure, federal cost-sharing subsidies cannot be applied to adult dental benefits.[52] In addition, adults purchasing dental coverage through the marketplace will still be subject to annual limits, which are common in private dental insurance, and typically range between $1,000 and $2,000 annually.[53] While most consumers currently enrolled in dental insurance do not reach the annual maximum, meeting participants suggested that the population newly eligible for

coverage under the ACA may have greater pent-up dental needs than the currently insured population. They also expressed concern that lower-income individuals who enroll in adult coverage may be at greater risk of dropping coverage partway through the plan year. Participants indicated that it will be important for states to monitor patterns in service utilization and premium payment among adults gaining dental coverage through the marketplace.

(See text box on page 21 for an example of how adult dental benefits are working in Nevada).

Dental Benefits Outside the Marketplace

For people purchasing individual coverage outside of the marketplace, there is an additional layer of complexity related to pediatric dental coverage. The preamble to the February 2013 federal rule on essential health benefits states that all plans bought on the individual and small group market *outside* of the marketplace must offer all ten EHB—including pediatric dental—unless an issuer can be "reasonably assured" that an individual has purchased a marketplace-certified stand-alone pediatric dental policy elsewhere.[54] This means that some consumers purchasing coverage outside of the marketplace may have to enroll in and pay for coverage that includes pediatric dental benefits whether they have children or not.

State participants expressed a desire for greater consistency in the treatment of dental benefits inside and outside the marketplace, since differing rules increase the complexity of program administration. To address this concern, many state insurance departments have exerted their authority to regulate their insurance markets outside of the marketplace by issuing guidance to more concretely define what constitutes "reasonable assurance."

Colorado has taken a unique approach to meeting "reasonable assurance" requirements while also allowing opportunities for adults to avoid paying for unnecessary pediatric dental coverage. Colorado worked with dental issuers to offer "child-only" pediatric dental policies at low or no cost to enrollees without children—these products allow adults to obtain the coverage for the full set of ten EHB "in full knowledge that [the pediatric dental] benefit will never be needed or used."[55]

The bullets below, adapted from a Delta Dental Plans Association analysis, summarize other state actions taken either by bulletin or through legislation to ensure individual and small group markets outside the marketplace are "reasonably assured" that consumers have purchased all ten EHB categories:

States indicating that a disclosure by the carrier that its plan does not include pediatric dental benefits constitutes "reasonable assurance."

- Arkansas[56]
- Idaho[57]
- Iowa[58]
- Montana[59]
- New Hampshire[60]
- New Mexico[61]
- Virginia[62]
- Wisconsin[63]

States requiring an attestation by the consumer that EHB pediatric coverage has been obtained/purchased from another carrier.

- Colorado[64]
- Hawaii[65]
- Massachusetts[66]
- Michigan[67]
- Oregon[68]

States restating the language on "reasonable assurance" from the preamble of the federal EHB final rule and citing issuer responsibility.

- Kentucky[69]
- New York[70]
- Ohio[71]
- South Dakota[72]

Policy Options for Addressing Issues with Dental Benefit Structure under the ACA

Below is a list of actions identified by meeting participants that state and federal policymakers could take to address issues with dental benefit structure. Depending on the authority that a marketplace has in a given state, some actions could require legislative or regulatory action. (Note that these are not consensus recommendations; the inclusion of a policy does not mean that all in the group agreed with the option.)

- Evaluate 2014 experience with embedded and stand-alone dental offerings to determine how many children enrolled in dental coverage, which benefit design approach worked best for consumers, and whether dental products offered in 2014 met the marketplace's goals.
- Examine ways that marketplaces could solicit and offer stand-alone dental products to provide coverage for individuals without dental insurance, including adults inside and outside the marketplace, or families with employer-sponsored medical insurance but no dental coverage.
- Monitor patterns in service utilization and premium payment among adults to determine if those gaining dental coverage through the marketplace are keeping it through the year.
- Explore options to encourage issuers to offer embedded pediatric dental products.
- Consider state legislation or regulation to apply insurance reforms (e.g. guaranteed issue, medical loss ratio) to stand-alone dental products.
- Consider plan certification requirements that extend consumer protections like age and geographic rating factors and guaranteed rates to stand-alone dental products.
- Develop a state approach to "reasonable assurance" of essential health benefit coverage for adults outside the marketplace that promotes consistency and ease of administration.
- At the federal level, consider expanding the ten essential health benefit categories to include adult dental.

Affordability of Dental Benefits in the Marketplace

The ACA and subsequent guidance create different rules for how affordability provisions—particularly advanced premium tax credits, cost-sharing reductions, and annual limits on cost-sharing—apply to pediatric dental benefits if offered as a stand-alone dental product. Therefore affordability of pediatric dental coverage in the marketplace will be a concern for many lower-income families.

Premiums

The Children's Dental Health Project conducted an analysis of premium rates for stand-alone dental plans in states with federally-facilitated and partnership marketplaces and found a wide range in premiums from state to state. West Virginia had the lowest rates, with low-cost plans averaging about $15 per child per month and high-cost plans averaging $19. In contrast, Alaska (a state with a high cost of living) was found to have the highest rates, with low-cost plans averaging $53 per child per month and high-cost plans averaging $77. The national average for stand-alone dental policies in federally-facilitated and partnership marketplaces is $30 for low-cost options and $37 for high-cost options.[73]

It is likely that dental coverage offered as an embedded benefit will be priced lower than dental coverage offered as a stand-alone dental product. An American Dental Association analysis of a sample of plans from 25 federally-facilitated states found the average premium for stand-alone dental plans to be $30.98 – $38.80 (for low and high actuarial value plans respectively) as compared to the average estimated cost of dental benefits embedded in a silver plan at $5.11.[74] Meeting participants indicated that the low cost might be due to the effect of spreading pediatric dental costs across the entire marketplace population. There is no federal requirement for states to display the portion of premium allocable to dental benefits when offered as part of an embedded or bundled plan, making it difficult for consumers to compare and decide on one of many plans that will be offered in a marketplace—particularly in states where stand-alone and embedded products are both available. Making the dental portion of a total premium explicit could help consumers make more informed decisions about the best option for them and their families.

Advanced Premium Tax Credits

The Advanced Premium Tax Credit (APTC) is a federal subsidy available to assist consumers purchasing coverage in the marketplace by reducing monthly premium amounts. APTC is available to U.S. citizens and legal residents with household incomes between 100 and 400 percent FPL and without access to affordable minimum essential coverage. The IRS will calculate tax credits based on the second-lowest cost silver plan in a marketplace, *regardless of whether this plan includes dental benefits*. If the second-lowest cost silver plan in the marketplace does not include dental benefits, the cost for dental coverage will not be counted in the tax credit calculation.[75] QHPs that embed dental benefits will have a single premium to which the premium tax credit will apply. For stand-alone and bundled dental plans, premium tax credits will first be applied to a family's medical QHP premium and any remaining tax credit amount will then be applied to a stand-alone dental policy premium.[76] It is likely that the tax credit amount will not be enough to fully cover pediatric dental benefits, whether offered through a bundled or stand-alone plan. Meeting participants suggested that in states where the second-lowest cost silver plan does not include dental, a change in federal policy to calculate APTC based on the combined cost of the medical plan and a stand-alone dental product would be useful.

Adult dental benefits are not part of EHB, therefore APTC cannot be used to subsidize dental benefits for adults. If a medical QHP or stand-alone dental plan offers dental coverage that an adult opts into, the adult must pay in full the portion of the total premium for the adult dental benefit. State and federal marketplaces will need to design systems that can accommodate this rule by properly calculating the separate allocation of premium tax credits.

Cost Sharing

In addition to premium tax credits, the ACA introduces cost-sharing reductions for individuals with incomes up to 250 percent FPL purchasing a silver-level plan in the marketplace. Cost-sharing reductions are designed to limit the amount an individual has to pay out-of-pocket to receive health care services covered by a plan. However, guidance from the Center for Consumer Information and Insurance Oversight (CCIIO) states that while cost-sharing reductions will apply to an embedded benefit, they will not be applied if the pediatric dental benefit is provided through a stand-alone dental plan.[77] Researchers at the George Washington University School of Public Health and Health Services have raised some questions about this policy—asking whether federal guidance is at odds with the original intent of the law and how states will operationalize this policy to ensure proper allocation of federal subsidies—which remain unanswered.[78]

In most states (28 plus the District of Columbia) children up to 250 percent FPL or higher are covered by CHIP.[79] However, CHIP funding past 2015 is uncertain and if funding is not reauthorized, eligible children will likely obtain coverage through the marketplace where coverage may no longer be affordable. Meeting participants identified this as an issue with important consequences that requires further clarification and action, particularly at the federal level.

The ACA also requires that certain preventive services recommended by the Health Resources and Services Administration's (HRSA's) *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* must be covered without cost sharing. This is intended to encourage individuals to seek early preventive care. The regulations that implemented the definition of "preventive services," however, left out many dental services—including professionally-applied fluoride and dental sealants—that are key to preventing dental disease. The regulations on preventive services only reference the Bright Futures periodicity schedule (a document that lists services that children should receive from pediatric medical providers at certain ages). In terms of preventive dental coverage, the periodicity schedule only includes referral to a dental home and fluoride supplements (e.g., tablets) for children living in areas without community water fluoridation. Supplements to the Bright Futures guidelines mention additional preventive dental care such as fluoride applications and sealants. Typically, dental insurance products have not required cost-sharing for preventive dental services, but some meeting participants suggested that federal officials revisit the rules to guarantee that evidence-based preventive dental services for children are available without cost-sharing.

Annual Limits on Consumer Out-of-Pocket Costs

Federal guidance establishes an annual maximum out-of-pocket cost-sharing limit for QHPs—$6,350 for an individual and $12,700 for a family in 2014—but allows a separate annual limit for stand-alone dental policies.[80] In 2014, state-based marketplaces were responsible for determining an annual maximum out-of-pocket limit for stand-alone dental policies that is "reasonable." The federally-facilitated marketplace set this annual limit at $700 for one child enrollee and $1,400 for two or more child enrollees for plan year 2014 and many state-based marketplaces followed its example (see Appendix C for state-based marketplace information).[81]

However, in February 2013, the Internal Revenue Service issued guidance allowing issuers to delay implementing the annual limit on out-of-pocket costs in cases where benefits are administered by multiple service providers (e.g. separate administrators for medical, behavioral, dental, and/or pharmacy benefits) until 2015.[82] The delay may affect some plans where dental benefits are embedded but administered through a third-party administrator.

In addition, CMS issued a proposed rule in December 2013 to lower the annual out-of-pocket maximum for stand-alone dental products and eliminate actuarial value standards for plan year 2015.[83] Final guidance, issued in March 2014, established the annual out-of-pocket maximum at $350 for one child and $700 for two or more children, and maintained that stand-alone dental plans must meet either "high" or "low" actuarial value standards in all marketplaces in plan year 2015.[84]

At the time of the expert meeting, the federal rule proposing to lower the dental out-of-pocket maximum and eliminate actuarial value standards for stand-alone dental products had not yet been finalized. Some state marketplace leaders represented at the meeting stated that their states already struggled to meet the 2014 out-of-pocket maximum and actuarial value standards and were concerned about the lower standards. State marketplace leaders and industry experts represented at the meeting agreed that the most likely result of the proposed changes would be an increase in dental premium rates, an increase in dental deductibles, or potentially the imposition of cost-sharing for preventive services. Meeting participants expressed significant concern that higher premium rates could further deter consumer purchase of dental benefits. In addition, state marketplaces that currently require purchase of pediatric dental benefits (discussed further in the following section) expressed the possibility of reversing their decision to require purchase if the higher premiums proved enough of a barrier to enrollees. Meeting participants agreed that further monitoring and evaluation of consumer utilization in this area is necessary.

Having a separate annual maximum out-of-pocket limit for dental benefits that sits on top of one for a family's medical QHP means that families purchasing stand-alone dental policies may be responsible for more total out-of-pocket costs than families enrolled in plans with embedded dental benefits. However, meeting participants noted that children in embedded plans could also face issues related to out-of-pocket costs, particularly as it relates to annual deductibles. Certain out-of-pocket spending applies towards reaching an annual deductible—once the deductible is met, consumers generally only pay a copayment or coinsurance for all covered services for the remainder of the year until reaching the out-of-pocket maximum. Embedded plans may have a single deductible to which medical and dental spending counts—in this case, children with high dental needs (e.g., a child with needs for extensive medically-necessary orthodontic care) but relatively modest medical needs must meet the higher combined deductible before the plan would begin to cover dental expenses and therefore be disadvantaged. The American Dental Association found that in a sample of plans drawn from 36 states, 42 percent of plans offering embedded pediatric dental benefits had separate medical and dental deductibles and the average amount ($34.21) was comparable to the average deductible for stand-alone dental policies ($41.10). Thirty-four percent of embedded plans, however, used a combined medical and dental deductible, and among these plans, the average amount was more than $2,900. (Among the remaining 24 percent of embedded QHPs surveyed, it was unclear whether there was a separate dental deductible.)[85]

California enacted a law that caps out-of-pocket spending at a single level across all medical and dental benefits. How this law affected the state's decisions about plan offerings and its approach to dental out-of-pocket spending are described in the text box below.

California: Changes for the 2015 Plan Year

California opted to offer dental benefits only through stand-alone policies for the 2014 plan year, with a separate out-of-pocket maximum of $1,000 for one child and $2,000 for two or more children. In September 2013, as a result of concern among children's advocates about the affordability and uptake of pediatric dental coverage, California Governor Jerry Brown signed SB 639, which caps the sum of separate out-of-pocket maximums for medical and dental coverage at the federal limit for QHPs—$6,600 for an individual and $13,200 for a family for 2015.[86] In August 2013, Covered California, the state marketplace, embarked on a comprehensive review of dental coverage options for the 2015 plan year and engaged Wakely Consulting Group to assess its future options. Wakely's report resulted in a recommendation to Covered California's Board that California embed pediatric dental in all plans in the marketplace while also implementing an integrated or "protective" dental out-of-pocket maximum inside the overall out-of-pocket limit. Under this scenario, all dental and medical charges would count towards a single out-of-pocket maximum, but out-of-pocket spending for pediatric dental services would be capped.[87] (See endnote for an example of how this protection would work.)

For 2015, the Covered California Board opted to offer QHPs with embedded dental side by side with stand-alone dental policies.[88] While the state marketplace is still accepting QHPs without a pediatric dental benefit, it is encouraging issuers to offer embedded pediatric dental benefits in medical policies in 2015.[89] Through a stakeholder review process, Covered California determined that implementation of a "protective" dental out-of-pocket maximum was not possible for the 2015 plan year. Instead, Covered California lowered the out-of-pocket maximum for medical QHPs—with or without embedded dental—to $6,250, allowing consumers who purchase a stand-alone dental product (with a separate $350 out-of-pocket maximum) to remain under the limit of $6,600 set by SB 639.[90]

Policy Options for Addressing Issues with Affordability

As noted throughout this section, many of the identified issues with respect to the ACA's affordability provisions would require action at the federal level.

- Revisit federal APTC guidelines to include the cost of dental benefits in the calculation of APTC for all who purchase pediatric dental benefits.
- Revisit preventive services guidelines to exempt routine preventive dental services from cost-sharing.
- Monitor the effect of any changes to dental out-of-pocket maximums on dental product premiums and consumers' uptake of coverage.
- Plan ways to ensure that affordability protections extend to children covered in the marketplaces, especially any children who move from CHIP to the marketplace should CHIP funding not be extended beyond FFY 2015.
- In states offering embedded pediatric dental benefits, consider implementing a "protective" dental deductible and/or out-of-pocket maximum inside the overall cost-sharing limits.

The Consumer Experience of Dental Benefits

Consumers shopping in the marketplace face a complex and potentially confusing set of choices related to dental coverage. As noted elsewhere in this report, both embedded and stand-alone products present issues related to transparency—consumers purchasing embedded plans may struggle to find clear information on covered dental benefits and dental deductibles, and consumers purchasing stand-alone products may find it challenging to understand how federal subsidies do or do not apply. States and the federally-facilitated marketplace can take steps to ensure consumers are able to navigate their options, make informed decisions, and seek assistance when needed. This section discusses key issues and state strategies related to ensuring transparency and assistance for consumers.

Purchasing Pediatric Dental Benefits

There is no federal requirement that consumers shopping on the marketplace purchase stand-alone pediatric dental coverage. Combined with potential additional costs for dental coverage, this may mean that some families will opt to forego dental coverage for their children. Early data from California's marketplace, which offered (but did not require purchase of) stand-alone pediatric dental policies in 2014, demonstrate that only some families will take up this coverage. Of the 56,535 California children enrolling in a marketplace QHP between October 2013 and February 2014, only 36 percent (20,317) also enrolled in a stand-alone dental policy.[91] Some states have chosen to implement requirements to purchase pediatric dental coverage in 2014:

Nevada weighed the pros and cons of different options for offering pediatric dental in its marketplace and decided to require that families with children purchase pediatric dental coverage for their children.[92] Following the purchase of a QHP, all applicants are directed to a screen that allows the consumer to choose and purchase a stand-alone dental product. Adults have the option to purchase dental coverage, but enrollees under age 19 are required to purchase a stand-alone dental product in order to complete their purchase.[93] (see text box on page 21 for more information on adults)

Kentucky. With strong support from advocate and lobbying groups, Kentucky enacted an emergency administrative regulation requiring the Kentucky Health Benefit Exchange to ensure that individuals up to age 21 enroll in pediatric dental coverage.[94,95] Families with children under 21 purchasing a QHP that does not offer pediatric dental benefits are prompted to purchase a stand-alone dental product, which is required in order to complete the transaction.

Washington also took a similar approach—the Washington Health Benefit Exchange board decided to ensure children receive all ten EHBs in the individual marketplace by requiring all families with children under 19 who do not qualify for CHIP to purchase dental benefits.[96]

Meeting participants identified a requirement to purchase pediatric coverage as a way to effectively spread costs across a broader group and keep dental coverage more affordable. Both Kentucky and Nevada shared that requiring purchase in their states has not resulted in consumer pushback, even though federal subsidies do not apply to the stand-alone dental policy. Both states emphasized that the requirement to purchase only applies to children and pediatric dental benefits.

Meeting participants discussed several other actions states could take to improve the experience of purchasing pediatric dental benefits. For example, one concern was whether marketplaces are well-equipped to adequately display information on dental benefits, allowing consumers to compare embedded with stand-alone policies in states that offer both options, and make an informed purchasing decision. The American Dental Association's survey of marketplace dental offerings identified inadequate detail on covered services and cost-sharing

in embedded policies as a concern.[97] Meeting participants suggested states could address this by implementing a more robust requirement for plans to report benefit information in a standardized manner and by programming marketplace systems to display dental benefits in a comparable way. Participants also suggested that state and federal agencies regularly report on uptake of dental benefits as a way to determine whether children are obtaining dental coverage.

Purchasing Adult Dental Benefits

States can include adult dental benefits in the marketplace as part of a stand-alone family dental policy or embedded in a medical policy. However federal subsidies are not applicable to adult dental benefits and states opting to include them have to build systems that properly allocate subsidies and implement policies that ensure adequate transparency for consumers. For plan year 2014, there is great variety in what adult dental benefits states are including in their marketplace and how they are being offered. Meeting participants indicated in January 2014 that adult dental offerings appear to be attractive to shoppers. Data released by the Department of Health and Human Services in March 2014 support this claim—21 percent of individuals enrolling in coverage through a federally-facilitated marketplace also purchased stand-alone dental plans. Of these individuals, 95 percent are over the age of 18, and 24 percent are over the age of 55.[98] However, meeting participants suggested that it remains too early to tell whether the current framework for adult dental benefits in the marketplace—voluntary purchase of unsubsidized products in states that allow it—will meet the needs of marketplace customers. Below are some examples of state approaches to adult dental benefits, and a look at how Nevada is using its marketplace to offer dental benefits to Medicaid-eligible adults.

Connecticut is offering adult dental plans as part of a stand-alone family dental product, primarily to target adults with employer-sponsored insurance that does not include dental coverage. In 2014, Connecticut's stand-alone dental product is not being sold directly through the Access Health CT site—instead the marketplace website directs individuals seeking adult dental coverage to a separate Anthem Blue Cross Blue Shield website where coverage can be purchased for about $40-$60 per month.[99] These stand-alone family dental products are reviewed and certified by Access Health CT.

Maryland. Adult dental coverage in Maryland is offered as part of a stand-alone family dental product. All adult consumers purchasing this product are notified that adult dental coverage is not part of the EHB and thus not eligible for subsidies.[100] As of September 2013, Maryland's marketplace is offering 20 stand-alone dental policies, eight of which will offer pediatric benefits only and 12 will offer family dental coverage.[101]

Washington is considering offering plans that include adult dental benefits in the marketplace in 2016 or later. In March 2014, the state's marketplace board discussed how to implement adult dental benefits in future years and expects that significant changes to its marketplace web portal may be necessary.[102] To implement these changes, Washington was awarded enhanced funding through a federal Level One Establishment Grant in January 2014. In addition, Washington intends to conduct analyses in 2014 to compare and explore the feasibility of various adult and family dental options.[103]

Nevada: Marketplace Dental Coverage for Adults in Medicaid

Health Link Nevada is one of three state-based marketplaces that requires customers to purchase stand-alone dental coverage for eligible children. (Nevada allowed plans to offer embedded or bundled dental benefits, but none did in 2014.) The state also allows dental plans to offer adult coverage, and has designed its website to ask shoppers who have not selected a dental plan whether they would like to add it to their "shopping cart" prior to checkout. The state does this for all adults, including those who are determined to be eligible for Medicaid. This has proved to be an unexpectedly attractive option for adults enrolling in Medicaid, which does not include a comprehensive adult dental benefit. It is still too early to know whether low-income individuals enrolling in this coverage will continue to pay monthly premiums of $20-60 and copayments for services in order to maintain it through the course of the plan year. However, the initial enrollment suggests a level of desire among enrollees for dental coverage (and potentially, of unmet needs for dental care).

Consumer Assistance for Dental Benefits

The ACA supports a variety of consumer assistance entities, such as Navigators, In-Person Assisters, Certified Application Counselors, and agents and brokers, to help consumers understand their coverage options and whether they qualify for federal subsidies. The federal government establishes standards for training assistance entities working in federally facilitated marketplaces (to which states can add), whereas state-based marketplaces may follow the federal marketplace's guidance or can establish their own. Meeting participants were concerned about the level of training that consumer assistance entities receive specifically related to dental benefits. Some states have taken extra steps to ensure that consumer assistance entities are trained on the specifics of dental coverage in their states in order to adequately help consumers make informed decisions. For example, the Children's Dental Health Project (CDHP) has partnered with state officials in Connecticut to help develop dental training modules and quick reference materials for the state's marketplace navigators and in-person assisters.[104] CDHP has also participated in web-based trainings sponsored by the federal Health Resources and Services Administration (HRSA) to educate stakeholders about pediatric dental benefits under the ACA and provide information designed to inform navigators and assisters.[105] To better inform their training efforts, Rhode Island provided an opportunity for each medical carrier to describe its products to state officials, and dental carriers were afforded the same opportunity. This process has helped ensure that adequate information about dental benefits is incorporated into training protocols in Rhode Island. Meeting participants identified a need for established mechanisms for obtaining feedback from navigators and other assister entities.

Policy Options for Addressing Issues with Consumer Experience

Meeting participants identified a range of potential actions, many of which are applicable to both states and federally-facilitated marketplaces.

- Provide dental training for navigators and other consumer assistance entities to ensure they understand the specifics of dental benefits in their state's marketplace.
- Utilize feedback from navigators and other consumer assistance entities to address consumer concerns and improve the provision of dental benefits.
- Develop relationships with other state entities that have expertise with oral health programs—including Medicaid, CHIP, Title V, and state dental directors—to partner around efforts to monitor uptake of dental insurance, measure access to care, and conduct dental-specific outreach.

- Monitor uptake, purchasing demographics, and any issues with access to care among the newly insured in order to identify issues and create targeted solutions. Provide periodic data reports to stakeholders.
- Require more robust and standardized benefit, premium, and cost-sharing information to enable comparisons of dental coverage between plans.
- Ensure that marketplace websites are designed to display clear information and messaging about dental products and options; highlighting the use of the Summary of Benefits and Coverage form to identify whether dental is included in a medical plan or not.
- Design websites to present adults shopping for Qualified Health Plans (and potentially Medicaid) with the option to purchase dental coverage prior to checkout.
- At the state level, require families with children to purchase pediatric dental in a state offering stand-alone dental products.

Conclusion

The ACA includes important dental coverage provisions that, when added to Medicaid and CHIP coverage, move the country closer toward ensuring dental coverage for all children. The inclusion of dental benefits in marketplace offerings also appears to have opened up new opportunities for adult dental coverage. However, states face unique challenges in offering dental benefits in the marketplace. The decisions states make will greatly impact consumers. In most states, consumers will encounter a wide variety of insurance options—including plans with embedded benefits, plans offering dental and medical benefits separately, and potentially plans that are a hybrid option. However, consumers in most states are not required to purchase dental benefits and may opt to forgo dental coverage entirely, particularly if coverage is not affordable. Consumers in different states may face vast differences in premiums, availability of Advanced Premium Tax Credit, limitations on annual out-of-pocket maximums, and availability of adult coverage. In addition, due to limitations in federal and state IT systems, dental offerings in the marketplace may lack transparency for the consumer. While these challenges are realities of the current environment, state and federal policymakers have the opportunity to reevaluate policies and implement program design changes to make dental benefits more accessible and affordable to marketplace consumers over the next several years. This report includes a number of suggestions for such policy and program changes, based on early state experience and expert opinion, that we hope will be useful to states and the federal marketplace as they work to evaluate and improve plan offerings and consumer experience in obtaining dental benefits.

NATIONAL ACADEMY
for STATE HEALTH POLICY®

APPENDICES

Appendix A. Expert Meeting Participant List

Jennifer Babcock
Vice President for Exchange Policy
and Director of Strategic Operations
Association of Community Affiliated Plans

Carrie Banahan
Executive Director
Office of the Kentucky Health Benefit Exchange

Chad Brooker
Chief Policy and Legal Analyst
Access Health Connecticut

John Cucco
Senior Policy Analyst
Rhode Island Health Benefit Exchange

Patrick Finnerty
Senior Advisor for State Oral Health Programs
DentaQuest Foundation

Ralph Fuccillo
Chief Mission Officer, DentaQuest
President, DentaQuest Foundation

Kris Hathaway
Director, Government Relations
National Association of Dental Plans

Damon Haycock
Finance and Research Officer
Nevada Health Link

Lena Hershkovitz
Manager, Plan Services
Maryland Health Benefit Exchange

Julia Lerche
Senior Consulting Actuary
Wakely Consulting Group

William Maas
Board Member At-Large Representative
Maryland Dental Action Coalition

Michael Monopoli
Director of Policy and Programs
DentaQuest Foundation

Laurie Norris
Senior Policy Advisor
Centers for Medicare & Medicaid Services

Chad Olson
Director, Government Relations
Delta Dental Plans Association

Lynn Quincy
Senior Health Policy Analyst
Consumers Union

Colin Reusch
Senior Policy Analyst
Children's Dental Health Project

Thomas Spangler
Senior Director, Legislative and Regulatory Policy
American Dental Association

Joe Touschner
Senior Health Policy Analyst
Georgetown Center for Children and Families

Devon Trolley
Health Insurance Specialist
Center for Consumer Information and Insurance Oversight
Department of Health and Human Services

Pam Vodicka
Program Director
Maternal and Child Health Bureau, Oral Health
Health Resources and Services Administration

Summary of Federal Guidance Related to Dental Benefits
(As of March 2014)

Date	Type	Title and Citation		Key Points Related to Dental
23-Mar-10	Statute	Patient Protection and Affordable Care Act (ACA) Section 1302(b)(1)(J)		• Includes "pediatric services, including oral and vision care" as part of the Essential Health Benefits (EHB).
23-Mar-10	Statute	ACA Section 1311(d)(2)(B)(ii)		• Allows marketplaces to offer pediatric dental benefits as stand-alone products.
23-Mar-10	Statute	ACA Section 1302(b)(4)(F)		• Allows qualified health plans (QHPs) to be certified even if they do not include pediatric dental benefits, as long as one stand-alone pediatric dental product is offered in the marketplace.
23-Mar-10	Statute	ACA Section 1311(d)(3)		• Requires states to cover the costs of state-mandated benefits that exceed EHB requirements.
23-Mar-10	Statute	ACA Section 1402(c)(5)		• For individuals enrolled in a QHP and a stand-alone dental product, cost-sharing reductions shall not apply to the portion properly allocable to pediatric dental benefits.
16-Dec-11	Sub-Regulatory Guidance	Essential Health Benefits Bulletin	Center for Consumer Information and Insurance Oversight	• Gives states flexibility for 2014-2015 to define an EHB package based on one of four benchmark plans: (1) the three largest small group market plans in the state (2) the three largest state employee health plans (3) the three largest Federal Employees Health Benefit Program plans or (4) the state's largest commercial non-Medicaid HMO plan.
27-Mar-12	Final Rule	Patient Protection and Affordable Care Act: Establishment of Exchange and Qualified Health Plans; Exchange Standards for Employers	Department of Health and Human Services FR 77, no. 59	• Clarifies that cost-sharing limits and restrictions on annual and lifetime limits apply to stand-alone dental products for coverage of the pediatric dental EHB. • Clarifies that states can choose to require QHPs to separately offer and price pediatric dental coverage if they find it in the best interest of the consumer, but there is no federal requirement. • Clarifies that stand-alone dental products are considered a type of QHP and therefore must meet applicable QHP certification standards and allows states to establish certification standards that are unique to stand-alone dental products. • Directs states to consider during the certification process whether stand-alone dental products in the marketplace will provide "sufficient access" to the pediatric dental EHB to all potential child enrollees.
23-May-12	Final Rule	Health Insurance Premium Tax Credit	Department of the Treasury FR 77, no. 100	• Establishes that Advanced Premium Tax Credits will be computed based on the second-lowest cost silver plan and that tax credits will be first applied to a QHP and any remaining credit will apply to a stand-alone dental product.

Date	Type	Title and Citation		Key Points Related to Dental
25-Feb-13	Final Rule	Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation	Department of Health and Human Services FR 78, no. 37	• States in the preamble that issuers *outside* the marketplace must be "reasonably assured" that an individual (with or without a child) has obtained all 10 EHB, including pediatric dental coverage. • Outlines two options for states to supplement base-benchmark plans to meet the pediatric dental EHB requirement: (1) Federal Employees Dental and Vision Insurance Program or (2) Separate-CHIP. • Clarifies that states must offer all 10 EHB to individuals purchasing coverage *inside* the marketplace, however there is no requirement for an individual (with or without a child) to purchase pediatric dental coverage. • Allows for a separate out-of-pocket maximum for stand-alone dental plans and gives marketplaces the responsibility in 2014 for determining a "reasonable" out-of-pocket maximum for stand-alone dental plans. • Establishes a "high" and "low" approach for the actuarial value calculation of stand-alone dental plans, with "high" meaning 85 percent and "low" 70 percent.
25-Feb-13	Sub-Regulatory Guidance	FAQs about Affordable Care Act Implementation Part XII	Departments of Labor, Health and Human Services, and Treasury	• Delays the limitations on annual out-of-pocket maximums in cases where multiple service providers help administer benefits (e.g. separate administrators for medical, behavioral, dental, and/or pharmacy benefits) until 2015.
5-Apr-13	Sub-Regulatory Guidance	Letter to Issuers on Federally-facilitated and State Partnership Exchanges	Center for Consumer Information and Insurance Oversight	• Establishes that the Federally-facilitated Marketplace (FFM) will not include bundled plans in 2014 nor will it require embedded plans to offer and price the pediatric dental EHB separately in 2014. • Requires stand-alone dental plans to publicly display whether their rates are guaranteed or not. • Cites ACA 1402(c)(5) to mean cost-sharing reductions can only be applied to pediatric dental benefits if offered through an embedded plan (not stand-alone or bundled). • Sets the limit on annual out-of-pocket maximums in the FFM at $700 for one child and $1,400 for two or more children for 2014. • Outlines which QHP certification standards are applicable to stand-alone dental products—including actuarial value (modified), inclusion of Essential Community Providers, service area requirements, non-discrimination, and network adequacy standards--and which are not applicable.

Date	Type	Title and Citation		Key Points Related to Dental
15-Jul-13	Final Rule	Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment	Centers for Medicare & Medicaid Services FR 78, no. 135	• Establishes the process for state selection of EHB benchmarks for Medicaid Alternative Benefit plans.
30-Oct-13	Final Rule	Patient Protection and Affordable Care Act; Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014	Centers for Medicare & Medicaid Services FR 78, no. 210	• Reiterates that while stand-alone dental products are a type of QHP, they are not subject to all requirements that apply to QHPs (as stated in the March 2012, Exchange Establishment Rule). Specifically, since dental benefits provided through a stand-alone product are considered "excepted benefits" under 2791 (c) of the Public Health Service Act, they are not subject to rating rules, medical loss ratio standards, or prohibition against denials for pre-existing conditions, though states or issuers have the option to apply these standards.
4-Feb-14	Sub-Regulatory Guidance	2015 Letter to Issuers in the Federally-facilitated Marketplace (FFM)	Center for Consumer Information and Insurance Oversight	• Generally upholds the approaches outlined in the 2014 Letter to Issuers as it relates to stand-alone dental policy standards.
11-Mar-14	Final Rule	Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2015	Centers for Medicare & Medicaid Services FR 79, no. 47	• Finalizes the annual limit on cost-sharing for stand-alone dental products at $350 for one child and $700 for two or more children, applicable to all marketplaces in the 2015 benefit year. • Maintains that stand-alone dental plans must meet either "high" or "low" actuarial value standards (70 and 85 percent respectively) for plan year 2015.

Appendix C. Individual Marketplace Pediatric Dental Benefit Decisions for 2014

Individual Marketplace Pediatric Dental Plan Decisions for 2014

(As of March 2014)

Source documents are embedded in the chart as links

State	Marketplace Type	Stand-Alone Dental Policy (SADP)	Embedded (QHP includes pediatric dental benefits)	Bundled (QHP contracts with a dental issuer)	Requirement to Purchase Pediatric Dental (inside the marketplace)	2014 Annual Out-Of-Pocket Maximum for SADP	Pediatric Dental Benchmark Selection
All Federally-Facilitated Marketplace (FFM) States		✓	✓		No	$700 for one child enrollee or $1,400 for two or more child enrollees.	Varies by state: 12 CHIP, 22 FEDVIP, 1 Included
California	State-Based Marketplace (SBM)	✓			No	$1,000 for one child, $2,000 for two or more children.	CHIP
Colorado	SBM	✓	✓	S	No	$700 for one child, $1,400 for two or more children.	CHIP
Connecticut	SBM		✓		N/A	N/A	CHIP
District of Columbia	SBM	S	✓	S	No	$1,000 for one child, $2000 for two or more children.	FEDVIP
Hawaii	SBM	✓	✓		No	$700 for one child, $1,400 for two or more children.[1]	CHIP
Idaho	SBM	✓	✓		No	$1,000 per person.	FEDVIP
Kentucky	SBM	✓	✓		Yes	$1,000 for one child, $2,000 for two or more children.	CHIP
Mass.	SBM	✓	✓		No	$1,000 for one child, $2,000 for two or more children.[1]	CHIP

State	Marketplace Type	Stand-Alone Dental Policy (SADP)	Embedded (QHP includes pediatric dental benefits)	Bundled (QHP contracts with a dental issuer)	Requirement to Purchase Pediatric Dental (inside the marketplace)	2014 Annual Out-Of-Pocket Maximum for SADP	Pediatric Dental Benchmark Selection
Maryland	SBM	✓	✓	S	No	$1,000 for one child, $2,000 for two or more children.	CHIP
Minnesota	SBM	✓	✓	S	No	$700 for one child, $1,400 for two or more children.[1]	FEDVIP
New York	SBM	✓	✓		No	$700 for one child, $1,400 for two or more children.	CHIP
Nevada	SBM	✓	S	S	Yes	$700 for one child, $1,400 for two or more children.	CHIP
Oregon	SBM	✓	✓		No	$1,000 per person.	CHIP
Rhode Island	SBM	✓	✓ (Individual market only)		No	$700 for one child, $1,400 for two or more children.[1]	FEDVIP
Vermont	SBM	S	✓	S	No	N/A	CHIP
Washington	SBM	✓ (Individual market only)			Yes	No imposed dollar amount – OOP deemed 'reasonable if EHB is covered and actuarial value is met.[2]	CHIP

Key

✓ = State is offering this type of product in plan year 2014

S = State solicited for this type of dental offering but did not receive any submissions and is not offering this type of product in plan year 2014

[1] Information obtained through correspondence with the National Association of Dental Plans

[2] Information obtained through correspondence with Washington marketplace officials.

Endnotes

1 Bruce A. Dye, et al., *Trends in Oral Health Status: United States, 1988-1994 and 1999-2004* (Washington, DC: U.S. Department of Health and Human Services Centers for Disease Control and Prevention, April 2007)

2 The Pew Children's Dental Campaign, *The Cost of Delay: State Dental Policies Fail One in Five Children* (Washington, DC: The Pew Center on the States, February 2010)

3 U.S. Government Accountability Office (GAO), *Dental Services: Information on Coverage, Payments, and Fee Variation* (Washington, DC: GAO, September 2013)

4 Ketchum and Lake Research Partners, *Informing CHIP and Medicaid Outreach and Education: Key Findings from a National Survey of Low-Income Parents Conducted for Centers for Medicare & Medicaid Services* (Washington, DC: U.S. Department of Health and Human Services, November 2011)

5 Genevieve M. Kenney, et al., "Improving Coverage for Children Under Health Reform Will Require Maintaining Current Eligibility Standards for Medicaid and CHIP," *Health Affairs* 30, no.12 (December 2011): 2371-2381

6 National Institute of Dental and Craniofacial Research, National Institutes of Health, *Oral Health in America: A Report of the Surgeon General* (Rockville, MD: U.S. Department of Health and Human Services, 2000)

7 The Henry J. Kaiser Family Foundation. "State Health Facts: Health Coverage & Uninsured Indicators." Retrieved March 14, 2014. http://kff.org/state-category/health-coverage-uninsured/

8 Center for Medicaid & CHIP Services, *Informational Bulletin, CMS Oral Health Initiative: Setting Baselines and Goals* (Baltimore, MD: U.S. Department of Health and Human Services, April 18, 2013)

9 Andrew Snyder, *Increasing Access to Dental Care in Medicaid: Targeted Programs for Four Populations* (Washington, DC: National Academy for State Health Policy, March 2009)

10 Alison Borchgrevink, Andrew Snyder, and Shelly Gehshan, *The Effects of Medicaid Reimbursement Rates on Access to Dental Care* (Washington, DC: National Academy for State Health Policy, March 2008)

11 The Henry J. Kaiser Family Foundation, "State Health Facts: Number of Children Ever Enrolled in the Children's Health Insurance Program (CHIP)." Retrieved March 14, 2014. http://kff.org/other/state-indicator/annual-chip-enrollment/

12 Genevieve M. Kenney, et al., "Improving Coverage for Children Under Health Reform Will Require Maintaining Current Eligibility Standards for Medicaid and CHIP," *Health Affairs* 30, no.12 (December 2011): 2371-2381

13 Kamyar Nasseh, Marko Vujicic, and Amanda O'Dell, Affordable Care Act Expands Dental Benefits for Children But Does Not Address Critical Access to Dental Care Issues. (Chicago, IL: American Dental Association Health Policy Resources Center, April 2013)

14 The Henry J. Kaiser Family Foundation, "State Health Facts: Medicare Indicators." Retrieved December 30, 2013. http://kff.org/state-category/medicare/

15 Claxton, Gary, et al., *Employer Health Benefits 2012 Annual Survey* (The Henry J. Kaiser Family Foundation and Health Research & Educational Trust, 2012)

16 National Association of Dental Plans, "ACA & Dental Coverage: The Basics." Retrieved December 10, 2013. http://www.nadp.org/Libraries/HCR_Documents/ACA_and_Dental_Coverage_Basics_2013.sflb.ashx

17 National Association of Dental Plans (NADP) and Delta Dental Plans Association (DDPA). *Offering Dental Benefits in Health Exchanges: A Roadmap for Federal and State Policymakers* (Dallas, TX: NADP and DDPA, September 2011

18 EHB does not apply to grandfathered plans—plans created on or before March 23, 2010 that have not made any changes that reduce their benefits or increase costs to the consumer. The ACA expands Medicaid to individuals with family incomes up to 133 percent FPL as of January 2014. The law requires states to enroll newly eligible people in benchmark or benchmark-equivalent benefit plans, which must include EHB. The Basic Health Program (BHP) is a state option that will begin in January 2015—BHP plans would provide subsidized coverage for individuals between 133 and 200 percent FPL who are not eligible for Medicaid or marketplace subsidies.

19 *The Patient Protection and Affordable Care Act (ACA),* Public Law 111-148, 111th Cong., 2nd sess., (March 23, 2013), sec. 1302

20 ACA, sec. 1311(d)(3)

21 Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin* (Washington, DC: U.S. Department of Health and Human Services, December 2011)

22 U.S. Department of Health and Human Services, *Federal Register* 78, no. 37 (February 25, 2013)

23 Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin* (Washington, DC: U.S. Department of Health and Human Services, December 2011)

24 StateRefor(u)m. “Digging in to Benchmark Plan Details Chart.” Retrieved March 14, 2014. https://www.statereforum.org/analyses/state-progress-on-essential-health-benefits

25 Centers for Medicare & Medicaid Services, *Frequently Asked Questions on Essential Health Benefits* (Baltimore, MD: U.S. Department of Health and Human Services, December 10, 2012)

26 U.S. Department of Health and Human Services. *Federal Register* 78, no. 37 (February 25, 2013)

27 American Academy of Pediatrics, American Dental Hygienists Association, Children’s Defense Fund, et al., “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015.” December 26, 2013. Retrieved March 14, 2014. http://childrenspartnership.org/storage/documents/Advocacy/Comments/CMS-9954-P_Group_comments.pdf

28 StateRefor(u)m, “Digging in to Benchmark Plan Details Chart.” February 5, 2014. Retrieved March 14, 2014. https://www.statereforum.org/analyses/state-progress-on-essential-health-benefits

29 PeHP, “Utah Basic Plus 2012 Benefits Summary.” Retrieved March 14, 2014. http://utahlegislature.granicus.com/MetaViewer.php?view_id=2&clip_id=1537&meta_id=59500

30 ACA, sec. 1311(d)(2)(B)(ii)

31 ACA, sec. 1302(b)(4)(F)

32 U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, “Qualified Health Plan (QHP) Webinar Series Frequently Asked Questions.” May 2, 2013. Retrieved March 5, 2014. http://www.delawareinsurance.gov/health-reform/QHP_FAQ_CMS_050213.pdf

33 Federal Trade Commission, Office of Policy Planning, “Letter to Senator Richard L. Brown in response to likely competitive effects of North Dakota House Bill 1332.” March 5, 2008. Retrieved March 14, 2014. http://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-honorable-richard-l.brown-concerning-north-dakota-h.b.1332-regulate-contractual-relationship-between-pharmacy-benefit-managers-and-covered-entities/050311northdakotacomnts.pdf

34 Joanna Shepherd, “Is More Information Always Better? Mandatory Disclosure Regulations in the Prescription Drug Market.” *Cornell Law Review Online* 99, no. 1 (2013)

35 The ACA bans annual and lifetime dollar limits and caps out-of-pocket maximums at $6,400 for single coverage and $12,800 for family coverage. The ACA also prohibits plans from denying coverage based on an applicants health status and only allows plans to vary premium rates based on whether coverage is for an individual or family, and the enrollee’s age, geographic location, and tobacco use.

36 Cassandra Yarbrough, Marko Vujicic, and Kamyar Nasseh, *Health Insurance Marketplaces Offer a Variety of Dental Options, but Information Availability is an Issue* (Chicago, IL: American Dental Association Health Policy Resources Center, March 2014)

37 U.S. Department of Health and Human Services, *Federal Register 77*, no. 59 (March 27, 2012)

38 U.S. Department of Health and Human Services, *Federal Register* 78, no. 37 (February 25, 2013)

39 U.S. Department of Health and Human Services, *Federal Register* 78, no. 210 (October 30, 2013)

40 Center for Consumer Information and Insurance Oversight, *2014 Letter to Issuers on Federally-facilitated and State Partnership Exchanges* (Washington, DC: U.S. Department of Health and Human Services, April 5, 2013)

41 Asian Americans Advancing Justice, Asian Law Alliance, Autism Health Insurance Project, et al., “Pediatric Dental Benefit Staff Recommendation.” January 17, 2014. Retrieved February 15, 2014. http://yourhealthsecurity.org/wordpress/wp-content/uploads/2014/01/pediatric-dental-2015-comment-letter-to-Board-UPDATED-1-22-14-1.pdf

42 California Assembly Bill 1962, introduced February 19, 2014

43 For more information on the arguments for and against a minimum loss ratio and considerations for California policymakers considering adopting requirements for dental plans, see this report: Len Finocchio and Matthew Newman, *Dental Loss Ratio: Factors to Consider in Establishing a Minimum Loss Ratio for Dental Insurance in California* (Sacramento, CA: The Blue Sky Consulting Group, March 2014)

44 Center for Consumer Information and Insurance Oversight, *2014 Letter to Issuers on Federally-facilitated and State Partnership Exchanges* (Washington, DC: U.S. Department of Health and Human Services, April 5, 2013)

45 U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, “Qualified Health Plan (QHP) Webinar Series Frequently Asked Questions.” May 2, 2013. Retrieved March 5, 2014. http://www.delawareinsurance.gov/health-reform/QHP_FAQ_CMS_050213.pdf

46 Center for Consumer Information and Insurance Oversight, *2014 Letter to Issuers on Federally-facilitated and State Partnership Exchanges* (Washington, DC: U.S. Department of Health and Human Services, April 5, 2013)

47 Colin Reusch. Teeth Matter Blog Post. “Greater Transparency Needed on Dental Coverage Provided by Health Plans.” March 10, 2014. Retrieved March 13, 2014. https://www.cdhp.org/blog/261-greater-transparency-needed-on-dental-coverage-provided-by-health-plans

48 Peter V. Lee, “California Health Benefit Exchange Board Resolution No. 2014-12.” January 23, 2014. Retrieved February 15, 2014. http://www.healthexchange.ca.gov/BoardMeetings/Documents/January%2023,%202014/Pediatric%20Dental%20Benefit%20(Resolution%202014-12).pdf

49 Access Health CT, “Solicitation to Health Plan Issuers for Participation in the Individual and/or Small Business Health Options Program (SHOP) Marketplace.” March 18, 2014. Retrieved March 28, 2014. http://www.ct.gov/hix/lib/hix/QHP_Solicitation_031814_Amended.pdf

50 Access Health CT, “Solicitation to Stand-Alone Dental Plan Issuers for Participation in the Individual and/or Small Business Health Options Program (SHOP) Marketplace.” March 17, 2014. Retrieved March 28, 2014. http://www.ct.gov/hix/lib/hix/AHCT_SADP_Solicitation_20140317.pdf

51 Evelyn F. Ireland, National Association of Dental Plans letter to Lieutenant Governor Nancy Wyman, State of Connecticut. March 26, 2014

52 U.S. Department of Health and Human Services, *Federal Register* 78, no. 37 (February 25, 2013)

53 National Association of Dental Plans (NADP) and Delta Dental Plan Association (DDPA), *Offering Dental Benefits in Health Exchanges: A Roadmap for Federal and State Policymakers* (Dallas, TX: NADP and DDPA, September 2011)

54 U.S. Department of Health and Human Services, *Federal Register* 78, no. 37 (February 25, 2013)

55 Colorado Department of Regulatory Agencies, Division of Insurance, “Bulletin No. B-4.69 Reasonable Assurance of Possession of Pediatric Dental Coverage.” January 14, 2013. Retrieved March 3, 2014. http://cdn.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%22B-4.69+Reasonable+Assurance+of+Possession+of+Pediatric+Dental+Coverage.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251930730425&ssbinary=true

56 Arkansas Insurance Department, “Bulletin No. 12-2013, Treatment of Pediatric Dental Coverage Provided Through Stand-Alone Dental Plans.” May 28, 2013. Retrieved March 3, 2014. http://www.insurance.arkansas.gov/Legal/Bulletins/12-2013.pdf

57 State of Idaho, Department of Insurance, “Idaho Carrier Questions and Answers, Part 2.” May 17, 2013. Retrieved March 3, 2014. http://www.doi.idaho.gov/press/text%20version/Idaho%20Exchange%20QandA%20Part%202.aspx

58 Nick Gerhart, “Treatment of Pediatric Dental Coverage Provided Through Stand Alone Dental Plans.” April 26, 2013. Retrieved March 3, 2014. http://www.iid.state.ia.us/sites/default/files/page/2013/03/15/treatment_of_pediatric_dental_coverage_provided_th_15724.pdf

59 Monica J. Lindeen, “Clarification Regarding What Constitutes “Reasonable Assurance” as it Relates to Pediatric Dental Benefits and Prohibiting “Forced” or “Automatic Enrollment,” November 13, 2013. Retrieved March 3, 2014. http://www.csi.mt.gov/news/bulletins/pediatricdental_120613.pdf

60 Roger Sevigny, “Bulletin INS. No. 13-039-AB, Auto-Enrollment for Pediatric Dental Benefits.” December 20, 2013. Retrieved March 3, 2014. http://www.nh.gov/insurance/media/bulletins/2013/documents/ins_13-039-ab.pdf

61 New Mexico Office of the Superintendent of Insurance. July 3, 2013. Retrieved March 3, 2014. http://osi.state.nm.us/healthcare-reform/docs/Pediatric%20dental%20assurance%20document.pdf

62 Virginia Senate Bill 484, enacted February 28, 2014

63 Theodore K. Nickel, “Treatment of Pediatric Dental Coverage Provided Through Stand-Alone Dental Plans.” April 2, 2013. Retrieved March 3, 2014. http://oci.wi.gov/bulletin/0413peddental.htm

64 Colorado Department of Regulatory Agencies, Division of Insurance, “Bulletin No. B-4.69 Reasonable Assurance of Possession of Pediatric Dental Coverage.” January 14, 2013. Retrieved March 3, 2014. http://cdn.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%22B-4.69+Reasonable+Assurance+of+Possession+of+Pediatric+Dental+Coverage.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251930730425&ssbinary=true

65 The Delta Dental Plans Association reports that there was no formal guidance, but instructions from the department were to include this language in major medical application: "The undersigned attests that they have purchased an Exchange-certified stand-alone pediatric dental coverage plan from any insurer whether purchased "on" or "off" the Exchange, and therefore are eligible to purchase a medical plan that excludes pediatric dental coverage. The undersigned acknowledges that the Patient Protection and Affordable Care Act require that pediatric dental be included as an essential health benefit for customers of small group and individual health insurance policies." (Chad Olson, Director, Government Relations, Delta Dental Plans Association, personal communication, February 28, 2014)

66 Joseph G. Murphy, "Bulletin 2013-07; Pediatric Dental Benefits within Plans Offered to Eligible Individuals and Eligible Small Employers outside the Massachusetts Exchange." June 19, 2013. Retrieved March 3, 2014. http://www.mass.gov/ocabr/insurance/providers-and-producers/doi-regulatory-info/doi-regulatory-bulletins/2013-doi-bulletins/bulletin-2013-07.html

67 Michigan Department of Insurance and Financial Services, "Essential Health Benefits and Plan Management FAQs." Retrieved March 3, 2014. https://www.michigan.gov/difs/0,5269,7-303-13648-293672--,00.html#q70

68 State of Oregon Department of Consumer and Business Services, "Revised Insurance Division Guidance on Reasonable Assurance." Retrieved March 3, 2014. http://www.oregon.gov/DCBS/insurance/insurers/rates-forms/Documents/enotify-documents/102813-reasonableAssurance-revised.pdf

69 Kentucky Department of Insurance, "Affordable Care Act Implementation Update, Frequently Asked Questions #2." May, 22, 2013. Retrieved March 3, 2014. http://insurance.ky.gov/Documents/acaimpfaq2_052313.pdf

70 New York Department of Financial Services, "Dental Question and Answers." Retrieved March 3, 2014. http://www.dfs.ny.gov/insurance/health/dent-file-g.pdf

71 Ohio Department of Insurance, "Plan Management Toolkit." February 10, 2014. Retrieved March 3, 2014. https://www.insurance.ohio.gov/Company/Documents/2013_Plan_Management_Toolkit_Page.pdf

72 South Dakota Legislature, 20:06:56:06 Pediatric Dental

73 Colin Reusch. Teeth Matter Blog Post. "UPDATE: Marketplace Pediatric Dental Premiums." February 6, 2014. Retrieved February 19, 2014. https://www.cdhp.org/blog/255-update-marketplace-pediatric-dental-premiums

74 Cassandra Yarbrough, Marko Vujicic, and Kamyar Nasseh, *Health Insurance Marketplaces Offer a Variety of Dental Options, but Information Availability is an Issue* (Chicago, IL: American Dental Association Health Policy Resources Center, March 2014)

75 U.S. Department of the Treasury, *Federal Register 77*, no. 100 (May 23, 2012)

76 Ibid

77 Center for Consumer Information and Insurance Oversight, *2014 Letter to Issuers on Federally-facilitated and State Partnership Exchanges* (Washington, DC: U.S. Department of Health and Human Services, April 5, 2013)

78 Sara Rosenbaum, *Access to Pediatric Oral Health Benefits offered through Health Insurance Exchanges* (Washington, DC: HealthReformGPS, April 2013)

79 The Henry J. Kaiser Family Foundation, *Where are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults as of January 1, 2014* (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, January 2014)

80 U.S. Department of Health and Human Services, *Federal Register* 78, no. 37 (February 25, 2013)

81 Center for Consumer Information and Insurance Oversight, *2014 Letter to Issuers on Federally-facilitated and State Partnership Exchanges* (Washington, DC: U.S. Department of Health and Human Services, April 5, 2013)

82 U.S. Department of Labor, "FAQs about Affordable Care Act Implementation Part XII." February 20, 2013. Retrieved December 11, 2013. http://www.dol.gov/ebsa/faqs/faq-aca12.html

83 U.S. Department of Health and Human Services, *Federal Register* 78, no. 231 (December 2, 2013)

84 U.S. Department of Health and Human Services, *Federal Register* 79, no. 47 (March 11, 2014)

85 Cassandra Yarbrough, Marko Vujicic, and Kamyar Nasseh, *Health Insurance Marketplaces Offer a Variety of Dental Options, but Information Availability is an Issue* (Chicago, IL: American Dental Association Health Policy Resources Center, March 2014)

86 California Senate Bill 639, approved by governor, September 20, 2013

87 For example, the state could set a dental out-of-pocket limit at $350 and a comprehensive out-of-pocket limit at $6,600. In this case, an enrollee would be relieved of all pediatric dental cost-sharing after spending $350 on covered pediatric dental care, but would not hit his or her limit on cost-sharing for all services until he or she spends another $6,250 on non-dental services. Or, if an enrollee spends only $200 on dental coverage and $6,400 on other services, he or she would spend $6,600 out-of-pocket and hit the total limit. This approach would eliminate the concern of having two separate and cumulative out-of-pocket limits, while also protecting families with high pediatric dental needs. Wakely Consulting Group, *Options for Covered California to Offer Pediatric Dental Coverage in 2015* (Charlestown, MA: Wakely Consulting Group, November 2013). Note that this report was issued before the March 2014 CMS rule on dental out-of-pocket maximums was finalized. We have updated this example to reflect a $350 annual dental out-of-pocket maximum.

88 Peter V. Lee, "California Health Benefit Exchange Board Resolution No. 2014-12." January 23, 2014. Retrieved April 8, 2014. http://www.healthexchange.ca.gov/BoardMeetings/Documents/January%2023,%202014/Pediatric%20Dental%20Benefit%20(Resolution%202014-12).pdf

89 Covered California, "Covered California Qualified Health Plan New Entrant Application for the 2015 Plan Year." February 20, 2014. Retrieved March 26, 2014. http://www.healthexchange.ca.gov/BoardMeetings/Documents/January%2023,%202014/Pediatric%20Dental%20Benefit%20(Resolution%202014-12).pdf

90 Casey Morrigan, Consultant for Plan Management and Diana Beckett-Hile, Policy Analyst, Covered California, April 8, 2014

91 Peter V. Lee. Presentation. "Executive Director's Report." Presented at Covered California Board meeting, Sacramento, CA, March 20, 2014. Retrieved April 8, 2014. http://www.healthexchange.ca.gov/BoardMeetings/Documents/March%2020,%202014/PPT%20-%20Executive%20Director%27s%20Report_March%2020,%202014.pdf

92 Silver State Health Insurance Exchange, "Pediatric Dental EHB Requirements." May 16, 2013. Retrieved December 10, 2013. http://exchange.nv.gov/uploadedFiles/exchangenvgov/Content/Meetings/03-Pediatric_Dental_EHB_Requirements.pdf

93 Silver State Health Insurance Exchange, "Pediatric Dental Essential Health Benefit." June 5, 2013. Retrieved December 10, 2013. http://exchange.nv.gov/uploadedFiles/exchangenvgov/Content/Resources/Dental%206.5.13.pdf

94 Cabinet for Health and Family Services, Office of Kentucky Health Benefit Exchange, “Exchange Participation Requirements and Certification of Qualified Health Plans and Qualified Dental Plans.” May 13, 2013. Retrieved December 20, 2013. http://healthbenefitexchange.ky.gov/Documents/907%20KAR%2010%20010%20E%20Cert%20of%20QHP%20as%20filed.pdf

95 Kentucky Health Benefit Exchange Advisory Board Qualified Health Plans Subcommittee, “Meeting Minutes.” March 28, 2013. Retrieved December 7, 2013. http://healthbenefitexchange.ky.gov/Documents/QHP%20Subcomm%20Mtg%20Minutes%2003-28-13.pdf

96 Washington Health Benefit Exchange, “Health Benefit Exchange Board Meeting Minutes.” September 19, 2012. Retrieved December 11, 2013. http://www.wahbexchange.org/files/5713/6503/0398/HBE_EB_120919_Minutes.pdf

97 Cassandra Yarbrough, Marko Vujicic, and Kamyar Nasseh, Health Insurance Marketplaces Offer a Variety of Dental Options, but Information Availability is an Issue (Chicago, IL: American Dental Association Health Policy Resources Center, March 2014)

98 Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplace: March Enrollment Report for the period October 1, 2013 – March 1, 2014* (Washington DC: U.S. Department of Health and Human Services, March 2014)

99 Anthem Blue Cross Blue Shield. “Shop for Anthem BCBS Insurance.” Retrieved December 11, 2013. http://store.anthemdentaladmin.com/

100 Maryland Health Connection, “Maryland Health Benefit Exchange Board of Trustees Meeting Minutes.” December 11, 2012. Retrieved December 10, 2013. http://marylandhbe.com/wp-content/uploads/2012/12/MHBE_Board_Minutes_December_11_2012.pdf

101 Maryland Health Connection. Presentation. “Individual Marketplace Plan Analysis.” Presented at Maryland health Benefit Exchange Board of Trustees meeting, Baltimore, MD, September 2013. Retrieved December 11, 2013. http://marylandhbe.com/wp-content/uploads/2013/09/Plan-Analysis-Revised-09102013.pdf

102 Molly Voris and Christine Gibert. Presentation. “Adult Dental Benefits in the Exchange.” Presented at Washington Health Benefit Exchange Advisory Committee meeting, Olympia, WA, December 3, 2013. Retrieved December 11, 2013. http://www.wahbexchange.org/files/6713/8602/3046/HBE_AC_131203_Adult_Dental.pdf

103 Washington Health Benefit Exchange. “Level One Establishment Cooperative Agreement Funding Request.” November 2013. Retrieved December 11, 2013. http://wahbexchange.org/files/4513/8540/1297/WAHBE_Project_Narrative.pdf

104 Children’s Dental Health Project (CDHP). “CDHP Offers Training to States for Navigators Assisting Dental Consumers,” press release, August 8, 2013

105 Colin Reusch, Teeth Matter Blog Post. “CDHP Participates in HRSA Webcast on Pediatric Dental Issues.” December, 20, 2013. Retrieved March 13, 2014. https://www.cdhp.org/blog/242-cdhp-participates-in-hrsa-webcast-on-pediatric-dental-issues

Filling the need for trusted information on health issues…

April 2014 | DATA NOTE

Measuring Changes in Insurance Coverage Under the Affordable Care Act

Gary Claxton, Larry Levitt, Mollyann Brodie, Rachel Garfield, Anthony Damico

The first open enrollment period under the Affordable Care Act (ACA) has come to an end, and many are looking for ways to assess the law and its implementation thus far. Of particular interest is how many people who were previously uninsured took up new coverage options, but questions about whether people with insurance changed their type of coverage also are receiving attention. Changes in employer-based insurance are particularly important because so many people get their coverage in this way.

The ACA provides significant new coverage options for people, particularly for those with lower incomes or problems with their health. The scope of the reforms, and the intense political controversy surrounding their approach and implementation, has fueled an intense demand for data about their effectiveness. Unfortunately, the information needed to adequately understand enrollment changes across private and public coverage sources will not be available for many months.

Most of what we know about who has health insurance and what type of coverage they have comes from large federal surveys, which provide estimates of the number of people enrolled in different types of coverage, including those with no coverage, along with information about their household demographics and incomes. These surveys can be used to track changes in coverage for different types of people over time. The main advantages of these surveys are their large size and their sophisticated sampling and interviewing techniques, which allow detailed analysis of coverage and coverage changes for people in different demographic and income groups. Further, many federal surveys enable analysis at the state level for at least some states, which is important because ACA implementation (e.g., the availability of expanded Medicaid coverage or the existence of a state-operated Marketplace) will vary greatly across states. Their main disadvantage is that they do not provide rapid turnaround. Because of their size and complexity, there is always a lag between when they are fielded and when findings are published. The data needed to evaluate the coverage changes between 2013 and 2014 will not become available until 2015.

In the interim, people will need to look to other sources of information. One is administrative data, such as the number of people who have enrolled through new health insurance marketplaces or the number of people who have enrolled in Medicaid. These data provide an incomplete picture since we do not know the enrollees' coverage status prior to enrollment: Did they have insurance before and, if so, what type? It also is difficult to

distinguish new enrollment from coverage changes that would have occurred in the absence of the law, since people's job status and income change throughout the year. Also, while insurer filings to state insurance departments will report changes in total enrollment in the individual insurance market, there are currently no administrative data that provide detail on the individual market outside of the marketplaces. In addition, there is no source that captures the entire employer market, so there is no information to help us understand how things are changing in the market that covers the majority of nonelderly people. And most importantly, because people without insurance are not enrolled in anything, they cannot be counted in administrative data. Administrative data can provide clues about where to look for changes, but we do not have administrative systems that provide information about changes across types of coverage or changes in the number of people without insurance.

The second interim source of information about health coverage is surveys by private entities, which ask about health insurance by type of coverage and track changes over time (or at least between a few points in time). This means that they provide some opportunity to look at changes across type of coverage as well as changes in the number of people who have any coverage. The main advantage of these surveys is their rapid turn around: indeed, several private surveys already have released findings that show that the number of people without health insurance has fallen between late 2013 and early 2014. Differences in approach and sampling mean that these surveys have different strengths and weaknesses and that their results may not be consistent or comparable.

Below we discuss the details and timing of some of the private and federal surveys that will be used to look at how coverage has changed due to the ACA. Different surveys offer different information and insight into coverage under the ACA, and we discuss the contribution and challenges in each type of effort (see Textbox 1).

Textbox 1: When Interpreting Survey Results, Pay Close Attention to the Time Frame

When looking at survey results about health insurance coverage, one important factor is for what time period the survey is trying to determine coverage (or lack of coverage).

One approach that surveys take is to ask about coverage at the time of the interview. For these surveys, it is then necessary to look at the period over which interviews were conducted. If the interviews were all collected within a short time period (e.g., a week or a month), then the survey is providing an estimate of coverage for that period. Some of the private surveys described in this data note compare coverage between different months or quarters. Other surveys, such as the National Health Interview Survey (NHIS), are conducted throughout the year. In this case, the survey is providing an estimate of the average number of people who had a particular type of coverage (or were not covered) at any point during the year.

Another approach taken in surveys is to ask about coverage for a particular period in the past. For example, the Survey of Income and Program Participation (SIPP) asks respondents about their coverage for the current month and for specific prior months, and survey results report

coverage for each month. This approach allows us to see how coverage changes for people over the course of a long period, although there may be issues with the ability of respondents to recall past events. In previous years, the Current Population Survey Annual Social and Economic Supplement (CPS ASEC) asked respondents if they had various types of coverage during the preceding calendar year. Despite asking about the previous year, the Census Bureau concluded that respondents were more likely reporting coverage at the time of the interview than coverage in the previous year, which means that the results were not responsive to the question being asked and that the findings were ambiguous as to the period over which coverage was being measured.[1] As part of its redesign, the CPS ASEC is moving to an approach that asks respondents about their current coverage and about their coverage for each month back to January of the preceding year.[2]

These different approaches provide different insights into coverage and coverage dynamics. For example, we are used to thinking about how many people are uninsured at any point in time, which is about 50 million people in 2011 according the SIPP. But looking over the course of the year, about 71 million people reported being uninsured for at least one month during the year, while only 29 million reported being uninsured for the entire year. Similar variability can be seen for people with nongroup insurance.[3] These differences are important as we think about how to measure changes over time or between periods of time.

In addition, the timing and extension of the 2014 open enrollment period (which ended on March 31, 2014 but was extended for some applicants) produces some challenges for surveys asking about health coverage during the first quarter of 2014. For some people, the enrollment process was extended over several weeks or months because they needed to provide more information or had difficulty completing their applications. For all new enrollees, coverage took effect at some period after they enrolled. It is not known how people who were in the process of enrollment but whose coverage was not yet effective responded to survey questions about their insurance status. Thus, questions fielded between January and March or April of 2014 may produce ambiguous results about people's coverage status at the time of the interview.

Private Surveys

Surveys conducted by private organizations have provided the first look at coverage changes under the ACA. Private surveys have been used to analyze a number of aspects of the early implementation, including public knowledge and attitudes, changes in the share of people with insurance, and the prior insurance status of early Marketplace enrollees. Many of these surveys are fielded at regular intervals with the goal of understanding how things change over time. In some cases, such as the Gallup-Healthways Well-Being Index ("Gallup"), these are broad public opinion surveys that contain a few questions related to health insurance. In other cases, such as the Urban Institute's Health Reform Monitoring Survey ("HRMS"), the Rand Health Reform Opinion

Survey ("RAND") and our Kaiser California Uninsured Panel Survey, surveys were developed specifically to track ACA implementation. Others, like our Kaiser Health Tracking Poll, focus mainly on opinions, knowledge and early experiences rather than on measuring changes in the share of people with health insurance or non-group coverage.

The main advantage of these private, population-based surveys is their rapidly available results. As opposed to the large federal surveys that will release initial indications many months following the close of open enrollment, we already have some estimates of coverage changes from private surveys, with updates likely in the near future. Several of these surveys had established baseline coverage estimates prior to the beginning of the 2014 open enrollment, making comparisons before and after implementation possible with mostly consistent questions and approaches.

There are, however, several potential limitations to many of the private surveys that need to be kept in mind when interpreting their results.[4] One is that the populations that we most want to know about account for a very small share of the overall population and therefore a small share of the sample in any population-based survey. These populations include, for example: the uninsured in states that expand Medicaid compared to states that do not, those with nongroup coverage before ACA implementation who switch to coverage through the Marketplace, those previously eligible for but not enrolled in Medicaid, and those uninsured who are now newly eligible for Medicaid or for subsidies in exchanges. Most private surveys have relatively small samples for these specific populations, which means that the estimates for these groups are imprecise (that is, estimates have large confidence intervals) and subject to meaningful volatility. Limited precision makes it hard to detect and compare statistically significant changes, particularly for subgroups (e.g., by race, former insurance status, or location).

A second challenge is that asking the questions to determine individuals' prior and current insurance status in a way the respondents can answer accurately is very complicated and time consuming in a survey. Compared to the large federal surveys, which generally devote a number of questions to identifying type of coverage, private surveys often make do with simpler approaches. People are often confused about the type of coverage they have and may answer wrongly or inconsistently when just asked to pick from a list of coverage sources. Several of the more prominent private surveys also have changed their coverage questions recently, which make interpreting changes over time more difficult.

As a result of these limitations, these private surveys are more likely to shed light on broader questions, such as changes in the overall number of people who have health insurance, than on narrower issues, such as changes by race, income, state, or type of coverage. And even though some of the private surveys manage to obtain a fairly large number of respondents, they still may have a relatively large uncertainty around their estimates, which means that they may be more reliable for pointing to trends in the direction of change rather than providing precise measures of the actual coverage rates overall or by type of coverage.

The recent releases of estimates of coverage changes from several private surveys illustrate some of these issues. Results from Gallup, HRMS, and RAND all find that the number of people without health insurance fell during the initial months of 2014 as new coverage options under the ACA took effect.[5] (Our own monthly tracking poll has shown a similar reduction in the number of adults uninsured at the beginning of 2014, though the survey was not designed to detect such changes, which are generally within the poll's margin of error in any given month.)

The three surveys agree that the number of uninsured people has gone down, despite using very different sampling approaches: Gallup accumulates response from their daily tracking poll, which uses telephone interviews of a random sample of adults each day[6]; HRMS is based on interviews from successive samples of an internet panel, which was randomly selected[7]; and RAND is based on repeated interviewing of the same group of adults in an internet panel, a portion of which were randomly selected and a portion of which are from a convenience sample.[8]

The agreement among the surveys on the direction of change reinforces the overall result, although a closer look at their actual coverage estimates shows that some differences make interpreting the specific results somewhat difficult (see Table 1).

To take one example, both HRMS and Gallup showed a comparable (roughly 2 percentage point) reduction in the percentage of nonelderly adults without health insurance over the first several months of 2014, but their estimates of percentage of nonelderly adults who were or are uninsured are quite different.[9] Focusing on the fourth quarter of 2013, Gallup reported that 17.1 percent of adults, including the elderly, were uninsured in the fourth quarter of 2013, which translates into about 20.5 percent of nonelderly adults.[10] In contrast, HRMS' fourth quarter 2013 estimate of uninsured adults is 17.5 percent of nonelderly adults.[11] So while both show that the share of uninsured adults fell, they are starting from fairly different places in their estimates of the share of nonelderly adults without health insurance. (We should note that the Gallup estimate for 2014 is an average over a period, but that the point estimate continued to fall throughout the period, so that the estimate of percent of adults without health insurance in the second half of March was 14.5 percent).[12]

Another example is the difference between RAND and Gallup relating to changes in employer-based coverage. Again, both surveys found that more people had health insurance in the early part of 2014 compared to the fall of 2013. RAND, however, found a significant increase in the number of nonelderly adults covered by employer-based coverage while Gallup found little change.[13] The differences between the two surveys may result from differences in approach, sampling, questions or just random variation. This issue will be worth watching as more survey findings are released.

Table 1: Early Results from Surveys of Coverage Under the ACA Conducted by Private Entities						
	September 2013		March 2014		Change In Share of Uninsured, Adults Age 18-64	Gains In Coverage
Survey	Interview Dates	Percent Uninsured	Interview Dates	Percent Uninsured		
Gallup-Healthways Well-Being Index	July 1 - Sept 30, 2013	18.0% adults age 18 and older	Jan 2- Mar 31, 2014	15.6% adults age 18 and older	-2.5 percentage points	N/A
Urban Institute's Health Reform Monitoring Survey (HRMS)	Sept 1-Sept 30, 2013	17.9% adults age 18-64	Mar 1 - Mar 31, 2014	15.2% adults age 18-64	-2.7 percentage points	Gain in coverage for about 5.4M
RAND Health Reform Opinion Survey	Sept 1-Sept 30, 2013	20.5% adults age 18-64	Mar 1 - Mar 31, 2014	15.8% adults age 18-64	-4.7 percentage points	Gain in coverage for about 9.3M

Federal Surveys

Most of what we know about who has health insurance and the type of coverage they have comes from large, federal population surveys, such as the National Health Interview Survey (NHIS), the Annual Social and Economic Supplement (ASEC) of the Current Population Survey, and the Survey of Income and Program Participation (SIPP). These surveys collect demographic, economic, health coverage and other information from large samples of the population, which can be used to provide fairly complete pictures of how people are distributed into different types of coverage and how this distribution changes over time. Their main advantages are their large size, sophisticated sampling, and interviewing techniques (often in person). While health insurance coverage estimates differ somewhat across the different federal surveys, in part because they each have different questions and approaches, their results are generally consistent. When available, the information from these surveys will provide the most complete and reliable descriptions of how health insurance has changed as the ACA has been implemented.

The main disadvantage of the federal surveys is that they will not have results reflecting coverage after ACA implementation for many months. An additional challenge is that several of the main surveys are using new questions or approaches to understanding health insurance coverage in order to accommodate the new coverage options under the ACA. Some changes to questions were necessary to allow people to accurately report their source of coverage, given the new options available to people. Others changes address longer-standing issues with measuring coverage.[14] These changes will in general improve the ability to compare insurance coverage before and after full implementation of the ACA, but methodological changes may in some cases make it challenging to discern trends across the period leading up to full ACA implementation, from 2012 to 2013.

Following are descriptions of the major federal surveys that will provide information about how coverage has changed under the ACA.

Table 2: Availability of Post-ACA Health Insurance Coverage Data from Major Federal Surveys				
Survey	Supports State-Level Analysis?	Post-ACA Data Availability		
		Date Released:	Type of Data Available:	Reflects Coverage for Period:
National Health Interview Survey	Only through restricted data center and limited to 40 largest states	September 2014	Preliminary Q1 Data	At date of interview (Jan.–March 2014)*
		December 2014	Preliminary Q2 Data	At date of interview (Jan.–June 2014)*
		March 2015	Preliminary Q3 Data	At date of interview (Jan.–Sept. 2014)*
		June 2015	Main 2014 Public Use File**	At date of interview (Jan.–Dec. 2014)*
Behavioral Risk Factor Surveillance System	Yes	Summer 2015	Main 2014 Public Use File	At date of interview (Jan.–Dec. 2014)
Annual Social and Economic Supplement	Yes, but for some analyses (such as insurance coverage rates) two years of data must be pooled	Spring–Summer 2015	New coverage questions from 2014 CPS ASEC	Monthly for all of 2013 up to date of interview (Feb.–April 2014)
		September 2015	2015 CPS ASEC	Monthly for all of 2014 up to date of interview (Feb.–April 2015)
Survey of Income and Program Participation	Limited to 20 largest states	Spring 2016	2014 Panel Wave 2	Monthly for all of 2013 and all of 2014
American Community Survey	Yes	December 2015	Main 2014 Public Use File	At date of interview (Jan.–Dec. 2014)
* Includes some information about prior coverage. ** Imputed income file may not be available for several months.				

NATIONAL HEALTH INTERVIEW SURVEY

The first-available federal survey that will have health insurance information covering at least some of the ACA's 2014 open enrollment period is the National Health Interview Survey (NHIS). The NHIS is a national household survey of civilians living outside of institutions conducted by the National Center for Health Statistics, with contractual assistance from the US Census Bureau.[15] The survey collects information throughout the year on a range of health topics (including health insurance status at the time of the interview) and on the income, employment, and other personal characteristics of respondents.

While full NHIS survey results for 2014 are not expected until June 2015 (see Table 2), preliminary data and reports are made available earlier through an early release program. In recent years, early release information for interviews conducted for the first quarter (January through March) of a year have been released in September of that year, with information for the first two quarters (January through June) released in

December and information from the first three quarters (January through September) released the following March. The early release data has included estimates of the percent of people in different age groups who were uninsured at the time of the interview, the percent of each group uninsured for at least part of the year prior to the interview, and the percent of each group who have been uninsured for more than a year at the time of the interview. Estimates of the percent of each age group with public or private coverage also are typically made available, along with a limited set of demographic variables that can be used to look at coverage statistics for some subpopulations. Household income information deserves caution: approximately one-quarter of respondents' family incomes are affected by an income imputation procedure that will not be implemented until a few months after the full file release in 2015.[16]

The first quarter early release data may provide some insight into the impact of the ACA open enrollment period, but the information will understate the full effect because most of the interviews were conducted in January, February, and early March, before the surge in enrollment at the end of March (see Textbox 1). The second quarter release will be more valuable because roughly half of the interviews will have occurred after the formal close of the open enrollment periods in the federal and state Marketplaces. Although enrollment opportunities in Medicaid (and even in Marketplaces in some circumstances) continue beyond March, interviews conducted in the second quarter are more likely to reflect the substantial enrollment activity that occurred at the end of March (with some ambiguity for people whose coverage had not yet become effective at the time of their interviews). Estimates from the early release data should be comparable to estimates from prior years, allowing for analysis of the change in the percentage of people uninsured as of the end of open enrollment. However, because the coverage categories are reduced to "public" and "private," changes across different types of coverage will be more difficult to analyze. Specifically, there will be no way to assess overall growth in the non-group market or changes in employer coverage. If restricted to the non-elderly, changes in public coverage should largely reflect changes in Medicaid and CHIP.

If the release schedule follows that of the past, the full data release for the 2014 NHIS should occur mid-summer in 2015, but full income information may not be available for several more months. The survey will provide estimates of coverage for both major public programs and private sources at the time of their interview. New questions ask whether coverage was obtained through healthcare.gov or a state exchange and whether the premium for that coverage is based on family income. People without health insurance are asked how long it has been since they last had coverage and why they lost their previous coverage. The main 2014 NHIS release will provide the first reasonably complete look at the first-year coverage effects of the ACA, although all of the first-quarter interviews will have been completed prior to the end of the open enrollment period. Since "month of interview" is included in the public release, earlier interviews can be examined separately or discarded, depending on the analysis aim. This survey is large enough to support analysis of subgroups, although analyses involving income will need to wait until the full income information is released later in 2015. The survey's sample size is sufficient to support analysis of some of the larger states, but accessing these variables requires application to a Research Data Center. While insurance coverage is estimated at the point of the interview in

the NHIS, a series of insurance transition questions will allow an assessment of whether people who report coverage through healthcare.gov or a state exchange were previously uninsured. Insurance coverage question wording remained consistent enough that annual trends across the 2013-2014 period, and to previous years, should be valid.

Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System (BRFSS) is a nationwide telephone survey conducted by state health departments with assistance from the Centers for Disease Control and Prevention (CDC) to monitor health behavior and identify emerging health problems.[17] Data are collected monthly in all states and some territories; over 400,000 interviews were conducted in 2012. While the survey focuses on health behavior, it also collects limited information on whether or not respondents have health insurance at the time of the interview. The survey does not collect information on the type of insurance that respondents have, so it is not a source of data for changes across types of coverage.[18]

While BRFSS has not historically been viewed as an authoritative source of information about coverage, its recent national estimates of people without coverage have tracked reasonably well to Census data. In 2011 and 2012, the BRFSS found that 21.3 and 20.4 of 18-64 year olds lacked insurance coverage compared to rates of 21.2 and 21.0 from the CPS ASEC over the same period.[19] Data from BRFSS for 2014 are expected to be released in mid-2015 and should be a source of information about whether the number of people without coverage declined. BRFSS is designed to support state estimates, and with its large sample size, will be the first available information about changes in the number of adults with coverage at the state level.

Annual Social and Economic Supplement

Another large survey that is often a source of health coverage estimates is Annual Social and Economic Supplement (ASEC) to the Current Population Survey (often referred to as the "CPS"), which provides socioeconomic and demographic information, including health coverage status, for the non-institutionalized U.S. population. The CPS ASEC interviews over 85,000 households each year during the months of February, March or April, with findings and data released in September of the same year. The CPS ASEC is the most widely-used source for counts of the uninsured because it is timely, supports both national and state-level estimates, and provides detailed information on insurance coverage, income, employment, and other personal characteristics. The health coverage questions on the CPS ASEC have historically asked respondents whether they had coverage in the previous year, the source of that coverage (e.g., through an employer, a public program, or purchased directly), and whether individuals are covered in their own name or as a dependent on someone else's policy. Although widely used, the Census Bureau acknowledges that health coverage is underreported in the survey. Technically, the CPS ASEC asks about coverage in the previous calendar year from the date of the interview, and the number of uninsured reported through the CPS ASEC represents those who

were uninsured for all of the previous year. However, researchers believe that many people may instead report their coverage status at the time of the interview rather than for the previous year.[20]

Changes to the 2014 CPS ASEC survey (which will reflect data for 2013) should greatly reduce this confusion and provide much better information about health coverage. However, this improvement will both cause a one-time delay of the release of the full survey results and create a break in the trend of health insurance questions from the 2013 CPS ASEC (which reflects data for calendar year 2012). Previously, respondents were asked, for each major type of health insurance, whether or not they were covered at any time during the previous year by that type of coverage. Respondents who said no for each coverage type were subsequently asked to verify that they were not covered by any type of insurance. Starting with the 2014 survey, the survey asks respondents about their coverage at the time of the interview (February, March or April of 2014) and then asks additional questions about coverage in each month from the date of the interview back to January of 2013. This approach should provide clearer information about the type of coverage people have at each point in time and new information about how people's coverage changes over the course of a year. In addition, the survey asks specifically about enrollment through Marketplaces and whether the premium for the coverage is subsidized based on family income. Other new questions ask respondents who are working but do not report having employment-based coverage whether their employer offers health insurance, whether they are eligible, and why they did not enroll.

Because of these and other changes to the survey[21], the 2014 CPS ASEC results will be released in three stages. The Fall 2014 release will report on coverage in 2013 and provide information similar to prior releases, looking at whether or not respondents had a type of coverage in 2013 or had no coverage. Information from the new questions, including coverage at the time of the interview and information about coverage in each month in 2013, will be released sometime in 2015, after the Census Bureau has time to analyze the results but before the complete 2015 CPS ASEC release in September of 2015. When available, the information from these new questions will allow analysis of how coverage during the first few months of 2014 compared to coverage by month in 2013, including providing estimates of those newly insured and those changing the type of coverage that they have. The survey is large enough to support some analyses at the state-level and by other subgroups like income category.

There will be some reasons for caution, however. Because many of the interviews will have been conducted before the formal open enrollment period ended on March 31, the survey will not capture the full effect of open enrollment. Further, it is unclear how people who were in the process of signing up for coverage at the time of the interview will answer the coverage question. For example, will people who have picked a plan but where coverage is effective the following month say that they were covered by the plan or say that they were uninsured at the time of the interview? Also, given the new question format, reported enrollment patterns may differ from those that we have previously seen from this survey. It is also unclear how consistent respondents

will be in reporting coverage at the time of the interview versus recalling how they were covered in each month of the previous year.

The 2015 CPS ASEC should be released in the Fall of 2015 and will have coverage information at the point of the interview (February, March and April) in 2015 and for each month of 2014. This release will provide a current insurance estimate following the close of the 2015 open enrollment period (November 15, 2014 through February 15, 2015) as well as monthly coverage estimates for the entire 2014 calendar year. If the Census Bureau does not make additional changes to the questionnaire, the health insurance categories should trend cleanly across the 2014 and 2015 CPS ASEC data sets, providing information on how people were covered before and after implementation of the ACA.

One aspect that will be missing from the CPS ASEC (and which will be supplied by SIPP, discussed below), will be the ability to fully tie coverage in 2014 to coverage status in the previous year for a given individual. While the 2015 CPS ASEC will have information about coverage changes throughout 2014, information on respondents' coverage status in 2013 will not be available. Thus, for many who gained coverage in 2014, we will be unable to ascertain whether they are newly-insured or whether they switched their coverage type. While the 2014 CPS ASEC will allow us to connect coverage in 2013 to the first few months of 2014, many people in the survey will have been interviewed prior to the close of open enrollment (March 31, 2014); thus, it will be difficult to measure the immediate effect of the availability of coverage in January 2014.

In general, the change in the health insurance questions in the CPS ASEC will allow for fuller and more precise estimates of the effect of the ACA. At the same time, because of the timing of the changes to the CPS ASEC, there will be no way to compare coverage at the time of interviews in 2014 to any previous year and no way to look at trends leading up to the first year of new coverage options under the ACA.

Survey of Income and Program Participation

The Survey of Income and Program Participation (SIPP) is another federal survey often used for coverage estimates. SIPP is a panel survey that follows a sample of households over a period of years. For previous panels, respondents were interviewed three times each year for several years (the panels vary in duration). SIPP collects detailed health coverage, income, employment and demographic information on a monthly basis, which can be used to analyze changes in circumstances for people and families with different types of coverage. The SIPP 2008 Panel started with more than 40,000 eligible households and ended in 2013.

The approach for the SIPP 2014 Panel has been revised so that households are contacted just once annually to collect information about the previous year and the current year up to the time of the interview. Specifically, respondents are being contacted between February and May of 2014 to collect monthly information, including health coverage, for the interview month and for the previous months all the way back to January of 2013. The initial release (the first wave) of the SIPP 2014 Panel will have monthly information for entire 2013 calendar

year and will be released in the Spring of 2015. This release is not expected to include any information about coverage in 2014. Interviews for the SIPP 2014 Panel's *second wave* should begin early in 2015 and collect monthly information from the same panel of households for each month during the 2014 calendar year. Data for this second wave should be released by the Spring of 2016, and with this release, it will be possible to analyze monthly coverage information for panel households from January of 2013 through December of 2014, which is the year prior to the first open enrollment period and the first year under the new coverage provisions. These data should provide a comprehensive picture of how coverage changed during the first full year of implementation. SIPP is large enough to support analysis of about half of all states and many other subgroups. The Census Bureau expects to release the third wave of this panel by early 2017 - about one year after the second wave - allowing for detailed exploration of coverage dynamics over the period of January of 2013 through December 2015.

Although there is high demand to know the immediate coverage impacts of the ACA, it is likely that the ultimate coverage changes will play out over a longer period of time as people become more familiar with new options for coverage and as employers revise their plans to accommodate new responsibilities and coverage alternatives. Over time, SIPP will likely be the best source of information to analyze those dynamics nationally, though its limited ability to permit analysis at the state level may restrict its usefulness given how much of the ACA is implemented as the state level.

American Community Survey

Another federal survey that has information on health insurance is the American Community Survey (ACS). This survey originated as a replacement for the long-form of the US Decennial Census and is distributed to one percent of the entire United States population every year. Its very large sample size allows for coverage estimates for very small geographic areas. However, because it has fewer health insurance questions and collects less information than other surveys on family income and structure, it has limited usefulness for national estimates of health insurance coverage. Comparing the 2012 ACS to the 2012 CPS, the two surveys find the nationwide uninsured rate to be about half a percentage point apart (14.8 and 15.4, respectively).

Though it has been in existence since as far back as 1996, the modern ACS only began asking a series of health insurance questions in 2008. While the Census Bureau expects to test new questions collecting ACA Marketplace-related information in the future, there is not currently any timeframe for making changes to the instrument; the health insurance questions currently in the field for the 2014 survey have the exact same structure as they've had since 2008. The Census Bureau generally releases the single-year file about one year after the completion of data collection, so the single-year 2013 ACS should be released in December of 2014 and the single-year 2014 ACS should be released in December of 2015.

CONCLUSION

The ACA includes provisions to address cost, quality, and access of health insurance coverage, and the expansion of health coverage to more Americans is a core goal of the law. Thus, a key measure of success of the ACA is whether the number of uninsured Americans drops. While that outcome seems like a relatively straightforward metric, it will in fact be surprisingly difficult to evaluate.

Early results from polls and surveys by private organizations – Gallup, the Urban Institute, and RAND – show clearly that the number of people uninsured nationally is falling as the ACA goes fully into effect. However, these polls are limited in their ability to precisely estimate the magnitude of the change and discern shifts among different types of coverage. They generally lack the sample size of large, federal surveys and therefore have substantial margins of error and generally do not support state-level analysis. And they are not able to collect as much detailed information on health insurance coverage of demographic groups as the significantly more resource-intensive surveys that often use in-person interviews.

Federal surveys also have their limitations, and in many cases these data sources will not be available for quite some time. For example, the CPS ASEC survey – the most widely-cited source for tabulations of the uninsured – is in the field February, March, and April and has historically asked respondents if they were uninsured for all of the entire previous year. However, researchers have long believed that many people respond to the CPS ASEC based on their insurance status at a point in time instead. The 2014 survey was changed to make the questions more precise, asking about insurance in the previous year as well as at the time of the interview. This will allow for a much better assessment of the effects of the ACA – permitting a comparison of the number of uninsured in 2013 vs. 2014 – but the initial release of this data will not be available until Spring of 2015. And because many of the interviews were completed while open enrollment was still in process, the 2014 survey will not reflect the surge of enrollment in late March.

Other federal survey data that can be used to evaluate the effects of the ACA will be available earlier. First quarter early release results from the NHIS should be available by September of 2014, though it too will not fully reflect the open enrollment period. NHIS results from the first half of 2014 (expected in December) will allow for a fuller assessment of coverage obtained during open enrollment, but even that will not account for Medicaid signups that can occur throughout the year.

A more complete picture of coverage under the ACA will start to emerge in June 2015, when NHIS insurance coverage data for all of 2013 and 2014 will be available. In September 2015 CPS ASEC coverage data for 2013, 2014, and early 2015 will be released (including information by state). By the end of 2015, ACS data will be released, allowing for coverage comparisons with larger sample sizes at the state level. And, by Spring of 2016, SIPP data for 2013 and 2014 will become available, which will permit tracking of coverage changes for the same individuals over time.

A complete understanding of the first year of full ACA implementation will require triangulating across many data sources. Administrative data sources will provide some information, but they have significant limitations. Private polls will provide the earliest look at overall coverage changes, but data from larger and more comprehensive federal surveys – which in many cases will not be available until well into 2015 – will be needed to precisely estimate the change in the number of uninsured, shifts across different types of coverage, the demographics of those who have signed up and those who remain uninsured, and trends by state. Even then, it will be difficult to sort out which changes in insurance coverage are due to the ACA and which would have occurred regardless amidst an improving economy. Just as the coverage changes under the ACA will take several years to fully roll out, it will also take time to capture the full effect of the law. In the meantime, efforts to quantify the impact of coverage expansions on individuals will be key to gauging the law's success.

This Data Note was Prepared by Gary Claxton, Larry Levitt, Mollyann Brodie, and Rachel Garfield from the Kaiser Family Foundation, along with Anthony Damico, an independent consultant.

Table 3: Relevant Release Dates

Expected Release Year	Approximate Release Month	Survey Name	Basic Release Description	Interviews for Health Insurance Coverage Over Period Of…	Approximate Sample Size	Survey Agency
2014	September	NHIS	Preliminary Q1 Data	At Time of Interview: January - March 2014, with some prior coverage questions. Difficult to interpret due to ongoing open enrollment.	25,000	CDC
2014	September	CPS-ASEC	5/8ths of Responding Households, Limited Insurance Coverage Information	Any Insurance in 2013, but respondents thought to answer "At Time of Interview"	125,000	Census Bureau
2014	December	NHIS	Preliminary Q2 Data	At Time of Interview: January - June 2014, with some prior coverage questions. Only latter half of interviews may be valid, since the first half occurred during open enrollment.	50,000	CDC
2014	December	ACS	Main 2013 Public-Use File	At Time of Written Response: Health Insurance Coverage Type Questionnaires mailed throughout the year.	3,000,000	Census Bureau
2015	Spring	CPS-ASEC	All Responding Households, Limited Insurance Coverage Information	Any Insurance in 2013, but respondents thought to answer "At Time of Interview"	200,000	Census Bureau
2015	March	NHIS	Preliminary Q3 Data	At Time of Interview: January - September 2014, with some prior coverage questions.	75,000	CDC
2015	Spring	SIPP	Panel Wave 1	Monthly: January 2013 until December 2013	75,000	Census Bureau
2015	Summer	CPS-ASEC	All Responding Households, New Insurance Coverage Definitions	Monthly: January 2013 until Month of Interview in Early 2014	200,000	Census Bureau
2015	Summer	BRFSS	Main 2014 Public-Use File	At Time of Interview: January - December 2014	500,000	CDC
2015	June	NHIS	Main 2014 Public-Use File	At Time of Interview: January - December 2014, with some prior coverage questions	100,000	CDC
2015	August	NHIS	2014 Imputed Income File	At Time of Interview: January - December 2014, with some prior coverage questions	100,000	CDC
2015	September	CPS-ASEC	All Responding Households, New Insurance Coverage Definitions	Monthly: January 2014 until Month of Interview in Early 2015	200,000	Census Bureau
2015	December	ACS	Main 2014 Public-Use File	At Time of Written Response: Health Insurance Coverage Type Questionnaires mailed throughout the year.	3,000,000	Census Bureau
2016	Spring	SIPP	Panel Wave 2	Monthly: January 2013 until December 2014	60,000	Census Bureau
2016	September	CPS-ASEC	All Responding Households, New Insurance Coverage Definitions	Monthly: January 2015 until Month of Interview in Early 2016	200,000	Census Bureau
2016	September	MEPS	2014 Consolidated File	Monthly: January 2014 until December 2014. Prior point-in-time coverage can be merged from NHIS 2012 and MEPS 2013.	35,000	AHRQ
2016	October	MEPS	2013 - 2014 Longitudinal File	Monthly: January 2013 until December 2014. Prior point-in-time coverage questions can be merged from NHIS 2012.	10,000	AHRQ
2017	Spring	SIPP	Panel Wave 3	Monthly: January 2013 until December 2015	50,000	Census Bureau
2017	September	MEPS	2015 Consolidated File	Monthly: January 2015 until December 2015. Prior point-in-time coverage can be merged from NHIS 2013 and MEPS 2014.	35,000	AHRQ
2017	October	MEPS	2014 - 2015 Longitudinal File	Monthly: January 2014 until December 2015. Prior point-in-time coverage questions can be merged from NHIS 2013.	10,000	AHRQ

[1] Pascale, Joanne. “Findings from a Pretest of a New Approach to Measuring Health Insurance in the Current Population Survey.” Statistical Research Division, U.S. Census Bureau, Nov. 16, 2009. See page 10, http://www.census.gov/srd/papers/pdf/rsm2009-07.pdf.
[2] Brault, Matthew; Medalia Carla; O'Hara, Brett; Rodean, Jonathan; and Steinweg, Amy. "Changing the CPS Health Insurance Questions And The Implications On The Uninsured Rate: Redesign and Production Estimates." U.S. Census Bureau, Feb. 3, 2014. www.census.gov/hhes/www/hlthins/publications/sehsd_wp_2014-16.pdf.
[3] Claxton, Gary; Levitt, Larry; Damico, Anthony; and Rae, Matthew. “Data Note: How Many People Have Nongroup Health Insurance?” Kaiser Family Foundation, Jan. 3, 2014. http://www.kff.org/private-insurance/issue-brief/how-many-people-have-nongroup-health-insurance/.
[4] “Data Note: Attempting to Measure Early Impact of the ACA through National Public Opinion Polls- A Note of Caution and What to Watch For”. Kaiser Family Foundation, Nov. 22, 2013. http://kff.org/health-reform/poll-finding/data-note-measuring-aca-early-impact-through-national-polls/.
[5] Levy, Jenna. “In U.S., Uninsured Rate Lowest Since 2008.” Gallup, Inc, Apr. 7, 2014. http://www.gallup.com/poll/168248/uninsured-rate-lowest-2008.aspx.
Witters, Dan. "Uninsured Rate Drops More in States Embracing Health Law.” Gallup, Inc, Apr. 16, 2014. http://www.gallup.com/poll/168539/uninsured-rates-drop-states-embracing-health-law.aspx.
Carman, Katherine and Eibner, Christine. “Survey Estimates Net Gain of 9.3 Million American Adults with Health Insurance.” The Rand Blog, Rand Corporation, Apr. 8, 2014. http://www.rand.org/blog/2014/04/survey-estimates-net-gain-of-9-3-million-american-adults.html.
Long, Sharon; Kenney, Genevieve; Zuckerman, Stephen; et al. “QuickTake: Number of Uninsured Adults Falls by 5.4 Million since 2013.” Health Reform Monitoring Survey, Urban Institute, Apr. 3, 2014. http://hrms.urban.org/quicktakes/changeInUninsurance.html.
Long, Sharon; Kenney, Genevieve; Zuckerman, Stephen; et al. “Early Estimates Indicate Rapid Increase in Health Insurance Coverage under the ACA: A Promising Star.” Health Reform Monitoring Survey, Urban Institute, Apr. 15, 2014. http://hrms.urban.org/briefs/early-estimates-indicate-rapid-increase.html.
[6] Levy, Jenna. “In U.S., Uninsured Rate Lowest Since 2008.” Gallup, Inc, Apr. 7, 2014. http://www.gallup.com/poll/168248/uninsured-rate-lowest-2008.aspx.
See also: Skopec, Laura; Musco, Thomas; & Sommers, Benjamin. "A potential new data source for assessing the impacts of health reform: Evaluating the Gallup-Healthways Well-Being Index." Healthcare, Mar. 3, 2014.
[7] For more information on HRMS and the methodology behind it, see: http://hrms.urban.org/faq.html.
[8] For more information on the RAND ALP Panel, see: https://mmicdata.rand.org/alp/index.php?page=panel.
[9] Gallup reported reductions in the percentage of adults without insurance between 4th quarter of 2013 and 1st quarter of 2014 of 1.8 percentage points (18-24, 25-34 age groups) and 1.9 percentage points (35-64 age group). See: http://www.gallup.com/poll/168248/uninsured-rate-lowest-2008.aspx.
The HRMS showed a reduction in the percent of adults without health insurance between the 4th quarter of 2013 and 1st quarter of 2014 of 2.3 percentage points. See: http://hrms.urban.org/quicktakes/changeInUninsurance.html.
[10] Gallup finds that 17.1 percent of all adults, including the elderly, lacked health insurance in the 4th quarter of 2013. If there were about 240 million adults, including the elderly in 2013, the number of uninsured adults would be just over 41 million (17.1% of 240 million). Gallup also found that two percent of the elderly were uninsured (2% of 45 million), or 900,000, leaving about 40.1 million uninsured nonelderly adults, or about 20.6 percent of nonelderly adults.
[11] Long, Sharon; Kenney, Genevieve; Zuckerman, Stephen; et al. “QuickTake: Number of Uninsured Adults Falls by 5.4 Million since 2013.” Health Reform Monitoring Survey, Urban Institute. http://hrms.urban.org/quicktakes/changeInUninsurance.html.
[12] Levy, Jenna. “In U.S., Uninsured Rate Lowest Since 2008.” Gallup, Inc, Apr. 7, 2014. http://www.gallup.com/poll/168248/uninsured-rate-lowest-2008.aspx.
[13] Rand found an increase in the percent of adults with employer-based insurance of 8.2 percentage points between September, 2013 and March, 2014. See page 3, http://www.rand.org/content/dam/rand/pubs/research_reports/RR600/RR656/RAND_RR656.pdf. Gallup found that the percent of adults with insurance who received their insurance through a current or former employer fell by about 2 percentage points between the 4th quarter of 2013 and the end of February, 2014. However, because the percentage of people with insurance increased over that period, the change is fairly small. See: http://www.gallup.com/poll/167798/uninsured-rate-continues-fall.aspx.
[14] For example, see Brault, Matthew; Medalia Carla; O'Hara, Brett; Rodean, Jonathan; and Steinweg, Amy. "Changing the CPS Health Insurance Questions And The Implications On The Uninsured Rate: Redesign and Production Estimates." U.S. Census Bureau, Feb. 3, 2014. www.census.gov/hhes/www/hlthins/publications/sehsd_wp_2014-16.pdf.

[15] For more information on NHIS data collection procedures, see: http://www.cdc.gov/nchs/nhis/about_nhis.htm#procedures.
[16] For more information, see page 8: http://www.cdc.gov/nchs/data/nhis/earlyrelease/microdata201403.pdf.
[17] See http://www.cdc.gov/chronicdisease/resources/publications/AAG/brfss.htm.
[18] In fact, the main health insurance question - *Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare, or Indian Health Service?* - does not even distinguish public from private insurance.
[19] DeNavas-Walt, Carmen; Proctor, Bernadette and Smith, Jessica. “Income, Poverty, and Health Insurance Coverage in the United States: 2012.” Current Population Reports, Sept. 2013. See Table 7, http://www.census.gov/prod/2013pubs/p60-245.pdf.
[20] DeNavas-Walt, Carmen; Proctor, Bernadette and Smith, Jessica. “Income, Poverty, and Health Insurance Coverage in the United States: 2012.” Current Population Reports, Sept. 2013. http://www.census.gov/prod/2013pubs/p60-245.pdf.
[21] The September 2014 release of the CPS will comprise a 5/8ths file using an income collection methodology consistent with prior definitions. At a later date, the remaining 3/8ths file (using a new methodology, expected to be comparable and trendable) will be released. More detail about this change can be found at: http://www.copafs.org/UserFiles/file/fcsm/H3_Semega_2013FCSM.pdf.

Small Businesses and Health Reform:

Results From a Survey of Five States

Catherine McLaughlin and Adam Swinburn, April 2014

Small businesses, especially those with fewer than 25 employees, are less likely than larger businesses to offer health insurance to their workers, often citing high premiums as the main barrier. Increasing the percentage of small businesses that do offer coverage is a focus of the Affordable Care Act (ACA). Businesses with 50 or fewer full-time-equivalent (FTE) employees are exempt from the employer mandate, a provision of the ACA that requires larger businesses to provide coverage, but there are several provisions in the act designed to reduce the cost of providing coverage or otherwise add value. One provision is a tax credit for firms (1) that have 25 or fewer FTEs with average wages of less than $50,000 and (2) that pay at least half the cost of single coverage for their employees. Another is the Small Business Health Options Program (SHOP), designed to offer new coverage choices to small businesses with up to 50 FTEs and their employees, providing them with side-by-side comparisons of health plans that offer a minimum set of benefits and a premium lower than commonly available.

To gain insight into the early and likely future effects of the ACA on small businesses, Mathematica Policy Research conducted the Small Business Health Insurance Survey, an online and telephone survey that took place from November 2012 to September 2013. The survey was administered in 5 of the 11 states in the Robert Wood Johnson Foundation's State Health Reform Assistance Network: Alabama, Colorado, Minnesota, New York, and Oregon. These states used a range of strategies to implement the ACA; combined with our survey results, these strategies provide a valuable window into how the ACA has already affected small businesses and give us a baseline to compare with future impacts.

Data

We randomly selected small employers of various sizes (between 3 and 100 employees) in each state from a sample provided by Dun & Bradstreet. We weighted the responses in each state to reflect the population of businesses in each size category and to account for potential nonrandom response to the survey (Table 1). Our response rate was 46 percent.

Table 1. Unweighted and Weighted Sample Sizes, by State

State	Unweighted Sample Size	Weighted Sample Size
Alabama	135	31,945
Colorado	131	38,009
Minnesota	163	39,529
New York	110	140,946
Oregon	168	37,948

Which Small Businesses Offer Coverage?

We asked employers key questions about their employees, including the numbers of full-time and part-time employees, employees younger than 26 or older than 49, and employees earning less than $50,000. Small businesses in Minnesota and New York had the highest shares of part-time workers across the five states (Table 2). On average, small firms in Colorado and New York had the smallest percentage of older employees, compared with firms in the other states, whereas Alabama had the largest percentage of employees earning less than $50,000. We also asked employers whether they offered any kind of health insurance and, if so, whether they self-insured or had a plan underwritten by an insurer. New York had the largest percentage of firms that self-insure; Colorado had the smallest (Table 2).

Table 2. Descriptive Statistics for Employers With 3 to 100 Employees, by State

State	Percentage Offering Health Insurance	Percentage That Self-Insure	Average Percentage of Employees Who:			
			Work Part Time[a]	Are Less Than 26 Years Old	Are More Than 49 Years Old[b]	Earn Less Than $50,000 a year[c]
Alabama	64%	9%	20%	13%	29%	85%
Colorado	58%	5%	24%	20%	25%	76%
Minnesota	67%	7%	42%	13%	34%	68%
New York	63%	21%	38%	25%	25%	65%
Oregon	56%	13%	25%	16%	34%	75%

Source: Mathematica calculations based on data from the Small Business Health Insurance Survey.
[a] The percentage of part-time workers is significantly higher among small businesses in Minnesota and New York than in Alabama, Colorado, and Oregon, at $p < 0.05$.
[b] Employers in Colorado have significantly lower shares of older employees compared with Minnesota, at $p < 0.1$.
[c] The percentage of low-wage workers is significantly higher in Alabama than in Minnesota and New York, at $p < 0.1$.

In general, the percentage of employers offering health insurance grew as firm size increased. In all five states, about half of the smallest firms—those with 3 to 9 employees—offered coverage, compared with more than 90 percent of those with 50 to 100 employees (Table 3). The relationship between firm size and the likelihood of offering coverage varied across the states, however. In Alabama and New York, this likelihood was significantly greater among firms with 10 to 24 staff compared to those with fewer staff, whereas in Colorado and Oregon, the biggest difference was between firms with 10 to 24 staff and those with 25 to 49 staff. In Minnesota, there was a steady increase from the smallest to the biggest firm (Table 3).

Table 3. Percentage of Employers Offering Health Insurance in Each State, by Firm Size

	Number of Employees			
State	3 to 9[a]	10 to 24	25 to 49[b]	50 to 100
Alabama	52%	81%	93%	99%
Colorado	50%	58%	94%	99%
Minnesota	55%	76%	85%	92%
New York	48%	81%	93%	97%
Oregon	51%	54%	86%	92%

Source: Mathematica calculations based on data from the Small Business Health Insurance Survey.
[a] Difference in percentage between 3-9 category and 10-24 category in Alabama is statistically significant at $p < 0.05$. Difference in percentage between 3-9 category and 10-24 category in New York is statistically significant at $p < 0.1$.
[b] Difference in percentage between 10-24 category and 25-49 category in Colorado is statistically significant at $p < 0.1$. Difference in percentage between 10-24 category and 25-49 category in Oregon is statistically significant at $p < 0.1$.

Why Do Some Small Businesses Not Offer Coverage?

For businesses that decided not to offer health coverage, we asked about their reasons for that decision and which of those reasons was most important. Cost was a major barrier; in every state, the most important reason for not offering coverage was that the business could not afford to (Table 4). In Colorado, however, the perception that employees do not want or need employer-sponsored insurance was mentioned almost as frequently as cost (43 percent versus 49 percent), and it was also mentioned by more than a quarter of respondents in New York. On the other hand, employers in Alabama were most likely to say that offering insurance was not their responsibility than to respond that employees do not want or need it (17 percent versus 6 percent).

Several ACA provisions are designed to address these concerns, in part by lowering the cost of offering coverage to employees. Other provisions (such as the establishment of individual exchanges, Medicaid expansion, and the availability of subsidies to individuals) may affect whether small business employees want or need insurance through their employers.

Table 4. Most Important Reason Cited for Not Offering Health Insurance, by Percentage of Small Businesses in Each State

State	Business Cannot Currently Afford It	Employees Do Not Want or Need It[a]	Not My Responsibility to Provide This Benefit	Other
Alabama	74%	6%	17%	3%
Colorado	49%	43%	5%	3%
Minnesota	59%	9%	6%	25%
New York	71%	26%	0%	3%
Oregon	70%	16%	1%	14%

Source: Mathematica calculations based on data from the Small Business Health Insurance Survey.
[a] Percentage of employers not offering coverage because they say their employees do not want or need it is significantly higher in Colorado than in Minnesota or Alabama, at $p < 0.1$.

Early Effects of the ACA

Employers who offer coverage were asked a number of questions about changes they made in response to the ACA provisions. For example, we asked whether any adult children who would not have been eligible for coverage before the ACA had since been enrolled in the employer's plans. The percentage of employers answering yes ranged from 8 percent in Oregon to 28 percent in New York (Table 5).

Table 5. Post-ACA Changes in the Provision of Health Insurance Among Small Businesses

	Percentage of Small Businesses That:			
State	Enrolled Adult Children Not Previously Eligible[a]	Changed Cost-Sharing Provisions for Preventive Care	Revised List of Preventive Care Services Covered	Considered Rules Limiting Changes in Grandfathered Plans When Deciding Whether to Renew Plan[b]
Alabama	16%	1%	27%	40%
Colorado	12%	5%	20%	34%
Minnesota	17%	4%	21%	34%
New York	28%	4%	14%	28%
Oregon	8%	3%	20%	17%

Source: Mathematica calculations based on data from the Small Business Health Insurance Survey.
[a] Among employers offering health insurance, the percentage that have enrolled adult children is significantly lower in Oregon than in New York and Minnesota, at $p < 0.1$.
[b] Among employers offering health insurance and reporting that ACA requirements for grandfathered plans affected their renewal decisions, the percentage is significantly lower in Oregon than in Alabama and Minnesota, at $p < 0.1$.

We also asked employers whether they had changed the cost-sharing provisions for preventive services or the list of services covered as a result of the ACA. While few changed cost-sharing, the percentage that revised what preventive services were included ranged from 14 percent in New York to 27 percent in Alabama (Table 5). We read employers a short description of a "grandfathered health plan," which is a plan in effect on March 23, 2010, with no significant benefit reductions or cost-sharing increases since that time. We then asked whether rules relating to grandfathered health plans had affected their decision to renew a plan. Most small businesses, particularly those in Oregon, had not taken these provisions into account in renewal decisions.

In addition, we asked employers who had responded that they were at least a little familiar with the health insurance tax credit for small businesses about whether they had applied for this credit in 2010 or 2011 and, if so, whether their claim was successful (Table 6). Small businesses in Alabama were most likely to apply for the tax credit, but least likely to receive it (Table 6). We do not know why they were not successful—whether they had more than 25 FTEs, had an average salary above $50,000, or did not pay for at least half of the cost of single coverage. We do know that, across the five states, virtually all of the firms that applied offered coverage in the current year. We also asked employers that offered coverage whether they started offering it in the previous year because of the tax credit. This appeared to be the case for only a few businesses.

Table 6. Percentage of Small Businesses Applying for and Receiving a Health Insurance Tax Credit

State	Applied for Tax Credit[a]	Application for Tax Credit Successful
Alabama	36%	69%
Colorado	21%	77%
Minnesota	18%	97%
New York	23%	99%
Oregon	9%	74%

Source: Mathematica calculations based on data from the Small Business Health Insurance Survey.
[a] Percentage that applied for a tax credit is significantly different between Oregon and Alabama at $p < 0.05$.

Awareness of and Reactions to Small Business Provisions in the ACA

We asked all employers, "What is your general impression of the health care reform law passed by Congress in March 2010, known as the Affordable Care Act or Obamacare?" Across all five states, employers in Alabama (the only state in our survey not establishing its own SHOP or individual marketplace) were the least likely to approve of the ACA: only 15 percent had a positive view of the act, compared with 48 percent in both Colorado and Minnesota (Table 7). In all five states, views of the ACA were more positive among employers that were aware of any provisions that could help small businesses, which could include either those targeted specifically at this population, such as the small business tax credit, or those more likely to affect small businesses than large businesses, such as the switch to community rating. Compared with employers that were not familiar with the tax credit or the SHOP, those that were familiar were also more likely to approve of the ACA, but only in Oregon was the difference statistically significant (Table 7).

Table 7. Percentage of Employers With a Positive View of the ACA

State	Overall[a]	Among Those Who Are:		
		Aware of Any Small Business Provisions[b]	At Least a Little Familiar With Small Business Tax Credits[c]	At Least a Little Familiar With SHOP Exchanges[d]
Alabama	15%	31%	12%	13%
Colorado	48%	49%	50%	41%
Minnesota	48%	57%	46%	53%
New York	42%	49%	52%	27%
Oregon	35%	66%	43%	58%

Source: Mathematica calculations based on data from the Small Business Health Insurance Survey.
[a] Percentage in Alabama with a positive view was significantly less than in other states, at $p < 0.05$.
[b] Percentage of those in Alabama and Oregon that were aware of any small business provisions and that had a positive view was significantly higher than the percentage that were not aware and had a positive view (31 versus 11 percent in Alabama and 66 versus 20 percent in Oregon), $p < 0.1$.
[c] Small businesses in Oregon that were at least a little familiar with small business tax credits were significantly more likely to have a positive view of the ACA (43 percent) than those that were unfamiliar (20 percent), $p < 0.05$.
[d] Small businesses in Oregon that were at least a little familiar with the SHOP exchange were more likely to have a positive view of the ACA (58 percent) than those that were unfamiliar (21 percent), $p < 0.05$.

Small business tax credit. We asked employers whether they knew about the small business tax credit in the ACA. Most employers in each state had at least heard of it. In Minnesota, employers that offered health insurance were significantly more likely to be at least a little aware of the credit, compared with those that did not offer insurance (Table 8).

We asked employers that knew about the tax credit whether they would apply for it in the future; those in Alabama were much more likely to say yes than those in Minnesota and Oregon. For employers unfamiliar with the credit, we read a brief description of the provision and asked them whether knowing this information made them more likely to apply for the credit in the future. In general, employers currently offering coverage said they were likely to apply for the tax credit after hearing this description, particularly in Alabama, Minnesota, and Oregon (Table 8).

Employers were also asked, "If [your business] qualified for this tax credit, how would it affect whether [your business] provided health benefits in the future?" The majority, in some cases more than three out of four respondents, replied that this would make them more likely to offer benefits (Table 8).

Table 8. Attitudes Toward the Tax Credit Among Small Businesses That Do and Do Not Currently Offer Health Insurance

State	Currently Offer Health Insurance	At Least a Little Familiar With Tax Credit[a]	Likely to Apply for Tax Credit, Among Those Familiar With It	Likely to Apply for Tax Credit After Hearing Description of It[b]	More Likely to Offer Health Insurance if Eligible for Tax Credit
Alabama	Yes	73%	85%	65%	73%
	No	56%	90%	25%	72%
Colorado	Yes	83%	72%	46%	83%
	No	79%	60%	63%	89%
Minnesota	Yes	79%	61%	58%	78%
	No	46%	15%	18%	55%
New York	Yes	31%	76%	53%	76%
	No	63%	11%	36%	54%
Oregon	Yes	76%	67%	64%	72%
	No	65%	43%	13%	72%

Source: Mathematica calculations based on data from the Small Business Health Insurance Survey.
[a] Difference in percentages between those that do and don't offer in Minnesota is statistically significant at $p < 0.1$.
[b] Differences in percentages between those that offer and don't offer in Alabama, Minnesota and Oregon are statistically significant at $p < 0.1$.

Table 9. Attitudes Toward SHOP Exchanges Among Small Businesses That Do and Do Not Offer Health Insurance

State	Currently Offer Health Insurance	Percentage at Least a Little Familiar With the SHOP	Percentage That Will Definitely or Probably Use the SHOP[a]	Percentage More Likely to Offer Health Insurance as a Result of the SHOP[b]
Alabama	Yes	37%	32%	11%
	No	33%	18%	32%
Colorado	Yes	45%	47%	19%
	No	31%	60%	78%
Minnesota	Yes	62%	38%	19%
	No	31%	16%	18%
New York	Yes	38%	46%	9%
	No	7%	69%	70%
Oregon	Yes	37%	44%	28%
	No	37%	32%	22%

Source: Mathematica calculations based on data from the Small Business Health Insurance Survey.
[a] Difference in percentages among those that do and don't offer in Minnesota is statistically significant at $p < 0.05$.
[b] Difference in percentages among those that offer and don't offer in Colorado is statistically significant at $p < 0.01$. Difference in percentages among those that offer and don't offer in Alabama is statistically significant at $p < 0.1$.

SHOP exchanges. Compared with the tax credit, awareness of the SHOP was low; in all states except Minnesota, less than half of employers were familiar with SHOP exchanges (Table 9). In New York, those offering health insurance were significantly more likely than other firms to be at least a little familiar with the program. Those that were not familiar were read a brief description of the program. We asked all employers whether they would take part in the SHOP in their state and whether the SHOP would motivate them to provide health benefits (Table 9). Small businesses in Colorado and New York were more likely to say they would participate, compared with Alabama and Minnesota. In Alabama, Colorado, and New York, businesses that did not offer health insurance were more likely than those that offered coverage to say that the SHOP would increase the likelihood that they will offer coverage in the future (Table 9).

Conclusions

Several ACA provisions are designed to help small businesses offer health insurance to their employees, often by directly or indirectly reducing the costs of providing coverage. This is crucial given that affordability is the biggest barrier to offering coverage among the small businesses we surveyed. However, many small businesses were not aware of these provisions; for example, only one in four employers in New York and one in three employers in Alabama, Colorado, and Oregon had heard of the SHOP. Noticeably more had heard of the small business tax credit, ranging from a low of 51 percent in New York to a high of 81 percent in Colorado; however, when asked whether they were aware of any provisions of the health care reform law that would help small business owners provide insurance, only 11 percent of employers in New York said yes, as did only 53 percent in Colorado.

The ACA provisions were ostensibly targeted to small businesses not currently offering health insurance, but these businesses were even less aware of the provisions than other small businesses. However, after they heard a brief description of the tax credit, many firms not offering coverage indicated that they would apply for the credit. This, and the fact that eligibility for the credit increased the likelihood that a firm would offer health insurance in the future, highlights the importance of raising awareness. We saw similar results after reading a description of the SHOP aloud and then asking employers if they would take part in an exchange (eligibility for the SHOP also increased a firm's likelihood of eventually offering health insurance).

Employers' views of the ACA also varied based on their state and degree of familiarity with the act, suggesting some states have more work to do than others if they wish to persuade employers of the potential benefits of health reform.

About Mathematica Policy Research

Mathematica Policy Research is dedicated to improving public well-being by bringing the highest standards of quality, objectivity, and excellence to bear on information collection and analysis for our partners and clients. The company has been at the forefront of assessing the effectiveness of policies and programs since 1968.

This study was funded by the Robert Wood Johnson Foundation.

About the Robert Wood Johnson Foundation

For more than 40 years the Robert Wood Johnson Foundation has worked to improve the health and health care of all Americans. We are striving to build a national culture of health that will enable all Americans to live longer, healthier lives now and for generations to come. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.

The Best Evidence Suggests the Effects of the ACA on Employment Will Be Small

Timely Analysis of Immediate Health Policy Issues

April 2014

Bowen Garrett and Robert Kaestner

Summary

A recent report by the Congressional Budget Office (CBO) concluded that the Affordable Care Act (ACA) will reduce the number of people working. Specifically:

> "CBO estimates that the ACA will reduce the total number of hours worked, on net, by about 1.5 percent to 2.0 percent during the period from 2017 to 2024, almost entirely because workers will choose to supply less labor—given the new taxes and other incentives they will face and the financial benefits some will receive."[1]

Much has been made of the CBO report, but as we describe below, the extensive attention to the report's conclusions seems misplaced. Qualitatively, the conclusion reached by the CBO is unsurprising because, as has been documented with similar social programs, reducing the receipt and quantity of low-income benefits as income increases provides an incentive for some people to work less. Also, as the CBO emphasized, nearly all of the employment effect is caused by workers choosing to reduce how much they work and not because employers demand fewer workers. Unemployment—wanting to work but not being able to find a job—will be largely unaffected by the ACA. Moreover, those who decide that not working is better than working because of their greater access to health insurance are made better-off. Quantitatively, even though the CBO revised its initial employment effect estimates upward, its current estimates are still small relative to the overall workforce. At the same time, the revised estimates may be too large given what the recent evidence suggests.

In this report, we place the ACA and its employment effects in the context of other social programs. Second, we assess the evidence on likely employment effects from four recent and directly relevant studies that the CBO used to derive its prediction.

The ACA Is Similar to Other Means-Tested Programs

The ACA is not the first major, public policy to link the receipt and level of benefits to income. In fact there are many such "means-tested" programs. The Supplemental Nutrition Assistance Program (SNAP, formerly the Food Stamp Program) is a well-known program that provides food benefits for families with incomes below 130 percent of the federal poverty level (FPL). SNAP benefits are reduced as family income increases. Other programs that tie benefits to income include Temporary Assistance to Needy Families (TANF, formerly AFDC), the Housing Choice Voucher Program (formerly Section 8), and the Earned Income Tax Credit (EITC).

For each of these programs, research has shown that incentives embedded in the programs affects people's choices about work. In some cases, evidence indicates very large effects (e.g., TANF), while in other cases the evidence indicates little effect (e.g., SNAP).[2] Most of these programs decrease work effort because they provide more resources (e.g., income, food, and housing) to the family that allow them to work less without decreasing their consumption of goods and services, and because they make work less rewarding—greater work effort and income result in reductions in program benefits. However, the incentives in the EITC program causes, on average, people to choose to work more because benefits increase, at least for a while, with greater work effort.[3]

It is instructive to compare the EITC, a universally lauded program, to the ACA expansion of Medicaid to isolate the differences and the similarities between the programs and why one program (EITC) appears to be well liked and the other (ACA) has attracted increased scrutiny following the CBO report. The costs and benefits of the two programs are similar.[4] The EITC will serve approximately twice as many people as the ACA Medicaid expansions, but it provides about half the dollar value of Medicaid benefits. The main difference is that the EITC generates some cost savings because the greater work effort associated with the program increases tax revenue, whereas the expansion of Medicaid will generate some extra costs because some people will work less and reduce tax revenue. However, the Internal Revenue Service (IRS) estimated that approximately $14 billion (25 percent of total expenditures) of EITC credits were fraudulent and a result of the complexity of the EITC. Despite this substantial cost relative to benefit, the EITC is widely believed to be successful because it causes some people to work more, although it also causes some people to work less.

The potential for the ACA to lead to fewer people working is a feature of almost all means-tested programs. In this regard, there is nothing special about the ACA and the adverse employment effects of the ACA are relatively small compared with some other social programs. Given this,

there is no reason to single out the ACA for special scrutiny, as has been done by some policy-makers and advocates. Any effort to provide benefits such as food subsidies, housing subsidies, wage subsidies (as in the EITC), and health insurance to low-income persons will inevitably come with unintended costs. While some program design features can minimize the unintended consequences, there is no feasible way to eliminate them.[5] Those who do not like any means-tested social programs will not like the ACA, but these same people also do not like SNAP, TANF, unemployment insurance, and other hugely valued and important safety net programs. In sum, criticism of the ACA because of small employment effects common to all social programs is largely a straw man.

What Does Recent Evidence Say About the ACA and the Labor Market?

Studies of Changes in State Medicaid Policy

The CBO was charged with the difficult task of making predictions about the future impacts of the ACA on employment when there is relatively little in the past that provides direct guidance. This is why the CBO estimate represents a best estimate instead of a precise prediction, and the CBO report was quite explicit in stating that there is substantial uncertainty as to the accuracy of its estimate.

> "CBO's estimate of the ACA's impact on labor markets is subject to substantial uncertainty, which arises in part because many of the ACA's provisions have never been implemented on such a broad scale and in part because available estimates of many key responses vary considerably."[6]

The CBO study relied on a few recent studies and a larger empirical base of evidence to draw its conclusions. It is worthwhile to review four recent studies that are most relevant and that provide the most direct evidence (i.e., not based on extrapolation from other types of social programs or populations) related to the possible effects of the ACA on the labor market (Table 1).

One of the most important of the recent studies is the analysis of the expansion of Medicaid to adults with incomes below FPL in Oregon in 2008.[7] Notably, the Oregon study was based on an experimental research design, which is generally thought of as the gold standard, in which the option to enroll in Medicaid was determined by lottery (randomly). The affected group in Oregon is very similar to the group affected by the ACA Medicaid expansions, although the ACA income eligibility threshold is somewhat higher (138 percent of FPL) than the threshold in Oregon (100 percent of FPL).

The results of the Oregon study are compelling, not only because of the credibility of the research design, but also because of its findings. Enrolling in Medicaid was associated with very small and statistically insignificant changes in employment and earnings. For example, enrollment in Medicaid was associated with a 1.6 percentage point, or 3 percent, decline in the probability of working, and a $195, or 3 percent, decrease in annual earnings. The change in employment and earnings

Table 1. Recent Studies of Effects of Subsidized Health Insurance on Employment

Study	Method	Main Findings	Quality of Evidence
Oregon Medicaid ("The Impact of Medicaid on Labor Force Activity")	Experimental research design. Compared applicants enrolled and not enrolled as determined by lottery (randomized).	Medicaid enrollment associated with 1.6 percentage point (3%) reduction in employment earnings (not significant) and $195 (3%) decrease in earnings (not significant).	Strong. Direct evidence with compelling design and credible findings.
Wisconsin Medicaid ("The Effect of Public Insurance on the Labor Supply")	Natural experiment from WI instituting enrollment cap/waitlist. Compared Medicaid enrollees to applicants eligible for enrollment but on a waitlist.	Medicaid enrollment associated with a decline in employment between 0.9 and 9.6 percentage points (between 2% and 18%).	Limited. Carefully conducted non-experimental study, but findings sensitive to different methods and samples. Demographics of comparison group differed somewhat from enrollee demographics.
Tennessee Medicaid ("Public Health Insurance")	Natural experiment from TN discontinuing eligibility for uninsurable (sick) population. Changes in employment and health insurance coverage for broad demographic groups before and after policy change in 2005 in TN compared with change in other southern states. Further stratified into household with and without children (difference-in-difference-in-difference).	For childless adults, those with less than high school degree, change in Medicaid policy (disenrollment) associated with 12 percentage point increase in employment (25%). No effect for other education groups. Ages 19–39: no effect. Ages 40–64: 9% increase in employment. Excellent/very good health: no effect. Good/fair/poor health: 8% increase in employment.	Limited. Carefully conducted non-experimental study, but findings sensitive to different methods and samples. Substantial error in the measurement of insurance coverage. Unexplained differences in findings by demographic group.
Massachusetts Health Insurance Reform ("Will Health Reform Lead to Job Loss?")	Natural experiment from MA implementing broad Medicaid expansion and subsidized exchange coverage in 2006. Compared employment before and after 2006 in MA to changes in group of selected comparison states with similar pre-reform trends.	Massachusetts reform had no statistically or economically significant effect on employment in the state. Findings held true for subgroups based on age, industry, and firm size. Health insurance increased in MA relative to comparison states.	Strong. Valid research design with high-quality data. Though work disincentives may be somewhat smaller in MA compared with ACA, expansion of subsidized health insurance in MA was broad-based, so meaningful employment effects should be detectable if they exist.

was small despite Medicaid benefits that constitute a large share of income. Gaining Medicaid coverage can be thought of as an increase in income, because of reduced out-of-pocket expenses and medical debt as a result of being insured. The average earnings of people in the Oregon study were $6,513 in 2009, which is approximately 60 percent of the FPL, and the average annual spending on medical care was $3,156.[8] Thus, obtaining Medicaid coverage represented a 50 percent increase in income. In response to that, employment decreased by only 3 percent.

The small impact in the Oregon study is consistent with much previous evidence.[9] It is interesting to note that the implied income elasticity[10] of this example is roughly -0.06 (=3 percent/50 percent), which is very close to the -0.05 income elasticity used by the CBO in their analysis. Therefore, it is likely that similar changes in resources as a result of gaining health insurance and inexpensive medical care under the ACA will have similarly small effects on people's choices about work.

Another study examined a Medicaid expansion in Wisconsin in 2009 that allowed low-income, childless adults with incomes below 200 percent of the FPL to enroll in Medicaid.[11] However, budgetary considerations prevented the program from meeting demand, and enrollment was capped three months after it started. The capping of enrollment provided a natural experiment to study how enrollment in Medicaid affected employment because people continued to apply for the program and were put on a waitlist. Thus, the authors compared the experience of those enrolled in Medicaid to those eligible for enrollment, but who were on the waitlist. An important limitation of the study is that those enrolled in Medicaid come from a larger pool of applicants who were eligible, applied, and then enrolled. The comparison group consists of those who were eligible and applied, but it is not clear whether they would have enrolled. Consistent with this difference are socioeconomic and demographic differences between the two groups. Those enrolled (treatment group) were older, more likely to be female, less likely to work, and they had lower earnings than those who were eligible and applied (i.e., comparison group).

The results of the Wisconsin study indicate that Medicaid enrollment was associated with a decline in employment of between 2 percent and 18 percent—a large range that reflects the sensitivity of estimates to changes in methods and samples. As noted above, the treatment and comparison groups were not perfectly matched so the "natural" experiment was not a true experiment. Therefore, different statistical methods were used to address likely confounding (bias) and these methods produced estimates that varied widely as described earlier. The wide range of estimates merits concern and is an important consideration when using this study to infer what may happen under ACA expansions of Medicaid.

Notably, the average incomes and employment rates in the Wisconsin sample were quite comparable to those in the Oregon sample. Also, there is overlap in the findings of the two studies, with the low-end of the estimates in Wisconsin (2 percent) being very close to the estimate found in Oregon (3 percent). Moreover, estimates in the upper range of those reported in Dague et al. (2013) are inconsistent with the large literature on the income elasticity of labor supply (McClelland and Mok 2012). While the Wisconsin study was carefully conducted, the non-experimental nature of the study and the potential bias in the analysis and variability of the estimates suggest that less weight should be placed on this study than the Oregon study.

A third study of the effect of a state Medicaid policy on employment focused on Tennessee, which in 2005 ended a policy that allowed any person who was uninsured or "uninsurable" to enroll in Medicaid, regardless of income.[12] As a result, approximately 170,000 people lost Medicaid coverage. Despite having no income eligibility threshold, those who lost Medicaid in Tennessee were thought to be overwhelmingly (93 percent) low-income (less than 200 percent of FPL), and therefore similar to those affected by the Oregon and Wisconsin changes. However, the figures on income and demographic characteristics of those who lost Medicaid are uncertain because they were derived from administrative data from 1995 when the discontinued program was started. There was no similar information on the group affected in 2005 and this group may have been much different than the group that was first enrolled in 1995.[13] If we assume that the income and demographic characteristics of the affected group in 2005 were the same as those in 1995, then the primary difference between the changes in policy between Oregon/Wisconsin and Tennessee was that the Tennessee Medicaid enrollees were selected partly on the basis of health—being uninsurable (sick).

The Tennessee analysis consisted of comparing changes in employment, hours of work, and health insurance coverage of persons in Tennessee before and after the 2005 change in policy to changes in the same outcomes of persons in other southern states (or all other states) before and after the change in policy. In the authors' preferred analyses, the comparison was further stratified into those households with and without children (i.e., difference-in-difference-in-differences).[14] Notably, the analysis did not compare changes in employment and hours of work for groups with and without Medicaid, as in the Oregon and Wisconsin studies, but instead compared changes in outcomes for broader demographic groups (e.g., childless adults, or childless low-educated adults) of whom only a small fraction (e.g., 5 percent) lost Medicaid.

The results from the Tennessee study are mixed (Table 1). For childless adults with less than a high school degree (dropouts), the change in Medicaid policy (disenrollment) was associated with a 25 percent (12 percentage point) increase in employment, but there was no effect for other educational groups.[15] Similarly, among childless adults, the results differed substantially by age group and self-reported health status. The authors can only speculate as to the cause of the heterogeneous results; they point to an unusually high value for health insurance among the relatively sick group of persons ("uninsurable) who were disenrolled in Tennessee that caused them to seek full-time employment with health insurance benefits. However, as described earlier, the

authors do not know that those who were disenrolled were particularly sick because they cannot identify the demographic characteristics of the disenrolled persons. This speculation is based on data from 1995, which may or may not apply ten years after.

Unfortunately, the Tennessee study results are not comparable to those of the Oregon and Wisconsin studies because the Tennessee study did not examine changes in employment for those who were and were not on Medicaid, but rather examined changes of broad demographic groups. To make the results comparable, it is necessary to use the separate estimates of the effect of the policy change on the proportion of each group covered by Medicaid. This raises the question of how Medicaid is measured in the data. Garthwaite et al. (2013) use a measure that they refer to as "public" insurance, which includes Medicare, Medicaid and military coverage. This is, at a minimum, a broad definition of Medicaid. The authors also measured insurance coverage using data from the following year, for example, the insurance coverage of childless adults in Tennessee in 2006 came from data in 2007. The reason for this is that the insurance information in the survey (Current Population Survey) refers to the past year, but researchers have long debated whether this is in fact understood by respondents to the survey, and there is evidence that some portion of respondents refer to their current situation.[16] The upshot is that the insurance status, as measured by Garthwaite et al. (2013), is likely measured with substantial error and estimates of the effect of Medicaid on labor supply that use this measure will reflect this problem.

One can see the importance of how insurance is measured in the range of estimates of the effect of Medicaid on employment reported by Garthwaite et al. (2013). If "public" coverage is used, then the authors reported an estimate indicating that 63 out of every 100 childless adults that lost "public" coverage found employment.[17] This is a stunningly large effect. The effect size gets even larger if only Medicaid coverage is considered. Based on figures reported in the paper, the results imply that 90 out of every 100 childless adults that lost Medicaid found employment.[18] Are the Tennessee estimates plausible? They differ dramatically from estimates in studies of similar changes among similar persons in Wisconsin and Oregon. They also suggest employment responses to changes in income (treating the value of Medicaid as income) that are orders of magnitude larger than anything previously found.[19] This response is 20 to 60 times the size of the normal employment response to similar changes in income (treating the value of Medicaid as income).[20]

The extremely large estimates, along with unexplained heterogeneity of estimates and evidence of a problematic research design, suggest that much caution should be used before taking the results of the Tennessee study literally. While there appeared to be an increase in employment among childless adults associated with the disenrollment of persons from Medicaid in Tennessee, the magnitude of that change and its implications for the ACA are very uncertain. The range of uncertainty of estimates from the Tennessee study can be illustrated by using the confidence intervals of estimates reported in the study.[21] Using various combinations of possible estimates of the change in employment and change in insurance coverage yields potential changes in employment among childless adults in response to the change in Medicaid policy of between 6 and 221 percentage points with the upper range of this interval clearly implausible.

Studies of Massachusetts Reform

Because Massachusetts implemented health care reform in 2006 with many of the same provisions that characterize the ACA, the employment experience before and after the change in policy in Massachusetts provides useful guidance as to possible employment consequences of the ACA. Dubay et al. (2012) compared changes in employment in Massachusetts before and after reform (2006) to changes in employment in a group of comparison states.[22] The study used an innovative statistical matching method to identify comparison states with employment trends very similar to those in Massachusetts in the pre-reform period.[23] The findings are clear. Massachusetts reform substantially increased insurance coverage, but had no statistically or economically significant effect on employment in Massachusetts. This conclusion held for subgroups defined by age, industry, and firm size.

The Massachusetts results imply that the ACA will have similarly minor effects on employment. Mulligan (2013),[24] however, argued that while there are similarities between the Massachusetts reform and the ACA, the degree to which the Massachusetts reform affected incentives to work is much less.[25] Yet the changes in work incentives in both Massachusetts and the ACA are sufficiently similar and the Massachusetts changes are sufficiently sizable in magnitude that, if there were large employment responses to such reforms, we would expect to see some measureable effect in Massachusetts. Instead, data from the best available analog to the ACA suggests its employment effects will be small to none.

Conclusion

There has been extensive debate over the potential effects of the ACA on the labor market. The recent CBO report has renewed the vigor of the debate and has led to some strong claims that the ACA will harm the economic recovery or even induce another recession. In this brief, we have put this debate in context, first by showing that the ACA is not a new, or a particularly different type of social program, and second by reviewing the most direct evidence of the likely effects of the ACA on the labor market.

The ACA is a means-tested program intended to provide health insurance to low-income persons. It is similar to other social programs that provide food, shelter, and income to low-income families. All means-tested programs have incentives that discourage work (including the EITC) or generate unintended costs. So the ACA is not different and not a program with unusually large work disincentives. More importantly, the decline in employment in the ACA will most likely stem from voluntary choices of people not to work because of the access to health insurance benefits makes them better off, and not because employers demand fewer workers.

Indeed, the best and most direct evidence to date suggests that the labor market consequences of the ACA are likely to be small. The Medicaid expansions are likely to have a very small effect on employment. The effect of the ACA expansions can be simulated using the Oregon results. If we use the 3 percent estimate from the Oregon study, assume that half of those affected were working, as in Oregon and Wisconsin, and apply it to the 11 million new Medicaid enrollees expected, the result is 165,000 fewer people working because of the ACA expansion of Medicaid. This represents a small fraction of the total decrease in employment predicted by the CBO.[26]

In regard to other aspects of the ACA, if Massachusetts is a guide, the remaining influences of the ACA are unlikely to have a substantial effect.[27] In this regard, the CBO estimate may be toward the high end of the potential employment effects of the ACA.

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

About the Authors and Acknowledgments

Bowen Garrett is a senior fellow at the Urban Institute's Health Policy Center. Robert Kaestner is a professor in the Institute of Government and Public Affairs of the University of Illinois and a professor in the Department of Economics of the University of Illinois at Chicago. The authors are grateful for the financial support of the Robert Wood Johnson Foundation and the careful review of Linda Blumberg, Genevieve Kenney, John Holahan, and Stephen Zuckerman.

About the Urban Institute

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic and governance problems facing the nation. For more information, visit http://www.urban.org. Follow the Urban Institute on Twitter www.urban.org/twitter or Facebook www.urban.org/facebook. More information specific to the Urban Institute's Health Policy Center, its staff, and its recent research can be found at www.healthpolicycenter.org.

Notes

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

2 For reviews see Moffitt R. "Welfare Programs and Labor Supply." In *Handbook of Public Economics*, Auerbach AJ and Feldstein M, (eds). Elsevier, 2002; and Hoynes, HW and Schanzenbach, DW. "Work Incentives and the Food Stamp Program," *Journal of Public Economics*, 96(1): 151–162, 2010. http://ideas.repec.org/a/eee/pubeco/v96y2012i1p151-162.html.

3 Eissa N and Hoynes HW. "Behavioral Responses to Taxes: Lessons from the EITC and Labor Supply." In *Tax Policy and the Economy Volume 20*, Poterba JM (ed), 73–110. Cambridge, MA: National Bureau of Economic Research, 2006.

4 In 2013, the EITC program cost approximately $60 billion, served 26 million households, and provided an average benefit of approximately $2,300 (see Maag E and Carasso A. "Taxation and the Family: What is the Earned Income Tax Credit?" Tax Policy Center, last modified February 12, 2014, http://www.taxpolicycenter.org/briefing-book/key-elements/family/eitc.cfm). The expansion of Medicaid under the ACA is estimated to cost about the same when fully phased in by 2017, will serve approximately 12 million people, and provide an average benefit of approximately $5,000 (see Appendix B in Congressional Budget Office. T*he Budget and Economic Outlook: 2014 to 2024*. Washington, DC: Congressional Budget Office, 2014. http://cbo.gov/sites/default/files/cbofiles/attachments/45010-Outlook2014_Feb.pdf).

5 Indeed, the ACA has several program features designed to minimize the employment effects. These include the gradual (up to 400 percent) phase-out of marketplace subsidies with higher income and the requirement that marketplace subsidies are limited to those without employer-sponsored health insurance. A productive strategy would be to search for ways to refine the incentives of the ACA to further minimize the labor market distortions.

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

7 Baicker K, Finkelstein A, Song J, and Taubman S. "The Impact of Medicaid on Labor Force Activity and Program Participation: Evidence from the Oregon Health Insurance Experiment." NBER Working Paper 19547, Cambridge, MA: NBER, 2013.

8 Ibid.

9 McClelland R and Mok S. "A Review of Recent Research on Labor Supply Elasticities." Congressional Budget Office Working Paper 2012-12, Washington, DC: Congressional Budget Office, 2012. http://www.cbo.gov/sites/default/files/cbofiles/attachments/10-25-2012-Recent_Research_on_Labor_Supply_Elasticities.pdf.

10 The percent change in employment in response to a given percent change in income or resources.

11 Dague L, DeLeire T, and Leininger L. "The Effect of Public Insurance on the Labor Supply of Childless Adults." Unpublished manuscript. College Station, Texas: George Bush School of Government and Public Service, Texas A&M University, 2013.

12 Garthwaite C, Gross T, and Notodowidigdo M. "Public Health Insurance, Labor Supply, and Employment Lock." Unpublished manuscript. Chicago, IL: Booth School of Business, University of Chicago, 2013.

13 There were no administrative data for 2005 (only 1995), and the publicly available data (Current Population Survey) could not be used to identify those on Medicaid who were part of the group affected by the policy change. When the change in policy occurred, the affected group may have been quite different from the group that was first enrolled in the program in 1995.

14 The difference-in-difference-in-differences analysis is preferred because of evidence presented by Garthwaite et al. ("Public Health Insurance, Labor Supply, and Employment Lock") and in a reanalysis (unpublished, available from the authors) that the difference-in-difference research design was not valid. For example, in our reanalysis, difference-in-differences estimates obtained in periods before the policy change in Tennessee, for example 1998 to 2005, were statistically significant and of the same approximate magnitude as those obtained using the 2000 to 2007 period that spans the policy change. We were able to replicate the Garthwaite et al. estimates.

15 In a re-analysis (unpublished, available from the authors) of the Tennessee data, the change in policy was not associated with a change in employment for those with just a high school degree and there was substantial evidence that the triple difference research design was not valid for this group or for the group of persons with more than a high school degree. The evidence against the validity of the triple difference research design for these groups is statistically significant estimates obtained using data from periods when there was no policy change (e.g., 1998 to 2005). The expected effect is zero, which was not the case, and magnitudes of the estimates were similar in size to those reported in the text for these groups.

16 Congressional Budget Office. "How Many People Lack Health Insurance and for How Long?" Economic and Budget Issue Brief. Washington DC: Congressional Budget Office, 2003; Davern M, Davidson G, Ziegenfuss J, et al. "A Comparison of the Health Insurance Coverage Estimates from Four National Surveys and Six State Surveys: A Discussion of Measurement Issues and Policy Implications." Minneapolis, MN: University of Minnesota, 2007. http://www.shadac.org/files/shadac/publications/ASPE_FinalRpt_Dec2007_Task7_2_rev.pdf.

17 The 63 percentage point estimate is obtained by dividing the change in employment for childless adults, 0.046, by the .0.073 change in "public" coverage of childless adults.

18 A reanalysis (unpublished, available from authors) using a contemporaneous measure of insurance status instead of the following year measure produces estimates that do not indicate a substantial disenrollment of persons on Medicaid in Tennessee. While this seems inconsistent with the administrative data presented in the Tennessee study, it illustrates the importance of the choice to use the following year to measure insurance status and highlights the potential measurement problem that underlies the estimates of the effect of Medicaid on employment.

19 Consider that the Tennessee policy had no income eligibility threshold. Therefore, it was possible to obtain Medicaid and continue working; there was no need to stop working because income was not a criterion for eligibility. So the availability of Medicaid was the equivalent of an increase in income (pure income effect).

20 Assume that Medicaid represented a $5,000 value for the Tennessee group affected (slightly sicker than typical Medicaid expansion group) and that the average income of the affected group was $15,000 (150 percent of FPL in 2005) in the absence of the program. The Tennessee estimates imply that this 33 percent increase in income associated with Medicaid benefits resulted in a decrease in the probability of employment of between 63 and 90 percentage points. Even if we assume an average income of $8,000 instead of $15000, the labor supply response is 20 times larger than the CBO consensus estimate (McClelland and Mok 2012).

21 The confidence interval for the employment estimates is 0.006 to 0.086, and the confidence interval for the "public insurance" estimates is 0.039 to 0.107.

22 Dubay L, Long S and Lawton E. "Will Health Reform Lead to Job Loss? Evidence From Massachusetts Says No." Washington, DC: Urban Institute and The Robert Wood Johnson Foundation, 2012. http://www.urban.org/UploadedPDF/412582-Will-Health-Reform-Lead-to-Job-Loss-Evidence-from-Massachusetts-Says-No.pdf.

23 These states were Delaware, Nebraska, Minnesota and Wisconsin. This refined matching procedure (using cluster analysis) strengthens the credibility of the research design and can be seen in graphs that show very similar levels and trends in employment and health insurance in Massachusetts and the comparison states before reform in Massachusetts.

24 Mulligan C. "Is the Affordable Care Act Different From Romneycare? A Labor Economics Perspective." Cambridge, MA: National Bureau of Economic Research, 2013.

25 The difference in the magnitudes of the work incentives between Massachusetts and the ACA derived by Mulligan ("Is the Affordable Care Act Different From Romneycare?") are the most similar (although still smaller in Massachusetts) for the two aspects of the ACA (Medicaid and Marketplace subsidies) that the Congressional Budget Office claimed would account for most of the employment changes associated with the ACA.

26 This figure represents only the simulated employment response to the Medicaid expansion in the ACA. It does not include other aspects of ACA, such as the sliding scale subsidies that may also decrease employment and hours of work.

27 The studies of the effect of Medicaid on labor supply reviewed in this article do not rely on data from scenarios in which people reduced work to gain Medicaid coverage. The Oregon and Wisconsin studies were based on samples that were already eligible for Medicaid, and the Tennessee study was in reference to a policy that did not have an income threshold.

Aiming Higher: Results from a Scorecard on State Health System Performance, 2014

April 30, 2014

Authors: David C. Radley, Douglas McCarthy, Jacob A. Lippa, Susan L. Hayes, and Cathy Schoen
Contact: Cathy Schoen, Senior Vice President for Policy, Research, and Evaluation, The Commonwealth Fund, CS@cmwf.org
Editor: Deborah Lorber and Chris Hollander

Overview

The Commonwealth Fund's *Scorecard on State Health System Performance, 2014,* assesses states on 42 indicators of health care access, quality, costs, and outcomes over the 2007–2012 period, which includes the Great Recession and precedes the major coverage expansions of the Affordable Care Act. Changes in health system performance were mixed overall, with states making progress on some indicators while losing ground on others. In a few areas that were the focus of national and state attention—childhood immunizations, hospital readmissions, safe prescribing, and cancer deaths—there were widespread gains. But more often than not, states exhibited little or no improvement. Access to care deteriorated for adults, while costs increased. Persistent disparities in performance across and within states and evidence of poor care coordination highlight the importance of insurance expansions, health care delivery reforms, and payment changes in promoting a more equitable, high-quality health system.

Feature

Interact with Scorecard data and see the infographics.

Executive Summary

The mixed performance of states' health systems over the five years preceding implementation of the Affordable Care Act's major reforms sends a clear message that states and the nation are still a long way from becoming places where everyone has access to high-quality, affordable care and an equal opportunity for a long and healthy life. In tracking 42 measures of health care access, quality, costs, and outcomes between 2007 and 2012 for the 50 states and the District of Columbia, The Commonwealth Fund's *Scorecard on State Health System Performance, 2014,* finds that, on a significant majority of measures, the story is mostly one of stagnation or decline. In most parts of the country, performance worsened on nearly as many measures as it improved.

On a positive note, the *Scorecard* also shows that combined national and state action has the potential to promote performance gains across the country. Yet the improvements uncovered in the *Scorecard* are not as widespread as Americans should expect, given the high level of resources the nation devotes to health care.

During the *Scorecard*'s time frame, a period that encompassed the Great Recession, health care spending rose $491 billion, reaching $2.8 trillion nationally according to government estimates.[1] Spending increased in all states on both a per-capita basis and as a share of total state income. And still, the *Scorecard* points to deteriorating access to care for adults, stagnant or worsening performance on other key measures such as preventive care for adults, and widespread disparities in peoples' health care experience across and within states. These findings together suggest that the return on our nation's health care investment is falling woefully short.

The *Scorecard* also reminds us, however, that that improvement is possible with determined, coordinated efforts. The most pervasive gains in health system performance between 2007 and 2012 occurred when policymakers and health system leaders created programs, incentives, and collaborations to raise rates of children's immunization, improve hospital quality, and lower hospital readmissions (Exhibit 1). These gains illustrate that state health system performance reflects a confluence of national policy and state and local initiatives that together can make a difference for state residents.

Like earlier scorecards in this series, the 2014 *State Scorecard* tracks and compares health care experiences across the states and recent trends in key areas of performance to help policymakers and health system leaders identify opportunities for improvement (Exhibit 2). In comparing the level of performance in each state to that in the top-performing states, it offers attainable benchmarks. Moreover, the *Scorecard* documents the trajectory of states' health system performance in the years leading up to the Affordable Care Act's major insurance coverage reforms, which will allow us to track in future editions how state and local policy and care system responses to health reform may alter this trajectory in the future. (See Scorecard Methodology for a detailed description of the *Scorecard*'s methods and performance indicators.)

Key Findings

In assessing change over the five years leading up to 2011–12, the *Scorecard* reveals persistent geographic disparity in the performance of state health care systems as well as variation in rates of change. These variations may partly reflect differences in state policies and funding of health care programs such as Medicaid, as well as in local norms and practices (Exhibits 3 and 4). Several themes stand out:

There were some improvements in state health system performance in recent years, but widespread gains remained the exception.

- On two-thirds of the 34 *Scorecard* indicators for which longitudinal data exist, there was no meaningful improvement or decline in performance in most states. On nine of the 34, meaningful improvement occurred in a majority of the states (Exhibit 1).[2] A few

states (Colo., Md., N.H., and N.Y.) stand out for their net improvement across indicators.

- Most states improved on indicators that have been the focus of national and state attention, including immunizations for children, safe prescribing of medications for the elderly, patient-centered care in the hospital, avoidable hospital admissions and readmissions, and cancer-related deaths.
- Lower premature mortality rates, including lower rates of cancer-related death, suggest that improvements in medical care are contributing to better health outcomes. Fifteen states saw meaningful reductions on each of two measures of premature death (mortality amenable to health care and years of potential life lost), but even greater progress may be possible through health system improvement.
- States lost ground in insurance coverage for adults and affordability of care. As a consequence, a greater number of adults in 42 states reported going without care because of its cost—a trend that likely reflects lingering effects of the 2007–2009 recession.
- Health care spending continued to rise, but to a greater degree in the private market than in Medicare, which saw a historic moderation in spending.

Click to View Exhibit 1

Troubling disparities and gaps in care persisted for children and other vulnerable populations.

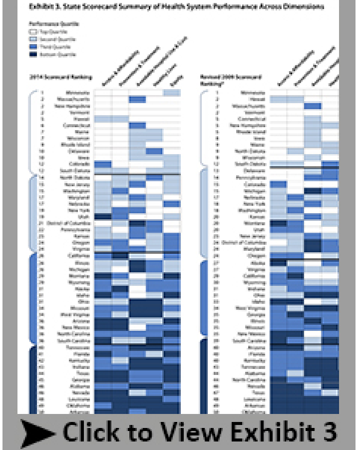
- For children, changes in health system performance were mixed. There have been some promising gains in recent years, such as a lower rate of asthma hospitalizations. But troubling declines on other health care indicators, such as the proportion of children with a primary care "medical home," emphasize the need for continued diligence to secure the health of future generations.
- Disparities in health care and outcomes remained wide between vulnerable and more-advantaged groups within all states. While states made progress in reducing disparities in premature mortality and certain other key *Scorecard* indicators, disparities also widened for others, such as poor health-related quality of life.

Widespread geographic variations in health system performance persist, providing benchmarks and illustrating opportunities to do better.

THE BEST AND WORST IN HEALTH CARE
A SAMPLING OF STATE PERFORMANCE

- There were two-to-eightfold gaps between leading and lagging states on multiple indicators of health care access, quality, prevention, costs, and outcomes (Exhibit 2).
- Although the range between top- and bottom-performing states remained wide on most indicators, the gap narrowed for several of the key indicators on which there was also widespread state improvement—illustrating that lagging states can close the gap, even as top states improve.
- The top-performing states—Minnesota, Massachusetts, New Hampshire, Vermont, and Hawaii—lead the nation across most dimensions of care, and have done so over time (Exhibits 3 and 4). Their consistently high performance may be the result of their willingness and wherewithal to address health system change with focused initiatives spanning the public and private sectors.
- Opportunities for improvement abound. Even leading states did not perform consistently well—or consistently improve—across all performance indicators.

How National Policies Combined with State and Local Action Can Spur Better Performance



It is notable that those indicators in which more than half the states improved have been the focus of national as well as state policy and attention. Health care gains for Medicare beneficiaries in the quality and use of hospital care occurred in the majority of states, providing a platform for further state and local action. States can build on national policy—as they did by expanding children's coverage through the federal–state Children's Health Insurance Program—to influence health system performance in many ways, such as by promoting accountable care in Medicaid and value-based purchasing of coverage for state employees and by supporting collaboration among public and private stakeholders to consistently measure and improve care.

Looking Toward the Future

Findings from the *Scorecard on State Health System Performance, 2014,* signal both promise and caution for the future. Massachusetts' experience with insurance coverage expansion suggests that cost-related barriers to care should ease for individuals and families who gain coverage under the Affordable Care Act.[3] This increased access, in turn, should support broader improvements in quality of care and health status.[4]

STATES AIMING HIGHER
HOW MUCH BETTER COULD WE BE?

It is possible, however, that geographic disparities in performance will widen, and health care inequities within states worsen, if such health system reforms and innovations are not evenly spread across states. Throughout this report, we demonstrate that better access to care is associated with better primary and preventive care services and improved health outcomes. To the extent that some states take the lead in expanding health coverage—through Medicaid and high-quality private insurance choices in the new marketplaces—while other states lag, we may see a widening rather than a narrowing of health outcomes and quality of care. Conversely, if many states seize on new federal opportunities and flexibility for creative action and learn from each other, we could hope for accelerated gains in the years ahead.

SCORECARD METHODOLOGY

The Commonwealth Fund's *Scorecard on State Health System Performance, 2014,* evaluates 42 key indicators grouped into four dimensions (Exhibit 2):

- **Access and Affordability** (six indicators): includes rates of insurance coverage for children and adults, as well as individuals' out-of-pocket expenses for medical care and cost-related barriers to receiving care.
- **Prevention and Treatment** (16 indicators): includes measures of receiving preventive care and the quality of care in ambulatory, hospital, and long-term care and postacute settings.
- **Potentially Avoidable Hospital Use and Cost** (nine indicators, with one indicator, hospital admissions for ambulatory care–sensitive conditions, reported separately for two distinct age groups): includes indicators of hospital use that might have been reduced with timely and effective care and follow-up care, as well as estimates of per-person spending among Medicare beneficiaries and the cost of employer-sponsored insurance.
- **Healthy Lives** (11 indicators): includes indicators that measure premature death and health risk behaviors.

In addition, the **Equity** dimension includes differences in performance associated with patients' income level (nine indicators) or race or ethnicity (10 indicators) that span the four other dimensions of performance.

The following principles guided the development of the *Scorecard*:

Performance Metrics. The 42 performance metrics selected for this report span the health care system, representing important dimensions of care. Where possible, indicators align with those used in previous state scorecards. Since the 2009 Scorecard, several indicators have been dropped either because all states improved to the point where no meaningful variations existed or the data to construct the measures were no longer available. Several new indicators have been added, including measures of premature death, out-of-pocket spending on medical care relative to income, and potentially avoidable emergency department use.

Measuring Change over Time. We were able to construct a time series for 34 of 42 indicators. There was generally five years between a historical and current year data observation, though the starting and ending points, as well as total length of time, varied somewhat between indicators. We considered a change in an indicator's value between the historical and current year data points to be meaningful if it was at least one half (0.5) of a standard deviation larger than the indictor's combined distribution over the two time points—a common approach in social science research.

Data Sources. Indicators draw from publicly available data sources, including government-sponsored surveys, registries, publicly reported quality indicators, vital statistics, mortality data, and administrative databases. The most current data available were used in this report. Appendix B provides detail on the data sources and time frames.

Scoring and Ranking Methodology. The scoring method follows previous state scorecards. States are first ranked from best to worst on each of the 42 performance indicators. We averaged rankings for indicators within each dimension to determine a state's dimension rank and then averaged dimension rankings to determine overall ranking. This approach gives each dimension equal weight, and within dimensions weights indicators equally. Ranking in the earlier period (i.e., revised 2009 data) was based on 34 of 42 indicators; if historical data were not available for a particular indicator, the most current year of data available was used as a substitute ensuring that ranks in each time period were based on the same number of indicators and as similar as possible.

---

[1] National health expenditure data (Table 1): http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf; State health expenditure data: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/res-tables.pdf.

[2] Changes in an indicator's value between the historical and current year data points are considered to be meaningful if they were at least one half (0.5) of a standard deviation larger than the indicator's distribution over the two time points. One indicator—hospitalizations for ambulatory care–sensitive conditions among Medicare beneficiaries—was measured for two age subpopulations: those ages 65 to 74, and those age 75 and older. We consider these a single measure for purposes of scoring and tallying state improvement counts. Refer to the Scorecard Methodology for additional information.

[3] A. H. Pande, D. Ross-Degnan, A. M. Zaslavsky et al., "Effects of Healthcare Reforms on Coverage, Access, and Disparities: Quasi-Experimental Analysis of Evidence from Massachusetts," *American Journal of Preventive Medicine,* July 2011 41(1):1–8.

[4] P. J. van der Wees, A. M. Zaslavsky, and J. Z. Ayanian, "Improvements in Health Status After Massachusetts Health Care Reform," *Milbank Quarterly,* Dec. 2013 91(4):663–89.

Citation

D. C. Radley, D. McCarthy, J. A. Lippa, S. L. Hayes, and C. Schoen, *Aiming Higher: Results from a Scorecard on State Health System Performance, 2014,* The Commonwealth Fund, May 2014.

ACA | ACOs | Finance | Government | Healthcare IT | Insurance | Physicians | Safety/Quality | Supply Chain

Log in | Free Newsletters | Subscribe | Get Password | Help

- Join Modern Healthcare's LinkedIn group
- Follow Modern Healthcare on Twitter
- Join Modern Healthcare's Facebook group
- Modern Healthcare's Google+ Channel
- Follow Modern Healthcare's Pinterest board
- Modern Healthcare's Flickr page
- Modern Healthcare's YouTube Channel
- Get a Modern Healthcare news feed

Modern Healthcare

News | Topics | Research | Opinion | Blog | Recognition | Videos & Webinars | Events | Marketplace | Jobs

The University of Vermont COLLEGE OF MEDICINE Online Public Health Courses MASTER AND CERTIFICATE PROGRAMS APPLY BY JULY 1 FOR FALL 2014

FREE ACCESS TO TODAY'S NEWS

Healthcare Business News

Reform Update: States that did not expand Medicaid may see higher premiums, industry experts say

By Virgil Dickson
Posted: April 22, 2014 - 4:00 pm ET
Tags: Centers for Medicare & Medicaid Services (CMS), Costs, Healthcare Reform, Insurance Exchanges, Insurance, Kansas, Medicaid, Payers, Reimbursement, Uncompensated Care, Uninsured

Some industry experts are warning that states that chose not to expand **Medicaid** coverage under **Obamacare** could see higher insurance premiums next year as hospitals continue to shift the costs of uncompensated care to private **insurers**.

Washington state Insurance Commissioner Mike Kreidler raised the issue at the White House last week during a gathering of state insurance commissioners with **President Barack Obama**.

Others, though, question whether uncompensated care could have much effect if any on 2015 rates, arguing that the rates are more likely to reflect each market's competitive landscape and the costs of caring for people newly covered through the **insurance exchanges**.

Washington was one of 26 states that did expand Medicaid in 2014. Kreidler is right, according to hospital associations in some of the states that did not.

Advertisement | **View Media Kit**

Medtronic Innovating for Life.

In Nebraska for instance, hospitals provide uncompensated care for many of the 54,000 uninsured residents who would have qualified for coverage under Medicaid expansion. “As a result of Nebraska's failure to expand Medicaid, insured Nebraskans are likely to see an increase in health insurance premiums as they continue to cover the uncompensated healthcare costs of the uninsured,” said Adrian Sanchez, a spokesman for the Nebraska Hospital Association.

In the course of Indiana hospitals' unsuccessful campaign to persuade state leaders to raise Medicaid eligibility last year, the Indiana Hospital Association generated a report indicating individuals would see premiums drop by $241 and families by $691 in 2015 if Indiana extended coverage to an additional 400,000 residents under the Patient Protection and Affordable Care Act.

“We do believe there would be savings in premiums for consumers from coverage expansion,” said Brian Tabor, vice president of government relations at the association.

Premium increases should be more moderate in states that have expanded Medicaid because of the downward effect on uncompensated care in the system, said Barbara Markham Smith and Vernon Smith of the consulting firm Health Management Associates.

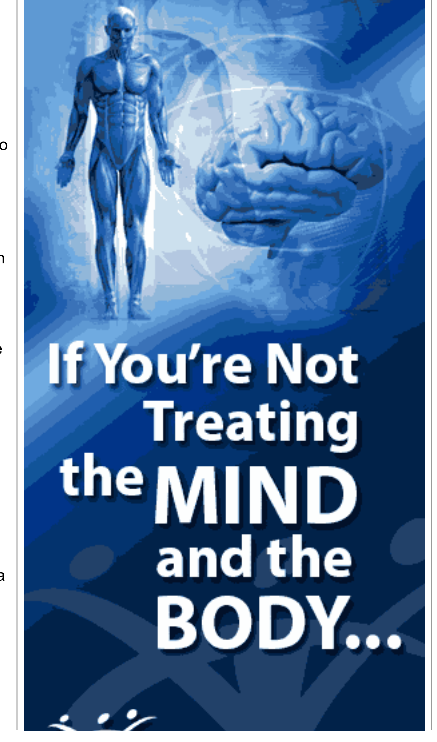
Vernon Smith is a former Medicaid director for Michigan and Barbara Markham Smith was director of HHS' division overseeing the CO-OP program, which provides grants and loans for consumer-oriented plans under the ACA. They added the effect would apply to premiums both inside and outside the new insurance marketplaces established under

This Week's Issue

Modern Healthcare

- 50 Most Influential Physician Execs list topped by system leaders
- Indiana MERS case handled efficiently by community hospital
- Experimental technology poses pricey dilemma for hospitals
- Top business schools for physician executives: 2014

Table of Contents
Digital Edition
Daily News App
Subscribe



the law.

But other factors could have more significant influence on premiums for 2015 and even 2016, such as the number and cost of healthcare services pursued by the newly insured and mix of young and healthy people in the risk pools, said Mary Beth Chambers, a spokeswoman for Blue Cross and Blue Shield of Kansas.

Further she added that even if Kansas had expanded Medicaid this year, insurance companies would base premiums on claims experience from 2013, a year without guaranteed issue of coverage, and its best actuarial assumptions for 2014 claims experience.

As a result, "the full impact of this first year of expanded coverage might not fully be reflected in premiums until 2016," she said.

Jeff Drozda, CEO of the Louisiana Association of Health Plans, agreed the biggest drivers of premiums increases, if there are any, will be the cost of medical procedures and specialty pharmaceutical drugs. He added that Louisiana has a generous fund to offset uncompensated care at hospitals.

The answer to whether a state expansion's decision will have an impact on premiums will also depend much on the makeup of a particular market, said John Holahan, a fellow at the Urban Institute.

In a competitive market, all the payers would have to agree to increase rates, Holahan said. "I'm skeptical that would

happen; all it would take is one that didn't want to charge higher premiums and then that would be it."

Representatives from the National Association of Insurance Commissioners and several insurance departments in states that declined to expand Medicaid said it's too soon to judge how that decision will affect rates.

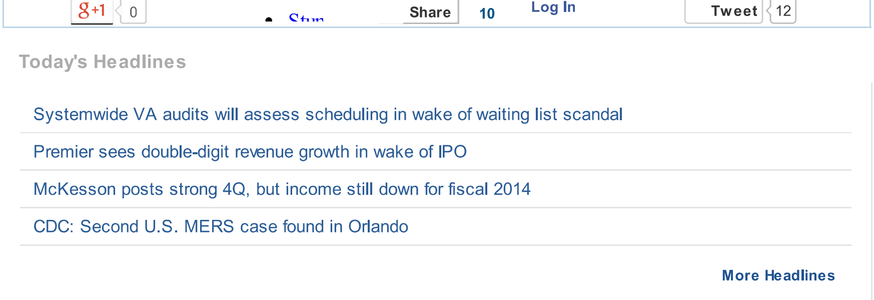
CMS clarifies Medicaid coverage for family planning

The CMS has **issued a notice to state Medicaid directors (PDF)** in response to reports of confusion over the range of family planning services Medicaid programs are required to cover under the healthcare reform law. Patients with a sexually transmitted disease can receive reimbursement for behavioral counseling on contraceptives, which the federal agency considers a family planning service, the April 16 notice reads. Medicaid must also pay for contraceptive counseling for men. "CMS does not believe there is any reason to make a distinction between contraceptive counseling for men versus women," the agency says in the notice.

Kansas can't expand Medicaid until 2015 at the earliest

Kansas Gov. Sam Brownback **signed a law** that would require explicit approval by state legislators before Medicaid could be expanded in the state under the Patient Protection and Affordable Care Act. The soonest lawmakers could vote on the matter would be 2015 because they have already adjourned for the year. If Brownback, a Republican, were to lose this fall to a Democratic challenger, the new governor would have to build political support to expand the program.

Follow Virgil Dickson on Twitter: ***@MHVDickson***



+1 0 Stum Share 10 Log In Tweet 12

Today's Headlines

Systemwide VA audits will assess scheduling in wake of waiting list scandal

Premier sees double-digit revenue growth in wake of IPO

McKesson posts strong 4Q, but income still down for fiscal 2014

CDC: Second U.S. MERS case found in Orlando

More Headlines

What do you think?

Share your opinion. Send a letter to the Editor or Post a comment below.

Post a comment

Loading comments...

SPONSORED CONTENT FROM OUR PARTNERS

Most Requested Articles

Second MERS case in U.S. reported in Fla.

Medicare ACO architect Gilfillan leads changes at CHE Trinity

Indiana hospital prepared when deadly MERS virus shows up

50 Most Influential Physician Execs list topped by system leaders

Post-acute care companies see earnings dive, operation challenges

Most Recent Research

Top business schools for physician executives: 2014

50 states ranked by ASC procedures per 100,000 people, based on fiscal 2012 data

25 highest paid execs at publicly traded healthcare industry companies

10 largest investor-owned, for-profit hospital chains

25 Largest publicly traded pharmaceutical companies

Submit, Nominate & Register

Voting begins for 100 Most Influential People in Healthcare

Design Awards nominations now open

Nominations now open for first Healthcare Marketing Impact Awards

Community Leadership nominations sought

Looking for the 'Best Places to Work in Healthcare'

MEMORANDUM April 21, 2014

Subject: **Deadlines for the HHS Secretary and Other Federal Entities in the Patient Protection and Affordable Care Act Through March 23, 2013: Addendum to CRS Congressional Distribution Memorandum Dated April 5, 2011**

From: C. Stephen Redhead (7-2261), Coordinator
Elayne J. Heisler (7-4453), Coordinator
Clifford Binder
Kirsten J. Colello
Sarah A. Lister
Amanda K. Sarata
Susan Thaul

This memorandum was prepared to enable distribution to more than one congressional office.

This memorandum is an addendum to a CRS memorandum, dated April 5, 2011, which summarized certain statutorily imposed deadlines in the Patient Protection and Affordable Care Act (ACA)[1] and the actions taken through April 1, 2011, to meet those deadlines.[2] That product focused on the ACA provisions requiring the Secretary of Health and Human Services (HHS) or another federal official or agency to take a specific action by a specific date within the first year of the law's enactment (i.e., through March 23, 2011).

The April 5, 2011 memo described the methodology used to determine what constituted a statutory deadline and whether the provision qualified for inclusion. To make those determinations, CRS relied on a close reading of the statutory text, acceptable principles of statutory interpretation, and subject matter expertise regarding typical implementing agency practice in the issue areas covered by the ACA. Accordingly, several categories of provisions were excluded.[3] This addendum employs the same methodology, the details of which are reproduced in the **Appendix**. In addition, the April 5, 2011 memo

[1] ACA was signed into law on March 23, 2010 (P.L. 111-148, 124 Stat. 119). On March 30, 2010, the President signed the Health Care and Education Reconciliation Act (HCERA; P.L. 111-152, 124 Stat. 1029), which amended numerous provisions in the ACA. HCERA also included multiple new freestanding provisions related to the ACA. Several other bills that were subsequently enacted during the 111th and 112th Congresses made additional changes to selected ACA provisions. All references to the ACA in this memo refer, collectively, to the law as amended and to the related HCERA provisions.

[2] CRS Congressional Distribution Memorandum, "Deadlines for the HHS Secretary and Other Federal Entities in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148), March 23, 2010 – March 23, 2011: Implementation Actions Taken as of April 1, 2011," by C. Stephen Redhead and Todd B. Tatelman, April 5, 2011.

[3] The largest category, by far, of excluded provisions were those that merely had an "effective date" attached to them, as opposed to a specific deadline for official government action. For example, the ACA made numerous changes to existing Medicare payment systems, either permanently or on a temporary basis, effective at the beginning of the payment year. In almost all cases, the Centers for Medicare & Medicare Services (CMS) has opted to address these changes in its annual rulemaking updates for the various payment systems. For example, the annual final rules updating Medicare payment policies and rates for physician services and for hospital inpatient services both include multiple sets of provisions to incorporate and implement ACA mandates.

also included some analysis of the legal enforceability of statutory deadlines, which also appears in the **Appendix**.

The statutory deadlines discussed in this addendum are presented in three tables. **Table 1** provides updated information on a number of deadlines that were included in the April 5, 2011 memo (i.e., deadlines within the first year of the ACA's enactment, through March 23, 2011). These were deadlines about which we were unable to locate any public information, or for which no, or only partial, implementation action had been taken as of the cut-off date in that memo (i.e., April 1, 2011). **Table 2** summarizes the ACA provisions that require the HHS Secretary or another federal entity to take specific action by a specific date during the second year of enactment (i.e., March 24, 2011, through March 23, 2012). **Table 3** summarizes the provisions in the ACA that require the federal entity to take specific action by a specific date during the third year of enactment (i.e., March 24, 2012, through March 23, 2013).

Each table row entry includes the following information: (1) the deadline; (2) the ACA section number; (3) a brief description of the provision's requirements; and (4) a summary of the actions taken *as of April 15, 2014*. The information on actions taken as of that date is largely, but not exclusively, based on an examination of publicly available sources. In obtaining this information, CRS relied on official federal sources, such as agency websites and the Federal Register.[4] If CRS was unable to find any public information about implementation of an ACA provision using these sources, then this is indicated in the table by the phrase "No public information located." That indication does not necessarily mean that an agency or other federal entity has taken no action towards meeting a deadline. It may be that there has been internal activity, but that CRS was unable to locate any public information about the activity.[5]

Acronyms

The following laws and federal agencies are referred to in the tables by their acronym:

- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Community Living Assistance Services and Supports (CLASS) Act
- Food and Drug Administration (FDA)
- Government Accountability Office (GAO)
- Health Insurance Portability and Accountability Act (HIPAA)
- Health Resources and Services Administration (HRSA)
- Indian Health Care Improvement Act (IHCIA)
- Indian Health Service (IHS)
- Public Health Service Act (PHSA)

---

[4] A more comprehensive analysis of federal government actions taken to meet ACA deadlines would require the examination of internal agency documents and interviews with agency officials. Such activities are beyond the scope of this memorandum. However, CRS did rely on personal communication with the IHS Congressional and Legislative Affairs Office for information on implementation of several of the ACA provisions relating to Indian health, with the CMS Office of Legislation, and the with HRSA Office of Legislation.

[5] Note that this addendum supersedes an earlier version, dated June 5, 2013, which was similarly organized and summarized implementation actions taken through May 31, 2013.

Table 1. ACA Deadlines in the First Year After Enactment (March 23, 2010 – March 23, 2011)

Updated Information on Selected Deadlines Included in the CRS Memorandum Dated April 5, 2011

Deadline	ACA Section	Requirements	Actions Taken as of April 15, 2014
Title I: Private Health Insurance			
March 23, 2011	1001	Requires the HHS Secretary, by regulation, to develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage in compiling and providing an accurate summary of benefits and coverage. Requires the Secretary, in developing such standards, to consult with the National Association of Insurance Commissioners (NAIC), a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals. [PHSA Sec. 2715]	On February 14, 2012, HHS and the Departments of Labor and the Treasury published jointly the following two documents: (1) "Summary of Benefits and Coverage and Uniform Glossary," Final Rule (77 *Federal Register* 8668); and (2) "Summary of Benefits and Coverage and Uniform Glossary – Templates, Instructions, and Related Materials," Guidance for Compliance and Notice of Availability of Templates, Instructions, and Related Materials (77 *Federal Register* 8706).
Title II: Medicaid, Children's Health Insurance Program (CHIP)			
Sept. 19, 2010	10201(i)	Requires the HHS Secretary to promulgate regulations relating to applications for, and renewals of, any Medicaid or CHIP section 1115 demonstration project that has an impact on eligibility, enrollment, benefits, cost-sharing, or financing.	On February 27, 2012, CMS published a final rule, "Medicaid Program; Review and Approval Process for Section 1115 Demonstrations" (77 *Federal Register* 11678).
Title III: Medicare, Health Care Quality			
Dec. 31, 2010	3012	Requires the Interagency Working Group on Health Care Quality, convened by the President and chaired by the HHS Secretary, to submit to Congress, and publish on the Internet, a report on its progress and recommendations.	The Interagency Working Group on Health Care Quality has been convened, consisting of senior-level officials from 24 federal agencies. The group held its first meeting on March 4, 2011, and meets once a year. No report has been submitted to Congress. See http://www.ahrq.gov/workingforquality/nqs/nqsfactsheet.htm.
Jan. 1, 2011	3006(f)	Requires the HHS Secretary to develop and submit to Congress a plan that would implement value-based purchasing for ambulatory surgery centers (ASCs).	On April 18, 2011, HHS released "Report to Congress: Medicare Ambulatory Surgical Center Value-Based Purchasing Implementation Plan." See https://www.cms.gov/ASCPayment/downloads/C_ASC_RTC%202011.pdf.

Deadline	ACA Section	Requirements	Actions Taken as of April 15, 2014
March 23, 2011	3507	Requires the HHS Secretary to submit to Congress a report providing the determination of whether the addition of quantitative summaries of the benefits and risks of prescription drugs would improve health care decision making by clinicians and patients.	On March 23, 2011, FDA's Office of Prescription Drug Promotion released "Report to Congress: Implementation of Section 3507 of the Patient Protection and Affordable Care Act of 2010, First Progress Report." The agency indicated that conducting the necessary research and literature reviews and consulting with the appropriate experts would take about three years. FDA subsequently submitted progress reports in May 2012 and July 2013. The 2013 report indicated that FDA had completed its literature review and quantitative study and that data analysis and interpretation of its display page and format studies was ongoing. The agency estimated a winter 2013 submission of its final report to Congress. For current activities, see http://www.fda.gov/aboutfda/centersoffices/officeofmedicalproductsandtobacco/cder/reportsbudgets/ucm369774.htm, and http://www.accessdata.fda.gov/FDATrack/track-proj?program=healthcare-reform&id=ACA-3507-Evaluation-of-Standardized-Risk-Benefit-Information.
Title IV: Prevention and Public Health			
March 23, 2011	4001(g)	Requires the chairperson of the National Prevention, Health Promotion and Public Health Council to publish a national prevention, health promotion and public health strategy.	On June 16, 2011, the U.S. Surgeon General and members of the National Prevention Council released "National Prevention Strategy: America's Plan for Better Health and Wellness." See http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf.
Title V: Health Workforce			
April 1, 2010; May 7, 2010; June 1, 2010; July 1, 2010	5602	Requires the HHS Secretary to appoint a negotiated rulemaking committee (pursuant to 5 U.S.C. §§ 561 et seq.) to establish a methodology and criteria for designating medically underserved populations and health professions shortage areas. By May 7, 2010, the Secretary must publish a notice announcing the intent to form such a committee to negotiate and develop a proposed rule. The committee is required to provide a status report to the Secretary by April 1, 2010. [Note: This predates the deadline for publication of a notice of intent to form the committee.] A final committee report containing a proposed rule is due by June 1, 2010. The target date for HHS to publish the proposed rule for notice and comment is July 1, 2010.	On May 11, 2010, HRSA published a notice of intent to form the negotiated rulemaking committee (75 *Federal Register* 26167-26171). The committee members were appointed on July 9, 2010, and the committee began meeting on a monthly basis. The committee submitted a preliminary report to the Secretary on March 17, 2011, and released its final report on October 31, 2011. See http://www.hrsa.gov/advisorycommittees/shortage/index.html. The committee failed to reach a consensus; therefore, the HHS Secretary was not required to use the results of its deliberations for the proposed rule. In March 2014, HRSA informed CRS that the proposed rule will be published in the fall of 2014.

Deadline	ACA Section	Requirements	Actions Taken as of April 15, 2014
Titles VII & X: 340B Drug Pricing, Indian Health			
Sept. 19, 2010	7102	Requires the HHS Secretary to promulgate regulations regarding the PHSA section 340B drug pricing program to (1) establish and implement an administrative process for the resolution of claims by covered entities that they have been overcharged for drugs purchased under the program, and manufacturers' post-audit claims of violations related to drug rebates or resale; and (2) establish civil monetary penalties (CMPs) for noncompliant drug manufacturers.	On September 20, 2010, HRSA published two Advance Notices of Proposed Rulemaking: (1) 340B Drug Pricing Program Administrative Dispute Resolution Process (75 *Federal Register* 57233-57235); and (2) 340B Drug Pricing Program Manufacturer Civil Monetary Penalties (75 *Federal Register* 57230-57232). A final rule has yet to be published. HRSA maintains a website on the 340B drug pricing program at http://www.hrsa.gov/opa/index.html. [Note: HRSA's FY2015 budget request includes a new user fee proposal to provide funding for the 340B drug pricing program, which was significantly expanded under ACA.]
June 21, 2010	10221	Requires the HHS Secretary to develop a plan to increase IHS's behavioral health care staff by 500 positions (200 of which will be devoted to child, adolescent and family services) within 5 years of enactment. [IHCIA Sec. 127]	In August 2011, IHS released "American Indian/Alaska Native Behavioral Health Strategic Plan 2011-2015," which included an implementation plan for developing a skilled and culturally competent behavioral health workforce. See http://www.ihs.gov/behavioral/documents/AIANNationalBHStrategicPlan.pdf. IHS informed CRS that the plan was submitted to the relevant congressional committees.
March 23, 2011	10221	Requires the HHS Secretary, acting through the IHS, to assess the need for, availability, and cost of inpatient mental health care for Indians. [IHCIA Sec. 181]	IHS completed its assessment on March 17, 2011.[a]
March 23, 2011	10221	Requires the HHS Secretary and the Secretary of the Interior to enter into a Memorandum of Agreement (MOA) regarding mental illness and self-destructive behavior among Indians and strategies for addressing unmet needs. [IHCIA Sec. 181]	In March 2011, HHS and the Department of the Interior amended a 2009 MOA on behavioral health care delivery to incorporate the requirements of the new IHCIA provision. [a]
March 23, 2011	10221	Requires the HHS Secretary to establish protocols, policies, and procedures for IHS programs for victims of domestic or sexual violence. [IHCIA Sec. 181]	In March 2011, IHS issued an agency-wide policy on how hospitals should respond to adult and adolescent victims of sexual assault. See http://www.ihs.gov/MedicalPrograms/MCH/V/DV01.cfm. [Note: On Oct. 26, 2011, GAO released report GAO-12-29, "Indian Health Service: Continued Efforts Needed to Help Strengthen Response to Sexual Assaults and Domestic Violence." See http://www.gao.gov/new.items/d1229.pdf.]

Source: Prepared by the Congressional Research Service based on (i) the text of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148), as amended; and (ii) publicly available information from official federal sources.

a. See Letter from Yvette Roubideaux, Director, Indian Health Service, to Tribal Leaders, May 5, 2011, http://www.npaihb.org/images/resources_docs/weeklymailout/2011/may/week2/GM_11-057_IHS_on_IHCIA_1stYearImplementation.pdf.

Table 2. Selected ACA Deadlines in the Second Year After Enactment (March 24, 2011 – March 23, 2012)

Deadline	ACA Section	Requirements	Actions Taken as of April 15, 2014
Title I: Private Health Insurance			
July 1, 2011	1104(b)	Requires the HHS Secretary to adopt operating rules for the following HIPAA electronic transactions: (i) health care claim status inquiry and response; (ii) health plan eligibility inquiry and response.	On June 30, 2011, HHS issued an interim final rule, "Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions." The rule was published on July 8, 2011 (76 *Federal Register* 40458).
Jan. 1, 2012	1104(b)	Requires the HHS Secretary to adopt a HIPAA electronic transactions standard for electronic funds transfers.	On January 5, 2012, HHS issued an interim final rule, "Administrative Simplification: Adoption of Standards for Health Care Electronic Funds Transfers (EFT) and Remittance Advice." The rule was published on January 10, 2012 (77 *Federal Register* 1556).
Jan. 1, 2012	10109(b)	Requires the HHS Secretary to seek input from the National Committee on Vital and Health Statistics (NCVHS) and the Health Information Technology Policy and Standards Committees on whether certain other specified administrative and financial transactions beyond those addressed under HIPAA would benefit from the adoption of standards and operating rules.	On March 2, 2012, NCVHS issued a letter to the HHS Secretary concluding that there are meaningful opportunities for increased efficiencies and simplification through standardization in all the areas specified in ACA Sec. 10109. NCVHS plans to develop a strategy for further action with a timeline by the end of June 2012. See http://www.ncvhs.hhs.gov/120302lt3.pdf. No further public information located.
March 23, 2012	1001	Requires the HHS Secretary to develop requirements for health plans to report on their efforts to improve health outcomes, prevent hospital readmission, ensure patient safety and reduce medical errors, and implement wellness and health promotion activities. Requires the HHS Secretary to promulgate regulations that provide criteria for determining reimbursement structure to improve quality.	No public information located.
Title II: Medicaid, Children's Health Insurance Program (CHIP)			
July 1, 2011	2702(a)	Requires the HHS Secretary to issue regulations prohibiting federal Medicaid payment for specified health care-acquired conditions.	On June 6, 2011, CMS published a final rule, "Medicaid Program; Payment Adjustment for Provider-Preventable Conditions Including Health Care-Acquired Conditions" (76 *Federal Register* 32816). The rule took effect on July 1, 2011.
March 23, 2012	2952(c)	Requires the HHS Secretary to submit to Congress a report on the benefits of screening for postpartum depression.	On March 9, 2012, AHRQ published a systematic review titled "Efficacy and Safety of Screening for Postpartum Depression." See http://effectivehealthcare.ahrq.gov/ehc/products/379/997/PPD_Protocol_20120309.pdf. No report has been submitted to Congress.

Deadline	ACA Section	Requirements	Actions Taken as of April 15, 2014
Title III: Medicare, Health Care Quality			
June 1, 2011	4204(e)	Requires the Comptroller General to submit to Congress a report on Medicare beneficiaries' access to recommended vaccines covered under Part D.	On December 15, 2011, GAO released report GAO-12-61, "Medicare: Many Factors, Including Administrative Challenges, Affect Access to Part D Vaccinations." See http://www.gao.gov/assets/590/587009.pdf.
July 1, 2011	3113	Requires the HHS Secretary to begin a 2-year, $100 million demonstration under Part B that will make separate payments to labs for complex diagnostic tests provided to Medicare beneficiaries.	On July 5, 2011, CMS published a notice of an opportunity to participate in the demonstration, "Medicare Program; Section 3113: The Treatment of Certain Complex Diagnostic Laboratory Tests Demonstration" (76 *Federal Register* 39110). See http://www.cms.gov/DemoProjectsEvalRpts/downloads/TCCDLT_FactSheet.pdf.
July 1, 2011	3313(a)	Requires the HHS Office of Inspector General (OIG) to submit to Congress an annual report (beginning in 2011) on the extent to which drugs commonly used by dual eligibles are included on Part D drug formularies.	On June 3, 2013, the HHS/OIG released the third annual report, "Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2013." See http://oig.hhs.gov/oei/reports/oei-05-13-00090.pdf.
Oct. 1, 2011	3006(a) & (b)	Requires the HHS Secretary to submit to Congress plans for implementing a value-based purchasing (VBP) program for Medicare payments to skilled nursing facilities (SNF) and to home health agencies.	On March 22, 2012, HHS released its plan to implement a home health agency VBP program. See http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/downloads/Stage-2-NPRM.pdf. On June 20, 2012, HHS released its plan to implement a SNF VBP program. See http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/SNF-VBP-RTC.pdf.
Oct. 1, 2011	3313(b)	Requires the HHS/OIG to submit to Congress a report that compares the prices of drugs covered under Part D with the prices of outpatient drugs covered under state Medicaid plans.	In August 2011, HHS/OIG released a report, "Higher Rebates for Brand-Name Drugs Result in Lower Costs for Medicaid Compared to Medicare Part D." See http://oig.hhs.gov/oei/reports/oei-03-10-00320.pdf.
Dec. 1, 2011	3014(b)	Requires the HHS Secretary to make publicly available a list of quality and efficiency measures for Medicare payment systems and other health care programs selected by multi-stakeholder groups under the direction of the National Quality Forum (NQF). [See additional deadlines below.]	On December 2, 2011, NQF posted a list of measures on its website. See http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx.
Jan. 1, 2012	3008(b)	Requires the HHS Secretary to submit to Congress a report with recommendations on expanding Medicare payment adjustments for healthcare acquired conditions beyond inpatient hospital services (required under ACA Sec. 3008(a)) to other providers participating in Medicare.	In December 2012, CMS published a report, "CMS Report to Congress: Assessing the Feasibility of Extending the Hospital Acquired Conditions (HAC) IPPS Payment Policy to Non-IPPS Settings." See http://innovation.cms.gov/Files/x/HospAcquiredConditionsRTC.pdf.

Deadline	ACA Section	Requirements	Actions Taken as of April 15, 2014
Jan. 1, 2012	3022	Requires the HHS Secretary to establish an integrated care delivery model—the Medicare Shared Savings Program—using Accountable Care Organizations (ACOs). While ACOs can be designed with varying features, most models put primary care physicians at the core, along with other providers, and emphasize simultaneously reducing costs and improving quality. Under the Medicare Shared Savings Program, CMS will contract for ACOs to assume responsibility for improving quality of care provided, coordinating care across providers, and reducing the cost of care Medicare beneficiaries receive. If cost and quality targets are met, ACOs will receive a share of any savings realized by CMS.	CMS's final rule to implement the Medicare Shared Savings Program was published on Nov. 2, 2011 (76 *Federal Register* 67802). Three additional documents were issued in connection with the shared savings program: (1) a joint CMS and HHS/OIG interim final rule with comment period establishing waivers of the application of the physician self-referral (Stark) law and the federal anti-kickback statute to ACOs (76 *Federal Register* 67992; Nov. 2, 2011); (2) a joint Federal Trade Commission (FTC) and Department of Justice (DOJ) policy statement regarding the application of federal antitrust laws to ACOs (76 *Federal Register* 67026; Oct. 28, 2011); and (3) an IRS notice summarizing how existing IRS guidance may apply to tax-exempt organizations such as charitable hospitals that participate in ACOs (IRS Notice 2011-20; Apr. 18, 2011). See https://www.cms.gov/sharedsavingsprogram/.
Jan. 1, 2012	3024	Requires the HHS Secretary to implement a 3-year Independence at Home demonstration to test whether home-based care can reduce hospitalization, improve patient care, and lower costs to Medicare.	On April 26, 2012, CMS announced the first 16 organizations that will participate in the Independence at Home demonstration. The demonstration began on June 1, 2012, and is scheduled to conclude on May 31, 2015. See http://innovation.cms.gov/initiatives/independence-at-home/.
Feb. 1, 2012	3014(b)	Requires NQF to transmit to HHS its first annual review of quality measures being considered for use in federal rulemaking.	In February 2012, 2013, and 2014, the Measure Applications Partnership (MAP), convened by NQF, published the required pre-rulemaking reports. These reports may be found at https://www.qualityforum.org/Setting_Priorities/Partnership/MAP_Final_Reports.aspx.
March 1, 2012	3014(b)	Requires the HHS Secretary to make publicly available an assessment of the quality and efficiency impact of the use of endorsed quality measures.	In March 2012, CMS published this information in a report, "National Impact Assessment of Medicare Quality Measures." See https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/NationalImpactAssessmentofQualityMeasuresFINAL.PDF.
March 23, 2012	3013(a)	Requires the HHS Secretary to develop at least 10 outcome measures for acute and chronic diseases.	CMS informed CRS in October 2013 that the 10 outcome measures for acute and chronic disease have been developed.
March 23, 2012	3505(a)	Requires the Secretary to submit to Congress a report on the status of grants to, and financial stability of, trauma centers.	No funding has been appropriated for these grants and, therefore, no report has been submitted.
March 23, 2012	3508	Authorizes the HHS Secretary to fund demonstration projects to integrate quality improvement and patient safety training into clinical education of health professionals, and evaluate such projects. Requires the Secretary, by Mar. 23, 2012, to submit to Congress a report on the projects and their evaluation.	No funding has been appropriated for these grants and, therefore, no report has been submitted.

Deadline	ACA Section	Requirements	Actions Taken as of April 15, 2014
Title IV: Prevention and Public Health, Health Disparities			
Sept. 23, 2011	4302(b)	Requires the HHS Secretary to submit to Congress a report evaluating health care disparities data collection under Medicaid and CHIP.	On Sept. 29, 2011, HHS released "Report to Congress: Approaches for Identifying, Collecting, and Evaluating Data on Health Care Disparities in Medicaid and CHIP." See http://www.healthcare.gov/law/resources/reports/disparities09292011a.pdf.
Sept. 23, 2011	4103	Requires the HHS Secretary to make publicly available a health risk assessment model to support Medicare coverage of personalized prevention plan services.	CDC's "Interim Guidance for Health Risk Assessments and their Modes of Provision for Medicare Beneficiaries" is available at http://www.cms.gov/coveragegeninfo/downloads/healthriskassessmentsCDCfinal.pdf.
March 23, 2012	4102(a)	Requires the HHS Secretary to implement a 5-year national public education campaign on oral health care prevention and education.	No funds have been appropriated for the public education campaign, which has not been implemented.
March 23, 2012	4203	Requires the Architectural and Transportation Barriers Compliance Board (the Access Board), in consultation with FDA, to promulgate standards to ensure that medical diagnostic equipment is accessible to, and usable by, individuals with disabilities.	The Access Board published proposed standards on Feb. 9, 2012 (77 *Federal Register* 6916) then organized an advisory committee to review the comments on the proposal and prepare recommendations for the Board to use in finalizing the standards. The advisory committee submitted its recommendations to the Board on Dec. 6, 2013. For more information, see http://www.access-board.gov/guidelines-and-standards/health-care/about-this-rulemaking.
March 23, 2012	4303	Requires CDC to conduct a national survey of employer-based health policies and programs.	CDC is exploring the feasibility of conducting this survey.
March 23, 2012	10407(d)	Requires the HHS Secretary to submit to Congress a report on the appropriate level of diabetes medical education.	No public information located.
Title V: Health Workforce			
April 1, 2011	5101	Requires the National Health Care Workforce Commission to submit to Congress a report containing a review of, and recommendations on, high-priority health care workforce issues.	The 15-member commission was appointed in 2010, but has received no funding and has not produced any reports. See http://www.cq.com/doc/hbnews-3962182?wr=bzR2QWhQbmtjMG1HalczZVVpWTNiZw; and http://www.nytimes.com/2013/02/25/health/health-care-panel-lacking-budget-is-left-waiting.html?_r=1&.
Oct. 1, 2011	5101	Requires the National Health Care Workforce Commission to submit to Congress a report containing a review of, and recommendations on, national health care workforce priorities, goals, and policies.	The 15-member commission was appointed in 2010, but has received no funding and has not produced any reports. See http://www.cq.com/doc/hbnews-3962182?wr=bzR2QWhQbmtjMG1HalczZVVpWTNiZw; and http://www.nytimes.com/2013/02/25/health/health-care-panel-lacking-budget-is-left-waiting.html?_r=1&.
Sept. 23, 2011	5507(a)	Requires the HHS Secretary to award 3-year demonstration grants to states for developing core training competencies and certification programs for personal or home care aides. ACA appropriated a total of $15 million for the grant program over the period FY2010-FY2012.	HRSA awarded Personal and Home Care Aide State Training (PHCAST) grants in FY2010-FY2012. See http://bhpr.hrsa.gov/nursing/grants/phcast.html.

Deadline	ACA Section	Requirements	Actions Taken as of April 15, 2014
July 1, 2011	5503(a) & (b)	Requires the HHS Secretary to reduce the residency caps of hospitals with unused residency positions for the purpose of making graduate medical education (GME) payments under Medicare. Further requires the Secretary to redistribute these unused positions, based on a specified formula. Direct GME and indirect medical education (IME) payments for the redistributed residency positions are to be made on the same basis as the payments for existing residency positions. Effective beginning July 1, 2011.	On Nov, 24, 2010, CMS published final rules for various Medicare hospital payment systems for 2011, which included the GME payment changes pursuant to ACA Sec. 5503 (75 *Federal Register* 72147).
July 1, 2011	5602	Requires the HHS Secretary to publish a final rule (incorporating public comment on an earlier interim final rule) on a comprehensive methodology and criteria for designating medically underserved populations and health professions shortage areas.	A final rule has yet to be published. See the entry for ACA Sec. 5602 in **Table 1** for the status of other HHS actions taken towards meeting this regulatory deadline.
March 23, 2012	5304	Requires the HHS Secretary to establish an alternative dental care providers demonstration project.	The FY2011, FY2012, FY2013, and FY2014 Labor-HHS-Education appropriations acts all prohibited funding the demonstration.
March 23, 2012	5507(a)	Requires the HHS Secretary to submit to Congress a report on initial implementation of the home health aide demonstration project.	HHS submitted a report to the relevant congressional committees in January 2012. See http://bhpr.hrsa.gov/nursing/grants/phcastimplementationreport.pdf.
Title VI: Elder Justice, Transparency and Program Integrity			
Sept. 23, 2011	6703(a)	Requires the Advisory Board on Elder Abuse, Neglect, and Exploitation to prepare and submit to the Elder Justice Coordinating Council and to Congress a report containing information on the status of federal, state, and local public and private elder justice activities and recommendations on elder justice programs, research, and enforcement, among other things.	On July 14, 2010, HHS published a notice establishing the Advisory Board (75 *Federal Register* 40838), but the Board has received no funding and has not submitted a report.
Sept. 23, 2011	6703(c)	Requires the HHS Secretary to submit to the Elder Justice Coordinating Council and to Congress a report containing the findings and recommendations of a study on establishing a national nurse aide registry.	No public information located.

Deadline	ACA Section	Requirements	Actions Taken as of April 15, 2014
March 23, 2012	6703(a)	Requires the Elder Justice Coordinating Council to submit to Congress a report on the Council's activities with recommendations for legislation, model laws, or other action as appropriate.	On Oct. 11, 2012, the HHS Secretary convened the inaugural meeting of the Elder Justice Coordinating Council (EJCC). The Council is a permanent group, anticipated to meet twice a year, and is supported by the Elder Justice Interagency Working Group (EJWG). Since the inaugural meeting, the Council has convened two times, on May 13, 2013 and Sept. 24, 2013. During these meetings EJWG members presented proposals for federal action and a summary of steps for federal involvement in the prevention, detection, and prosecution of elder abuse. In addition, the EJWG has coordinated a report of federal activities in elder justice since 2010. For a copy of the report, a list of EJCC members, and more information on EJCC meetings and proposals, see http://www.aoa.gov/AoA_programs/Elder_Rights/EJCC/Index.aspx.
Mar. 23, 2012	6101(a)	Requires the HHS Secretary to promulgate final regulations on required disclosure of ownership and other information by nursing facilities.	On May 6, 2011, CMS published the FY2012 Skilled Nursing Facility (SNF) reimbursement update proposed rule (76 *Federal Register* 26364), which included a discussion of the agency's proposals for implementing ACA Sec. 6101(a) and requested comments. On Aug. 8, 2011, CMS published the FY2012 SNF final rule (76 *Federal Register* 48486), in which it indicated that the proposed changes to implement ACA Sec. 6101 would be issued at a later, but unspecified, date. No additional public information on the implementation of 6101(a) has been located. The HHS/OIG has indicated that it is reviewing SNF ownership disclosure information and state and federal processes for verifying this information. See FY2013 HHS/OIG work plan at http://oig.hhs.gov/reports-and-publications/archives/workplan/2013/Work-Plan-2013.pdf.
Mar. 23, 2012	6102	Requires the HHS Secretary in collaboration with the OIG to promulgate regulations for an effective compliance and ethics program at nursing facilities.	Regulations implementing ACA Sec. 6102 have yet to be issued; however, prior to ACA's enactment nursing facilities were required to have an effective compliance program in place. The HHS/OIG has published guidance on implementation of compliance and ethics programs that are effective until new regulations are issued. See 73 *Federal Register* 56832, Sept. 30, 2008, "OIG Supplemental Compliance Program Guidance for Nursing Facilities," http://www.gpo.gov/fdsys/pkg/FR-2008-09-30/pdf/E8-22796.pdf.
Mar. 23, 2012	6102	Requires the HHS Secretary to establish and implement a Quality Assurance and Performance Improvement (QAPI) program for nursing homes.	CMS has not yet published a proposed rule to implement a QAPI program for nursing homes and other long-term care facilities. The agency maintains a nursing home QAPI website at http://cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/NHQAPI.html.

Deadline	ACA Section	Requirements	Actions Taken as of April 15, 2014
Mar. 23, 2012	6107	Requires GAO to submit a report to Congress on the Five-Star Quality Rating System for nursing facilities.	On Mar. 23, 2012, GAO published a report (GAO-12-390), "Nursing Homes: CMS Needs Milestones and Timelines to Ensure Goals for the Five-Star Quality Rating System Are Met." See http://www.gao.gov/assets/590/589563.pdf. GAO's report examined (1) how CMS developed and implemented the Five-Star System and what key methodological decisions were made during development, (2) the circumstances under which CMS considered modifying the Five-Star System, and (3) the extent to which CMS established plans to help ensure it achieves the Five-Star System goals.
Titles VII, VIII & X: 340B Drug Pricing, CLASS Act, Indian Health			
Sept. 23, 2011	7103(a)	Requires the Comptroller General to submit to Congress a report on whether the 340B program should be expanded, whether mandatory 340B sales of certain products could hinder patients' access to those therapies through any provider, and whether 340B income is being used by covered entities to further program objectives.	On Sept. 23, 2011, GAO released report GAO-11-836, "Drug Pricing: Manufacture Discounts in the 340B Program Offer Benefits, but Federal Oversight Needs Improvement." See http://www.gao.gov/new.items/d11836.pdf.
Jan. 1, 2012	8002(a)	Requires the HHS Secretary to establish an eligibility assessment system for individuals who apply to receive benefits under the CLASS Act.	On Jan. 3, 2013, President Obama signed the American Taxpayer Relief Act of 2012 (ATRA, P.L. 112-240). Among its provisions, ATRA repealed the CLASS Act and made several conforming statutory changes to the Medicaid statute. ATRA also repealed ACA's annual appropriation (FY2011-FY2015) to the National Clearinghouse for Long Term Care Information and rescinded the unobligated balance.
Jan. 15, 2012	7002(f)	Requires the HHS Secretary to transmit to Congress its plans for establishing an abbreviated licensure pathway for biological products that are demonstrated to be biosimilar to or interchangeable with an FDA-licensed biological product.	On Feb. 15, 2012, FDA published three draft guidance documents on key scientific and regulatory factors involved in submitting applications for approval of biosimilar products (77 *Federal Register* 8883, 8884, 8885). See http://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/ApprovalApplications/TherapeuticBiologicApplications/Biosimilars/default.htm.
Sept. 23, 2011	10221	Requires the HHS Secretary to submit a report to Congress on protocols, policies, procedures, and other programs for victims of domestic or sexual violence. [IHCIA Sec. 181]	IHS informed CRS on Apr. 15, 2014, that the report is completed and is in the IHS clearance process.
Sept. 23, 2011	10221	Requires the HHS Secretary to submit a report describing the specified elements of the prescription drug monitoring program. [IHCIA Sec. 196]	IHS informed CRS on Apr. 15, 2014, that the report is completed and is in the IHS clearance process.
Sept. 23, 2011	10221	Requires the Attorney General (AG) to submit a report to Congress describing certain factors regarding the AG's responsibility related to prescription drug abuse in Indian communities. [IHCIA Sec. 196]	In Oct. 2011, the Department of Justice released "Indian Health Care Improvement Act, Report Required by 25 U.S.C. 1680q(b)(2)." See http://www.justice.gov/tribal/docs/ihia-pdmp-rpt-to-congress.pdf.

Deadline	ACA Section	Requirements	Actions Taken as of April 15, 2014
Sept. 23, 2011	10221	Requires the HHS Secretary to submit a report to Congress describing disease and injury prevention activities by IHS and other federal agencies. [IHCIA Sec. 198]	IHS informed CRS on Apr. 15, 2014, that the report is completed and is in the IHS clearance process.
Sept. 23, 2011	10221	Requires GAO to submit a report to Congress containing the results and recommendations resulting from a study evaluating the effectiveness of the coordination of health care services provided to Indians either through Medicare, Medicaid, or CHIP, with those provided by IHS, with funding from state or local governments or Indian tribes. [IHCIA Sec. 199]	On September 5, 2013, GAO released report 13-553, "Indian Health Service: Most American Indians and Alaska Natives Potentially Eligible for Expanded Health Coverage, but Action Needed to Increase Enrollment." See http://www.gao.gov/products/GAO-13-553.
Sept. 23, 2011	10221	Requires the Comptroller General to study (in consultation with IHS, Indian tribes, and tribal organizations) and make recommendations to improve the use of health care services provided under the contract health service (CHS) program. This will include analyses of amounts reimbursed to providers, suppliers, and entities under CHS, compared to reimbursements through other public and private programs; barriers to access to health care under CHS; adequacy of federal funding of CHS; and other matters that GAO determines appropriate. [IHCIA Sec. 199]	On Sept. 23, 2011, GAO released report GAO-11-767, "Indian Health Service: Increased Oversight Needed to Ensure Accuracy of Data Used for Estimating Contract Health Service Need." See http://www.gao.gov/new.items/d11767.pdf. On June 15, 2012, GAO released a second CHS report in response to this mandate: GAO-12-446, "Indian Health Service: Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program." See http://www.gao.gov/assets/600/591631.pdf. On April 13, 2013, GAO released Report GAO-13-272, "Capping Payment Rates for Nonhospital Services Could Save Millions of Dollars for Contract Health Services." See http://www.gao.gov/assets/660/653728.pdf.
Feb. 6, 2012	10221	Requires the President to include, within IHS's annual budget request and justification, amounts that reflect changes in the cost of health care services adjusted by the consumer price index and amounts adjusted to reflect changes in the IHS service population. [IHCIA Sec. 195]	IHS's FY2015 budget included these adjustments. See http://www.ihs.gov/budgetformulation/includes/themes/newihstheme/documents/FY2015CongressionalJustification.pdf.
Feb. 6, 2012	10221	Requires the Secretary to submit a report to the President describing the health care facility priority system and the top 10 priorities for various construction projects under this priority system. This report is to be included in the annual report that the President is required to transmit to Congress at the time the annual budget is submitted (see above). [IHCIA Sec. 141]	IHS updates its health care facility priority report annually. The most recent update is dated July 13, 2012. IHS has informed CRS that the 2013 annual update is in preparation.
March 23, 2012	10221	Requires the Secretary to submit a biennial report to Congress on the grants awarded for the prevention, control, and elimination of communicable and infectious diseases. [IHCIA Sec. 133]	No funding has been appropriated for these grants and, therefore, no report has been submitted.

Deadline	ACA Section	Requirements	Actions Taken as of April 15, 2014
March 23, 2012	10221	Requires the Secretary, through IHS, to submit a report to Congress describing the activities carried out by the Office of Indian Men's Health and findings related to Indian Men's Health. [IHCIA Sec. 136]	IHS informed CRS on Apr. 15, 2014, that the report is completed and is in the IHS clearance process.
March 23, 2012	10221	Requires the Director of the IHS office of HIV/AIDS Prevention and Treatment to submit a report to Congress describing the office's activities and findings related to HIV/AIDS prevention and treatment activities specific to Indians. [IHCIA Sec. 201]	IHS informed CRS on Apr. 15, 2014, that the report is completed and is in the IHS clearance process.

Source: Prepared by the Congressional Research Service based on (i) the text of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148), as amended; and (ii) publicly available information from official federal sources.

Table 3. Selected ACA Deadlines in the Third Year After Enactment (March 24, 2012 – March 23, 2013)

Deadline	ACA Section	Requirements	Actions Taken as of April 15, 2014
Title I: Private Health Insurance			
July 1, 2012	1104(b)	Requires the HHS Secretary to adopt operating rules for electronic funds transfers and health claims payment/remittance transactions.	On August 7, 2012, HHS issued an interim final rule, "Administrative Simplification: Adoption of Operating Rules for Health Care Electronic Funds Transfers (EFT) and Remittance Advice Transactions." The rule was published on August 10, 2012 (77 *Federal Register* 48008).
Oct. 1, 2012	1104(c)	Effective date for a new standard unique health plan identifier, which the HHS Secretary is required to adopt.	On August 24, 2012, HHS issued a final rule, "Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier," which became effective on November 5, 2012. The rule was published on September 5, 2012 (77 *Federal Register* 54664).
Jan. 1, 2013	1104(c)	Effective date for the operating rules for the following electronic transactions: eligibility for a health plan, and health care claim status.	The operating rules for health plan eligibility and health care claim status were published on July 8, 2011 (see **Table 2**). The compliance deadline for the operating rules was January 1, 2013.
Jan. 1, 2013	1411(i)	Requires the HHS Secretary to report to Congress the results of a study on the procedures necessary to protect certain employer and employee rights under ACA.	No public information located.
Title II: Medicaid, Children's Health Insurance Program (CHIP)			
Jan. 1, 2013	2701	Requires the HHS Secretary, in consultation with the states, to develop a standardized format for reporting adult health quality measures.	CMS has provided states with technical specifications and a resource manual with which to collect the Medicaid Adult Core Set measures. See http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Health-Care-Quality-Measures.html.
Title III: Medicare, Health Care Quality			
Oct. 1, 2012	3004	Requires the HHS Secretary to publish quality measures for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs.	On Aug. 18, 2011, CMS published three finalized quality measures for use in the Long-Term Care Hospital Quality Reporting Program (76 *Federal Register* 51745-51750). On Aug. 5, 2011, CMS published two finalized quality measures for use in the Inpatient Rehabilitation Hospital Quality Reporting Program in the FY2012 Inpatient Rehabilitation Facility (IRF) PPS final rule (76 *Federal Register* 47874). On Aug. 4, 2011, CMS published two finalized quality measures for use in the Hospice Quality Reporting Program in FY2014 (76 *Federal Register* 47302, 47320).

Deadline	ACA Section	Requirements	Actions Taken as of April 15, 2014
Oct. 1, 2012	3005	Requires the HHS Secretary to publish quality measures for cancer hospitals.	On Aug. 31, 2012, CMS published five finalized quality measures for use in the PPS-Exempt Cancer Hospital Quality Reporting Program beginning with FY2014 (77 *Federal Register* 53561).
Oct. 1, 2012	10322	Requires the HHS Secretary to publish quality measures for psychiatric hospitals.	On Aug. 31, 2012, CMS published six finalized quality measures for use in the Inpatient Psychiatric Facility Quality Reporting Program beginning with FY2014 (77 *Federal Register* 53652).
Jan. 1, 2013	10331	Requires the HHS Secretary to implement a plan for making comparable information on physician performance available through the Physician Compare website.	The CMS Physician Compare website has been established. See http://www.medicare.gov/physiciancompare/search.html. Currently, Physician Compare includes information about provider participation in certain CMS quality programs (e.g., Physician Quality Reporting System). In 2014 it will include quality of care ratings for group practices only.
Mar. 23, 2013	3013(a)	Requires the HHS Secretary to develop at least 10 outcome measures for primary and preventive care.	CMS informed CRS in October 2013 that the 10 outcome measures for primary and preventive care are under development.
Title IV: Prevention and Public Health, Health Disparities			
Mar. 23, 2013	1201	Requires the HHS Secretary to submit a report to Congress regarding the impact and effectiveness of wellness programs and incentives.	HHS and the Department of Labor contracted with RAND, which published *Workplace Wellness Programs Study, Final Report*, May 30, 2013, http://www.rand.org/pubs/research_reports/RR254.html.
Title VI: Transparency and Program Integrity			
May 1, 2012	6001	Requires the HHS Secretary to begin conducting audits of physician-owned hospitals to determine compliance with Stark Law requirements.	No public information located. [Note: ACA Sec. 6001 amends certain exceptions to the Stark law to impose additional limitations on physician ownership or investment in hospitals, including restrictions on facility expansion. CMS extended the deadline for physician-owned hospitals to report ownership and investment information, pursuant to Sec. 6001, to Mar. 1, 2014; see http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Spotlight.html.]
Mar. 28, 2012	6402(j)	Requires the HHS Secretary to submit a report to Congress on the effectiveness of the Medicare Integrity Program (MIP) funds.	No public information located.
Titles VII, VIII & X: 340B Drug Pricing, CLASS Act, Indian Health			
Feb. 5, 2013[a]	10221	Requires the President to include, within IHS's annual budget request and justification, amounts that reflect changes in the cost of health care services adjusted by the consumer price index and amounts adjusted to reflect changes in the IHS service population. [IHCIA Sec. 195]	IHS's FY2015 budget included these adjustments. See http://www.ihs.gov/budgetformulation/includes/themes/newihstheme/documents/FY2015CongressionalJustification.pdf.

Deadline	ACA Section	Requirements	Actions Taken as of April 15, 2014
Feb. 5, 2013[a]	10221	Requires the Secretary to submit a report to the President describing the health care facility priority system and the top 10 priorities for various construction projects under this priority system. This report is to be included in the annual report that the President is required to transmit to Congress at the time the annual budget is submitted (see above). [IHCIA Sec. 141]	IHS updates its health care facility priority report annually. The most recent update is dated July 13, 2012. IHS informed CRS that the 2013 annual update is in preparation.
March 23, 2013	10221	Requires the HHS Secretary to submit a report to Congress on the current health status and resource deficiencies of each tribe or service unit. [IHCIA Sec. 121]	IHS informed CRS on Apr. 15, 2014, that the report is in progress.
March 23, 2013	10221	Requires the HHS Secretary to submit a report to Congress considering the feasibility of considering the Navajo Nation[b] as a state for Medicaid purposes. [IHCIA Sec. 155]	CMS has informed CRS that the report is completed and is in the clearance process.

Source: Prepared by the Congressional Research Service based on (i) the text of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148), as amended; and (ii) publicly available information from official federal sources.

a. This is the date that the President's FY2014 budget was due. The FY2014 budget was actually released on April 10, 2013.

b. Navajo Nation resides on the Navajo reservation that is located in parts of Arizona, Utah, and New Mexico.

Appendix. Methodology for Determining Statutory Deadlines and their Legal Enforceability

The following material is reproduced from the CRS Congressional Distribution Memorandum, “Deadlines for the HHS Secretary and Other Federal Entities in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148), March 23, 2010 – March 23, 2011: Implementation Actions Taken as of April 1, 2011,” by C. Stephen Redhead and Todd B. Tatelman, dated April 5, 2011.

Categorical Exclusions

Given the complexity of the ACA and the variety of legislative drafting techniques used, CRS was required to make a number of decisions as to whether a specific provision qualified for inclusion in the tables. To make those determinations, CRS relied on a close reading of the statutory text, acceptable principles of statutory interpretation (commonly referred to as “canons”), and subject matter expertise regarding typical implementing agency practice in the issue areas covered by the ACA. As a result of our review of the ACA, several categories of provisions, described below, were excluded from the tables.

Effective Dates

Perhaps the largest category of exclusions were provisions that merely had an “effective date” attached to them, as opposed to a specific deadline for official federal government action. For example, ACA Sec. 1001, which adds new sections to the Public Health Service Act (PHSA), requires the HHS Secretary to define several terms related to private health insurance coverage. Pursuant to ACA Sec. 1004, these definitions took effect on September 23, 2010. However, because the ACA did not provide a specific date for the Secretary’s actions, merely an effective date, the provisions were not included in the tables.

In contrast, it should be noted that there are a few provisions in the ACA where an effective date operates as a deadline. For instance, in ACA Sec. 10501(i), the Administrator of the Centers for Medicare & Medicaid Services (CMS) is directed to develop and implement a new prospective payment system for federally qualified health centers. The ACA establishes January 1, 2011, as the effective date of the provision. Given that the only lawful way in which the effective date can be met is if CMS takes the necessary actions to authorize payments to qualified centers the effective date functions as a deadline. Thus, this type of provision was included in the tables. However, several other ACA provisions that require CMS to modify *existing* Medicare payment systems, either permanently or on a temporary basis, were not included in the tables. These types of provisions are being implemented as part of CMS’s annual rulemaking updates for the applicable Medicare payment systems.[6]

Medicaid and Medicare Benefit Expansions

The ACA includes a number of provisions that require coverage of new Medicare benefits, effective for services provided on or after a specified date. None of these provisions are included in the tables. While

[6] For example, ACA Sec. 3002, which extends the Physician Quality Reporting Initiative incentive payments and introduces a new bonus for professionals who meet a continuous assessment requirement, is addressed in the final rule updating the Physician Fee Schedule for 2011. The final rule was published in the November 29, 2010 *Federal Register*. See http://edocket.access.gpo.gov/2010/pdf/2010-27969.pdf.

the effective date appears to operate as a deadline, there is no explicit requirement for a specific action to be taken. As with the Medicare payment changes, CMS seems to have opted to implement the required benefit expansions in its annual rulemaking updates for applicable Medicare payment systems.[7] The ACA also includes two provisions that mandate new Medicaid benefits (i.e., Secs. 2301 and 4107), both of which have an effective date. Again, while the effective date appears to operate as a deadline, there is no explicit requirement for a specific action to be taken. Moreover, meeting the deadline depends on actions to be taken by the states. For these reasons, the two provisions were not included in the tables.

Discretionary Appropriations

Another category of provisions that has been excluded from the tables are those that contain deadlines that are contingent on future appropriated funds. In other words, even if the ACA authorized the funding, without an actual appropriation, it is unlikely that the deadline will be binding. Because Congress is not legally required to appropriate funds, even for authorized programs, there is nothing that guarantees the entity charged with meeting the deadline will have the necessary funding to do so. ACA Sec. 3503 serves as an example of such a provision. It requires the HHS Secretary to establish a grant program to support medication management services provided by pharmacists. Although the ACA provided an authorization of appropriations for this grant program, there is no actual funding available and, therefore, the provision is contingent on future appropriations by Congress that are discretionary. Thus, inclusion of the provision as a deadline is arguably misleading as Congress must first act to provide the funding, which they are under no legal or political obligation to do.[8]

Transfer Payments

Several provisions in the ACA require the transfer of funds from one federal account to another within a specified fiscal year. For example, ACA Sec. 3014 requires the HHS Secretary to transfer $20 million from the Medicare Trust Funds to CMS's Program Management Account for each of FY2010 through FY2014 for the development and adoption of Medicare quality and efficiency measures, among other things. As these transfers can legally be executed at any point during the relevant fiscal year, there does not appear to be a definitive deadline for agency action. Thus, these and other similar transfer provisions were excluded from the tables.[9]

Non-Federal Government Actors

A number of provisions in the ACA that contained deadlines imposed these deadlines on non-federal actors, such as state governments, third-party groups, or private insurance providers. For example, ACA Sec. 1001 prohibits health plans from rescinding coverage except in instances of fraud or misrepresentation. That provision, along with several other ACA provisions that apply to health plans and health insurance issuers, became effective for plan years beginning on or after September 23, 2010. As the

---

[7] For example, ACA Sec. 4103 requires Medicare Part B to cover personalized prevention plan services, including a comprehensive health risk assessment, effective January 1, 2011. CMS addressed this new benefit in the final rule updating the Physician Fee Schedule for 2011. The final rule was published in the November 29, 2010 *Federal Register*. See http://edocket.access.gpo.gov/2010/pdf/2010-27969.pdf.

[8] For a summary of all the programs in ACA that are subject to discretionary appropriations, see CRS Report R41390, *Discretionary Funding in the Patient Protection and Affordable Care Act (ACA)*, coordinated by C. Stephen Redhead.

[9] For a summary of all the Medicare fund transfers in ACA, see CRS Report R41301, *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (ACA)*, by C. Stephen Redhead.

provision does not require any action on the part of a federal government agency or official to become effective, it and similar provisions were excluded from the tables. Likewise, ACA provisions that imposed deadlines on state officials, including several Medicaid provisions, were excluded both because of the voluntary nature of the Medicaid program itself, but also because the various states do not have uniform methods and mechanisms for complying with such deadlines. Thus, providing information on compliance would require a survey of each separate jurisdiction.

Other Exclusions

In addition to the categorical exclusions discussed above, there were several other provisions of the ACA that contained deadlines that are not included in the tables. For instance, ACA Sec. 4306, which appropriated funds for an obesity demonstration program authorized by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA),[10] was not included because the February 4, 2011 deadline for awarding a grant is contained in CHIPRA, not the ACA. Another excluded provision, Sec. 4101(a), requires the HHS Secretary to create a grant program for the establishment of school-based health centers. The provision appropriates funding for the program for each of FY2010 through FY2013, with the funds to remain available until expended, but it does not establish a definitive deadline for starting the program. Thus, because the deadline is ambiguous and the agency could use the funds at any time between FY2010 and FY2013 the provision was excluded. Similarly excluded was Sec. 6403, which among other things requires the HHS Secretary to terminate the Healthcare Integrity and Protection Data Bank and transfer the data to the National Practitioner Data Bank. This action must be completed by March 23, 2011, or a date determined by the Secretary through regulation, whichever is later. Because the Secretary retains discretion in setting the effective date, the provision was excluded as having an ambiguous deadline.

Finally, it should be noted that ACA Sec. 5605 was omitted from the tables as well. This provision imposed a deadline directly on congressional leadership, specifically the Speaker and Minority Leader in the House of Representatives and the Majority and Minority Leaders in the Senate, to appoint members of a commission by April 22, 2010. The commission, once constituted, then has statutorily imposed annual reporting deadlines. Finally, the National Academy of Sciences is required to take specific actions based on deadlines met by the commission. The congressional leadership did not meet the deadline for appointing the commission members. As each subsequent deadline is contingent on the appointment of the members of the commission, it appears that they cannot be satisfied as the commission's members have not yet been appointed. The expiration of the 111th Congress raises the question of whether the leadership of the 112th Congress, which convened on January 5, 2011, is lawfully required to make the commission appointments. It would appear that the answer is no. The principle at issue is that one Congress cannot bind a future Congress.[11] The incoming leadership may, of course, choose to make the appointments, but it would be doing so voluntarily, not out of any legal obligation.

Legal Effect of Deadlines

As a matter of administrative law, the enforceability of statutory deadlines is handled primarily via private civil litigation against the agency for failure to comply with the deadline. Typically, reviewing courts have deferred to the judgment of the agencies with respect to claims that they have unreasonably delayed

[10] The Children's Health Insurance Program Reauthorization Act of 2009, P.L. 111-3, 123 Stat. 8 (2009).

[11] See, e.g., *Cooper v. Gen. Dynamics*, 533 F.2d 163, 169 (5th Cir.1976) (holding that one Congress cannot insulate a statute from amendments by future Congresses).

action or violated statutory deadlines. In one prominent example, the Circuit Court of Appeals for the District of Columbia (D.C. Circuit) declined to compel a rulemaking by the Mine Safety and Health Administration (MSHA) even though the agency had violated a statutory deadline for completing regulation.[12] The court did, however, agree to retain jurisdiction and required MSHA to report regularly on the status of its rulemaking process.[13] In another decision, *In re Bluewater Network*,[14] the D.C. Circuit established standards for adjudicating unreasonable delay cases, in which the relevance of congressionally imposed deadlines was specifically discussed. The court noted that the general rule ought to be a "rule of reason," which is arguably consistent with the traditional deference afforded to agency judgment over rulemaking priorities. The court noted, however, that "where Congress has provided a timetable or other indication of the speed with which it expects the agency to proceed in the enabling statute, that statutory scheme may supply content for this rule of reason."[15] The permissive language used indicates that congressional deadlines will not always supplant the "rule of reason," but depending on the specific situation before the court, statutory deadlines may overcome the court's traditional deference to agency priority setting.

Congress may not always wish to rely on judicial enforcement of its statutorily imposed deadlines. In some cases, though not in any of the ACA provisions reviewed and included in the tables below, it has sought to impose legislative "hammers" or legal consequences on an agency's failure to adhere to a deadline. Some examples of previous "hammers" have included the automatic imposition of a congressionally regulated result,[16] a requirement that an agency's proposed rule take effect if a final rule was not promulgated by the deadline,[17] and the loss of agency funding if the final regulations were not promulgated by the statutory deadline.[18] As previously noted, none of the provisions in the ACA establishing deadlines on agency implementation appear to contain any type of legislative "hammer." Thus, it would appear that enforcement of any of these deadlines is to be left either to political enforcement, such as through congressional oversight and/or other forms of legislative pressure, or to the types of civil litigation discussed above.

[12] See *In re United Mine Workers of Am. Int'l Union*, 190 F.3d 545, 553-56 (D.C. Cir. 1999).

[13] *Id.*

[14] 234 F.3d 1305 (D.C. Cir. 2000).

[15] *Id.* at 1315-16.

[16] See 42 U.S.C. § 6924(d)(1-2) (2006).

[17] See Nutrition Labeling and Education Act of 1990, P.L. 101-535, 104 Stat. 2353 (1990).

[18] See Department of Transportation and Related Agencies Appropriations Act, 1988, P.L. 100-202, 101 Stat. 1329 (1987).

The New York Times | http://nyti.ms/1rgNKpB

U.S. | NYT NOW

Looking at Costs and Risks, Many Skip Health Insurance

By ABBY GOODNOUGH APRIL 21, 2014

LOUISVILLE, Ky. — Steve Huber, an affable salesman who is still paying off an unexpected medical bill, was not among the millions of Americans who signed up for health insurance under the Affordable Care Act during the enrollment period that ended March 31.

After seeing television ads for Kentucky's new online insurance marketplace, Mr. Huber, 57, made several attempts to explore the website but found it too complicated. Moreover, his income has dropped in recent years, he said, and he felt certain that he could not afford coverage. So he never priced plans or researched whether he qualified for financial assistance.

"I realize that I'm gambling," he said, stopping at a coffee shop before a sales call. "But I don't have a lot of patience, and I'm on a pretty tight budget anyway."

After a surge of last-minute sign-ups, eight million people bought private coverage through the federal and state marketplaces during the initial six-month enrollment period, exceeding the Obama administration's target. Mr. Huber represents the next challenge for the administration as it struggles to reduce the ranks of the uninsured and broaden support for the president's signature health care law.

For every individual who did sign up, there were others who resembled Mr. Huber: people who have decided to stay uninsured for now,

despite the law's requirement that most Americans get coverage this year or pay an income tax penalty of $95 or more.

A common thread running through stories of the unenrolled is cost. Many people either do not qualify for federal subsidies or believe that the assistance is not enough to make insurance affordable, interviews with consumers and experts suggested. According to enrollment counselors in several states, people who have gone without health insurance or major illness for years can be especially resistant to investing in coverage.

To be sure, some of those who chose not to sign up were motivated by ideological opposition to Mr. Obama, to the law's mandate that they buy insurance, or to both. And for many others, confusion and lack of understanding, including about whether they could get financial help buying coverage, were the overriding reasons.

But a New York Times/CBS News poll of uninsured people in December found that of those who did not plan to get coverage, half said that cost was the main reason. Nearly three in 10 said they objected to the government's requiring it, while about one in 10 said they felt they did not need it.

Heidi Reinberg, 53, a freelance documentary producer who lives in Brooklyn, said she had gone uninsured for most of her adult life and had managed just fine.

She did check out her options through New York's marketplace but said she was not impressed. She did not qualify for a subsidy based on her 2013 income, she said, and was particularly put off by the high deductibles on many of the plans available to her.

With an income that fluctuates unpredictably, she said that she could not justify a new expense for something that was "not a priority."

"It doesn't scare me not to have it," said Ms. Reinberg, adding that she exercised, ate healthily and rarely got sick. "I'd rather pay down my credit cards than take on another bill for something I don't know that I'm going to need."

She acknowledges that she could have major medical expenses as she

ages. And she might buy insurance in the future if her income stabilizes, she said. But for now, like many others, she has decided that the financial penalty for not buying insurance is more palatable than the cost of premiums and deductibles.

"I know what the penalty is going to be," she said, "and I can get my head around that."

There is no demographic data on the uninsured who could have bought coverage through the exchanges but chose not to. But a federal report last year on the overall uninsured population eligible for coverage under the new law estimated that 45 percent had incomes low enough to qualify for financial assistance buying exchange plans. Many others were poorer and eligible for Medicaid because their state opted to expand the program. Another federal report last year said that young and healthy people made up nearly half of the uninsured, and that more than half were men.

For Mr. Huber, the salesman, the complexity of the process was enough to make him give up trying to enroll.

In 2011, Mr. Huber lost a better-paying job with health benefits. For a while, he paid $450 a month to continue his employer-based coverage under the federal Cobra law. But that quickly grew unaffordable, and he has been uninsured for the last two years. He has a new job as a battery salesman but is making about half of what he used to, he said.

Not having insurance has also carried a price. A bout of diverticulitis, an intestinal inflammation, left him with a $1,100 medical bill last fall. He stretches his blood pressure medicine, taking it "exactly half as often as I'm supposed to," and pays out of pocket when he sees his internist.

Declaring himself impatient and not good with computers, Mr. Huber said he had become flummoxed when trying to explore Kynect, Kentucky's insurance marketplace, including late last month, when the online application form would not accept his phone number. He did not know that he could have sought enrollment help, he said.

"I tried four times and said, 'Forget this,' and logged off," he said.

He said he would probably try again during the next open enrollment period, from Nov. 15 through Feb. 15, perhaps enlisting an insurance agent's help. As for the tax penalty, he had heard it would be $95 for everyone and was surprised to learn he could owe more.

"They can get in line, I guess," he said of the Internal Revenue Service, shaking his head.

Drew Lacy, 32, a self-employed carpenter in Louisville, encountered a technical glitch with the online marketplace that dissuaded him from signing up.

Mr. Lacy enrolled last fall in a plan with monthly premiums of about $200 after a subsidy and what appeared to be a $250 annual deductible. But in December, his broker informed him that Kynect had miscalculated because of a programming error.

The error, which the exchange acknowledged, affected about 2,100 people. Mr. Lacy's deductible, he learned, would actually be much higher; other out-of-pocket costs would be higher, too.

Put off by the error, he canceled his enrollment and did not explore other options.

"I went from being very hopeful and excited to do this to being infuriated," he said, standing in his carpentry shop in a former distillery.

Mr. Lacy had been covered for several years by an inexpensive, bare-bones plan — "If I was in a helicopter crash, it might pay for something," he joked. But he wanted more comprehensive benefits so that he could see doctors for elbow and neck problems, among other things.

For now, he is holding on to his old plan, which costs $98 a month and has a $3,500 deductible. But it will be canceled this fall, he said, because it does not meet the new coverage requirements of the Affordable Care Act. At that point, he might check back in with Kynect.

"Let's see what this actually turns out to be and what changes are made," he said.

Tammy Williams of Bothell, Wash., based her decision to opt out partly on philosophical resistance to the law.

"The government comes into our life and makes these decisions for us without even asking us," said Ms. Williams, 56. "It just makes me want to rebel."

Ms. Williams, who earns less than $40,000 a year at a small marketing firm in Seattle, said she did not want to hand over what little discretionary money she had after rent and other living expenses to an insurance company. She has been uninsured since moving a year ago from Ohio, where she had a job with health benefits.

She qualified for a subsidy to help buy coverage through Washington's marketplace, but said that she still would have had to pay around $135 a month for the least expensive plan, with a $6,000 deductible that she said made it unfeasible.

"I am opting out," she said on the last day of the enrollment period, adding that she might instead buy dental coverage outside the marketplace to take care of a chipped crown and a cavity.

A political independent, Ms. Williams said she at first chided herself about not buying coverage, thinking, "There's plans out there that make it a good thing for people, and I'm just going for rebelling against the government."

But when she looked closely at the costs, she decided her resentment was justified.

"If given a voice — 'Do you want to participate or not?' — I would have said no," Ms. Williams said. "But I don't remember being asked."

Yet for all the resisters, there were people who intended not to enroll, then changed their minds at the last minute.

Cindy Whitely, who works for a small home-improvement company in Louisville, initially decided not to buy insurance through Kynect because, even with a subsidy, it would have cost more than $400 a month for her family of three.

But her income fell over the winter, and when an enrollment counselor she met in the fall called recently to see if she wanted to reconsider, she agreed. With less income, she and her husband qualified

for a bigger subsidy, and their 6-year-old son qualified for Medicaid.

Just before the March 31 deadline, they bought a plan with monthly premiums of $176 and an $1,800 deductible — still expensive "for something I may never use," she said. In her 44 years, Ms. Whitely said, she has never had health insurance.

For her, the mandate and its threat of a penalty were important. "I'm doing it more because I have to," she said.

Still, she is relieved that her son now has Medicaid coverage. And now that she has health insurance for the first time, she has already begun worrying about losing it. Might she have to give it up if her income grows and her subsidy shrinks?

"If work picks back up and I jump right back up there," she said, "then I'm stuck."

A version of this article appears in print on April 22, 2014, on page A1 of the New York edition with the headline: Looking at Costs and Risks, Many Skip Health Insurance.

Next in U.S.
White House Debates How Far to Go in Easing Deportations

© 2014 The New York Times Company

ACAView: Measuring the Impact of Health Care Reform

Metrics that assess the ACA's impact on providers, patients and physicians

March 2014 | Publisher: Robert Wood Johnson Foundation | Publication: Reform by the Numbers

Author(s): athenahealth

The ACAView project represents a unique partnership between athenahealth and RWJF.

To create ACAView, athenahealth, a cloud-based health IT company, is developing an expanding list of metrics to measure the ACA's impact on provider access, patient financial obligation, health status of new patients, physician revenue cycle, and provider reimbursement in the ambulatory care setting. Data will be updated monthly and quarterly reports will provide more perspective.

athenahealth is a leading provider of cloud-based services for electronic health record (EHR), practice management, and care coordination. The company works with more than 50,000 providers across the U.S. and, via its national cloud-based network, is able to monitor real-time data on financial, operational and clinical characteristics of patient encounters. For more information, please visit www.athenahealth.com.

Our mission: to improve the health and health care of all Americans.

© 2001–2014 Robert Wood Johnson Foundation. All Rights Reserved.

COVERED CALIFORNIA

(From left) Peter V. Lee, executive director, California Health Benefit Exchange; David Maxwell-Jolly, former chief deputy executive director for strategy, California Health Benefit Exchange; Karen Ruiz, CalHEERS project director, California Health Benefit Exchange; Juli Baker, chief technology officer, California Health Benefit Exchange

California's health benefits exchange hasn't been perfect. In the early weeks of Covered California, there were site crashes, incorrect doctor listings and glitches similar to other state-run exchanges. Perhaps initial problems were inevitable since the project was built in 15 months — a tight schedule made possible with 300 staff at Accenture along with 40 more from the state workforce.

Slowly but surely California's exchange has come into its own, becoming more stable and offering more functionality than when it went live last fall, thanks to collaborative work by the California Health Benefit Exchange, the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) and the California Department of Health Care Services. Unsurprisingly, California's health benefits exchange is the largest state-run exchange in the nation, with more than 625,000 sign-ups for health insurance by mid-January and 584,000 applicants deemed likely eligible for Medi-Cal, the state's Medicaid program.

Peter V. Lee, executive director of the California Health Benefit Exchange, said solid project governance has been a constant. Early on, the state discussed project specs with potential vendors, policymakers and health-care providers so that when it came time to accept RFPs, a good road map already was in place.

"Effective design, good vendor selection and good oversight are the three overlapping elements of why we think we were relatively successful," Lee said.

Nevertheless, California Health Benefit Exchange CTO Juli Baker said the state had to stay focused and delay some functionality in order to make the Oct. 1 deadline. In December, the state rolled out an enrollment application in Spanish, making California the only state Lee knows of that has put complete enrollment forms online in both English and Spanish.

California also improved at monitoring users' experience, Lee said. Website users can complete a post-enrollment survey and the state now tracks page load times and other metrics within a performance dashboard. A recent report found that 82 percent of Covered California users said they got all the information they needed to make an informed choice.

"That, to our mind, is a really good point of data," Lee said.

BY MATT WILLIAMS