Reports and Research

Table of Contents

June 19, 2014 Board Meeting

- *Analysis of Benefit Design in Silver Plan Variations* – **Avalere**
  June, 2014

- *Growth and Variability in Health Plan Premiums in the Individual Insurance Market before the Affordable Care Act* – **The Commonwealth Fund**
  June, 2014

- *Hospital Networks: Updated National View of Configurations on the Exchanges* – **McKinsey Center for U.S. Health System Reform**
  June, 2014

- *How to Make Reference Pricing Work for Consumers* – **Families USA**
  June, 2014

- *Improving Enrollment for Immigrant Families Could Cut the Number of Uninsured Kids in Half* – **Georgetown University Health Policy Institute/Center for Children and Families**
  June, 2014

- *Mapping Gender Gaps in Health Care* – **RAND**
  June, 2014

- *Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014 (ASPE Research Brief)* – **Department of Health & Human Services**
  June 18, 2014

- *CSU Health Insurance Education Project: Project Poll & Analysis* – **CSU Health Insurance Education Project**
  June 12, 2014

- *Consumer Assistance Dataset* – **Robert Wood Johnson Foundation**
  June 5, 2014

- *Who Are the Newly Insured as of Early March 2014?* – **Health Reform Monitoring Survey**
  May 22, 2014

- *Why did Some People Enroll and Not Others?* – **Enroll America and Perry Undem Research Communication**
  May 21, 2014

- *Eligibility for Assistance and Projected Changes in Coverage Under the ACA: Variation Across States (May 2014 Update)* – **Robert Wood Johnson Foundation and Urban Institute**
  May, 2014

- *How is the ACA Impacting Medicaid Enrollment?* – **The Henry J. Kaiser Family Foundation**
  May, 2014

- *Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care* – **The Center on Health Insurance Reforms (Georgetown University Health Policy Institute) and Urban Institute**
  May, 2014

- *The Affordable Care Act and Insurance Coverage in Rural Areas* – **The Henry J. Kaiser Family Foundation**
  May, 2014

- *Will Premiums Skyrocket in 2015?* – **Robert Wood Johnson Foundation and Urban Institute**
  May, 2014

- *Women and Health Care in the Early Years of the Affordable Care Act* – **The Henry J. Kaiser Family Foundation**
  May, 2014

- *GRIST Report: Updated COBRA Model Notices and Guidance Clarify ACA Exchange Options* – **MERCER**
  May 29, 2014

- *ACA and the Children's Health Insurance Program* – **The PEW Charitable Trusts**
  May 21, 2014

- *New Rules Protect Navigators and Certified Application Counselors from Over-Reaching State Laws but Also Impose New Requirements* – **The Center on Health Insurance Reforms (Georgetown University Health Policy Institute)**
  May 21, 2014

Analysis of Benefit Design in Silver Plan Variations

June 2014

Kelly Brantley
Hillary Bray
Caroline Pearson
Avalere Health LLC

This analysis was funded by PhRMA. Avalere maintained editorial control over the content of the analysis and release.

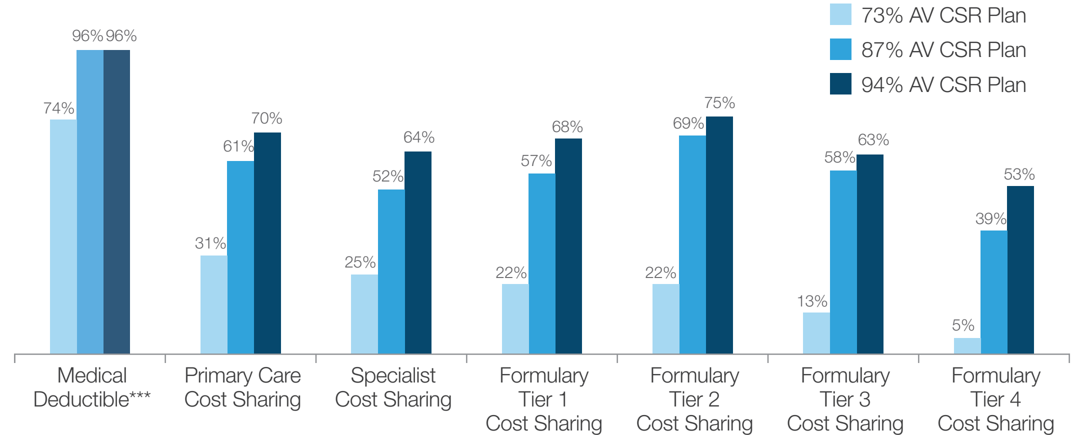
EXECUTIVE SUMMARY

Both state-based and federally-facilitated exchanges offer financial assistance for low-income enrollees. The assistance takes two forms: advanced premium tax credits and cost-sharing reductions (CSRs). This report focuses on CSR plans, which are available to individuals and families earning between 100% of the federal poverty level (FPL) and 250% FPL; this corresponds to individual income of $11,670 to $29,175 in 2014.[i]

CSR plans use federal subsidies to increase their actuarial value (AV) and lower cost-sharing for low-income exchange enrollees. Avalere Health conducted an analysis of the standard silver and CSR plans offered in the federally-facilitated exchange (FFE) that spans 34 states.[ii] While the Affordable Care Act (ACA) requires CSR plans to lower maximum out-of-pocket (MOOP) limits, health insurers have broad flexibility about how to adjust cost-sharing for other services to reach the required actuarial values. Notably, plans do not evenly reduce cost-sharing across all types of benefits; in fact, plans vary substantially in how they alter cost-sharing for each of the benefits examined in this analysis. Key findings from the analysis include:

Cost-sharing reductions are more often applied across multiple types of benefits in 94% and 87% AV plans compared to 73% AV plans. As expected, in comparison to the standard silver plans, most issuers are implementing moderate to high cost-sharing reductions for their 94% and 87% AV CSR plans across all types of benefits examined in this analysis; fewer issuers are reducing cost-sharing across all benefits for their 73% AV CSR plans.

Figure 1: Percent of Silver Plan Variations that Alter Cost-Sharing Structure* from the Standard Silver Plan**



** Data in the Landscape file is structured into four formulary tiers. For plans that have fewer or more than four formulary tiers, the data in this file may be inaccurate.*

*** For the purposes of this analysis, Avalere used the coinsurance and copayment amounts that applied after the deductible was met. Plans that noted that there was no charge, or no charge after the deductible was met were excluded. Amounts are rounded to the nearest dollar or percent.*

**** For the purpose of this analysis, medical deductibles include combined deductibles as well as separate medical-only deductibles.*

Source: Avalere PlanScape, updated March, 2014. Avalere collected plan information that was publically available in the 11th volume of the HHS Landscape File, accessed via: https://www.healthcare.gov/. The file contained 5,800 silver plans spanning 34 FFM states.

AV = Actuarial Value

CSR = Cost Sharing Reduction

Many CSR plans have MOOP limits lower than the amount required by law. Across all CSR variations in this analysis, consumers will have access to plans with lower MOOPs than required, and the average MOOP is substantially lower than the mandated MOOP limit. For example, among 87% AV CSR plans, the average MOOP is $450 lower than the required limit, while among 94% AV CSR plans, the average MOOP is $1,140 lower.

Almost all CSR plans feature lower deductibles than the standard silver plans, though wide variation remains. Issuers reduce deductibles almost universally (96%) for their 87% AV and 94% AV CSR plans. Approximately three-quarters of 73% AV CSR plans have lower deductibles than the standard silver plan (Figure 1). On average, deductibles for the 73% AV CSR plans are $688 lower than the standard silver plan deductibles, while average deductibles in the 94% AV CSR plans are $2,813 lower than the average standard silver plan deductible. Even so, wide variation across plans remains; the highest deductible among 94% AV CSR plans is three times greater than the average deductible.

Consistent with standard silver plans, copays for specialist visits are higher than those for primary care visits. Exchange consumers visiting a specialist will encounter much higher, often double, copays in comparison to primary care physician (PCP) copays.

Low-income consumers may face very high coinsurance for drugs on tiers three and four, which is least likely to be reduced in CSR plans. Over half of the 87% AV and two-thirds of 94% AV CSR plans reduce cost-sharing for tier one (generic) prescription drugs, while only 39% and 53% of such plans, respectively, reduce cost-sharing for tier four drugs (Figure 1). As such, despite receiving cost-sharing subsidies, low-income consumers may face barriers accessing brand-name drugs due to high cost-sharing requirements, which are particularly prevalent on higher formulary tiers. For example, among 94% AV CSR plans—which enroll individuals earning less than 150% FPL ($17,505 for a single person in 2014)—of the plans utilizing coinsurance, one-third of plans have coinsurance greater than 30% for tier three drugs, and one-fifth of these plans require such coinsurance for tier four drugs.

Based on our analysis, it is evident that issuers are selective when applying cost-sharing reductions across different benefits in CSR plans. For example, there is a trend among issuers to consistently reduce medical deductibles, while at the same time only slightly more than half of the plans alter cost-sharing for tier four prescription medications in the 94% AV CSR plans. Given the continued flexibility granted to issuers designing CSR plans and the high proportion of enrollees eligible for financial assistance, stakeholders may wish to identify trends in benefit design of CSR plans and assess consumer affordability heading into the 2015 plan year.

BACKGROUND ON COST-SHARING REDUCTION PLANS

Health plans offered in the individual and small group markets, including those offered on the exchange, must meet one of four actuarial values, known as "metal levels." Plans with the lowest AV are bronze plans with an AV of 60%, followed by silver plans (70% AV), gold plans (80% AV), and platinum plans (90% AV). Actuarial value is the percentage of total covered healthcare costs that the plan would pay for an average population. A high AV means that the plan pays a larger portion of covered costs, while the consumer pays a smaller portion. Conversely, a low AV means that the plan pays a smaller portion of covered costs, and the consumer pays a larger portion.

Both state-based and federally-facilitated exchanges offer two forms of financial assistance: advanced premium tax credits (APTC) and cost-sharing reductions (CSRs). Individuals and families eligible for APTCs receive tax credits, on a sliding scale, that limit the amount they must pay toward their health insurance premium to a percent of income. APTCs are available for individuals and families with incomes between 100% and 400% of the federal poverty level (FPL).[iii] APTCs are calculated based on the premium of the second-lowest cost silver plan available, but may be used to purchase any exchange plan.

CSRs allow individuals and families with incomes between 100% and 250% FPL to enroll in silver plans with increased AVs and reduced out-of-pocket costs. Qualifying individuals and families are eligible for "silver variation plans" that have, on average, lower deductibles, coinsurance, and copayments. The law requires issuers participating in the exchange to offer CSR plans based on each of the issuer's standard silver plans.[iv]

For each standard silver plan offered on the exchange, issuers must offer three CSR plans with increasing AVs: 73%, 87%, and 94%. To meet the required AV for each CSR plan, issuers must first reduce the maximum out-of-pocket (MOOP) limit of the CSR plan. If this change does not increase the AV to the required level, issuers must then lower cost-sharing for covered services. Mandated AV levels and out-of-pocket spending caps associated with each bracket of income are included in Figure 2.[v]

Figure 2: Cost-Sharing Reduction Plan Overview

Actuarial Value	Household Income	OOP Cap for 2014	Individual Income Range	Family of Four Income Range
94%	100 – 150% FPL	$2,250	$11,670 – $17,505	$23,850 – $32,197.50
87%	150 – 200% FPL	$2,250	$17,505 – $23,240	$32,197.50 – $47,700
73%	200 – 250% FPL	$5,200	$23,240 – $29,175	$47,700 – $59,625

Based on the 2012 American Community Survey, it is estimated that nearly 16 million uninsured individuals have incomes between 100% and 250% FPL, which is the qualifying income range for CSR plans on the exchange.[vi] It is important to note that this data point includes individuals with incomes from 100% to 138% FPL in states that are not expanding Medicaid, who otherwise would have been eligible for Medicaid coverage.[vii]

Trends from the most recent HHS Enrollment Report indicate that 85% of exchange enrollees who have selected a plan are eligible for financial assistance.[viii] This figure includes eligibility for both APTCs and CSRs; therefore, the large proportion of enrollees eligible for financial assistance who chose to enroll in a silver plan suggests that many may be eligible for CSR plans.

Notably, four states (CA, CT, NY, and VT) opted to limit plan variability by mandating standardized benefit structures for the CSR plans offered on their state-based exchanges. For example, in California, standard silver plans must charge $45 for a primary care office visit copay, while 94% AV CSR plans must charge $3 for a primary care office visit copay.[ix] In FFM states, the federal government has afforded issuers a substantial amount of flexibility when designing the CSR plans, provided they meet required AV levels and the lower MOOPs. Plans are under no obligation to reduce cost-sharing for all covered benefits or to do so evenly across benefits. Federal regulations require that CSR plans may not increase cost-sharing for any service as the value of the cost-sharing subsidy (and resulting plan AV) increases.[x] Thus, consumers are assured that they receive the most generous benefits by enrolling in the CSR plan for which they are eligible.

SILVER PLAN VARIATION DATA ANALYSIS

Data Sources, Methodology, and Limitations

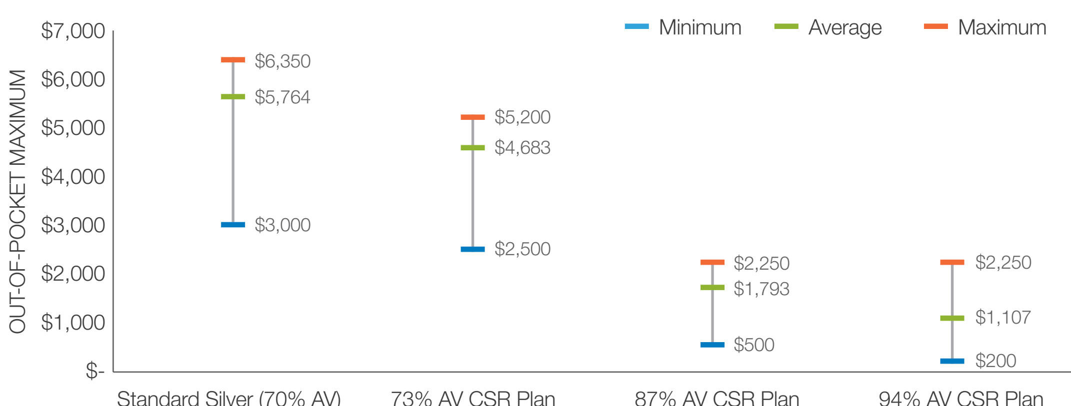
Avalere analyzed the most recent version (11th volume) of the Department of Health and Human Services (HHS) Landscape file available on HealthCare.gov.[xi] The file contains details on individual and family premiums and benefit designs for plans across the 34 states in the FFE.[xii] This analysis focuses solely on this data file and, therefore, does not reflect plans offered in any state-based exchange. The file contains 5,800 total silver plans, including standard silver plans as well as the required "silver plan variations." Drug coverage data in the HHS Landscape file are structured into four formulary tiers; therefore, for plans that have fewer or more than four formulary tiers, the data in this file may not align with the plan's true formulary structure. The accuracy of all analysis is limited by the accuracy of the data included in the Landscape file itself.

FINDINGS

Maximum Out-of-Pocket (MOOP)

Maximum out-of-pocket (MOOP) limits are capped at $6,350 for all standard metal level plans. Issuers offering silver plan variations are required to reduce this standard MOOP to no greater than $2,250 for individuals between 100% and 200% FPL and $5,200 for individuals between 200% and 250% FPL. Some plans, however, have lowered the MOOPs below those limits. Average MOOPs for standard silver, 73% AV CSR, and 87% AV CSR plans are between $450 and $600 lower than the maximum allowed MOOPs for these plan types. The average MOOP in 94% AV CSR plans is approximately half of the required MOOP of $2,250 (Figure 3).

Figure 3: Out-of-Pocket Maximums by Silver Plan and Silver Plan Variations



Source: Avalere PlanScape*, updated March, 2014. Avalere collected plan information that was publicly available in the 11th volume of the HHS Landscape File, accessed via: https://www.healthcare.gov/ . The file contained 5,800 silver plans spanning 34 FFM states.*
AV = Actuarial Value
CSR = Cost-sharing Reduction

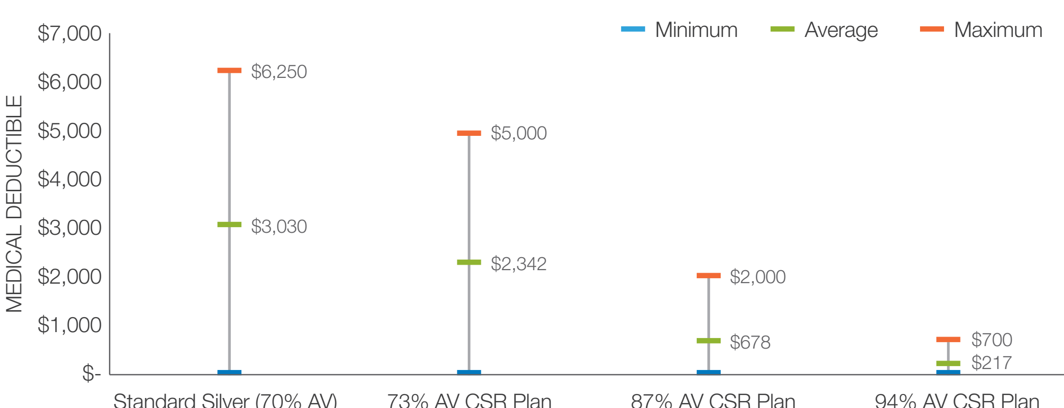
Medical and Drug Deductibles

Medical deductibles in the standard silver and CSR plans vary considerably across plans. Across all types of silver plans, the maximum deductibles are two to three times higher than average deductibles. For example, the average medical deductible for the 94% AV CSR plan is $217 as compared to the maximum deductible of $700.[xiii] That said, only 26 plans in Ohio and Wisconsin include the $700 deductible. However, approximately 1,500 (26%) of the 94% AV CSR plans have deductibles at or above $400, which is nearly twice the average deductible.

The HHS Landscape file indicates that over one-third of silver plans have a $0 drug deductible, signifying that drugs are not subject to any deductible in those plans. We further reviewed a sample of plan summary of benefits and coverage documents to

confirm that these plans do in fact exempt drugs from the deductible altogether versus including drugs in a combined, but not drug-specific, deductible. Through our review, we confirmed that two-thirds of these plans do exempt drugs from the deductible.[xiv] We could not confirm this for the remaining one-third of plans, meaning that data from the Landscape file alone may not be enough to determine whether these plans allow first dollar coverage of drugs.

Figure 4: Medical Deductibles* by Silver Plan and Silver Plan Variations



** For the purpose of this analysis, medical deductibles include combined deductibles as well as separate medical-only deductibles.*
Source: Avalere PlanScape, *updated March, 2014. Avalere collected plan information that was publicly available in the 11th volume of the HHS Landscape File, accessed via: https://www.healthcare.gov/ . The file contained 5,800 silver plans spanning 34 FFM states.*
Note: The analysis in this graph includes plans with $0 medical deductibles.
AV = Actuarial Value
CSR = Cost-sharing Reduction

Some standard silver and CSR plans have separate, non-zero dollar drug deductibles. Notably, the number of plans with a separate drug deductible decreases as the plan's AV level increases. More specifically, 16% of standard silver plans, 15% of 73% AV CSR plans, 12% of 87% AV CSR plans, and 8% of 94% AV CSR plans have separate non-zero dollar drug deductibles. These deductibles average $730 for standard silver plans; $490 for 73% AV CSR plans; $200 for 87% AV CSR plans; and $150 for 94% AV CSR plans.

Cost-Sharing for Primary Care Physician and Specialist Visits

For primary care physician (PCP) and specialist visits, the maximum and minimum copayment and coinsurance amounts are relatively stable across standard silver and CSR plans; however average cost-sharing steadily decreases as the AV level increases.

Across standard silver and CSR plans, the maximum copays for PCP visits range from $50 to $60, while minimum copays are consistently $0. Furthermore, the average copay for a PCP visit drops by more than half from the standard silver plan to the 94% AV CSR, falling from $32 in standard silver plans to $12 in 94% CSR plans (Figure 5).

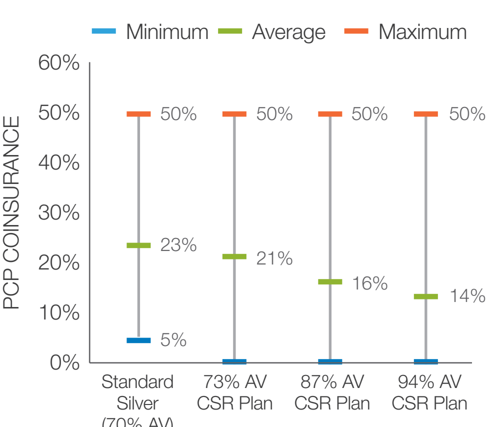
Similarly, the average coinsurance rate for a PCP visit drops from 23% in standard silver plans to 14% in 94% AV CSR plans (Figure 6). For each type of silver plan, the average coinsurance rates for PCP and specialist visits are nearly identical (Figures 6 & 8). However, the cost of a specialist visit may be higher than that for a PCP visit, meaning that a patient's out-of-pocket cost (in dollars) could be higher when visiting a specialist.

Coinsurance maximums are consistently 50% for both PCP and specialist visits, across the standard silver plan and all CSR plans, while the minimum coinsurance ranges from 0% to 5% (Figures 6 & 8). Notably, only 71 of the 5,800 standard silver and CSR plans charge 50% coinsurance for a PCP or specialist visit; these outliers are plans in Kansas, North Carolina, and Tennessee.

In comparison to the standard silver plans, 31% of 73% AV CSR plans, 61% of 87% AV CSR plans, and 70% of 94% AV CSR plans lower cost-sharing amounts for PCP visits (Figure 1). However, on average, plans do not substantially reduce the required cost-sharing for PCP visits in 73% AV CSR plans.

Figure 5: PCP Copayments

Figure 6: PCP Coinsurance



Source: Avalere PlanScape, *updated March, 2014. Avalere collected plan information that was publicly available in the 11th volume of the HHS Landscape File, accessed via: https://www.healthcare.gov/. The file contained 5,800 silver plans spanning 34 FFM states.*
Note: For the purpose of this analysis, Avalere used the coinsurance and copayment amounts that applied after the deductible was met. Plans that noted that there was no charge after the deductible for the standard option were excluded. When plans indicated no charge for the standard option, Avalere assumed a $0 copay. For other CSRs, when no charge was indicated, Avalere used a $0 or 0% based on any cost-sharing structure for the lower AV level.

AV = Actuarial Value
CSR = Cost-sharing Reduction

Specialist visits have much higher copays, often double, than PCP visits; coinsurance rates, however, as discussed above, are comparable for specialist and PCP visits. Similar to PCP cost-sharing trends, minimum copay and coinsurance amounts for specialist visits vary by only $10 or 5 percentage points, respectively, across silver plan types. Average cost-sharing for specialist visits declines as AV increases (Figures 7 & 8).

Fewer issuers reduce cost-sharing for specialist visits in CSR plans relative to the standard silver plan than do for PCP visits. In comparison to standard silver plans, 25% of 73% AV CSR plans, 52% of 87% AV CSR plans, and 64% of 94% AV CSR plans lower cost-sharing for specialist visits (Figure 1).

Figure 7: Specialist Copays

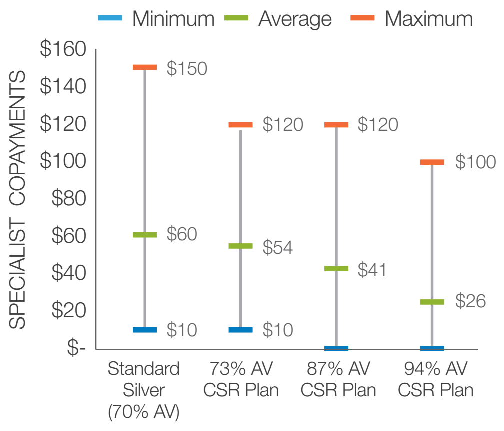
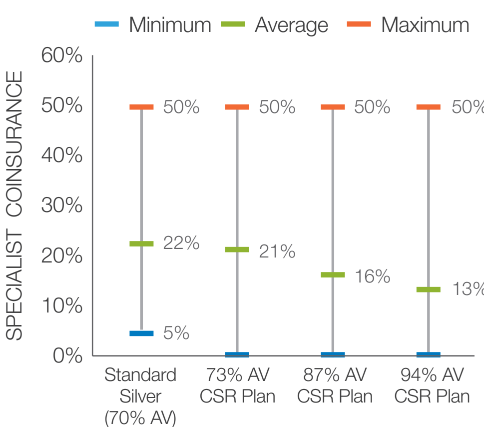


Figure 8: Specialist Coinsurance



Source: Avalere PlanScape, *updated March, 2014. Avalere collected plan information that was publicly available in the 11th volume of the HHS Landscape File, accessed via: https://www.healthcare.gov/. The file contained 5,800 silver plans spanning 34 FFM states.*
Note: For the purpose of this analysis, Avalere used the coinsurance and copayment amounts that applied after the deductible was met. Plans that noted that there was no charge after the deductible for the standard option were excluded. When plans indicated no charge for the standard option, Avalere assumed a $0 copay. For other CSRs, when no charge was indicated, Avalere used a $0 or 0% based on any cost-sharing structure for the lower AV level.

AV = Actuarial Value
CSR = Cost-sharing Reduction

Cost-Sharing for Prescription Drugs

Among analyzed plans, the range of copay and coinsurance amounts for each formulary tier is similar across the standard silver and all CSR plans. In general, issuers use copayments for lower tier drugs and shift to coinsurance rates for higher tier drugs.

As expected, average cost-sharing increases along with formulary tier and decreases with increasing AV level among the CSR plans. The average copay for a tier one drug in a 94% AV plan is $6—less than half the average cost-sharing in the standard silver plans. The majority of all silver plans (84%) utilize copays for tier one drugs, while only 12% of plans have coinsurance.[xv]

Figure 9: Average Copayments and Coinsurance Amounts Across Silver Plan Variations

	Standard Silver Plan (70% AV)	73% AV CSR Plan	87% AV CSR Plan	94% AV CSR Plan
Average Copayments**				
First Tier Drugs*	$13	$11	$8	$6
Second Tier Drugs*	$49	$46	$31	$22
Third Tier Drugs*	$87	$84	$59	$49
Fourth Tier Drugs*	$165	$160	$124	$98
Average Coinsurance**				
First Tier Drugs*	29%	28%	17%	14%
Second Tier Drugs*	30%	29%	20%	15%
Third Tier Drugs*	36%	35%	27%	24%
Fourth Tier Drugs*	31%	31%	26%	23%

** Data in the Landscape file is structured into four formulary tiers. For plans that have fewer or more than four formulary tiers, the data in this file may be inaccurate.*

*** For the purposes of this analysis, Avalere used the coinsurance and copayment amounts that applied after the deductible was met. Plans that noted that there no charge after the deductible was met were excluded. For plans that noted no charge for the standard plan on a tier, Avalere used $0 copays for tiers 1-3 and 0% coinsurance for tier 4. For analyzing the no charge for the CSRs, Avalere assigned a $0 or 0% based on the type of cost sharing used for that tier by the standard plan. Amounts are rounded to the nearest dollar or percent.*

Source: Avalere PlanScape, *updated March, 2014. Avalere collected plan information that was publically available in the 11th volume of the HHS Landscape File, accessed via: https://www.healthcare.gov/. The file contained 5,800 silver plans spanning 34 FFM states.*

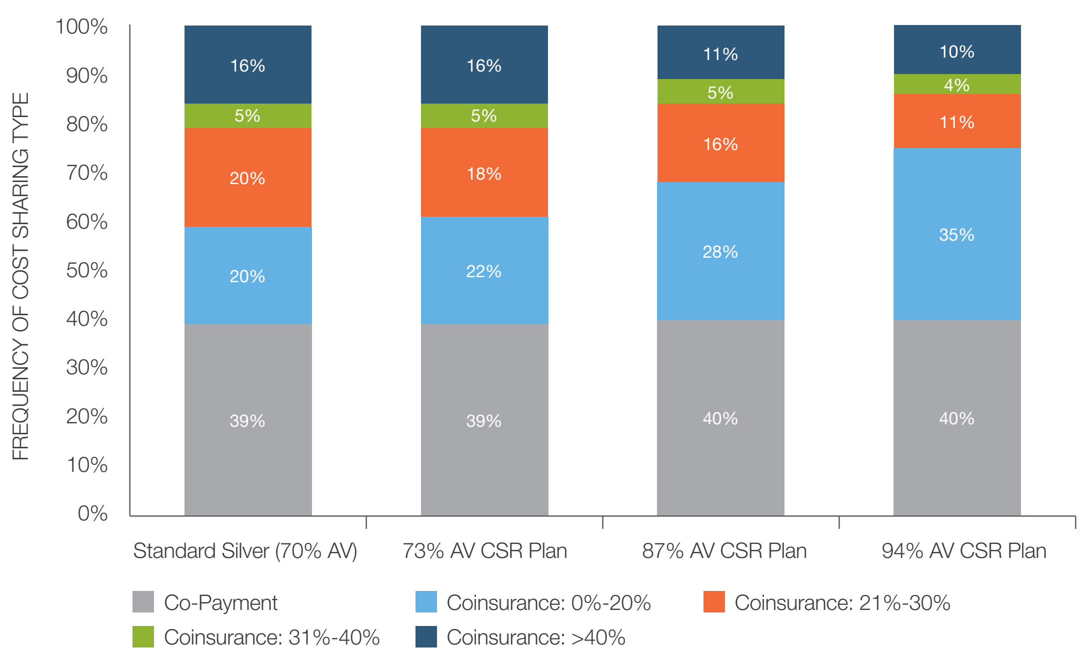
AV = Actuarial Value

CSR = Cost Sharing Reduction

At the other end of the spectrum, copayments on tier four range from $0 to $395 for standard silver plans, and from $0 to $300 for CSRs, while coinsurance ranges from 0% to 75% for all types of silver plans. The 75% coinsurance rate is an outlier limited to 26 silver and CSR plans in Michigan. The average copay for tier four drugs is $165 among standard silver plans and $98 among the 94% AV CSR plans. The average coinsurance rate for tier four drugs is 31% in standard silver plans and drops to 23% in the 94% AV CSR plans. Across all standard silver and CSR plan types, plans use coinsurance for tier four in approximately 60% of plans, while the remaining 40% of plans use copayments.

Use of coinsurance is quite common for higher formulary tiers; in comparison, of all standard silver and CSR plans, only 12% use coinsurance on tier one, and 20% use it on tier two. Of the nearly third of plans utilizing coinsurance for tier three drugs, more than half of the standard silver and 73% AV CSR plans require at least 30% coinsurance, while about one-third of the 87% AV and 94% AV CSR plans do.

Figure 10: Tier Four Cost Sharing in FFM States, By Silver and Silver CSR Plans



**Data in the Landscape file is structured into four formulary tiers. For plans that have fewer or more than four formulary tiers, the data in this file may be inaccurate.*

***For the purpose of this analysis, Avalere used the coinsurance and copayment amounts that applied after the deductible was met. Plans were excluded that noted that there was no charge after the deductible was met.*

Source: Avalere PlanScape, *updated March, 2014. Avalere collected plan information that was publicly available in the 11th volume of the HHS Landscape File, accessed via: https://www.healthcare.gov/. The file contained 5,800 silver plans spanning 34 FFM states.*

AV = Actuarial Value

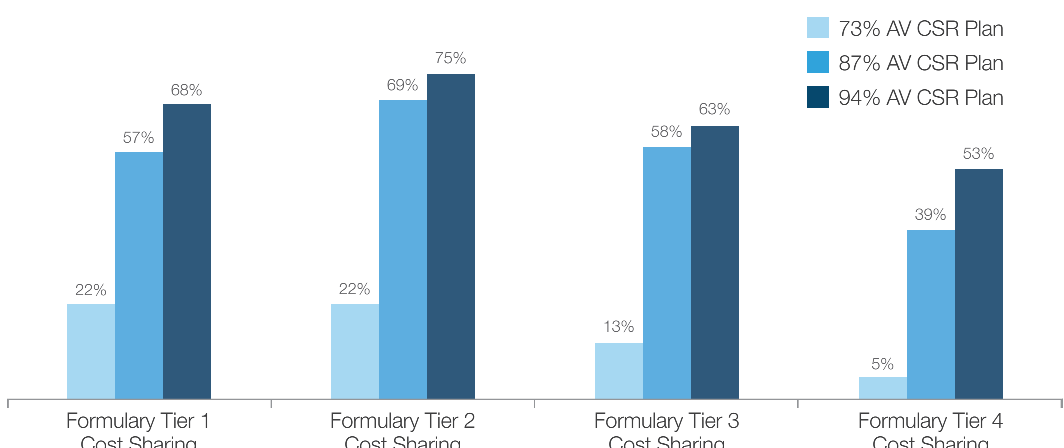
CSR = Cost-sharing Reduction

As noted above (Figure 10), on tier four 21% of standard silver and 73% AV CSR plans have more than 30% coinsurance, while roughly 15% of the 87% AV and 94% AV CSR plans do. High coinsurance amounts on the standard silver and 73% AV CSR plans is not the only factor leading to high out-of-pocket costs on tier four—higher copays also are a contributor. More specifically, of the 2,151 plans with copays for tier four, approximately 92% of standard silver plans and 90% of 73% AV CSR plans charge over $150. As AV increases, use of lower coinsurance (i.e., up to 20% coinsurance) is more common than higher coinsurance. Around 10% of 94% AV and 87% AV CSR plans have coinsurance of more than 40% on tier four; this figure rises to 16% of standard silver and 73% AV CSR plans (Figure 10).

Plans vary in whether and how they alter cost-sharing across formulary tiers. Less than one-quarter of 73% AV CSR plans reduce cost-sharing from the standard silver plan for any formulary tier, and only 5% of 73% AV CSR plans reduce cost-sharing on tier four (Figure 11). The 87% AV and 94% AV CSR plans were more likely to have reduced

cost-sharing for all formulary tiers. For example, 39% of 87% AV CSR plans reduce cost-sharing on tier four and 69% do so on tier two. Additionally, 53% of 94% AV CSR plans reduce cost-sharing on tier four, and 75% reduce such costs for tier two. Generally across all CSR variations, more CSR plans reduce cost-sharing for tier two drugs, typically preferred brand drugs, than for other formulary tiers. Across all formulary tiers, fewer CSR plans reduced cost-sharing for tier four drugs, typically specialty drugs, than any for other formulary tier.

Figure 11: Percent of Silver Plan Variations that Alter Cost-Sharing Structure* From the Standard Silver Plan**



** For the purpose of this analysis, Avalere used the coinsurance and copayment amounts that applied after the deductible was met. Plans that noted that there was no charge after the deductible was met were excluded.*
Source: Avalere PlanScape, *updated March, 2014. Avalere collected plan information that was publicly available in the 11th volume of the HHS Landscape File, accessed via: https://www.healthcare.gov/. The file contained 5,800 silver plans spanning 34 FFM states.*
*** Data in the Landscape file is structured into four formulary tiers. For plans that have fewer or more than four formulary tiers, the data in this file may be inaccurate.*
AV = Actuarial Value
CSR = Cost-sharing Reduction

The large variation in co-payments, co-insurance, and deductibles required by CSR plans may not be clear to exchange enrollees with limited income. An individual at 200% FPL ($23,340 annually) would be eligible for an 87% AV CSR plan.[xvi] A large portion of the 87% AV CSR plans in this analysis do not reduce cost-sharing for any prescription drugs; for example, only 39% of plans alter cost-sharing from the standard silver plan on tier four. Therefore, consumers who qualify for financial assistance could pay the same cost-sharing for a prescription drug as higher income consumers who do not qualify for such assistance. While low-income enrollees will be protected by a lower MOOP, consumers who rely on brand or specialty medications may meet a CSR plan's MOOP on the first drug fill. Consumers with limited incomes at or below 200% FPL may not have the means necessary to pay the full out-of-pocket costs to meet the cap, up to $2,250, upon the first drug fill. For individuals with incomes 200% to 250% FPL,

the out-of-pocket cap is raised to $5,200. A recent Kaiser Family Foundation study found that individuals from 100% to 250% FPL have an average of just $670 in liquid assets, which means that even with a reduced OOP cap, these consumers may still face difficulty affording their cost-sharing.[xvii]

DISCUSSION

Across all CSR plans, there is broad variation in how issuers reduce cost-sharing across benefit categories relative to the standard silver plans. Because issuers have a high level of flexibility in designing these CSR plans, cost-sharing amounts vary across services and in some cases mirror the cost-sharing in standard silver plans. Therefore, consumers with limited income have a great deal of financial incentive to review plan cost-sharing requirements given the variable application of cost-sharing reductions across services.

The large variation in how plans apply the cost-sharing reductions across covered benefits may not be clear to consumers while they are shopping and comparing plans. Exchange websites, including HealthCare.gov, may not clearly explain the different cost-sharing amounts of the qualifying CSR plans in comparison to other available plans on the exchange, and it may be difficult for consumers to understand how the reductions apply to specific services. Further, the federal government did not require issuers to create unique Summaries of Benefits and Coverage (SBCs) for CSR plans, and as a result consumers may not be able to access accurate CSR plan SBCs.

Notably, consumers with the lowest income who qualify for the highest level of financial assistance (100% to 150% FPL) could encounter some 94% AV CSR plans with cost-sharing requirements for specific services that are identical to standard silver plans. Even for CSR plan cost-sharing that is reduced, out-of-pocket costs could still serve as a barrier to accessing care. For example, among 94% AV CSR plans, the average deductible is $217, the average coinsurance for tier four drugs is 23%, and the average MOOP is $1,107. For an individual with income at 100% FPL (or $970 monthly), a single high cost service or drug could be unaffordable. Patients at this income level who reach the average of $1,107 MOOP will have spent 9.5% of their annual income on out-of-pocket costs.

Aside from states with standardized CSR plans, all regulations and guidance issued from the federal government indicate that for the 2015 plan year, issuers will continue to maintain flexibility to adapt non-uniform cost-sharing reductions in the benefit designs for CSR plans on the exchange. Consumers and stakeholders should pay close attention to plan benefits and cost-sharing to ensure they are picking the option that best meets their needs.

This research was supported by the Pharmaceutical Research and Manufacturers of America®.

NOTES

i Annual income for a family of four at 100% FPL is $23,850 and at 250% FPL is $59,625, accessed at ASPE 2014 Poverty Guidelines: http://aspe.hhs.gov/poverty/14poverty.cfm

ii The 34 states in the federally-facilitated marketplace include: Alaska, Alabama, Arkansas, Arizona, Delaware, Florida, Georgia, Iowa, Illinois, Indiana, Kansas, Louisiana, Maine, Michigan, Missouri, Mississippi, Montana, North Carolina, North Dakota, Nebraska, New Hampshire, New Jersey, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, West Virginia, and Wyoming.

iii The eligibility threshold for individuals receiving subsidies in states expanding their Medicaid programs is higher (138% FPL).

iv ACA Sec. 1402

v 2014 Poverty Guidelines accessed at: http://aspe.hhs.gov/poverty/14poverty.cfm

vi Avalere examined the uninsured population by income from the American Community Survey for coverage in 2012, accessed at: https://www.census.gov/acs/www/. This data point does not take into account individuals with prior sources of insurance that may enroll into exchange plans, those with affordable offers of employer coverage, or those who may not qualify for coverage due to citizenship requirements.

vii To date, 28 states and DC have committed to expanding Medicaid under the ACA. Nineteen of the remaining states rejected expansion for 2014 and three states (TN, UT, VA) remain undecided.

viii *ASPE Issue Brief, "Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period"* accessed at: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf

ix Covered California, "Health Insurance Companies for 2014: Making the Individual Market in California Affordable," October 2013, accessed at: https://www.coveredca.com/coverage-basics/PDFs/CC-health-plans-booklet-rev3.pdf.

x *HHS Notice of Benefit and Payment Parameters for 2015* released on March 11, 2014 and accessed at: http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf

xi "Health plan information for individuals and families," accessed at: https://www.healthcare.gov/health-plan-information/

xii Ibid.

xiii 2014 Poverty Guidelines accessed at: http://aspe.hhs.gov/poverty/14poverty.cfm

xiv Note: A portion of silver plans in the HHS Landscape file indicated a zero dollar drug deductible. An examination of a subset of the Summary of Benefits and Coverage (SBC) documents from these plans confirmed that two-thirds of the sample of plans did not actually require drugs to be subject to a deductible, and the remaining third could not be validated with the data from the plan's SBC. If this rate holds true, two-thirds of the plans in the HHS Landscape file with the zero dollar drug deductible designations do, in fact, exempt drugs from the deductible, and approximately 1,360 standard silver plans are likely to have no drug deductible. Therefore, one-quarter of standard silver plans allow access to drugs without an enrollee meeting the deductible.

xv Avalere excluded plans that noted no charge after the deductible; therefore, data will not round to 100%.

xvi 2014 Poverty Guidelines accessed at: http://aspe.hhs.gov/poverty/14poverty.cfm

xvii See Table 3 on Page 8 of the Kaiser Family Foundation, "Medical Debt among People with Health Insurance," January 2014; accessed via http://kaiserfamilyfoundation.files.wordpress.com/2014/01/8537-medical-debt-among-people-with-health-insurance.pdf

About Us

Avalere is a vibrant community of innovative thinkers dedicated to solving the challenges of the healthcare system. We deliver a comprehensive perspective, compelling substance, and creative solutions to help you make better business decisions. We partner with stakeholders from across healthcare to help improve care delivery through better data, insights, and strategies. For more information, please contact Kelly Brantley at kbrantley@avalere.com. You can also visit us at www.**avalere**.com. We look forward to working with you.

Contact Us

Avalere Health
1350 Connecticut Ave, NW Suite 900
Washington, DC 20036
202.207.1300 | Fax 202.467.4455
www.**avalere**.com

ISSUE BRIEF
JUNE 2014

Growth and Variability in Health Plan Premiums in the Individual Insurance Market Before the Affordable Care Act

Jonathan Gruber, MIT

Abstract Before we can evaluate the impact of the Affordable Care Act on health insurance premiums in the individual market, it is critical to understand the pricing trends of these premiums before the implementation of the law. Using rates of increase in the individual insurance market collected from state regulators, this issue brief documents trends in premium growth in the pre-ACA period. From 2008 to 2010, premiums grew by 10 percent or more per year. This growth was also highly variable across states, and even more variable across insurance plans within states. The study suggests that evaluating trends in premiums requires looking across a broad array of states and plans, and that policymakers must examine how present and future changes in premium rates compare with the more than 10 percent per year premium increases in the years preceding health reform.

The mission of The Commonwealth Fund is to promote a high performing 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 author and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

For more information about this brief, please contact:

Jonathan Gruber, Ph.D.
Professor of Economics
Massachusetts Institute of Technology
gruberj@mit.edu

OVERVIEW

The Affordable Care Act (ACA) represents the most fundamental change to the structure of U.S. insurance markets in decades. The law introduces, among other things: modified community rating, which restricts insurers from charging consumers different rates based on factors like health status (although with the exception of some, like age and tobacco use); new state marketplaces to promote competition among insurers; substantial tax credits to offset the cost of insurance in the marketplaces for lower-income Americans; and regulation to ensure that plans sold both within and outside the marketplaces meet a minimum level of benefits. These reforms will influence the pricing of plans sold in the individual health insurance market.

However, the individual insurance markets in the United States before the implementation of the ACA had a host of problems that motivated health care reform, including rapidly rising and highly variable health insurance premiums. It is unclear how these reforms will influence the overall rate of increase in premiums in this market and their variability across and within states. The purpose of this issue brief is to describe premium increases and variability before the ACA was implemented.

This brief uses data collected by Jon Gabel and colleagues at the National Opinion Research Center (NORC).[1] The researchers collected premium rate change filings for the individual market in 30 states for the 2008–2010 period before ACA

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

Commonwealth Fund pub. 1750
Vol. 11

regulations were imposed. The data are not fully comprehensive, but provide the best available overview of rate growth in the individual insurance market. Data from this period can be used to provide information on premium rate growth before the ACA.

These data show that from 2008 to 2010 there was high and variable premium growth in the individual insurance market. Overall, premium growth averaged 10 percent or more per year during this period before the implementation of the ACA. Growth rates were highly variable across states, with premiums rising by as little as 3 percent or by as much as 21 percent. Across individual insurer filings there was even more variability; for example, in 2008, the top 1 percent of insurers raised rates by more than 28 percent.

These results provide important guidance for interpreting the rate increases we will see over 2014 to 2015 in state marketplaces. They suggest that strong conclusions about rate effects of the ACA cannot be gleaned from individual insurance filings or even from single states. These findings also illustrate that any interpretation of the rate increases from 2014 to 2015 should be compared with the increases of 10 percent or more that occurred in the period before the law took effect.

BACKGROUND

How Might the Affordable Care Act Affect Insurance Pricing?

The Affordable Care Act includes a wide range of provisions that might affect the pricing of insurance in the individual market (Appendix 1). Because of the multifaceted effects of these provisions on premiums, it is hard to predict exactly how the ACA will change premiums.

There is little systematic research showing how the ACA affected prices in the individual insurance market since 2010, which partially reflects the difficulty of obtaining solid baseline data on pricing, particularly in the individual market. A number of studies projected how the ACA would affect pricing in the individual market for comparable insurance products, with results varying from decreases to sizeable increases.[2]

The 2014 rates that were issued in the state marketplaces were lower than many of these estimates. In particular, the typical silver plan premium (i.e., one that pays 70 percent of health care expenses) was about 16 percent below the level projected by the Congressional Budget Office (CBO).[3] In its most recent report, CBO now projects modest growth in premiums in the coming years, with premiums rising by less than 3 percent from 2014 to 2015, and by 6 percent per year on average from 2015 through 2024.

For 2015 and beyond, we will not have to rely on comparing current rates to projected rates, but will be able to compare to the rates that were available in 2014. It will be useful to compare the rate of growth of premiums on the marketplaces with the rate of growth in these markets before the ACA. The purpose of this brief is to provide a baseline for such a comparison

Collecting Data on Insurance Premium Growth

There is no systematic reliable national data on premium levels in the individual market before the ACA.[4] In a number of states, data on rate growth are available through state insurance regulators. NORC collected data in two waves: for 2008–2011 and then again for 2011–2012, albeit with a somewhat different set of states. This analysis focuses on premium increases filed from 2008–2010 because premium rate increases from 2011 and after are strongly influenced by three provisions of the ACA, outlined below.

First, in 2010, the law initiated a number of important benefit mandates, such as limitations on the ability of insurers to impose annual or lifetime caps on benefits. These reforms may have raised premiums, making it difficult to use post-2010 information as a baseline.

Second, the ACA authorized states or the federal government (in cases where the state's review process was not deemed effective) to review the reasonableness of rate increases. In particular, justification was required for any rate increase of 10 percent or more. This review began in September 2011, and the effect on rate submissions was immediate.[5] The share of rate filings of 10 percent or more fell by more than half after September 2011. Overall, the share of filings of 10 percent or more fell from three-quarters in 2010 to one-third by 2012.

Finally, the ACA introduced target medical loss ratios (MLRs) in the individual and small-group markets. These regulations required insurers to spend at least 80 percent of premiums on medical benefits and quality improvement activities. Any insurers not meeting these targets were required to rebate the excess to consumers. These rebates began in summer 2012, based on MLRs calculated in 2011.

Because of these provisions, it is difficult to separate baseline trends in insurance premium increases after 2011 from the impacts of the ACA itself. This brief therefore focuses on the pre-ACA period, 2008–2010, for measuring premium trends.

The NORC study, which was presented in a November 2012 report, collected data from 30 states, relying on states for which data were available on insurance rate filings, mostly through publicly available websites.[6] Data were collected for the individual insurance and conversion markets (i.e., markets for people who lost group insurance and converted to individual policies). Appendix 2 reviews the data collection process and associated limitations. For these states, the NORC data collection represented about half of insurance coverage in 2008, and more than 70 percent of the coverage in 2009 and 2010. While the data are not comprehensive, the findings are consistent under sensitivity testing. This demonstrates that the findings are robust—that is, there is no systematic bias in the data.

It is important to note one benefit of the ACA: a move away from the lack of transparency in the individual insurance market. Beginning in 2014, rates for insurance will be readily available in a clear and transparent way to consumers and state regulators will be required to collect comprehensive data on rate changes that can make future analysis of this sort much more rigorous.

FINDINGS

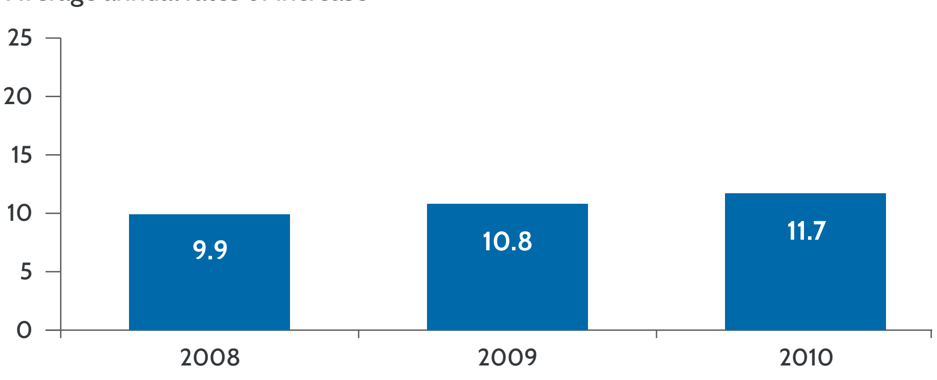
Premium Growth in the Period Before the Affordable Care Act

National Trends

Nationally, premiums in the full NORC sample rose by 9.9 percent in 2008, 10.8 percent in 2009, and 11.7 percent in 2010 (Exhibit 1).

The NORC data collection varies in the intensity with which different states are represented, due to incomplete insurance filings across the states and to the sampling strategy of focusing on the largest insurance companies. To address this concern, Exhibit 2 shows the year-by-year results under various restrictions to the sample:

Exhibit 1. National Average Rates of Premium Increase in Individual Market



Note: Includes individuals who are able to convert existing insurance policies into the individual market, under HIPAA.
Sources: NORC, "Trends in Premiums in the Small Group and Individual Insurance Markets, 2008–2011," Nov. 6, 2012; author's analysis.

Exhibit 2. National Average Rates of Premium Increase in Individual Market

Year	Overall	>60% Market Share	>80% Market Share	Consistent High Share
Total	10.9%	11.5%	12.2%	10.7%
2008	9.9%	10.4%	10.4%	9.97%
2009	10.8%	11.0%	11.5%	10.1%
2010	11.7%	12.2%	13.1%	12.1%

Note: Includes individuals who are able to convert existing insurance policies into the individual market, under HIPAA.
Sources: NORC, "Trends in Premiums in the Small Group and Individual Insurance Markets, 2008–2011," Nov. 6, 2012; author's analysis.

- the first column shows the full sample results represented in Exhibit 1;
- the second column shows results when we restrict only to states and years where more than 60 percent of the enrollment in the individual market is represented in the NORC data;
- the third column shows results when we restrict only to states and years where more than 80 percent of the enrollment in the individual market is represented in the NORC data; and
- the fourth column shows results when we included only states in all years where more than 60 percent of the market is represented in each year of the sample for that state.

The consistency of the results across these samples is striking. Premium increase in each year and in each case are in the 10 percent and 12 percent range. The large premium increases appear consistent, despite any limitations in the data.

State Variability

There is sizeable variability across states in the premium rate increases in the individual insurance market. Exhibit 3 shows the mean premium increases by state and year. Values are shown only for states where the data include at least 50 percent of the market.

As the exhibit illustrates, there is enormous variation in rate increases across states. In 2008, state average rate increases ranged from 2.8 percent in Iowa to 14.7 percent in Wisconsin; in 2009, from 4.1 percent in New Jersey to 20.1 percent in Connecticut; in 2010, from 3.0 percent in Idaho to 21.8 percent in Nebraska. There is no clear geographic pattern to these rate increases.

Carrier Variability

There is additional variability by carrier within state. To illustrate this phenomenon, Exhibits 4 and 5 show the distribution of premium increases by year. In Exhibit 5, each row shows results from different percentiles of the distribution of premium change. For example, the 10th percentile row of the premium change distribution shows that 10 percent of premium changes in that year are below this value and 90 percent are higher. Likewise, the 90 percentile row is the point at which 90 percent of premium changes are below this value and 10 percent are above it. The 50th percentile row is the median value, the midpoint in the distribution of premium changes.

For example, for 2008, the median premium increase is 10.8 percent. But the 10th percentile value is zero, meaning that 10 percent of enrollment is in plans with no rate increase. At the other extreme, the 90th percentile value is at 17.8 percent, meaning that 10 percent of premium increases are 17.8 percent and above. One percent of premium filings in that year reduce rates by 9.5 percent or more (1st percentile), while another 1 percent raise rates by 28.0 percent or more (99th percentile).

The variation is somewhat lower, but still quite large, in 2009 and 2010. In 2009, for example, 5 percent of the sample has premium increases of 1.5 percent or lower, and 5 percent of the sample has premium increases of 20.5 percent or higher. In 2010, 5 percent of the sample has premium increases of 1 percent or lower, while 5 percent of the sample has premium increases of 21.8 percent or higher.

These results also highlight the importance of weighting the data to reflect the market shares of different insurers when interpreting the distribution of premium changes. That is, plans that had very small numbers of people enrolled were given less weight in the overall estimates than plans with large numbers of enrollees. Exhibit 5 also shows the results without weighting the data using the enrollment weights from NORC. In 2009 and 2010, the mean change in premiums is fairly similar to when the data are weighted; in 2008, the unweighted mean is much higher. More important, the variation across filings is much larger when not weighted. This is important to note as many reports of rate changes will simply refer to individual insurer rate filings without considering their importance to the overall market.

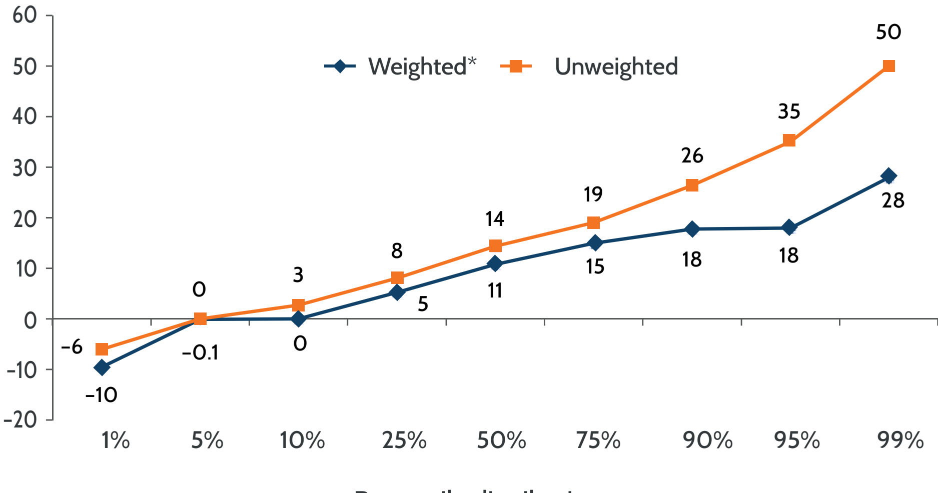
Moreover, it is important to highlight that these are changes in base rates of premium growth. Before the Affordable Care Act, rates were also highly variable based on factors such as health. This is no longer permitted in today's market. While we cannot show the rate increases facing individual enrollees, they were certainly much more variable that those illustrated in Exhibit 5. The ACA will play a crucial role in limiting this enormous variation because of changes in individual enrollee's health status and other factors.

Exhibit 3. State Average Rates of Premium Increase in Individual Market

State	2008	2009	2010
Mean U.S.	9.9%	10.8%	11.7%
Alabama		17.5%	10.8%
California			15.7%
Colorado			16.4%
Connecticut		20.1%	
Florida	8.2%	8.9%	13.6%
Idaho		6.9%	3.0%
Illinois	14.4%	10.4%	9.6%
Indiana	13.5%	15.1%	8.2%
Iowa	2.8%	7.3%	18.4%
Kentucky	8.1%	7.1%	5.5%
Maine		11.0%	11.1%
Minnesota		10.7%	7.4%
Nebraska			21.8%
New Jersey		4.1%	10.8%
North Carolina			11.6%
Oklahoma		8.2%	13.0%
Oregon	12.2%	15.2%	14.9%
Pennsylvania			9.0%
South Dakota		14.1%	16.2%
Virginia		13.8%	8.9%
Washington			12.8%
Wisconsin	14.7%	11.1%	14.0%

Note: Includes individuals who are able to convert existing insurance policies into the individual market, under HIPAA.
Sources: NORC, "Trends in Premiums in the Small Group and Individual Insurance Markets, 2008–2011," Nov. 6, 2012; author's analysis.

Exhibit 4. Distribution of Premium Changes in Individual Market, 2008



Note: Includes individuals who are able to convert existing insurance policies into the individual market, under HIPAA.
* Weighted by the estimated number of people enrolled in the plan. Plans that had very small numbers of people enrolled are given less weight in the overall estimates than are plans with large numbers of enrollees.
Sources: NORC, "Trends in Premiums in the Small Group and Individual Insurance Markets, 2008–2011," Nov. 6, 2012; author's analysis.

Exhibit 5. Distribution of Premium Changes in Individual Market

		Weighted*	
Percentile distribution	**2008**	**2009**	**2010**
1%	-9.5%	-3.2%	-5.0%
5%	-0.1%	1.5%	1.0%
10%	0.0%	4.0%	3.0%
25%	5.3%	7.6%	8.9%
50% (median)	10.8%	9.5%	11.2%
75%	15.0%	14.4%	15.0%
90%	17.8%	19.4%	18.8%
95%	18.0%	20.5%	21.8%
99%	28.0%	26.5%	25.0%
		Unweighted	
Percentile distribution	**2008**	**2009**	**2010**
1%	-6.0%	-3.2%	-9.0%
5%	0.0%	0.0%	0.0%
10%	2.7%	3.2%	1.4%
25%	8.1%	8.0%	6.6%
50% (median)	14.4%	12.0%	12.0%
75%	19.0%	20.0%	16.0%
90%	26.4%	25.0%	22.0%
95%	35.0%	30.0%	25.0%
99%	50.0%	40.0%	38.2%

Note: Includes individuals who are able to convert existing insurance policies into the individual market, under HIPAA. Each row shows results from different percentiles of the distribution of premium change. For example, the 10th percentile row of the premium change distribution shows that 10 percent of premium changes in that year are below this value and 90 percent are higher.
* Weighted by the estimated number of people enrolled in the plan. Plans that had very small numbers of people enrolled are given less weight in the overall estimates than are plans with large numbers of enrollees.
Sources: NORC, "Trends in Premiums in the Small Group and Individual Insurance Markets, 2008–2011," Nov. 6, 2012; author's analysis.

CONCLUSION

These data help set the stage for interpreting the rate changes from 2014 to 2015 that will soon become available from the state marketplaces. Before the implementation of the ACA, the insurance market experienced double-digit rate increases, as well as tremendous volatility across states and across plans within states. Premium growth nationally and at the state level from 2014 to 2015 should be compared to this benchmark. Conclusions should not be drawn from a small set of reported filings but rather from a comprehensive picture of the national trends in premium growth. While the Affordable Care Act should help address the rapid and volatile growth in premiums in the individual insurance market, it does not eliminate the nature of the market, which is inherently volatile and where insurers face more uncertainty than in their large-group offerings.

Notes

[1] NORC, "Trends in Premiums in the Small Group and Individual Insurance Markets, 2008–2011," Nov. 6, 2012, final report to the U.S. Department of Health and Human Services, http://aspe.hhs.gov/health/reports/2014/Premiums/20121119%20PremTrendsRptFnl.pdf; and NORC, "Effects of Implementing State Insurance Market Reform, 2011–2012," June 7, 2013, final report to the U.S. Department of Health and Human Services, http://aspe.hhs.gov/health/reports/2014/Premiums/20130607InsMktReformReportFnl.pdf.

[2] The Congressional Budget Office (CBO) projected in 2009 a rise in premiums of 10 percent to 13 percent, driven entirely by increases in the generosity of purchased insurance. Controlling for plan generosity, CBO projected a decline in premiums of 14 percent to 20 percent. A series of state studies, some of which I authored, projected increases in premiums relative to baseline because of the ACA. These studies generally predicted premium increases in the range of 20 percent to 30 percent in the individual market, with about half of the rise coming from more generous insurance and about half coming from a worsening risk pool. Of course, these analyses were all carried out before the inclusion of offsetting tax credits. When tax credits are included, people's average premiums fell.

[3] T. Spiro and J. Gruber, *The Affordable Care Act's Lower-Than-Expected Premiums Will Save $190 Billion* (Washington, D.C.: Center for American Progress, 2013).

[4] Studies, such as one conducted by America's Health Insurance Plans in 2009, provide rates for a selected sample of policies, while data from consumer surveys such as the MEPS provide very noisy and incomplete data on premiums paid. Moreover, these surveys provide data on average premiums paid for policies in force, which incorporate the changes in benefits in those policies. The past decade has seen enormous reductions in insurance generosity in aggregate as firms and individuals have reacted to higher premiums by raising employee cost-sharing and making other plan limitations. For this reason, evidence from those sources will lead to a substantial underestimate of the underlying trend premium for a fixed set of individual insurance policies.

[5] The Henry J. Kaiser Family Foundation, *Focus on Health Reform: Quantifying the Effects of Health Insurance Rate Review* (Menlo Park, Calif.: Kaiser Family Foundation, Oct. 2012); R. Chu and R. Kronick, *Health Insurance Premiums in the Individual Market Since the Passage of the Affordable Care Act* (Washington, D.C.: HHS, Office of the Assistant Secretary for Planning and Evaluation, Feb. 2013). Both studies rely on rate collections from a sample of states

[6] NORC, "Trends in Premiums," 2012; NORC, "Effects of Implementing," 2013. Data were collected for 21 states in 2008, 29 states in 2009, and 28 states in 2010, with 30 individual states represented across the three years.

Appendix 1. How The ACA Affects The Individual Insurance Market

The ACA includes a broad set of provisions that might affect the pricing of insurance in the individual market:

- Regulations requiring “guaranteed issue” (i.e., insurance must be sold to all, regardless of health), “guaranteed renewability” (i.e., insurance plans must be renewable for all, regardless of health), and banning preexisting conditions exclusions;
- Regulations banning premium rating on factors other than family size, age (limited to a 3:1 rate band), location, and smoking status (limited to a 1.5:1 rate band);
- Regulations that limit variation in benefits, in particular the requirement that plans be sold at four different metallic tiers (bronze, silver, gold, and platinum) at specified levels of actuarial value; or the average share of medical costs covered;
- A set of minimum essential benefits that must be offered by insurance plans;
- The introduction of state-based insurance marketplaces;
- Tax credits for low-income individuals purchasing insurance through the individual marketplaces;
- A requirement that individuals purchase insurance or be subject to a tax penalty, unless insurance is sufficiently expensive as to trigger an affordability exemption, among other exemptions; and
- The introduction of a sophisticated set of three risk-sharing mechanisms to redistribute risk across insurers in an effort to shield any given insurer from a particularly adverse population selection.

These varied provisions have both positive and negative expected effects on premiums in the individual insurance market. Community rating regulations and banning of preexisting conditions provisions are likely to raise premiums as less-healthy individuals enter the market and are priced as part of the same pool, but the individual mandate and tax credits should offset that to some extent by bringing healthier individuals into the market. Regulations that limit benefit variation and impose benefit minimums make it harder to find the most inexpensive plans, particularly in the individual market where such plans were more prevalent. However, competition through the marketplaces will lower premiums by allowing more effective shopping.

APPENDIX 2. DETAILS ON THE NORC DATA COLLECTION

NORC's data collection effort is by far the most comprehensive overview of rate changes in the individual insurance market in the pre-ACA period. That said, it does have a number of limitations. First, the data do not cover the entire nation, but only include states for which data were available to the public. In an additional three states, NORC acquired data through connections between study researchers and senior executives at the state insurance departments. Consequently, the study does not include all states in the pre-ACA period. Second, even within the study states, the data were not collected for every insurance carrier, but rather for the five largest carriers in the state and a sampling of smaller carriers. Weights were developed based on National Association of Insurance Commissioners data on carrier enrollment size. The weights were estimated to represent each rate filing's relative size for a carrier when enrollment data were missing in the rate filing. Lastly, many filings were missing information about enrollment, or the final decision on the allowed rate increase following state regulatory review.

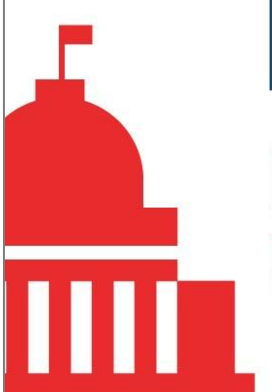
The potential issue that arises from such limitations is that the data do not represent an accurate portrayal of national patterns of rate increase. To address the second limitation, in this brief the author uses sensitivity analyses that are restricted to only states where there is a large share of the individual market represented in the collected data. We show that the results are not sensitive to these tests. But it is not possible to address the fact that data were not available in some states. Nevertheless, Exhibit 3 shows that there is no clear pattern across areas of the country in the states that are represented, suggesting that the results are broadly applicable.

About the Author

Jonathan Gruber, Ph.D., is a professor of economics at the Massachusetts Institute of Technology and the director of the Health Care Program at the National Bureau of Economic Research. Dr. Gruber's research focuses on the areas of public finance and health economics. He has authored more than 150 published research articles and serves as associate editor of the *Journal of Public Economics* and the *Journal of Health Economics.* Dr. Gruber received his Ph.D. in economics from Harvard University. He was elected to the Institute of Medicine in 2005.

Editorial support was provided by Deborah Lorber.

www.commonwealthfund.org



McKinsey&Company

McKinsey Center for U.S. Health System Reform

Hospital networks: Updated national view of configurations on the exchanges

In December 2013, we released an Intelligence Brief on exchange hospital network trends based on analyses of the silver-tier plans offered in 20 geographically dispersed urban areas.[1] We have since enhanced our hospital network database to include all products in all tiers in all 501 rating areas in the U.S., which has given us a comprehensive view of the exchange network landscape. By leveraging the new database, we were able to generate additional insights into local market differences and patterns of network formation. We augmented these insights with findings from our April national open enrollment period (OEP) consumer survey, which explored (among other things) consumers' purchasing patterns during the 2014 OEP.[2]

Our database includes all 282 payors filing on the 2014 exchanges and all 4,773 acute care hospitals in the U.S.[3] The payors offered a total of 20,818 on-exchange products across the five metal tiers; these products included 2,366 unique individual exchange networks. These networks had to meet adequacy requirements that were in place before, and then expanded by, the ACA; these requirements include the minimum number and types of providers, and the maximum driving distance and wait time, to ensure that patients have adequate access to care.[4]

For a few of the more detailed analyses discussed in this Intelligence Brief, we focused on silver-tier networks specifically. The vast majority of exchange

---

[1] "Hospital networks: Configurations on the exchanges and their impact on premiums," McKinsey Center for U.S. Health Reform, December 2013.

[2] Our national consumer survey included 2,874 consumers eligible for qualified health plans. More details about the survey and the methodology it used can be found in our May 2014 Intelligence Brief, "Individual market: Insights into consumer behavior at the end of open enrollment."

[3] Includes general, medical, and surgical hospitals, orthopedic hospitals, heart and cancer hospitals, ear, nose and throat hospitals, and children's general hospitals, as defined by the American Hospital Association. See appendix for further detail.

[4] Before passage of the ACA, network adequacy requirements existed for HMOs in almost all states and for PPOs in about half of the states. The ACA set network adequacy requirements for all QHPs but left it to the states to define and regulate adequacy. Both national agencies and the states may continue to add regulations over time.

networks (93 percent) are offered on the silver tier, and this tier is the only one in which income-eligible consumers can receive both federal premium and cost-sharing subsidies. More than 60 percent of all consumers who enrolled in an exchange product chose one in the silver tier.

For comparison with the 2014 hospital networks offered on individual exchanges, we used network data from the 2013 individual market products of all incumbent payors. In our analyses, we categorize each network based on the extent of hospital participation, as follows: broad networks have more than 70 percent of all hospitals in the rating area participating, narrow networks have 31 to 70 percent of all hospitals in the rating area participating, and ultra-narrow networks have 30 percent or less of all hospitals in the rating area participating. We classified a network as tiered if the payor put different hospitals into different tiers with different co-payment requirements. In the remainder of this Intelligence Brief, we use the phrase *narrowed network* to refer to narrow, ultra-narrow, and tiered networks in the aggregate.[5]

Seven key observations emerged from our analyses:

- Consumers now have an expanded choice of network offerings at the point of health plan purchase on exchanges. Broad networks are available to close to 90 percent of the addressable population.[6] In addition, narrowed networks are available to 92 percent of that population; they make up about half (48 percent) of all exchange networks across the U.S. and 60 percent of the networks in the largest city in each state. The increased prevalence of narrowed networks gives consumers a wider range of value propositions and prices among health insurance plans. But, if a consumer purchases a narrowed network product, then at the point of access, the choice of providers is reduced.
- Compared to plans with narrowed networks, products with broad networks have a median increase in premiums of 13 to 17 percent (when the analysis is controlled for payor, product type, rating area, and metal tier); the maximum increase is 53 percent. Across the country, close to 70 percent of the lowest-price products are built around narrow, ultra-narrow, or tiered networks.[7]

[5] Narrowing of provider networks can occur across hospitals or physicians. For the purposes of this Intelligence Brief, we have focused on hospital networks.

[6] Addressable population is defined as people who are eligible to purchase qualified health plans on the exchanges (i.e., non-elderly adults with incomes above 100 percent FPL in non-Medicaid expansion states and above 138 percent FPL in Medicaid expansion states).

[7] Out of all rating areas where ultra-narrow or narrow networks are present (329 of the 501 rating areas). For each rating area, when the same payor offered multiple products based on the same network, the lowest-price product was used to determine the price of the network. Payor count represents unique payors at a state level. See methodology in the appendix for further details.

- There is no meaningful performance difference between broad and narrowed exchange networks based on Centers for Medicare and Medicaid Services (CMS) hospital metrics such as the composite value-based purchase score as well as its three sub-components (outcome, patient experience, and clinical process scores).[8] However, broad networks have higher rates of academic medical center participation.
- Certain market conditions are associated with a greater prevalence of narrowed networks—specifically, higher excess bed capacity, greater provider or payor fragmentation, and more significant potential for growth from the uninsured than from people who previously had coverage. Each of these market conditions is associated with 1.4 to 1.9 times as many ultra-narrow networks, and the combination of factors is associated with an even higher prevalence of ultra-narrow networks (up to 4.7 times as many).
- In those rating areas in which at least two different payors offer ultra-narrow, silver-tier networks,[9] 67 percent of the ultra-narrow networks share the majority of their hospitals (on average, over 80 percent) with at least one other ultra-narrow network. Fourteen percent of all acute-care hospitals participate in ultra-narrow networks; of them, 23 percent are in more than one such network.[10]
- Seventy-five percent of all ultra-narrow, silver-tier products include only some of the hospitals within participating health systems. Forty-four percent of these products exclude at least one hospital from every single participating health system. Ultra-narrow networks excluding hospitals from every participating health system are priced an average of 13 percent lower than ultra-narrow networks containing entire health systems.
- In our April consumer survey, 42 percent of the respondents who indicated they had enrolled in an ACA plan and were aware of the network type reported purchasing a product with a narrowed network. However, 26 percent of those who indicated they had enrolled in an ACA plan were unaware of the network type they had selected.

---

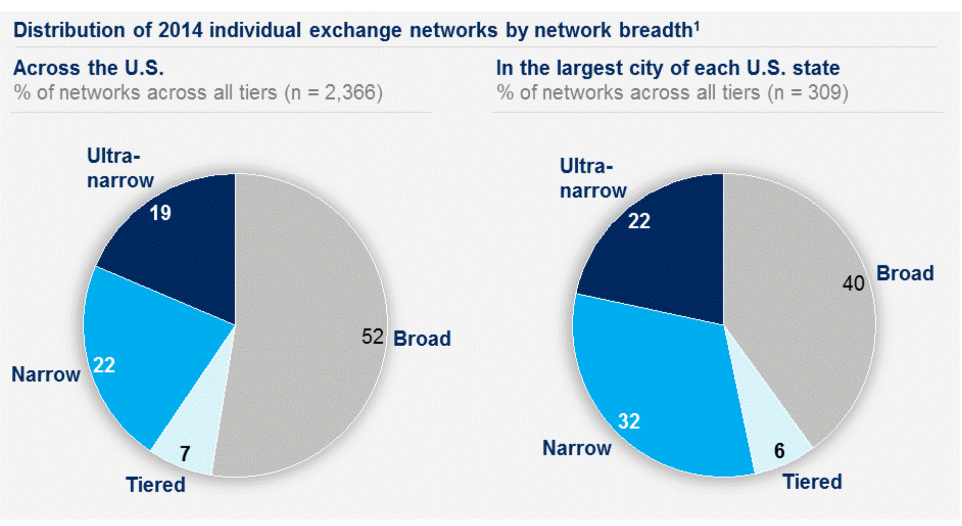
[8] Specifically, we used the following metrics: the outcomes score of 30-day mortality rate for acute myocardial infarction, the patient-reported score of hospital rating, and the clinical process scores for surgery patient antibiotics delivery.

[9] 211 of the 501 rating areas in the U.S.

[10] Of all acute-care hospitals in the U.S., 96 percent participate in an exchange network—84 percent in broad, 38 percent in narrow, and 14 percent in ultra-narrow networks. (Numbers add up to more than 100 percent because some hospitals are in multiple networks).

Consumers now have expanded choice at the point of health plan purchase. Broad networks are available to 90 percent of the addressable population; narrowed networks, to 92 percent

Across the U.S., at the point of purchase there is an expanded choice of network offerings. Broad networks are available on the exchanges in 419 of the 501 rating areas,[11] which together cover close to 90 percent of the addressable population.[12] Narrowed network options exist in 380 of the 501 rating areas (representing 92 percent of the addressable population). Narrowed networks make up 48 percent of all exchange networks across the U.S. and 60 percent of the networks in the largest city in each state *(Exhibit 1)*. Of all networks, 22 percent are narrow, 19 percent are ultra-narrow, and 7 percent are tiered. Although the choice of offerings at the point of purchase has expanded, consumers who select a narrowed network have a reduced choice of providers at the point of access.



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information; AHA database

Data as of 02.24.2014

1 Broad networks: more than 70 percent of hospitals within a rating are participating; narrow networks: 31 to 70 percent of hospitals within a rating area are participating; ultra-narrow networks: 30 percent or less of hospitals within a rating area are participating; tiered networks: narrowing is introduced when the payor puts different hospitals into different tiers with different co-payment requirements.

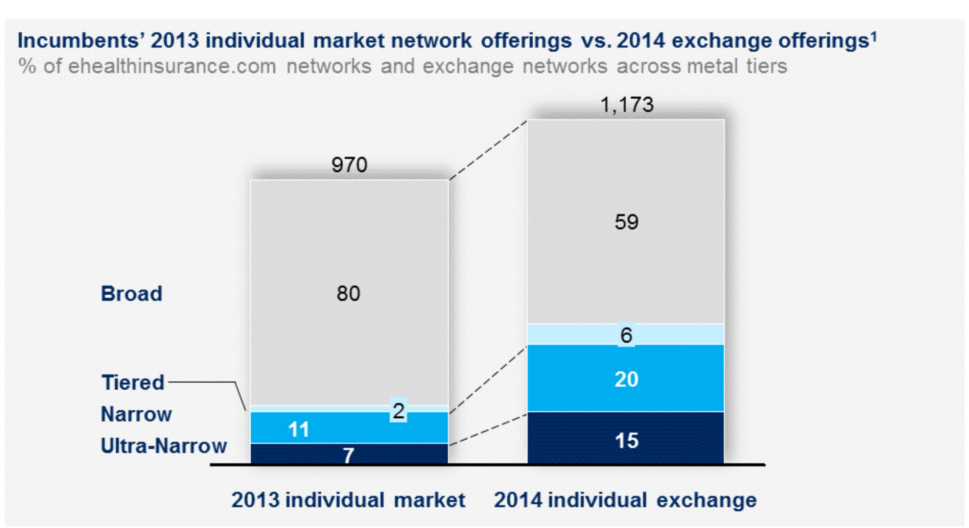
---

[11] Of the 82 rating areas that do not have a broad network on the 2014 exchange, 35 did not have any broad networks in the 2013 individual market either.

[12] Addressable population is defined as people who are eligible to purchase qualified health plans on the exchanges (i.e., non-elderly adults with incomes above 100 percent FPL in non-Medicaid expansion states and above 138 percent FPL in Medicaid expansion states).

The prevalence of broad and narrowed networks varies by geography. In 104 rating areas (representing 8 percent of the addressable population), broad networks are the only network type offered. In many cases, these are rural areas with provider market structures not conducive to narrowing (e.g., they contain only one or two hospitals). In addition, local regulations in some markets may lead to different network configurations or levels of narrowing. In contrast, across the largest cities in each state (which together include 30 percent of the addressable population), the prevalence of narrowed networks is 60 percent.

The increased choice for consumers at the point of health plan purchase is illustrated through the comparison of incumbents' network offerings in the 2013 individual market against products in the 2014 individual exchanges in the same rating areas *(Exhibit 2)*.[13] Across the country, incumbent payors now offer 20 percent more products, driven by the increased number of narrowed network offerings. In addition to the expanded number of incumbent products, 90 percent of the new entrants are offering narrowed network plans as well. The resulting increase in the number of network configurations gives consumers a greater range of value propositions and prices among health plans.



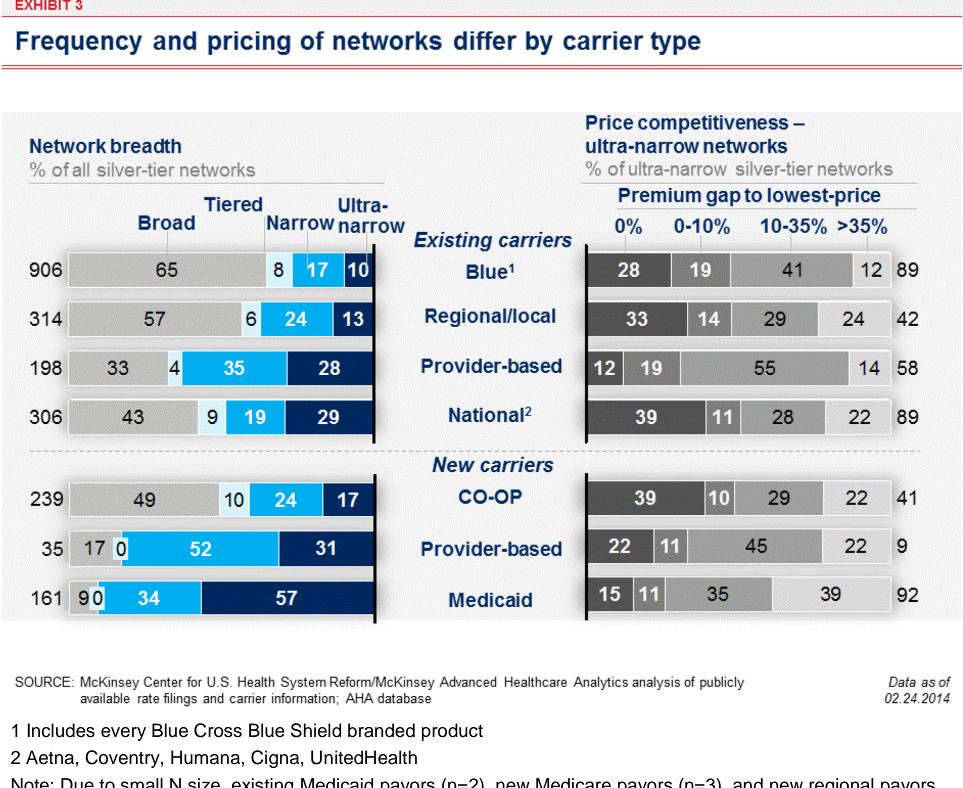
SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information; AHA database

Data as of 02.24.2014

1 Incumbents are defined as any 2013 payor that filed on the exchanges in 2014, for which 2013 individual network data was available (2013 data was available for 138 of the 202 incumbents that filed on the 2014 exchanges).

13 Incumbents are defined as any 2013 payor that filed on an exchange in 2014.

All payor types (but not all payors within each type) are offering products with narrowed networks. However, the prevalence of these networks differs by payor type *(Exhibit 3)*. New entrants offer a higher percentage of narrowed networks than incumbents do (68 percent versus 45 percent). Among the new entrants, Medicaid payors[14] and provider-based plans offer the highest percentage of ultra-narrow networks (57 percent and 31 percent, respectively). Among the incumbents, national payors[15] use ultra-narrow networks most often (29 percent).



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information; AHA database

Data as of 02.24.2014

1 Includes every Blue Cross Blue Shield branded product

2 Aetna, Coventry, Humana, Cigna, UnitedHealth

Note: Due to small N size, existing Medicaid payors (n=2), new Medicare payors (n=3), and new regional payors (n=2) are not included

Products with broad hospital networks have median premiums 13 to 17 percent higher than plans with narrowed networks; close to 70 percent of the lowest-price products include narrowed networks

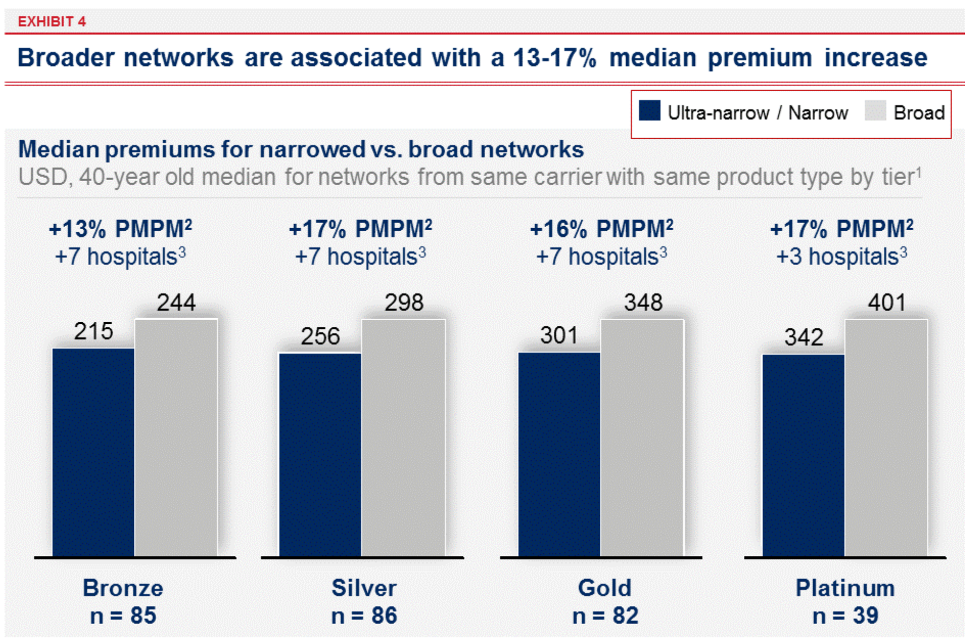
In general, narrowed networks appear to be an important and effective cost-control lever for payors. We found 292 instances in which the same payor is offering two

---

[14] Defined as payors that are both formerly focused on the Medicaid segment *and* new to the individual segment

[15] The term "national payors" refers to UnitedHealth, Cigna, Humana, and Aetna/Coventry. Anthem, HCSC, and Regence are excluded because they are classified as Blues plans. Molina and Centene are classified as Medicaid payors.

networks of different breadths (ultra-narrow or narrow network versus broad network) in the same rating area, on the same metal tier, and within products of the same type (i.e., HMO, PPO, EPO, POS). In these instances, the median difference in premiums between the narrowed and broad network products ranges from 13 to 17 percent ($29 to $59 per member per month[16]) across tiers. The maximum difference in premiums ranges up to 31 to 53 percent ($84 to $125 per member per month) *(Exhibit 4)*.



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information; AHA database

Data as of 02.24.2014

1 If more than two networks offered by a payor had the same plan type (i.e., HMO, PPO, EPO, POS), only the broadest and narrowest networks are included. Analysis is based on PMPM premium for a 40-year-old nonsmoker not eligible for premium subsidies. When the same payor offered multiple products on the same network, the lowest-price product was used.

2 Median change in the premium difference from the narrowed network to the broad network.

3 Median change in the number of hospitals participating from the narrowed network to the broad network.

Although 69 percent of the lowest-price exchange products include narrow, ultra-narrow, or tiered networks,[17] network breadth does not always correlate with premium levels *(Exhibit 5)*. This finding may reflect other factors affecting payor costs that are not part of our analysis: for example, starting points for provider reimbursement levels; the choices made by low-operating-cost, more efficient

---

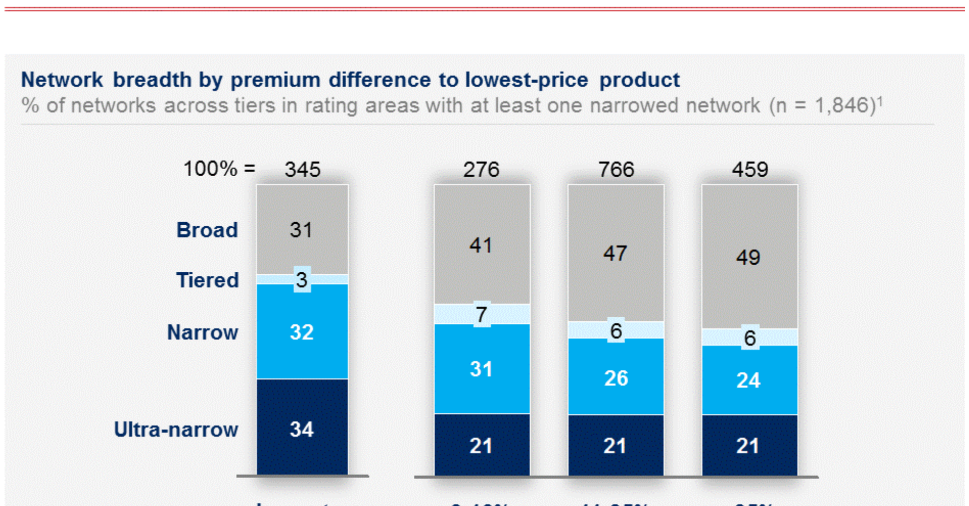
[16] Analysis is based on PMPM premium for a 40-year-old nonsmoker who is not eligible for premium subsidies.

[17] Out of all rating areas where ultra-narrow or narrow networks are present (329 the 501 rating areas).

hospitals whether to participate in narrowed networks or not; and assumptions regarding care management effectiveness and risk selection and adjustments (i.e., morbidity of expected membership, impact of risk adjustors/re-insurance). Some of these assumptions, especially those related to morbidity, vary widely with the uncertainty of a new market.

EXHIBIT 5

Close to 70% of lowest-price products are narrowed



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information; AHA database

Data as of 02.24.2014

1 When the same payor offered multiple products based on the same network, the lowest-price product was used in the analysis.

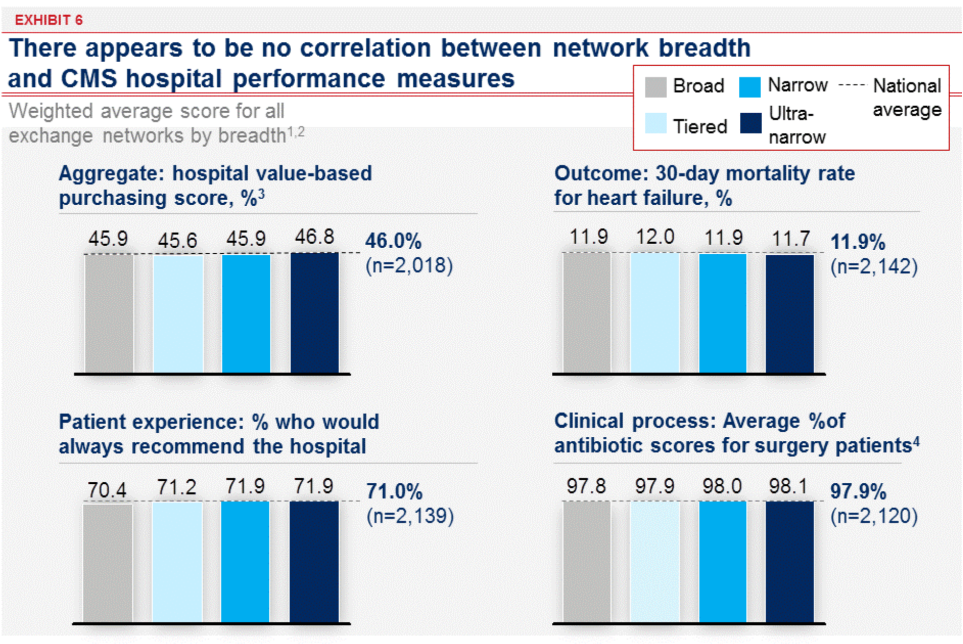
2 Premium gap to the lowest-price product is the difference between a network's lowest-priced plan and the lowest-priced plan within the same metal tier in the same rating area. For networks with multiple tiers, the tier used for the network price is chosen in priority order: silver, bronze, gold, platinum, catastrophic.

The ability to translate ultra-narrow networks into competitively priced products varies by payor type. Medicaid entrants have the lowest prevalence of competitively priced ultra-narrow networks (defined as being priced within 10 percent of the lowest-price product, regardless of network type, in a rating area); 26 percent of their ultra-narrow networks are competitively priced. In contrast, 51 percent of the ultra-narrow networks offered by national payors are competitively priced. Other payors use broad networks more often, yet achieve price leadership at times. For instance, 70 percent of the Blues' 2014 exchange networks are broad, and 42 percent of those networks are priced competitively.

Incumbents are more likely than new entrants to offer multiple silver-tier network options in a given rating area (25 percent and 13 percent, respectively). Among the incumbents, Blues payors offer multiple network options most often; 34 percent of them offer multiple silver-tier networks in at least one rating area.

There is no meaningful performance difference between broad and narrowed exchange networks based on key CMS hospital metrics. Broad networks are more likely to include an AMC

The performance of participating hospitals (as defined by the four metrics discussed below) appears to be similar across network breadths *(Exhibit 6)*. The four metrics we used are gathered routinely by CMS: the composite value-based purchase (VBP) score of outcome, patient experience, and clinical process measures;[18] the 30-day mortality rate from heart failure; the likelihood that a patient would recommend a hospital (as measured by the Hospital Consumer Assessment of Healthcare Providers and Systems); and the rate of antibiotic delivery to surgical patients. We acknowledge, however, that others may use different definitions of hospital performance, and differences among the hospitals might have emerged had other data been widely available.



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information; AHA database

Data as of 02.24.2014

1 Across all exchange networks. N refers to the number of networks and varies across metrics because CMS does not publish all metrics across all hospitals.

2 Scores reflect the weighted average of all network scores for given network breadths, weighted by the number of inpatient admissions for each in-network hospital in a given network.

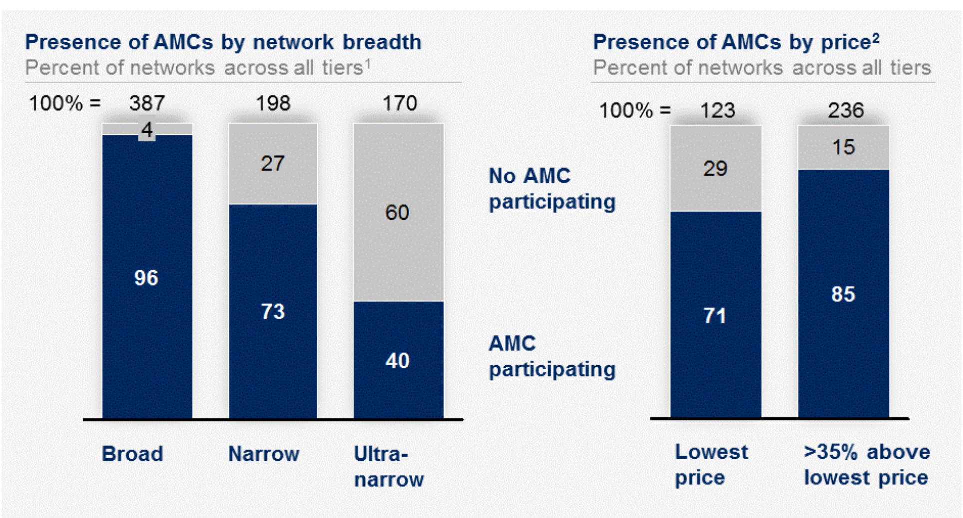
3 Composite score that looks at outcomes, patient experience, and clinical processes.

4 Average of the following three measurements: 1) percentage of surgery patients given an antibiotic at the right time (within one hour before surgery) to help prevent infection; 2) percentage of surgery patients whose preventive antibiotic was stopped at the right time (within 24 hours after surgery); and 3) percentage of surgery patients who were given the right kind of antibiotic to help prevent infection.

---

18 The VBP score is a composite; 12 core clinical process measures account for 70 percent of the score, and 8 patient experience metrics account for the other 30 percent. See the appendix for more details.

Academic medical centers (AMCs)[19] are participating most often in products with broad networks and higher premiums. For example, 96 percent of the broad networks across the U.S. have an in-network AMC, compared with 40 percent of the ultra-narrow networks. However, AMCs are participating in 71 percent of the lowest-price silver-tier offerings in each rating area, compared with 85 percent of the highest-price products in that tier *(Exhibit 7)*.[20] Products including an AMC have premiums that, on average, are 9 percent higher than products without AMCs ($317 versus $291, respectively).[21]



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information; AHA database

Data as of 02.24.2014

1 Only for rating areas that include at least one AMC (125 of 501 rating areas across the U.S.)

2 Analysis was based on PMPM costs for 40-year-old nonsmoker not eligible for premium subsidies. Premium gap to the lowest-price product is the difference between a network's lowest-priced plan and the lowest-priced plan within the same metal tier in the same rating area.

Certain market conditions—higher excess bed capacity, provider and/or payor fragmentation, more growth potential from uninsured—are associated with a greater prevalence of narrowed networks

Across markets, narrowed networks are more prevalent in regions with higher excess bed capacity, greater provider and/or payor fragmentation, or greater

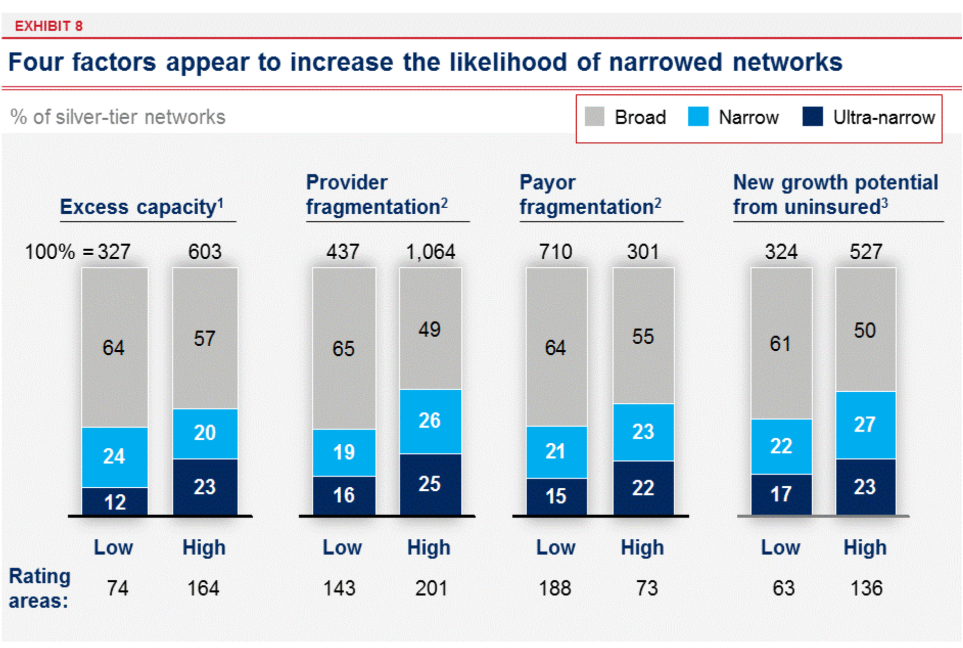
---

[19] Defined as a hospital affiliated with an accredited U.S. medical school, according to the Association of American Medical Colleges. For medical schools with more than one affiliated hospital, the largest hospital was used.

[20] Defined as more than 35 percent greater than the lowest-price product.

[21] Based on the silver-tier premium for a 40-year old nonsmoker.

potential for growth from the uninsured than from those previously insured *(Exhibit 8)*.[22] In markets with even one of these conditions, the prevalence of narrowed networks is 1.2 to 1.5 times higher, and the prevalence of ultra-narrow networks of 1.4 to 1.9 times higher, than in other markets. When more than one of these factors is present, the prevalence of narrowed networks increases further (up to 4.7 times higher).



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information; AHA database

1 Utilization was calculated as the rating area's total facility inpatient days divided by total facility staffed beds multiplied by 365 ; low utilization: <55 percent; high utilization: >70 percent.

2 Level of fragmentation was measured via Herfindahl-Hirschman Index, calculated as sum of squares of market share (for provider, defined as inpatient market share; for payor, defined as commercial market share); low fragmentation: >5,000 for provider, >2,500 for payor; high fragmentation: <2,500 for provider, <1,500 for payor.

3 Growth potential was calculated by QHP-eligible uninsured divided by total QHP-eligible population to compare new growth from those previously uninsured against a change in coverage among those previously insured; low growth: <60 percent; high growth: >75 percent.

In ratings areas in which at least two payors offer ultra-narrow, silver-tier networks, 67 percent of those networks share the majority of their hospitals with at least one other payor's network

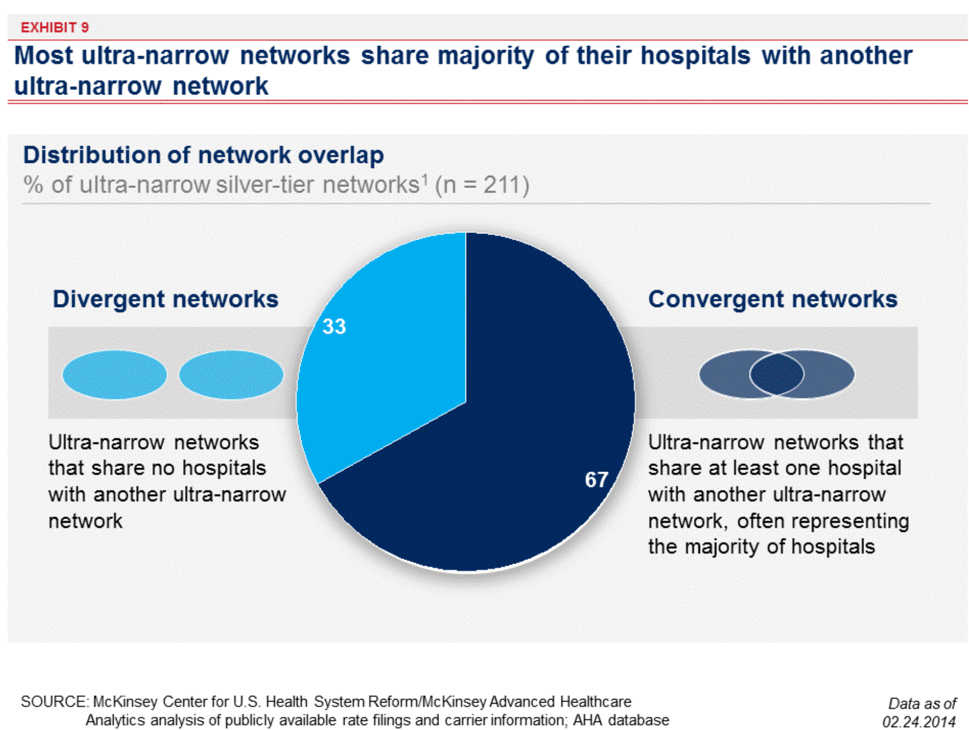
Among the 75 markets with multiple ultra-narrow networks within the silver tier, the extent of convergence—the participation of one or more hospitals (in most cases, the majority of the network's hospitals) in more than one ultra-narrow network—varies greatly. While almost all acute-care hospitals (96 percent) are participating in an exchange product, less than half are participating in a narrow or

---

22 "Uninsured" and "previously insured" based on 2013 coverage status of all QHP-eligible individuals living in each rating area.

ultra-narrow network (32 and 14 percent, respectively). Of the hospitals participating in an ultra-narrow network, 23 percent are in more than one such network.

Nationwide, 67 percent of ultra-narrow, silver-tier networks are convergent (as defined above). Of these convergent ultra-narrow network products, 21 percent are the lowest-price product in their rating area. The remaining one-third of ultra-narrow networks are divergent—they did not share any hospitals with other ultra-narrow networks (*Exhibit 9*).



1 Networks must be in rating areas with 2 or more ultra-narrow networks.

In areas with a high prevalence of divergent networks, a hospital's basis of competition for patients moves "forward" from the point of access to the point of health plan purchase. A hospital not participating in a given network essentially loses access to patients in that network (at least for elective procedures) for the entire enrollment period, potentially altering competitive dynamics in the market.

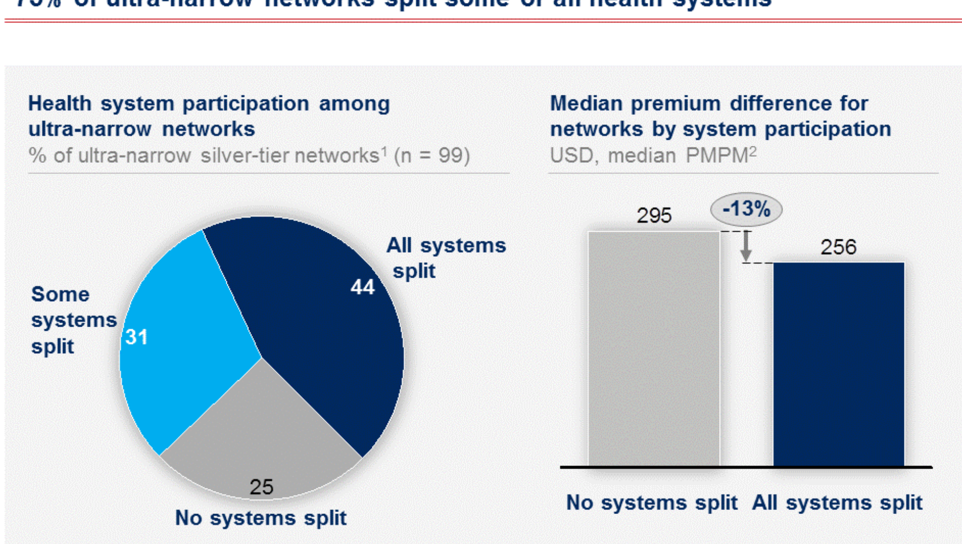
Three-fourths of ultra-narrow networks include only some of the hospitals within a health system. These networks are typically priced lower than ultra-narrow networks that contain entire health systems

Seventy-five percent of all ultra-narrow, silver-tier products include only some of the hospitals within participating health systems. Forty-four percent of these products exclude at least one hospital from every single participating health

system; only a subset of each system's hospitals is included *(Exhibit 10)*. Another 31 percent of the products exclude at least one hospital from at least one health system. The ultra-narrow networks excluding at least one hospital from every participating health system are priced 13 percent lower, on average, than those including all hospitals from every participating health system.

EXHIBIT 10

75% of ultra-narrow networks split some or all health systems



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information; AHA database

Data as of 02.24.2014

1 Networks were analyzed on a state level to account for health systems that span multiple rating areas.

2 Analysis was based on PMPM costs for a 40-year-old nonsmoker not eligible for premium subsidies.

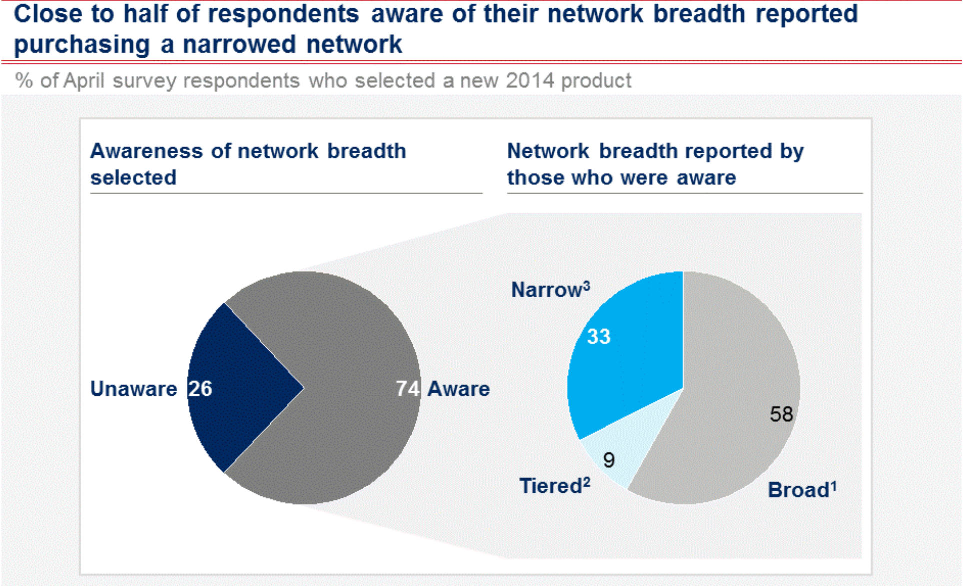
Partial health system participation in a network may be the choice of either the provider or the payor. For strategic or financial reasons, a health system may opt to trade price for volume, thereby gaining disproportionate access to the exchange, or it may choose to maintain price and forgo the volume. Alternatively, a payor may select (where regulations permit) only the subset of the more efficient or more attractively priced hospitals within a system.

Local, regional, and national health systems are all represented in ultra-narrow networks with partial participation. The payors most often offering ultra-narrow networks with partial health system participation are the national players (54 percent of their networks) and new Medicaid entrants (47 percent).

In our survey, 42 percent of those who indicated they had enrolled in an ACA plan and were aware of their network type reported purchasing a product with a narrowed network

Among the topics covered in our April consumer survey was whether respondents had shopped for and then purchased healthcare coverage, as well as how network

breath may have influenced their decisions. Twenty-six percent of the respondents who indicated they had enrolled in an ACA plan were not aware of their selected product's network breadth *(Exhibit 11)*. This lack of awareness was highest among previously uninsured respondents[23]; they were more than twice as likely as previously insured respondents to be unaware of network breadth (41 percent versus 21 percent, respectively).



SOURCE: McKinsey Consumer Health Insights, Open Enrollment Tracker, McKinsey Advanced Healthcare Analysis, April, 2014

1 Survey response was "Broad network (includes almost all doctors and hospitals in my area)".

2 Survey response was "Tiered network (includes almost all doctors and hospitals in my area, but puts them into different levels where I pay a different amount for different levels)".

3 Survey response was "Narrow network (includes a limited selection of doctors and hospitals in my area; for those that are out-of-network, I would have to pay a significantly higher fee or the full bill)".

Among the respondents aware of the network breadth in their plans, close to half (42 percent) indicated they purchased a narrowed or tiered network.[24] This rate was also higher among the previously uninsured than among those previously insured (45 percent vs. 40 percent, respectively). In some cases, price may have been a factor affecting network choice, as the respondents who reported having selected a narrowed network product were more likely than other respondents to have indicated that they picked the lowest-price product in a given tier.

---

23 Our survey 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 …." Those we defined as being previously uninsured answered "I did not have health insurance, I was uninsured.")

24 As noted earlier, the survey did not ask respondents to differentiate between narrow and ultra-narrow networks.

Of all respondents who reported selecting a new ACA plan, 40 percent indicated they would have liked additional information about the providers included in different plans. Among the respondents reporting that they had shopped for health coverage but did not purchase a plan, only 7 percent thought the information regarding which providers were included in the plans was "extremely clear."

These survey results provide an early indication of how consumers are considering network configuration in their purchase decisions and are reconciling the tradeoff between premium levels and provider access. Yet, it will take much longer to gauge the full impact of consumers' reactions to narrowed network products and how they utilize out-of-network services. The resulting impact could affect the sustainability of narrow and ultra-narrow network products in terms of both economic performance and member retention, and will therefore have implications for product and network design in 2016 and beyond.

□ □ □

The findings presented in this Intelligence Brief provide an updated view of the network configurations being offered on the public exchanges across the country, as well as early indicators of the types of networks that consumers are purchasing. The exchange network data suggest that consumer choice of health plan design is expanding to include an increased number of offerings with varying breadths of hospital networks. We do not yet know how some of these network configurations will influence utilization and member retention. We will analyze data on enrollment and utilization as they become available to further inform the observations and implications described in this Intelligence Brief.

Noam Bauman, Erica Coe, Jessica Ogden, Ashish Parikh

The authors would like to thank Joseph Levenson, Brock Mark, Joseph Mitchell, Jim Oatman, and Brendan Murphy for their support.

Appendix

Additional background on the underlying research

The analyses supporting this Intelligence Brief are informed by a new McKinsey Health Systems and Services Practice asset that has been developed jointly by the Center for U.S. Health System Reform and McKinsey Advance Healthcare Analytics (MAHA). Instead of estimates and projections, this tool offers a real-time view of what was actually filed on the 2014 exchanges— 20,818 qualified health plans. The Reform Center/MAHA tool can compare individual and small-group rate filings, pre- to post-ACA trends, pricing across product types and actuarial value tiers by consumer characteristics, exchange network trends, predictions of market share based on filings and consumer-predicted dynamics, and more. Specific analyses are available upon request from the Reform Center/MAHA team; we look forward to helping our clients achieve success in the post-ACA market through the use of data-driven analysis on specific market trends.

Please contact reformcenter@mckinsey.com with any inquiries.

Methodology

The major analyses and other data sources used to develop this Intelligence Brief include:

Main analysis for targeted markets. For 2014 individual exchange market trends, we based our network analysis on exchange offering data accessed directly from the public exchanges as of February 24, 2014. All data was obtained directly from the public exchanges by shopping directly on all exchanges and by analyzing datasets released by the federal exchange. In addition, details about products' underlying exchange hospital networks were obtained directly from payor sites, utilizing their "provider search" capabilities. For pre-reform 2013 individual market data, we based our analysis on product data and underlying hospital network details accessed from both ehealthinsurance.com and payor sites.

We ran an in-depth analysis of all 2,366 hospital networks included on all 20,818 exchange products offered across all tiers in 2014. 2,366 distinct exchange networks were offered by 282 payors (every payor that filed on the 2014 exchanges). Across the country, 4,605 acute care hospitals (including 374 health systems) are participating in these exchange networks, out of a nationwide total of 4,773 acute care hospitals (378 health systems). Our payor calculations are based on the number of payors that offered plans in each state. As a result, a national payor that offered plans in 12 states in 2013 was counted as 12 "unique payors" in that year. However, a payor that offered 2014 exchange plans in four rating areas within a state was counted as a single payor in that state. Network calculations are based on the number of networks offered in each rating area (the same network

offered in four different rating areas would be considered four different networks, each capable of different network breadths). For some of the more detailed analyses discussed in this Intelligence Brief, we focused on silver-tier networks, for three reasons. First, the majority of exchange networks (93 percent) are offered on the silver tier. Second, because all payors are required to offer a silver product to compete on the exchanges, products on the silver tier reflect all exchange payors in a given rating area. Third, the silver tier is the only tier for which income-eligible consumers can receive federal premium and cost-sharing subsidies, and more than 60 percent of all consumers who enrolled in an exchange product chose the silver tier. In addition, we limited our analysis to on-exchange offerings, as comprehensive off-exchange 2014 filings are not consistently available in a single source.

Classifications. The criteria we used to classify networks, hospitals, products, and payors are summarized below.

- *Network breadth.* Hospital networks were classified based on the degree of restrictions imposed, as defined by the percentage of hospitals participating in each network in the respective rating area.
    - Broad: More than 70 percent of hospitals participating
    - Narrow: 31 to 70 percent of hospitals participating
    - Ultra-narrow: 30 percent or less of hospitals participating
    - Tiered: different hospital tiers with different co-payment requirements for different hospitals
- *Hospital type.* Our analysis focused on acute care facilities defined general medical and surgical, surgical, cancer, heart, eye, ear, nose, and throat, orthopedic, and children's general, as classified by the American Hospital Association (AHA). We did not include psychiatric, rehabilitation, or veterans hospitals. Academic medical centers were defined as hospitals affiliated with an accredited U.S. medical school, according to the AHA.
- *Product type.* The product type of each exchange network offering was defined based on the product offering details listed on respective exchange websites.
    - EPO: an exclusive provider organization is a plan model similar to an HMO. It provides no coverage for any services delivered by out-of-network providers or facilities except in emergency or urgent care situations; however, it generally does not require members to use a primary care physician for in-network referrals.
    - HMO: a health maintenance organization is a plan model centered around a primary care physician who acts as gatekeeper to other services and referrals; it provides no coverage for out-of-network services except in emergency or urgent-care situations.

- POS: a point-of-service plan is hybrid of an HMO model and a PPO model; it is an open-access model that assigns members to a primary care physician and provides partial coverage for out-of-network services.
- PPO: a preferred provider organization is a plan model that allows members to see physicians and get services that are not part of a network, but out-of-network services require a higher copayment.

- *Payor type.* Insurance payors were classified based on the following definitions:
  - Blues: a Blue Cross Blue Shield payor; includes Anthem, HCSC, Regence; considered an incumbent.
  - Consumer-operated and oriented plan (CO-OP): a new entrant that is a recipient of federal CO-OP grant funding and is not a prior commercial payor.
  - Medicaid: a new entrant that formerly offered only Medicaid insurance in the past; includes Molina and Centene.
  - National: a commercial payor with a presence in more than four states that has filed on the exchanges (specifically, UnitedHealth, Cigna, Humana, and Aetna/Coventry); considered incumbents.
  - Provider-based: an entrant that operates as a provider/health system; classified as new or existing based on presence of individual business in 2013.
  - Regional/local: commercial payor with a presence in four or fewer states (most often just one state) that has filed on the exchanges; classified as new or existing based on presence of individual business in 2013.

Pricing analyses. When a payor offered multiple products on an exchange, plans with different premiums could be based on a single hospital network. In these cases, the premium used in our pricing analyses was the lowest one among the plans (e.g., if a payor offered three plans with the same network on the same tier, for $200, $220, and $240 per month, $200 was used for all pricing analyses).

Quality analyses. To test for a relationship between hospital performance and exchange network participation, we analyzed the elements of the Centers for Medicare and Medicaid Services (CMS) value-based purchase (VBP) score across the different categories of VBP metrics for 2014 (clinical process, patient experience, and outcomes). The VBP score was created under the ACA to incentivize individual hospitals to improve quality of care. It is a composite score of outcomes-based metrics, patient-reported metrics (from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)), and clinical process measurements. VBP performance scores are used to determine

the value-based incentive payment for each hospital. We used the FY2013 VBP based on hospital performance between July 2011 and March 2012.

- The *30-day mortality rate for heart failure* measures deaths from heart failure-related causes within 30 days of a hospital admission. Patients need not be admitted at the time of death. We used 30-day mortality rates reported between July 1, 2009 and June 30, 2012.
- A *patient-reported: yes they would recommend the hospital* is the sum of the scores reflecting that the patient would "usually" recommend and "always" recommend the hospital. We used the HCAHPS metrics reported between July 1, 2012 and June 30, 2013.
- The *clinical process: average of antibiotics scores* for *surgery patients* is an average of the scores reflecting: "Percent of Surgery Patients given an antibiotic at the right time (within one hour before surgery) to help prevent infection", "Percent of Surgery Patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery)", and "Percent of Surgery Patients who were given the right kind of antibiotic to help prevent infection". We used metrics reported between July 1, 2013 and June 30, 2013

Pre- and post-reform network analyses. We identified and pulled information about the individual pre-reform 2013 networks that were offered by incumbents that filed on the 2014 exchanges across the country (907 distinct 2013 individual networks in total, for 138 of the 202 incumbents that filed on the 2014 exchanges.) To identify pre-reform networks, we analyzed a list of 2013 products and networks from eHealthinsurance.com and identified all 2013 networks for incumbents. We applied the same network breadth methodology to the 2013 networks as was used for the 2014 networks. To measure the percentage contraction of each incumbent's network breadth from 2013 to 2014, we compared each incumbent's 2014 exchange network's hospital participation rate to the respective payor's 2013 individual market networks in the same rating area, for all 2014 exchange networks offered across metal tiers.

Please contact reformcenter@mckinsey.com with any inquiries about our methodology.

Obtaining previous Intelligence Briefs

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

- "Individual market: Insights into consumer behavior at the end of open enrollment" (May 2014)
- "2015 Medicare Advantage rates: Perspectives for payors" (April 2014)
- "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)

June 2014

Copyright © 2014 McKinsey & Company

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

WWW.FAMILIESUSA.ORG

Health System Improvement

How to Make Reference Pricing Work for Consumers

ISSUE BRIEF / JUNE 2014

/ Consumer Incentives

Reference pricing programs can help counter the wide variation in prices for health care services that exist across the country.

In our current health care system, prices for medical care often vary greatly—even for the same services from providers in the same network. This variation in health care prices often does not reflect the quality of the care provided. Instead, it reflects the fact that some providers have greater market power and can negotiate higher prices with insurers.

Moreover, information on prices is usually not available, so consumers usually do not have the information they need to choose providers based on both price and quality. As a result, consumers often pay too much for health care, and there is little pressure on overly expensive providers to set fairer prices for care.

In an effort to control costs, health care payers—including employers, state employee health plans, and private insurers—are increasingly implementing reference pricing. Reference pricing is a practice health care payers use in which they set a threshold price (above which they will not pay) for a particular health care service in a given area. If a consumer receives care from a provider that charges his or her health plan more than the reference price, the consumer is responsible for paying the difference.

If implemented effectively, reference pricing programs can give consumers the information they need to compare providers based on both price and quality, and they can encourage consumers to receive care from providers that deliver the best care at the best price (high-value care). More importantly, reference pricing programs have the potential to pressure overly expensive providers to set more competitive prices.

This brief explains price variation and reference pricing and discusses how reference pricing can be used to minimize variation in health care prices. It then outlines the key elements that reference pricing programs must include to be effective and consumer-friendly.

Why prices for health care services vary so widely

How do health care providers and private health insurers typically set prices? Each provider negotiates with individual insurers to set prices that the provider is willing to accept as payment for specific services from that particular health plan. Providers of equal quality may charge very different prices for the same services. We end up with widely varying prices[1]—but little to no correlation between price and quality.

What does this mean for consumers? It means that they can face vastly different prices for the same care,

Reference pricing programs use financial incentives to encourage consumers to shop for health care based on price and quality, and to pressure overly expensive providers to set fairer prices.

These programs can help minimize price variation. But they must follow certain guidelines to ensure that they protect consumers' access to high-quality, affordable care and give consumers the understandable, up-to-date price information they need to make informed decisions.

depending on their provider and their health plan. It also means that consumers cannot use higher prices as a reliable proxy for higher-quality care. Providers who charge more may simply have greater negotiating power because they control a larger share of the market or have brand recognition in that region.

For example, recent research has found that, while high-priced hospitals tend to have some unique characteristics that could affect prices (such as offering more specialized health care services and being involved in medical education), these hospitals also enjoy significantly larger market shares than low-priced hospitals. This enables them to negotiate higher prices. Research also found that high-priced hospitals do not consistently perform better on outcome-based measures of quality compared to low-priced hospitals.[2]

Lack of price transparency makes it difficult for consumers to make informed decisions

This immense price variation persists, in some part, because there is limited public information available about the prices that providers negotiate with insurers (often referred to as "price transparency"). While many states require providers to report what their "charges" are for certain services, these charges are almost always hypothetical list prices that are typically higher than the negotiated prices insurers actually pay providers (see "Key Terms").

Without price transparency about the negotiated prices health plans and providers set, consumers are unable to select health care providers based on price and quality. And providers and insurers have little incentive to set competitive, fair prices.

How does reference pricing work?

The goal of reference pricing is to promote greater price transparency, to encourage consumers to shop for care based on price and quality, and to pressure overly expensive providers to set fairer prices for care.

A reference pricing program targets health care services where there is significant variation in the prices that different providers charge—but little to no correlation between higher-priced providers and the delivery of higher-quality care. Reference pricing programs target only "shopable" health care services for which consumers have the opportunity to select a provider (not emergency care). For these services, the insurer sets a "reference price," which is the most that the health plan will pay for that particular health care service. When an insurer is establishing this maximum price, it must make sure that it has an adequate number of high-quality providers whose prices for that service fall within the reference price threshold.

If consumers receive a service from a provider that is within the reference price, they are responsible for paying only the regular out-of-pocket costs they would typically pay under their plan. A plan could also waive

Key Terms

Charge: The amount a provider bills for a particular service. This number is often much higher than the negotiated amount a provider accepts as payment from an insurer (the price). Some parties may also refer to a "chargemaster," which is a list of a provider's charges for numerous services.

Price: The negotiated amount that a provider has agreed to accept as payment for a service from a particular insurer. This is sometimes referred to as the "allowed amount."

Price transparency: The availability of provider-specific information on the price of a specific health care service or set of services.[3]

or reduce cost-sharing for a service that is subject to reference pricing when consumers receive that care from a provider that charges within the reference price.

But if consumers receive a service from a provider that charges *more than* the reference price, they are responsible for paying the full difference between the reference price and the price the provider charges their plan. This cost is *in addition* to any cost-sharing they must pay.

Lets say a health plan sets a reference price of $1,200 for a standard colonoscopy. A consumer in that plan opts to get a colonoscopy from a provider that has negotiated a price of $2,000. That consumer would be responsible for covering the additional $800 that his or her provider charges the health plan for the colonoscopy, in addition to any cost-sharing.

Reference pricing can be applied to individually billed health care services (such as the hospital fee for a colonoscopy), or a bundle of services for a particular episode of care (such as all care for a routine knee replacement surgery, including hospital and physician fees).

Reference pricing can also be set for groups of substitutable medications that are equally effective but that have significant price variation, such as medications with multiple brand-name and generic equivalents.

Reference pricing can encourage providers to set fair prices

One of the most significant benefits of reference pricing is its potential to drive health care savings by pressuring providers to lower their prices. When consumers have understandable information about price and quality and a financial incentive to shop for care within a reference price, providers that want their business may

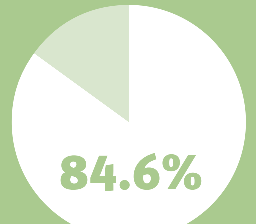
California's Reference Pricing Saved $2.8 Million in 2011

California's experience shows how reference pricing can generate savings when providers lower their prices for care. In 2011, the California Public Employees Retirement System (CalPERS), which provides health insurance to California's public employees, retirees, and family members, established a reference pricing program for knee and hip replacement surgeries.

Internal analysis of the program found that the program led to $2.8 million in savings in 2011.[4] The vast majority of this savings—84.6 percent—resulted from hospitals lowering their prices (including hospitals that charged more than the reference price and those that already charged within the reference price). Across all hospitals, the average price charged to CalPERS members for knee and hip replacements declined by 26 percent in 2011. And among hospitals that originally charged more than the reference price, the average price for these services dropped by 34.3 percent.[5]

California's CalPERS reference pricing program saved

$2.8 million



of this savings resulted from hospitals lowering their prices

be motivated to set more competitive prices. Providers that charge more than the reference price face pressure to lower their prices to within the reference price. And even providers that charge within the reference price may feel pressure to lower their prices to stay competitive with other high-quality providers in the area.

Reference pricing programs that are implemented by payers that insure a large number of consumers will likely be most effective at driving providers to lower prices.

Potential risks of reference pricing

If not implemented properly, reference pricing programs also have the potential to create serious barriers to affordable care. For example, if a program sets its reference price too low, it could be difficult for consumers to get care from providers who charge within the reference price. Thus, the program would simply be shifting costs to consumers. Setting a reference price too low could also encourage providers to avoid complex patients in order to keep costs low, or it could lead them to raise their prices for other health care services in order to make up lost revenue.

Below, we identify eight key elements a reference pricing program must include in order to be effective and consumer-friendly.

Principles for creating a consumer-friendly reference pricing program

1 Build the program around price transparency

Before a health care payer can implement a reference pricing program, it must obtain information about the prices providers charge for certain services and be able to share this information with consumers in their plan. This information should be specific to the negotiated prices that providers charge the payer that is implementing reference pricing.

Programs must ensure that this price information is presented to consumers in easy-to-use formats that help consumers compare providers and help them understand their share of costs and the total cost of care. (Also see “Provide consumers with resources that explain how reference pricing works and tools to compare providers based on quality and price,” on page 8.)

Health care payers need this information to identify services where there is significant price variation and where it is appropriate to apply a reference price. And consumers need this information to compare and shop for providers based on price and quality once the program is in place.

Payers should obtain price information for as many health care services as possible. This will enable them to monitor

whether a reference pricing program targeted at one service successfully drives providers to charge fairer prices across the board, or whether providers lower their prices only for services that are subject to a reference price and raise their prices for other services in order to make up that lost revenue.

Obtaining this information may not always be easy. Contracts between health plans and health care providers may include "gag clauses" that prohibit health plans from sharing this type of information, even with employers that contract with their health plan.

Some states have passed legislation to ban these types of contract agreements, opening the door for health plans to make price information more available to payers like employers, as well as to consumers. A handful of states also have efforts underway to develop all-payer claims or multi-payer claims databases that systematically collect claims data across payers. Whether these claims databases can provide the price information necessary for reference pricing will depend on the scope of data they collect and make available.

2 Establish reference prices for targeted services

Reference prices should be set only for health care services that have significant price variation across providers in a region, and where little to no correlation exists between more expensive providers and the delivery of better-quality care. This ensures that consumers have the opportunity to shop for care and are able to compare providers based on predictable estimates of out-of-pocket costs.

This strategy should also be limited to standard and scheduled health care procedures, like colonoscopies or scheduled hip or knee replacement surgeries, and only in situations where there are no complications related to providing that care (see "Has accessible exceptions and appeals processes" on page 8).

Some procedures, like surgery, involve multiple health care services that are typically billed separately, like a facility fee from the hospital and a separate physician's fee. A program could set a reference price only for the hospital facility fee, or a program could set a reference price that covers multiple or all billed services provided during the surgery. It is important that reference pricing programs clearly define and explain to plan members the scope of services a reference price is meant to cover.

3 Set fair reference prices based on the local market

Reference pricing should be used to increase transparency and minimize unfair price variation, not to limit access to care or shift costs to consumers. To this end, it is paramount that programs set fair reference prices reflecting what the majority of high-quality providers within that region charge for care.

Reference prices should be based on prices within a local region. The range of prices providers charge for a particular service can be very different from state to state,

and even between different regions within a state, depending on how competitive the health care market is across those regions.

In a state or region where health care providers generally have significant market power and can negotiate higher prices, all providers in that area may charge higher prices compared to a region with a generally more competitive health care market. Because of this, programs should never apply a single reference price to consumers across different states and should be very cautious if considering applying a uniform reference price statewide.

4 Offer an adequate network of high-quality providers whose prices fall within the reference price

Programs must ensure that an adequate network of providers across all geographic regions that the program serves, including rural and underserved regions, charge prices that fall within the reference price. The plan must also have an adequate number of providers who charge within the reference price that are equipped to meet the cultural and linguistic needs of diverse consumers.

In some cases, patients may need to travel longer distances to obtain care from providers that best meet their needs and charge within the reference price. In these situations, programs should cover transportation costs for both the patient and a family member or caregiver to ensure that consumers can get access to patient-centered care within a reference price. (See “Unique Challenges Facing Centers of Excellence.”)

Unique Challenges Facing Centers of Excellence

Some health insurers also have Centers of Excellence programs. These programs identify a few providers across the country that excel at delivering high-quality care for specific health conditions, like hip or knee replacements or cardiac surgeries. Centers of Excellence programs will reduce or waive consumers’ cost-sharing altogether and pay for both travel and lodging expenses if consumers receive these types of care from a Centers of Excellence provider.

Centers of Excellence programs face unique challenges to maintaining the continuity of patients’ care, because patients may be traveling long distances from home for treatment. It is important that Centers of Excellence programs cover travel and lodging expenses for both patients and a caregiver and cover lodging for as long as is necessary to ensure that a patient can safely travel home. Programs should also have sufficient strategies to ensure that Centers of Excellence providers work closely with patients’ local health care providers to seamlessly coordinate patients’ care once they return home.

Generally, if a plan already has an inadequate network of providers within a particular specialty, reference pricing should never be applied to services delivered by those providers. This would further limit an already insufficient network of affordable providers.

5 Prioritize quality when designing the program

Programs should encourage consumers to choose providers that are both fairly priced and high-quality. Programs can do this in two ways. First, reference prices should be set high enough to include an adequate number of high-quality providers. This should be an upfront factor that is used to determine the reference price. Second, programs can create incentives to

encourage consumers to seek care from providers that are within the reference price and that also perform well on a range of quality measures. For example, a program could reduce or waive cost-sharing altogether for care from these providers.

Programs should always use up-to-date and robust measures of provider quality.

6 Provide consumers with resources that explain how reference pricing works and tools to compare providers based on quality and price

Programs should develop rigorous outreach and education strategies to inform consumers about how the reference pricing program works, including which services have a reference price, what the reference price is, in what situations it applies, and a list of which local providers fall within the reference price.

This education strategy should include regularly sending notices to all plan members about the program. It also should include targeted outreach to consumers who may require a health service that is subject to reference pricing in the future. For example, CalPERS' reference pricing program for knee and hip replacement surgeries sent targeted communications about the program to plan members who had visited an orthopedist for knee or hip issues in the past year.[6]

Programs should also have tools (such as online provider comparisons tools) that give consumers easily understandable information about provider price and quality. These tools should allow consumers to search and compare providers based on price, quality, and other factors so they can find providers that best meet their needs. Ideally, programs should also provide consumers with easily understandable information about what their personal out-of-pocket costs would be for care from different providers based on any cost-sharing they must pay, like deductibles or copayments, and, if applicable, the portion of a provider's price that exceeds the reference price.

7 Have accessible exceptions and appeals processes

It is inappropriate to apply reference pricing to care when consumers either do not have the opportunity to shop for care or when consumers require more specialized and costly care due to complications. Broadly, reference pricing should never apply to services when they are received during a course of emergency care, or when patients require more complex care during the course of treatment due to unforeseen complications. In these situations, programs should automatically exempt patients from paying any outstanding balance above a reference price.

Patients with one or more diseases or disorders may also need more complex treatment for what would otherwise be a standard health care procedure. This may mean that that they need to see highly specialized providers that charge more than the reference price or that they need additional services that make the price of their care more expensive.

It is inappropriate to apply reference pricing to care when consumers either do not have the opportunity to shop for care or when consumers require more specialized and costly care due to complications.

Reference pricing programs should have simple processes for granting exceptions to ensure that consumers in these situations do not have to pay any outstanding balance above the reference price. These programs should also offer an appeals process for consumers who believe that they were wrongly required to cover excess costs due to reference pricing, given their circumstances.

These exceptions and appeals processes should be clearly outlined in consumer notices about the program. Since providers are uniquely suited to identify patients with special circumstances, programs should also educate providers about how they can help patients receive an exception from paying excess costs.

8 Evaluate the program regularly

Reference pricing programs should annually evaluate whether they encourage consumers to seek care from providers who charge within the reference price, and whether they drive more expensive providers to lower their prices for care. If an evaluation shows that a high proportion of consumers are continuing to seek care from providers that charge more than the reference price, it may be a sign that the program needs to strengthen its outreach and education, or that the reference price is set too low and consumers are having trouble finding providers who charge within the reference price.

It is also important to evaluate how the program affects utilization of care to ensure that the program does not inadvertently create barriers to necessary care or lead consumers to stop treatments. For example, if reference pricing is implemented for medications, programs should monitor how the program affects medication adherence. This is critical to ensure that consumers who originally used versions of a drug that cost more than the reference price do not stop taking necessary medications altogether.

Reference pricing programs should pay particular attention to how they affect access to care and health outcomes among lower-income consumers, who will be most sensitive to price increases.

Programs should also survey consumers about their experience with the program. This should include questions about whether:

- Consumers found it easy or difficult to obtain care from providers who charged prices that fell within the reference price
- Consumers who received services subject to reference pricing knew about the program prior to receiving care
- Consumers used shopper tools created for the program
- Consumers felt they could use the exceptions process to get fair coverage for the care they needed

Conclusion

Reference pricing aims to minimize price variation in our health care system by providing more transparent information about the prices providers charge, and by creating financial incentives for consumers to shop for care based on both price and quality. This, in turn, can put external pressure on overly expensive providers to charge more competitive, fair prices.

To succeed at these goals, reference pricing programs must be built on a foundation of price transparency and must be limited to shopable health care services that have wide price variation. It is also critical that these programs be designed so that consumers can easily obtain care from providers who charge within the reference price and not simply become a tool to shift costs to consumers. Only then will these programs succeed at pressuring providers to set fairer prices.

When designed in consumer-friendly ways, reference pricing programs can help control health care costs by encouraging providers to set fairer prices for care. These programs can also give consumers the resources they need to compare providers based on both price and quality and can encourage consumers to choose providers that deliver the best care at the best price.

Endnotes

1 Paul B. Ginsburg, *Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power* (Washington: Center for Studying Health System Change, November 2010), available online at http://www.hschange.com/CONTENT/1162/.

2 Chapin White, James D. Reschovsky, and Amelia M. Bond, "Understanding Differences between High- and Low-Price Hospitals: Implications for Efforts to Rein in Costs," *Health Affairs* 33, no. 2 (February 2014): 324-331.

3 Government Accountability Office (GAO), *Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care* (Washington: GAO, September 2011), available online at www.gao.gov/products/GAO-11-791.

4 James C. Robinson and Timothy T. Brown, "Increases in Consumer Cost-Sharing Redirect Patient Volumes and Reduce Hospital Prices for Orthopedic Surgery," *Health Affairs* 32, no. 8 (August 2013): 1,392-1,397.

5 Ibid.

6 Amanda E. Lechner, Rebecca Gourevitch, and Paul B. Ginsburg, *The Potential of Reference Pricing to Generate Health Care Savings: Lessons from a California Pioneer* (Washington: Center for Studying Health System Change, December 2013), available online at http://www.hschange.org/CONTENT/1397/.

A selected list of relevant publications to date:

Principles for Consumer-Friendly Value-Based Insurance Design (December 2013)

Key Differences between Wellness Reward/ Penalty Programs and Value-Based Insurance Design (October 2013)

Working Toward Wellness: Creating Consumer-Friendly Workplace Wellness Programs (July 2012)

For a more current list, visit:
www.familiesusa.org/publications

Publication ID: 000HSI060914

This publication was written by:
Lydia Mitts, Senior Policy Analyst, Families USA

The following Families USA staff contributed to the preparation of this material (listed alphabetically):

Caitlin Morris, Senior Policy Analyst

Evan Potler, Art Director

Carla Uriona, Director of Content Strategy

Ingrid VanTuinen, Director of Editorial

Alexandra Walker, Senior Web Editor

© Families USA 2014

1201 New York Avenue NW, Suite 1100
Washington, DC 20005
202-628-3030
info@familiesusa.org
www.FamiliesUSA.org
facebook / FamiliesUSA
twitter / @FamiliesUSA

A children's health policy blog
CCF - Center For Children and Families / All / Improving Enrollment for Immigrant Families Could Cut the Number of Uninsured Kids in Half
Welcome to Say Ahhh! a health care policy blog by Georgetown University's Center for Children and Families. Our policy experts have their fingers on the pulse of what's happening on health care coverage for children and families. Our experience is diverse, our perspectives unique, our mission united.

Improving Enrollment for Immigrant Families Could Cut the Number of Uninsured Kids in Half

June 05, 2014
Sonya Schwartz / Sonya Schwartz
Publisher : CCF
Medicaid : Blog Posts /
CHIP : Blog Posts / All

It's hard to believe that the next open enrollment period is only 5 months away. As the federal marketplace and states work to fix enrollment challenges, it's important to consider what groups are most likely to be uninsured and smooth their pathway to coverage.

A study recently came out that makes it clear that enrollment system fixes for immigrant families should be on the top of the list. The findings were eye-opening: ***almost half of uninsured children live in immigrant families.*** In other words, if we could reach and enroll children in immigrant families, we could cut the number of uninsured children in half (prior studies had looked at how many children in immigrant families are uninsured). Here are a few other key facts from the study:

- Almost half (42%) of uninsured children in the US live in immigrant families in 2010. A decade ago this number was close to one third, so that percentage is growing.
- Two thirds (69%) of these uninsured children in immigrant families are US citizens.

The first open enrollment period was acutely difficult for lawfully present immigrants with incomes low enough to qualify for the ACA's premium tax credits. As my colleague, Tricia Brooks, mentioned in her recent *Health Affairs* article, Open Enrollment, Take Two, the federal and state marketplaces can address the most significant challenges faced by immigrant families (including families with a mix of members who are immigrants and citizens) with just two main fixes:

- Developing applications in additional languages other than just English and Spanish;
- Improving the electronic and alternative processes for verifying identity and qualified immigration status

When immigrant parents can't apply for coverage, their children also lose out on enrolling in coverage. There are other simple but important ways that Medicaid, CHIP and the marketplace can support the enrollment of immigrant families:

- Providing resources for community groups to provide enrollment assistance.
- Training call center and consumer assistance staff about the nuances of immigrant eligibility rules, and the specific barriers—like language access, providing SSN, verification of identity and immigration status—that prevent immigrants from applying and how to overcome them (these are all discussed in a blog series by my colleague Dinah Wiley).

With so many uninsured kids in immigrant families and so little time until November, it makes sense to put enrollment system fixes for immigrant families at the top of the list.

Categories: Blog Posts , Blog Posts , All
Tags: CHIP , coverage , enrollment , immigrants , marketplace , medicaid

-
- Tweet 5
- g+1 Recomm this on

Search
blog menu

- About This Blog
- Our Bloggers

Authors
QF carrousel
+

The ACA has helped maintain or improve access to preventive services for **54% of children.** (Source: ACA Protects and Improves Access to Preventive Care for Children)

view all quick facts
CCF Research Digest, at zotero.com

quote

- “More than half of America’s children gained or maintained access to preventive care services as a result of the Affordable Care Act.”
  Joan Alker

connect with us

Facebook Twitter Email Updates RSS
Share
SHARE THIS PAGE
BACK TO TOP

bottom menu

- Privacy Policy

BRIEF

Mapping Gender Gaps in Health Care

While cholesterol screening may be as familiar to many Americans as getting their pulse checked or their temperature taken, recent RAND research that mapped regional rates of this important annual test among patients with cardiovascular disease and diabetes reveals that there are often significant gaps in how often women, as opposed to men, get these tests when they are indicated.

By creating visual displays based on data supplied by a leading California health care plan, it is possible to see these gender-based disparities more vividly and see how they vary geographically. The gaps where men are more likely than women to receive the annual low-density lipoprotein (LDL) cholesterol screening—when both have cardiovascular disease or diabetes—are more pronounced at the county level than across larger regions within the state.

The RAND research team's mapping of care is something not typically done to compare men's and women's quality of care. Figure 1 shows, based on LDL cholesterol screening rates, that cardiovascular care was better for men in seven of eight regions.

Figure 1. Gender Disparities in Cardiovascular Care in California Based on LDL Cholesterol Screening Rates

Men

Sacramento/North
Bay Area
Central Valley
Central Coast
Los Angeles
Inland Empire
Orange County
San Diego

Women

Sacramento/North
Bay Area
Central Valley
Central Coast
Los Angeles
Inland Empire
Orange County
San Diego

Men Minus Women

Sacramento/North
Bay Area
Central Valley
Central Coast
Los Angeles
Inland Empire
Orange County
San Diego

Screening rates

- Greater than 80%
- 78% to 80%
- 76% to 78%
- 74% to 76%
- 72% to 74%
- 70% to 72%

Difference in rates (M – W)

- No gap (M = W)
- Small gap favoring men (M > W)
- Moderate gap favoring men (M > W)

NOTE: We consider gender differences in LDL cholesterol testing rates of 10 or more percentage points as a large gap, 5 to less than 10 percentage points a moderate gap, 1 to less than 5 percentage points as a small gap, and less than 1 percentage point as no gap.

For diabetes, which does not have a history as a disease primarily affecting men, the gaps in care were smaller but still favored men in five of eight regions (Figure 2).

Differences in whether women versus men receive cholesterol tests raise larger, important questions about gender inequity in quality and outcomes of health care, particularly for cardiovascular disease. Cardiovascular disease is the leading cause of death in women: 1 in 3 adult women are afflicted with it, and 1 in 3 women die because of it. Diabetes, which takes its own considerable toll on the health of men and women, is also a major cardiovascular disease risk factor that increases risk among women more than men.

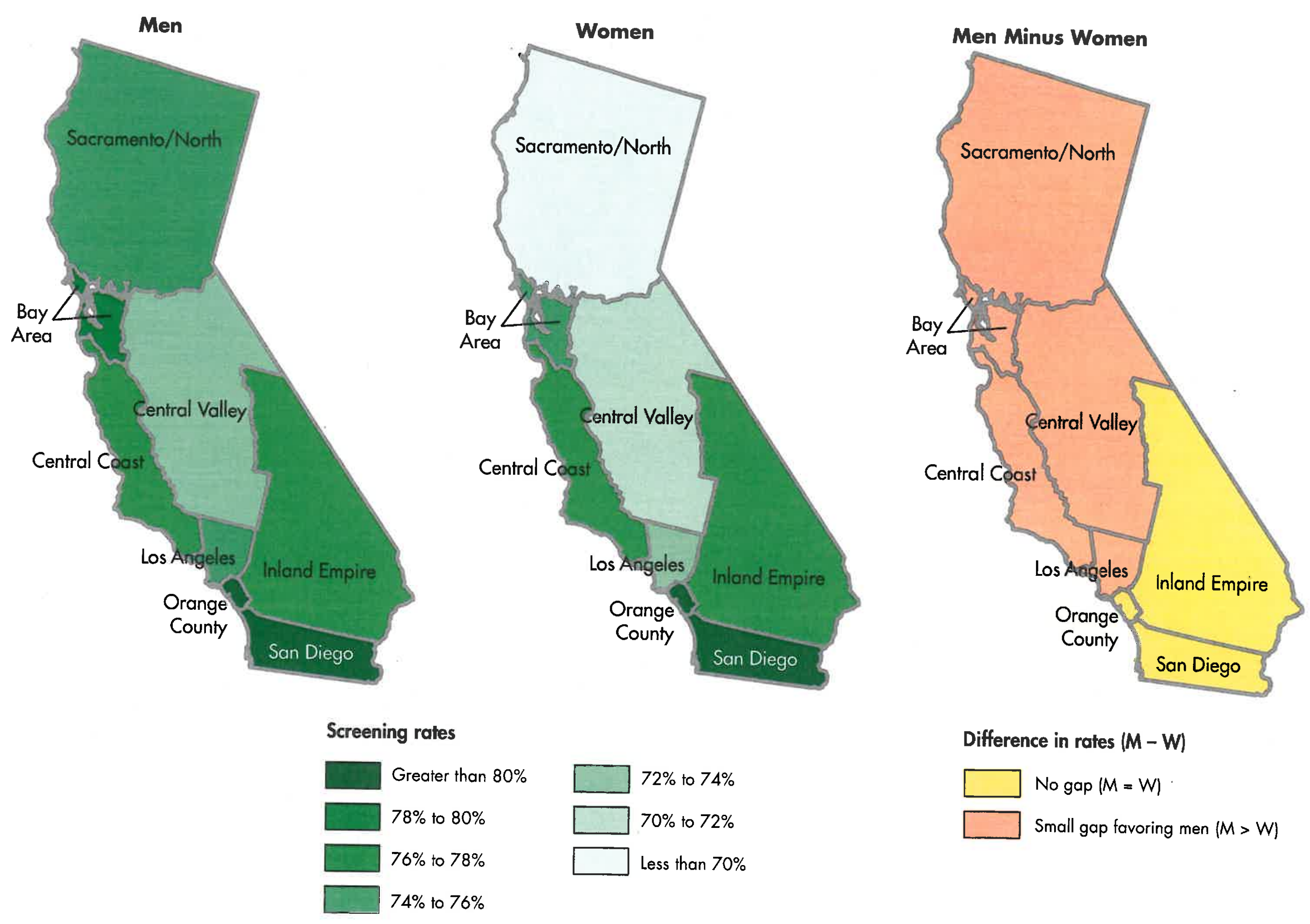
Because far more people have diabetes than cardiovascular disease, the smaller gender gap in cholesterol screening among adults with diabetes still results in more women not receiving indicated care than among adults with cardiovascular disease, where the gender gap is larger.

Pronounced Gender Gaps

At the county level, visual displays show the gender gaps in the most pronounced fashion (Figure 3). For cardiovascular disease, the maps show the following disparities:

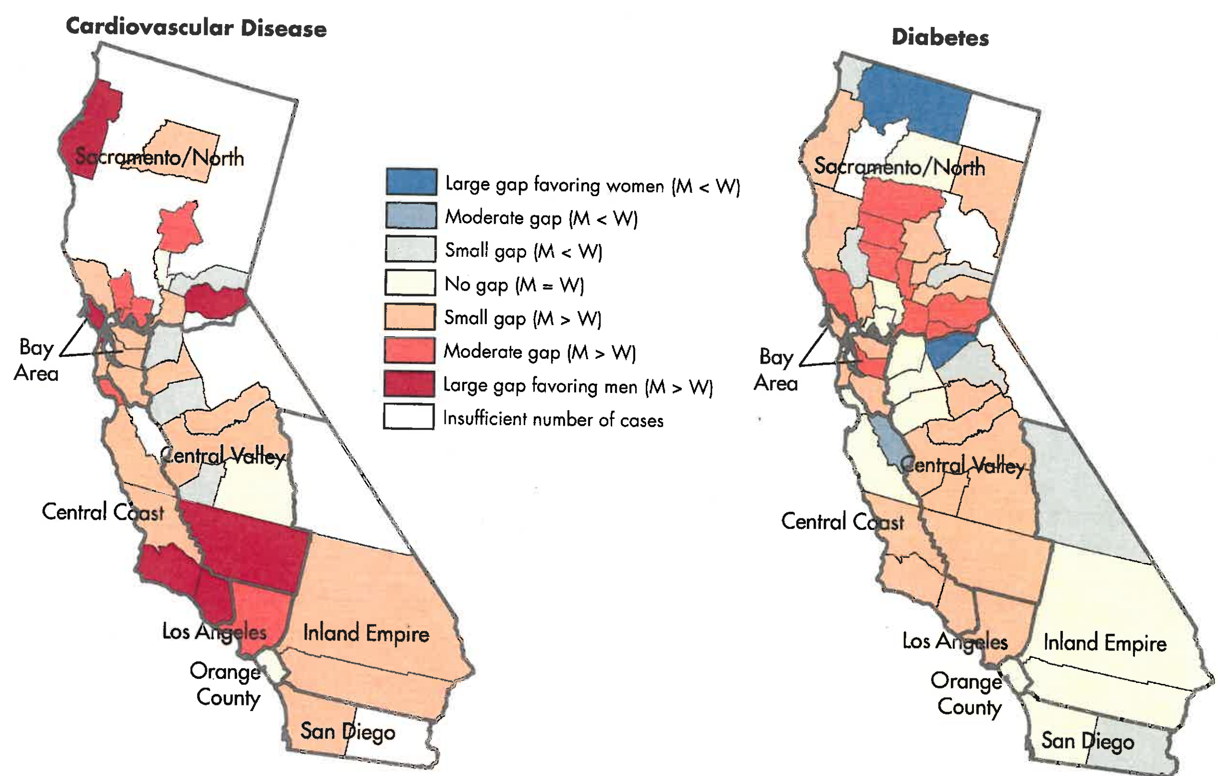
- In 79 percent of counties, care favored men; 35 percent had moderate to large gaps favoring men.

Figure 2. Gender Disparities in Diabetes Management in California Based on LDL Cholesterol Screening Rates



NOTE: We consider gender differences in LDL cholesterol testing rates of 10 or more percentage points as a large gap, 5 to less than 10 percentage points a moderate gap, 1 to less than 5 percentage points as a small gap, and less than 1 percentage point as no gap.

Figure 3. Gender Gaps in LDL Cholesterol Testing in California, by County



NOTES: Labels on these maps identify the regions shown in Figures 1 and 2. The map shows the gender differences only in areas for which there are at least 30 men and 30 women in the eligible population (i.e., health plan members with cardiovascular disease or diabetes, respectively). We consider gender differences in LDL cholesterol testing rates of 10 or more percentage points as a large gap, 5 to less than 10 percentage points a moderate gap, 1 to less than 5 percentage points as a small gap, and less than 1 percentage point as no gap.

- There were no moderate to large gaps favoring women, and only 12 percent of the counties had small gaps favoring women.

For diabetes, the following disparities are seen:

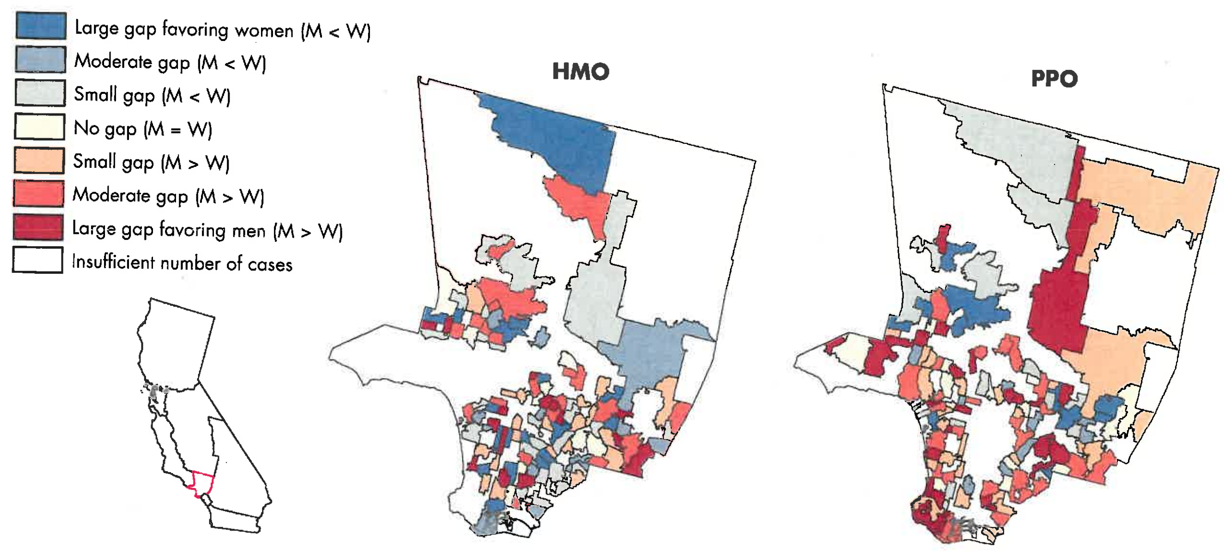
- 57 percent of the counties had gaps favoring men, and 18 percent had gaps favoring women.
- 17 percent had moderate gaps favoring men, and 6 percent had moderate or large gaps favoring women.

The extent of local variation in care for men versus women is clearest when similar maps are prepared for densely populated areas where the majority of zip codes have sufficient cases to estimate gender gaps.

Insurance and Gender Gaps

Figure 4 shows how gender gaps differ by insurance type. The size and pattern of gender gaps varied depending on the type of insurance. For example, on average, there were no significant gender gaps found in LDL cholesterol testing for patients with either cardiovascular disease or diabetes among those with commercial health maintenance organization (HMO) insurance. However, gender gaps were present for commercial preferred provider organization (PPO) populations. The gender differences among adults in commercial PPO plans remained even after taking into account other factors, such as age, region, and area income. Overall, rates of LDL testing were higher among those with commercial HMO insurance than among those with commercial PPO insurance.

Figure 4. Gender Gaps in LDL Cholesterol Testing in Los Angeles County, by Insurance Type and ZIP Code



NOTE: We consider gender differences in LDL cholesterol testing rates of 10 or more percentage points as a large gap, 5 to less than 10 percentage points a moderate gap, 1 to less than 5 percentage points as a small gap, and less than 1 percentage point as no gap.

Next Steps

More gender-related health and health care data could be collected, analyzed, and reported within and across provider groups and health plans to identify the size and location of gender gaps. Making the findings accessible and widely available by mapping the gaps can help guide health care decisionmakers and local stakeholders in their efforts to improve quality. All California health care plans and provider groups may wish to consider assessing and reporting gender differences in quality of care for cardiovascular disease and diabetes and using mapping to make the information both visible and actionable.

Key Findings

- Men had higher rates of LDL cholesterol screening than did women in both the cardiovascular disease and diabetes populations. These gaps varied by age and insurance type.
- Mapping gender gaps revealed larger gaps at local levels than were apparent at the state or regional level.
- Gender-stratified reporting and mapping can make disparities in care actionable.

This work was sponsored by the Barbra Streisand Women's Heart Center in the Cedars-Sinai Heart Institute.

This brief describes work done in RAND Health and documented in *Mapping Gender Differences in Cardiovascular Disease and Diabetes Care: A Pilot Assessment of LDL Cholesterol Testing Rates in a California Health Plan*, by Bird CE, Fremont A, and Hanson M, RR-539-CSMC (available at http://www.rand.org/pubs/research_reports/RR539.html), 2014. Abstracts of all RAND Health publications and full text of many research documents can be found on the RAND Health website at www.rand.org/health. The RAND Corporation is a nonprofit research institution that helps improve policy and decisionmaking through research and analysis. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors. **RAND**® is a registered trademark. © RAND 2014

RB-9781-CSMC (2014)

CHILDREN AND FAMILIES
EDUCATION AND THE ARTS
ENERGY AND ENVIRONMENT
HEALTH AND HEALTH CARE
INFRASTRUCTURE AND TRANSPORTATION
INTERNATIONAL AFFAIRS
LAW AND BUSINESS
NATIONAL SECURITY
POPULATION AND AGING
PUBLIC SAFETY
SCIENCE AND TECHNOLOGY
TERRORISM AND HOMELAND SECURITY

The RAND Corporation is a nonprofit institution that helps improve policy and decisionmaking through research and analysis.

This electronic document was made available from www.rand.org as a public service of the RAND Corporation.

Support RAND

Browse Reports & Bookstore

Make a charitable contribution

For More Information

Visit RAND at www.rand.org

Explore the RAND Corporation

View document details

Research Brief

This product is part of the RAND Corporation research brief series. RAND research briefs present policy-oriented summaries of individual published, peer-reviewed documents or of a body of published work.

Limited Electronic Distribution Rights

This document and trademark(s) contained herein are protected by law as indicated in a notice appearing later in this work. This electronic representation of RAND intellectual property is provided for non-commercial use only. Unauthorized posting of RAND electronic documents to a non-RAND website is prohibited. RAND electronic documents are protected under copyright law. Permission is required from RAND to reproduce, or reuse in another form, any of our research documents for commercial use. For information on reprint and linking permissions, please see RAND Permissions.

ASPE RESEARCH BRIEF

PREMIUM AFFORDABILITY, COMPETITION, AND CHOICE IN THE HEALTH INSURANCE MARKETPLACE, 2014

Amy Burke, Arpit Misra, and Steven Sheingold
June 18, 2014

A central feature of the Affordable Care Act[1] is the establishment of the Health Insurance Marketplace ("Marketplace") where consumers can purchase health insurance plans in a competitive market. Consumers may be eligible for financial assistance to offset the cost of premiums, if their income meets certain requirements.[2] Since October 1, 2013, over eight million Americans have selected a private health insurance plan through the Marketplace, the vast majority of whom are receiving financial assistance—making coverage even more affordable.[3]

As an initial step to understanding how the Marketplace is working in its first year of operation, and in looking forward to future years, we provide an overview of health insurance plan premiums available in the Marketplace and the important role of the advanced premium tax credit ("tax credit") in helping families afford coverage. We analyze data on the change in the premium cost associated with the tax credit for Marketplace plan selections that were made through the Federally-facilitated Marketplace (FFM) during the initial open enrollment period. Also, we examine over 19,000 Marketplace plans[4] for 2014, within the four metal levels (bronze,

[1] The Patient Protection and Affordable Care Act, Pub. L. 111-148, was enacted on March 23, 2010; the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, was enacted on March 30, 2010. In this research brief, we refer to the two Acts collectively as the Affordable Care Act.

[2] The type of financial assistance offered is known as "The Premium Tax Credit (PTC)" and is calculated as the difference between the cost of the adjusted monthly premium for the second-lowest cost silver with respect to the applicable taxpayer and the applicable percentage determined by household income that a person is statutorily required to pay. An individual may choose to have all or a portion of the PTC paid in advance to an issuer of a qualified health plan to reduce their monthly premiums. This is referred to as the "Advance Premium Tax Credit" (APTC). APTCs are provided to people with projected household income between 100 percent (133 percent in states that have chosen to expand their Medicaid programs) and 400 percent of the Federal Poverty Level (FPL). A reconciliation of the APTC paid on behalf of an individual or family and the PTC they are eligible for will occur during their annual tax return. If an individual receives a greater APTC than the PTC they are determined eligible for, the individual may be required to repay the difference. The applicable percentage that a qualified individual or family will pay toward a health insurance premium will range from 2.0 percent of income at 100 percent FPL to 9.5 percent of income at 400 percent FPL.

[3] For more information, see the Marketplace Summary Enrollment Report, which can be accessed at http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf.

[4] A Marketplace plan is a qualified health plan (QHP) that has been certified to be offered in a Marketplace. A health insurance issuer may offer multiple Marketplace plans. For example, a silver plan and a bronze plan from one health insurance issuer would

silver, gold, and platinum)[5] for each of the 501 rating areas across 50 states and the District of Columbia.[6] Our analysis shows how differences in plan and market characteristics are associated with differences in premiums across the nation.

Research Brief Highlights

Marketplace Plan Choices and the Impact of Advanced Premium Tax Credits on Premiums:

- Individuals who selected plans in the FFM with tax credits[7] have a post-tax credit premium that is 76 percent less than the full premium, on average, as a result of the tax credit—reducing their premium from $346 to $82 per month.
- 69 percent of individuals selecting plans with tax credits in the FFM have premiums of $100 or less after tax credits—nearly half (46 percent) have premiums of $50 or less after tax credits.
- Individuals choosing silver plans in the FFM tended to select lower premium plans—65 percent chose the lowest or second-lowest cost silver plan.

Overview of the 2014 Health Insurance Marketplace and the Association Between Competition, Other Market Factors, and Variation in Premiums:

- Most individuals had a wide range of health plan choices. Eighty-two percent of people eligible to purchase a qualified health plan live in rating areas with 3 to 11 issuers in the Marketplace; 96 percent live in rating areas with 2 to 11 issuers in the Marketplace.
- Competition, as measured by the number of issuers in a rating area, is associated with more affordable benchmark plans (the second-lowest cost silver plan) for individuals and reduced costs for the federal government. An additional issuer in a rating area is associated with a 4 percent lower benchmark premium.
- Areas with a greater number of issuers also tend to offer a wider range of choices among plan types (e.g. PPOs, HMOs, CO-OP) to better meet consumers' preferences and financial needs.

---

be counted as two Marketplace plans. Catastrophic plans were not counted toward this total. This analysis also excludes Virginia plans that required coverage of bariatric surgery as these were extreme price outliers.

[5] The Affordable Care Act requires that Marketplace plans must be one of four tiers, or "metal levels," based on actuarial value (AV) (Catastrophic plans are exempt from this requirement). Section 1302(d)(2)(A) of the Affordable Care Act stipulates that AV be calculated based on the provision of essential health benefits (EHB) to a standard population. The statute groups the plans into four tiers: bronze, with an AV of 60 percent; silver, with an AV of 70 percent; gold, with an AV of 80 percent; and platinum, with an AV of 90 percent. The final rule implementing the calculation of AV establishes that a de minimis variation of +/- 2 percentage points of AV is allowed for each tier.

[6] Plan and premium data were taken from the following publicly available sources: Healthcare.gov, state rate filings (where available), and State-based Marketplace websites.

[7] Represents individuals who have selected a Marketplace plan with a non-zero tax credit.

I. The Impact of Advanced Premium Tax Credits on Consumer Share of Premiums

Section I Highlights

Marketplace Plan Selection Choices and Premiums:

- Individuals who selected Marketplace plans with tax credits through the FFM have a post-tax credit premium that is 76 percent less than the full premium amount, on average, as a result of premium tax credits.
- 69 percent of individuals who selected Marketplace plans with tax credits in the FFM had premiums of $100 or less after tax credits—46 percent had premiums of $50 or less after tax credits.
- Individuals choosing silver plans in the Federally-facilitated Marketplace (FFM) tended to select lower premium plans—65 percent chose the lowest or second-lowest cost silver plan.

During the initial open enrollment period more than 5.4 million people selected a Marketplace plan through the Federally-facilitated Marketplace (FFM). This section utilizes data on these individuals and their plan selections in the 36 FFM states to assess the impact of tax credits on consumers' premiums. Comparable data for SBM states are not available. In the FFM, 87 percent of the individuals who selected a Marketplace plan during the initial open enrollment period selected a plan with tax credits.[8]

Advance Premium Tax Credit Basics

The Affordable Care Act caps the amount that individuals who are eligible for advance premium tax credits must pay toward obtaining "benchmark" coverage through the Marketplace; benchmark coverage is defined as the second-lowest cost silver plan available in the Marketplace to that individual. Individuals with family incomes between 100 percent (133 percent in states that have chosen to expand their Medicaid programs) and 400 percent of the FPL must pay only a specified percentage of their income for benchmark coverage. This maximum percentage increases with income, so lower-income individuals receive a larger tax credit toward their purchase of Marketplace coverage.

While the second-lowest cost silver plan is designated as the benchmark for determining the amount of the tax credit, an individual may apply her tax credit toward a Marketplace plan from any metal level (excluding catastrophic). In some cases, the tax credit amount may even exceed a plan's price, resulting in a plan that costs the enrollee $0 after tax credits.

To calculate the premium tax credit amount, the Affordable Care Act specifies that an individual or family with a particular income will pay a fixed percentage of their income for the second-

[8] This estimate is based on FFM plan selections through 5/12/2014. Data presented in the Marketplace Summary Enrollment Report is based on plan selections through 4/19/2014. For more information, the Marketplace Summary Enrollment Report can be accessed at: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf

lowest cost silver plan available in the Marketplace in their local area (see Table 1). This is a fixed percentage, expressed as a percentage of the federal poverty level (FPL), without regard to age or the actual premiums in the Marketplace. For example, the law specifies that a single individual earning 150 percent of the FPL, or $17, 235 per year, will pay no more than 4 percent of her income ($57 per month) for the second-lowest cost silver plan. Her tax credit will cover the difference between $57 and the monthly cost of the second-lowest cost silver plan available to her. Table 1 shows the percent of income and maximum payment associated with various incomes for single individuals.

TABLE 1
Examples of Maximum Monthly Health Insurance Premiums for the Second-Lowest Cost Silver Plan for a Single Adult, by Income[9]

Single Adult Income[10]	Percent of the Federal Poverty Level	Maximum Percent of Income Paid toward Second-Lowest Cost Silver Plan	Maximum Monthly Premium Payment for Second-Lowest Cost Silver Plan
$11,490[11]	100%	2.0%	$19
$17,235	150%	4.0%	$57
$22,980	200%	6.3%	$121
$28,725	250%	8.05%	$193
$34,470	300%	9.5%	$273
$40,215	350%	9.5%	$318
$46,075	401%	None	No Limit

For example, the amount that a 27-year-old woman with an income of $25,000 (218 percent of the FPL) would pay for the second-lowest cost silver plan is capped at $145 per month. If she lived in Jackson, Mississippi, the premiums for the second-lowest cost silver plan available would cost her $336 per month before tax credits. Therefore, the amount of the premium tax credit would be $191 per month—the difference between specified contribution to the benchmark plan and the actual cost of the benchmark plan. Her use of the tax credit would not be restricted to the second-lowest cost silver plan. She could apply the $191 per month tax credit toward any plan of her choosing in any metal level. By applying her tax credit to the lowest-cost bronze plan in Jackson, which is priced at $199 per month, she could obtain Marketplace coverage for just $8 per month after tax credits.

---

[9] For more information, see the Internal Revenue Service final rule on "Health Insurance Premium Tax Credit" (*Federal Register*, May 23, 2012, vol, 77, no. 100, p. 30392; available at: http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf) and the 2013 federal poverty guidelines (available at: http://aspe.hhs.gov/poverty/13poverty.cfm).

[10] Income examples are based on the federal poverty guidelines for the continental United States. The FPL percentages in Column 2 correspond to higher income amounts in Alaska and Hawaii.

[11] In Medicaid expansion states, an individual at 133 percent of the FPL may be Medicaid eligible, rather than eligible for tax credits in the Marketplace.

Advance Premium Tax Credit Reduces Monthly Consumer Premiums

Table 2 and Figure 1 show the impact of the tax credit on the monthly premiums for consumers who selected Marketplace plans with tax credits in the FFM (see Appendix for state-level estimates).[12] Approximately 87 percent of individuals in the FFM selected plans with tax credits and these individuals have post-tax credit premiums that are 76 percent less than the full premium, on average. The average premium before tax credits for persons selecting Marketplace plans of any metal level with tax credits through the FFM was $346. The average tax credit amount was $264 and the after-tax credit premium was $82. The tax credit for people who selected silver plans resulted in the highest percent reduction in premiums after tax credits (80 percent) relative to the persons selecting plans from the other three metal levels. Persons who selected bronze plans had the next highest percent reduction in premiums after tax credits (76 percent), followed by persons who selected gold and platinum plans—51 percent for both. However, it is important to note that people selecting bronze plans are not eligible for cost-sharing reductions, so consumers selecting bronze plans may be trading off a lower premium at the time of purchase for higher cost sharing at a later date.

The tax credit also helped many individuals select Marketplace plans for less than $100 per month. Table 3 and Figure 2 show the percent of individuals whose premiums fell into one of several categories after tax credits (see Appendix for state-level estimates). Of all individuals who selected a Marketplace plan with tax credits through the FFM, 82 percent selected plans with a monthly premium of $150 or less after tax credits, 69 percent with a premium of $100 per month or less after tax credits, and 46 percent with a premium of $50 or less after tax credits. While the average premium before tax credits across all metal levels was $346 for selected Marketplace plans with tax credits, only 18 percent of plan selections with tax credits have premiums that cost more than $150 on average after tax credits.

Consumer Selections Based on Price

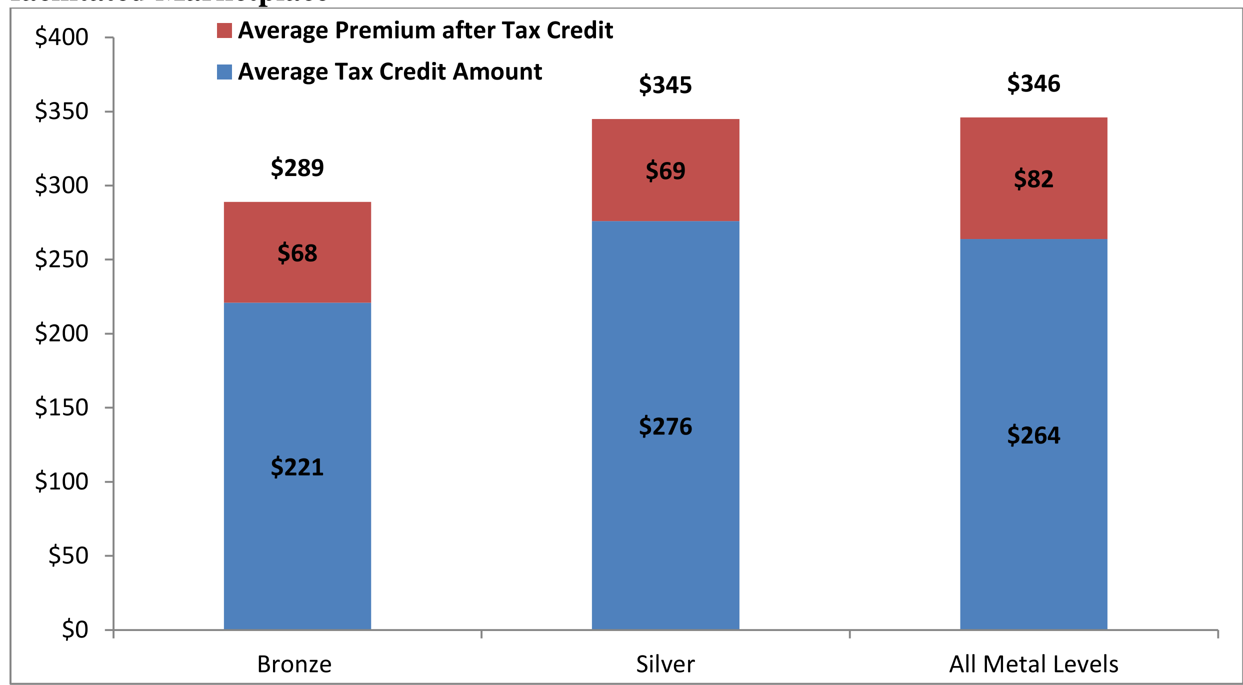
Analysis of data on FFM plan selections reveals that within each metal level, individuals tended to select the plans with the lowest premiums (see Table 4 and Figure 3). Within the FFM, the lowest or second-lowest plan accounted for 60 percent or more of plan selections in the bronze, silver and platinum metal levels, 54 percent in the gold metal level, and 93 percent in the catastrophic level. For the silver level, 22 percent of Marketplace plan selections were for the benchmark plan (the second-lowest cost silver plan), while 43 percent were for the lowest cost silver plan and 35 percent were for silver plans at other premium price levels. On average, consumers had 16 silver plans per rating area to choose from, ranging from a low of two silver plans to a maximum of 67 silver plans.

[12] The analyses presented in Tables 2 and 3 and Figures 1 and 2 are based on plan selections of people with non-zero tax credits, who self-identified as non-tobacco users, and those who selected a bronze, silver, gold, or platinum metal level plan. Catastrophic plans were not included as these plans are not eligible for tax credits. Table 4 and Figure 3 include all individuals who selected a plan through the FFM.

TABLE 2 **Average Monthly Premiums before and after Tax Credits, Tax Credit Amount, and Percent Reduction in Premium after Tax Credits for Individuals Who Selected Plans with Tax Credits through the 2014 Federally-facilitated Marketplace**					
Metal Level	**Percent of Individuals Who Selected Plans With Tax Credits**	**Average Premium before Tax Credits**	**Average Tax Credit Amount**	**Average Premium after Tax Credits**	**Average Percent Reduction in Premium after Tax Credits**
Bronze	73%	$289	$221	$68	76%
Silver	94%	$345	$276	$69	80%
Gold	65%	$428	$220	$208	51%
Platinum	64%	$452	$232	$220	51%
All Metal Levels	87%	$346	$264	$82	76%

Source: ASPE computations of CMS Federally-facilitated Marketplace data as of 5/12/2014.
*Calculated as the number of individuals who selected Marketplace plans with tax credits as a percentage of all individuals who selected a Marketplace plan.

FIGURE 1: Average Monthly Tax Credit Amount and Premiums after Tax Credits by Metal Level for Individuals Who Selected Plans with Tax Credits, 2014 Federally-facilitated Marketplace

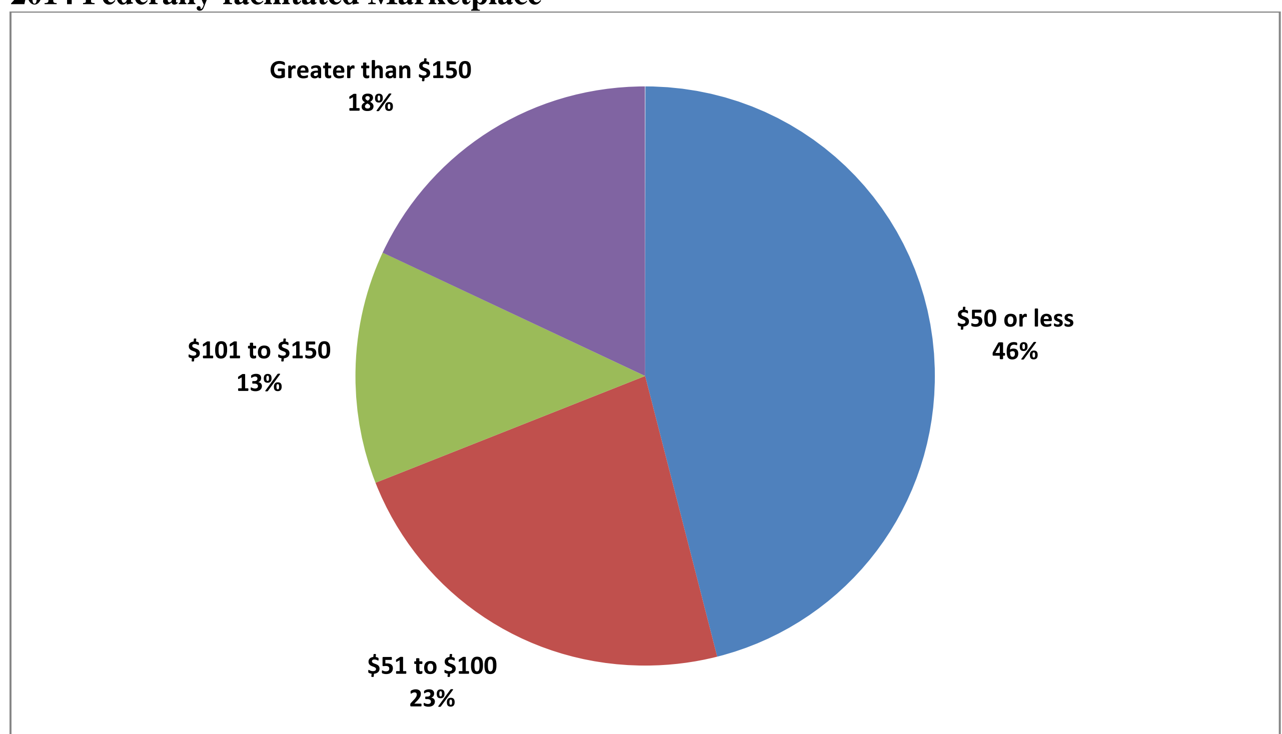


Source: ASPE computations of CMS Federally-facilitated Marketplace data as of 5/12/2014.

TABLE 3 **Percent of Marketplace Plan Selections by Selected Monthly Premium Amounts After Tax Credits for Individuals Who Selected Plans with Tax Credits, 2014 Federally-facilitated Marketplace**		
	Percent of Marketplace Plan Selections with Tax Credits Through the FFM	
Monthly Premiums After Tax Credits	**%**	**Cumulative %**
$50 or Less	46%	46%
$51 to $100	23%	69%
$101 to $150	13%	82%
Greater than $150	18%	100%

Source: ASPE computations of CMS Federally-facilitated Marketplace data as of 5/12/2014.
Note: Represents distribution of monthly Marketplace plan selections across bronze, silver, gold, and platinum metal levels.

FIGURE 2: Distribution of Marketplace Plan Selections by Monthly Premiums after Tax Credits at Selected Amounts for Individuals Who Selected Plans with Tax Credits, 2014 Federally-facilitated Marketplace



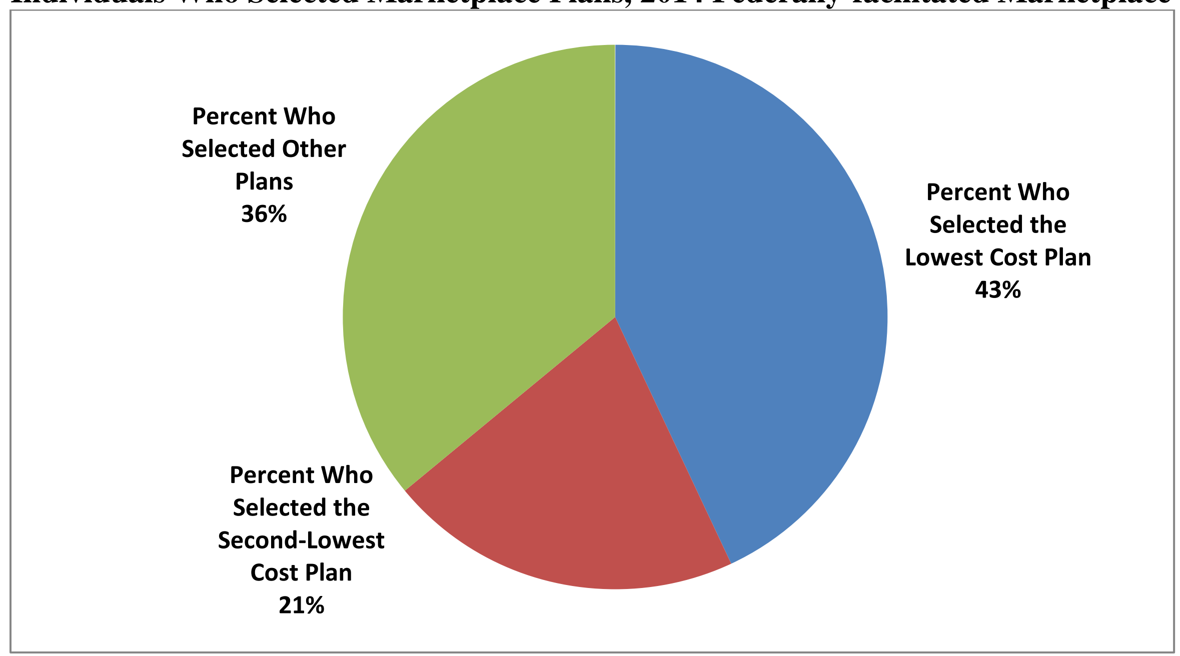
Source: ASPE computations of CMS Federally-facilitated Marketplace data as of 5/12/2014.
Note: Represents distribution of monthly Marketplace plan selections across bronze, silver, gold, and platinum metal levels.

TABLE 4
Distribution of Marketplace Plan Selections within Metal Level and Plan Cost Rank for All Individuals Who Selected Marketplace Plans, 2014 Federally-facilitated Marketplace

Metal Level	Percent Who Selected the Lowest or Second-Lowest Cost Plan	Percent Who Selected the Lowest Cost Plan	Percent Who Selected the Second-Lowest Cost Plan	Percent Who Selected Other Plans
Bronze	60%	39%	21%	40%
Silver	65%	43%	22%	35%
Gold	54%	37%	16%	46%
Platinum	69%	50%	19%	31%
Catastrophic	93%	76%	17%	7%
Total Where Metal Level Is Known	**64%**	**43%**	**21%**	**36%**

Source: ASPE computations of CMS Federally-facilitated Marketplace data as of 5/12/2014.
Note: The lowest and second-lowest plans are defined as the lowest cost Marketplace plan available in the rating area, even if that plan may not have a service area that covers the entire rating area. If multiple plans are tied for lowest (or second-lowest) in a metal level and rating area, then selections of those plans are all counted toward selection of the lowest (or second-lowest) plan.

FIGURE 3: Distribution of Marketplace Plan Selections by Plan Cost Ranking for All Individuals Who Selected Marketplace Plans, 2014 Federally-facilitated Marketplace



Source: ASPE computations of CMS Federally-facilitated Marketplace data as of 5/12/2014.
Note: The lowest and second-lowest plans are defined as the lowest cost Marketplace plan available in the metal level in the rating area, even if that plan may not have a service area that covers the entire rating area.

The Health Insurance Marketplace: Choice and Competition

One aim of the Affordable Care Act is to promote competition in the individual health insurance market to improve the coverage, quality, choices, and affordability of premiums available for purchase. The Affordable Care Act eliminated the ability of issuers to use medical underwriting to establish premiums for most new plans in the individual and small group market, and required issuers to accept all applicants for non-grandfathered coverage, regardless of health status. The new Marketplace facilitates comparison shopping, and those who qualify can also receive financial assistance to help pay for coverage. As a result, consumers now have greater opportunities to find affordable health plans that fit their preferences regarding premiums and type of coverage.

The Marketplace represents a new market environment that will evolve over time and there are different theories on how competition will work in this setting. The simplest view of competition suggests that as the number of issuers increase in a market, premium rates should decline. A more nuanced view of competition suggests a more varied set of outcomes. In that view health plans are not identical and their different features are valued differently by different consumers. This creates customer loyalty to plans that, in turn, means issuers of those plans can exert some limited control over the premiums they charge. A potential outcome of this type of competition is that rating areas with a larger number of issuers[13] may exhibit a greater variety of plan types being offered and a corresponding wider variety of premiums relative to markets with fewer issuers. In this brief, we examine these potential effects by using a number of premium measures by rating area to assess the effects of larger numbers of issuers.

[13] A health insurance issuer is a company that may offer multiple Marketplace plans. For example, a hypothetical Blue Cross and Blue Shield licensed company would be a health insurance issuer, while its $2000 deductible silver plan would be a Marketplace plan. An enrollee may have fewer issuers participating in his or her rating area than the total number participating in that state, because issuers are not required to offer a Marketplace plan in every rating area.

II. Overview of Premiums in the 2014 Individual Health Insurance Marketplace

Section II Highlights

Overview of Premiums for the Second-Lowest Cost Silver Plans:

- 82 percent of people eligible to purchase a Marketplace plan live in rating areas with 3 to 11 issuers; 96 percent live in rating areas with 2 to 11 issuers.
- On average, consumers eligible to purchase a Marketplace plan can choose from 5 health plan issuers and 47 Marketplace plans across all metal levels—of which, approximately 16 are silver plans.
- The national average for the second-lowest cost silver plan premium rate is $226 per month for a 27-year-old, ranging between a low of $127 to a high of $406.
- Second-lowest cost silver plan premium rates were comparable for rating areas located in both Federally-facilitated Marketplace (FFM) and State-based Marketplace (SBM) states and those located in states that chose to expand their Medicaid programs under the Affordable Care Act and those states that did not choose to expand.

Rating areas are geographic markets where insurers compete on premiums and other factors for customers in the Marketplace. The number of rating areas[14] varies by state from a low of one rating area in smaller states like Rhode Island or Vermont to a high of 67 rating areas in Florida—corresponding to each of Florida's 67 counties. However, rating areas are often an aggregation of counties. On average, there are approximately 10 rating areas per state for the 50 states and the District of Columbia.

There were a total of 266 issuers by state[15] offering Marketplace plans, ranging from a low of one issuer in New Hampshire and West Virginia to a high of 16 issuers in New York. New issuers[16] represent almost 26 percent of all state issuers. Among the new entrants, the majority had a history as Medicaid issuers and now offer commercial coverage through the Marketplace. New entrants also include consumer-operated and oriented plans (CO-OPs) authorized by section 1322 of the Affordable Care Act.[17]

[14] Rating areas are state-defined pricing regions for issuers. They overlap with the issuer service areas in many, but not all, cases. In general, the number of issuers or plans available in a rating area will be the number of choices available to all individuals and families living in that rating area. Issuers are not required to offer a Marketplace plan in every rating area within a state, however, so the number of available issuers and Marketplace plans varies by rating area. These totals exclude catastrophic plans, which are not available to all enrollees.
[15] This is the number of unique issuer-state combinations nationally. For example, Aetna offers coverage in both Arizona and Florida, which is considered as two issuer-state combinations. Therefore, although Aetna is one company, it would be counted twice in the summation of issuer-state combinations for the total of 266 nationally.
[16] New issuers are defined as issuers participating in the individual market for the first time in a given state.
[17] The Consumer-Operated and Oriented Plan (CO-OP) program was created by the Affordable Care Act to provide support for the creation of nonprofit, member-controlled health insurance plans that offer ACA-compliant policies in the individual and small business markets.

On average, there are approximately five health plan issuers per rating area, ranging from one to 11 issuers. The rating areas with the most choice as measured by the number of issuers are located in New York and Oregon; the rating areas with the most choice as measured by the number of Marketplace plans available are located in Wisconsin and Florida. On average, consumers shopping in the Marketplace can choose from approximately 47 Marketplace plans.

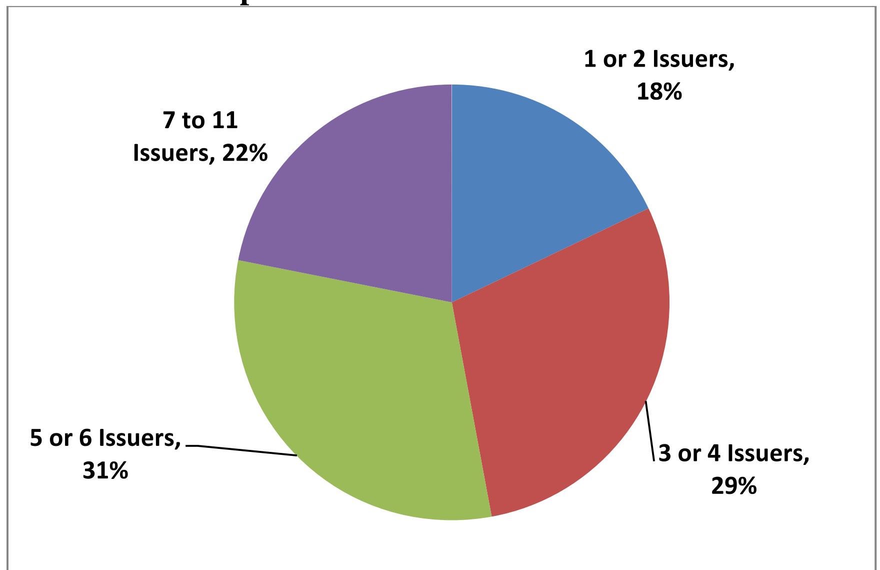
TABLE 5
Summary of Rating Areas, Health Plans, and Health Plan Issuers by Rating Area or State, 2014 Health Insurance Marketplace

	Average	Minimum	Maximum
Rating Areas per State	10	1	67
Marketplace Plans (excluding Catastrophic Plans)	47	6	165
Bronze Plans	14	1	42
Silver Plans	16	2	67
Gold Plans	13	2	45
Platinum Plans	5	1	23
Issuers	5	1	11

Source: ASPE computations of plan and premium data from the following publicly available sources: Healthcare.gov, state rate filings (where available), and State-based Marketplace websites. Averages are weighted by the QHP-eligible[18] population in each rating area estimated using the 2011 American Community Survey Public Use Microdata Sample.

[18] For the purposes of this analysis, we define "QHP eligible" as U.S. citizens and others lawfully present who have only individual market coverage or are uninsured and have incomes that are: above 133 percent of the FPL for adults in Medicaid expansion states; above 100 percent of the FPL for adults in non-expansion states; and above 250 percent of the FPL for children (age 0-18) in all states. These estimates do not take into account the eligibility requirements relating to other minimum essential coverage.

FIGURE 4: Percent of QHP-Eligible Population by Number of Issuers in a Rating Area, 2014 Health Insurance Marketplace



Source: Source: ASPE computations of plan and premium data from the following publicly available sources: Healthcare.gov, state rate filings (where available), and State-based Marketplace websites.

As displayed on Figure 4, 82 percent of the people eligible to purchase a Marketplace plans live in rating areas with at least three issuers of Marketplace plans and 96 percent live in areas with at least two issuers. Fifty six percent can choose from plans offered by five or more issuers. This compares favorably with those covered by employer-sponsored insurance. One study found that approximately 46 percent of employees could choose from more than two issuers, while 25 percent had two issuer options, and the remaining 24 percent had only one issuer of plans from which to choose.[19] In addition, prior to the implementation of the Marketplace, the individual market was dominated by one or two different issuers in most states. In 2012, 11 states had 85 percent of the individual market covered by the largest two issuers in the state. In 29 states, more than half of all enrollees in the individual market were covered by only one issuer and in 46 states (including DC)—two issuers covered more than half of the individual market.[20]

Variation in Premiums—Second-Lowest Cost Silver Plan Premium by Rating Area

We are interested in understanding the pattern of premium levels across rating areas. There are several premium measures that might be used in order to analyze variation in premiums across rating areas. In this brief we study differences with respect to a benchmark premium (the second-lowest cost silver plan premium in a rating area), all premiums and a measure of

[19] Meredith B. Rosenthal, Bruce E. Landon, Sharon-Lise T. Normand, Richard G. Frank, Thaniyyah S. Ahmad, Arnold M. Epstein. 2007. "Employer's Use of Value-Based Purchasing Strategies." *JAMA*. 2007 Nov 21. 298(19):2281-8.

[20] The White House, "Early Results: Competition, Choice, and Affordable Coverage in the Health Insurance Marketplace in 2014," Available at: http://www.whitehouse.gov/sites/default/files/docs/competition_memo_5-30-13.pdf .

premium dispersion (coefficient of variation).[21] One rationale for choosing to focus on the second-lowest cost silver plan premium is that it is the benchmark used to determine premium tax credits. If premiums for second-lowest cost silver plans are lower, the cost of tax credits will also be lower, saving taxpayers money.[22] In addition, evidence from other insurance markets suggests that lower-cost plans may be of particular importance to consumers.[23,24] Notably, the majority (65 percent) of people who selected a Marketplace plan during the initial open enrollment period selected a silver plan.[25]

In most states, premium rates differ according to a person's age (at the time of the policy's effective date). In contrast, New York and Vermont do not permit age rating, meaning that an individual's premium is not dependent upon the individual's age. In other words, a 21-year-old in New York or Vermont would pay the same rate as someone who is 64-years-old, despite the difference in age.

Table 6 presents the average second-lowest cost silver plan premium by selected ages across rating areas. The average second-lowest silver plan premium for a 27-year-old individual is approximately $226 per month before tax credits and drops to $219 per month (3 percent) when New York and Vermont, which do not age rate, are excluded from the calculation. A 27-year-old living in rating area 8 in Minnesota (which includes 11 counties in the greater Minneapolis area) can purchase the second-lowest cost silver plan for $127 a month—almost half the national average. As a point of comparison, in 2013, statewide premiums averaged across covered employees of all ages in the small group market were approximately $446 per month in Minnesota.[26]

---

[21] The coefficient of variation is a normalized measure of dispersion defined as the ratio of the standard deviation to the mean. Here it is used to measure the dispersion in premiums within a rating area.

[22] As premiums decline, the amount of public funds needed to subsidize consumers also declines.

[23] Leemore Dafny, Jonathan Gruber, and Christopher Ody. "More Insurers Lower Premiums: Evidence from Initial Pricing on the Health Exchanges." *NBER Working Paper No. 20140*. May 2014.

[24] Keith M. Ericson and Amanda Starc. "Heuristics and Heterogeneity in Health Insurance Exchanges: Evidence from the Massachusetts Connector." *American Economic Review*, 2012. 102(3) 493-97.

[25] The Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, May 1, 2014, "Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period," http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf

[26] John Holahan. "Will Premiums Skyrockets in 2015?" *In-Brief: Timely Analysis of Immediate Health Policy Issues*. The Robert Wood Johnson Foundation/Urban Institute. May 2014.

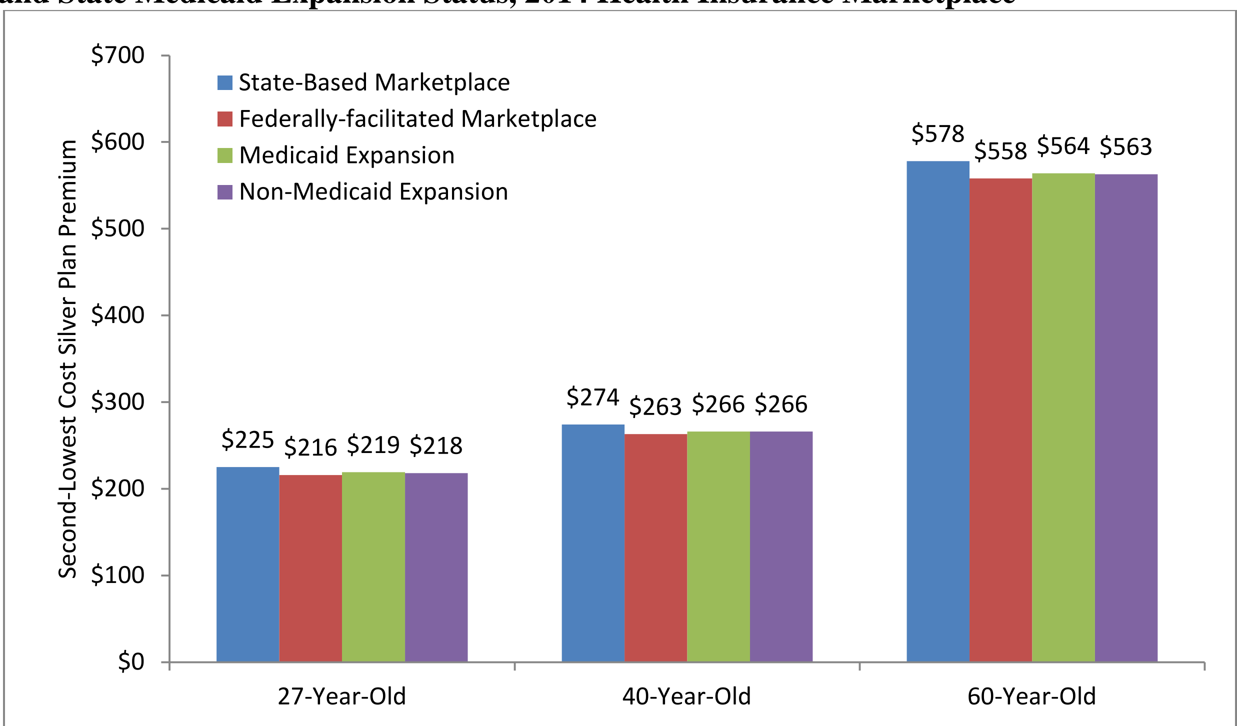
TABLE 6 Second-Lowest Cost Silver Plan Monthly Premiums (before Tax Credits)* by Selected Ages and Rating Area, 2014 Health Insurance Marketplace				
	Average (NY & VT Included)	**Average** (NY & VT Excluded)	**Minimum** (NY & VT Excluded)	**Maximum** (NY & VT Excluded)
27-Year-Old	$226	$219	$127	$406
35-Year-Old	$260	$254	$148	$474
40-Year-Old	$271	$266	$154	$496
50-Year-Old	$371	$371	$215	$693
60-Year-Old	$572	$584	$335	$1,136

Source: ASPE computations of plan and premium data from the following publicly available sources: Healthcare.gov, state rate filings (where available), and State-based Marketplace websites. Averages are weighted by the QHP-eligible population in each rating area estimated using the 2011 American Community Survey Public Use Microdata Sample.
*These premiums represent the premiums before the application of tax credits. Of those consumers who purchased plans through the Marketplace, 85 percent selected plans with financial assistance.[27]

Figure 5 shows the average second-lowest cost silver plan premium by selected ages and rating areas grouped by Marketplace type (FFM or SBM) and state decisions to expand their Medicaid programs or not. By the end of the initial open enrollment period (March 31, 2014), 25 states and the District of Columbia had chosen to expand their Medicaid programs under the ACA, including all 15 SBM states and 11 of the 36 FFM states.[28] The premiums are comparable between the rating areas based on market type and the decision by a state to expand or not to expand its Medicaid program under the Affordable Care Act.

[27] Represents individuals who have selected a Marketplace plan, and qualify for an advance premium tax credit (APTC), with or without a cost-sharing reduction (CSR) from: The Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, May 1, 2014, "Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period," http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf .
[28] These numbers represent the status of states regarding FFM, SBM, and Medicaid expansion decisions for the time of the initial open enrollment period. A FFM state is one in which the Marketplace is administrated by the Federal government, and a SBM is one in which the state opted to create and operate its own Marketplace. Here we include states that are a hybrid of the FFM and SBM, a State Partnership Marketplace (SPM) in the FFM group of states. For current information on the sates regarding Medicaid expansion decisions see http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf .

FIGURE 5: Second-Lowest Cost Silver Plan Premium by Age Group, Marketplace Type, and State Medicaid Expansion Status, 2014 Health Insurance Marketplace



Source: ASPE computations of plan and premium data were taken from the following publicly available sources: Healthcare.gov, state rate filings (where available), and State-based Marketplace websites. The national average is weighted by the QHP-eligible population in each rating area estimated using the 2011 American Community Survey Public Use Microdata Sample. Second-lowest cost silver plan premiums for rating areas in New York (nine rating areas) and Vermont (one rating area), which do not establish premium rates based on age, were excluded from the analysis.

III. Competition, Other Market Factors, and Second-Lowest Cost Silver Plan Premiums

Section III Highlights

The Association Between Competition, Other Market Factors, and Second-Lowest Cost Silver Plan Premiums:

- The number of issuers in a rating area was associated with lower premiums among the second-lowest cost silver plans.
- On average, an increase of one issuer in a rating area is associated with a 4 percent decline in the second-lowest cost silver plan premium.

In order to more carefully examine the sources of variation in second-lowest cost silver plan premiums among rating areas, we applied statistical models to obtain estimates of the association between second-lowest cost silver plan premiums for selected ages and a number of Marketplace characteristics. Our primary indicator of competition is the number of issuers in a rating area. We also examine the percent of all issuers that were defined as "established," meaning that they issued a policy in the private individual market within the state during 2012 and 2013. Such

issuers may have greater knowledge of the area or have established provider markets that allow them to charge a lower premium; or, on the other hand, they may have a loyal customer base that is willing to accept higher premiums. We also included a variable to reflect a specific type of issuer—the consumer operated and oriented plan issuers (CO-OP). The consumer operated and oriented plan program was established to foster the creation of qualified nonprofit health insurance issuers to offer competitive health plans in the individual and small group markets. We expect the presence of a CO-OP in a rating area to have a negative association with the second-lowest cost silver plan premium.

In addition, we use a measure of hospital market concentration, the Herfindahl-Hirschmann Index (HHI),[29] in our statistical models. Since more concentrated hospital markets could result in higher prices for hospital services, insurance premiums may be higher in these rating areas relative to those with less concentrated hospital markets. Since we focus on premiums within age bands, a variable was included to denote market areas in New York and Vermont, which are the only two states that do not permit setting premium rates based on age. Other market characteristics included an indicator of a Federally-facilitated Marketplace, an indicator of a Medicaid expansion state, the percent of the rating area population that is uninsured, the log of state health care expenditures, and the log of the rating area population density. We used three different model specifications in order to investigate the association between premiums and both an alternative measure of health expenditures and the exclusion of health expenditure measures from the model.[30]

Results indicate that the premiums are negatively correlated with the number of issuers (see Table 7). Specifically, an increase of one issuer in a rating area is associated with a decrease of approximately 4 percent in the second-lowest cost silver plan premium for a 27-year-old individual.[31] These results are consistent with recent findings using a somewhat different approach that also found that greater competition reduced second-lowest cost silver plan premiums in 2014.[32] In addition, a greater percent of established issuers in a state is associated with lower premiums—approximately a 2 percent reduction in second-lowest cost silver premiums for each 10 percentage point increase in the percent of all issuers that were established issuers. However, this finding was not statistically significant for all model specifications shown

---

[29] The HHI refers to the Herfindahl-Hirschmann Index which is the standard measure used in economic analysis of market competition and is computed as the sum of squared market shares in the market. The HHI ranges from 0 indicating perfect competition to 10,000 indicating monopoly. The Department of Justice and the Federal Trade Commission guidelines define a market as "highly concentrated" if the HHI exceeds 2500.

[30] Variations of the final model use as the dependent variable the logged values of the second-lowest cost silver premiums for ages 27, 35, 40, 50, and 60 with consistent results across these different model specifications. The model is a multivariate linear regression model utilizing the cluster option in Stata to produce robust standard errors that take into account the potential that premiums in rating areas within a state may not be independent of each other. State-level health care expenditures were estimated using Truven MarketScan Commercial Claims and Encounters Database for 2012 and the average state-level small group premiums were taken from the Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2012 Medical Expenditure Panel Survey-Insurance Component, Table II.C.1, "Less than 50 Employees."

[31] The observed association may also reflect other factors which we could not currently measure, such as the extensiveness of provider networks. Our cross-sectional analysis implies association and not causality.

[32] Leemore Dafny, Jonathan Gruber, and Christopher Ody. "More Insurers Lower Premiums: Evidence from Initial Pricing on the Health Exchanges." *NBER Working Paper No. 20140*. May 2014.

in Table 7. The hospital market concentration did not have a statistically significant association with the second-lowest cost silver plan premium.

TABLE 7
Linear Regression Model Results of the Association Between Second-Lowest Cost Silver Plan Premiums, the Number of Issuers, and Other Marketplace Characteristics, by Rating Area, 2014 Health Insurance Marketplace

	Log of the Second-Lowest Cost Silver Plan Premiums For a 27-Year-Old (N=494)		
	Model 1	**Model 2**	**Model 3**
Market Characteristics by Rating Area	**Coefficient (P-Value)**	**Coefficient (P-Value)**	**Coefficient (P-Value)**
Number of Issuers	**-0.04 (<0.001)**	**-0.04 (<0.001)**	**-0.04 (<0.001)**
Percent of Established Issuers	**-0.19 (0.03)**	-0.22 (0.11)	-0.14 (0.19)
CO-OP (1,0)	-0.03 (0.48)	-0.05 (0.30)	-0.02 (0.63)
FFM State (1,0)	-0.09 (0.23)	-0.05 (0.51)	-0.08 (0.27)
Medicaid Expansion State (1,0)	0.00 (0.83)	0.01 (0.81)	-0.01 (0.85)
Full Community Rating State (1,0)	**0.55 (<0.001)**	**0.50 (<0.001)**	**0.56 (<0.001)**
Log of Hospital Market Concentration (HHI)	-0.01 (0.78)	0.01 (0.73)	-0.00 (0.98)
Percent Uninsured Population	0.18 (0.57)	0.13 (0.72)	0.09 (0.79)
Log of State-Level Health Care Expenditures	**0.54 (0.001)**	NA	NA
Log of State-Level Small Group Premiums	NA	**0.56 (0.01)**	NA
Log of Population Density	-0.01 (0.41)	-0.01 (0.63)	-0.00 (0.80)
Constant	1.32 (0.28)	0.94 (0.59)	**5.73 (<0.001)**
F-Statistic	**60.57 (<0.001)**	**114.93 (<0.001)**	**105.66 (<0.001)**
R^2	0.32	0.31	0.26

Source: ASPE computations of plan and premium data from the following publicly available sources: Healthcare.gov, state rate filings (where available), and State-based Marketplace websites.
NOTE: Other model specifications included using the second-lowest cost silver plan premiums for 35, 40, 50, and 60-year-olds as the dependent variable, respectively. Results were consistent across different specifications.

IV. Competition, Other Market Factors, and Different Measures of Marketplace Premiums

Section IV Highlights

The Association Between Competition, Other Market Factors, and All Marketplace Premiums

- The absolute number of issuers within a rating area did not, on average, have a significant association with the average premium for 27-year-olds for all plans by metal level (bronze, silver, gold, and platinum). In part, this difference may be due to markets with more issuers exhibiting greater variability in premiums—that is, these markets had both higher and lower premiums within each metal level.
- Consumers had a wider choice of plan types in areas with more issuers. The variability in premiums associated with a greater number of issuers was in part related to these rating areas being more likely to have the full range of plan types including; CO-OPs, HMOs and plans issued by insurers offering Medicaid plans in the market prior to Marketplace implementation.
- CO-OPs and HMOs exhibited significantly lower premiums than other plan types.
- Areas that had more concentrated hospital markets (higher HHI) exhibited higher average premiums.
- A higher percentage of established issuers in a state was associated with lower premiums at each metal level.

In the preceding analyses, we examined factors that were associated with variation in one measure of market premiums (the second-lowest cost silver plan) across rating areas. In order to conduct a more complete analysis, we examined factors that affected the full range of Marketplace premiums in all four metal levels. In our initial models of the second-lowest cost silver plan premium, we also examined similar statistical models, replacing the second-lowest cost silver plan premium with both the average and median silver plan premiums for the rating area (not displayed in this Brief). In contrast to the results for the second-lowest cost silver plan premium, the number of issuers did not have an effect on either the mean or median silver plan premium.[33]

To further examine these findings, we conducted several other analyses. Specifically, we examine the extent to which a greater number of issuers results in greater variation in plan types being offered in the rating area. A greater dispersion of premiums could mean that the lower premiums offered are offset, on average, by higher premium plans offered for particular plan types.

[33] Our results are comparable to those from Dafny, Gruber and Ody (2014) who found a relatively consistent relationship between their measure of competition and the second-lowest cost, mean, and median silver plan premiums in a rating area. While Dafny et. al. use the change in issuer HHI if United Healthcare had entered the 2014 Marketplace to test the effect of competition based on pre-Affordable Care Act shares of the individual market, in our analysis, we incorporate both the number of issuers and the proportion of issuers that had been established in the individual market prior to the implementation of the Marketplace. While we did not find a statistically significant association between the number of issuers and the mean and median silver plan premiums, it is notable that we find that established issuers generally offered lower premiums.

First, we examined models at the individual plan level rather than for the rating area. Hierarchal linear modeling techniques were utilized to examine the effect of market factors and competition on all premiums across all four metal levels (bronze, silver, gold and platinum).[34] We present in the discussion and Table 8 the results related to premiums for 27-year-old individuals.

In addition to the results for the number of issuers, there are several other results of interest. These models included indicators for whether the plan was a PPO, HMO, CO-OP or other type of plan.[35] As displayed in Table 8, the results suggest that premiums for HMO plans were lower on average than PPO, point of service (POS) and exclusive provider organizations (EPOs). In addition, CO-OP plans tended to have lower premiums than non-CO-OP plans within areas, which is consistent with the intent of their creation— to offer competitive health plans. Established issuers were also associated with lower bronze, silver, and gold premiums, but higher platinum plan premiums. As discussed previously, such issuers may have greater knowledge of the area or have established provider markets that allow them to charge a lower premium; or, on the other hand, they may have a loyal customer base that is willing to accept higher premiums. These results indicate that both of these dynamics may be in play for plans at varying metal levels.

Another important factor was the measure of hospital market concentration (HHI). While this variable was not associated with premium levels for the second-lowest cost silver plan premium, it does demonstrate a positive and statistically significant effect on the full range of premiums across all metal levels. This result supports the view that insurers likely have less price negotiating leverage in more concentrated hospital markets, resulting in higher premiums.

In the plan-level models, the number of issuers does not have a significant effect on premiums in any metal level. Thus, it appears that a greater number of issuers is associated with lower benchmark (second-lowest cost silver) plan premiums being offered, but is not related to the average of all premiums offered. Further statistical analyses offer a plausible explanation for this finding. We find that the variability in premiums increases with the number of issuers in a rating area. As displayed in Table 9, a common measure of variability—the coefficient of variation—increases with the number of issuers. This indicates that as the number of issuers increases, the number of plans offered also increases which leads to a greater dispersion of premiums. As the regression results in Table 10 demonstrate, the association between number of issuers and the coefficient of variation is statistically significant after removing the variation that might be attributable to other market factors. So, even while controlling for other factors that may contribute to the dispersion in premiums, the association between the number of issuers and premium dispersion remains.

---

[34] Hierarchical linear modeling (HLM) regression techniques are designed to deal with clustered or grouped data in which analytic units are naturally nested or grouped within other units of interest. For example, the number of Marketplace plans nested within issuer nested within rating area nested within state. Hierarchal linear models recognize the existence of such data hierarchies by allowing for residual components at each level in the hierarchy. In analyzing premiums of Marketplace plans being offered by issuers within a rating area, interest centers on the effects of plans, issuers, rating area, and state characteristics.
[35] The reference group for the PPO and HMO variables consists of plans that are POS or EPO. For the CO-OP variable, the reference group is established issuers, including all commercial and Medicare plans.

The premium variation is in turn at least partly attributable to the plan types offered. The rating areas with more issuers are more likely to offer HMOs and CO-OP plans than those with only one issuer, while only areas that have four or more issuers offer the full range of plan types—corresponding to the dispersion of a full-range of premium rates (see Table 11). Consumers can expect more choice in plan types in markets with robust competition as measured by number of issuers participating.

TABLE 8
Hierarchical Linear Regression Model Results, Premiums for 27-Year-Olds by Plan and Metal Level, 2014 Health Insurance Marketplace

	Log of the Average Premiums for 27-Year-Olds By Metal Level			
	Bronze (n=5,721)	**Silver (n=6,896)**	**Gold (n=5,221)**	**Platinum (n=1,523)**
Market Characteristics by Plan	**Coefficient (P-Value)**	**Coefficient (P-Value)**	**Coefficient (P-Value)**	**Coefficient (P-Value)**
Number of Health Insurance Issuers	0.00 (0.97)	-0.00 (0.36)	-0.00 (0.27)	0.00 (0.46)
PPO Plan (1,0)	**0.11 (<0.001)**	**0.09 (<0.001)**	**0.10 (<0.001)**	**0.05 (0.003)**
HMO Plan (1,0)	**-0.04 (<0.001)**	**-0.05 (<0.001)**	**-0.06 (<0.001)**	**-0.04 (0.001)**
FFM State (1,0)	0.02 (0.76)	0.01 (0.93)	-0.02 (0.70)	0.01 (0.95)
Medicaid Expansion State (1,0)	-0.00 (0.96)	-0.00 (0.93)	-0.02 (0.73)	-0.00 (0.96)
Full Community Rating State (1,0)	**0.52 (<0.001)**	**0.50 (<0.001)**	**0.49 (<0.001)**	**0.58 (<0.001)**
Established Issuers (1,0)	**-0.08 (<0.001)**	**-0.08 (<0.001)**	**-0.07 (<0.001)**	**0.06 (0.001)**
Issuers Offering Medicaid Plans (1,0)	**0.06 (0.001)**	0.02 (0.17)	0.02 (0.27)	-0.00 (0.95)
Issuers that are CO-OPs (1,0)	**-0.09 (<0.001)**	**-0.05 (0.001)**	**-0.07 (<0.001)**	**-0.08 (0.02)**
Log of Hospital Market Concentration (HHI)	**0.02 (0.04)**	**0.02 (0.05)**	**0.02 (0.01)**	**0.05 (<0.001)**
Constant	-0.19 (0.90)	0.75 (0.59)	0.43 (0.76)	-1.38 (0.58)
Wald (X^2)	**776.77 (<0.001)**	**901.93 (<0.001)**	**991.61 (<0.001)**	**118.94 (<0.001)**
Log Likelihood	5,082.93	6,674.71	4,714.07	1,247.09

Source: ASPE computations of plan and premium data from the following publicly available sources: Healthcare.gov, state rate filings (where available), and State-based Marketplace websites.
*Other market characteristics for a rating area include the percent of the population that is uninsured, log of state health care expenditures, and the log of the population density.
NOTE: Other model specifications included: 1) excluding the log of state health care expenditures and 2) excluding the log of state health care expenditures and replacing it with the log of the average state small group premium. Results were consistent across specifications.

TABLE 9 Coefficient of Variation of Silver Plan Premiums for 27-Year-Olds, by Rating Area and Number of Issuers, 2014 Health Insurance Marketplace	
Number of Issuers	**Coefficient of Variation**
Only 1 Issuer	0.06
2 or 3 Issuers	0.09
4 to 6 Issuers	0.12
7 to 11 Issuers	0.15

Source: ASPE computations of plan and premium data from the following publicly available sources: Healthcare.gov, state rate filings (where available), and State-based Marketplace websites.

TABLE 10 Coefficient of Variation (CV) Regression Analysis Including the Number of Issuers and Other Market Characteristics,* Premiums for 27-Year-Olds by Rating Area and Metal Level, 2014 Health Insurance Marketplace				
	CV Based on Premiums for 27-Year-Olds by Metal Level			
	Bronze	**Silver**	**Gold**	**Platinum**
Market Characteristics by Rating Area	**Coefficient (P-Value)**	**Coefficient (P-Value)**	**Coefficient (P-Value)**	**Coefficient (P-Value)**
Number of Health Insurance Issuers	**0.01 (<0.001)**	**0.01 (<0.001)**	**0.01 (<0.001)**	**0.01 (<0.001)**
Number of Observations (Rating Areas)	483	494	494	205
F-Statistic	**12.83 (<0.001)**	**9.42 (<0.001)**	**9.22 (<0.001)**	**26.11 (<0.001)**
R^2	0.32	0.31	0.32	0.49

Source: ASPE computations of plan and premium data from the following publicly available sources: Healthcare.gov, state rate filings (where available), and State-based Marketplace websites.
*Other market characteristics for a rating area include established issuers as a proportion of all issuers, issuers offering Medicaid plans in the rating area prior to the implementation of the Marketplace as a proportion of all issuers, indicator that a CO-OP has plans available in the rating area, indicator of a Federally-facilitated Marketplace state, indicator of a Medicaid expansion state, indicator of a full-community rating state, log of the hospital HHI, the percent of the population that is uninsured, log of state health care expenditures, and the log of the population density.

TABLE 11
The Percent of Rating Areas with at Least One Silver Plan of Selected Types, by Number of Issuers, 2014 Health Insurance Marketplace

	The percent of rating areas with at least one silver plan that is one of the following types:			
	HMO	**CO-OP**	**Medicaid***	**HMO, CO-OP, Medicaid**
Any Number of Issuers	55%	32%	22%	5%
Only 1 Issuer	21%	0%	2%	0%
2 or 3 Issuers	46%	31%	13%	0%
4 to 6 Issuers	75%	40%	26%	8%
7 to 11 Issuers	62%	45%	77%	21%

Source: ASPE computations of plan and premium data from the following publicly available sources: Healthcare.gov, state rate filings (where available), and State-based Marketplace websites.
*These are plans provided by issuers that were offering only Medicaid plans in the market prior to the implementation of the Marketplace.

V. Conclusion

The Affordable Care Act aims to improve consumer access to and choice of affordable coverage by promoting competition in the individual health insurance market and by providing financial assistance to consumers based on their income.

Premium affordability is enhanced by the advance premium tax credit—69 percent of the individuals who selected a plan with tax credits through the Marketplace have coverage that costs $100 or less a month in premiums after tax credits. Overall, individuals selecting plans with tax credits have premiums that are 76 percent less, on average, than the full premium before tax credits. Individuals selecting silver plans with tax credits experienced an 80 percent reduction in premiums due to the tax credits and have a monthly premium of $69, on average.

We find that consumers have, on average, five issuers and 47 Marketplace plans from which to choose when considering their options for coverage. Our analysis of second-lowest cost silver plan premiums indicates that in markets with more sellers there are lower premiums for the second-lowest cost silver plan. This analysis finds that each additional issuer is associated with a 4 percent decline in the second-lowest cost silver plan premium.

Areas with a greater number of issuers also tend to offer a wider range of choices for consumers among plan types (e.g. PPOs, HMOs, CO-OPs) that appear to result in greater variation in premiums across the rating areas, suggesting complex competitive interactions. If more issuers come into the Marketplace in future years, it seems likely not only that consumers will have a greater choice of plans, but also that the benchmark plan (second-lowest cost silver plan) will become even more affordable.

The findings in this brief represent early analyses for the first year of the Marketplace, and we expect this new, competitive health insurance market will continue to evolve.

APPENDIX

TABLE A1
Average Monthly Premiums Before and After Tax Credits, Tax Credit Amount, and Percent Reduction in Premium after Tax Credits for Individuals Who Selected Plans with Tax Credits through the 2014 Federally-facilitated Marketplace

State	Average Premium after Tax Credits	Average Percent Reduction in Premium after Tax Credits	Average Premium before Tax Credits	Average Tax Credit Amount	Percent of Individuals Who Selected Plans with Tax Credits*
Alabama	$76	77%	$334	$258	85%
Alaska	$94	81%	$507	$413	88%
Arizona	$113	58%	$272	$159	76%
Arkansas	$94	76%	$387	$293	89%
Delaware	$130	67%	$392	$263	81%
Florida	$68	80%	$347	$278	91%
Georgia	$54	84%	$341	$287	87%
Idaho	$68	75%	$276	$207	91%
Illinois	$114	64%	$316	$202	76%
Indiana	$88	79%	$424	$336	89%
Iowa	$108	69%	$350	$242	83%
Kansas	$67	77%	$290	$223	78%
Louisiana	$83	79%	$397	$314	88%
Maine	$99	78%	$443	$344	89%
Michigan	$97	72%	$342	$246	87%
Mississippi	$23	95%	$438	$415	94%
Missouri	$59	83%	$344	$286	85%
Montana	$99	71%	$345	$246	85%
Nebraska	$94	69%	$308	$214	87%
New Hampshire	$100	74%	$390	$290	76%
New Jersey	$148	68%	$465	$317	84%
New Mexico	$120	64%	$334	$214	78%
North Carolina	$81	79%	$381	$300	91%
North Dakota	$132	62%	$350	$218	84%
Ohio	$121	67%	$372	$250	84%
Oklahoma	$75	73%	$277	$202	79%
Pennsylvania	$84	74%	$330	$246	81%
South Carolina	$84	77%	$367	$283	87%
South Dakota	$101	73%	$372	$271	89%
Tennessee	$86	69%	$281	$195	78%
Texas	$72	76%	$305	$233	84%
Utah	$84	66%	$243	$159	86%
Virginia	$77	77%	$331	$254	82%
West Virginia	$113	73%	$415	$302	85%
Wisconsin	$112	74%	$427	$316	90%
Wyoming	$113	79%	$536	$422	93%
All FFM States	**$82**	**76%**	**$346**	**$264**	**87%**

Source: ASPE computations of CMS Federally-facilitated Marketplace (FFM) data as of 5/12/2014.
*Calculated as the number of individuals who selected Marketplace plans with tax credits as a percentage of all individuals who selected a Marketplace plan.

TABLE A2
Average Monthly Silver Plan Premiums before and after Tax Credits, Tax Credit Amount, and Percent Reduction in Premium after Tax Credits for Individuals Who Selected Silver Plans with Tax Credits through the 2014 Federally-facilitated Marketplace

State	Average Premium After Tax Credits	Average Percent Reduction in Premium after Tax Credits	Average Premium Before Tax Credits	Average Tax Credit Amount	Percent of Individuals Who Selected Plans with Tax Credits*
Alabama	$58	82%	$323	$264	94%
Alaska	$82	85%	$531	$449	95%
Arizona	$94	63%	$257	$163	89%
Arkansas	$83	79%	$393	$309	96%
Delaware	$103	73%	$378	$275	91%
Florida	$50	85%	$340	$290	98%
Georgia	$39	88%	$332	$293	96%
Idaho	$54	80%	$274	$220	97%
Illinois	$105	67%	$320	$214	89%
Indiana	$86	81%	$441	$355	94%
Iowa	$95	73%	$350	$255	94%
Kansas	$50	83%	$289	$239	93%
Louisiana	$68	83%	$401	$332	97%
Maine	$87	81%	$452	$365	95%
Michigan	$87	75%	$342	$255	94%
Mississippi	$15	96%	$434	$419	98%
Missouri	$45	87%	$347	$302	96%
Montana	$78	78%	$347	$269	95%
Nebraska	$79	74%	$309	$230	94%
New Hampshire	$87	78%	$396	$309	88%
New Jersey	$127	72%	$457	$330	91%
New Mexico	$115	66%	$338	$224	88%
North Carolina	$70	82%	$382	$312	97%
North Dakota	$106	69%	$344	$238	94%
Ohio	$111	70%	$372	$261	92%
Oklahoma	$72	75%	$286	$214	90%
Pennsylvania	$60	81%	$312	$252	90%
South Carolina	$75	80%	$371	$296	95%
South Dakota	$90	76%	$370	$280	94%
Tennessee	$78	72%	$281	$204	90%
Texas	$68	78%	$314	$246	94%
Utah	$68	72%	$242	$174	95%
Virginia	$66	80%	$338	$272	94%
West Virginia	$89	78%	$407	$317	93%
Wisconsin	$103	76%	$429	$326	95%
Wyoming	$99	82%	$543	$444	96%
All FFM States	**$69**	**80%**	**$345**	**$276**	**94%**

Source: ASPE computations of CMS Federally-facilitated Marketplace (FFM) data as of 5/12/2014.
*Calculated as the number of individuals who selected Marketplace plans with tax credits as a percentage of all individuals who selected a Marketplace plan.

TABLE A3 Distribution of Marketplace Plan Selections by Monthly Premiums after Tax Credits for Individuals Who Selected Plans with Tax Credits, 2014 Federally-facilitated Marketplace				
State	**$50 or Less**	**$51 to $100**	**$101 to $150**	**Greater than $150**
Alabama	53%	20%	11%	16%
Alaska	42%	21%	14%	23%
Arizona	26%	32%	17%	25%
Arkansas	35%	30%	15%	19%
Delaware	20%	30%	19%	31%
Florida	56%	19%	10%	15%
Georgia	60%	19%	10%	11%
Idaho	50%	27%	11%	12%
Illinois	25%	31%	18%	26%
Indiana	41%	26%	14%	18%
Iowa	29%	28%	19%	25%
Kansas	52%	22%	12%	14%
Louisiana	45%	25%	13%	17%
Maine	38%	25%	14%	23%
Michigan	39%	24%	15%	23%
Mississippi	68%	17%	7%	7%
Missouri	57%	20%	11%	13%
Montana	37%	26%	16%	22%
Nebraska	38%	26%	15%	21%
New Hampshire	38%	24%	15%	23%
New Jersey	20%	25%	17%	38%
New Mexico	20%	30%	21%	29%
North Carolina	48%	23%	12%	16%
North Dakota	15%	31%	21%	33%
Ohio	24%	28%	19%	29%
Oklahoma	47%	27%	13%	13%
Pennsylvania	47%	21%	12%	20%
South Carolina	45%	25%	13%	17%
South Dakota	34%	27%	16%	23%
Tennessee	42%	28%	14%	16%
Texas	50%	24%	12%	14%
Utah	36%	33%	17%	15%
Virginia	48%	25%	12%	15%
West Virginia	31%	27%	15%	27%
Wisconsin	32%	25%	16%	27%
Wyoming	33%	21%	15%	30%
All FFM States	46%	**23%**	**13%**	**18%**

Source: ASPE computations of CMS Federally-facilitated Marketplace (FFM) data as of 5/12/2014.
Note: Represents distribution of monthly Marketplace plan selections across bronze, silver, gold, and platinum metal levels.

TABLE A4
Cumulative Distribution of Marketplace Plan Selections by Monthly Premiums after Tax Credits for Individuals Who Selected Plans with Tax Credits, 2014 Federally-facilitated Marketplace

State	$50 or Less	$100 or less	$150 or Less	All Plans
Alabama	53%	73%	84%	100%
Alaska	42%	62%	77%	100%
Arizona	26%	58%	75%	100%
Arkansas	35%	65%	81%	100%
Delaware	20%	50%	69%	100%
Florida	56%	75%	85%	100%
Georgia	60%	79%	89%	100%
Idaho	50%	77%	88%	100%
Illinois	25%	56%	74%	100%
Indiana	41%	67%	82%	100%
Iowa	29%	57%	75%	100%
Kansas	52%	75%	86%	100%
Louisiana	45%	70%	83%	100%
Maine	38%	63%	77%	100%
Michigan	39%	62%	77%	100%
Mississippi	68%	86%	93%	100%
Missouri	57%	77%	87%	100%
Montana	37%	62%	78%	100%
Nebraska	38%	64%	79%	100%
New Hampshire	38%	62%	77%	100%
New Jersey	20%	45%	62%	100%
New Mexico	20%	50%	71%	100%
North Carolina	48%	71%	84%	100%
North Dakota	15%	46%	67%	100%
Ohio	24%	52%	71%	100%
Oklahoma	47%	74%	87%	100%
Pennsylvania	47%	68%	80%	100%
South Carolina	45%	70%	83%	100%
South Dakota	34%	61%	77%	100%
Tennessee	42%	69%	84%	100%
Texas	50%	74%	86%	100%
Utah	36%	69%	85%	100%
Virginia	48%	73%	85%	100%
West Virginia	31%	58%	73%	100%
Wisconsin	32%	57%	73%	100%
Wyoming	33%	55%	70%	100%
All FFM States	**46%**	**69%**	**82%**	**100%**

Source: ASPE computations of CMS Federally-facilitated Marketplace (FFM) data as of 5/12/2014.
Note: Represents distribution of monthly Marketplace plan selections across bronze, silver, gold, and platinum metal levels.

CSU Health Insurance Education Project: Project Poll & Analysis

Walter Zelman
Project Director, CSU HIEP
Chair, Department of Public Health, CSULA
June 12, 2014

Our grant

$1.25 million

Jul 2013 - Dec 2014

Our Mission

Educate
CSU students, families & staff

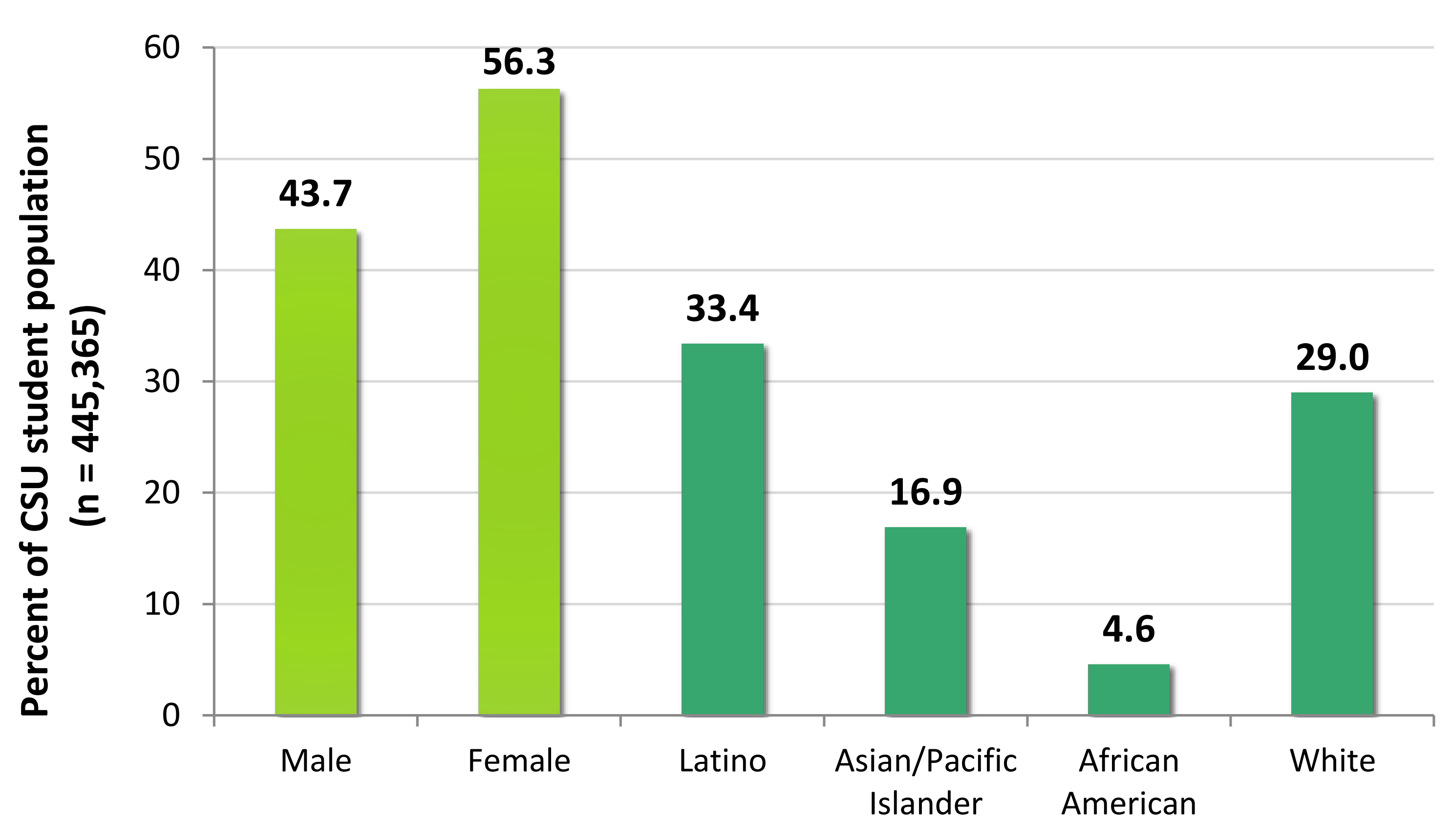
Our Function

Outreach & education,
not enrollment

Campus selection

23 CSU campuses; staffed at
15 campuses

CSU Demographics: 455,365 Students

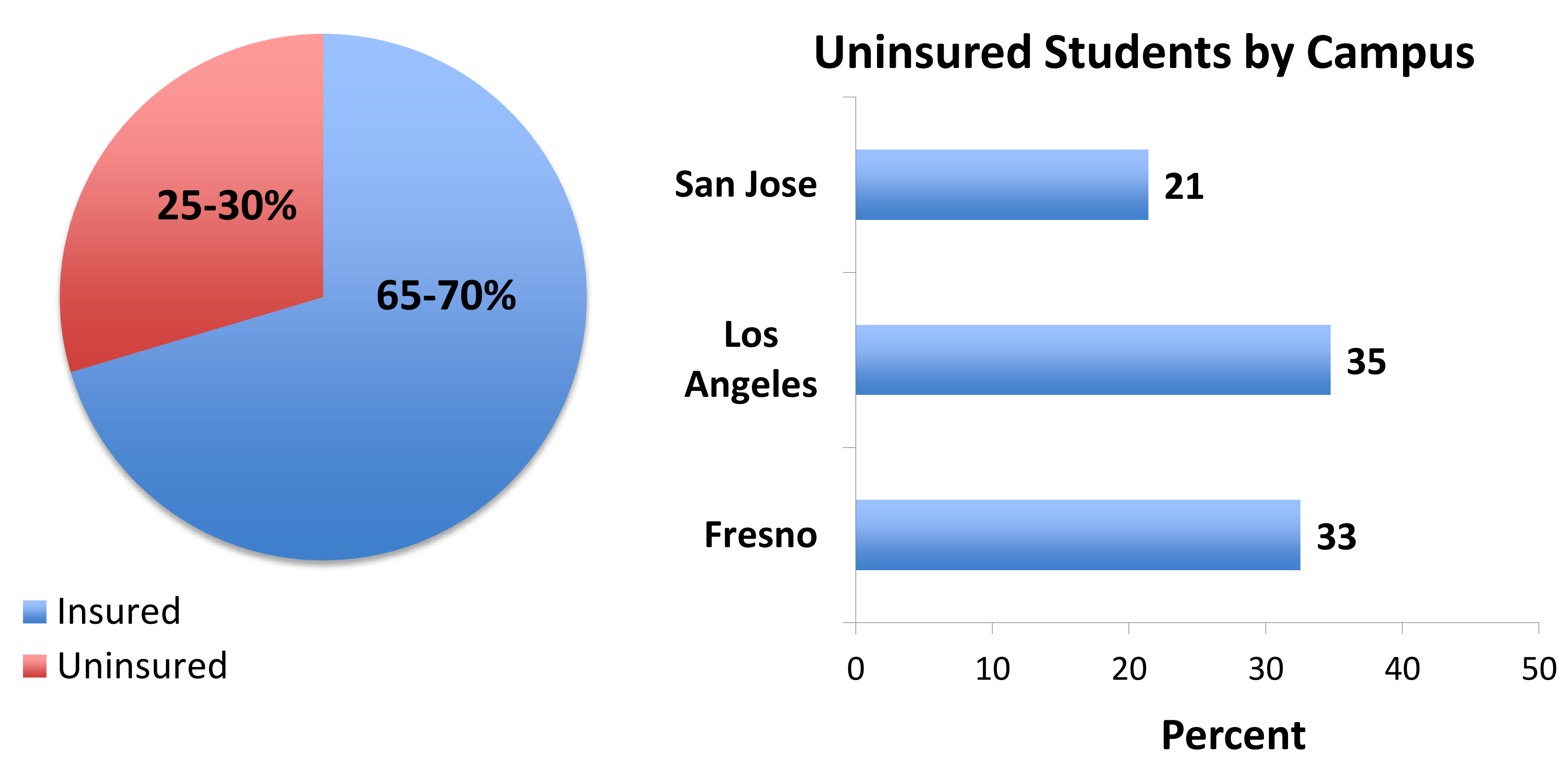


**Note:* Data from CSU Statistical Reports for 2013-2014 (http://www.calstate.edu/as/stat_reports/2013-2014/).

Polling of CSU students

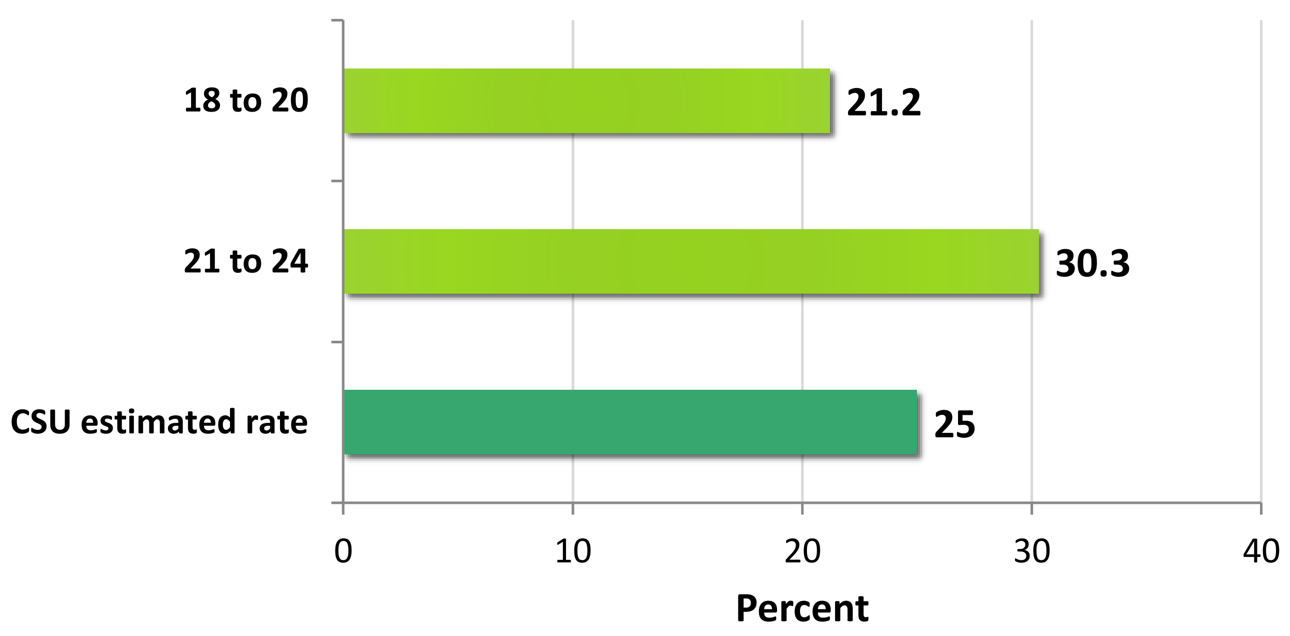
- **First poll: To help us develop strategy**
  - 836 surveys
  - 3 campuses (Fresno, Los Angeles, San Jose) in September 2013
- **Second poll: To assess how we did on outreach/education**
  - 1,971 surveys
  - 7 campuses (Fresno, Fullerton, Long Beach, Los Angeles, Northridge, Sacramento, San Jose) in April/May 2014

In September 2013, nearly one-third of CSU students were uninsured*



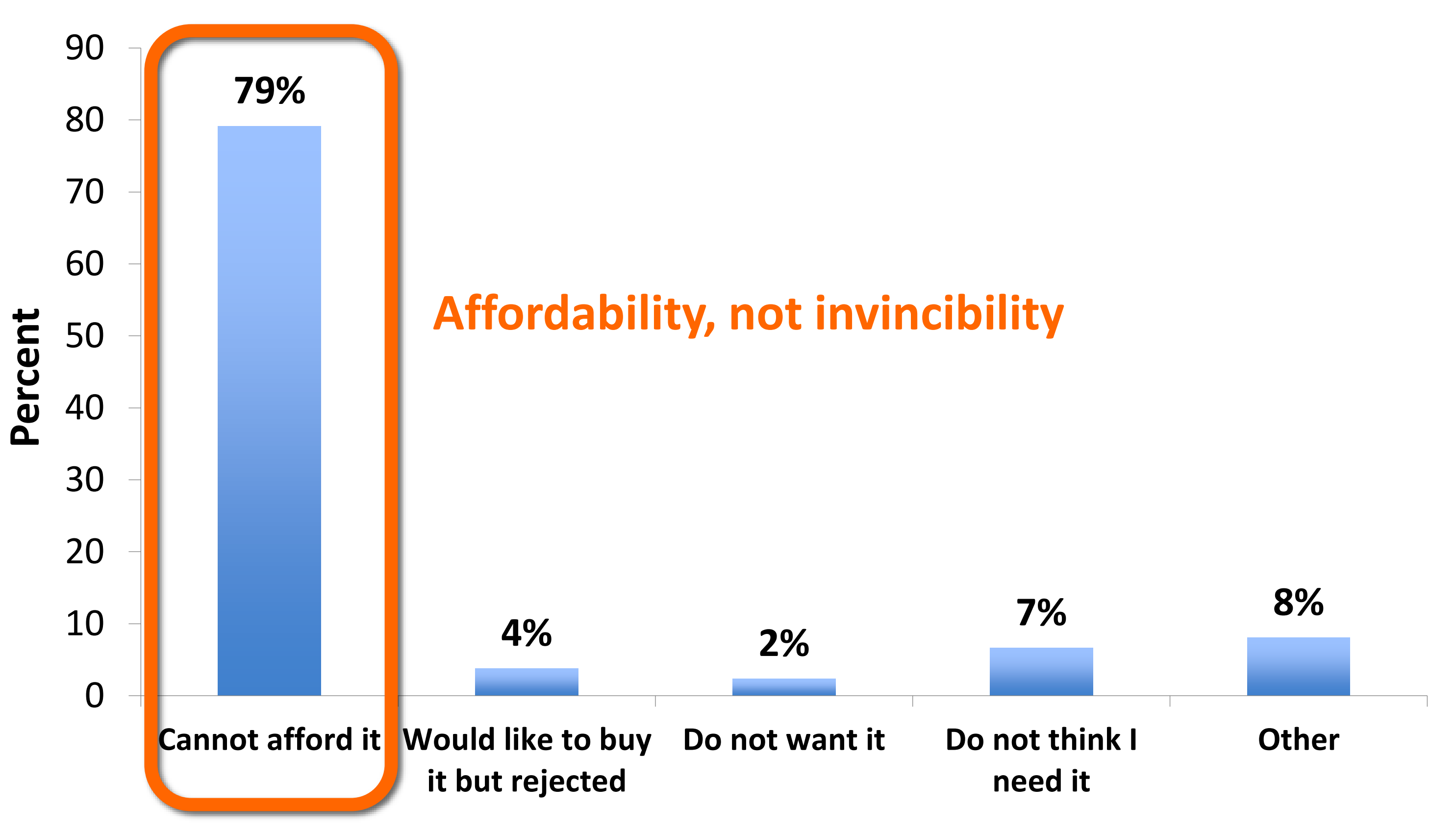
**Note:* Data from CSU Health Insurance Education Poll conduced in Fall 2013. Three CSU campuses were surveyed (n=836).

Rate of uninsured among CSU students consistent with statewide average



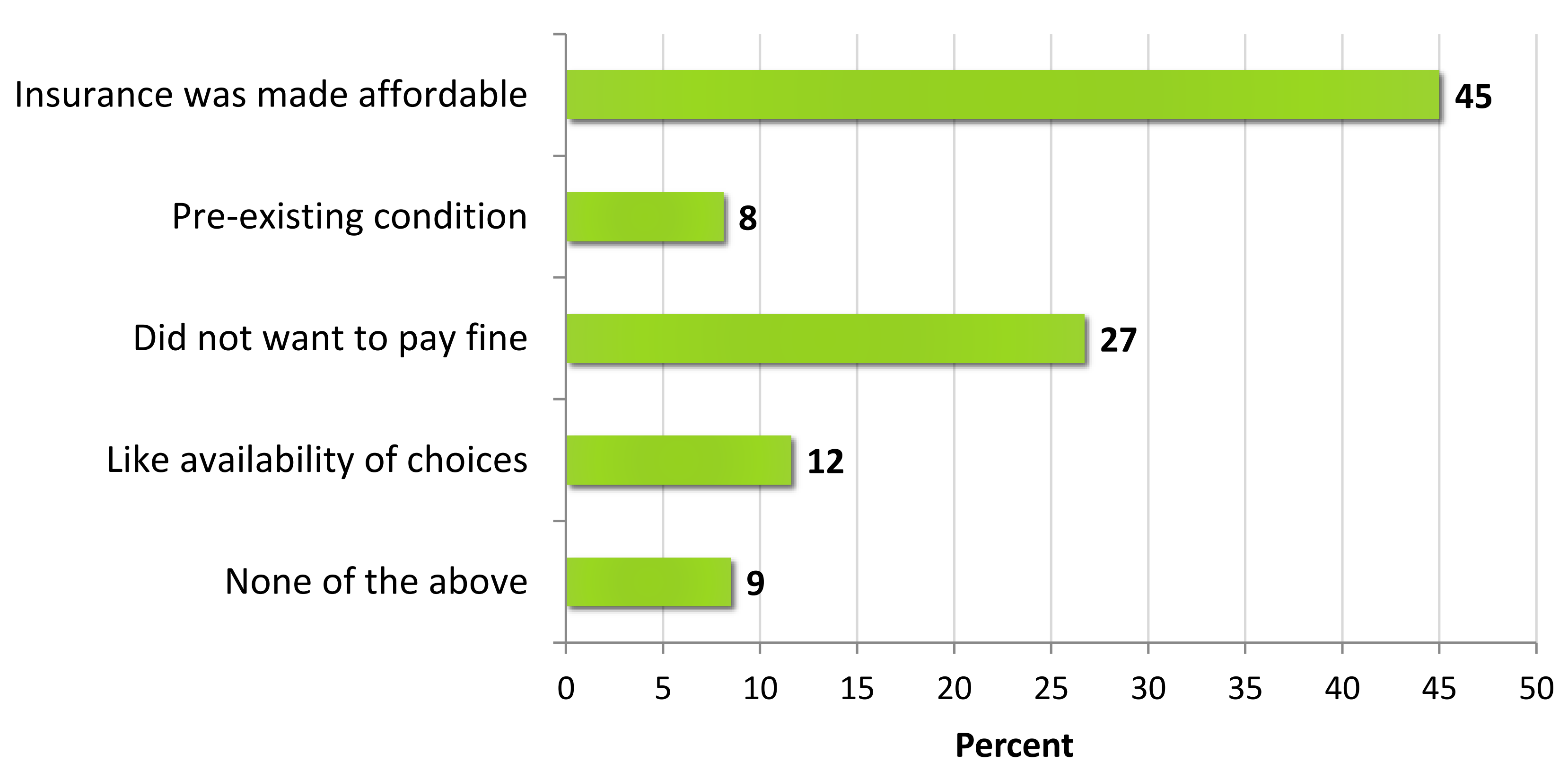
**Note:* Data shown are from the California Healthcare Foundation Almanac "California's Uninsured: By the Numbers, December 2013" (http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20CaifornaUninsured2013.pdf). CSU estimated rate is based off adjustment of results from first poll.

2013: Why were students uninsured?



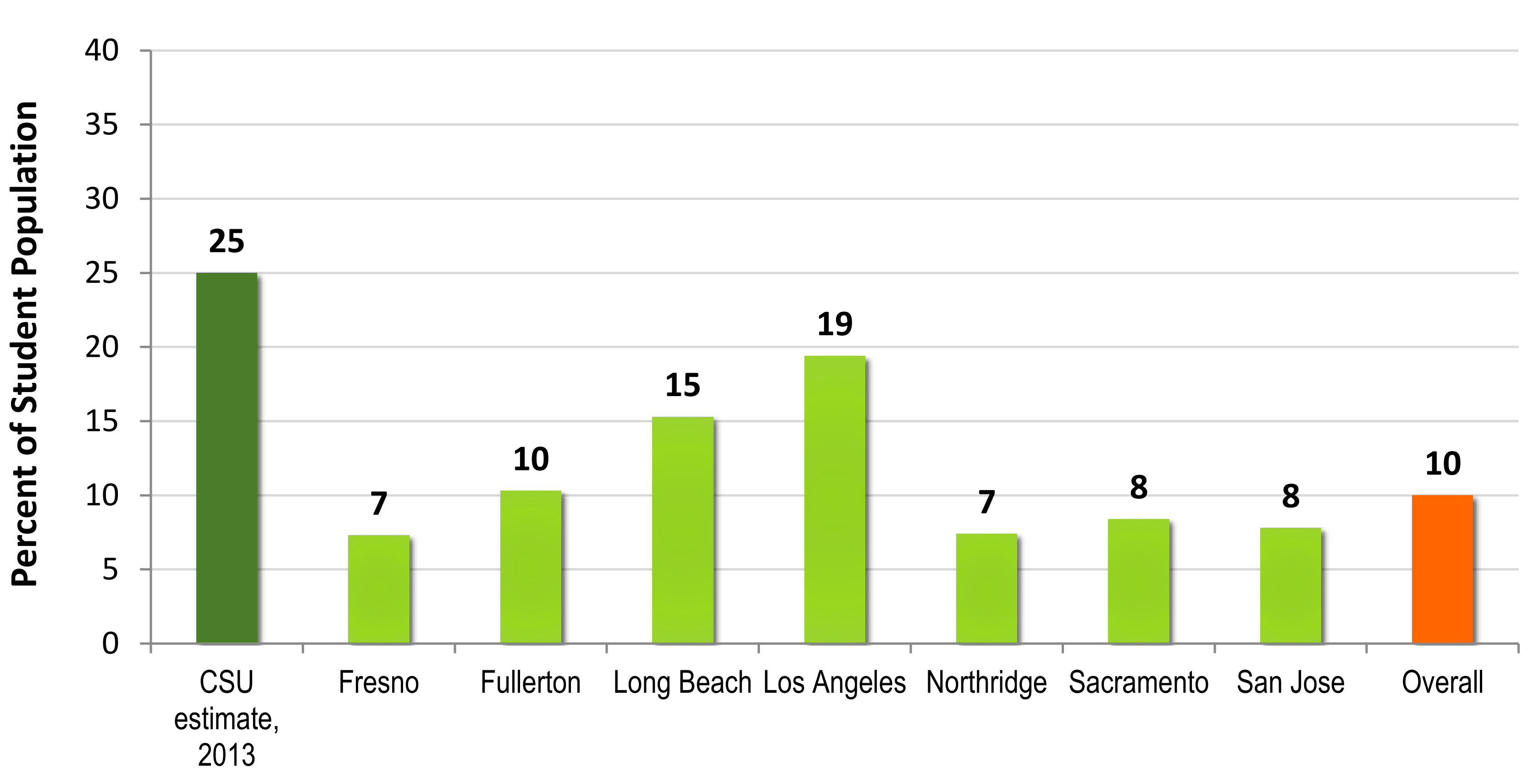
*Note: Data from CSU Health Insurance Education Poll conduced in Fall 2013. Three CSU campuses were surveyed (n=836).

2014: Why did students get covered through Covered CA?



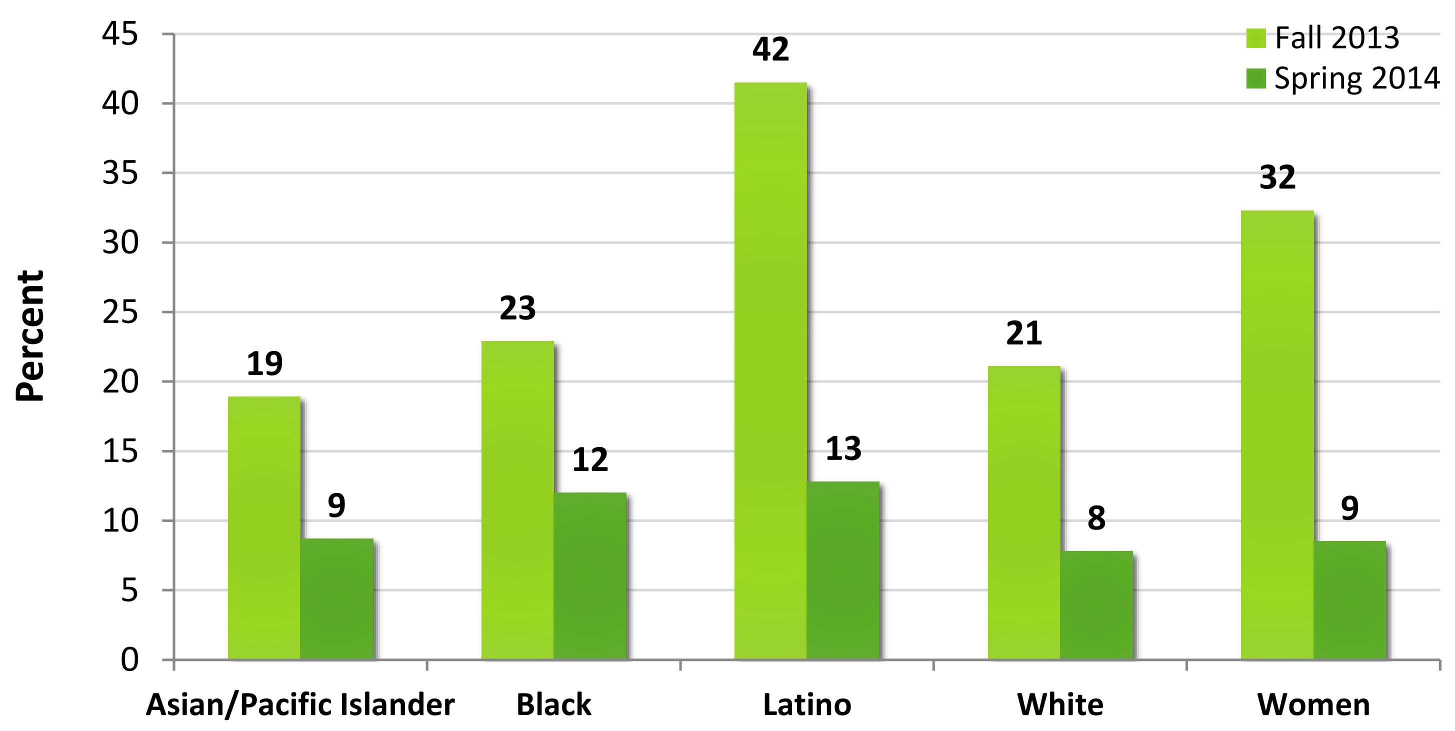
**Note:* Data from CSU Health Insurance Education Poll conducted in Spring 2014. Seven CSU campuses were surveyed (n=1971).

2014: Uninsured by campus



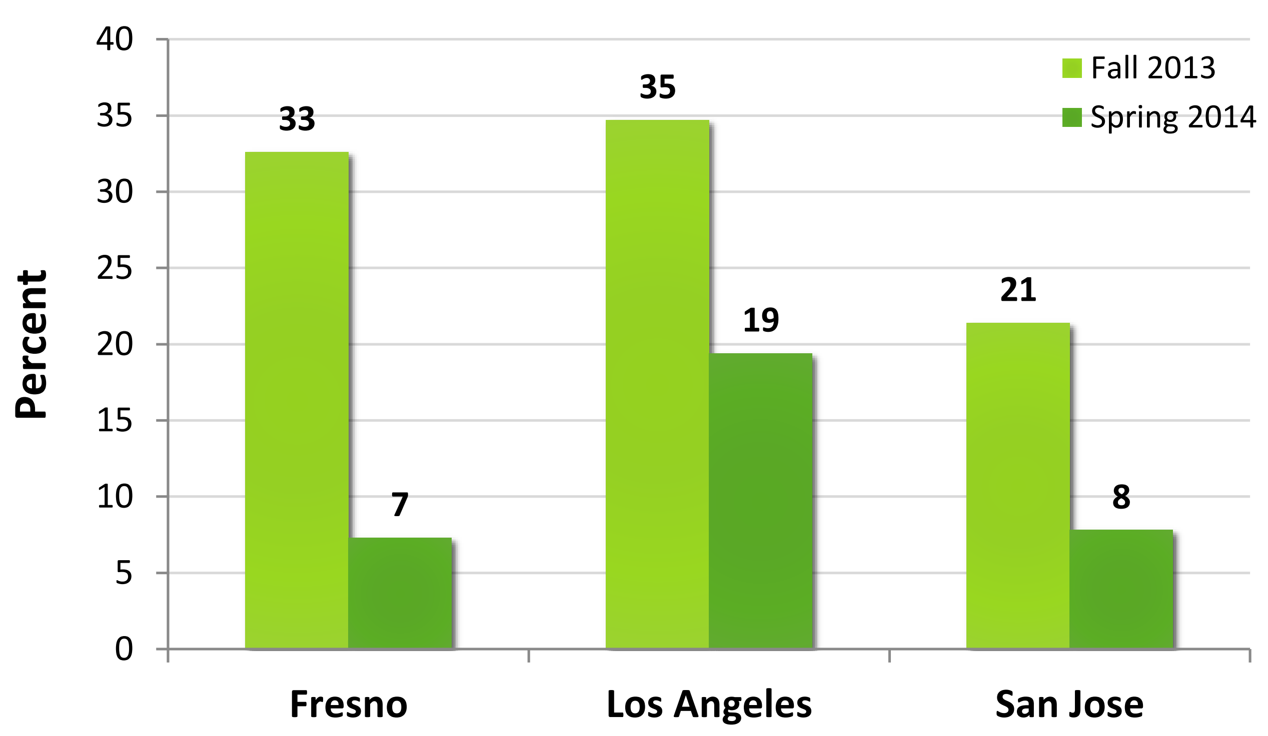
**Note:* Data from CSU Health Insurance Education Poll conducted in Spring 2014. Seven CSU campuses were surveyed (n=1971).

Demographics of uninsured



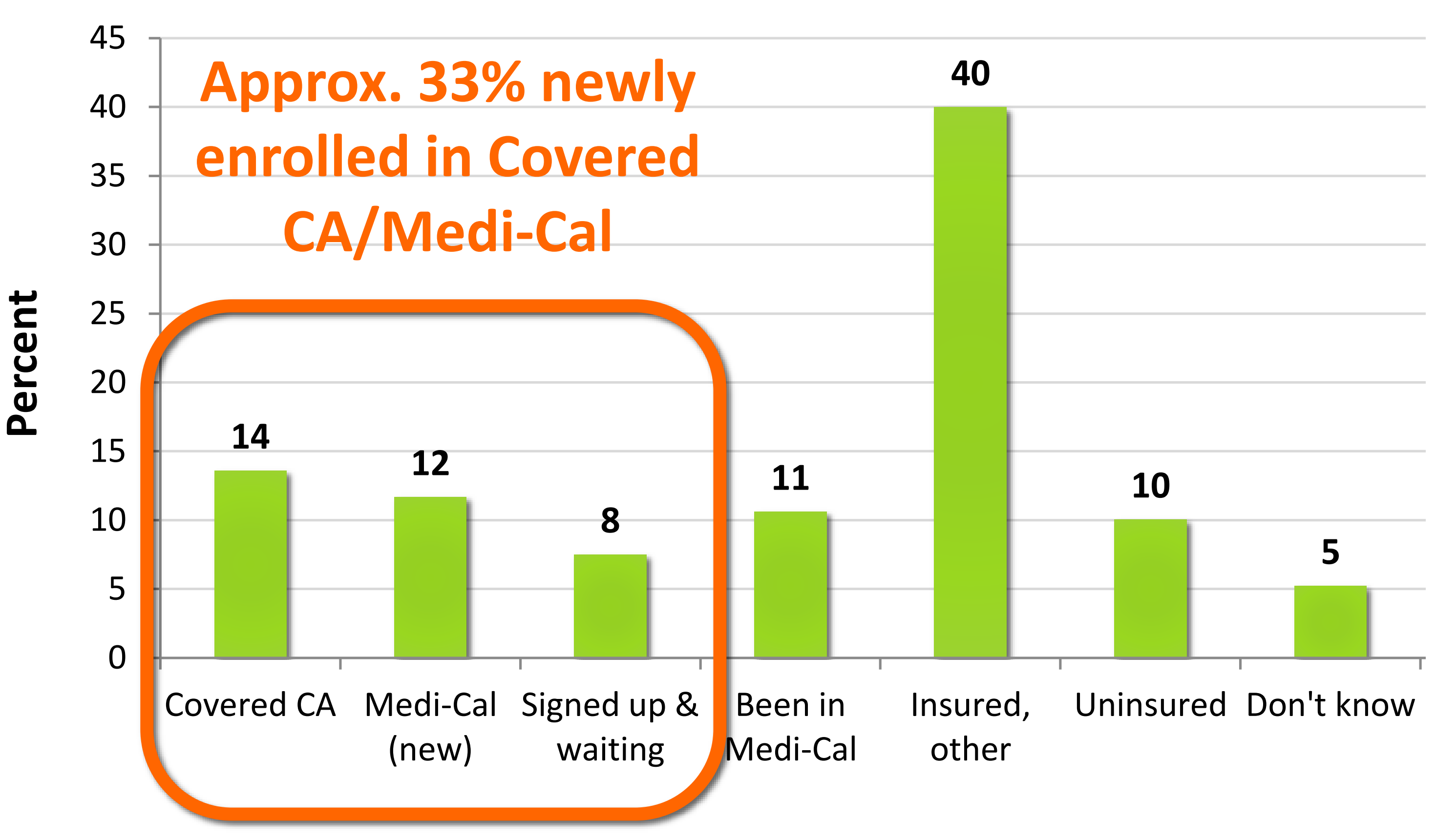
**Note:* Data from CSU Health Insurance Education Poll conducted in Spring 2014. Seven CSU campuses were surveyed (n=1971).

Uninsured: before & after



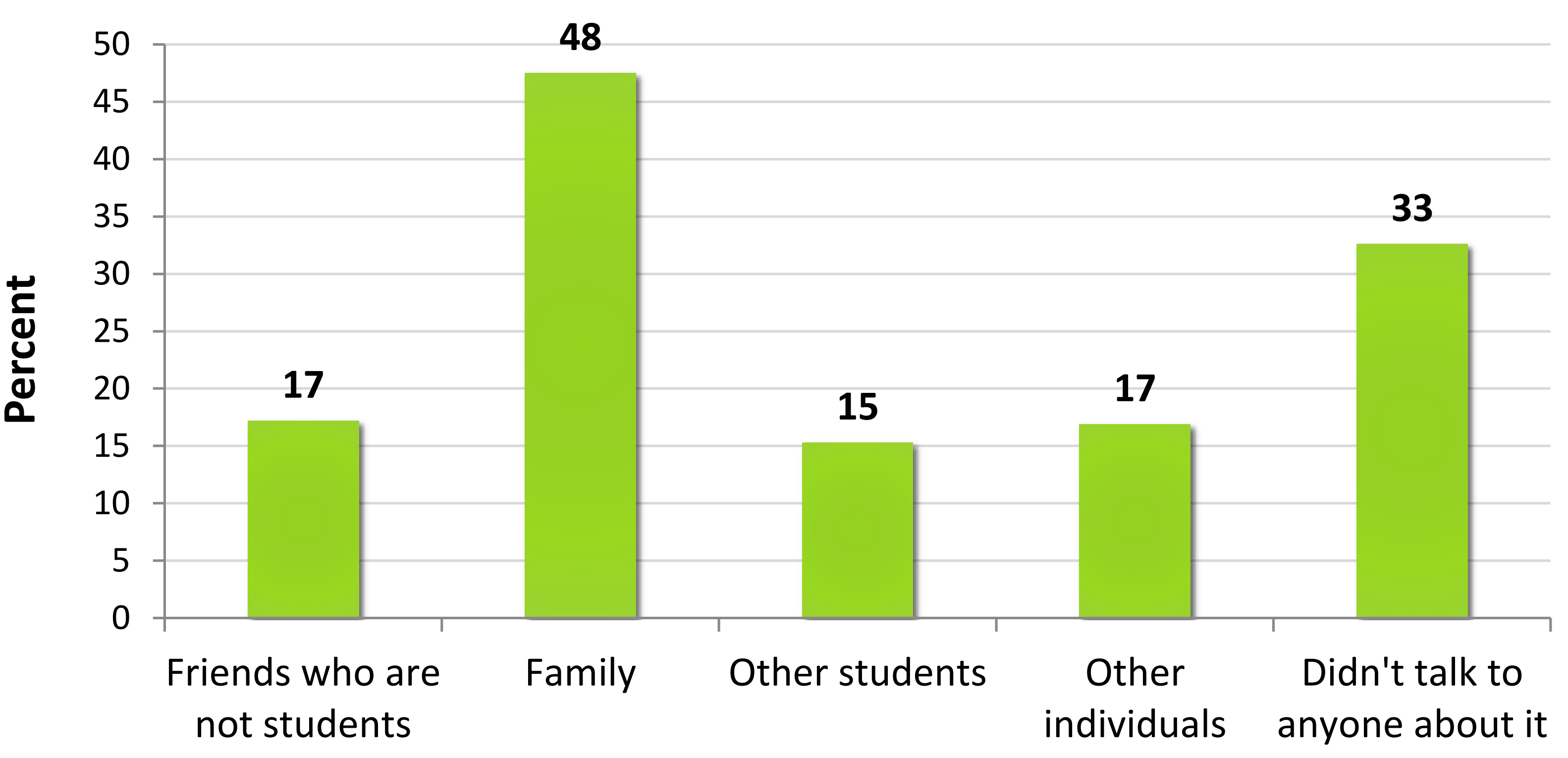
**Note:* Data from CSU Health Insurance Education Poll conducted in Spring 2014. Seven CSU campuses were surveyed (n=1971).

2014: How many people signed up?

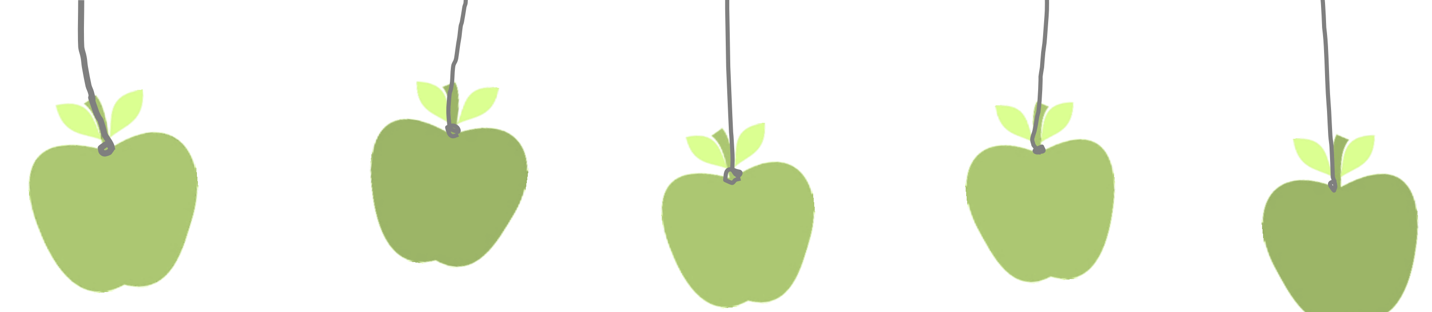


**Note:* Data from CSU Health Insurance Education Poll conducted in Spring 2014. Seven CSU campuses were surveyed (n=1971).

2014: Students talked to others about getting health insurance



**Note:* Data from CSU Health Insurance Education Poll conducted in Spring 2014. Seven CSU campuses were surveyed (n=1971).



State university systems as the low hanging fruit

- Middle to lower income populations
- Large numbers of uninsured students and families
- Unique access to students
- Trusted educators
- Students are reachable and educable

Almost all states have a state university system.

Additional information:

- For press release and data graphs, please visit **www.calstatela.edu** (under "*Recent News*")

- For any questions or follow-up, please contact Elena Stern (estern@calstatela.edu) or CSULA Office of Communications and Public Affairs at (323) 343-3050

Consumer Assistance Dataset

June 5, 2014 | Publisher: Robert Wood Johnson Foundation | Publication: Reform by the Numbers

Author(s): University of Pennsylvania

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 set includes variables tracking variation between states in terms of types of assistance available and the level of funding for each state in the first year of marketplace operations.

Funding for HIX 2.0, and the Consumer Assistance Dataset, was provided by the Robert Wood Johnson Foundation and the Alfred P. Sloan Foundation.

Note: If you are using the Consumer Assistance Dataset for research purposes please cite the dataset as follows: Baker, T.; Town, R. (2014): Health Insurance Exchanges 2.0 Dataset. Leonard Davis Institute of Health Economics, Wharton School, University of Pennsylvania. http://www.rwjf.org/en/research-publications/find-rwjf-research/2014/03/hix-2-0/consumer-assistance-dataset.html

The Consumer Assistance Dataset was last updated on 6/11/14.

The creation of the datasets is a work in progress. We welcome your suggestions. Please contact Gabbie Nirenburg at gni@wharton.upenn.edu with any questions, comments, or ideas for improvement in the datasets. The datasets are regularly updated and we will attempt to incorporate your comments.

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

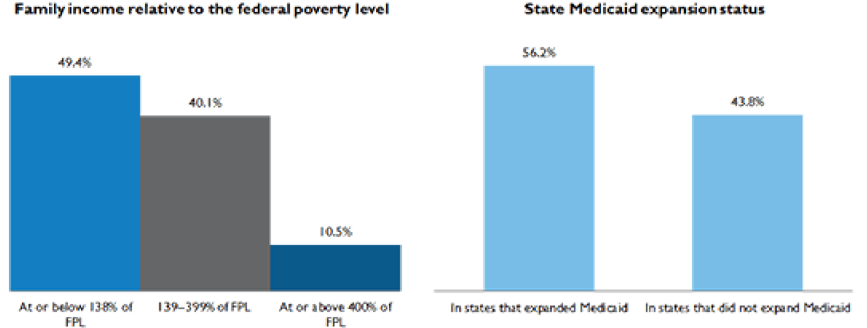
© 2001–2014 Robert Wood Johnson Foundation. All Rights Reserved.

Download Dataset (XLSX file format)

HEALTH REFORM MONITORING SURVEY

URBAN INSTITUTE Health Policy Center

POLICY BRIEFS QUICK TAKES DATA TABLES SURVEY INSTRUMENTS FAQ ABOUT



AT A GLANCE

- Most newly insured adults are in the income groups targeted by the ACA's Medicaid expansion and the Health Insurance Marketplace subsidies.
- Newly insured adults tend to be younger than adults who had coverage for the full year; however, they are more likely to report fair or poor health than full-year insured adults.
- Newly insured adults often lack a strong connection to the health care system; many do not have a usual source of care and have not had a routine checkup in the past year.

Who Are the Newly Insured as of Early March 2014?

Adele Shartzer, Sharon K. Long, and Stephen Zuckerman

May 22, 2014

In May 2014, the US Department of Health and Human Services (HHS) announced that enrollment in health plans through the health insurance Marketplaces had exceeded 8 million people, with 5.4 million people signing up through the federal Marketplace and another 2.6 million enrolling through state-based Marketplaces. Estimates suggest that another 5 million people purchased Affordable Care Act (ACA)-compliant plans outside the Marketplaces (HHS 2014). The Centers for Medicare and Medicaid Services (CMS) report that total Medicaid and CHIP enrollment increased by an estimated 4.8 million people between October 2013 and March 2014 relative to the July–September 2013 period (CMS 2014). Although some of these individuals may already have had coverage, data from multiple sources suggest that the uninsured rate declined rapidly in early 2014 (Carman and Eibner 2014).[1] For example, Long and colleagues report a 2.7 percentage-point drop in uninsurance between September 2013 and early March 2014, representing a gain in coverage for about 5.4 million people.[2]

Knowledge about the characteristics of these newly insured individuals provides an early assessment of how well the different components of the ACA are working at expanding coverage as of early March. Further, information on the health needs and health care experiences of newly insured individuals is important for understanding their likely health care demands as they gain coverage, along with their potential effect on the risk pools in private and public insurance programs.

What We Did

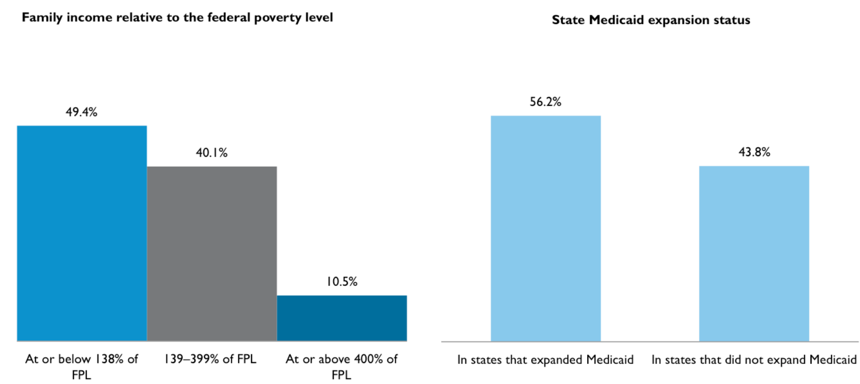
This brief draws on data collected in the March 2014 wave of the Health Reform Monitoring Survey (HRMS). We examine the demographic characteristics and health status of the newly insured, whom we define as those who have gained coverage within the past 12 months and were uninsured just before enrolling in their current coverage. We compare them to those who already had coverage for the whole previous 12-month period (whom we refer to as the "full-year insured"), and provide some information on those who are uninsured at the time of the March 2014 survey (the "remaining uninsured").[3]

It is important to note several things about these data. First, the newly insured group includes those who gained Medicaid or CHIP as well as those who gained private coverage through an employer or the Marketplaces.[4] Second, because 80 percent of the March 2014 HRMS sample had completed the survey by March 6, these estimates do not capture the characteristics of adults who enrolled in a Marketplace plan during the enrollment surge in late March and early April, which increased enrollment by about 3.8 million (HHS 2014). Our definition of "newly insured" restricts the population to those with coverage changes within the previous 12 months (i.e., since March 2013), and so we miss any previously uninsured people who gained coverage under ACA changes that occurred before 2013 (such as the ability to keep dependents on a parent's health plan until age 26 and early state Medicaid expansions). Finally, small sample sizes for some subgroups within the newly insured population limit the analyses that are possible with a single quarter of data. We plan to provide more in-depth analyses of the uninsured in the future by pooling multiple quarters of the HRMS.

What We Found

Most of the newly insured adults are in the income groups targeted by the ACA's Medicaid expansion and the health insurance Marketplaces. Nearly half of the newly insured adults (49.4 percent) have family incomes at or below 138 percent of the federal poverty level (FPL), the income group targeted by the Medicaid expansion (figure 1). Another 40.1 percent have family income between 139 and 399 percent of FPL, the income group that could be eligible for subsidized coverage through the Marketplace. Only 10.5 percent of the newly insured adults have family income at or above 400 percent of FPL.

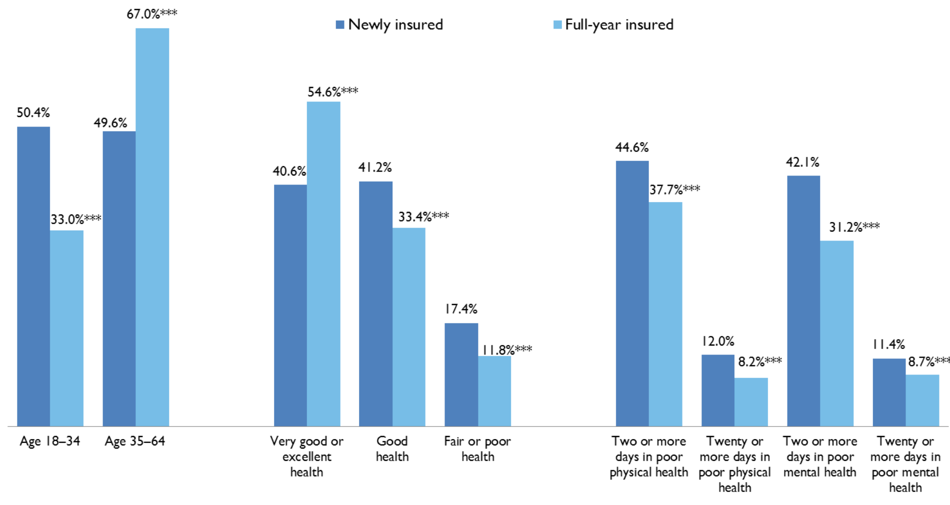
Figure 1. Share of Newly Insured Adults by Family Income Categories and State Medicaid Expansion Status



Source: Health Reform Monitoring Survey, quarter 1 2014.
Notes: Newly insured are those who changed coverage within the past 12 months and were uninsured just before enrolling in their current coverage; it includes those with Medicaid, employer-sponsored insurance, and private nongroup coverage. Of the newly insured, 32.3 percent were insured none of the previous 12 months, 31.9 percent were insured 1–5 months, and 33.5 percent were insured 6–11 months. Full-year insured have had the same type of coverage for the whole12-month period before the survey.

Consistent with the strong gain in coverage among the population targeted by the Medicaid expansion, the majority of the newly insured adults (56.2 percent) are in the states that expanded Medicaid under the ACA. Despite the gain in coverage for low-income adults, however, the majority of the remaining uninsured are also in this low-income group in both the Medicaid expansion states and in the nonexpanding states, at 58.7 percent with family income at or below 138 percent of FPL in the Medicaid expansion states and 68.9 percent in the nonexpanding states (data not shown).

Figure 2. Age and Self-Reported Health Status of Newly Insured and Full-Year Insured Adults (Age 18–64)

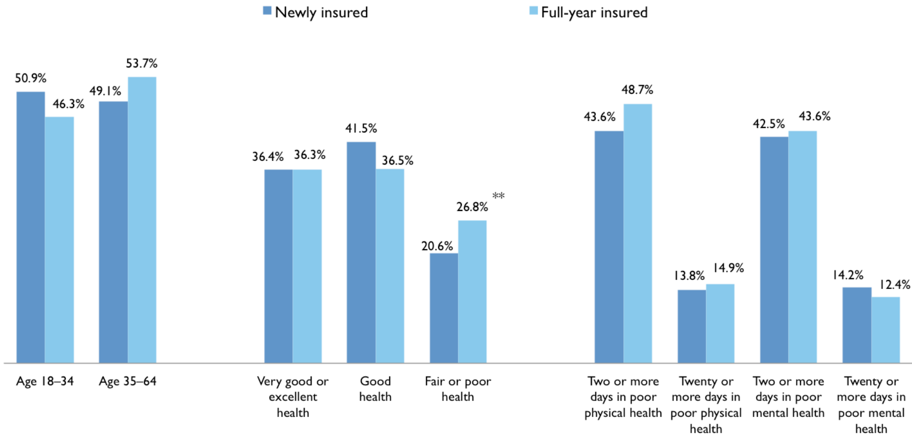


Source: Health Reform Monitoring Survey, quarter 1 2014.
Notes: Newly insured are those who changed coverage within the past 12 months and were uninsured just before enrolling in their current coverage; it includes those with Medicaid, employer-sponsored insurance, and private nongroup coverage. Of the newly insured, 32.3 percent were insured none of the previous 12 months, 31.9 percent were insured 1–5 months, and 33.5 percent were insured 6–11 months. Full-year insured have had the same type of coverage for the whole12-month period before the survey.
*** Estimate differs significantly from the newly insured at the 0.01 level, using a two-tailed test. No estimates differ significantly at the 0.10/0.05 (*/**) levels.

The newly insured adults tend to be younger than adults who had coverage for the full year (50.4 percent versus 33.0 percent under age 35); however, they are more likely to report fair or poor health than full-year insured adults (17.4 percent versus 11.8 percent).[5] While 81.8 percent of the newly insured are in good, very good, or excellent health, about 1 in 5 newly insured adults is in fair

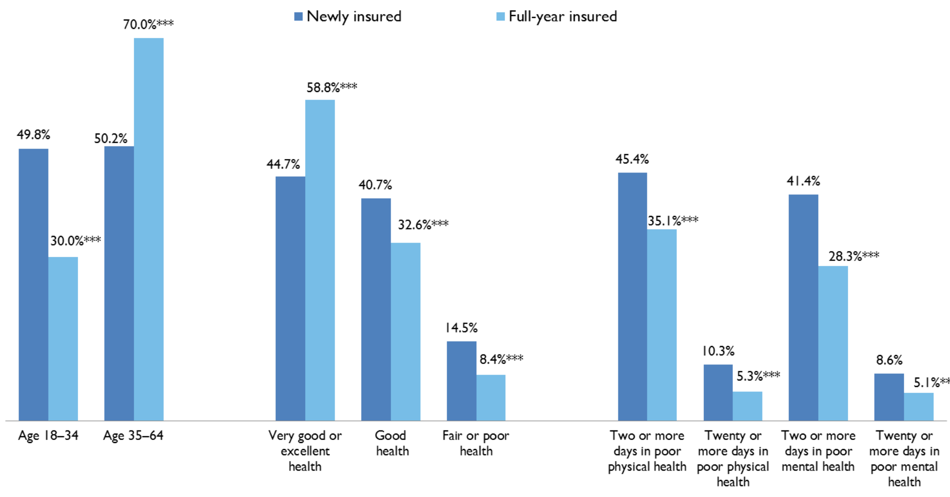
or poor health. The newly insured adults are also more likely than adults who had coverage for the full year to report days with poor physical and mental health, a measure of health-related quality of life (figure 2). However, when we focus on the population targeted by the Medicaid expansion (family income at or below 138 percent of FPL), we find that newly insured low-income adults are less likely than the full-year insured adults in that income range to be in fair or poor health (figure 3). However, among adults with family incomes above 138 percent of FPL, we find the newly insured are more likely than the full-year insured to be in fair or poor health and to report having days in poor physical or mental health (figure 4). Thus, while the newly insured overall may have higher health care needs than all adults with full-year coverage, that is not the case among adults within the target populations for the Medicaid expansion.

Figure 3. Age and Self-Reported Health Status of Newly Insured and Full-Year Insured Adults Age 18–64 with Family Income at or below 138% of FPL



Source: Health Reform Monitoring Survey, quarter 1 2014.
Notes: Newly insured are those who changed coverage within the past 12 months and were uninsured just before enrolling in their current coverage; it includes those with Medicaid, employer-sponsored insurance, and private nongroup coverage. Of the newly insured, 32.3 percent were insured none of the previous 12 months, 31.9 percent were insured 1–5 months, and 33.5 percent were insured 6–11 months. Full-year insured have had the same type of coverage for the whole12-month period before the survey.
** Estimate differs significantly from the newly insured at the 0.05 level, using a two-tailed test. No estimates differ significantly at the 0.10/0.01 (*/***) levels.

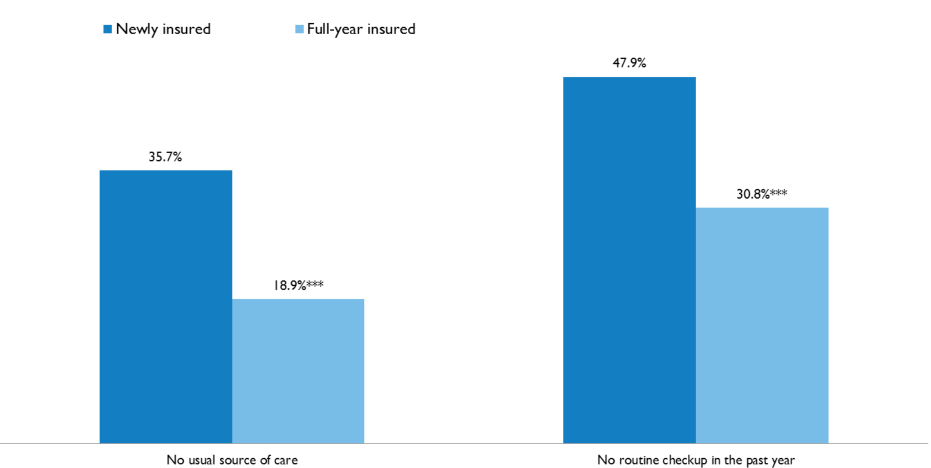
Figure 4. Age and Self-Reported Health Status of Newly Insured and Full-Year Insured Adults (Age 18–64) with Family Income above 138% of FPL



Source: Health Reform Monitoring Survey, quarter 1 2014.
Notes: Newly insured are those who changed coverage within the past 12 months and were uninsured just before enrolling in their current coverage; it includes those with Medicaid, employer-sponsored insurance, and private nongroup coverage. Of the newly insured, 32.3 percent were insured none of the previous 12 months, 31.9 percent were insured 1–5 months, and 33.5 percent were insured 6–11 months. Full-year insured have had the same type of coverage for the whole12-month period before the survey.
/* Estimate differs significantly from the newly insured at the 0.05/ 0.01 level, using two-tailed tests. No estimates differ significantly at the 0.10 (*) level.

The newly insured adults often lack a strong connection to the health care system; more than a third (35.7 percent) did not have a usual source of care at the time of the survey. Further, almost half (47.9 percent) reported that it has been a year or more since their last routine checkup. These levels are much higher than those reported for full-year insured adults, at 18.9 percent without a usual source of care and 30.8 percent without a routine checkup in the previous year (figure 5).

Figure 5. Gaps in Health Care Access and Use among Newly Insured and Full-Year Insured Adults (Age 18 to 64)



Source: Health Reform Monitoring Survey, quarter 1 2014.
Notes: Newly insured are those who changed coverage within the past 12 months and were uninsured just before enrolling in their current coverage; it includes those with Medicaid, employer-sponsored insurance, and private nongroup coverage. Of the newly insured, 32.3 percent were insured none of the previous 12 months, 31.9 percent were insured 1–5 months, and 33.5 percent were insured 6–11 months. Full-year insured have had the same type of coverage for the whole 12-month period before the survey.
*** Estimate differs significantly from the newly insured at the 0.01 level, using a two-tailed test. No estimates differ significantly at the 0.10/0.05 (*/**) levels

What It Means

As the first open enrollment period in the health insurance Marketplaces began its last month, data from the March HRMS suggests that many of those who gained coverage were within the ACA target populations for the Medicaid expansion and Marketplace subsidies. Nearly half of the newly insured have family income below 138 percent of FPL, the income range targeted by the Medicaid expansion in the 24 states (plus the District of Columbia) that implemented a coverage expansion by April 1, 2014.[6] Another 40 percent have family income in the range that could qualify them for subsidized coverage through the Marketplace. Thus, both of the key components of the ACA that were implemented in early 2014 played a role in expanding coverage.

Nonetheless a large share of the adults who remained uninsured in March (64.7 percent) also fall within the target population for the Medicaid expansion. While the gains in coverage for low-income adults have been impressive for the states that expanded Medicaid, the high share of the remaining uninsured with family income at or below 138 percent of FPL in those states highlights the continued need for outreach to enroll more of the adults who are eligible under the Medicaid expansion. This should be the priority group for state outreach and education efforts for most of 2014, because most higher-income adults cannot enroll through the Marketplace until the next open enrollment period in November.[7] In states that had not expanded Medicaid, there are few coverage options for the remaining uninsured with low family incomes.

Expanded insurance coverage under the ACA is just the first step toward improved access to and use of health care, with the long-term goal of improving health status. The findings here highlight challenges faced by the newly insured and the health plans and providers that serve them. Although most of the newly insured are in good or better health, roughly 1 in 5 are in fair or poor health, and more than half report poor health days due to either physical or mental health issues. Yet, even with these high levels of health care needs, only about a third of the newly insured have a usual source of care and only about half had a routine checkup in the past year. Helping the newly insured form connections with primary care providers and obtain the care that they need in the appropriate settings is the next step in moving from coverage to care. Making that transition may be difficult as the newly insured, particularly the newly insured who have not had health insurance before, may need help learning how to access care through their coverage (Decker et al. 2012; Taubman et al. 2014).

References

Carman, K., and C. Eibner. 2014. Changes in Health Insurance Enrollment since 2013. Santa Monica, CA: RAND.

Centers for Medicare and Medicaid Services. 2014. Medicaid & CHIP: March 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report. Washington, DC: US Department of Health and Human Services.

Decker, S. L., J. A. Doshi, A. E. Knaup, and D. Polsky. 2012. "Health Service Use among the Previously Uninsured: Is Subsidized Health Insurance Enough?" Health Economics 21(10): 1155–68.

Taubman, S., H. Allen, B. Wright, K. Baicker, and A. Finkelstein. 2014. "Medicaid Increases Emergency Department Use: Evidence from Oregon's Health Insurance Experiment." Science 343(6168): 263–268.

US Department of Health and Human Services (HHS). 2014. Enrollment in the Health Insurance Marketplace Totals over 8 Million People. Washington, DC: HHS.

About the Series

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

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

About the Authors

Adele Shartzer is a research associate, Sharon Long is a senior fellow, and Stephen Zuckerman is a senior fellow and codirector in the Urban Institute's Health Policy Center.

The authors gratefully acknowledge the suggestions and assistance of Dana Goin, Michael Karpman and Katherine Hempstead.

Note

---

[1] See also "US Uninsured Rate Drops to 13.4%," Gallup, May 5, 2014.

[2] Long, Sharon K., Genevieve M. Kenney, Stephen Zuckerman, Douglas Wissoker, Dana Goin, Katherine Hempstead, Michael Karpman, and Nathaniel Anderson. "Early Estimates Indicate Rapid Increase in Health Insurance Coverage under the ACA: A Promising Start." Washington, DC: Urban Institute, 2014.

[3] In this brief, comparisons between the newly insured, full-year insured, and remaining uninsured are not adjusted for age, gender, or other demographic characteristics. Among the newly insured, 32.3 percent were insured none of the previous 12 months, 31.9 percent were insured 1–5 months, and 33.5 percent were insured 6–11 months.

[4] By definition, the newly insured excludes those who had coverage before enrolling in Medicaid or health plans through Marketplaces.

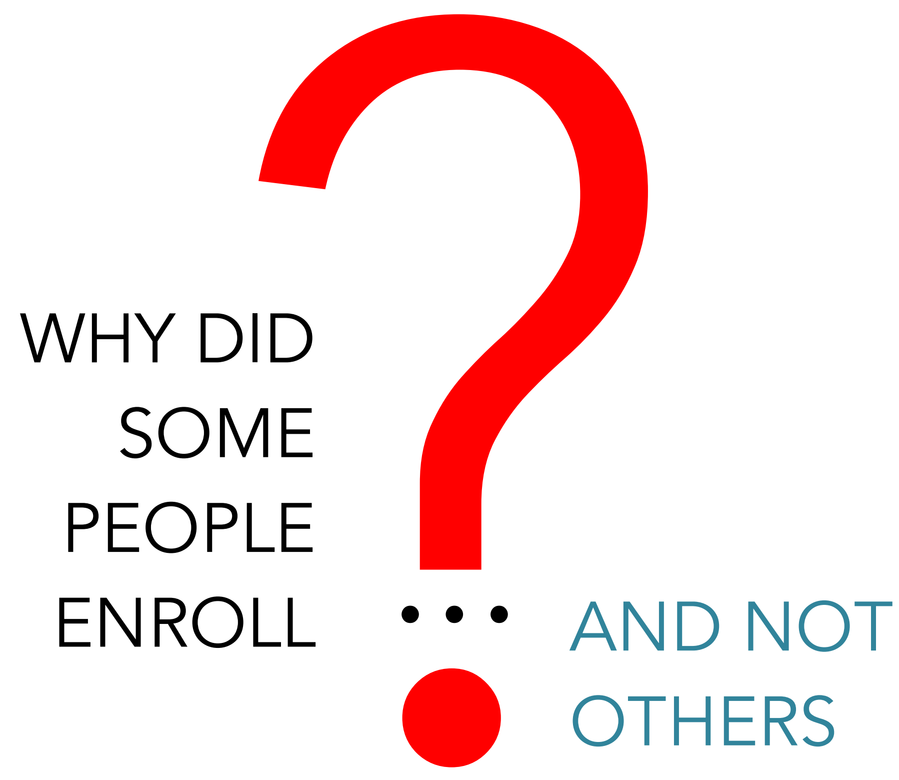
[5] April 2014 estimates from HHS find that 28 percent of enrollees in health plans through the Marketplace were under age 35; our definition of newly insured differs from the population in the HHS report in important ways that could contribute to the different age distributions. For example, we include in the newly insured adults with Medicaid and ESI, and the HHS estimates include those who may have had coverage prior to enrolling in health plans through the Marketplace.

[6] Two states elected to expand Medicaid coverage but had not implemented the expansion as of April 1, 2014.

[7] Special enrollment periods in Marketplace health plans are possible if an individual experiences a qualifying life event, such as a move to another state or a change in income or family size.

© 2013 Urban Institute | Contact Us | Privacy Policy |

THE AFFORDABLE CARE ACT'S FIRST ENROLLMENT PERIOD



May 21, 2014 A new survey for Enroll America, conducted by PerryUndem Research/Communication and funded by the Robert Wood Johnson Foundation and The California Endowment, provides fresh insights into why some individuals enrolled in health coverage during the Affordable Care Act's first open enrollment period and why some individuals did not.

The survey, conducted April 10-28, 2014, among 671 newly enrolled individuals and 853 who remained uninsured, is the first in-depth examination of these populations and explores their attitudes, knowledge, and experiences with enrollment, costs, and health coverage.

Key Findings

There was a high demand for health insurance during the Affordable Care Act's first open enrollment period. Those who enrolled were willing to put time and effort into the process.

Those who enrolled had more information. For example, the newly enrolled were more than twice as likely to know about the availability of financial help to low- and moderate-income people than those who did not enroll (56% vs. 26%).

Individuals enrolled for many reasons, particularly the law/fine. As many as 40% indicate they might not have enrolled without the mandate. Other important motivations: being able to see a doctor and avoid big medical bills.

Many newly enrolled individuals felt enrolling was easy – but others faced difficulties. While 69% of the newly enrolled thought enrolling was "easy," some of those who tried but did not enroll successfully found it confusing.

Three-quarters (74%) of the newly enrolled feel confident they can afford their premiums. They are also more than four times as likely to say their plans have enough doctors than not (56% vs. 13%).

Healthy people enrolled. The self-reported health status of those who enrolled and those who did not was similar.

Most of those who did not enroll (61%) wanted coverage. They wanted to enroll but could not find anything or say things got in the way of enrolling. Fifteen percent did not even know they could enroll. Only 15% did not want coverage.

Affordability concerns kept many away. The top reason why some people did not even look for coverage was the perception that they could not afford insurance.

Latinos and young adults (18-29) lagged behind in knowledge but wanted coverage. Latinos particularly valued in-person enrollment assistance. Young adults were more motivated by the fine than others.

More than eight in ten of the uninsured (84%) may be open to enrolling next time. Only 14% say they will not look for coverage.

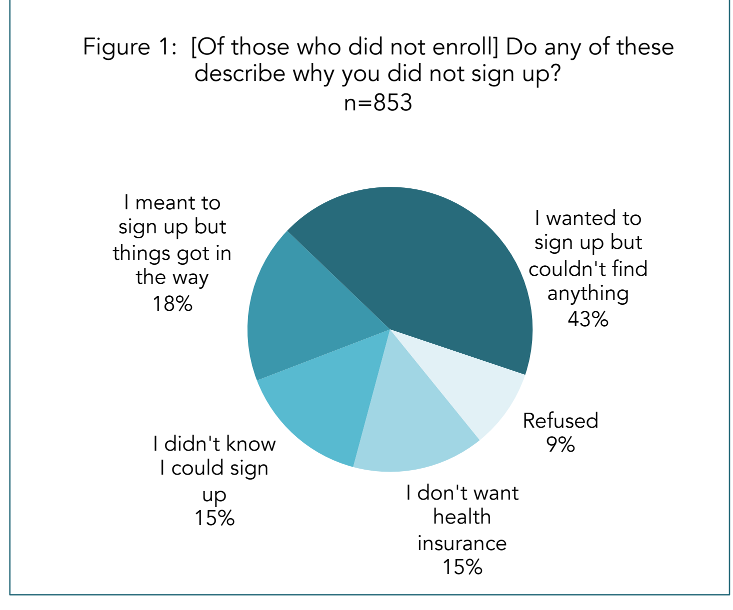
Detailed Findings

The Uninsured Want Health Insurance.

There was high interest in enrolling in health coverage.

A number of survey findings reveal that people wanted health coverage during the Affordable Care Act's first open enrollment period. Those who enrolled put time and effort into the process, suggesting health coverage was important to them. Six in ten (60%) of the newly enrolled spent more than a week on the process from beginning to end; 55% of those who went to the marketplace website visited it more than three times while enrolling; and 37% spent four or more hours looking at plans and signing up for insurance.

Six in ten of those who did not enroll wanted coverage. A clearer picture of interest emerges when looking at those who did not enroll during the first enrollment period. Sixty-one percent wanted coverage but either could not find anything (43%) or things got in the way of signing up (18%). Fifteen percent (15%) did not even know they could enroll. Only 15% said they did not enroll because they did not want insurance. [Figure 1]



Box 1: Enrollment Efforts by the Thirty-Five Percent Who Tried to Enroll but Were Unsuccessful (n=345)

- ✓ 59% looked to see if they qualified for financial help
- ✓ 56% looked at the plans that were available
- ✓ 52% tried to get answers to questions
- ✓ 44% started an application
- ✓ 36% created a user account with a password
- ✓ 26% called the customer service number for help

Even many of those who did not successfully enroll spent time on the process. One-third (35%) report they looked for insurance during the open enrollment period. Many of these individuals took multiple steps to enroll. [Box 1]

Many plan to get insurance during the next open enrollment period.

Near the end of the survey, those who did not enroll were asked if they are likely to sign up for insurance for next year if they are still uninsured. Half read details about the mandate and the fine before answering, while the other half did not. The statement that half read is as follows:

Most people who did not sign up for insurance by March 31st, 2014 will have to pay a fine. The fine will be $95 or 1% of your income – whichever is higher. The fine goes up every year. By 2016, the fine will be $695 or 2.5% of your income, whichever is higher.

As many as 84% seem open to enrolling. Regardless of whether they read details of the mandate or not, most of those who did not enroll seem open to applying next time. Specifically, four in ten (42%) said they would "definitely" or "probably" get insurance for next year if they are still uninsured and another four in ten are not sure (42%). Only 14% say they will "probably" or "definitely" not apply. [Table 1]

Table 1: Do you think you will get insurance for next year if you are still uninsured?

	Total	*Received Mandate Details n=446*	*Did Not Receive Mandate Details n=407*
Definitely	16%	20%	12%
Probably	26%	23%	30%
I'm not sure	42%	41%	43%
Probably not	7%	6%	9%
Definitely not	7%	9%	5%

Learning about the mandate and the increasing fine increases intensity around enrolling. Those who read about the mandate and the increasing fine were more likely to say they will "definitely" get insurance next year than those who were not exposed to this information (20% vs. 12%).

African Americans (48%) and Latinos (46%) are more likely than others to say they will "definitely" or "probably" enroll next year. Other groups more likely to enroll next year: the college-educated (49%), employed individuals (49%), and 45-64 year olds (48%).

Knowing Is Half the Battle.

There are knowledge gaps between those who enrolled and those who did not.

Those who enrolled knew more. The survey probed knowledge about key issues related to the marketplace, the law, and enrollment. Two insights emerge when looking at responses to these questions: 1) there is a widespread lack of awareness about some important facets of the law that could have impacted decisions about enrollment, and 2) those who enrolled knew more than those who did not. Table 2 provides examples of the knowledge gap.

Table 2: Knowledge Differences between the Newly Enrolled and Those Who Did Not Enroll

	Newly Enrolled n=671	*Did Not Enroll n=853*
Knew the law gives financial help/tax subsidies to low- and moderate-income Americans	56%	26%
Knew that there is free in-person help with signing up for health insurance	43%	28%
Knew that the health law required plans to cover preventive care for free	41%	24%
Knew that health plans cannot deny people coverage based on pre-existing conditions	67%	42%
Knew the health law says most people have to pay a fine if they do not get insurance	84%	69%

There was lack of awareness of exceptions for life-changing events. Sixty-three percent of those who enrolled and 80% of those who did not enroll were unaware that the health law allows people to sign up any time during the year if they have a life-changing event like getting married or having a baby. This is an issue relevant now for those who may be looking for insurance and where additional education could be helpful.

There also are knowledge gaps when it comes to insurance terminology. Frequently used terms in marketplace marketing such as "premium" and "open enrollment" are understood by less than half of those who did not enroll. [Table 3]

Table 3: Do you know what each of these terms mean?

	Newly Enrolled N=671 "Yes"	*Did Not Enroll N=853 "Yes"*
Open enrollment	69%	47%
Deductible	76%	56%
Co-pay	80%	63%
Premium	70%	48%
Out-of-pocket maximum	71%	48%

News was the top source of information. "News" was the main way many learned about new insurance options and HealthCare.gov for

both the newly enrolled (39%) and those who did not enroll (44%). Websites/online searches were also important information sources (newly enrolled 36%/those who did not enroll 23%). Finally, friends and family were a valued resource (newly enrolled 21%/those who did not enroll 21%).

Local TV news was a top source. Survey respondents who said that "news" was a main source of information were asked to identify their top news sources. In response, they were most likely to say local television news (newly enrolled 42%/those who did not enroll 49%), national/cable television news programs (newly enrolled 25%/those who did not enroll 27%), and online news sources (newly enrolled 19%/those who did not enroll 15%).

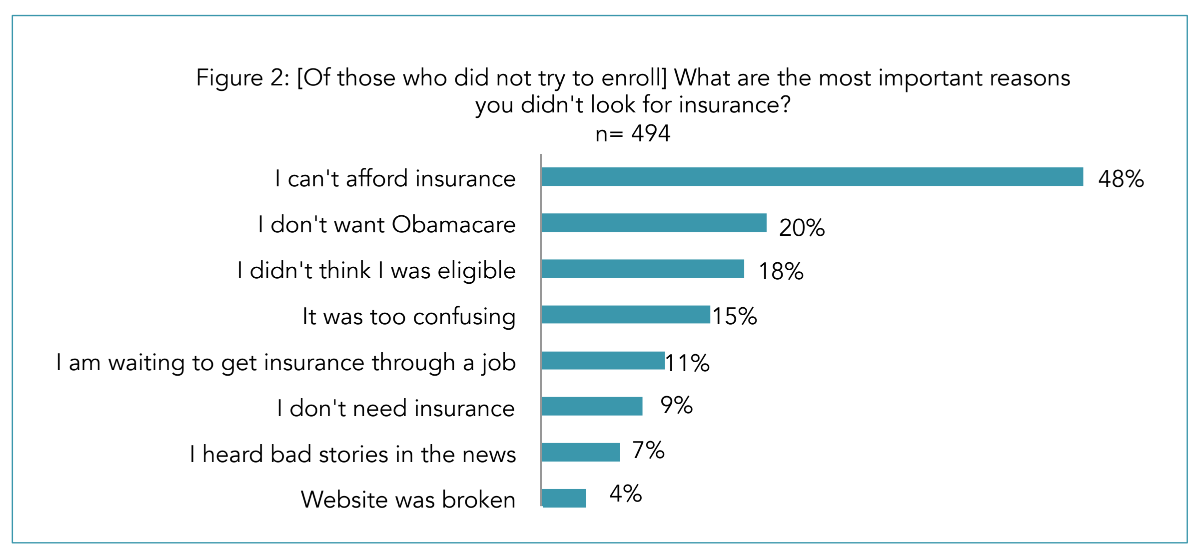
Advertising had an impact on knowledge levels. Individuals who saw or heard ads about new health coverage options, including HealthCare.gov or their state marketplace, knew more about the law and enrollment than those who did not see or hear ads. They were more likely to have heard of HealthCare.gov, for example, or know about financial help/the tax subsidy.

Affordability worries kept many from taking a first step.

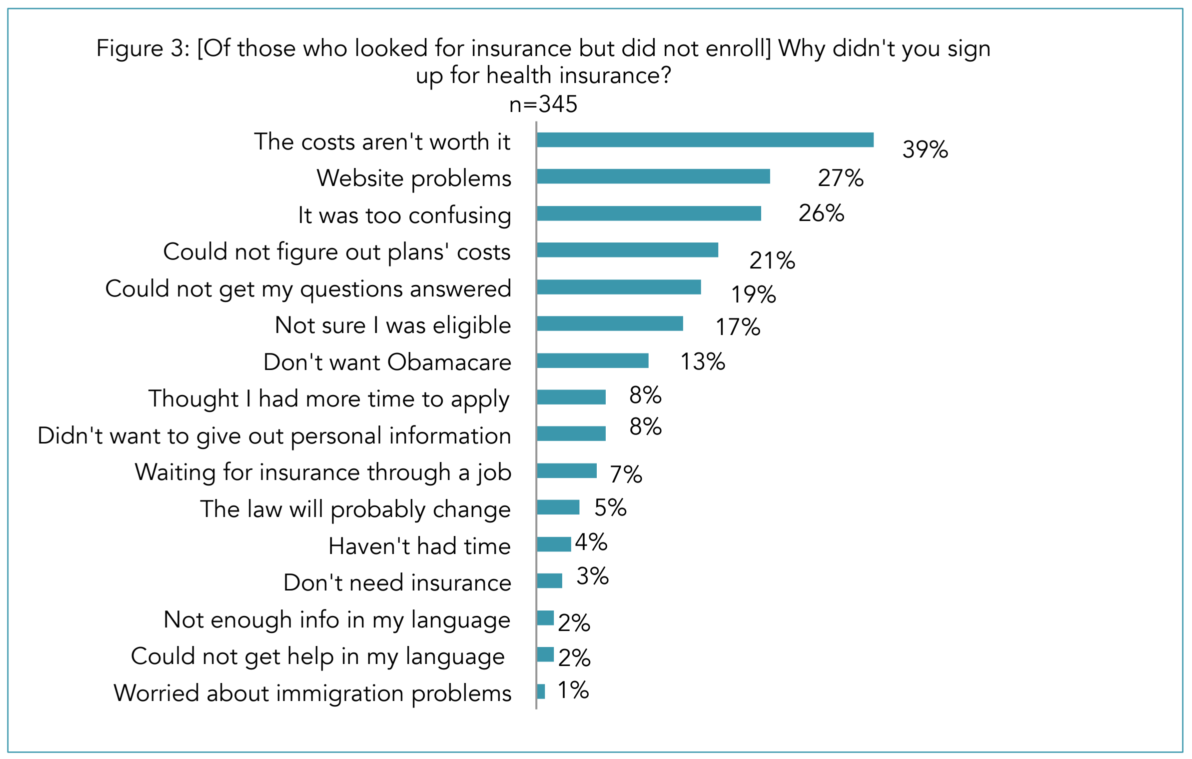
The survey identifies two groups of individuals who did not enroll in health coverage: those who did not look for insurance during open enrollment (63%) and those who tried but were unsuccessful (35%). For both, cost concerns were the main barrier.

Perceptions they could not afford insurance kept many from looking. Looking specifically at those who did not try to enroll, a perception that they could not afford insurance was by far the top barrier that kept them from taking the first step toward enrollment. Of note, fewer than 1 in 10 (9%) said that the reason they did not look for insurance was that they do not need insurance. [Figure 2]

Not knowing about available financial help may have affected affordability perceptions. It is noteworthy that only one in five (21%) of those who did not try to enroll knew that financial help/a tax subsidy was available to most low- and moderate-income people (while 38% of those who tried to enroll knew this information). Knowing this information may have mattered in whether or not someone took a first step to enroll, particularly since affordability was the top barrier to even looking for coverage.



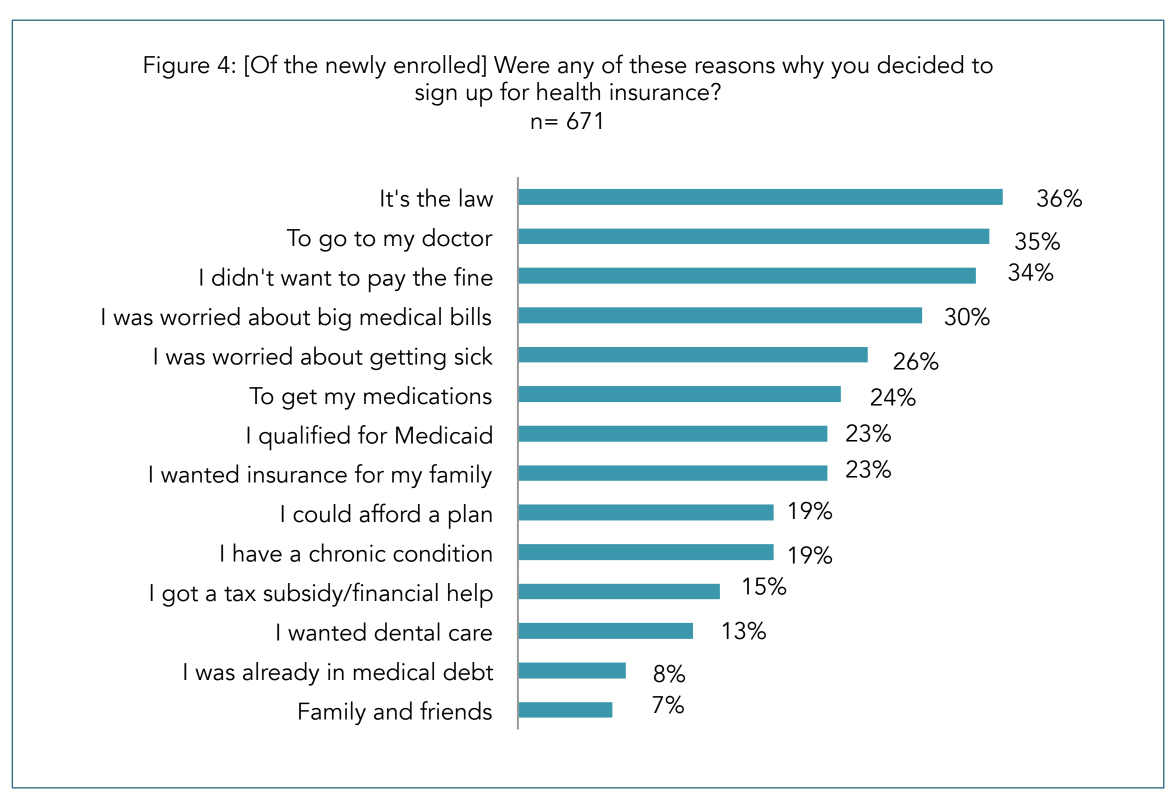
Cost was also a top barrier for those who looked for insurance. For those who looked for insurance but were not successful, costs (39%), website problems (27%), and confusion about enrollment (26%) were top reasons given for not enrolling. The "website problems" barrier is likely more about overall confusion and frustration with the website and less about technical glitches with the website. [Figure 3]



The Law and Opportunity Drove Enrollment.

Many factors influenced enrollment decisions – the mandate, wanting access to care, and wanting to avoid medical bills.

The newly enrolled weighed many factors when making decisions about enrollment. When asked why they decided to sign up for health insurance – and allowed to select multiple responses – the law and wanting to see their doctor come out on top followed by the fine and avoiding medical bills. [Figure 4]

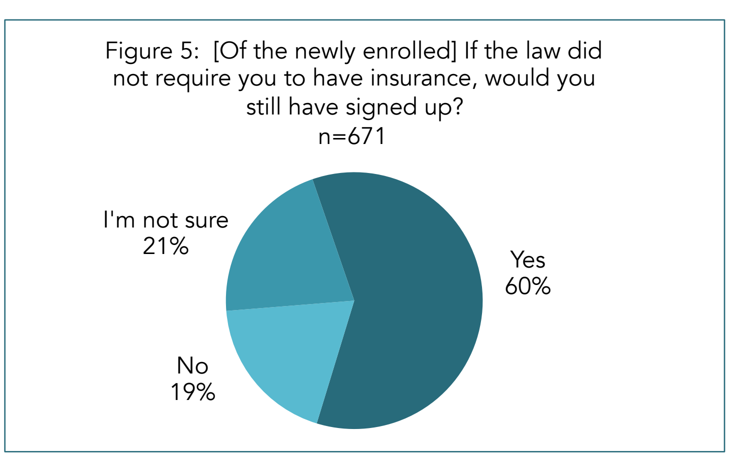


Of note, wanting to access health services was an important motivation to enroll. This not only includes wanting to see a doctor (35%) but also wanting to get care when sick (26%) and being able to get medications (24%). Of note, accessing care seemed more important to women than men: women were more likely than men to say they enrolled because they wanted to go the doctor (40% vs. 30%).

Avoiding the fine was more important to young adults (18-29) while the "law" mattered more to Latinos and older adults (45-64). Young

adults (18-29 years old) were more likely to say “avoiding the fine” was a reason they enrolled (42%). Similarly, Latinos (42%) and people ages 45-64 (41%) were more likely to say a reason they enrolled was because “it’s the law.”

Four in ten might not have enrolled without the mandate. While six in ten of the newly enrolled (60%) report they would have signed up for insurance without the mandate, four in ten indicate they would not have enrolled (19%) or are unsure if they would have enrolled (21%) without the law. [Figure 5]



Access to Medicaid was critical for the newly enrolled. Of the newly enrolled, nearly one quarter (23%) cited "I qualified for Medicaid" as a reason they enrolled and over half of that population said it was the main reason.

Latinos and Youth: Interest Is There, but So Are Knowledge Gaps.

Latinos faced more barriers to enrollment.

Latino survey respondents show lower awareness levels of key aspects of the law. They were much less likely to know about the availability of financial help/tax subsidies or that health plans could not deny them because of pre-existing conditions. [Table 4]

The lower levels of awareness may be related to less recent experience with health insurance. More than seven in ten Latinos who enrolled in coverage (72%) were uninsured before signing up compared to 51% of whites and 65% of African Americans. Of those who did not enroll, Latinos were also more likely to have been uninsured for more than a year (Latinos 87%, whites 76%, and African Americans 71%).

Table 4: Knowledge Differences by Race	White n=896	Latinos n=341	African-Americans n-179
Knew the law gives financial help/tax subsidies to low- and moderate-income Americans	47%	25%	37%
Knew that there is free in-person help with signing up for health insurance	33%	37%	40%
Knew that the health law required plans to cover preventive care for free	35%	28%	28%
Knew that health plans cannot deny people coverage based on pre-existing conditions	64%	37%	51%
Knew the health law says most people have to pay a fine if they do not get insurance	82%	71%	68%

Latinos were more likely to say the process was confusing or be unsure about their eligibility. Like other individuals, the biggest reason Latinos did not look for coverage was the perception they could not afford it (Latinos 41%, whites 58%).[1] However, Latinos who did not look for coverage are more likely to say the process was too confusing (Latinos 20%, whites 9%) and to believe that they were not eligible (Latinos 26%, whites 7%).

Latinos were more likely to enroll in person. In terms of the enrollment process, Latinos who are newly enrolled stood out in being more likely to say they received in-person enrollment assistance than others (Latinos 34%, whites 12%) and much less likely to enroll online on their own (Latinos 30%, whites 57%), suggesting that in-person enrollment was important to this population. Latinos overall – both those who enrolled and those who did not – were more likely to know that free in-person assistance was available than white enrollees (Latinos 37%, whites 33%.

Latinos who did not enroll wanted or meant to get health coverage. They are just as likely as other groups to say that they wanted coverage but could not find anything or that they wanted coverage but things got in the way (Latinos 61%, whites 61% and African Americans 60%). Only 13% of Latinos who did not enroll said they did not want coverage. In terms of the next open enrollment period, 46% of Latinos say they are definitely or probably going to look for insurance.

[1] The sample size for African Americans was too small to compare for some questions.

Latinos and African Americans enrolled later in the enrollment period. Both African-American and Latino consumers went from 25% of enrollees in the first three months of open enrollment to 38% of enrollees in 2014.

The young knew less but wanted insurance.

Young adults (ages 18-29) were less aware about the specifics of the law and insurance terminology. For example, among enrolled individuals, only 45% of 18- to 29-year-olds knew of the availability of financial help/subsidies, compared with 63% of 30- to 44-year-olds, and 60% of 45- to 64-year-olds. Three in ten (30%) 18- to 29-year-olds knew that new plans now offered free preventive care – while more than 45% of older adults knew this. While nearly eight in ten (77%) knew about the fine, this still trails 30- to 44- (90%) and 45- to 64-year-olds (86%). Young adults also are less familiar with insurance terminology. While 60% knew what "deductible" means, older adults (30- to 44-year-olds 77%, 45- to 64-year-olds 87%) are much more familiar with the term.

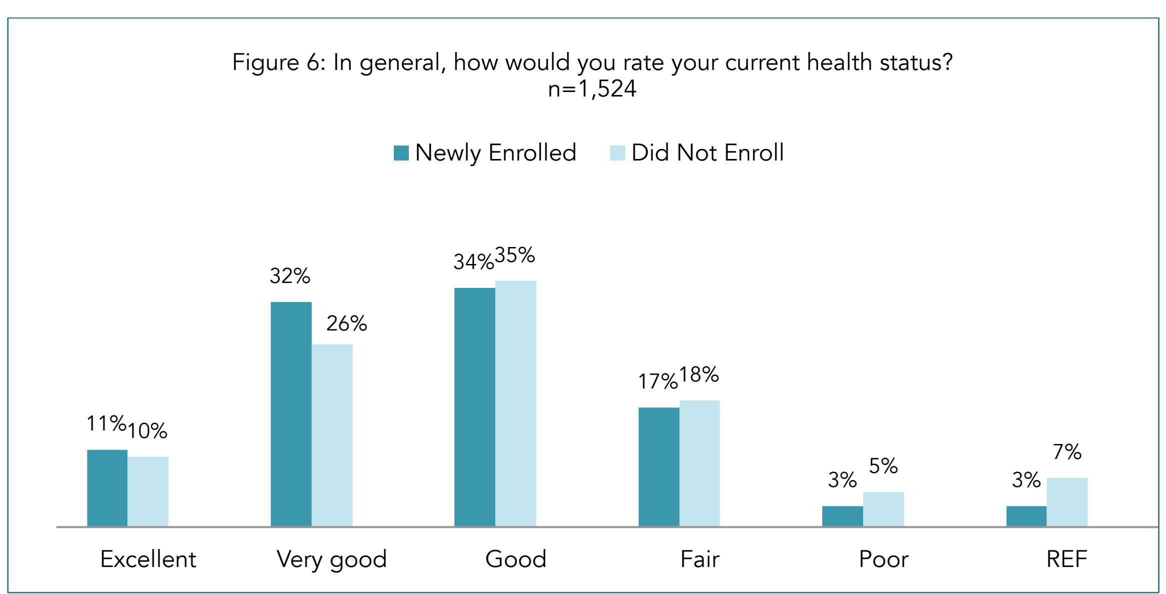
The mandate was a top motivator for young adults. Forty-two percent said they enrolled to avoid the fine and 32% said they enrolled because it was the law. Still, more than one-quarter of young adults enrolled because they wanted to go to the doctor (29%) or were worried about getting sick (25%).

More than half of young adults who did not enroll during open enrollment wanted coverage. Forty percent said they wanted to sign up but could not find anything and 18% said they meant to enroll but things got in the way. Only 17% of young adults said they did not want coverage. Looking ahead, 43% of uninsured 18-29 year olds say they will definitely or probably sign up for insurance next year.

The Healthy Want Insurance Too.

The healthy were just as likely to enroll in insurance.

The self-reported health status of those who enrolled looks similar to the self-reported health status of those who did not enroll. If anything, the newly enrolled are more likely to report their health is "very good" than those who did not enroll. While this is only self-reported health status, it questions the conventional wisdom that sicker individuals would be more motivated to enroll. [Figure 6]



Many Perceived Enrolling to Be "Easy," but Was It?

The majority described enrolling as "easy," including specific components of enrollment – but the process took time.

Half enrolled online on their own. The most common enrollment method for the newly enrolled was online on their own (52%), followed by telephone (20%), in person (18%), paper (14%) or some other way (9%). Men were more inclined to enroll online than women (57% vs 47%), while women were more likely to enroll over the phone (24% vs 15%).

Family and friends were key to enrollment. While 44% of the newly enrolled said that no one helped them in the process, one-third (33%) said a family member or friend helped them enroll. Others who provided help: insurance agents (13%), someone from a local organization who was trained to help them (10%), or a telephone customer service representative who worked at the marketplace (9%). Of note, "moms" were particularly important to the enrollment of young adults 18-29 (19% said "mom" helped them enroll).

The majority of the newly enrolled said enrolling was easy. The way they enrolled mattered on this question. Those who enrolled in person are most likely to say the process was easy (75%) while those who enrolled by phone were least likely to say this (59%). One-quarter to four-in-ten newly enrolled say the process was hard. [Table 5]

Table 5: [Of the newly enrolled) How easy or hard was it to sign up for health insurance? (n=671)

	Easy	*Hard*
Online	69%	31%
In-person	75%	25%
Phone	59%	41%
Paper Application	68%	32%
Other	72%	26%

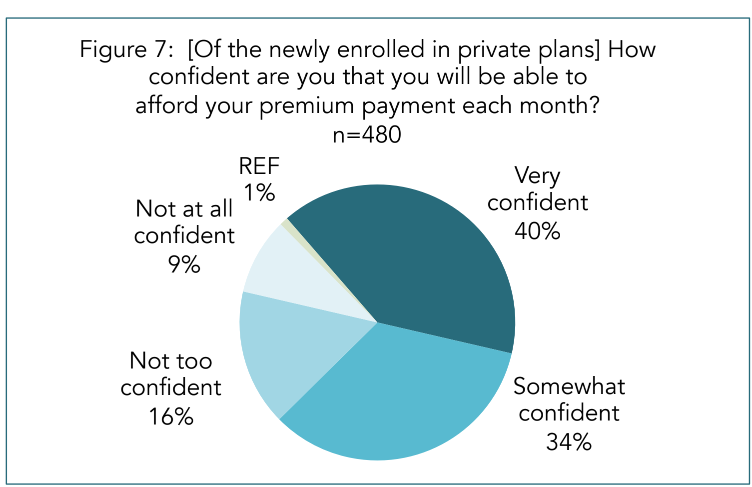
When asked about specific enrollment tasks, the majority of the newly enrolled also described them as "easy." Among the easier steps were proving their identity, calculating their income, figuring out their potential costs, and creating a user account with a password. Those steps deemed more difficult (although a majority still considered these tasks easy) include finding what doctors participated in plans, finding out what plans covered, choosing a plan, and figuring out next steps once they completed the process.

Those who did not successfully enroll may not agree the process was easy. In Figure 3 (p.6), reasons why individuals did not enroll suggest the process was hard for some: website problems (27%), it was too confusing (26%), could not figure out plans' costs (21%), and could not get my questions answered (19%).

How the Newly Enrolled Feel about Their Coverage.

The majority of private plan enrollees feel confident about paying their premiums.

Three-quarters are confident they can afford their monthly premiums. When it comes to paying premiums, the survey shows that 40% of the newly enrolled are very confident and 34% are somewhat confident they



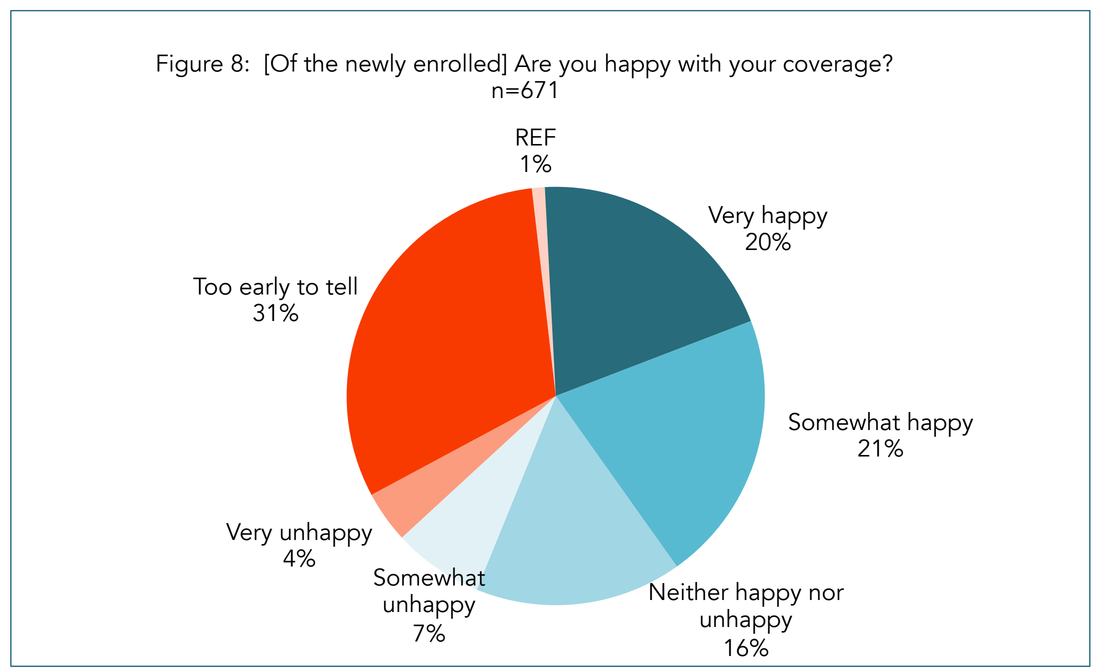
can afford their premiums. [Figure 7]

The newly enrolled in private plans are split on whether their premium amounts are more or less than expected. Thirty-one percent say their monthly premium is more than they expected, 25% say it is less than they expected, and 28% say it is about what they expected (15% are not sure). Those most likely to say their premium amount is higher than expected includes 30- to 44-year-olds (38%), college-educated individuals (37%), married individuals (36%), and those who are unemployed (35%).

There is low awareness that some may have to pay money back. A challenge for those newly enrolled in private plans is the low awareness of what happens if their income goes up during the year. The majority (54%) is unaware they may have to pay money back if their income goes up, while 22% believe they will have to pay money back and 23% believe they will not have to pay money back.

Most of those who have used their insurance have not faced access problems.

They are more likely to be happy than unhappy with their new plans. Those newly enrolled in private health plans or Medicaid who have been able to form an opinion are much more likely to feel "happy" about their new coverage (41%) than unhappy (11%). [Figure 8]



The newly enrolled feel "relief." The feeling that best expresses how the newly enrolled feel about having health insurance is "relieved" (47%), followed by "in control" (12%), "financially stressed" (12%), and "confused" (10%). Seventeen percent say having insurance "does not really affect me."

Few have faced access problems. While half of the newly enrolled have not yet used their coverage (49%), 42% report they have had no problems accessing care so far and 9% report they have faced problems.

The majority feels their plans have enough doctors. Fifty-six percent of the newly enrolled believe their plan has enough doctors and providers to choose from while 13% feel there are not enough doctors. Thirty percent are unsure still.

The newly enrolled plan to use their health care. Of note, the newly enrolled are more likely to be planning to use health care services in upcoming months than those who did not enroll in coverage. Specifically, in the next few months, the newly enrolled are more likely to say they will get a checkup (58% vs. 33%), pay for a prescription (32% vs. 18%), or see a specialist (23% vs. 6%).

How Medicaid Enrollees and Private Plan Enrollees Differ.

There Are Differences in When, How, and Why Medicaid Enrollees Signed Up for Coverage.

Of the newly enrolled in the survey, 69% signed up for a private plan and 31% enrolled in Medicaid.[2] There are a number of differences between these populations. For example, private plan enrollees were more likely to enroll at the end of the open enrollment period (i.e., March 1-April 15, 2013) than Medicaid enrollees (44% vs. 28%), who seem more dispersed in their enrollment. Likewise, private plan enrollees were more likely to enroll through HealthCare.gov or the state marketplace than Medicaid enrollees (67% vs. 34%).

Medicaid and private plan enrollees emphasized different enrollment methods. Private plan enrollees primarily enrolled online on their own (60%), followed by phone (23%), in person (13%), or by paper (8%). Medicaid enrollees also primarily enrolled online on their own (35%) but were much more likely to have

[2] Those enrolled in private plans are drawn from those who signed up for "marketplace" plans (72%) as well as people who purchased plans outside of the marketplace (28%).

enrolled through paper application (28%) or in person (27%). Only 13% said they enrolled by phone.

Half of Medicaid enrollees thought they would qualify when they applied. Fifty-two percent of those who enrolled in Medicaid thought they would qualify for the program when they started looking for insurance. However, 25% did not think they would qualify and 21% did not think about it either way.

There was also a difference in motivation. The top three reasons for private plan enrollees to sign up for coverage were to get insurance for their family, wanting to avoid the fine, and it is the law. For Medicaid enrollees, the top reasons to sign up were "I qualified for Medicaid," wanting to go to the doctor, and avoiding the fine.

Looking Forward

What lessons can be learned from the Affordable Care Act's first open enrollment period and how can enrollment be improved for the next one?

This survey adds to the growing body of knowledge about why some people enrolled in health coverage and why others did not enroll during the law's inaugural open enrollment period. It shows there was a high demand for health coverage, even among those who ultimately did not enroll. It identifies knowledge and perception barriers to enrollment, which may be hard to overcome. But perhaps most critical, the survey suggests there could be a large consumer market for the next open enrollment period – 84% of uninsured survey respondents seem at least open to looking for coverage.

Based on these survey findings, the following are recommendations from Enroll America and PerryUndem for the next open enrollment period:

1. **Recognize that most uninsured individuals want affordable health coverage.** The survey suggests this is true and that individuals are willing to put time and effort into enrolling. They want insurance.

2. **Understand that the law and fine (and how it is increasing) motivated many to enroll.** Talking more explicitly about the mandate and the increasing fine may encourage more people to enroll next time. However, this will not be enough. Being able to see a doctor and avoid big medical bills were also important motivators and should be part of the conversation.

3. **Address affordability perceptions/misperceptions.** The belief that insurance is not affordable kept many from even looking for coverage. This is the barrier that must be addressed. Part of the issue may be the low awareness that financial help was available to low- and moderate-income individuals. Continuing to raise awareness about the tax subsidy may be important.

4. **Keep educating.** There were many knowledge gaps about key aspects of the Affordable Care Act – and about insurance – that still need to be addressed. Those who enrolled knew more; knowledge may be a factor in enrollment.

5. **Use the "news" to educate.** For better or worse, "news" is where most survey respondents get their information on this topic – particularly local TV news programs and online sources. It may be important to consider the role of these sources in relaying important information about the law and enrollment to the remaining uninsured. Advertising may also be an effective tool – those who saw ads knew more facts about the law and enrollment.

6. **Provide Latinos with more details and enrollment help.** They were more likely than others to find enrolling confusing and to question whether they were eligible or not. They also seem to value in-person enrollment assistance more than others.

7. **Activate moms (and other family members and friends) to enroll young adults.** Moms played an important role in enrollment for young adults. Also important is talking about the mandate and the increasing fine with this age group.

8. **Improve the enrollment process.** While enrolling was easy for many, it was not for others. Many of those who did not successfully enroll dealt with website problems and confusion and could not find answers to questions. Perhaps educating this population about free in-person enrollment assistance could help – people who enrolled this way were more likely to find the process "easy."

For more details about this survey, contact Mike Perry at mike@perryundem.com.

Survey Methods

PerryUndem Research/Communication conducted a nationally representative online survey from April 10-28, 2014. The survey had n=1524 total respondents; n=671 respondents were newly insured/enrolled, and n=853 respondents were currently uninsured. The margin of error for the total sample is +/- 2.9%. For the newly insured/enrolled sample, the margin of error is +/-5.2%; the margin of error for the uninsured sample is +/-3.8%. The survey was conducted in both English and Spanish.

Newly enrolled/insured respondents had to have private insurance or Medicaid, and must have enrolled in health insurance during open enrollment through the marketplace or outside of the marketplace (October 1, 2013 – April 15, 2014). Uninsured respondents had to be currently uninsured, and could not have supplemental health care like Veterans benefits.

The national survey was conducted online using GfK's KnowledgePanel, the only probability-based web panel designed to be representative of the United States. The web panel is constructed with probability-based sampling from the U.S. Postal Service's Delivery Sequence File, which allows for an estimated 97% of households to be covered. Respondents took the survey online; those who did not have access to a computer were provided with one to take the survey.

This report is the first release from the survey. There will be additional reports focusing on specific subpopulations.

Eligibility for Assistance and Projected Changes in Coverage Under the ACA: Variation Across States

May 2014 Update

Matthew Buettgens, Genevieve M. Kenney, and Hannah Recht

Timely Analysis of Immediate Health Policy Issues

MAY 2014

In-Brief

Under current legislation, just over half (56 percent) of the uninsured became eligible for financial assistance with health insurance coverage through Medicaid, CHIP or subsidized private coverage through the new marketplaces. In states that have expanded Medicaid eligibility under the ACA, 68 percent of the uninsured became eligible for assistance, compared with only 44 percent in states that have not expanded Medicaid. If the latter states were to expand Medicaid eligibility, 71 percent of their uninsured would be eligible for assistance.

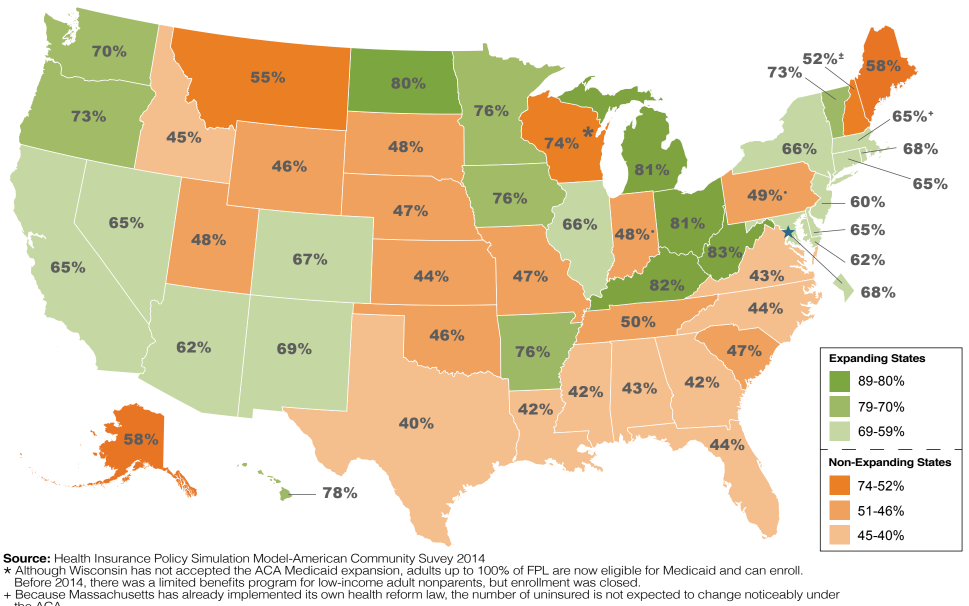
Among states expanding Medicaid, the ACA is projected to reduce the number of uninsured people by 56 percent, compared with a 34 percent reduction in the uninsured among states not expanding Medicaid. If the states that have not expanded eligibility were to do so, the number of uninsured in those states would decrease by 59 percent.

How Many Uninsured People Are Eligible for Assistance Under the Affordable Care Act?

Robert Wood Johnson Foundation

The Affordable Care Act (ACA) makes health insurance coverage more affordable for millions of low-income families. The map below illustrates the percentage of people in each state who are eligible for coverage assistance programs under the ACA as of May 2014.

Percentage of Uninsured Residents Eligible for Insurance Assistance in 2014



Source: Health Insurance Policy Simulation Model-American Community Suvey 2014

* Although Wisconsin has not accepted the ACA Medicaid expansion, adults up to 100% of FPL are now eligible for Medicaid and can enroll. Before 2014, there was a limited benefits program for low-income adult nonparents, but enrollment was closed.

\+ Because Massachusetts has already implemented its own health reform law, the number of uninsured is not expected to change noticeably under the ACA.

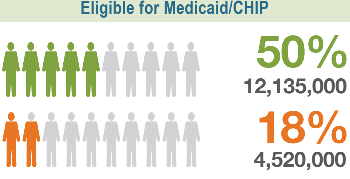
± New Hampshire plans to expand Medicaid in July 2014.

• Pennsylvania and Indiana have submitted Medicaid expansion proposals that are pending CMS review.

The data come from an updated Urban Institute report finding that significantly more people are eligible for assistance in states that opted to expand Medicaid coverage versus those states that elected not to expand the program.

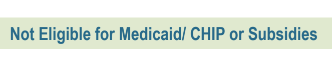
Nationwide **27.7 MILLION** —or 56 percent—of previously uninsured people are eligible for coverage assistance programs under the ACA.

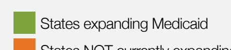
Eligible for Medicaid/CHIP



Eligible for Subsidies

Not Eligible for Medicaid/ CHIP or Subsidies





States expanding Medicaid

States NOT currently expanding Medicaid

May 2014

Introduction

The Patient Protection and Affordable Care Act (ACA) is already helping millions of low-income families make health coverage more affordable.[1] States can choose to expand eligibility for Medicaid to adults and families with incomes up to 138 percent of the federal poverty level (FPL). New health insurance marketplaces offer subsidized private health coverage to people with incomes up to 400 percent of FPL who are not eligible for public coverage, do not have access to employer coverage deemed affordable under the law,[2] and are lawfully resident. In states that do not expand Medicaid, those with incomes below 100 percent of the FPL are not eligible for subsidized coverage.

In this brief, we examine how many uninsured in each state became eligible for health coverage assistance programs (i.e., Medicaid, the Children's Health Insurance Program [CHIP], and subsidized private coverage through the new health insurance marketplaces) under the ACA in 2014. In light of the Supreme Court decision that made the Medicaid expansion a state option, our estimates take into account state decisions in effect as of May 2014.[3] We then show how the ACA is expected to increase insurance coverage in each state. We estimate the share of the remaining uninsured under the ACA who are projected to be eligible for assistance programs but not enrolled. This group could be reached by additional outreach programs. Finally, we show the percentage of the uninsured eligible for assistance and the change in the number of uninsured for each state both with and without Medicaid expansion.

We estimate the share of the uninsured that gained eligibility for assistance in 2014. Some of these people enrolled in coverage during the first few months of 2014. A number of nongovernmental surveys indicate that the number of uninsured has declined since September 2013, just before the first ACA open enrollment period began.[4] At the time of writing, however, the available enrollment data for Medicaid and subsidized marketplace coverage were not detailed enough to determine state-by-state the number of previously uninsured individuals who obtained Medicaid or subsidized marketplace coverage during the open enrollment period. We will update our estimates as more enrollment data become available.[5] Our estimates of the number of people gaining eligibility if states that have not expanded Medicaid were to do so and of the full impact of the ACA on the number of uninsured people are not affected by initial 2014 enrollment under current eligibility rules.

These estimates update our paper from October 2013.[6] The state expansion decisions and eligibility thresholds that came into effect on January 1 differed in some states from those available on September 30, 2013, which were used in the earlier paper. Also, our estimates are based on more recent survey data, particularly newer data for the number and characteristics of the uninsured in each state. This is important because the number of uninsured has declined from its levels at the height of the recession in 2008 and 2009. We present estimates for 2016 in order to show the effect of the ACA when fully implemented. New enrollment in subsidized coverage and Medicaid will likely not reach its full level in 2014 and 2015. Finally, these estimates use the latest major revision of our microsimulation model and therefore reflect the most up-to-date information available on marketplace premiums and final ACA regulations, particularly those which define eligibility for Medicaid, CHIP or subsidized marketplace coverage.

The brief relies upon analysis of the Health Insurance Policy Simulation Model-American Community Survey version (HIPSM-ACS). The model uses ACS data from 2009, 2010, and 2011 to obtain representative samples of state populations and their pre-ACA implementation insurance coverage. HIPSM simulates individual and family health insurance enrollment under the ACA based on eligibility for programs and subsidies, health insurance coverage and options in the family, health status, sociodemographic characteristics, any applicable penalties for remaining uninsured, and other factors.[7] Subsidy eligibility is determined taking into account state decisions to expand Medicaid under the law and access to employer-based coverage. State-level estimates of target populations, subsidy-eligible individuals, and projected enrollment are based on aggregate individual- and family-level estimates for those residing in each state. [8]

Eligibility for Assistance Among the Uninsured Under the ACA

Under current ACA rules, just over half (56 percent) of the uninsured became eligible in 2014 for financial assistance with health insurance coverage through Medicaid, CHIP or subsidized private coverage through the new marketplaces (Table 1).

Among states that have expanded Medicaid eligibility under the ACA, 68 percent of the uninsured became eligible for assistance, compared with only 44 percent in states that have not expanded Medicaid (Figure 1).

About half of the uninsured in expansion states would be eligible for Medicaid or CHIP, and nearly one-fifth would be eligible for subsidized private coverage in the marketplaces. The share eligible for assistance in the states that have expanded Medicaid ranges from 60 percent in New Jersey to 83 percent in West Virginia. The Medicaid expansion states with the lowest share of uninsured eligible for assistance tend to be those in which Medicaid eligibility for adults had already been expanded above minimum required levels before the ACA. The share of uninsured eligible for assistance exceeds three-quarters of the uninsured in nine states.

In the states that did not expand Medicaid by May 2014, only 44 percent of the uninsured would be eligible for assistance under the ACA. Just over one-quarter would be eligible for subsidized coverage in the marketplaces and 18 percent would be eligible for Medicaid or CHIP. A higher share are eligible for subsidized coverage than among states expanding Medicaid, because the lowest income level for subsidy eligibility falls to

Table 1. The Uninsured and Simulated Eligibility for Assistance Under the ACA in 2016, by State

	Uninsured Without the ACA				Projected Uninsured Under the ACA	
State	**Total**	**Eligible for Medicaid/CHIP**	**Eligible for Subsidies**	**Eligible for Any Assistance**	**Total**	**Decrease**
Nationwide	**49,472,000**	**16,655,000**	**11,088,000**	**56%**	**27,151,000**	**45%**
States Expanding Medicaid, May 2014						
Arizona	1,191,000	525,000	216,000	62%	488,000	59%
Arkansas	504,000	288,000	93,000	76%	195,000	61%
California	7,457,000	3,618,000	1,208,000	65%	3,070,000	59%
Colorado	821,000	392,000	161,000	67%	382,000	53%
Connecticut	331,000	149,000	65,000	65%	166,000	50%
Delaware	89,000	41,000	18,000	65%	48,000	46%
District of Columbia	49,000	27,000	6,000	68%	24,000	51%
Hawaii	104,000	62,000	20,000	78%	42,000	59%
Illinois	1,767,000	861,000	297,000	66%	750,000	58%
Iowa	279,000	154,000	58,000	76%	116,000	58%
Kentucky	637,000	408,000	114,000	82%	233,000	63%
Maryland	651,000	285,000	122,000	62%	331,000	49%
Massachusetts	307,000	129,000	70,000	65%	--[2]	--[2]
Michigan	1,219,000	753,000	235,000	81%	437,000	64%
Minnesota	491,000	304,000	67,000	76%	243,000	51%
Nevada	628,000	305,000	105,000	65%	305,000	51%
New Jersey	1,251,000	507,000	238,000	60%	632,000	49%
New Mexico	455,000	235,000	78,000	69%	208,000	54%
New York	2,435,000	1,107,000	502,000	66%	1,365,000	44%
North Dakota	69,000	37,000	19,000	80%	25,000	64%
Ohio	1,384,000	841,000	278,000	81%	479,000	65%
Oregon	657,000	351,000	127,000	73%	281,000	57%
Rhode Island	127,000	59,000	28,000	68%	58,000	55%
Vermont	57,000	21,000	20,000	73%	27,000	52%
Washington	997,000	499,000	198,000	70%	450,000	55%
West Virginia	274,000	176,000	52,000	83%	91,000	67%
All Expansion States	**24,231,000**	**12,135,000**	**4,393,000**	**68%**	**10,590,000**	**56%**
States Not Expanding Medicaid, May 2014						
Alabama	682,000	116,000	177,000	43%	489,000	28%
Alaska	141,000	36,000	46,000	58%	74,000	48%
Florida	4,153,000	667,000	1,148,000	44%	2,592,000	38%
Georgia	1,968,000	350,000	482,000	42%	1,369,000	30%
Idaho	272,000	45,000	79,000	45%	175,000	36%
Indiana[4]	939,000	172,000	275,000	48%	614,000	35%
Kansas	380,000	67,000	100,000	44%	259,000	32%
Louisiana	820,000	109,000	236,000	42%	557,000	32%
Maine	143,000	23,000	59,000	58%	81,000	43%
Mississippi	531,000	95,000	128,000	42%	367,000	31%
Missouri	816,000	143,000	236,000	47%	539,000	34%
Montana	190,000	36,000	68,000	55%	110,000	42%
Nebraska	222,000	41,000	63,000	47%	141,000	36%
New Hampshire[3]	140,000	19,000	53,000	52%	81,000	42%
North Carolina	1,612,000	297,000	420,000	44%	1,008,000	37%
Oklahoma	707,000	143,000	184,000	46%	465,000	34%
Pennsylvania[4]	1,302,000	227,000	408,000	49%	842,000	35%
South Carolina	805,000	163,000	217,000	47%	543,000	33%
South Dakota	107,000	19,000	33,000	48%	67,000	37%
Tennessee	951,000	207,000	266,000	50%	624,000	34%
Texas	6,288,000	1,050,000	1,435,000	40%	4,334,000	31%
Utah	436,000	94,000	113,000	48%	273,000	38%
Virginia	1,009,000	151,000	280,000	43%	684,000	32%
Wisconsin[1]	537,000	238,000	158,000	74%	222,000	59%
Wyoming	88,000	12,000	29,000	46%	51,000	42%
All Nonexpansion States	**25,241,000**	**4,520,000**	**6,694,000**	**44%**	**16,561,000**	**34%**

Source: Health Insurance Policy Simulation Model-American Community Suvey 2014

1. *Although Wisconsin has not accepted the ACA Medicaid expansion, adults up to 100% of FPL are now eligible for Medicaid and can enroll. Before 2014, there was a limited benefits program for low-income adult nonparents, but enrollment was closed.*
2. *Because Massachusetts has already implemented its own health reform law, the number of uninsured is not expected to change noticeably under the ACA.*
3. *New Hampshire plans to expand Medicaid in July 2014.*
4. *Pennsylvania and Indiana have submitted Medicaid expansion proposals which are pending CMS review.*

100 percent of FPL in a state that does not expand Medicaid eligibility, down from 138 percent of FPL.[9]

One nonexpanding state stands out from the rest: nearly three-quarters of the uninsured in Wisconsin are eligible for assistance. This is because Wisconsin changed its Medicaid waiver such that beginning in 2014, all adults (both parents and nonparents) up to 100 percent of FPL are eligible for Medicaid. Previously, parents were eligible up to 200 percent of FPL. There was a limited benefits program for adult nonparents, but enrollment was closed. Therefore, Wisconsin resembles a Medicaid expansion state in these estimates.

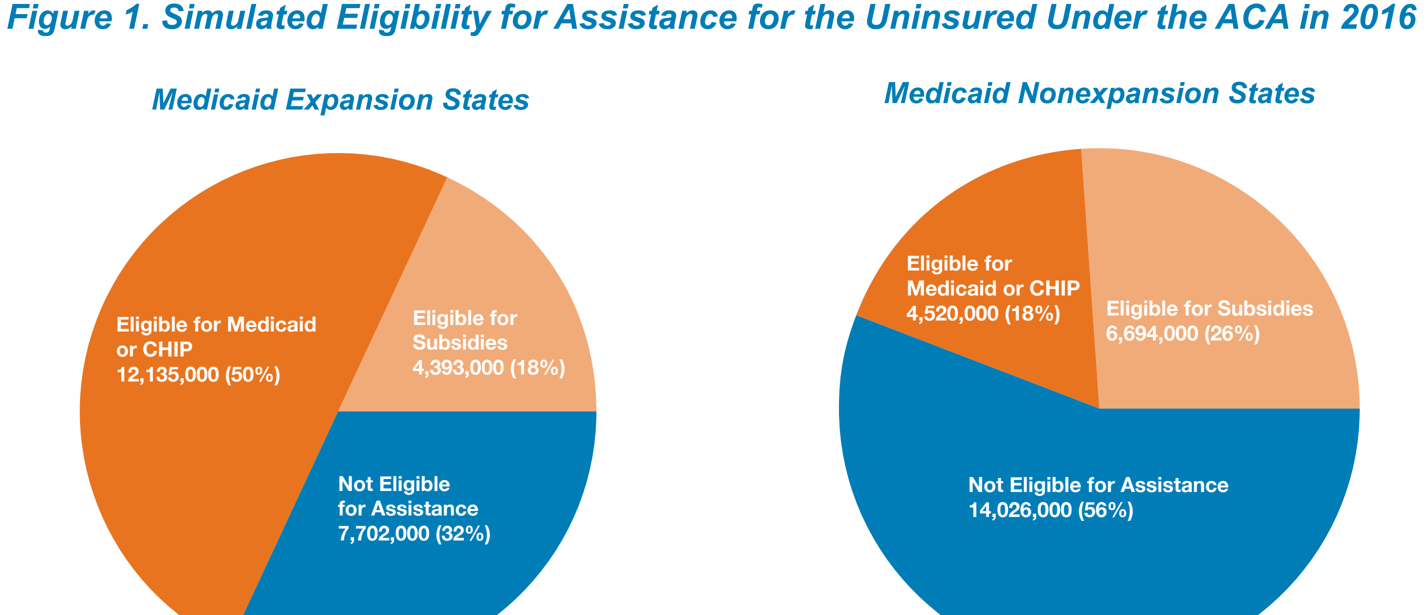
With the exception of Wisconsin, the share of the uninsured in nonexpanding states eligible for assistance ranges from 40 percent in Texas to 58 percent in Alaska and Maine. The states with the lowest shares eligible for assistance (Texas, Mississippi, Louisiana, and Georgia) have particularly large shares of residents below 100 percent of FPL. People with incomes that low can only receive assistance through Medicaid expansion and none of these states have elected to expand Medicaid at this point in time.

What would happen if nonexpanding states were to expand Medicaid eligibility? A majority of the uninsured in all states would be eligible for assistance, ranging from 64 percent in Texas to 81 percent in Montana (Table 2). More than three-quarters of the uninsured would be eligible for assistance in 14 of the 25 nonexpanding states. In particular, Indiana, New Hampshire, and Pennsylvania, all of which have proposed expanding Medicaid with Waiver authority in the coming year would see the share of the uninsured who would be eligible for assistance rise by 31, 24, and 29 percentage points, respectively. States with more immigrants who are not lawfully present, such as Texas and Florida, tend to have lower shares of the uninsured eligible for assistance even under the Medicaid expansion, because those not lawfully present are barred from both Medicaid and the health insurance marketplaces.

The Impact of the ACA on Insurance Coverage

Among states that expanded Medicaid on January 2014, the ACA is projected to cut the number of uninsured by more than half by 2016 (56 percent, Table 1). States that have already expanded Medicaid eligibility for adults are expected to see smaller percent decreases than those that have not. For example, Massachusetts has already implemented its health reform law; therefore, it is not expected that the ACA will noticeably affect the state's already low uninsured rate. New York and Delaware had also expanded Medicaid eligibility before the ACA, but people would still gain eligibility under the ACA Medicaid expansion and be subject to the individual mandate in these states. Hence, a noticeable reduction in the number of uninsured of 44 and 46 percent is projected for New York and Delaware, respectively. Twenty-one states are expected to see their number of uninsured reduced by more than 50 percent, with the largest reduction (67 percent) expected in West Virginia (Table 1, Figure 2).

Figure 1. Simulated Eligibility for Assistance for the Uninsured Under the ACA in 2016



Source: Health Insurance Policy Simulation Model-American Community Suvey 2014
Note: Data reflect Medicaid expansion decisions as of April 2014.
The uninsured are modeled as uninsured in 2016 without the ACA. Using 2016 weights, there would be 49,472,000 in 2016 without the ACA—17.9% of the 2016 U.S. population.There would be 48,571,000 in 2014 without the ACA—17.7% of the 2014 U.S. population.

Table 2. Uninsured Eligible for Assistance and Simulated Reduction in the Uninsured Under the ACA in 2016 in Nonexpansion States, With and Without the Medicaid Expansion

State	Uninsured Eligible for Assistance		Reduction in Number of Uninsured	
	With Expansion	Without Expansion	With Expansion	Without Expansion
Alabama	80%	43%	61%	28%
Alaska	76%	58%	64%	48%
Florida	69%	44%	61%	38%
Georgia	71%	42%	56%	30%
Idaho	74%	45%	62%	36%
Indiana[3]	79%	48%	63%	35%
Kansas	73%	44%	58%	32%
Louisiana	77%	42%	63%	32%
Maine	78%	58%	64%	43%
Mississippi	80%	42%	64%	31%
Missouri	80%	47%	64%	34%
Montana	81%	55%	68%	42%
Nebraska	73%	47%	59%	36%
New Hampshire[2]	76%	52%	65%	42%
North Carolina	70%	44%	61%	37%
Oklahoma	72%	46%	58%	34%
Pennsylvania[3]	78%	49%	62%	35%
South Carolina	77%	47%	59%	33%
South Dakota	80%	48%	67%	37%
Tennessee	77%	50%	59%	34%
Texas	64%	40%	53%	31%
Utah	70%	48%	58%	38%
Virginia	69%	43%	57%	32%
Wisconsin[1]	76%	74%	63%	59%
Wyoming	70%	46%	63%	42%
All Nonexpansion States	**71%**	**44%**	**59%**	**34%**

Source: Health Insurance Policy Simulation Model-American Community Suvey 2014

1. *Although Wisconsin has not accepted the ACA Medicaid expansion, adults up to 100% of FPL are now eligible for Medicaid and can enroll. Before 2014, there was a limited benefits program for low-income adult nonparents, but enrollment was closed.*
2. *New Hampshire plans to expand Medicaid in July 2014.*
3. *Pennsylvania and Indiana have submitted Medicaid expansion proposals which are pending CMS review.*

Among nonexpanding states, the number of uninsured would be reduced by just over one-third (Table 1). Wisconsin would see the largest reduction (59 percent) because of the expansion of coverage to adult nonparents contained in its Medicaid waiver, as noted. In contrast to expanding states, no other nonexpanding state would see a reduction of more than half in the number of uninsured. Alaska comes the closest (48 percent). Nineteen nonexpanding states would see reductions of less than 40 percent, with the smallest reductions in Alabama, Georgia, Mississippi, and Texas (28, 30, 31, and 31 percent respectively).

If these states were to expand Medicaid eligibility, each one of them would see the number of uninsured cut by more than half (Table 2). The smallest reduction would be in Texas (53 percent), the largest in Montana (68 percent).

While the large majority of those gaining coverage under the ACA are eligible for assistance, some will newly enroll in employer-sponsored or unsubsidized private coverage as well. This new enrollment will mainly be due to the individual coverage requirement, though other provisions of the law, such as tax credits for some small businesses offering coverage, contribute as well. In an earlier report, for example, we considered the effect of the law on employer-sponsored coverage.[10]

Who Would Remain Uninsured?

Nationally, among the 27.1 million we project to remain uninsured under the ACA in 2016, 37 percent would be eligible for Medicaid, CHIP, or subsidized marketplace coverage (Table 3). With additional outreach, more of these people could be enrolled. Almost a quarter of the uninsured would be immigrants not lawfully present, who are barred from the marketplaces, Medicaid, and CHIP. About 22 percent would be low-income people in states not expanding Medicaid that would gain eligibility for assistance if their state were to expand eligibility. These people are exempt from the individual mandate. The remaining 17 percent of the uninsured are higher-income people who are not eligible for assistance. These people will generally not be exempt from individual mandate penalties.[11]

The composition of the uninsured differs notably between expansion and nonexpansion states. Among states that have expanded Medicaid, 50 percent of those we estimate would remain uninsured under the ACA will be eligible for assistance, but not enrolled (Table 3). One hundred percent participation is unrealistic, but states with effective outreach have achieved high participation rates in Medicaid and CHIP.[12] Almost one-third of the uninsured under the ACA in expansion states would likely be immigrants not lawfully present. The remaining 18 percent would have incomes too high to qualify for Medicaid or CHIP and are ineligible for subsidized marketplace coverage either because their income is too high or because they have an offer of coverage from an employer that disqualifies them from eligibility.[13]

The composition of the uninsured under the ACA will be notably different in nonexpanding states. Only 29 percent are projected to be eligible for assistance. 36 percent would be uninsured people with incomes below 138 percent of FPL who would qualify for assistance if their state

Table 3. Simulation of the Uninsured Under the ACA and Eligibility for Assistance in 2016, by State

	Projected Uninsured Under the ACA									
		Eligible for Assistance					Not Eligible for Assistance			
State	Total	Eligible for Medicaid/ CHIP	Eligible for Exchange Subsidies	% Eligible for Any Assistance	Immigrants Not Lawfully Present	%	Low Income, Exempt From Mandate[3]	%	Higher Income	%
Nationwide	**27,151,000**	**5,996,000**	**4,124,000**	**37%**	**6,502,000**	**24%**	**5,996,000**	**22%**	**4,533,000**	**17%**
States Expanding Medicaid, May 2014										
Arizona	488,000	146,000	49,000	40%	171,000	35%	NA		122,000	25%
Arkansas	195,000	79,000	26,000	54%	46,000	24%	NA		44,000	22%
California	3,070,000	1,092,000	344,000	47%	1,119,000	36%	NA		514,000	17%
Colorado	382,000	121,000	52,000	45%	142,000	37%	NA		67,000	18%
Connecticut	166,000	51,000	22,000	44%	65,000	39%	NA		27,000	17%
Delaware	48,000	20,000	5,000	53%	13,000	28%	NA		9,000	19%
District of Columbia	24,000	10,000	2,000	54%	7,000	30%	NA		4,000	16%
Hawaii	42,000	19,000	7,000	61%	8,000	20%	NA		8,000	19%
Illinois	750,000	277,000	102,000	51%	241,000	32%	NA		130,000	17%
Iowa	116,000	48,000	19,000	57%	26,000	22%	NA		24,000	20%
Kentucky	233,000	123,000	32,000	67%	32,000	14%	NA		45,000	19%
Maryland	331,000	93,000	45,000	42%	138,000	42%	NA		56,000	17%
Massachusetts	144,000	40,000	22,000	44%	53,000	37%	NA		28,000	20%
Michigan	437,000	213,000	70,000	65%	58,000	13%	NA		96,000	22%
Minnesota	243,000	129,000	27,000	64%	47,000	19%	NA		40,000	16%
Nevada	305,000	93,000	31,000	41%	133,000	44%	NA		47,000	15%
New Jersey	632,000	150,000	76,000	36%	296,000	47%	NA		111,000	17%
New Mexico	208,000	69,000	26,000	46%	75,000	36%	NA		38,000	18%
New York	1,365,000	571,000	162,000	54%	395,000	29%	NA		237,000	17%
North Dakota	25,000	11,000	5,000	63%	1,000	3%	NA		8,000	33%
Ohio	479,000	250,000	77,000	68%	37,000	8%	NA		115,000	24%
Oregon	281,000	99,000	41,000	50%	92,000	33%	NA		49,000	18%
Rhode Island	58,000	18,000	9,000	47%	20,000	34%	NA		11,000	20%
Vermont	27,000	12,000	6,000	65%	1,000	5%	NA		8,000	30%
Washington	450,000	148,000	66,000	48%	150,000	33%	NA		85,000	19%
West Virginia	91,000	49,000	16,000	71%	2,000	2%	NA		24,000	27%
All Expansion States	**10,590,000**	**3,930,000**	**1,341,000**	**50%**	**3,371,000**	**32%**	**NA**		**1,948,000**	**18%**
States Not Expanding Medicaid, May 2014										
Alabama	489,000	63,000	81,000	29%	58,000	12%	229,000	47%	59,000	12%
Alaska	74,000	13,000	16,000	39%	5,000	7%	23,000	32%	16,000	22%
Florida	2,592,000	300,000	487,000	30%	442,000	17%	943,000	36%	420,000	16%
Georgia	1,369,000	167,000	205,000	27%	312,000	23%	497,000	36%	188,000	14%
Idaho	175,000	20,000	27,000	27%	27,000	16%	69,000	40%	31,000	18%
Indiana[4]	614,000	83,000	116,000	32%	66,000	11%	257,000	42%	93,000	15%
Kansas	259,000	33,000	41,000	29%	51,000	20%	95,000	37%	38,000	15%
Louisiana	557,000	58,000	103,000	29%	44,000	8%	257,000	46%	95,000	17%
Maine	81,000	11,000	24,000	43%	1,000	1%	26,000	31%	20,000	24%
Mississippi	367,000	50,000	53,000	28%	21,000	6%	179,000	49%	63,000	17%
Missouri	539,000	72,000	97,000	31%	40,000	7%	245,000	45%	86,000	16%
Montana	110,000	15,000	28,000	39%	2,000	2%	46,000	42%	20,000	18%
Nebraska	141,000	18,000	25,000	30%	27,000	19%	50,000	36%	21,000	15%
New Hampshire[2]	81,000	8,000	22,000	37%	5,000	6%	30,000	36%	17,000	20%
North Carolina	1,008,000	135,000	175,000	31%	173,000	17%	372,000	37%	153,000	15%
Oklahoma	465,000	75,000	76,000	32%	70,000	15%	162,000	35%	82,000	18%
Pennsylvania[4]	842,000	108,000	176,000	34%	74,000	9%	337,000	40%	146,000	17%
South Carolina	543,000	80,000	91,000	32%	78,000	14%	210,000	39%	84,000	16%
South Dakota	67,000	8,000	14,000	33%	2,000	4%	31,000	46%	12,000	18%
Tennessee	624,000	96,000	119,000	34%	92,000	15%	222,000	36%	95,000	15%
Texas	4,334,000	461,000	577,000	24%	1,274,000	29%	1,378,000	32%	644,000	15%
Utah	273,000	40,000	38,000	29%	72,000	26%	85,000	31%	38,000	14%
Virginia	684,000	69,000	118,000	27%	160,000	23%	228,000	33%	110,000	16%
Wisconsin[1]	222,000	77,000	65,000	64%	31,000	14%	8,000	3%	41,000	18%
Wyoming	51,000	5,000	11,000	30%	5,000	10%	18,000	36%	12,000	24%
All Nonexpansion States	**16,561,000**	**2,066,000**	**2,783,000**	**29%**	**3,131,000**	**19%**	**5,996,000**	**36%**	**2,585,000**	**16%**

Source: Health Insurance Policy Simulation Model-American Community Suvey 2014

1. *Although Wisconsin has not accepted the ACA Medicaid expansion, adults up to 100% of FPL are now eligible for Medicaid and can enroll. Before 2014, there was a limited benefits program for low-income adult nonparents, but enrollment was closed.*
2. *New Hampshire plans to expand Medicaid in July 2014.*
3. *Not applicable in states that have expanded Medicaid.*
4. *Pennsylvania and Indiana have submitted Medicaid expansion proposals which are pending CMS review.*

were to expand Medicaid. This includes both those below 100 percent of FPL who are not eligible for Medicaid or CHIP under current rules, as well as those between 100 and 138 percent of FPL who are ineligible for subsidized marketplace coverage due to an employer offer of coverage. This group is exempt from the ACA's individual coverage requirement. Just under one-fifth of the uninsured in expansion states would be immigrants not lawfully present, and the remaining 16 percent would be people with higher incomes who are lawfully present and not eligible for assistance.

There is notable variation between states in the composition of the uninsured under the ACA. Perhaps the biggest source of variation is in the prevalence of immigrants not lawfully present. Such immigrants generally have very low income, so higher shares of immigrants not lawfully present among the uninsured generally mean smaller shares of the uninsured eligible for assistance.

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

Matthew Buettgens is a senior research associate, Genevieve M. Kenney is co-director, and Hannah Recht is a research assistant in the Urban Institute's Health Policy Center. The authors appreciate the comments and suggestions of John Holahan, Stephen Zuckerman, and Katherine Hempstead. 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

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 Long SK, Kenney GM, Zuckerman S, Wissoker D, Goin D, Hempstead K, Karpman M and Anderson N. "Early Estimates Indicate Rapid Increase in Health Insurance Coverage under the ACA: A Promising Start." Washington, DC: Urban Institute, 2014, http://hrms.urban.org/briefs/early-estimates-indicate-rapid-increase.html.

2 Specifically, if one family member is offered employer coverage for which the worker contribution of the single premium is less than 9.5 percent of the family income, then the entire family is ineligible for subsidies.

3 Centers for Medicare and Medicaid Services. "State Medicaid and CHIP Income Eligibility Standards Effective January 1, 2014." Baltimore: Centers for Medicare and Medicaid Services, 2013. Michigan expanded Medicaid on May 1, 2014 and New Hampshire is slated to expand Medicaid eligibility in July 2014.

4 See for example, Long et al. "Early Estimates Indicate Rapid Increase," and Levy, J, "In U.S., Uninsured Rate Lowest Since 2008." *Gallup*, Monday, April 7, 2014.

5 However, it will not be possible to provide a definitive assessment of how eligibility for coverage assistance, uninsured rates, and the composition of the residual uninsured are changing at the state level until information is available from key federal surveys later this year and in 2015.

6 Buettgens M, Kenney GM, Recht H and Lynch V. "Eligibility for Assistance and Projected Changes in Coverage Under the ACA: Variation Across States." Washington, DC. Urban Institute, 2013, http://www.urban.org/health_policy/url.cfm?ID=412918.

7 For an overview of HIPSM, see Urban Institute. "The Urban Institute's Health Microsimulation Capabilities." Washington, DC: Urban Institute, 2010, http://www.urban.org/publications/412154.html. For a more detailed description of the model, see Buettgens, M. "Health Insurance Policy Simulation Model (HIPSM) Methodology Documentation: 2011 National Version." Washington, DC: Urban Institute, 2011, http://www.urban.org/publications/412471.html.

8 More information about methodology can be found at "Further Methodological Information for 'Tax Preparers Could Help Most Uninsured Get Covered," accessed May 1, 2014, http://www.urban.org/health_policy/health_care_reform/taxfilingmethodology.cfm.

9 Lawfully present immigrants who are ineligible for Medicaid because they have been resident fewer than five years are eligible for subsidized marketplace coverage even if their income is below this level.

10 Blumberg LJ, Buettgens M, Feder J and Holahan J. "Implications of the Affordable Care Act for American Business." Washington, DC: Urban Institute, 2012, http://www.urban.org/health_policy/url.cfm?ID=412675.

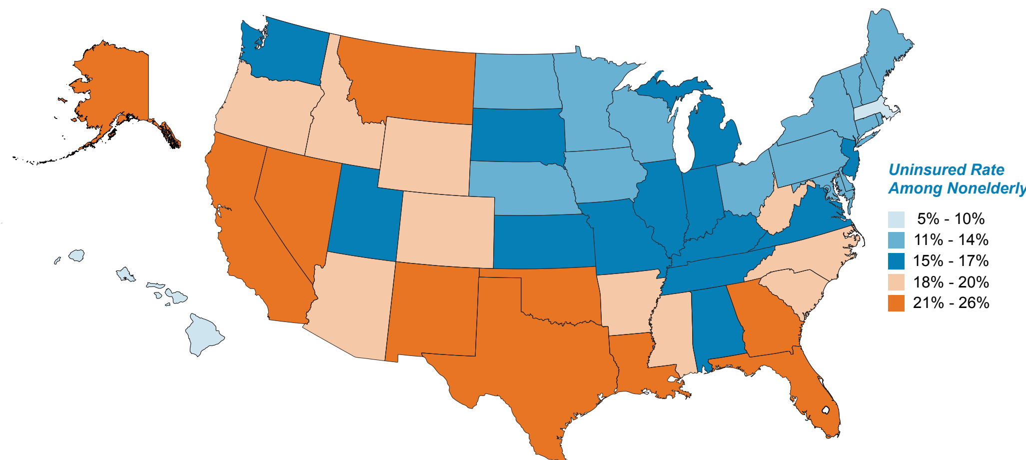
11 We are not able to model exemptions based on special circumstances such as hardship or religious conscience.

12 Kenney GM, Anderson N and Lynch V. "Medicaid/CHIP Participation Rates Among Children: An Update." Washington, DC. The Urban Institute, 2014, http://www.urban.org/health_policy/url.cfm?ID=412901.

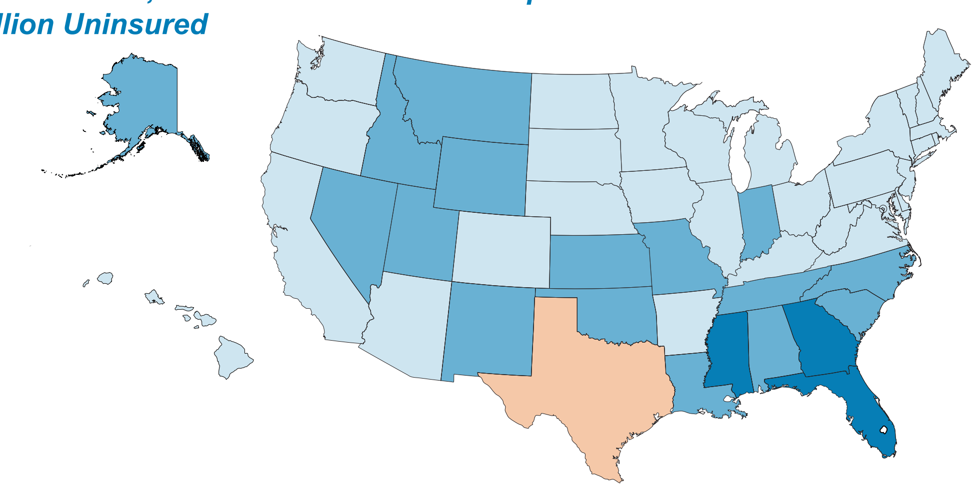
13 If any family member is offered single coverage at less than 9.5 percent of family income, the entire family is ineligible for subsidized coverage.

Figure 2. ACA Projected to Reduce Uninsured From 49.5 to 27.2 Million by 2016

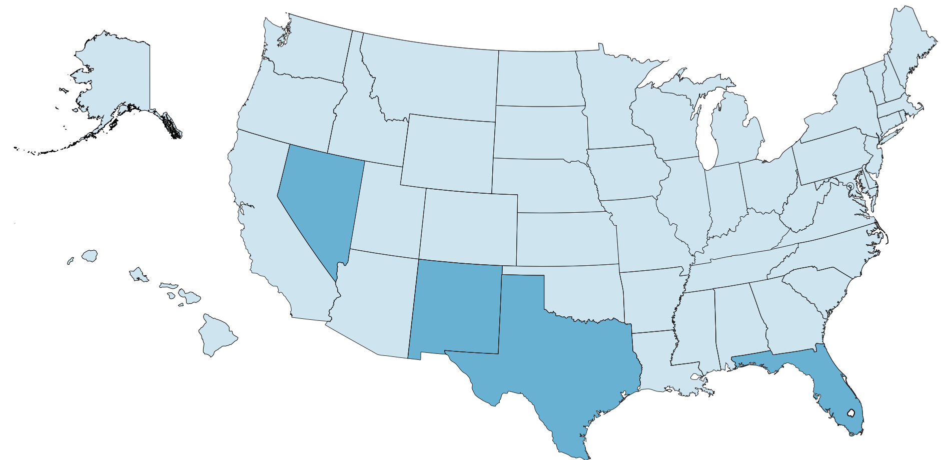
Nonelderly Uninsured Rate Without the ACA: 18% Nationally, 49.5 Million Uninsured



With the ACA, Current State Medicaid Expansion Decisions: 10% Nationally, 27.2 Million Uninsured



With the ACA, if Every State Expands Medicaid: 8% Nationally, 21.0 Million Uninsured



Source: Urban Institute Analysis, ACS-HIPSM 2014, based on pooled American Community Survey 2009-2011 datasets.

THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

Filling the need for trusted information on health issues…

May 2014 Update | Issue Brief

How is the ACA Impacting Medicaid Enrollment?

Vikki Wachino, Samantha Artiga, and Robin Rudowitz

New data released by the Centers for Medicare and Medicaid Services (CMS) shows that as of the end of March 2014, Medicaid and CHIP enrollment had increased by over 4.8 million people since open enrollment began for the new Health Insurance Marketplaces in October 2013. These data help provide a better understanding of how the Affordable Care Act (ACA) is impacting Medicaid enrollment, which has been a keen focus and subject of debate among the press, policymakers, and analysts. However, understanding the ACA's impact on Medicaid enrollment remains complex given that the ACA promotes increased Medicaid enrollment in varied ways, including changes in eligibility, modernization and simplification of enrollment processes, and increased outreach and enrollment efforts. To interpret the data, it is important to understand what they represent, what they show about the impact of the ACA on Medicaid enrollment, and what questions still remain. This brief discusses the data and its interpretation to assess the influence of the ACA on Medicaid enrollment and finds:

- As of March 2014, Medicaid and CHIP enrollment grew by more than 4.8 million people compared to average monthly enrollment in the three months leading up to the start of open enrollment.

- Enrollment growth in states that have expanded Medicaid coverage to low-income adults outpaced the national average, and was significantly higher than growth in non-expanding states (12.9% vs. 2.6%).

- The recent data show very strong enrollment growth relative to historic trends, with the recent growth exceeding reported growth at the height of the most recent economic downturn.

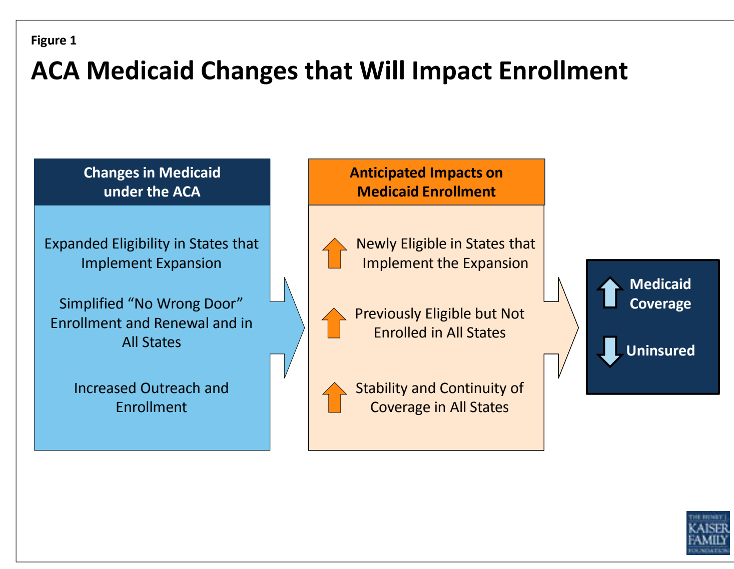
- Overall, the data suggest that the ACA is having a positive impact on Medicaid and CHIP enrollment, particularly in states that have implemented the Medicaid expansion. However, it remains challenging to quantify and separately identify the impacts of the specific ACA policies on enrollment.

- Although enrollment gains are an important indicator of progress, ultimately the key measure of the ACA's success in achieving its coverage goals will be a reduction in the number of uninsured.

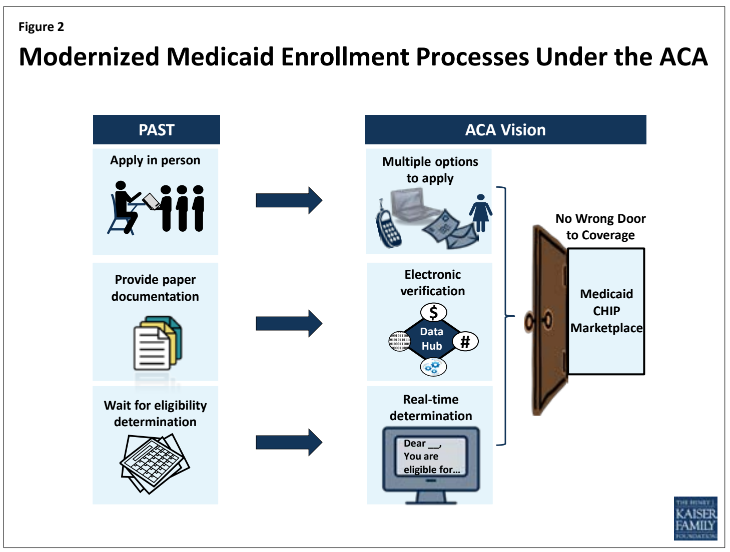
Three main ACA changes lead to Medicaid enrollment gains.

Even though most observers remain focused on the ACA's Medicaid expansion, the ACA strengthens and improves Medicaid in other key ways that will increase Medicaid enrollment. Overall, there are three main changes the ACA makes to eligibility and enrollment that are expected to contribute to Medicaid enrollment gains (Figure 1):

1. **Medicaid expansion to low-income adults.** The ACA expands Medicaid eligibility to adults with incomes at or below 138 percent of the poverty line, which is just over $16,000 per year for an individual today. Historically, Medicaid covered low-income children, pregnant women, elderly and disabled individuals, and some parents, but excluded other low-income adults. The expansion, which the Supreme Court effectively made optional for states in 2012, fills this longstanding gap in the program. To date, 27 states, including DC, are implementing the expansion and additional states may expand moving forward.[1]



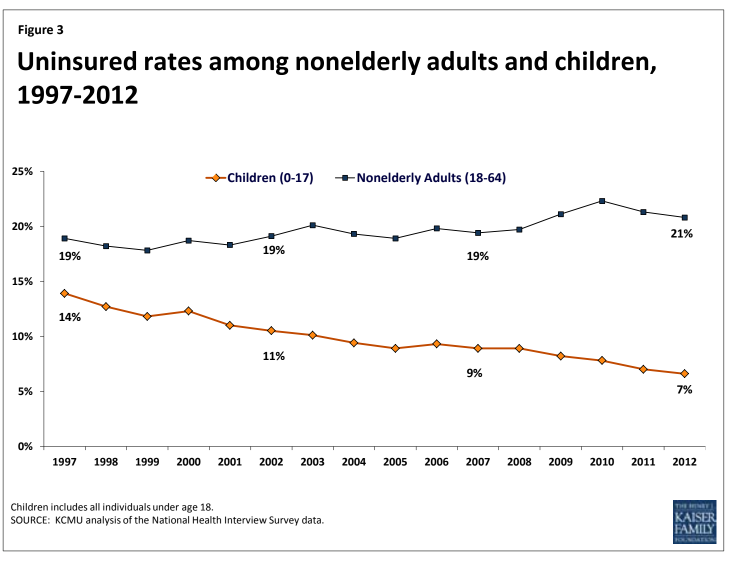
2. **Modernized, simpler enrollment processes.** The ACA makes it easier for people to enroll in and renew Medicaid coverage. Prior to the ACA, states had achieved varied progress in modernizing and simplifying their Medicaid enrollment processes. Under the ACA, all states must offer individuals multiple options to apply (for example, online or by mail or phone), seek to rely on electronic data instead of paper to verify information, and, in as many cases as possible, provide "real time" determinations of eligibility for coverage (Figure 2). These processes are designed to coordinate with the new Marketplaces to create a "no wrong door" enrollment system, so that regardless of whether an individual applies directly to Medicaid or through a Marketplace, he or she is enrolled in the program for which he or she is eligible. All states must implement these changes, regardless of whether a state expands Medicaid.



3. **Increased outreach and enrollment efforts.** The ACA spurred outreach and enrollment efforts to help connect eligible people to coverage. Leading up to and throughout the open enrollment period for the Marketplaces, there was significant outreach to encourage individuals to apply for coverage and an array of assistance was available to help individuals enroll. Moreover, because Medicaid enrollment is not limited to the Marketplace open enrollment period, Medicaid outreach and enrollment efforts continue year-round.

Together, these three key changes are expected to lead to increased Medicaid coverage and a reduction in the number of uninsured. In states that expand Medicaid, there will be enrollment gains among adults made newly eligible by the expansion. But, in all states, the simpler enrollment processes and broad outreach and enrollment efforts will promote increased enrollment among individuals who were already eligible for Medicaid before the ACA, but not enrolled, many of whom are children. Prior to the ACA, these individuals may not have known that coverage was available, did not think they would be eligible, or may have encountered difficulties enrolling.

Previous experience with CHIP shows that the combined effects of increased eligibility, simplified enrollment, and enhanced outreach and enrollment efforts lead to decreases in the uninsured rate for children. CHIP was created in 1997 as a complement to Medicaid. It expanded eligibility to uninsured children who were not eligible for Medicaid, led states to simplify enrollment and renewal processes for children, and spurred broad outreach and enrollment efforts. Together, the combined effects of these changes not only increased enrollment of children in both Medicaid and CHIP, but resulted in a steady decline in the uninsured rate for children. Between 1997 and 2012 the uninsured rate for children was cut in half from 14% to a record low of 7%, even as uninsured rates for adults climbed during the recent economic downturn (Figure 3).



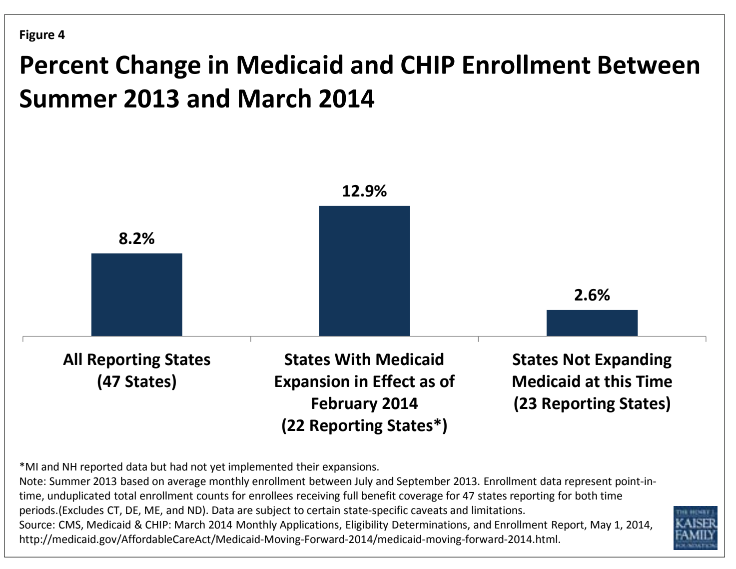
What do CMS Medicaid enrollment data show?

CMS recently began publishing monthly reports as part of an initiative to provide data on a broad set of Medicaid and CHIP eligibility and enrollment performance indicators to inform program management and oversight.[2] This type of timely data had never before been reported and is providing some of the fastest insights on national Medicaid enrollment in the program's history. The initial monthly reports provided data on the number of applications submitted and eligibility determinations made for Medicaid and CHIP. The press and assorted experts focused on trying to tease out what share of these determinations were attributable to the ACA and, in particular, the Medicaid expansion. However, it was difficult to disentangle the impacts of the ACA given the limitations of the data. Beginning in its April 2014 report, CMS also began reporting data on total Medicaid and CHIP enrollment. The addition of this data represents progress toward the agency's goal of reporting a broader set of performance indicators and allows for greater insight into the ACA's impact on enrollment. To date, CMS has reported point-in-time total Medicaid enrollment as of February 2014 and March 2014, as well as average monthly enrollment data for a comparison period prior to open enrollment (July through September 2013). However, the data are new and remain subject to gaps, inconsistencies and limitations.

The CMS data show that between the comparison period prior to open enrollment (July to September 2013) and March 2014, total Medicaid and CHIP enrollment grew by over 4.8 million people (from 58.9 to 63.7 million) among the 47 states reporting data for both periods. Nearly all of this growth occurred among the reporting states implementing the Medicaid expansion. In the states expanding Medicaid that reported data for both periods, enrollment grew by 4.2 million (from 34.1 to 38.3 million). In states that are not expanding Medicaid and that reported data for both periods enrollment grew by just over 643,000 people (from 24.7 to 25.4 million).[3] This growth reflects a combination of increased enrollment among newly eligible adults in states that have implemented the Medicaid expansion and increased enrollment among previously eligible individuals in all states due to changes in enrollment processes and stronger outreach and enrollment efforts. In the non-expansion states, it is likely that most enrollment gains have been among children, given that children make up most of the eligible but not enrolled uninsured

population due to the higher income eligibility levels for children and limited eligibility for adults in these states. The 4.8 million enrollment increase does not reflect the 950,000 individuals enrolled under early expansions in seven states, since most individuals enrolled in these expansions were already enrolled in Medicaid by the July-September 2013 comparison period before the ACA.[4]

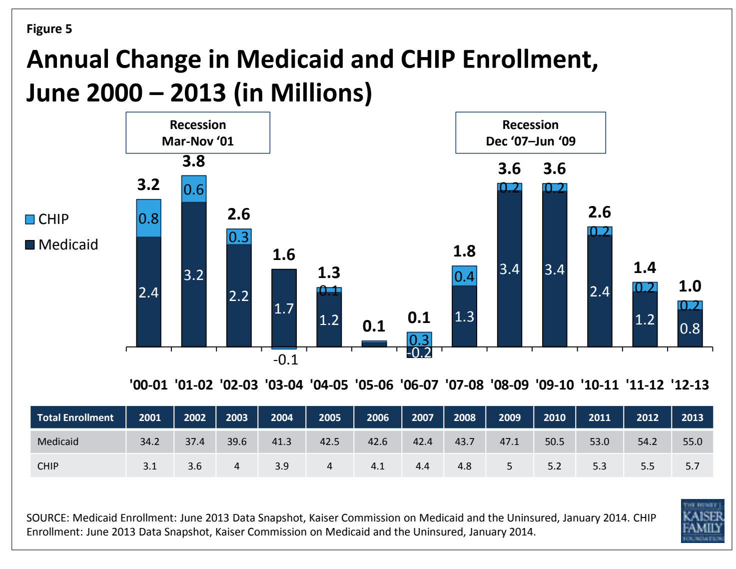
There are wide disparities in enrollment growth between states that have already expanded Medicaid and those that have not expanded. Across the 47 states that reported data for both the period prior to open enrollment and March 2014, enrollment grew by an average of 8.2% between summer 2013 and March 2014 (Figure 4). The 22 states that had their Medicaid expansions in effect as of March 2014 and reported data for both periods experienced significantly greater enrollment growth compared to reporting states that are not expanding at this time (12.9% vs. 2.6%). Overall, 16 of the 22 reporting states that had already expanded Medicaid reported enrollment growth that exceeded 10%, including 5 that experienced growth exceeding 30%. Among expansion states, the variation in enrollment changes in part reflects differences in the size of the coverage expansion that is occurring in 2014. For example, states that previously covered many adults may see a smaller increase. Nearly all (22 of 23) states that are not expanding Medicaid and reported data for both periods had enrollment growth of less than 10%, with 7 reporting negative enrollment growth or net declines in enrollment over the period (Appendix Table 1).[5]



It is expected that Medicaid and CHIP enrollment will continue to grow. As noted, not all states reported enrollment data for the period and the data that were reported are preliminary and expected to increase as states finalize their data and incorporate retroactive enrollments into their enrollment counts. These enrollment adjustments will likely include some individuals determined eligible for Medicaid or CHIP by the Federally Facilitated Marketplace (FFM) who may not have had their enrollment completed due to delays in the transfers of accounts between the FFM and Medicaid and CHIP agencies. Moreover, because Medicaid and CHIP enrollment is not limited to the open enrollment period for the Marketplaces, new enrollments will continue year-round.

WHAT HAVE WE LEARNED FROM THE NEW ENROLLMENT DATA?

The recent enrollment data from CMS show strong growth relative to previous enrollment trends. Earlier Medicaid and CHIP enrollment data collected and analyzed by the Kaiser Commission on Medicaid and the Uninsured for multiple years show that enrollment growth was slowing prior to the beginning of open enrollment as economic conditions continued to improve, at 1.4 million between June 2011 and 2012 and 1.0 million between June 2012 and 2013 (Figure 5).[6] The CMS-reported enrollment gain of 4.8 million between summer 2013 and March 2014 is greater than enrollment trends at the height of the most recent economic downturn, which peaked at 3.6 million between June 2008 to 2009 and June 2009 to 2010. Although these earlier data are not directly comparable to the new CMS data because not all states reported to CMS and there are differences in data adjustments, they both similarly report monthly point-in-time enrollment. Comparing the recent enrollment change reported by CMS to earlier trends suggests that the ACA policy changes are having a positive impact on enrollment. However, it is important to recognize that additional factors may also be influencing enrollment, including seasonal fluctuations, changing economic conditions, and overall population growth.



Total Enrollment	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Medicaid	34.2	37.4	39.6	41.3	42.5	42.6	42.4	43.7	47.1	50.5	53.0	54.2	55.0
CHIP	3.1	3.6	4	3.9	4	4.1	4.4	4.8	5	5.2	5.3	5.5	5.7

SOURCE: Medicaid Enrollment: June 2013 Data Snapshot, Kaiser Commission on Medicaid and the Uninsured, January 2014. CHIP Enrollment: June 2013 Data Snapshot, Kaiser Commission on Medicaid and the Uninsured, January 2014.

Even with the new enrollment data, it remains challenging to quantify and separately identify the impacts of the specific ACA policies on enrollment. Although, in principle, it should be relatively easy to calculate the number of adults enrolled in the Medicaid expansion in the states that have expanded, the reality has proven challenging. Many state systems are not yet able to track enrollment in this group separately and report in real-time. Only a few states (such as Washington) have reported data on the number of people enrolling in the expansion group, and it is not possible to extrapolate from a few states to estimate the entire expansion population accurately. In addition, the CMS enrollment data are for overall enrollment and do not separately identify expansion enrollees. In the future, data on expansion enrollees will become available when states begin requesting payments for the higher federal matching rate provided for adults made newly eligible by the Medicaid expansion. It also is difficult to identify how many people are enrolling in Medicaid as a result of the new, simpler processes or as a result of the ACA's broad outreach and enrollment efforts. Unlike the Marketplaces, Medicaid was an existing program with ongoing enrollment at the time the ACA was implemented, so separating usual enrollment changes from ACA-driven changes is complex. In contrast, the Marketplaces are entirely new entities created by the ACA, so any enrollee in the Marketplace is, by definition, new and growth in enrollment over time can be more easily measured and compared across states.

Looking Ahead

The new enrollment data reported by CMS suggest that the ACA is having a strong positive impact on Medicaid enrollment, particularly in states that have implemented the Medicaid expansion. However, ultimately the key measure of the ACA's success will changes in the number of uninsured. Early survey findings show promising reductions in the uninsured rate to date. However, fully assessing the impact of the ACA will require monitoring changes in coverage over longer periods of time to determine changing patterns in health insurance coverage and access to care and the extent to which individuals are able to maintain continuous coverage. While waiting for these measures is challenging, they ultimately will provide the most meaningful measures of the ACA's progress in achieving its broader coverage goals. In the meantime, the data released by CMS is expected to continue to improve and expand over time, allowing for greater analysis, and surveys like the Kaiser Survey of Low-income Americans will provide insight into low-income consumers' experiences to provide greater understanding about the impact of the ACA on the low-income uninsured.[7]

This insight was prepared by Vikki Wachino from NORC at the University of Chicago and Samantha Artiga and Robin Rudowitz from the Kaiser Family Foundation.

Appendix Table 1: Total Medicaid and CHIP Enrollment, February and March 2014					
State	**Medicaid Expansion Status**	**Monthly Average July-Sept 2013**	**February 2014**	**March 2014**	**Percent Change July- Sept 2013 to March 2014**
Arizona	Expanded	1,201,770	1,234,401	1,301,010	8.3%
Arkansas	Expanded	680,920	763,356	805,785	18.3%
California	Expanded	9,157,000	9,999,000	10,334,000	12.9%
Colorado	Expanded	783,420	962,210	1,012,944	29.3%
Connecticut	Expanded	-	-	704,387	
Delaware	Expanded	-	230,165	233,786	-
District of Columbia	Expanded	235,786	238,000	241,243	2.3%
Hawaii	Expanded	288,358	313,669	320,567	11.2%
Illinois	Expanded	2,753,227	2,735,224	2,791,737	1.4%
Iowa	Expanded	493,515	557,501	572,375	16.0%
Kentucky	Expanded	840,926	966,365	1,125,964	33.9%
Maryland	Expanded	856,297	1,053,589	1,092,409	27.6%
Massachusetts	Expanded	1,296,359	1,453,213	1,455,069	12.2%
Michigan	Expansion effective 4/1/14	1,912,009	1,845,112	1,942,437	1.6%
Minnesota	Expanded	873,040	976,350	972,683	11.4%
Nevada	Expanded	332,559	404,825	437,218	31.5%
New Hampshire	Expansion effective 7/1/14	127,082	133,110	134,699	6.0%
New Jersey	Expanded	1,283,851	1,361,513	1,382,091	7.7%
New Mexico	Expanded	572,111	602,014	632,489	10.6%
New York	Expanded	5,678,418	5,823,995	6,022,253	6.1%
North Dakota	Expanded	-	-	-	
Ohio	Expanded	2,341,482	2,361,103	2,549,762	8.9%
Oregon	Expanded	626,357	900,933	900,038	43.7%
Rhode Island	Expanded	190,833	227,095	244,162	27.9%
Vermont	Expanded	127,162	168,233	173,609	36.5%
Washington	Expanded	1,117,576	1,369,179	1,369,825	22.6%
West Virginia	Expanded	354,544	473,401	490,962	38.5%
				Percent Change in States with Expansion in Effect as of March 2014*	***12.9%***
Alaska	Not Currently Expanding	799,176	116,720	119,767	-1.0%
Alabama	Not Currently Expanding	120,946	769,295	774,293	-3.1%
Florida	Not Currently Expanding	3,086,445	3,233,195	3,309,501	7.2%
Georgia	Not Currently Expanding	1,702,650	1,773,327	1,801,484	5.8%
Idaho	Not Currently Expanding	251,926	270,594	270,943	7.5%
Indiana	Not Currently Expanding	1,120,674	1,120,847	1,165,718	4.0%
Kansas	Not Currently Expanding	397,989	415,284	420,487	5.7%
Louisiana	Not Currently Expanding	1,019,787	1,008,176	1,011,883	-0.8%
Maine	Not Currently Expanding	-	-	-	
Missouri	Not Currently Expanding	714,055	828,478	829,585	-3.9%
Mississippi	Not Currently Expanding	863,417	720,292	731,876	2.5%
Montana	Not Currently Expanding	139,604	149,245	153,736	10.1%
North Carolina	Not Currently Expanding	244,600	1,786,369	1,802,167	3.3%
Nebraska	Not Currently Expanding	1,744,160	238,121	235,054	-3.9%
Oklahoma	Not Currently Expanding	790,051	814,881	828,329	4.8%
Pennsylvania	Not Currently Expanding	2,386,046	2,398,718	2,427,034	1.7%
South Carolina	Not Currently Expanding	988,349	1,017,333	1,041,993	5.4%
South Dakota	Not Currently Expanding	115,501	115,013	115,711	0.2%
Tennessee	Not Currently Expanding	1,244,516	1,279,336	1,298,181	4.3%
Texas	Not Currently Expanding	4,441,605	4,425,316	4,444,819	0.1%
Utah	Not Currently Expanding	322,442	330,306	332,826	3.2%
Virginia	Not Currently Expanding	1,003,266	1,058,839	1,039,822	3.6%
Wisconsin	Not Currently Expanding	1,161,876	1,162,614	1,151,225	-0.9%
Wyoming	Not Currently Expanding	71,962	72,378	119,767	-5.6%
				Percent Change in States Not Expanding*	***2.6%***
				Percent Change in All States*	**8.2%**

* Percent change based on states reporting for both the July-September 2013 and March 2014 periods.
Sources: CMS March 2014 and Updated February 2014 Medicaid and CHIP Application and Eligibility Report. See CMS reports for data definitions and state-specific data notes and caveats.

[1] State Health Facts, "Status of State Action on the Medicaid Expansion Decision, 2014," Kaiser Family Foundation, http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

[2] See Monthly Medicaid and CHIP reports, Medicaid Moving Forward 2014, Eligibility Data http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/medicaid-moving-forward-2014.html#.

[3] Centers for Medicare and Medicaid Services, "Medicaid & CHIP: March 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report," May 1, 2014, http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/medicaid-moving-forward-2014.html#.

[4] Seven states (CA, CO, CT, DC, MN, NJ, WA) implemented an "early option" to expand Medicaid coverage to adults between April 1, 2010 and January 1, 2014, using new state plan authority provided by the ACA or a Section 1115 demonstration waiver. Some of these states previously covered some adults enrolled in these early expansions through state- or locally-funded coverage programs. Overall, nearly 950,000 people are covered under these early expansions. Because most of these individuals were already enrolled in Medicaid by the July-September 2013 comparison period before the ACA, most of these beneficiaries are not counted as part of the 4.8 million enrollment gain.

[5] Ibid.

[6] Snyder, L., et al., "Medicaid Enrollment: June 2013 Data Snapshot," Kaiser Family Foundation, January 29, 2014, http://kff.org/report-section/medicaid-enrollment-june-2013-data-snapshot-total-enrollment/ and Smith, V., et al, "CHIP Enrollment: June 2013 Data Snapshot," Kaiser Family Foundation, January 29, 2014, http://kff.org/medicaid/issue-brief/chip-enrollment-june-2013-data-snapshot/.

[7] Garfield, R., Licata, R., and K. Young, "The Uninsured at the Starting Line: Findings from the 2013 Kaiser Survey of Low-Income Americans," February 6, 2014, http://kff.org/uninsured/report/the-uninsured-at-the-starting-line-findings-from-the-2013-kaiser-survey-of-low-income-americans-and-the-aca/.

Urban Institute

MAY 2014

Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care

By Sabrina Corlette and JoAnn Volk
Georgetown University Center on Health Insurance Reforms

Robert Berenson and Judy Feder, The Urban Institute

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

Authors

Sabrina Corlette
Senior Research Fellow and Project Director
Center on Health Insurance Reforms
Georgetown University Health Policy Institute

JoAnn Volk
Senior Research Fellow and Project Director
Center on Health Insurance Reforms
Georgetown University Health Policy Institute

Robert Berenson
Institute Fellow
The Urban Institute

Judy Feder
Institute Fellow
The Urban Institute

The Health Policy Institute at Georgetown University is a multi-disciplinary group of faculty and staff dedicated to conducting research on key issues in health policy and health services. In addition to this core research mission, the Institute also acts as a focal point for policy and health services research in the University and has provided support for the development of new, interdisciplinary health services research initiatives.

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

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

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.

Table of Contents

Introduction 1

Background 2

- Narrowing Networks Part of Broader Health System Trends 2
- The Narrow Network Strategy 3
- Network Adequacy Under the ACA 4

Policy Options: Balancing Consumer Protections With Affordability 5

- Any Willing Provider and Freedom of Choice Laws 5
- Network Adequacy Standards: Quantitative and Subjective Approaches 6
- Protecting Access While Preserving Flexibility 7

Striking the Balance: Improve Transparency and Facilitate Better Consumer Choices 8

- Reaching a Better Standard 8
- Improving Transparency 9
- Better Data Collection and Oversight 10

Conclusion 10

Acknowledgments 10

Introduction

Many health insurance plans offered in the individual market—both inside and outside the new marketplaces (also referred to as "Exchanges")—have narrowed their provider networks relative to what they have offered in the past.[1] Although it is not yet known how widespread this practice is, anecdotal reports of narrower networks have garnered notice from the media as well as federal and state policy-makers.[2] As one state official put it, "I don't know that many of us a year ago anticipated that qualified health plans inside the exchange were going to be changing their networks as dramatically as we experienced them."[3]

New network configurations offer trade-offs for consumers. Many insurers were able to lower their overall costs by reducing the prices they pay participating providers, which in turn allowed them to lower their premiums to attract price-conscious shoppers. However, in many cases, consumers have been surprised to discover that their new plan offers a more limited choice of providers. Some others willing to pay more to purchase a plan with broader access to providers have found that only limited-network plans are available in their area.[4]

It is not yet clear whether these new, narrower network plans can effectively deliver on the benefits promised under the plan. If policyholders opt to seek medically necessary care out-of-network, it could expose them to significant financial liabilities. If policyholders delay or forgo care because in-network providers can't meet their needs, it could put their health at risk.

Consequently, state and federal policy-makers are taking another look at the Affordable Care Act (ACA) requirement that plans participating on the new health insurance marketplaces maintain an adequate provider network. In doing so, they must strike a delicate balance. If they overly constrain insurers' ability to negotiate with providers, consumers could face significant premium increases. On the other hand, consumers must be able to choose among plans with confidence that they have a sufficient network to deliver the benefits promised and that they will not be exposed to unanticipated health and financial risks because of an inadequate network. Insurers also need incentives to take provider quality into account (in addition to prices).

In this paper we assess the benefits and risks of a range of policy and regulatory options available to federal and state policy-makers. We acknowledge that the development, review and oversight of health plan networks involves trade-offs between premium costs and consumers' access to and choice of providers. We know of no current regulatory approach that can satisfy all objectives or all stakeholders. However, we conclude that an appropriate balance between consumer choice and cost containment can be struck with a mix of strategies that include regulatory standards, better consumer information and more robust oversight. Specifically, we recommend the following:

- **Regulatory standards should establish a floor of consumer protection:**
  - Insurers should be required to meet a minimum standard for adequate access to primary care, but allowed greater flexibility with the provision of non-emergency specialty care, particularly when local providers can't meet quality expectations or demand unreasonably high payment levels.
  - Insurers who do not have a skilled and experienced in-network hospital or clinician to perform a needed service should be required to provide coverage for that service out-of-network, at no additional cost to the policyholder. This requirement helps ensure that consumers are held harmless if the care they need is only available out-of-network.
- **A regulatory floor will be both challenging to implement and by itself insufficient; consumer protection will also require transparency and oversight.**
  - Insurers, insurance regulators, and the marketplaces should dramatically improve and expand the information available to consumers about plans' network design and participating providers so that they have the tools to make informed choices.
  - State and federal regulators need to expand their capacity to monitor plans' provider networks and the extent to which consumers are using in- versus out-of-network care.

Background

In preparation for the ACA's 2014 market reforms, insurers used network design to lower costs in different ways. Some decided to exclude certain high-price providers from their networks; others offered all providers lower payment rates (leading some providers to decline to participate). Still others implemented tiered networks so that consumers face lower cost-sharing when they obtain care from an inner tier of preferred providers and higher cost-sharing for care obtained from another tier of less-preferred (but still in-network) providers. Tiered networks can become the functional equivalent of narrow networks when high cost-sharing deters use in less-preferred tiers or use of out-of-network providers. For the purposes of this paper, all of these approaches are labeled "narrow" network strategies, and they stem from insurers' belief that to gain market share on the new marketplaces, they must offer price-sensitive consumers a competitive premium. One national poll suggests this belief is well-founded—a majority of individuals likely to purchase coverage through the new marketplaces reported that they prefer less-costly narrow network plans over more-expensive plans with broader networks.[5]

Federal and state regulators generally gave insurers a significant amount of flexibility to narrow their networks for the 2014 plan year, even though marketplace plans are required to meet a minimum standard for network adequacy. Although some states adopted more detailed network adequacy standards than the federal one, many state officials tended to place a greater value on encouraging insurer participation than on robust network adequacy standards.[6]

As marketplace consumers enroll in plans and begin to use their new benefits, different parties are reacting to narrow network plans. Consumer groups, along with excluded providers, have expressed concerns about the networks' ability to provide access to quality care.[7] Some states—and the federal government—have responded with proposals for 2015 that would strengthen regulatory oversight, restrict insurers' plan design flexibility, and expand provider networks.

Narrowing Networks Part of Broader Health System Trends

The use of narrower networks as a mechanism to reduce premiums is not new, and it is not limited to plans in the new marketplaces. In the recent past, commercial health insurers have offered both narrow and broad network products, largely in response to demand from their employer-based customers. For example, in response to complaints about rising health costs from employer-based health care purchasers, insurers in the late 1980s and early 1990s increasingly offered tightly managed Health Maintenance Organizations (HMOs) or other products that constrained choice of provider in exchange for lower premiums. But these and other access restrictions contributed to a backlash from providers and consumers and led federal and state policy-makers to propose minimum standards for the adequacy of provider networks. While attempts at a federal standard for commercial health insurance foundered, many state legislatures filled the gap.[8] In 1996, the National Association of Insurance Commissioners (NAIC) adopted a model state law requiring managed-care plans to maintain networks that ensure access to services "without unreasonable delay;" this standard later became the template for federal standards under the ACA.[9]

Whether in response to tougher rules from regulators or employer demand, insurers in the late 1990s and early 2000s shifted to broader networks. While consumers had greater access to and choice of providers, health care premiums for employer-sponsored plans also accelerated, averaging 11 percent per year.[10]

These premium increases were not entirely due to expanded networks, but employers increasingly sought ways to constrain their costs, and the pendulum on network design began to swing again. Narrowing networks have again become more common in employer-based insurance, making up 23 percent of the plans offered by employers in 2012, up from 15 percent in 2007.[11] As one benefits expert noted, "It's definitely a growing trend…. there are only so many levers health plans and plan sponsors can pull if they want…. greater efficiency."[12]

In the individual market, insurers have long had many levers to constrain costs, such as the use of health status underwriting to avoid covering people with health care needs, benefit exclusions (such as declining to cover maternity care or prescription drugs), annual or lifetime dollar limits on benefits, and high cost-sharing (deductibles of $10,000 or more were not uncommon).[13] Therefore, they have not historically had the same incentives to narrow the provider networks for their individual market products. With the ACA's insurance

reforms removing those options for insurers, and in the face of concerns that an influx of sicker enrollees would require higher premiums, narrowing networks became the lever of choice for many individual market plans seeking to reduce costs and appeal to price sensitive consumers.

The Narrow Network Strategy

Current Impetus

The primary current impetus for health insurers to adopt narrow network benefit designs is to gain greater leverage to negotiate lower prices with providers, especially hospitals and large medical groups. In contrast to the situation with public payers, which are able to set nonnegotiable provider rates, commercial carriers negotiate payment rates with providers. Over the past 10–15 years, primarily due to provider consolidation, providers in many markets have been able to achieve greater power to raise prices for their services.[14] Consolidation has been particularly rampant among hospitals and hospital systems as well as single specialty medical groups merging into larger entities. Hospitals are also buying physician practices and employing physicians for various reasons, one of which is to enhance the hospital's and physicians' negotiating leverage with insurers. Wide disparities of hospital prices, mostly reflecting variations in pricing power, have been documented in recent years.[15] For example, commercial insurers on average pay hospitals about 40 percent more than Medicare pays,[16] but variations in payment rates range from near Medicare rates to as much as 600 percent more than Medicare.[17]

If an insurer cannot make a bona fide threat to either exclude a provider from its provider network or place it in a disadvantageous cost-sharing tier, it gives up an important source of leverage in payment negotiations. The threat of excluding or limiting a provider's network participation helps price negotiations in two ways. First, the threat itself might moderate a provider's price demands so it can be included in the network. Second, by actually limiting the network, the insurer can obtain a discount in exchange for the additional volume that the selected provider will receive.

While gaining leverage over negotiated prices is the primary reason insurers are returning to limited networks, some insurers report the desire to develop "high-performance" or "value" networks, at least for some markets. In this approach, the providers favored for inclusion in the narrow network not only are willing to provide comparatively favorable prices but also are potentially able to meet insurer objectives for improving quality and limiting unnecessary care. For example, some insurers are designating Centers of Excellence to which an enrollee is encouraged to go for certain elective specialty services, such as cardiac or other surgeries. While these centers may be outside the plan's service area—and in some cases in a different region or state—they are chosen because they deliver better outcomes at a lower price than local providers, even after the plan has paid for the travel expenses of the patient and a family member.[18]

Risks for Consumers

Narrow networks can be advantageous to insurers as a risk-selection mechanism because sicker individuals are likely to be more attracted to broad network plans. Over time, insurers currently offering broader network plans could be tempted to narrow their offerings in order to compete on price and discourage the enrollment of sicker individuals, leading to a race to the bottom. The ACA's risk adjustment mechanism is intended to largely eliminate this incentive, but its effectiveness remains uncertain.

If the network overly limits choice of provider, excluding those with specialized expertise in treating particular conditions, it could not only compromise the quality of care but also expose policyholders to unanticipated and potentially crippling financial liabilities. This can happen when they feel forced to seek care outside the plan network or in a less-preferred provider tier, or unwittingly rely on out-of-network services and face unexpected extra fees.[19] Some consumers may be willing to trade choice of providers for a lower premium, but they may be unaware of the risk they take. Insufficient regulatory oversight and transparency about insurers' network designs may prevent consumers from making informed decisions. In some marketplaces across the country, insurers in the individual market may only be offering narrow network plans, meaning that consumers who want a broad choice of providers do not have that option, even if they are willing to pay more.[20]

If a network is inadequate, policyholders are also more likely to be charged the difference between the provider's charge and what the insurer has agreed to pay, a phenomenon called "balance billing."[21] Consumers may know about the potential for balance billing before they obtain a service, but it is not uncommon for patients to receive unexpected charges when treated by out-of-network physicians working at in-network hospitals. The consumer may have specifically selected an in-network hospital

to avoid out-of-network cost-sharing, unaware that the hospital-based physicians (such as anesthesiologists, pathologists and radiologists) at that hospital are out-of-network. These physicians in essence own a monopoly on their specialty's services within the hospital, leaving patients little choice but to use their services and be exposed to out-of-network obligations. Indeed, in states that do not limit balance billing or impose on insurers the obligation to pay out-of-network providers, hospital-based physicians may take advantage of their captive patients by dropping out of plan networks.

In one extreme case, New Jersey physicians were sued for charging what one insurer called "unconscionable" amounts for simple services, including $59,490 for an ultrasound that would normally cost $74.[22] In most states, if the insurer doesn't pay the full amount demanded by the out-of-network provider, the patient can be billed for the remainder. New York's insurance regulators have logged at least 10,000 reimbursement complaints since 2008, with tens of thousands of dollars attributed to balance billing charges.[23] Some states have attempted to address the problem of balance billing with laws that regulate how much an insurer is expected to pay an out-of-network provider; a few states restrict balance billing by out-of-network providers, at least for some services (i.e., emergency care).[24] New York enacted legislation in early 2014 that, in addition to holding consumers harmless from unexpected balance billing also requires greater up-front disclosure of consumers' potential out-of-pocket costs when obtaining care from an out-of-network provider.[25]

Network Adequacy Under the ACA

The ACA establishes the first national standard for network adequacy in commercial health insurance by requiring plans sold on the health insurance marketplaces to maintain a provider network that is "sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay." Marketplace plans must also include in their networks essential community providers (ECPs) that serve predominantly low-income, medically underserved individuals. A plan's provider directory must be available online and in hard copy upon request.[26] In addition, the ACA prohibits insurers from charging consumers out-of-network cost-sharing for emergency services, even if those services are delivered by out-of-network providers.[27]

At the same time, the ACA's new insurance rules raise the stakes for consumers who use out-of-network providers. First, out-of-network cost-sharing does not count towards the ACA's limit on policyholders' annual out-of-pocket costs (which for 2014 is set at $6,350 for an individual and $12,700 for a family).[28] Consumers in plans with a network that cannot meet their health care needs could therefore be at significant financial risk. Second, while the ACA establishes a minimum actuarial value[29] for each plan, the cost of out-of-network care is not included in the actuarial value calculation. As a result, consumers cannot rely solely on a plan's precious metal level (bronze, silver, gold, and platinum) to fully assess a plan's relative generosity.[30]

As implemented, network adequacy standards under federal rules give states and insurers considerable flexibility in interpreting what would constitute "sufficient" numbers and types of providers that can deliver covered benefits without "unreasonable delay." Some states conducting plan management for the marketplace, either as a state-based marketplace or a state partnership marketplace, have enacted additional standards. For example, Vermont and Delaware set standards for maximum geographic distances and drive time to obtain primary care services. California requires plans to make services in urban areas reasonably accessible by public transportation.[31] Pre-dating the ACA, several states (including Colorado, Missouri and Montana) also required insurers that did not have an in-network provider to meet a patient's needs to allow the patient to obtain care out-of-network at the in-network cost-sharing level.[32]

In federally facilitated marketplaces, where federal regulators have been responsible for health plan certification, states were largely left responsible for reviews of network adequacy—as long as the state had authority to review plan networks and a network adequacy standard at least as stringent as is required under federal rules. In states without sufficient network adequacy reviews, the Centers for Medicare and Medicaid Services (CMS) accepted an insurer's accreditation from two national accrediting bodies, the National Committee for Quality Assurance and URAC to satisfy the requirement.[33]

To date, some plans on the marketplaces have gained significant market share because their narrow networks allowed them to offer low premiums. In response to concerns that insurers narrowed their networks too much, federal regulators have said they intend to strengthen their review of insurers' networks for the 2015 plan year. For insurers operating in states with federally facilitated

marketplaces, federal regulators may conduct network reviews themselves, rather than simply accepting state reviews or accreditation status. In doing so, the CMS will "focus most closely on those areas which have historically raised network adequacy concerns," including hospitals and mental health, oncology and primary care. Federal officials have further intimated that they may develop new, quantitative limits on the length of time or distance required to access benefits.[34]

Policy Options: Balancing Consumer Protections With Affordability

States seeking to address concerns about the adequacy of plans' provider networks while also constraining premium cost growth face a range of legislative and regulatory options. As one state regulator put it, "If the carriers don't push against provider pricing, who will?"[35] One option is to have government address provider payment rates directly. During the 1970s and 1980s, eight states adopted rate-setting systems to set limits on inpatient and outpatient hospital prices.[36] However, all but two states—Maryland and West Virginia—abandoned rate setting in the 1990s. Some stakeholders have advocated a "public option" plan that could, like Medicare, offer enrollees access to a broad network while using market power to limit prices. For the foreseeable future, however, the prospects for government rate-setting and a public option in most states are slim.

A pressing need is for the exercise of state authority to review and revise current regulation of the adequacy of insurers' networks. In doing so, policy-makers must balance the interests of many consumers and provider stakeholders in having a broad choice of in-network providers with consumers' equally important interest in affordable premiums. To meet the latter interest, insurers will need negotiating flexibility to extract lower prices from providers, particularly hospital systems and large single-specialty and multispecialty group practices. At the same time, states must hold insurers accountable for delivering on promised benefits and consumers must be able to make informed choices from among plan options.

Over the years, states have taken specific steps to address concerns about network adequacy, ranging from laws requiring insurers to contract with "any willing provider," to quantitative standards of network adequacy, to more laissez-faire approaches. We review the benefits and risks of these approaches and ultimately submit one multipronged approach that could help states strike a better balance between ensuring consumers' access to covered services, constraining providers' pricing power, and encouraging the development of networks based primarily on the value (high quality at a reasonable cost) of the care provided.

Any Willing Provider and Freedom of Choice Laws

In response to the consumer and provider backlash against the tightly managed care networks that proliferated in the 1990s, some states enacted laws intended to restrict the ability of managed care insurers to selectively contract with providers. These state laws vary considerably but come in two general forms. The first is termed an "any willing provider" (AWP) law. AWP laws generally require insurers to accept into their network any provider willing to comply with the insurer's rates and terms and conditions.[37] Other AWP laws simply require health plans to negotiate with providers, without requiring the insurers to contract with providers seeking network inclusion. According to one count, 22 states have an AWP law in place, though the specifics vary considerably from state to state and some are limited to pharmacy providers.[38]

In the wake of concerns about narrowing plan networks on the new health insurance marketplaces, some states—such as Mississippi and New Hampshire—have considered adopting AWP requirements.[39] These laws are controversial, however. Insurers argue that limits on their contracting flexibility increase their costs. While some providers and consumer advocates support these laws, others, even in the provider community, recognize that requiring insurers to include any provider who agrees to contract terms and conditions could adversely affect insurer discretion to develop networks designed to improve quality and reduce costs.[40]

The second type of law is called a "freedom of choice" (FOC) law, which allows a health plan's policyholders to receive health care services from any qualified provider,

even if the provider has not signed a contract with the health plan. According to one estimate, 23 states have enacted some variation of an FOC law.[41] FOC laws come with their own set of disadvantages, the primary one being that while they permit consumers to obtain care out-of-network, most do not protect them against high out-of-pocket charges.

Network Adequacy Standards: Quantitative and Subjective Approaches

Establishing a standard for network adequacy—or for what it means for an insurer to provide reasonable access to services—is no simple matter. Currently, when states regulate the adequacy of commercial insurers' networks, they have taken two primary approaches. Some set quantitative standards such as time and distance limits, provider-to-enrollee ratios, and appointment waiting time limits.

Examples of Quantitative Standards for Network Adequacy
Provider-to-enrollee ratios
Maximum travel time
Maximum travel distance
Maximum appointment wait times
Minimum number of providers accepting new patients
Minimum percentage of available providers within a service area

For example, California's Department of Managed Care sets out maximum travel times and distances, maximum wait times and minimum provider-to-enrollee ratios. Texas caps an HMO policyholder's travel to no more than 30 miles in nonrural areas and 60 miles in rural areas for primary care, with the maximum distance for specialty care and specialty hospitals set at 75 miles.[42] The federal government has established quantitative network standards in the Medicare Advantage program, and 29 states have set such standards for their Medicaid managed care organizations.[43]

Other states impose more subjective or flexible standards for commercial plans, similar to the reasonable access standard defined in the NAIC's model law and now in federal regulations. For example, Colorado requires managed care plans to demonstrate that their network is "sufficient" to provide access "without unreasonable delay," and allows insurers to set provider-enrollee ratios according to "reasonable criteria."[44]

Whether quantitative or subjective, when states have standards for commercial health plans, most are directed toward HMOs and not other network-based plans, such as Preferred Provider Organizations or Exclusive Provider Organizations. Over time, as distinctions between these different types of plans have blurred (i.e., many HMOs offer an out-of-network option and Exclusive Provider Organizations may not), failure to set a common standard among all plans creates an unlevel playing field and leads to consumer confusion. See Table 1.

Setting clear quantitative standards and conducting an upfront review of plans' networks to determine whether they meet those standards has advantages and disadvantages. Among the advantages are the clarity and certainty of numerical standards, and a level playing field among insurers, who, if given flexibility to define adequacy would likely do so differently.

However, this type of regulation is not without problems. First, because networks evolve over time as clinicians and hospitals are added or dropped from the network, the network adequacy review process provides only a temporary snapshot—and may tell a consumer little about the plan at the point in time he or she is purchasing it. Second, it may be difficult to set a standard that sufficiently accounts for geographic and market variables across the state. For example, while a state might impose a different standard in a rural region than in an urban one, it can be challenging to calibrate the standard to all the different conditions that may exist from market to market within a state. In addition to population density, local market conditions can also affect insurers' ability to develop and maintain robust, high quality and efficient networks. Local markets can vary by levels of provider consolidation and concentration, usage and referral patterns, performance on quality metrics, and insurers' use of out-of-area Centers of Excellence for certain services or procedures.

Third, for the population of people enrolling in marketplace plans—particularly those who were previously uninsured—it is not yet fully understood how they are likely to seek and receive care. While there is evidence they are more accepting of a narrow network when choosing a plan than those with employer-based coverage, research also shows that many are less familiar with health insurance and benefit concepts, including the concept of a provider network.[45] Some may enroll in plan networks that prove too limited if and when they develop a health condition; many also have more limited resources and are therefore at greater financial risk if

Table 1. Types of Network Design

Type of plan	Definition
Health Maintenance Organization (HMO)	An HMO integrates health insurance with the provision of health care services. An HMO directly provides (i.e., through their own hospitals and employed physicians) or arranges for health care for their enrollees. The HMO does not generally cover any portion of the cost of care obtained outside the HMO's network of providers.
HMO with Point of Service (POS) option	The POS option allows enrollees of an HMO to obtain covered care outside of the HMO's network of providers, but usually at higher cost-sharing.
Exclusive Provider Organization (EPO)	An EPO is a network of medical care providers who have entered into written agreements with an insurer to provide health care services to enrollees. The insurer will only pay for the health care services of an enrollee if they are obtained within the EPO network.
Preferred Provider Organization (PPO)	A PPO is a network of physicians, hospitals and other providers that agree to provide health care services at discounted rates to the enrollees of a health insurer. Enrollees can generally obtain health care services from providers outside the PPO network, but usually with higher cost-sharing.

Sources: Claxton, G. *How Private Insurance Works: A Primer,* Menlo Park, CA: Kaiser Family Foundation, 2002.; Pan, A. *Exclusive Provider Organizations,* http://www.healthinsurance.info/plans/EPO.HTM.

they obtain care out-of-network. Thus, an approach to network adequacy that has worked well for a population with a stable source of employer-based coverage and care may be insufficient for the population of people enrolled in marketplace plans. Fourth, and more pragmatically, many state insurance regulators lack capacity to conduct a comprehensive, pre-market review of insurers' provider lists and contracts across all their plan offerings. An NAIC white paper on network adequacy recommends that state regulators have a "general familiarity" with provider availability in a given area, medical referral patterns, hospital-based providers who might not be in-network when the facility is, and any geographic barriers in an area.[46] However, many state insurance agencies do not have the staffing to systematically collect, analyze and use this kind of information in their reviews. In a number of states, network adequacy reviews have also historically been done by a separate agency (often the Department of Health) or may in the future be done by the marketplace. This could lead to a lack of coordination and disjointed oversight.[47] Information technology and network review software may be able to help with this over time, but current tools are limited.

Instead of quantitative standards, many states may prefer to give insurers more flexibility to tailor their networks by taking a subjective approach. However, a subjective standard—such as ensuring policyholders can receive services without "unreasonable delay"—leaves the determination of reasonableness in the eye of the beholder. For example, Anthem Blue Cross Blue Shield in New Hampshire responded to the new federal network adequacy requirements by excluding over 30 percent of the state's hospitals from its networks. For the insurer and for regulators, this amounted to a reasonable network. But for at least some consumers, and the state hospital association, it is not.[48] And Washington's insurers found that their definition of "reasonable access" was at odds with that of the state insurance commissioner, who initially rejected the marketplace applications of five insurers on the grounds that they had inadequate networks. The commissioner's interpretation of reasonableness was in turn rejected by an administrative law judge and the state's own marketplace, which urged inclusion of the insurers.[49] Without a clear standard, it is hard to determine when an insurer's reductions in the provider panel go too far, rendering the plan unable to deliver on promised benefits and reducing policyholders' ability to obtain convenient, needed services within their plan's network. Despite its flaws, a clear, numeric adequacy standard may be preferable to ensure that a network can fully meet policyholders' needs.

Protecting Access While Preserving Flexibility

Whether a state adopts a quantitative or subjective regulatory approach to its evaluation of plan networks, no state should consider its oversight job complete after a plan is approved for sale. In addition to a review of the

overall number and distribution of in-network providers, officials need to consider consumers' ability to understand what kind of plan they are purchasing and once purchased, their ability to obtain in-network care.

Under the ACA, federal and state regulators have new authority to collect data from insurers on the volume and types of services enrollees are receiving out-of-network.[50] While capacity to collect and analyze that data may currently be limited, over time regulators will gain the opportunity to identify outliers or trends suggesting a lack of network adequacy. Data could also be made available to health researchers, whose published studies could help supplement analyses from state agencies. State and federal regulators should also be publicizing and closely monitoring plans' consumer satisfaction scores, such as through the Consumer Assessment of Healthcare Provider and Systems survey, as well as any complaints received by insurers, the Department of Insurance, and the health Insurance marketplace. They could be conducting "secret shopper" surveys to assess whether policyholders can actually obtain necessary care within the network on a timely basis and within a reasonable geographic radius of their home or workplace.

In addition, state and federal regulators have not historically included metrics on access that reflect the changing nature of care delivery. Effective regulation needs to be flexible enough to accommodate new and emerging delivery models. A white paper published by the National Committee for Quality Assurance observes, "Current network adequacy standards put a premium on the number of providers in a plan's network. They rarely address whether those in-network providers are high quality or offer expanded access."[51] For example, regulators could review whether insurers are providing incentives for physicians to offer weekend and evening hours. They could assess whether providers' training, experience, and performance on quality metrics are driving insurers' decisions to include them in networks or whether network inclusion is mostly price-driven. They could ask whether providers in the network are reimbursed when they use information technology such as videoconferencing, email, live chat and electronic health records to communicate with and deliver care to patients. Reviewers could also examine whether the insurer is using reimbursement or cost-sharing incentives to encourage providers and patients to use the most appropriate care setting for the care being delivered.

While it may reduce consumers' premiums when insurers configure their networks to include low-cost hospitals and other providers and exclude the highest-cost, consumers pay a price when cost is the only factor taken into account. Insurers and other payers collect from providers a wide range of data on quality metrics and consumer experience. But current regulatory standards do not require them to take providers' performance on those metrics into account as they build or cull their networks.

Striking the Balance: Improve Transparency and Facilitate Better Consumer Choices

As federal and state officials assess their current network adequacy standards, they need to account for new mechanisms of care delivery and new ways in which consumers are comparing and shopping for health coverage. This also means recognizing the difference between provider access and provider choice. Consumers in all plans, no matter how narrow, deserve to be confident they'll have access to a provider network that can deliver the benefits promised under their policy. But that commitment doesn't require unrestricted choice of providers. Many consumers are willing to forgo an unrestricted choice of providers in exchange for a lower premium, so long as in-network providers deliver high-quality care that can meet their needs.

Reaching a Better Standard

First, to protect consumers from a potential race to the bottom, policy-makers should require all insurers, both inside and outside the marketplaces, to meet a minimum network adequacy standard that limits the amount of time and distance a policyholder must travel in order to access emergency, primary care, and high-volume specialty services. A similar quantitative time and distance standard should also be required for nonemergency specialty care, but regulators should have the flexibility to grant insurers waivers if they can demonstrate that hospitals and specialty providers within the requisite geographic area do not meet or are not willing to meet

the plan's requirements for price and quality. With such flexibility, providers who use telemedicine, meet plan expectations for quality performance, offer evening and weekend office hours, and serve as Centers of Excellence for specialized care could be considered as if they are within the time/distance limits. As they are currently, quantitative time and distance standards would still need to be calibrated within the state to local conditions. A model for this is the Medicare Advantage program, which has time/distance limits that vary based on five different types of geographic areas, ranging from dense urban areas to less populated rural and frontier areas.[52] As noted above, quantitative network adequacy standards have drawbacks, but they currently offer the most effective way to hold insurers accountable to a common standard, build confidence that marketplace plans are high quality, and help ensure consumers receive needed care within a reasonable proximity to their home or place of work.[53] With greater transparency, better consumer information, and robust market oversight, over time these quantitative standards, given their many limitations, may prove to be unnecessary.

At a minimum, however, insurers who do not have an in-network hospital or clinician to perform a needed service, or do not have a provider with the appropriate training and expertise, should be required to provide coverage for that service out-of-network at no additional cost to the policyholder. Such a requirement helps ensure that consumers are held harmless if the care they need is only available out-of-network. This requirement, accompanied by advance disclosure, can also help consumers who might face balance billing when they receive care at an in-network facility from out-of-network physicians, such as anesthesiologists, radiologists and pathologists. New York's 2014 law holding patients harmless for surprise bills when at in-network facilities, while not yet implemented, could become a model for other states.[54] However, this option is not a replacement for maintaining an adequate network. Because it requires a case-by-case assessment, it places a burden on consumers both to be informed enough to seek out-of-network care with in-network cost-sharing and to have the time and energy to pursue it with their insurer. Unfortunately, some of these issues can only be resolved through an appeals or dispute resolution process, which can place considerable demands on patients' time and resources.

Improving Transparency

Second, all consumers need the ability to make an informed choice—an ability that is inadequate in the individual insurance market today—both inside and outside the marketplaces. At a minimum, consumers need standardized information about the breadth and restrictiveness of plan networks, before they make a purchasing decision. The ACA requires plans sold on the marketplaces to include a provider directory and to denote when a listed provider is not accepting new patients.[55] However, provider directories are notoriously inaccurate and unreliable. Some provider directories offered on insurers' websites don't clearly display how the network configuration may change among different plans offered by the same insurer. At least one state-based marketplace has had to pull its own provider directory off its website because of errors.[56]

Consumers, whether shopping for coverage on or off the marketplace, should be able to quickly assess what kind of network a plan has (i.e., broad or restrictive choice) and compare it easily to other plans in their price range. They should also be able to have confidence that the provider directory is accurate and up-to-date. Provider directories are a two-way street: insurers have an obligation to keep them current and avoid errors, but providers must also be held accountable for reporting when a provider leaves the network or is no longer taking new patients. To ensure consumers can make informed decisions, both in selecting a plan and then in using their coverage, insurers should be required to make monthly updates to their on-line provider directories. Consumers cannot be expected to make optimal plan and provider choices if they cannot get easy-to-understand, up-to-date and clear information about the type of plan network they are buying and the names, locations and types of participating providers. The state and federal marketplaces should offer consumers a special enrollment opportunity if they need to switch plans or carriers because they were given inadequate or incorrect network information when making their initial plan selection.

Consumers also benefit from standardized, consumer-friendly information about each health plan's performance on enrollees' ability to obtain needed care quickly and easily, such as through a star rating system and consumer satisfaction scores. However, in this first year of implementation, with many other technology challenges confronting them, the marketplaces did not provide that information to consumers in an actionable way.[57]

Better Data Collection and Oversight

Lastly, state and federal regulators need to actively monitor plans inside and outside the marketplaces by collecting and analyzing data regarding policyholders'

use of out-of-network services, consumer satisfaction scores, complaints filed with the department of insurance or the marketplaces and internal or external appeals. As noted above, such oversight would be enhanced through "secret shopper" calls or spot-check audits to ensure that policyholders are able to access the provider they need in a timely fashion. Regulators should also require insurers to report mid-year changes to their network to departments of insurance and to enrollees. Plans that don't deliver on promised benefits should be required to not hold consumers financially accountable if they can only obtain needed care outside the network.

The above recommendations address some but not all of the challenges raised by narrow or restrictive provider networks. Because many of the ACA's insurance market and delivery system reforms have only just been fully implemented, they will require continued monitoring and adaptation to improve the functioning of insurance markets and protect consumers' access to affordable, high quality care.

Conclusion

There is no perfect approach to the oversight of health plan networks. In the absence of other government policies to constrain provider prices, insurers' ability to exclude or threaten to exclude providers from the network is important to their ability to negotiate reimbursement rates and offer more affordable premiums to consumers. On the other hand, if insurers narrow their networks too much, consumers could be harmed if forced to go out-of-network or to a less-preferred provider tier to meet their needs. Policy-makers therefore need to strike a balance between consumer protection and insurer flexibility.

Our proposed approach sets minimum quantitative standards, with waivers for certain providers based on price and quality; improves transparency and consumer information to give consumers better tools to make informed choices; gives insurers the flexibility to develop more value-oriented network designs so long as they maintain a provider network that can meet people's needs; and—to assure effective consumer protection—calls for continuous monitoring of consumers' use of out-of-network services, complaints and appeals, and more active oversight of plan behavior.

Acknowledgments

The authors gratefully acknowledge the editorial contributions of Kevin Lucia, David Cusano, Sally McCarty, Jack Hoadley, Jenny Kenney, Christina Goe, Linda Blumberg, Peggy O'Kane, Michael Johnson, Stephanie Mohl, and Christine Barber, and the research support provided by Elissa Dines.

Endnotes

1 McKinsey Center for U.S. Health System Reform. "Hospital Networks: Configurations on the Exchanges and Their Impact on Premiums." New York: McKinsey & Company 2013. See also Hancock, J, "'Narrow Networks' Trigger Push-Back from State Officials," *Kaiser Health News,* Monday, November 25, 2013, http://www.kaiserhealthnews.org/stories/2013/november/25/states-balk-at-narrow-networks.aspx.

2 See, for example, U.S. Senator Jeanne Shaheen, letter to Secretary Kathleen Sebelius, 29 January 2014. http://www.shaheen.senate.gov/imo/media/doc/1-29-14%20Letter%20to%20Secretary%20Sebelius%20on%20Network%20Adequacy%20Standards.pdf.

3 Hansard S. *Some States Look at Limits on Insurers' Ability to Exclude Providers from Plans,* BNA, Dec. 17, 2013.

4 See, for example, Jan T, *With Health Law, Less-Easy Access in New Hampshire, Boston Globe,* Monday, January 20, 2014, http://www.bostonglobe.com/news/nation/2014/01/20/narrow-hospital-networks-new-hampshire-spark-outrage-political-attacks/j2ufuNSf9J2sdEQBpgIVqL/story.html; and Gottlieb L, *Daring to Complain About Obamacare, New York Times,* Sunday, November 10, 2013, http://www.nytimes.com/2013/11/11/opinion/daring-to-complain-about-obamacare.html?_r=0.

5 Hamel, L, Firth, J and Brodie M. *Kaiser Health Tracking Poll: February 2014.* Menlo Park, CA: Kaiser Family Foundation, 2014, http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-february-2014/.

6 Holahan J, Lucia KW, and Monahan C. *Cross-Cutting Issues: Insurer Participation and Competition in Heath Insurance Exchanges: Early Indications from Selected States.* Princeton, NJ: Robert Wood Johnson Foundation, 2013, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf406939

7 *Insurers Face Pressure to Make Networks Less Narrow.* Washington, D.C.: Advisory Board Company, 2014, https://www.advisory.com/daily-briefing/2014/02/07/insurers-face-pressure-to-make-aca-networks-less-narrow; and Schneider, ME, "Feds Pledge Closer Scrutiny of Provider Networks in 2015," *Cardiology News,* Wednesday, March 26, 2014, http://www.ecardiologynews.com/index.php?id=8736&type=98&tx_ttnews[tt_news]=243721&cHash=da03e20e36.

8 McCarty S and Farris M. *ACA Implications for State Network Adequacy Standards.* Washington, D.C.: State Health Reform Assistance Network, 2013, http://www.statenetwork.org/wp-content/uploads/2014/02/State-Network-Georgetown-ACA-Implications-for-State-Network-Adequacy-Standards.pdf.

9 *Managed Care Plan Network Adequacy Model Act #74.* Washington, D.C.: National Association of Insurance Commissioners, 1996, http://www.naic.org/store/free/MDL-74.pdf.

10 Authors' calculation based on annual average premiums for family employer-sponsored coverage in large firms, 1999 to 2005. *Employer Health Benefit Survey.* Menlo Park, CA: Kaiser Family Foundation, 2013. Available from: http://kff.org/private-insurance/report/2013-employer-health-benefits/.

11 ibid.

12 Burns, J, "Narrow Networks Found to Yield Substantial Savings," *Managed Care Magazine,* February 2012, Available from: http://www.managedcaremag.com/archives/1202/1202.narrow_networks.html.

13 Corlette S, Volk J and Lucia KW. *Real Stories, Real Reforms, Georgetown University Center on Health Insurance Reforms.* Washington, D.C.: Robert Wood Johnson Foundation, 2013, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407972.

14 Berenson RA, Ginsburg PB, Christianson JB and Yee T, *The Growing Power of Some Providers to Win Steep Payment Increases From Insurers Suggests Policy Remedies May Be Needed, Health Affairs,* 31(5): 973–981, 2012.

15 See, for example, *Examination of Health Care Cost Trends and Cost Drivers.* Boston: Office of Attorney General Martha Coakley, 2010, http://www.mass.gov/ago/docs/healthcare/2010-hcctd-full.pdf; and Ginsburg, PB. *Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power.* Washington, D.C.: Center for Studying Health System Change, 2010, http://www.hschange.com/CONTENT/1162/1162.pdf.

16 *A Data Book: Health Care Spending and the Medicare Program.* Washington, D.C.: MedPAC, 2012, http://www.medpac.gov/documents/Jun12DataBookEntireReport.pdf.

17 Ginsburg, *Wide Variation in Hospital and Physician Payment Rates.*

18 Burns, "Narrow Networks Found to Yield Substantial Savings."

19 See, for example, Wendy Kaufman, "Health Insurance Seekers Find Networks Missing Key Providers," *Morning Edition,* Friday, December 13, 2013. http://www.npr.org/templates/story/story.php?storyId=250656121.

20 See, for example, Doughman A, "Nevada's Health Exchanges to Open, but Will They Work?" *Las Vegas Sun,* Monday, September 30, 2013, http://www.lasvegassun.com/news/2013/sep/30/nevadas-health-exchanges-open-will-they-work/; and Nahmias L and Goldberg D. "After a Good Start, State May Change Exchange Rules," *Capital New York,* Tuesday, March 4, 2014, http://www.capitalnewyork.com/article/albany/2014/03/8541192/after-good-start-state-may-change-exchange-rules

21 McCarty and Farris, *ACA Implications for State Network Adequacy Standards.*

22 Waldman P, "Ultrasound at $59,490 Spurs Aetna Outrage in Suit Naming Doctors," *Bloomberg News,* Thursday, March 24, 2011, http://www.bloomberg.com/news/2011-03-24/ultrasound-at-59-490-is-outrage-in-aetna-claim-against-doctors.html.

23 "Superintendent Lawsky Sends Letter to Legislature Urging Passage of Legislation in State Budget to Protect Consumers From Surprise, Out-of-Network Medical Bills." *New York Department of Financial Services,* Monday, March 24, 2014, http://www.dfs.ny.gov/about/press2014/pr1403241.htm; and Kardish C, "New York's Patient Protections May be National Model," *Governing Magazine,* Tuesday, April 15, 2014, http://www.governing.com/topics/health-human-services/gov-new-york-passes-patient-protections.html.

24 "State Restrictions Against Balance Billing Managed Care Enrollees." Georgetown University Center on Health Insurance Reforms and Kaiser Family Foundation, accessed May 9, 2014, http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/; see also Hoadley J, Lucia K and Schwartz S. *Unexpected Charges: What States are Doing About Balance Billing.* Oakland, CA: California HealthCare Foundation, 2009, http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/U/PDF%20UnexpectedChargesStatesAndBalanceBilling.pdf.

25 N.Y. S.B. 6914 (2014).

26 45 CFR § 156.230.

27 45 CFR § 147.138(b).

28 45 CFR § 156.130.

29 Actuarial value refers to the percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70 percent, policyholders, on average, would be responsible for 30 percent of the costs of all covered benefits. The ACA sets a minimum actuarial value of 60 percent (called a bronze-level plan), and requires plans to be offered at multiple "precious metal" tiers. Seventy percent actuarial value equates to a silver-level plan, 80 percent to a gold-level plan, and 90 percent to a platinum-level plan.

30 Clemans-Cope L, Blumberg L, Feder J and Pollitz K. *Protecting High-Risk, High-Cost Patients: "Essential Health Benefits," "Actuarial Value" and other Tools in the Affordable Care Act.* Washington, D.C.: Urban Institute, 2012, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73171.

Endnotes

31 Rosenbaum S, Lopez N, Mehta D, Dorley M, Burke T and Widge A. *Realizing Health Reform's Potential: How Are State Insurance Marketplaces Shaping Health Plan Design?* Washington, D.C.: The Commonwealth Fund, 2013, http://www.commonwealthfund.org/Publications/Issue-Briefs/2013/Dec/State-Insurance-Marketplaces-Shaping-Health-Plan-Design.aspx.

32 Colo. Rev. Stat. § 10-16-704; Mo. Rev. Stat. § 354.603; Mont. Code Ann. § 33-36-201; *see also NAIC Managed Care Plan Network Adequacy Model Act Model Adoption* chart. Available from: http://www.naic.org/store/free/MDL-74.pdf.

33 "Letter to Issuers on Federally-facilitated and State Partnership Exchanges." Baltimore: Center for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, 2013, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf.

34 "2015 Letter to Issuers in the Federally-facilitated Marketplaces." Baltimore: Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, 2014, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/draft-issuer-letter-2-4-2014.pdf.

35 Telephone communication with state health insurance department official, Apr. 14, 2014. Name not included to preserve confidentiality.

36 Sommers AS, White C and Ginsburg PB. *Addressing Hospital Pricing Leverage through Regulation: State Rate Setting.* Washington, D.C.: National Institute for Health Care Reform, 2012, http://www.nihcr.org/1tl92.

37 Hellinger FJ. "Any-Willing-Provider and Freedom-of-Choice Laws: An Economic Assessment." *Health Affairs,* 14(4): 297–302, 1995.

38 National Conference of State Legislatures. *Managed Care State Laws and Regulations, Including Consumer and Provider Protections.* Washington, D.C.: National Conference of State Legislatures, 2010, http://www.ncsl.org/research/health/managed-care-state-laws.aspx.

39 Miss. HB 553 (2014); Ramer, H, "Insurers Limited Health Network Prompts NH Bill," *Boston Globe,* January 28, 2014, http://news.yahoo.com/insurers-limited-health-network-prompts-200830275.html; see also NH HJR 12 (2014).

40 American College of Physicians. *Progress, Challenges and Opportunities: Taking the Next Steps to Reduce Barriers to Access and Reform Medicare Physician Payments.* Philadelphia: American College of Physicians, 2014, http://www.acponline.org/advocacy/advocacy_in_action/state_of_the_nations_healthcare/assets/2014/snhc_report2014.pdf.

41 National Conference of State Legislatures, *Managed Care State Laws and Regulations.*

42 McCarty and Farris, *ACA Implications for State Network Adequacy Standards.*

43 Kaiser Family Foundation. *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey, Appendix 8.* Menlo Park, CA: Kaiser Family Foundation, 2011, http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8220.pdf.

44 McCarty and Farris, *ACA Implications for State Network Adequacy Standards.*

45 Hamel, et al., *Kaiser Health Tracking Poll: February 2014;* see also Blumberg LJ, Long SK, Kenney GM and Goin D. *Public Understanding of Basic Health Insurance Topics on the Eve of Health Reform.* Washington, D.C.: Urban Institute, 2013, http://hrms.urban.org/briefs/hrms_literacy.html.

46 *Plan Management Function: Network Adequacy White Paper.* Washington, D.C.: National Association of Insurance Commissioners, 2012, http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf.

47 Corlette S, Volk J and Lucia KW. *Plan Management: Issues for State, Partnership, and Federally Facilitated Exchanges.* Washington, D.C.: National Academy of Social Insurance, 2012, http://www.nasi.org/sites/default/files/research/Plan_Management_Issues_for_Exchanges.pdf.

48 Hancock, J, "'Narrow Networks' Trigger Push-Back from State Officials."

49 Landa AS and Ostrom CM, "Many Wash. Health-Exchange Plans Exclude Top Hospitals From Coverage." *Kaiser Health News,* December 3, 2013, http://www.kaiserhealthnews.org/stories/2013/december/03/many-exchange-plans-exclude-top-hospitals.aspx.

50 42 U.S.C. §§ 300gg–15a , 18031 (2010).

51 *Network Adequacy and Exchanges.* Washington, D.C.: National Committee for Quality Assurance, 2013, http://www.ncqa.org/Portals/0/Public%20Policy/Exchanges&NetworkAdequacy_2.11.13.pdf.

52 *MA Health Services Delivery Provider & Facility Specialties and Network Adequacy Criteria Guidance.* Baltimore: Centers for Medicare and Medicaid Services, 2014, http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2015_MA_HSD_Network_Criteria_Guidance.pdf.

53 While staff-model HMOs or integrated plans should not be required to contract with providers outside the plan, they can meet quantitative standards for such things as maximum travel distance and time and provider-to-enrollee ratios.

54 N.Y. S.B. 6914 (2014).

55 45 CFR § 156.230.

56 Terhune C, "California Health Exchange Pulls Error-Ridden Physician List—Again," *LA Times,* February 7, 2014, http://www.latimes.com/business/money/la-fi-mo-covered-california-pulls-provider-directory-20140206,0,3930552.story#axzz2t1OD4hHk.

57 The federally facilitated marketplace and some state-based marketplaces are working to develop quality rating systems that rely in part on consumer satisfaction to rate based on performance. But these systems are still being developed and it is unlikely they will provide useful information on the networks of marketplace plans before 2016.

Georgetown University Health Policy Institute
3300 Whitehaven Street, N.W., Suite 5000
Washington, DC 20057-1485
Telephone (202) 687-0880
http://chir.georgetown.edu/

THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

Filling the need for trusted information on national health issues...

May 2014 | Issue Brief

The Affordable Care Act and Insurance Coverage in Rural Areas

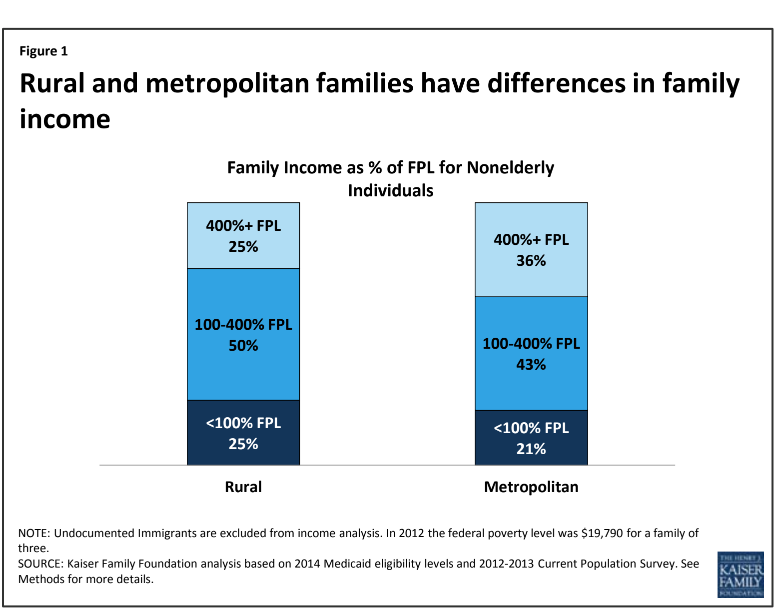
Vann R Newkirk II and Anthony Damico

Introduction

Almost 50 million people, or about 16 percent of the population of the United States, live in rural areas. These rural areas are defined as those outside of Metropolitan Statistical Areas (MSAs). MSAs are urban areas with more than 50,000 residents and surrounding suburbs. The populations of rural areas have different demographics, health needs and insurance coverage profiles than their urban counterparts, which means that Medicaid and Marketplace coverage reforms in the Affordable Care Act (ACA) may affect the two populations differently. In particular, rural populations tend to have high shares of low-to-moderate-income individuals, those who are in the target population for ACA coverage reforms. However, nearly two-thirds of uninsured people in rural areas live in a state that is not currently implementing the Medicaid expansion, meaning they are disproportionally affected by state decisions about ACA implementation. As a result, uninsured rural individuals may have fewer affordable coverage options moving forward. This brief examines these differences in populations and coverage patterns and assesses how ACA coverage reforms will affect rural and metropolitan areas in different ways.

The Challenge of Extending Health Insurance Coverage in Rural Areas

Compared to populations in metropolitan areas, the rural population has lower income (Figure 1). One-quarter of the nonelderly rural population has family income below the federal poverty level (FPL, about $19,790 for a family of 3 in 2014) compared to about one-fifth of the nonelderly population in metropolitan areas. Conversely, a greater share of the nonelderly population in metropolitan areas is in families with incomes



over 400% FPL than rural families. Lower incomes make it difficult for people to afford coverage on their own, since health insurance coverage is expensive.

In addition, individuals in rural areas are less likely than their urban counterparts to have access to coverage through a job. The nonelderly population in rural areas is more likely than metropolitan counterparts to live in family without either a full-or part-time worker (17% versus 14%). Further, among workers, those in rural areas are more likely to work in blue collar jobs (jobs outside of managerial, business, and financial occupations) than workers in metropolitan areas (71% versus 63%). Blue-collar workers tend to earn less and have fewer overall benefits than white-collar workers.[1] Half of all rural workers work in "Low ESI industries," or industries in which less than 80% of workers are covered by employer-sponsored insurance coverage.

These differences in income and access to coverage through a job are reflected in different coverage patterns in rural and urban areas. Only slightly more than half (51%) of the rural population was enrolled in employer-sponsored coverage between 2012 and 2013 a significantly lower proportion than the 57% of the metropolitan population with employer coverage. However, before ACA implementation, the rural population was significantly more likely to be covered by Medicaid (21%) or other public insurance (4%) than the metropolitan population (16 and 3 percent, respectively). Because Medicaid made up some of the gap in employer-sponsored coverage in rural areas, the uninsured rate was similar across rural and metropolitan populations prior to the ACA (Figure 2).

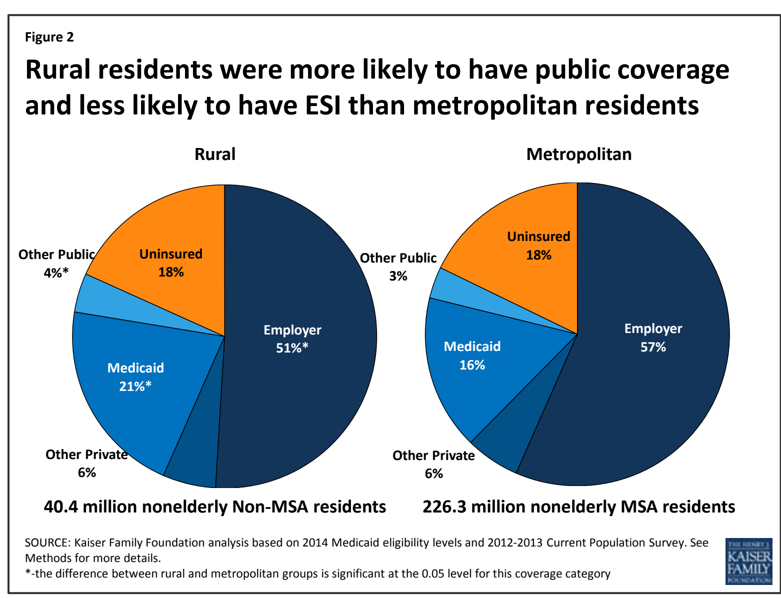


Figure 2

Rural residents were more likely to have public coverage and less likely to have ESI than metropolitan residents

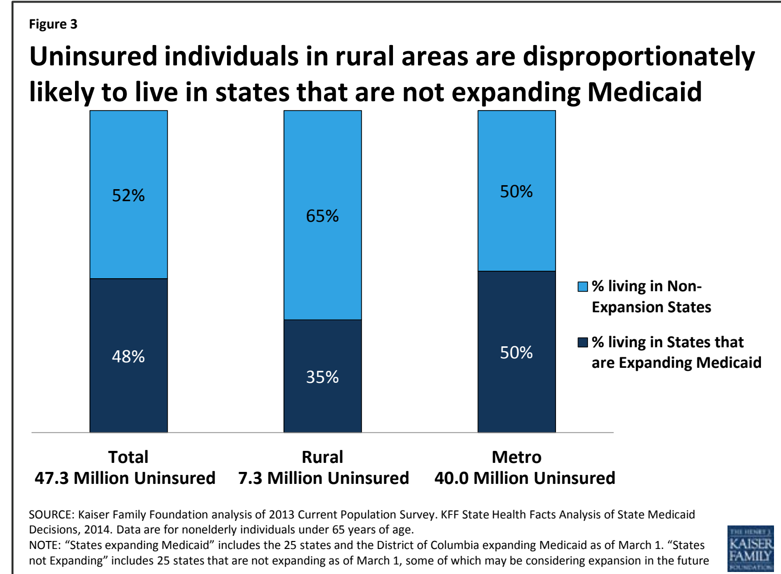
SOURCE: Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels and 2012-2013 Current Population Survey. See Methods for more details.
*-the difference between rural and metropolitan groups is significant at the 0.05 level for this coverage category

Like the uninsured population nationally, uninsured individuals in rural areas are likely to live in low-income working families, are primarily adults (who were historically ineligible for public coverage), and are generally unable to afford coverage on their own. Compared to their urban counterparts, however, rural uninsured may face particular challenges in accessing health care services when needed due to more limited supply of providers who can provide low-cost or charity care. Thus, there is a particular need to extend coverage in rural areas.

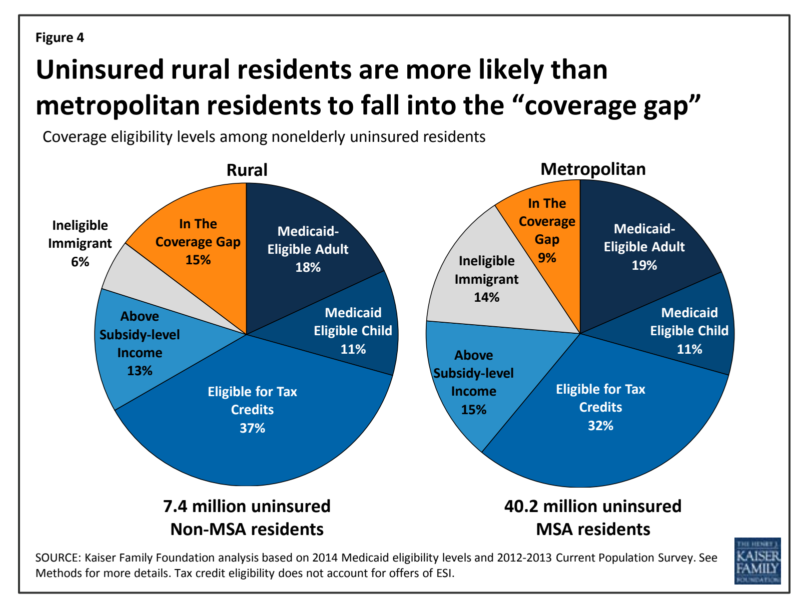
The Impact of ACA Coverage Expansions in Rural Areas

The ACA offers the opportunity to expand health coverage among the rural population through the expansion of Medicaid for people with incomes at or below 138% of poverty and the availability of premium tax credits for the purchase of private insurance through the Health Insurance Marketplaces for moderate income families (those with incomes between 100% and 400% of poverty). Among the rural uninsured population, about three in four are in the income range (and meet the immigration requirements) for these coverage provisions.

However, with the Supreme Court ruling in June 2012, the Medicaid expansion became essentially optional for states, and as of May 2014, 24 states were not implementing the Medicaid expansion. In states that do not expand Medicaid, some individuals with incomes between 100% FPL and 138% FPL will be eligible for premium tax credits in the Marketplace. However, many uninsured individuals under poverty will be left in a "coverage gap" in which their incomes are above Medicaid eligibility levels but below eligibility levels for tax credits.[2] As a result, many will be left without an affordable insurance option. State decisions about expanding Medicaid have a disproportionate effect on coverage options for uninsured individuals in rural areas. Almost two-thirds of the rural uninsured population lives in states that are not expanding Medicaid at this time (Figure 3).



As a result of state decisions, rural individuals are much more likely than their urban counterparts to fall into the "coverage gap." Among uninsured rural individuals, about 15% – over a million people – are estimated to fall into the coverage gap compared to 9% of the uninsured in metropolitan areas (Figure 4). About equal shares of rural and urban (30%) uninsured individuals may be eligible for Medicaid or CHIP, but a greater share (37%) of uninsured rural individuals than metropolitan uninsured (32%) are within the income range to be eligible for premium tax credits in the marketplaces than are metropolitan individuals.[3] Immigration status for the uninsured is less a factor barring coverage in rural areas compared to metropolitan areas, with only 6% vs 14% ineligible due to immigration status. Adequate outreach and consumer assistance are key to reaching individuals who are eligible for coverage under the ACA, particularly in rural areas where resources to help with enrollment may require traveling long distances.



Conclusion

The rural population is poorer and less likely to be covered by employer-based insurance than the metropolitan population. Prior to the ACA, rural individuals were more likely to receive coverage through public insurance than metropolitan individuals. Many uninsured people in rural areas will be eligible for Medicaid coverage or tax credits to purchase coverage under the ACA. While the uninsured population in rural areas is less likely than their metropolitan counterparts to be ineligible for coverage due to their immigration status or incomes, they are more likely to fall into the "coverage gap" due to state decisions not to expand Medicaid coverage. People in rural areas may face particularly high barriers to accessing coverage, such as transportation barriers or limited provider availability and may also continue to face financial barriers to accessing needed care.

This Issue Brief was prepared by Vann Newkirk from the Kaiser Family Foundation and Anthony Damico, an independent consultant.

Appendix: Methods

This analysis uses pooled data from the 2012 and 2013 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC). The CPS ASEC provides socioeconomic and demographic information for the United Sates population and specific subpopulations. Importantly, the CPS ASEC provides detailed data on families and households, which we use to determine income for ACA eligibility purposes (see below for more detail). We merge two years of data in order to increase the precision of our estimates.

Medicaid and Marketplaces have different rules about household composition and income for eligibility. For this analysis, we calculate household membership and income for both Medicaid and Marketplace premium tax credits for each person individually, using the rules for each program. For more detail on how we construct Medicaid and Marketplace households and count income, see the detailed technical Appendix A available here.

Immigrants who are undocumented are ineligible for Medicaid and Marketplace coverage. Since CPS data do not directly indicate whether an immigrant is lawfully present, we impute documentation status for each person in the sample. To do so, we draw on the methodology in the State Health Access Data Assistance Center (SHADAC) paper, "State Estimates of the Low-Income Uninsured Not Eligible for the ACA Medicaid Expansion."[4] This approach uses the Survey of Income and Program Participation (SIPP) to develop a model that predicts immigration status; it then applies the model to CPS, controlling to state-level estimates of total undocumented population from Department of Homeland Security. For more detail on the immigration imputation used in this analysis, see the technical Appendix B available here.

As of January 2014, Medicaid financial eligibility for most nonelderly adults will be based on modified adjusted gross income (MAGI). To determine whether each individual is eligible for Medicaid, we use each state's MAGI eligibility level that will be effective as of 2014.[5] Some nonelderly adults with incomes above MAGI levels may be eligible for Medicaid through other pathways; however, we only assess eligibility through the MAGI pathway.[6]

An individual's income is likely to fluctuate throughout the year, impacting his or her eligibility for Medicaid. Our estimates are based on annual income and thus represent a snapshot of the number of people in the coverage gap at a given point in time. Over the course of the year, a larger number of people are likely to move in and out of the coverage gap as their income fluctuates.

Marketplace premium tax credit eligibility determination is most accurately established by modeling the employment status and likelihood of an ESI offer, since tax credit eligibility requires the absence of an affordable ESI offer. This analysis did not account for this "offer rate reduction" so the tax credit eligibility is overestimated and likely to include between 1 and 3 million total individuals who will have affordable ESI offers.

[1] Duckett, Philethea, and Samantha Artiga. "Health Coverage for the Black Population Today and Under the Affordable Care Act." Kaiser Family Foundation. http://kff.org/disparities-policy/fact-sheet/health-coverage-for-the-black-population-today-and-under-the-affordable-care-act/.

[2] Kaiser Family Foundation. "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid." http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.

[3] See Methods section

[4] State Health Access Data Assistance Center. 2013. "State Estimates of the Low-income Uninsured Not Eligible for the ACA Medicaid Expansion." Issue Brief #35. Minneapolis, MN: University of Minnesota. Available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf404825.

[5] Kaiser Commission on Medicaid and the Uninsured. *Fact Sheet: Medicaid Eligibility for Adults as of January 1, 2014.* (Washington, DC: Kaiser Family Foundation), October 1, 2014. Available at: http://www.kff.org/medicaid/fact-sheet/medicaid-eligibility-for-adults-as-of-january-1-2014/.

[6] Non-MAGI pathways for nonelderly adults include disability-related pathways, such as SSI beneficiary; Qualified Severely Impaired Individuals; Working Disabled; and Medically Needy. We are unable to assess disability status in the CPS sufficiently to model eligibility under these pathways. However, previous research indicates high current participation rates among individuals with disabilities (largely due to the automatic link between SSI and Medicaid in most states, see Kenney GM, V Lynch, J Haley, and M Huntress. "Variation in Medicaid Eligibility and Participation among Adults: Implications for the Affordable Care Act." *Inquiry*. 49:231-53 (Fall 2012)), indicating that there may be a small number of eligible uninsured individuals in this group. Further, many of these pathways (with the exception of SSI, which automatically links an individual to Medicaid in most states) are optional for states, and eligibility in states not implementing the ACA expansion is limited. For example, the median income eligibility level for coverage through the Medically Needy pathway is 15% of poverty in states that are not expanding Medicaid, and most states not expanding Medicaid do not provide coverage above SSI levels for individuals with disabilities. (See: O'Mally-Watts, M and K Young. *The Medicaid Medically Needy Program: Spending and Enrollment Update*. (Washington, DC: Kaiser Family Foundation), December 2012. Available at: http://www.kff.org/medicaid/issue-brief/the-medicaid-medically-needy-program-spending-and/. And Kaiser Commission on Medicaid and the Uninsured, "Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities," February 2010. Available at: http://www.kff.org/medicaid/issue-brief/medicaid-financial-eligibility-primary-pathways-for-the-elderly-and-people-with-disabilities/.

Will Premiums Skyrocket in 2015?

John Holahan

Timely Analysis of Immediate Health Policy Issues

MAY 2014

In-Brief

The first open enrollment has ended and a surprisingly large number of people, 8.0 million, have enrolled in Marketplace insurance plans.[1] Medicaid rolls have also increased, particularly in states that have expanded Medicaid, and early evidence suggests that the number of uninsured is falling.[2] But with open enrollment behind us, a new set of concerns is surfacing: a major one is whether premiums will increase sharply in 2015. Some experts have predicted sharp increases, arguing, for example, that premiums were artificially low in 2014 and that insurers will attempt to recoup any 2014 losses by increasing premiums in 2015.[3] In this brief, we review 2014 premiums and the effect of market competition on rates. We further suggest that this experience provides the best guidance as to what we are likely to see in 2015. We conclude that while there may be reasons to believe that premiums will increase substantially, particularly in less competitive markets, there are even stronger reasons to believe that premium increases will be moderate (in line with underlying cost growth) rather than growing by double-digits.

Market Competition Led to Surprisingly Low Monthly Premiums in 2014; Same Expected for 2015

Portland
$430.83
$176.00
$300.00

Denver
$440.50
$212.96
$365.36

Minneapolis
$445.83
$135.99
$231.75

Detroit
$464.17
$183.75
$313.14

Baltimore
$451.50
$197.00
$335.00

New York City
$525.33
$365.28
$365.28

Fairfax City (Washington, DC Area)
$449.92
$176.00
$300.00

Birmingham
$439.08
$135.99
$231.75

Premiums for the Second Lowest Cost Silver Plan

Statewide Pre-ACA Small Group Average

27-Year-Old

50-Year-Old

** Costs before subsidies*

Robert Wood Johnson Foundation

Urban Institute

The 2014 Experience With Market Premiums

The 2014 premium setting experience is useful in projecting what might occur in 2015.[4] In general, in 2014 premiums were moderate and below original expectations in most markets, even in rural areas.[5] There was high insurer participation in most urban markets, though less so in rural areas, and fairly intense competition. The most compelling explanation for lower than expected premiums is the managed competition structure of the Marketplaces. Subsidies in the individual nongroup market are tied to the second lowest cost silver plan. Individuals buying a more expensive silver plan or a gold or platinum plan would have to pay additional amounts. This creates strong incentives for insurers to price aggressively to gain market share. In general, the evidence suggests that this is what occurred in most markets, resulting in competitive rates.[6]

The insurers participating in the nongroup market consist of existing insurers such as Blue Cross plans, new entrants including Medicaid plans and co-ops, and, in a few cases, new start-up insurers. Large commercial insurers such as Aetna, United, and Cigna participated only in some markets. Some insurers priced aggressively to gain market share; others, particularly the national commercial companies, were more cautious to avoid risk. Anecdotal evidence, as well as reported results for New York, is that those that priced their products low seem to be getting the bulk of enrollees, but there are also reports of individuals choosing well-known brand names, such as Blue Cross plans.[7]

The premiums in 2014 are shown in Table 1. We examine data on premiums in cities in eight states. The states are generally representative of insurance markets around the country. Some have many participating plans, some have Medicaid plans and/or co-ops, and others have one dominant carrier.

We found that in general, premiums for adults in the nongroup market compare favorably with premiums in the pre-reform small employer market. It is difficult to evaluate premiums in the pre-reform individual market; policies often have limited benefits or large cost sharing requirements, and there could be largely healthy people in plans due to medical underwriting. Because benefits offered and premium pricing tended to vary with the characteristics of the individual enrollee, average premiums are not comparable. This has been less the case in the nation's small group markets, although small group medical underwriting persisted in almost all states through 2013, and cost sharing requirements tended to be lower and benefits higher than in nongroup policies. The ACA's market reforms tend to move nongroup policy offerings closer to small group policies in benefits and cost sharing requirements. However, since small employers tend to choose plans with lower cost sharing requirements than the typical nongroup insurance individual purchaser, the small group average premiums shown in Table 1 should be reduced by 10-15 percent in order to be more comparable to the ACA compliant silver plans most often chosen by nongroup purchasers.

Even with 10-15 percent reductions, premiums set by the lower cost Marketplace nongroup insurers are, in general, still less expensive, often by a considerable margin. In Table 1, we show individual market premiums for 27- and 50-year olds; the average small group premiums should reflect an average age distribution in small firms that falls somewhere in that age range. In all eight states, there are nongroup premiums that fall below what we observed in the pre-reform small group market. Several carriers report offering narrow network products, and limiting networks when possible to providers accepting lower payment rates. Interestingly, we see higher premiums in many rural markets than in urban areas, primarily because of the lack of competition in those markets as well as the difficulty in negotiating with the limited supply of physicians and hospitals there.[8]

Table 1 shows premiums in one large urban area in eight selected states. The key characteristics of these states are as follows.

Colorado. There is strong competition among eight carriers in the Denver market, with Kaiser Permanente and Humana having the lowest premiums. In two other markets we examined, the Rocky Mountain Health Plan, based in Grand Junction, was the most competitive plan followed by Anthem Blue Cross. The latter is considerably more expensive than the former. Premiums in the rural county for the three lowest cost plans were all higher than in Denver.

Maryland. CareFirst is dominant in the state's commercial market and had the lowest premiums in all regions, followed closely by the Blue Cross multistate plan and Kaiser Permanente. The latter is a strong competitor in Baltimore and the Washington, DC metro area where the bulk of the Maryland population resides. The state's new co-op, Evergreen, and United have much higher premiums.

Minnesota. Minnesota's market is characterized by competition among several local commercial plans. Preferred One has the lowest premium rates in most markets, followed by Health Partners. Because of more competition, rates are lower in Minneapolis than in other parts of the state. The significant competition in all markets led to the lowest premiums of any of the eight states.

New York. There was significant participation of Medicaid plans, particularly in New York City, but also throughout the state. In New York City, the lowest cost plans were a Medicaid plan (MetroPlus) and the state's co-op (Health Republic). In many other markets, the lowest cost plan was offered by Fidelis Care, a statewide Medicaid plan. The Blue Cross Plans and Emblem, a large local commercial plan, had premiums well above the lowest, but benefited from name recognition. It is also noteworthy that the second lowest cost silver plan in rural Alleghany county, offered by Blue Shield of Western New York, was substantially higher than the second lowest cost plan in New York City.

Oregon. There was substantial competition among local commercial plans in the markets we examined, including Moda Health, Health Net, Lifewise, and

Pacific Source. Oregon's premiums reflect this competition and are among the lowest of the eight states.

Alabama. Blue Cross Blue Shield (BCBS) is the overwhelmingly dominant carrier in the state, although it has competition in the Birmingham area from Humana. In other areas, BCBS is the only carrier but premiums are surprisingly low throughout the state; BCBS did not exercise the market power that it has.

Michigan. Blue Cross Blue Shield is also a dominant carrier in Michigan, but it has substantial competition from Humana and Total Healthcare in the Detroit market. Elsewhere in the state, the Blue Cross HMO product generally offers the lowest premiums. The second lowest cost plan in markets outside of Detroit have higher premiums than seen in the Detroit market, reflecting either the lack of competition in those insurance markets or the market power of local providers.

Virginia. Anthem Blue Cross Blue Shield has substantial market share throughout most of the state. CareFirst, also a Blue Cross product, offers coverage in the northern-most section of the state. The Blue Cross products are HMOs and among the lowest-cost plans in most parts of Virginia. Anthem does have significant competition in most parts of the state from Optima Health, an insurer connected to a major hospital system. In Fairfax County, the Innovations Health Insurance company, a new plan co-owned by Aetna and the Inova hospital system, has the lowest premiums and appears to be competing successfully against Anthem, CareFirst Blue Choice, and Kaiser Permanente in the Northern Virginia market.

Thus, in most markets we studied, at least in urban areas, there seems to be considerable competition. The Blue Cross plans are often the lowest cost plans but not always. In some markets, particularly New York, Medicaid plans have driven premiums to relatively low levels; elsewhere, Medicaid plans are less important. Co-op plans also offer fairly low rates in New York, but not in the other markets. Rural markets in many of these states have higher premiums than urban markets, reflecting substantially less competition at the carrier or provider level, or both. The result of competition in these markets has led to premiums for silver plans that are relatively low, despite the structure of the markets differing quite a bit across states. The incentives that led to those outcomes are essentially unchanged for 2015 though there are factors that could result in changes.

What Does This Mean For 2015?

One could argue that premiums will increase considerably in 2015 because first round premium setting was overly aggressive, and insurers may attempt to make up for any 2014 losses in 2015. But in competitive markets, unless all insurers behave similarly, those that increase premiums will suffer the loss of market share to those that continue to price more aggressively.[9] Markets with limited competition (e.g., Alabama, rural areas of many states) could see larger increases in premiums due to their market conditions; for example, carriers could exploit market power in ways they did not in 2014. In some states, insurers that achieved relatively little market share in 2014 could leave, resulting in less competitive markets. There could also be pressure to expand provider networks. This could come from the federal government or from the states' own political environments. The market may also dictate that insurers broaden their networks, if desirable consumers appear to be avoiding narrow network plans. Broadening networks is likely to require carriers to offer higher payment rates to providers, leading to higher premiums. Finally, 2015 premiums will depend on how insurers respond to the reduced funding levels for reinsurance in 2015 and the new policy for fiscal neutrality for risk corridors.

But the forces that would result in more moderate increases in 2015 are likely to be stronger. First, the underlying rate of growth in health care costs remained

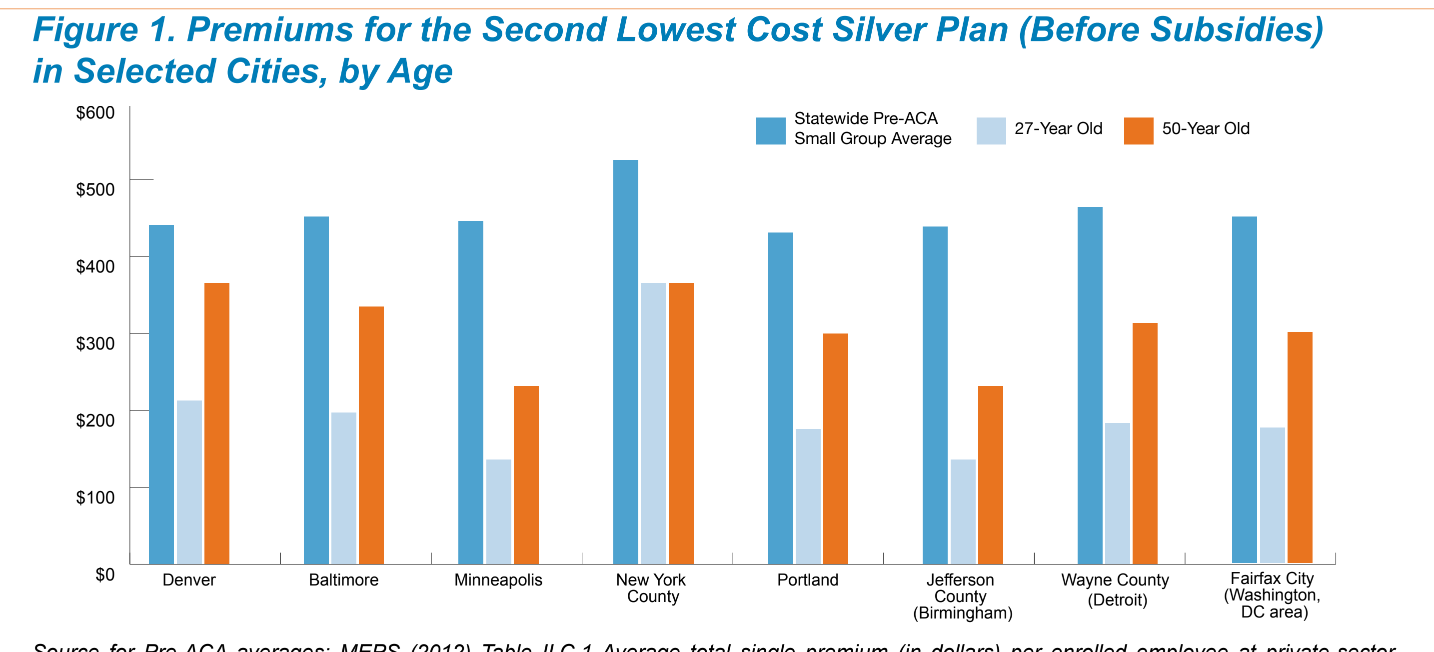


Figure 1. Premiums for the Second Lowest Cost Silver Plan (Before Subsidies) in Selected Cities, by Age

Source for Pre-ACA averages: MEPS (2012) Table II.C.1 Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and State: Less than 50 Employees.

Table 1. Premiums for the Lowest Cost Silver Plan (Before Subsidies) for the Top Lowest Cost Insurers in Selected Cities

State	Location	Insurer	Type	Premium	
				27-year-old	50-year-old
CO	Statewide	Pre-ACA Small Group Average		$440.50	
	Denver	Kaiser Permanente	HMO	$208.52	$357.77
		Humana	HMO	$212.96	$365.36
		Colorado HealthOP	PPO	$232.10	$398.23
MD	Statewide	Pre-ACA Small Group Average		$451.50	
	Baltimore	CareFirst Blue Choice*	HMO/POS	$187.00	$319.00
		CareFirst BCBS (MSP)	PPO	$197.00	$335.00
		Kaiser Permanente	HMO	$221.27	$377.11
MN	Statewide	Pre-ACA Small Group Average		$445.83	
	Minneapolis	PreferredOne*	PPO	$126.21	$215.09
		HealthPartners	PPO	$135.99	$231.75
		Blue Cross Blue Shield of Minnesota	PPO	$150.72	$285.95
NY	Statewide	Pre-ACA Small Group Average		$525.33	
	New York County (Contains Manhattan)	MetroPlus Health Plan	HMO	$359.26	$359.26
		Health Republic	PPO	$365.28	$365.28
		Oscar	PPO	$384.72	$384.72
OR	Statewide	Pre-ACA Small Group Average		$430.83	
	Portland	Moda Health*	PPO	$159.00	$270.00
		HealthNet	POS	$176.00	$300.00
		Providence	EPO	$192.00	$327.00
AL	Statewide	Pre-ACA Small Group Average		$439.08	
	Jefferson County (Contains Birmingham)	Humana	PPO	$209.16	$356.46
		Blue Cross and Blue Shield of Alabama	PPO	$211.24	$360.00
MI	Statewide	Pre-ACA Small Group Average		$464.17	
	Wayne County (Contains Detroit)	Humana Medical Plan of Michigan, Inc.	HMO	$156.16	$266.14
		Total Health Care USA, Inc.	HMO	$183.75	$313.14
		Blue Care Network of Michigan	HMO	$198.76	$338.73
VA	Statewide	Pre-ACA Small Group Average		$449.92	
	Fairfax City (Washington, DC, area)	Innovation Health Insurance Company	PPO	$213.00	$362.00
		CareFirst Blue Choice	HMO/POS	$222.97	$379.99
		Kaiser Permanente	HMO	$225.54	$383.55

**Insurer offered the two lowest cost plans in the area noted.*
Source for Pre-ACA averages: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2012 Medical Expenditure Panel Survey – Insurance Component. Table II.C.1 Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and state: Less than 50 employees http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2012/tiic1.pdf.

slow through 2012—3.7 percent in 2012 and is projected to be 3.8 percent in 2013—though there is some evidence that spending growth has picked up (6.3 percent from first quarter of 2013 to first quarter of 2014).[10] This will have some effect on premiums but is not enough to cause a spike. Second, enrollment in Marketplace plans should be substantially higher in 2015 than 2014, with improved IT systems, higher individual mandate penalties, and greater awareness of the law and its insurance options. The recent surge resulted in 8.0 million Americans being insured in Marketplaces throughout the country, and this surge seems to have improved the mix of risks as seen by the increased enrollment of younger groups.[11] Enrollment is likely to continue to increase over the course of 2014 through special open enrollment for those experiencing significant life changes (e.g., changes in family composition, changing work circumstances, changing income circumstances). CBO projects an additional 7 million individuals will enroll in Marketplace plans in 2015. This is likely to assure an even more stable mix of risks available to insurers. Third, the cost sharing in the silver tier, the plans most often selected, are high enough to dampen utilization. And the presence or threat of narrow networks will help constrain provider payments.

Finally, the increasing size and attractiveness of the nongroup markets could intensify the amount of competition from insurers. Not only are plans participating in 2014 unlikely to exit, but others could enter. Large insurers that stayed out of many Marketplaces or bid at high premium rates—Aetna, United, Cigna—could enter more Marketplaces in 2015 and price more aggressively because of the higher enrollment and the perception of a more stable risk pool.[12] United has already indicated that it will be more active; the same is true of Blue Cross Blue Shield plans where they did not participate in 2014. How these scenarios will play out is hard to know, but claims that premiums will skyrocket are unwarranted based on 2014 experience and the evolving conditions for 2015 suggest otherwise as well.

CONCLUSION

There are several reasons to believe there could be significant premium increases in 2015, e.g., underpricing in 2014, increases in health care costs, and pressure to broaden networks. But the dominant force behind the surprisingly low premiums in 2014 remains intact—the strong incentives for markets to be highly competitive, which forces insurers to set premiums aggressively to attain or retain market share. These incentives should be even stronger in 2015 with increased enrollment and a more stable risk pool. High deductibles and narrow networks will continue to place downward pressure on spending. It also must be noted that it is not the increase in a particular insurer's premiums that matters; rather it is the premiums of the second lowest cost silver plans in each market that matter and these should rise more slowly.

Notes

1 U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation. *Health Insurance Marketplace: Summary Enrollment Report*, ASPE Issue Brief, May 1, 2014.

2 Long SK, Kenney GM, Zuckerman S et al. "QuickTake: Number of Uninsured Adults Falls by 5.4 Million since 2013." Washington DC: The Urban Institute, 2014.

3 Alonso-Zaldivar R. "7M Enrolled Doesn't Guarantee Health Law's Success." Associate Press, April 5, 2014.

4 Holahan J, Peters R, Lucia K. "The Launch of the Affordable Care Act in Selected States: Insurer Participation, Competition, and Premiums." Washington, DC: The Urban Institute, 2014.

5 Millman J. "Lower premiums (yes, really) drive down Obamacare's expected costs, CBO says," Washington Post, April 14, 2014; Radnofsky L. "CBO Projects Lower Premiums in Health-Insurance Exchanges," The Wall Street Journal, April 14, 2014; Office of the Assistant Secretary for Planning and Evaluation. *Health Insurance Marketplace Premiums for 2014*. September 2013

6 Holahan J, Lucia K, Peters R, Monahan C. "Insurer Participation and Competition in Health Insurance Exchanges: Early Indications from Selected States." Washington, DC: The Urban Institute, 2013; Holahan et al., 2014.

7 NY State of Health. *The Official Health Plan Marketplace December 2013 Enrollment Report*. January 13, 2014. http://info.nystateofhealth.ny.gov/sites/default/files/December%202013%20Enrollment%20Report_Jan%2013%202014_0.pdf

8 Holahan et al. 2014.

9 Blumberg L and Holahan J. "The Affordable Care Act Can Survive Low Enrollment and Adverse Selection in the First Year." Washington, DC: The Urban Institute, 2013.

10 Bureau of Economic Analysis. Gross Domestic Product: First Quarter 2014 (Advance Estimates). April 30, 2014.

11 Millman J, "Facing Obamacare deadline, more young people signed up in March," Washington Post, April 4, 2014.

12 Cheney K and Norman B. "Insurers see brighter Obamacare skies." Politico, April 15, 2014.

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

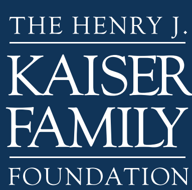
John Holahan is an Institute fellow at the Urban Institute's Health Policy Center. The author appreciates the comments and suggestions of Linda Blumberg and Stephen Zuckerman. The authors are grateful to the Robert Wood Johnson Foundation for supporting this research.

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

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*.



REPORT

May 2014

Women and Health Care in the Early Years of the Affordable Care Act

Key Findings from the 2013 Kaiser Women's Health Survey

Prepared by:

Alina Salganicoff, Usha Ranji, Adara Beamesderfer, and Nisha Kurani

Kaiser Family Foundation

Acknowledgements

The authors are grateful to many colleagues at the Kaiser Family Foundation and Princeton Survey Research Associates International who provided valuable contributions to this survey. In particular, the authors would like to thank Rachel Licata, formerly of the Kaiser Family Foundation, for her assistance with survey analysis.

Table of Contents

Executive Summary 1

Introduction 6

Methods 10

Coverage, Access, and Affordability 11

Connections to Health Providers 18

Preventive Services 23

Reproductive and Sexual Health Services 28

Conclusions and Implications 40

Endnotes 45

Executive Summary

The passage of the Affordable Care Act (ACA) in 2010 heralded a new era in health care coverage, with major implications for women's health and access to care. Provisions such as the mandatory inclusion of maternity care, coverage without cost sharing for preventive services such as contraceptives, and a prohibition on charging women more than men for the same plan were all designed to address gaps and inequities in women's health insurance. Some of these provisions were implemented shortly after the passage of the ACA, including the expansion of dependent coverage and the preventive services coverage rules. The requirement for mandatory insurance coverage and the expansion in Medicaid eligibility and state-based Marketplaces are just getting underway.

Understanding the law's myriad impacts on women's health and access to care will take many years, but it is important to have a baseline with which to compare future outcomes. The Kaiser Family Foundation undertook this survey to provide an initial look into the range of women's health and care experiences, especially those that are not typically addressed by most surveys nor often analyzed through a gender lens. The Kaiser Family Foundation conducted this nationally representative survey in the fall and early winter of 2013, just before the ACA's major coverage expansion began. The findings presented in this report examine women's coverage, access, and affordability to care, as well as their connections to health providers and use of preventive care based on an analysis of a nationally representative sample of 2,907 women ages 18 to 64. In addition, a shorter survey of 700 men ages 18 to 64 was also conducted and key findings are included in the text for the purposes of comparison. To provide the data for the analysis of women's use of reproductive and sexual health services, this report analyzes the responses of a nationally representative sample of 1,403 women ages 15 to 44.

This report addresses a wide range of topics that are at the heart of women's health care and changes that women may experience as a result of the ACA. It also highlights differences for uninsured, low-income, and minority women--groups of women that have been historically underserved –which is especially important in light of the characteristics of women in the U.S. today. Nearly one in three women ages 18 to 64 live in households that are below 200% of the federal poverty level (FPL) which was $19,530 for a family of three in 2013. One in three women identify as racial and ethnic minorities (13% Black, 14% Hispanic, and 9% Asian or Other) and half are in their childbearing years. A sizable minority of women also report that their health is fair or poor (15%) and over four in ten have a health condition that requires monitoring and treatment (43%). For these women in particular, access to health care is an essential and ongoing concern. Key findings from the survey include:

Coverage, Access and Affordability

The health coverage expansion will fill a major gap in coverage for women.

In the late fall and early winter of 2013, as the ACA's coverage expansion kicked into gear, approximately one in five women ages 18-64 were uninsured (18%). Employer-sponsored insurance (ESI) covered the majority of women (57%), with nearly half of that group covered as a dependent either through a spouse or parent. Just 7% of women were covered by individual insurance and about one in ten women (9%) had Medicaid, the nation's health program for low-income individuals. In the coming years, millions of uninsured women could gain access to coverage that includes a wide range of benefits that are important to their care.

Gaps in coverage are experienced by a disproportionately high share of low-income women and women of color.

For low-income women, the gaps in coverage are considerable, with 4 in 10 reporting that they were uninsured at the end of 2013. Nearly a quarter of Black (22%) and over one-third (36%) of Hispanic women were also uninsured. Eligibility for Medicaid and availability of subsidies in the form of tax credits will help many women gain access to coverage. While many may have enrolled in the state Marketplaces or in Medicaid during the open enrollment period, some of the poorest women do not qualify for assistance because they reside in a state that is not expanding Medicaid or are undocumented immigrants that are explicitly excluded from Medicaid and state Marketplace plans.

Coverage under a parent's plan is now the leading way that women under age 26 get their coverage, but few are aware that parents may get information about their care.

One of the earliest ACA provisions that took effect in September 2010 was the extension of dependent coverage to young people up to age 26, who had the highest uninsured rate of any age group at the time the law was passed. In 2013, over four in ten (45%) women ages 18 to 25 reported that they were covered on a parent's plan as a dependent. Because they are adult children, the extension of coverage has raised concerns about their ability to maintain privacy regarding the use of sensitive health services such as reproductive and sexual health care and mental health. The survey finds that less than four in ten young women (37%) are aware that private insurers typically send an explanation of benefits (EOB) documenting use of health care services to primary policy holders, often a parent. Yet, the vast majority (71%) of young women state that it is important to them that their use of health services be confidential.

Many women report they face cost-related barriers to health care, and many report that medical bills are a problem that force them to make difficult trade-offs.

One in four (26%) women have had to delay or forgo care in the past year due to cost compared to 20% of men. While health costs are a major barrier to care for nearly two-thirds (65%) of uninsured women, 16% of women with private insurance and 35% of women with Medicaid also said they delayed or went without care because they could not afford it. Nearly three in ten women have had problems paying medical bills in the past year (28%). Problems are, not surprisingly, more common among uninsured women (52%) and low-income women (44%), who have fewer resources to cover their bills. A substantial share of women with medical debt reported they either used up most of their savings, had difficulty paying for basic necessities, or had to borrow money from friends or relatives to pay for their bills.

Logistical barriers to care beyond coverage and affordability are challenges for many women.

Many women report they can't find the time (23%) or take time off work (19%) to get their care. Childcare (15%) and transportation problems (9%) also prevent some women from getting to care, and are more frequently reported among low-income women (19% and 18%, respectively). One-quarter of all women, regardless of income, reported that lack of time to go to the doctor was a reason they went without care. While the ACA and other reforms have the potential to help offset coverage gaps and assist with the burdens of costs, the survey finds that factors such as work place flexibility, sick leave, and child care also have implications for women's access to care.

Connections to Care

Coverage and delivery system reforms could result in more women having a stronger connection to health providers, but new models of care need to be gender sensitive.

The vast majority of women say they have a place to go when they need care (86%), have a doctor that they see regularly (81%) and have seen a provider in the past two years (91%). On average, a higher share of women than men report that they have an existing connection to a health care provider or place. Among women, however, those who are uninsured have considerably weaker connections to the health care system, reporting lower rates on all of these indicators. About seven in ten uninsured women (69%) have a regular site of care, but only half (50%) have a regular clinician, and three-quarters (75%) have had a recent provider visit. Women who are younger, Hispanic, low-income or uninsured are also more likely to lack these important connections to care. Women's care can also be complex because some see Obstetrician/Gynecologists for their reproductive needs and different providers for their other health needs. The ACA includes incentives to improve primary care and develop new models for patient centered medical homes. Given the importance of sexual and reproductive health for women, incorporating these sensitive services into new models of care will be a key consideration.

While most women get their care in a private doctor's office, community health centers and family planning clinics are sources of care for a sizable minority of women covered by Medicaid or without insurance.

Among women who identify a place where they usually seek care when they are sick or need medical advice, almost three in four (73%) go to a doctor's office or a health maintenance organization setting (HMO). While eight in ten women with private insurance (82%) go to a doctor's office for routine care, this share drops to two-thirds of women with Medicaid (66%) and less than half of uninsured women (45%). Medicaid beneficiaries (23%) and uninsured women (28%) have much higher reliance on clinics than privately-insured women (7%). Nearly one in six uninsured women (16%) say they get their routine care from an emergency room. While it is too soon to tell how safety net providers will fare as more people gain coverage and shift to private or Medicaid plans, many women will still rely on these providers for their care.

Preventive Services

The ACA rules that require private plans to cover preventive services without cost sharing may help boost use of preventive services, but awareness of the requirement and use of services are still lagging.

The ACA included new requirements for private plans to cover a wide range of recommended preventive screening and counseling services without cost sharing. Public awareness of these insurance reforms, however, is far from universal. Six in ten women know that plans must now cover well-woman visits and 57% know that mammograms and pap tests are covered without cost sharing. While most women report a recent checkup or well woman visit (82%), rates of specific preventive counseling and screenings are uneven. Most women report that they have discussed diet and nutrition (70%) with a provider in the past 3 years, but fewer than half of women have recently talked to a provider about smoking (44%), alcohol or drug use (31%), and mental health (41%). A deeper focus on the content of well woman visits, along with patient education, may be needed to broaden use of clinical preventive services for women.

Women enrolled in Medicaid use preventive care at rates that are similar or higher than women with private insurance.

Women enrolled in Medicaid, despite their lower incomes and constrained provider options, obtain preventive screening and counseling services at rates that are on par with women with private coverage. The ACA includes a small financial incentive for state Medicaid programs to provide coverage of all services recommended by the USPSTF without cost-sharing. Efforts to expand no-cost coverage under Medicaid to these recommended evidence-based services could further access to screening and counseling services for the millions of low-income women served by the program.

Reproductive and Sexual Health Services

There is considerable room for improvement in the rates of counseling on reproductive and sexual health topics.

Despite the high rates of sexually transmitted infections (STIs) and unintended pregnancy, counseling on these topics is not routine among women of reproductive age (15 to 44 years). While most reproductive age women have had recent conversations with a provider about contraception (60%), the rate is much lower regarding sexual history (50%), HIV (34%), other STIs (30%), and intimate partner violence (IPV) (23%). Furthermore, many women are incorrectly under the impression that HIV and STI tests are routinely included as part of their gynecological exams. While four in ten reproductive age women report that they have had a test for HIV (44%) or other STIs (40%) in the past two years—about half of these women mistakenly assumed this test was a routine part of an examination. Therefore, the actual screening rates are likely lower than the share of women who report being tested. This assumption clearly has implications for the treatment and the prevention of transmission of these infectious diseases.

A substantial share of sexually active women is not using any contraception and is at high risk for unintended pregnancy.

While the effectiveness of FDA approved contraceptives in preventing unintended pregnancy is widely known, an estimated one in five (19%) sexually active women ages 15 to 44 who do not want to get pregnant are at high risk for unintended pregnancy because they and their partner are not using contraceptives and have not had a sterilization procedure. Among women of reproductive age who have had sex in the past year, about half (51%) report that they or their partners used at least one contraceptive method, one in ten (10%) are pregnant or trying to conceive, and one in five (20%) women report that they or their partner have had a sterilization procedure or cannot become pregnant. Among sexually active women who have used contraceptives in the past year, nearly two-thirds (63%) report using male condoms and almost half have used birth control pills (48%).

A sizable minority of women using contraceptives now rely on long acting reversible contraceptives (LARCs).

LARCs, which include IUDs, sub-dermal implants and injections, are among the most effective methods of birth control. While condoms and oral contraceptives are the most common forms of birth control that women use, about one-third of women who have been sexually active in the past year and using a contraceptive say they used a LARC. About one in five (19%) say they have an intrauterine device (IUD), 6% report using an implant, and 7% report using hormonal injections as their contraceptive. LARCs, particularly IUDs, can have significant upfront costs and require provider insertion and follow up care. The ACA contraceptive coverage

provision may result in the increased adoption of these highly effective approaches by eliminating potential cost barriers associated with these contraceptives.

While awareness of emergency contraceptive pills is quite high, a small fraction of women say they have actually used or purchased them.

Emergency contraceptive (EC) pills can be taken after unprotected sex or as a backup method to prevent unintended pregnancy in cases of contraceptive failure. In 2009, the EC pills, Plan B®, became available without a prescription and in 2010, a new prescription formulation (ella®), was approved by the FDA. As with other contraceptives, private plans are required to cover prescriptions for EC without cost sharing under the ACA's preventive services policy. It has now been 15 years since EC pills were approved by the FDA and 86% of women ages 15 to 44 report that they have heard of them. However, a small percentage of women (5%) say they have used or bought EC pills, ranging from 12% of women ages 19 to 24 to 2% of both teens ages 15 to 18 and women ages 35 to 44.

One in three women with private insurance say their insurance covered the full cost of contraception.

The ACA includes provisions that require new plans to provide no-cost coverage for prescription FDA-approved contraceptive services and supplies for women (including insertion, removal and follow up care). While this provision only applies to "new" or "non-grandfathered" plans, over time it is anticipated that most women with private coverage will be enrolled in plans that offer this coverage. Nearly one and half years after the ACA contraceptive coverage rule took effect, insurance covered the full cost for one-third (35%) of women with private insurance. Another 41% reported that insurance covered part of the costs and about one in ten (13%) women with private insurance reported they did not have any coverage for birth control.

Family planning providers and community health centers play a major role in providing contraceptive care for uninsured women and women of color.

Most sexually active women who use birth control state that they receive contraceptives at a doctor's office or HMO (61%) and 16% obtain contraceptive care at a clinic-based setting. Established to provide care regardless of income, essential community providers finance contraceptive care largely through Title X (the federal planning program) and Medicaid. These clinics provide contraceptive care to substantial shares of uninsured (43%), Hispanic (37%), and Black women (23%). As care systems increasingly shift to private managed care plans, it will be important to monitor how care changes for the women who have been relying on these providers for their reproductive and sexual health care. In addition, because some low-income women will either not qualify for coverage or may not be able to afford to enroll in plans, many will still be reliant on these safety-net providers for their sexual and reproductive health care.

Introduction

For women, health care has long been a priority issue for reasons stemming from their own health needs and their central roles in managing their families' health. As such, many of the reforms in the Affordable Care Act (ACA) were developed to address the perceived shortcomings that were part of health insurance design before the passage of the law. The ACA includes a ban on gender rating, a policy that permitted plans in the individual insurance market to charge women more than men for the same coverage. The law eliminates pre-existing condition exclusions that affected women who were pregnant or victims of intimate partner violence or who had chronic medical conditions. It provides coverage without cost sharing for a wide range of recommended preventive services. These preventive benefits ultimately required coverage of contraceptives as well as seven other services specifically for women including well woman visits, screening for intimate partner violence, and breastfeeding support.

The impact of the law on women's access to coverage and care will take many years to assess. Will it make coverage and care more affordable for women? Will access be improved? Will the new coverage requirements improve the use of preventive services? How will contraceptive coverage affect the contraceptive choices that women make and where they get that care? And ultimately, will the changes in coverage improve health and provide stability of coverage for women? These questions will take time and will be difficult to answer.

While it is too early even to begin to answer these and other questions about the ACA, this survey was conducted to get a window into women's health care and coverage experiences at the early stage of the ACA's implementation. This survey builds on prior Kaiser Family Foundation surveys on women's health, conducted in 2001, 2004, and most recently in 2008 in the early days of the Great Recession. The survey was conducted in the fall and early winter of 2013 and reports on experiences related to health care coverage, access, affordability, providers, and preventive care among a nationally representative sample of women ages 18 to 64. It also reports on women's access to reproductive and sexual health services among a nationally representative sample of women ages 15 to 44. While most of the report presents findings for women ages 18 to 64, a shorter survey of men ages 18 to 64 was also conducted and key findings are included in the text for the purposes of comparison. All women and men were interviewed by telephone (landline and cell phone).

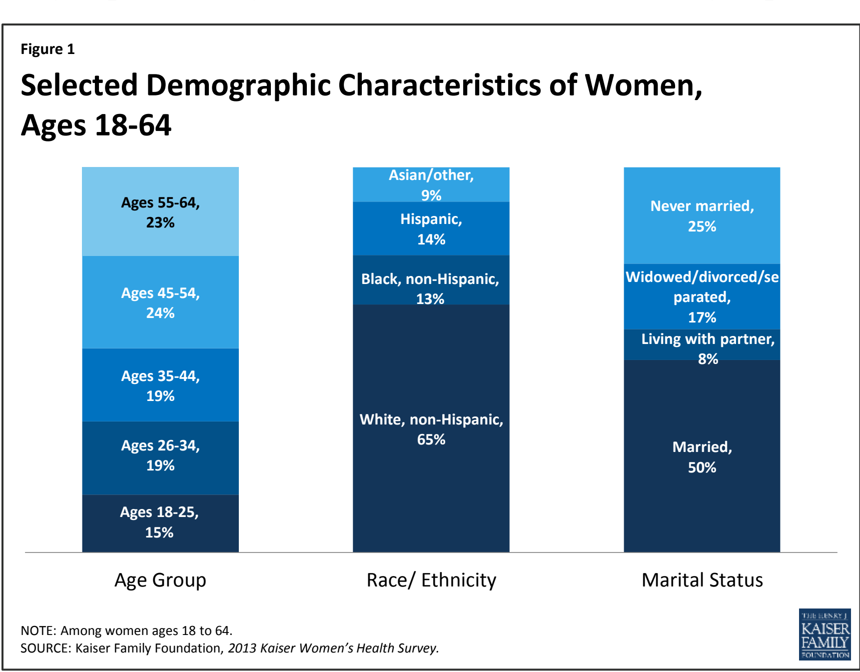
This report provides new data on women's health insurance coverage, their access to care and use of health care services, as well as health care affordability. This survey addresses topics that affect women across their lifespans, including the importance of the ACA for women's reproductive and sexual health care and establishes a useful baseline to help us understand and measure changes in women's health care experiences as health reform implementation moves forward over the coming years. We hope that these data will provide a useful lens through which to begin to gauge the impact of the ACA on women's health and their care.

Profile of Demographic and Health Characteristics of Women in the U.S.

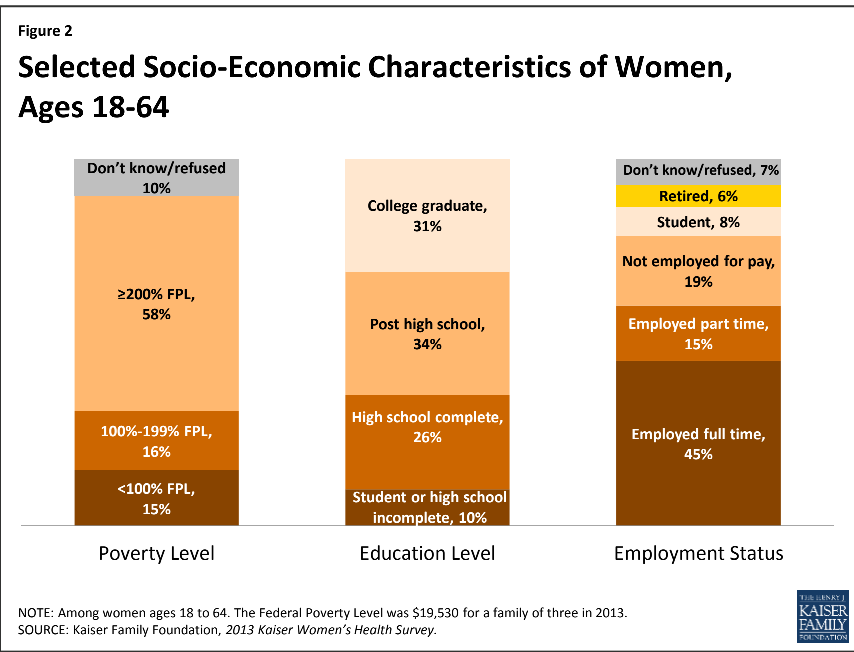
Health care is shaped by and intertwined with many aspects of women's lives. It is, therefore important to assess the demographic characteristics of the survey populations, non-elderly adult women ages 18 to 64 as well as reproductive age women, 15 to 44 years old.

Nonelderly adult women ages 18 to 64

Not surprisingly, the nation's women are a diverse population in many respects. Fifteen percent of women are in their early adult years, ages 18 to 25. Another 38% are ages 26 to 44 and almost half (47%) are in their middle years, ages 45 to 64. Almost two-thirds of women are White, non-Hispanic (referred to as White throughout this report), 13% are Black, non-Hispanic (referred to as Black throughout this report), 14% are Hispanic, and 9% are of another racial or ethnic group, including Asian, Pacific Islander, and other groups (**Figure 1**). Throughout this report, data are presented for White, Black, and Hispanic women. Data by other racial/ethnic groups are not presented because the sample sizes for these subgroups were not sufficient to provide reliable national estimates. The authors recognize that women of other races and ethnicities have important health needs and distinct health concerns; however, we were not able to report on these in this report. Half of women ages 18 to 64 are married (50%), nearly one in ten live with a partner (8%), 17% are widowed, divorced, or separated, and a quarter of women never married (25%).



Many women face challenging economic circumstances **(Figure 2)**. Fifteen percent live below the poverty line, which was just under $20,000 for a family of three in 2013, when this survey was conducted. Another 16% of women have incomes between 100 and 199% of poverty. Together, 31% of women ages 18 to 64 have incomes under 200% of the federal poverty level, referred to as "low income," throughout this report. Almost six in ten women (58%) have incomes above this level and data are not available for 10% of women. About a third (36%) have a high school degree or less education. Most women work outside the home, either full-time (45%) or part-time (15%). About a third are not employed for pay (19%), students (8%), or retired (6%).

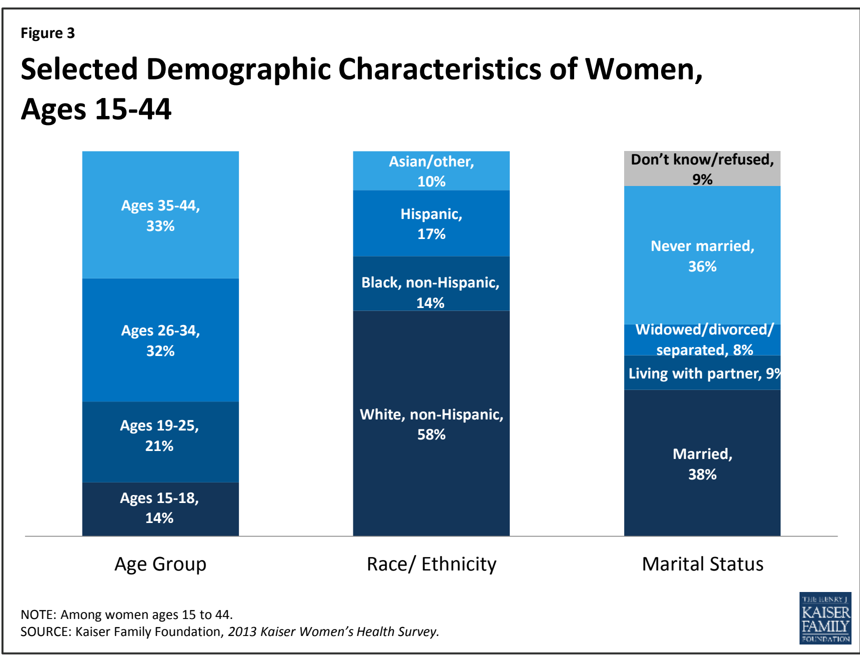


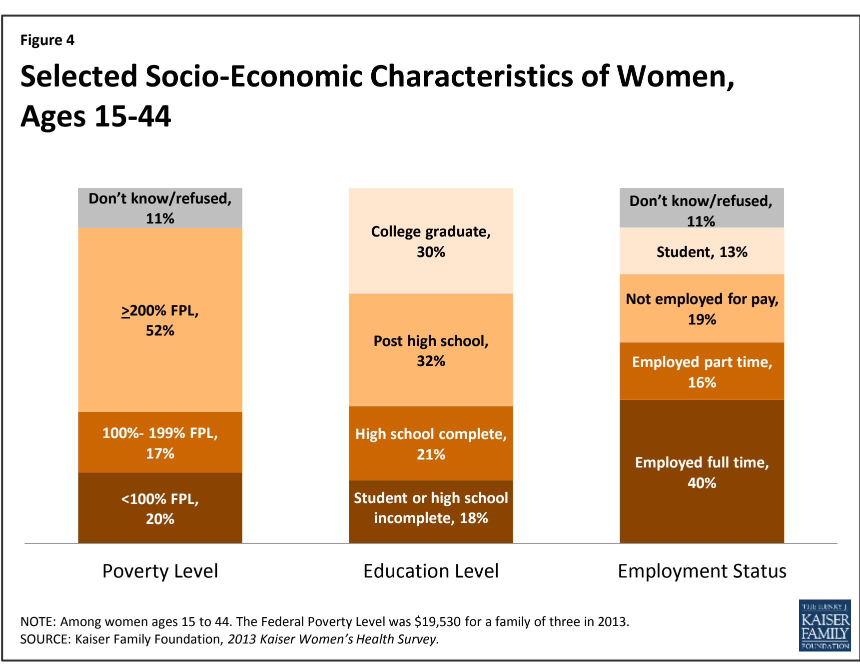
Reproductive age women ages 15 to 44

The survey also includes a sample of teen girls ages 15 to 17 as part of the reproductive age group. Although most females ages 15 to 17 are not yet sexually active, many are dating and reproductive and sexual health

services are an important component of health care for this age group. **Figures 3 and 4** present demographic characteristics of women ages 15 to 44, the population discussed in the section on reproductive and sexual health. About a third (35%) of this group are young adults through age 25 and the rest are 26 to 44. Almost six in ten are White (58%) and about four in ten (41%) are women of color. Not surprisingly, this group has a lower marriage rate (38%) than women 18 to 64, and more than a third (36%) have never been married. More than a third (37%) of reproductive age women are low-income, with incomes less than 200% of the poverty line, 18% are students or do not have a high school degree, and over half (56%) are working full or part time.

Throughout this report, data are presented to highlight the range of experiences that different subpopulations of women face when they use health care, particularly the challenges facing those who are at risk for poor access to care, those who are low-income, and women of color. These are the women who are most likely to benefit from the insurance and benefit reforms that are part of the ACA.





Women's health status

In addition to diversity in demographic characteristics, women have a wide range of health needs, which set the framework for the care they need and seek. How women assess their health status is an important gauge of their overall health and medical care needs. Women who rate their health as "fair" or "poor" typically need and use more health care services than women reporting better health ("excellent," "very good" or "good"). In addition to the global measure of self-reported health status, the rates of chronic conditions and the impact of those conditions on women's ability to lead productive lives are important measures of women's health status and provide a window into their health needs over their lifetimes.

Overall, 15% of non-elderly adult women ages 18 to 64 rate their health as fair or poor (**Table 1**). This rate increases with age, from 12% of adult women in their reproductive years (ages 18 to 44) to nearly one in five women (19%) ages 45 to 64. Among Hispanic women, 28% report fair or poor health, also 12% of White and 16% of Black women. Fourteen percent of women report that they have a disability or chronic condition that

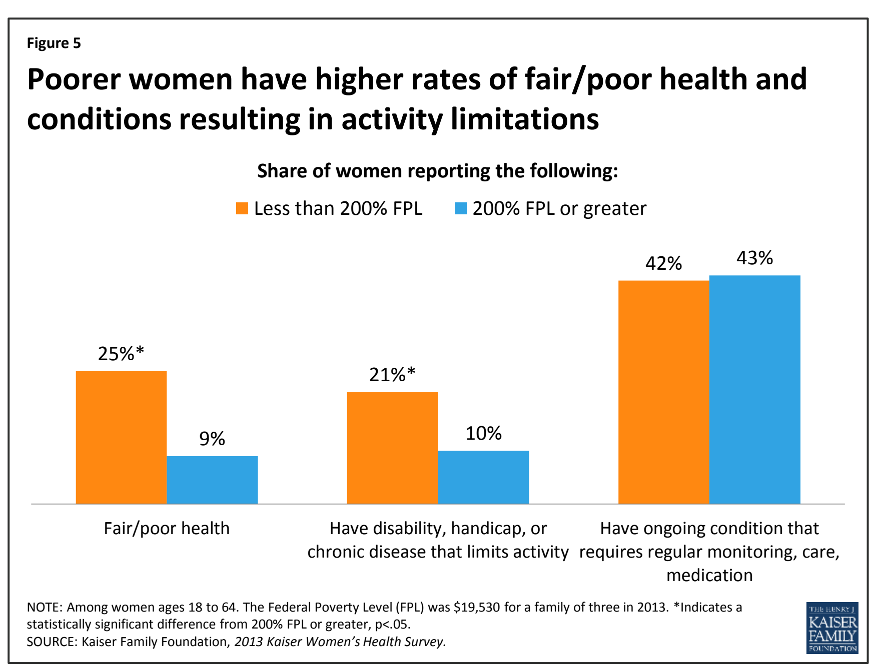
limits their daily activities. This is the case among 8% of women ages 18 to 44, but is reported by more than twice as many middle-aged and older women ages 45 to 64 (21%).

Table 1: Health problems reported by women, by age and race/ethnicity						
	All Women	**Age Group**		**Race/Ethnicity**		
Share of women reporting:		Ages 18-44	Ages 45-64	White	Black	Hispanic
Fair/poor health	15%	12%	19%	12%	16%	28%*
Have disability, handicap, or chronic disease that limits activity	14%	8%	21%*	15%	15%	14%
Have ongoing condition that requires regular monitoring, care, or medication	43%	32%	55%*	48%	38%*	35%*

NOTE: Among women ages 18-64. *Indicates a statistically significant difference from Ages 18-44, White, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

A sizable minority of women (43%) say that they have an ongoing condition that requires regular monitoring, treatment, or medication. This is reported by about one-third of women ages 18 to 44 (32%) and rises to over half of older women (55%). In contrast to self-reported health status, White women (48%) report ongoing health conditions that require monitoring, care or medication at higher rates than both Black (38%) and Hispanic women (35%). This difference could be attributable, in part, to poorer access to care experienced by women of color. Women with more limited access may be more likely to have undiagnosed conditions that require care, but they are unaware of their presence.

The difference in health status between women of different poverty levels is also notable and of particular relevance, given the ACA's focus on health care costs and spending in addition to coverage. Low-income women report higher rates of health problems than more affluent women (**Figure 5**). One in four low-income women rate their health as fair or poor, which is over twice the rate of higher-income women (9%). Similarly, the rate of women reporting an activity-limiting disability or chronic disease is twice as high among low-income women (21%) than their higher income counterparts (10%). The lack of differences in the share reporting that they have a medical condition that requires ongoing care could be attributable to the poorer health care access experienced by many low-income women.



Methods

The 2013 Kaiser Women's Health Survey obtained land line and cellular telephone interviews with a nationally representative sample of 3,015 women ages 15 to 64 living in the United States. The survey was conducted by Princeton Survey Research Associates International (PSRAI). Interviews were done in English and Spanish by Princeton Data Source LLC from September 19 to November 21, 2013. A combination of landline and cellular random digit dial (RDD) samples was used to represent all women ages 15 to 64 in the United States who have access to either a landline or cellular telephone. Both samples were provided by Survey Sampling International, LLC (SSI) according to PSRAI specifications.

For the landline sample, interviewers first asked to speak with the youngest female adult ages 18 to 64 who was at home. Once an eligible adult respondent was on the phone, interviewers determined if any eligible teens ages 15 to 17 lived in the household. If the household contained both an eligible adult and an eligible teen, one was chosen to interview, but priority was given to the teen interviews in recognition of the challenges of obtaining those interviews. Cell phone interviews started by first determining whether the person who answered the phone was eligible for the adult interview. If not, the interview was coded as ineligible and terminated. If the cell phone respondent was eligible for the adult interview, it was then determined whether or not they were the parent or guardian of any girls ages 15 to 17. Parental consent was obtained for all teen interviews and households where a teen interview was completed were sent $50 for their participation.

The samples were disproportionately-stratified to reach more low-income women and to increase the incidence of African American and Latina respondents. The data were weighted in the analysis to remove the disproportion from the selection rates by stratum and to make the data fully representative of women ages 15 to 64 living in the United States, as well as to compensate for patterns of nonresponse that might bias results. The weighting was accomplished in multiple stages to account for [a] the disproportionately-stratified samples, [b] the overlapping landline and cell sample frames, [c] household composition and [d] differential non-response associated with sample demographics.

A shorter companion survey of men was conducted via telephone (landline and cell phone) interviews with a nationally representative sample of 700 men ages 18 to 64 living in the United States to examine differences between women and men on a range of measures. Limited amounts of data on men are presented in this report and more detailed findings on men will be the subject of another forthcoming paper.

The margin of sampling error for the complete set of weighted data and for age subgroups of women as well as the full sample of men are shown in **Table 2** below. When possible, statistically significant at $p<.05$, differences are noted in the tables and graphics included in the report.

Table 2: Survey sample size and margin of error

	Sample Size	Margin of Error
Total sample of women ages 15-64	3,015	2.9 percentage points
Women ages 18-64	2,907	3.0 percentage points
Women ages 15-44	1,403	4.1 percentage points
Total sample of men 18-64	700	4.3 percentage points

Coverage, Access, and Affordability

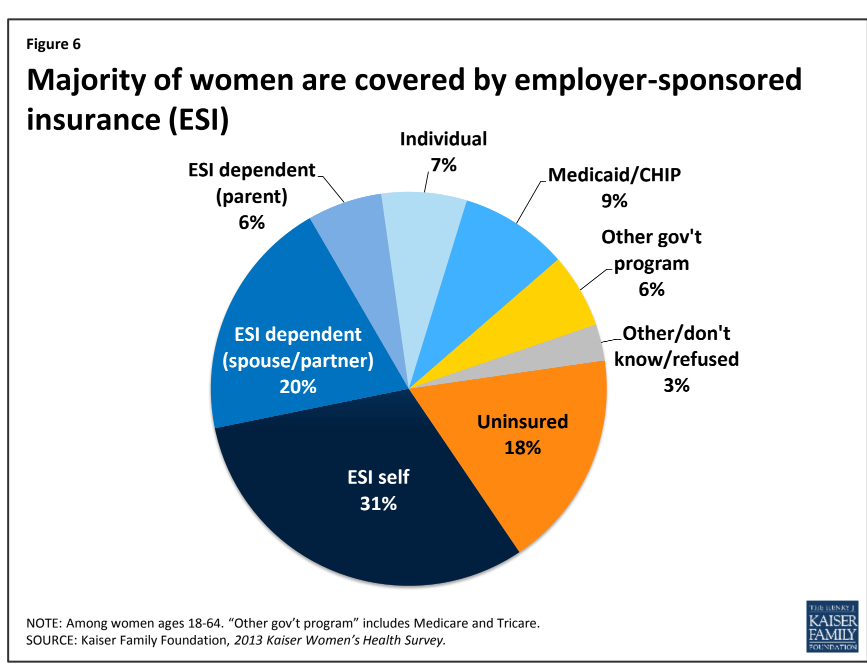
Health insurance coverage is a critical factor in making health care accessible and affordable to women. Women with health coverage are more likely to obtain needed preventive, primary, and specialty care services, and have better access to new advances in women's health. The primary goal of the ACA was to expand coverage to millions of uninsured across the country and to make reforms so that coverage is stable, affordable, and comprehensive. The law requires that most individuals have health insurance coverage in 2014 or pay a tax penalty. To facilitate access to coverage, the law includes a major expansion of Medicaid to many low-income individuals and establishes new Marketplaces in each state where most uninsured individuals who do not qualify for Medicaid can purchase a private insurance policy. While the law's primary focus is on expanding coverage and reducing the number of uninsured, it also makes a number of other changes designed to make care more affordable and accessible.

Coverage

The ACA extends coverage to uninsured individuals through a combination of changes in private and public coverage. The ACA was designed to expand eligibility for Medicaid to the poorest individuals (less than 138% of the federal poverty level) and to make to make coverage more affordable and available to individuals with incomes between 100% and 400% of poverty by establishing state-based Marketplaces where individual can obtain coverage and receive assistance with premium costs through a graduated system of tax credit subsidies. However, because of a 2012 Supreme Court ruling, the Medicaid expansion is now optional for states; about half have decided not to expand their programs at this time. In the states that have not expanded Medicaid, this choice has had the consequence of limiting access to affordable coverage for the poorest uninsured residents and lowering the number of people who qualify for coverage under the program.

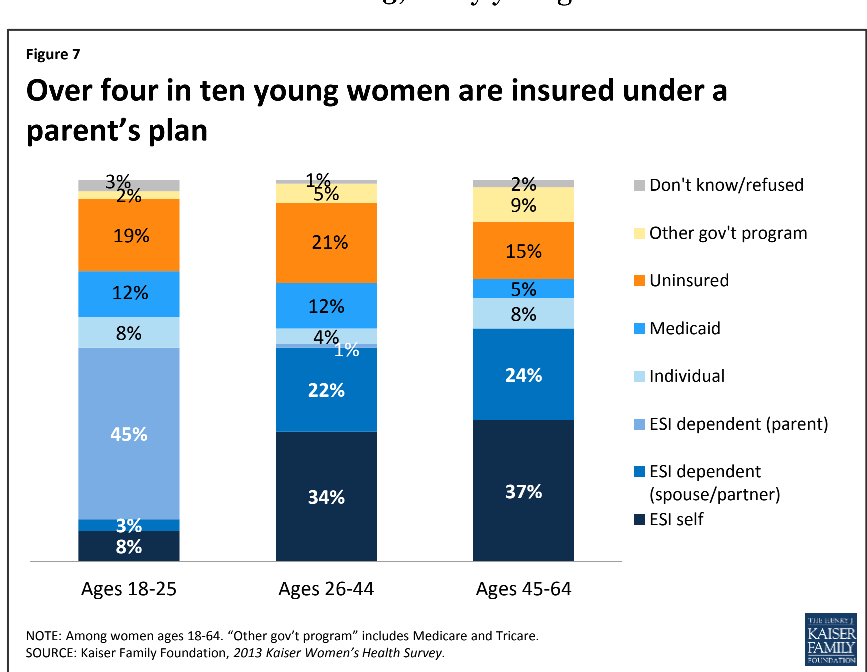
As the major part of the ACA's coverage expansion begins, almost one in five women are uninsured.

Most women (82%) have health coverage, but nearly one in five women (18%) between the ages of 18 and 64 are uninsured (**Figure 6**). Men, however, are uninsured at a higher rate (23%) than women. Employer-sponsored insurance (ESI) covers the majority of women (57%), with nearly half of that group covered as a dependent either through a spouse or parent. One in four women are covered as dependents (26%) and can be more vulnerable to losing their insurance should they become widowed or divorced, their spouse or parent loses a job, or if their spouse's or parent's employer drops family coverage. Just 7% of women are covered



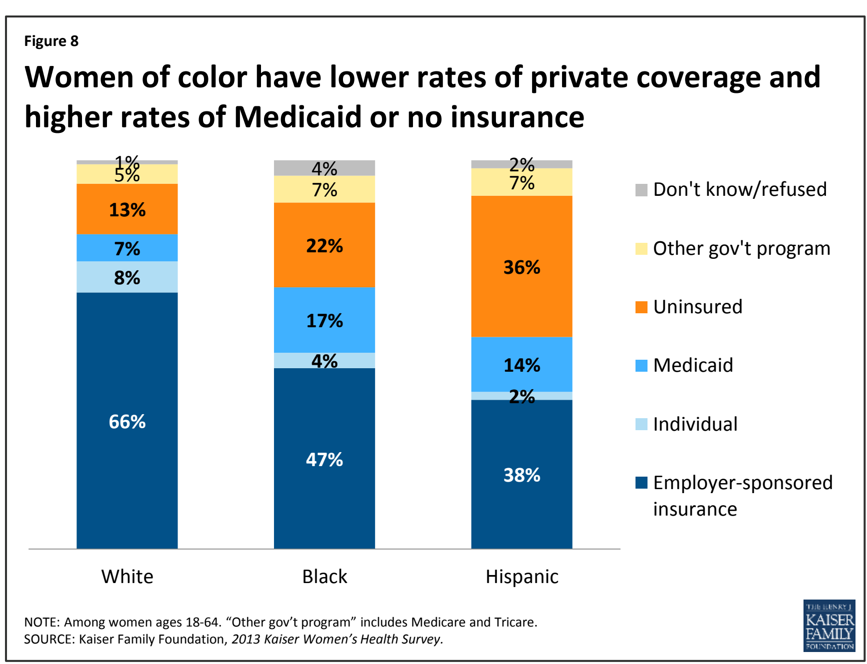
by private individually purchased insurance, with that proportion expected to change, as many turn to state-based marketplaces to obtain their coverage under the ACA. Currently, Medicaid, the nation's coverage program for low-income individuals, covers about one in ten women (9%). Before the ACA was enacted, eligibility for Medicaid in most states was limited to women with dependent children, those who were pregnant and those with a disability. The ACA's coverage expansion was designed to broaden Medicaid to many more low-income individuals and offer a new coverage pathway to poor adults without children who were largely ineligible before the law was passed. Although not all states are expanding Medicaid, the program's enrollment is expected to grow significantly in the coming years.

The ACA also included a major reform that allows adult children to stay on their parents' health insurance policies up to the age of 26. This policy went into effect in 2010 and in 2013, many young adults were covered under their parents' employer sponsored plans. While the overall rate of ESI coverage is similar between women of different age groups, 45% of women ages 18 to 25 are covered through a parent's policy, accounting for the single largest segment of coverage in this age group (**Figure 7**). In prior years, this age group had the lowest coverage rates. Among women in older age groups, most women with ESI obtain coverage through their own job or through a spouse's job. Medicaid also plays a prominent role for women under age 45, insuring 12% in that age group, a rate that is over twice the rate of middle aged women ages 45 to 64.



Lack of coverage is a problem facing a significant share of women of color.

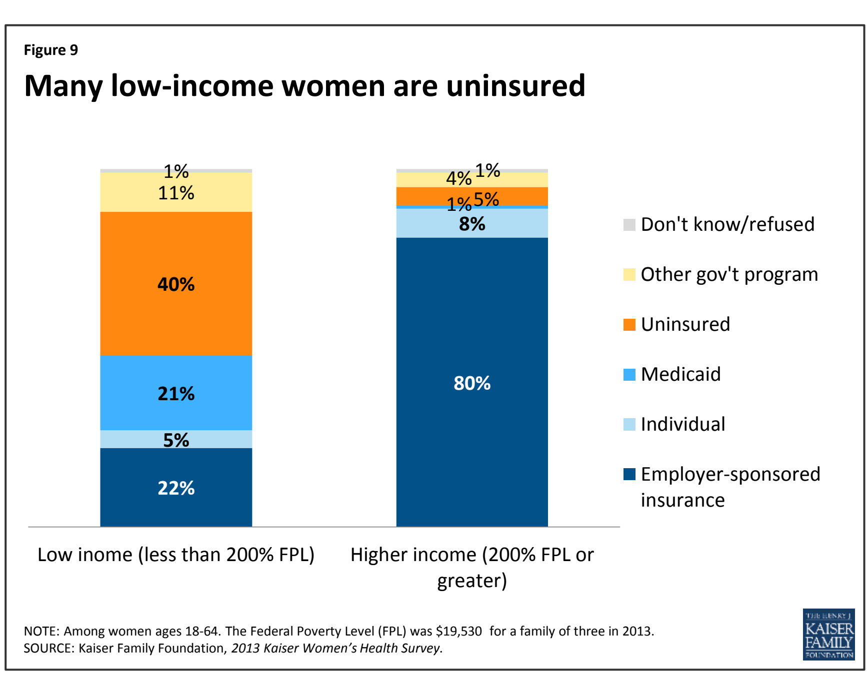
Minority women have higher rates of uninsurance and lower rates of employer-sponsored insurance compared to White women (**Figure 8**). While two-thirds of White women (66%) have insurance through an employer, either their own or as a dependent, this is the case for less than half of Black (47%) and Hispanic women (38%). These differences in part reflect the fact that minority women and their spouses are more likely to work in low-wage jobs that do not provide access to employer-sponsored insurance and have fewer financial resources to purchase coverage on their own. The rate of



Medicaid coverage among Black (17%) and Hispanic women (14%) is double that of White women (7%), reflecting the lower average incomes and concentration of poverty among racial and ethnic minority women who may be more likely to qualify for the program. The highest uninsured rate is among Hispanic women (36%), followed by Black women (22%), compared to 13% of White women. However not all women have access to Medicaid or federal tax credit subsidies under the ACA. Most women who are recent immigrants (who on average have high rates of poverty) do not qualify for Medicaid for at least five years after entering the U.S. legally, as a matter of federal law. Undocumented individuals, however, do not have any avenue to coverage, as they are barred both from Medicaid eligibility and from purchasing a plan or receiving subsidies through the state-based Marketplaces.

Low-income women have much lower coverage rates, and even among those who are currently covered, some have been without insurance earlier in the year.

Four in ten low-income women (40%) are uninsured currently, compared to 5% among higher-income women (**Figure 9**). Not surprisingly, low-income women also have much higher rates of Medicaid coverage (21%) than their higher income counterparts (1%) due to Medicaid eligibility rules. They also have much lower rates of employer-sponsored insurance (22% vs. 80% respectively) than higher-income women largely due to the fact that they are more likely to work part-time or part-year, work in a low wage job that lacks health benefits, or live in a household without an attachment to the workplace.



Even among women who have insurance, coverage is not always stable. Women can have spells of being uninsured as a result of job loss or change, premium prices becoming unaffordable, or in the case of dependent coverage, a spouse's job loss, or divorce or widowhood. While 82% of women report they had insurance at the time of the survey, a small share of that group report that there was a period in the prior when they were without insurance, which means that 77% were insured for the full year. Spells without insurance are more common among low-income women who have lower coverage rates to begin with. Only 53% of low-income women had coverage for a full year, compared to 90% of higher income women.

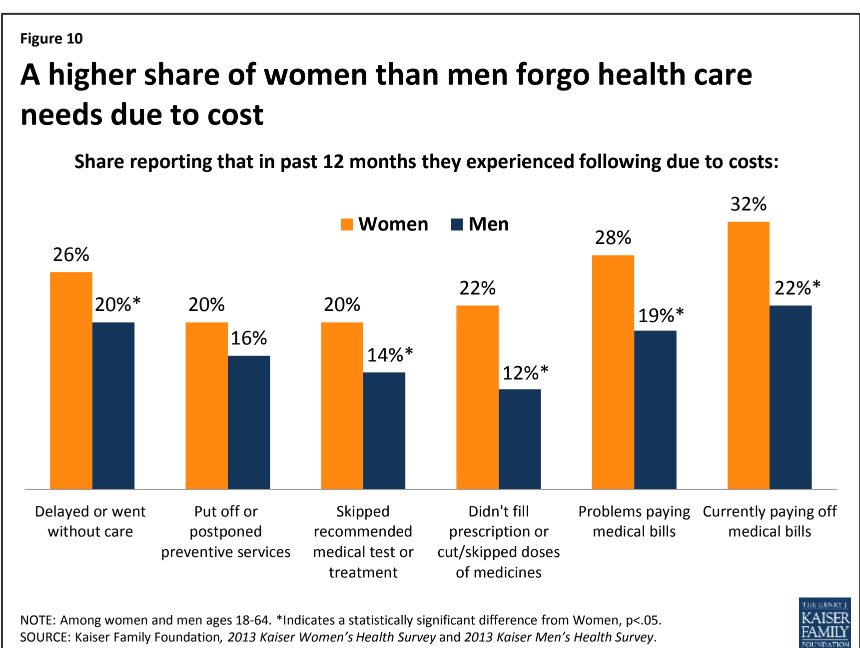
Access Challenges

While coverage plays a large role in accessing health care services, there are numerous factors that affect whether or not a woman actually obtains health care. These include health care costs, provider availability and capacity, as well as practical logistical issues such as transportation and finding time to make it to medical appointments. Some of these factors can be ameliorated by reforms in the ACA, such as the caps on out-of-

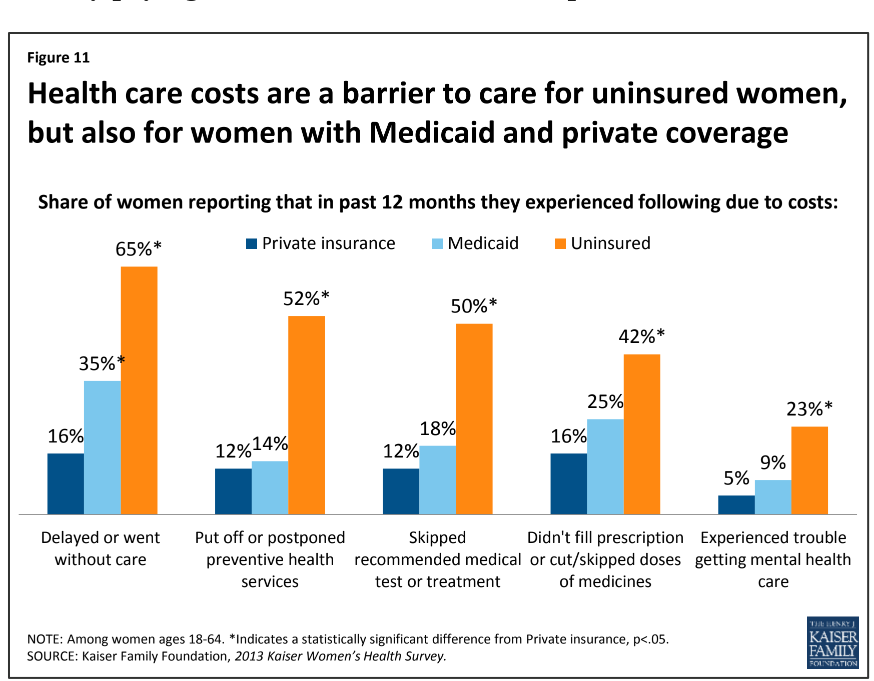
pocket costs and the coverage expansions, but others are systemic such as workplace benefits and flexibility, child care, transportation, and the availability of health care in communities where low-income women reside.

Out-of-pocket health costs are barriers to care for women and men, but are more common among women.

A higher share of women forgo health care needs due to cost compared to men. Insurance premiums, co-payments, deductibles, and services that are not covered by insurance can be expensive, potentially limiting access to care or jeopardizing a woman's and her family's financial health. While women and men both feel the impact of health costs, they are burdensome for a higher share of women, who on average earn lower wages, have fewer financial assets, accumulate less wealth, and have higher rates of poverty. This is compounded by women's greater health care needs, including reproductive health care services, and higher expenses throughout their lifespans.



A sizable share of women report that health care costs impede their access to services, force them to make tradeoffs, or result in unpaid medical bills (**Figure 10**). Across the board, these problems are more common among women than men. One in four (26%) women and one in five men (20%) have had to delay or forego care in the past year due to cost. Because of costs, approximately one in five women have also postponed preventive care (20%), skipped a recommended test or treatment (20%), or made medication tradeoffs such as not filling a prescription or cutting dosages (22%). About three in ten women report that they have had problems paying medical bills (28%) in the prior year or are currently paying off medical bills (32%), compared to about one in five men who report problems paying bills (19%) or who are currently paying them off (22%).



Costs are particularly burdensome for uninsured and low-income women.

For uninsured women, health costs can be a considerable barrier to care (**Figure 11**). Compared to women with private or public coverage, higher shares of uninsured women report that cost-related barriers to care. Almost two-thirds (65%) of uninsured women went without or delayed care because of the costs. Half

postponed preventive services (52%) and half skipped a recommended medical test or treatment (50%). Four in ten uninsured women either didn't fill a prescription or skipped or cut pills as a result of costs (42%) and about a quarter experienced problems obtaining mental health care (23%). However, it is important to recognize that even some women with coverage also experience affordability challenges that lower their access to health care. Sixteen percent of women with private insurance delayed or went without care because they could not afford it and many experienced other cost barriers as well. Although in some states Medicaid charges very nominal cost sharing amounts, this can still be an obstacle since women enrolled in the program have very low incomes by definition. One-third (35%) of women with Medicaid report postponing or going without care due to cost and many encountered other barriers too. One-quarter (25%) report that they made tradeoffs related to prescription drugs, which could be attributed to state policies that permit cost sharing or place caps on the number of prescriptions covered by their state Medicaid program.

Not surprisingly, low-income women report cost-related barriers at significantly higher rates than their higher income counterparts. One-third of low-income women report that cost was a reason they postponed preventive services (35%) or skipped medical tests and treatments (34%), a rate that was over twice as high among women with higher incomes (**Table 3**).

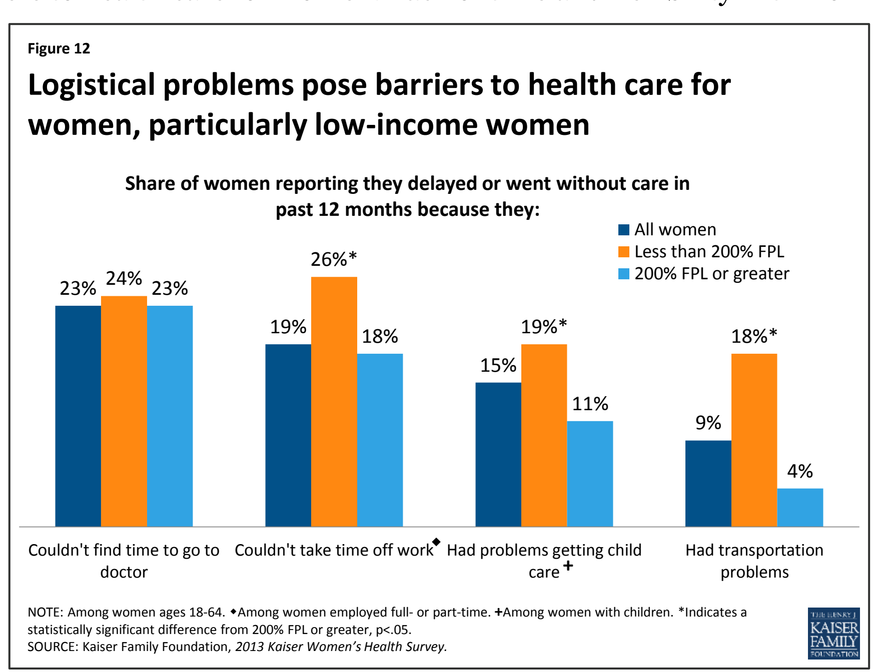
Table 3: Cost barriers to health care for women, by race/ethnicity and poverty level

	All Women	Race/Ethnicity			Poverty Level	
Share of women reporting they:		White	Black	Hispanic	Less than 200% FPL	200% FPL or greater
Put off or postponed preventive health services due to cost	20%	18%	23%	23%	35%*	13%
Skipped a recommended medical test or treatment due to cost	20%	19%	25%	21%	34%*	14%

NOTE: Among women ages 18-64 reporting actions within past 12 months. *Indicates a statistically significant difference from White, 200% FPL or greater, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

In addition to costs, women face logistical barriers to health care related to their roles as mothers and in the work place.

Costs and affordability are not the only barriers to health care for women. Lack of time and flexibility with work can pose a challenge in getting care for a sizable fraction of women. One in four women report that they did not obtain care they needed because they didn't have time (23%) and one in five delayed or went without care because could not take time off work (19%). These barriers affect women of all socio-economic statuses to different extents **(Figure 12)**. However, childcare and transportation problems are much more frequently reported among low-income women. Among women with children, one in ten (11%) with higher incomes report they delayed or couldn't obtain needed care because they had



problems getting child care, but the rate is almost double among low-income women (19%). For many women, getting to a doctor can be a challenge, but nearly one in five low-income women cited transportation problems as a reason for going without care (18%).

Impact of Medical Bills

Many women and their family members face problems paying medical bills for a variety of reasons. While this problem is greater for women who are uninsured, women with Medicaid and with private insurance also have difficulties covering their out-of pocket medical costs. Medical bills can easily pile up given high cost sharing, charges associated with out of network use, coverage limits or exclusions, or high deductibles for women with insurance. Uninsured women are often charged "full price," a higher amount than the negotiated rate insurance plans pay for medical services, and do not have insurance to pay any of the costs of their care. Some women incur significant out-of-pocket medical expenses because of an unexpected health event such as a pregnancy, illness, or injury. These events may also limit a woman's ability to continue working and result in lost income, further limiting her ability to pay medical bills. Medical debt can have serious financial consequences. Prior research has found that it is the leading reason for personal bankruptcy, and can cause women to exhaust their savings, make tradeoffs with other needed expenses, or compromise their credit standing.[1] As more women gain coverage under the ACA, this should help alleviate the impact of medical bills but for some women, there could still be considerable costs associated with care, even among those gaining coverage.

Problems paying medical bills are reported by a sizable minority of women.

Approximately three in ten women have had problems paying medical bills in the past year (28%) compared to 19% of men. Nearly a third of women say they currently have medical bills that are unpaid or are in the process of paying them off (32%), also at a rate that is higher than for men (22%). Not surprisingly, uninsured women report problems paying medical bills in the prior year (52%) and having current outstanding bills (52%) at twice the rate of women with private insurance (21% and 26% respectively) (**Table 4**). This is however still a problem for a significant fraction of women with insurance. About one-third of women covered by Medicaid, who have very low incomes to use to pay off medical debt, also report having problems (37%) with medical bills or are currently paying them off (36%). These problems are also more common among younger women, who also tend to have lower earnings.

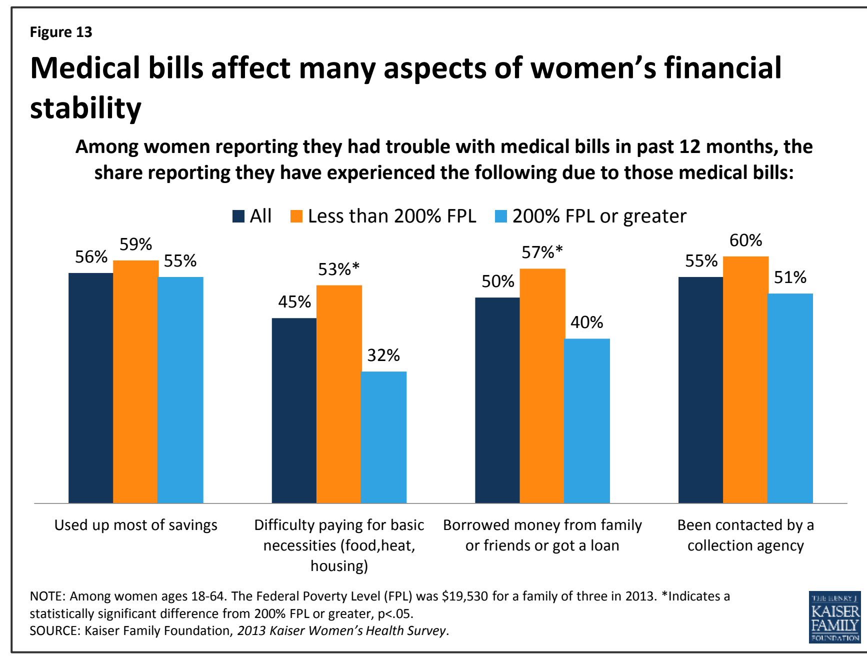
Table 4: Rates of unpaid medical bills, by age group, insurance status, and poverty level

	All Women	Age Group		Insurance Status			Poverty Level	
Share of women reporting:		Ages 18-44	Ages 45-64	Private insurance	Medicaid	Uninsured	Less than 200% FPL	200% FPL or greater
They or family member had trouble paying medical bills in past 12 months	28%	31%	26%	21%	37%*	52%*	44%*	21%
They currently have unpaid medical bills or bills currently being paid off	32%	35%	28%*	26%	36%	52%*	46%*	25%

NOTE: Among women ages 18-64. *Indicates a statistically significant difference from Ages 18-44, Private insurance, 200% FPL or greater, p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Medical bills have serious consequences for women’s finances and can force women to make difficult tradeoffs.

Medical bills have tangible consequences for other areas of women’s financial security. Among women reporting they had problems paying medical bills in the prior year, more than half report that they used up most of their savings (56%) or were contacted by a collection agency (55%) as a result of those bills. Many women also say they have had to borrow money from family or friends (50%), and or faced difficulties in paying for basic necessities such as food and electricity (45%) because of their medical bills. Not surprisingly, higher shares of low-income women face these difficult tradeoffs attributable to medical debt (**Figure 13**).



Connections to Health Providers

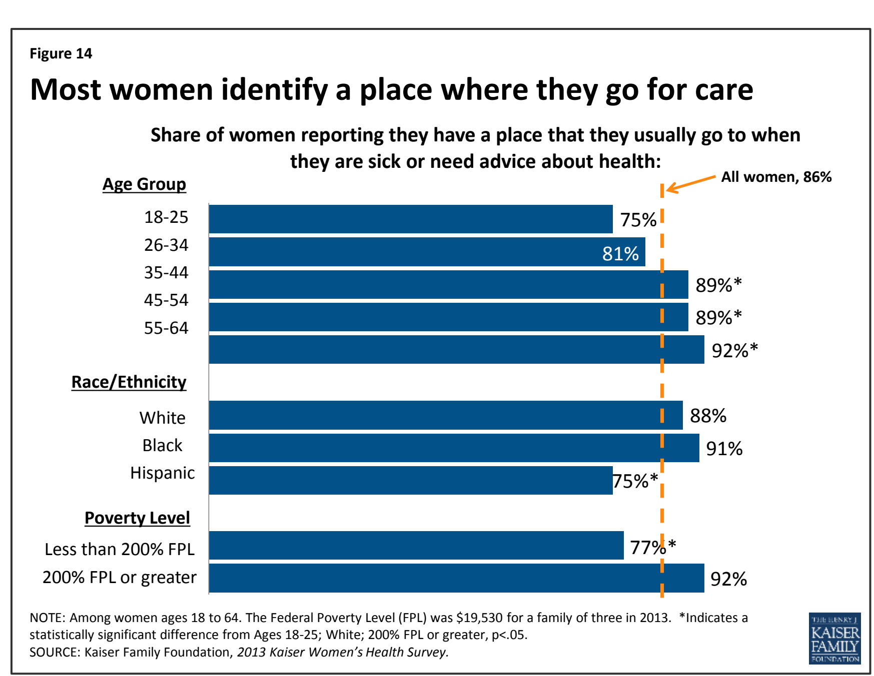
Women have a broad range of health needs that evolve over the course of their lives. In their younger years, health concerns related to reproductive and sexual health are priorities. As they age, management of chronic health problems takes on a larger role. Women's health needs and connections to providers are major factors in how they use health care. The ACA includes a number of measures that affect the delivery of care, such as incentives to increase the supply of primary care providers, who are often a woman's main connection to the larger health system. However, in recent years, there has been much concern that the supply of primary care providers is already insufficient and that this problem will be exacerbated by the health care demands of the newly insured. The ACA also prioritizes the development and expansion of health care delivery models, such as medical homes and accountable care organizations, which include financial incentives for providers to work in partnerships. The goal is to provide a strong linkage to a primary care provider and integrate the wide array of clinicians that women may turn to for health care. The expectation is that this will result in better coordination and continuity of care, as well as enhanced access to the full range of services women may need.

Usual Sources of Care

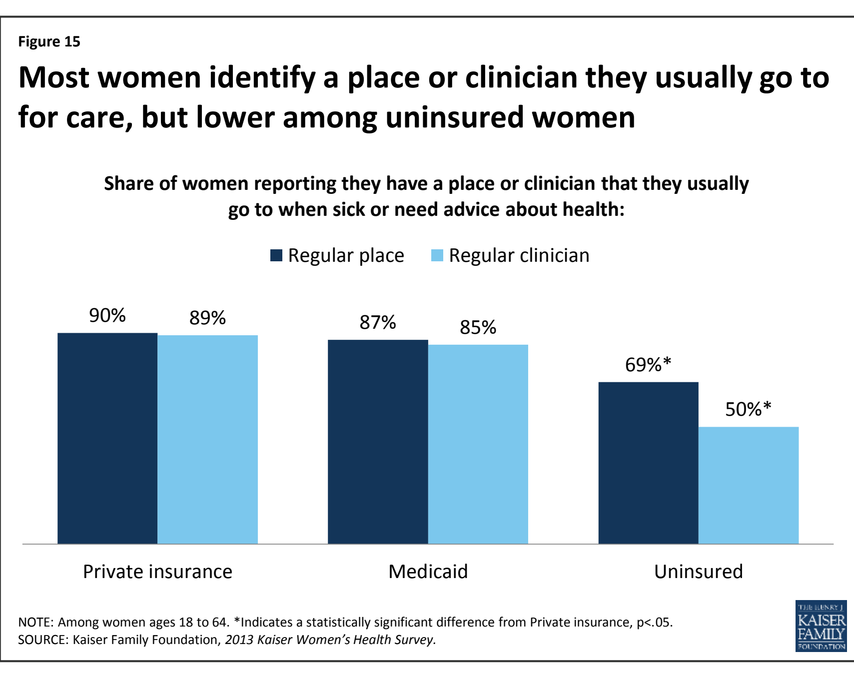
Having a usual site of care and a doctor are markers of women's access to care and are associated with higher use of recommended preventive care and screening services. Having a regular place or provider helps with care coordination and can promote access and continuity. There is increased attention in the ACA to the concept of a "medical home." In the case of women, this would be a health care setting where women's health needs can be addressed and coordinated in a way that can promote the quality of care and reduce duplication in care. This is especially important for women, who are more likely than men to rely on at least two providers for their routine care.

Most women have a place that they go for routine care, but it is less common among young, Hispanic, low-income and uninsured women to have a usual source of care.

Most women (86%) report they have a place to go for care when they are sick or need advice about their health (**Figure 14**). This rate is significantly higher than for men (72%). Among women, however, the rate is lowest among younger women, with 75% of women ages 18 to 25 and 81% of women 26 to 34 reporting they have a usual place to get their care, significantly lower than the rates for women who are older. Fewer Hispanic women (75%), low-income (77%) and uninsured women (69%) report they have a routine place to get their care.



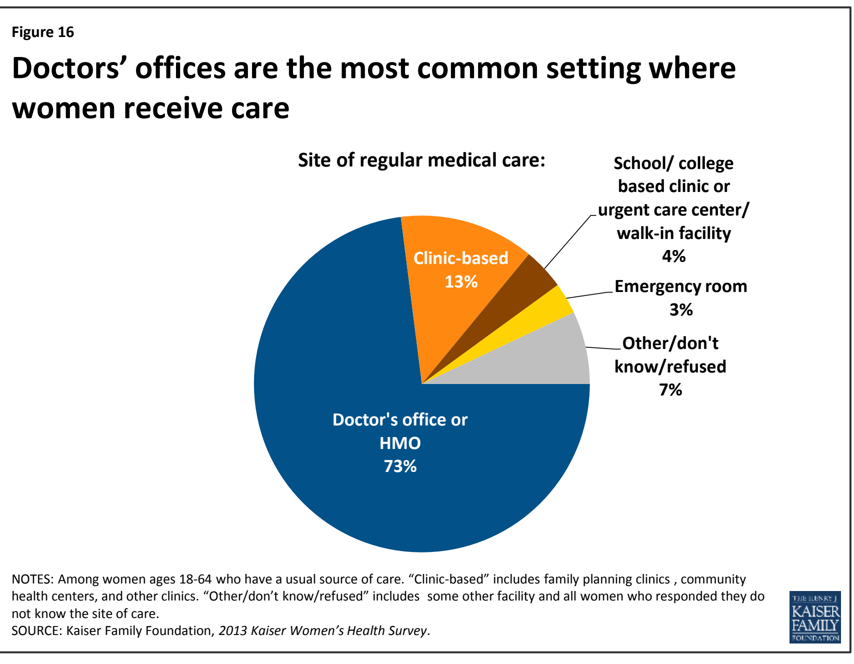
The vast majority of women also report that they have a specific clinician (doctor or other health provider) that they see for their routine care. Overall, more than eight in ten women report that they have a provider (81%) they use when they are sick or need routine care, compared to 68% of men. The rate is similar between privately insured women (89%) and those covered by Medicaid (85%) (**Figure 15**). For uninsured women, however, connections with individual providers are the most tenuous. While about two-thirds (69%) say they have a place they get their care, only half report that they have a specific clinician that they see for routine care (50%).



Health care settings

Most women get their routine care from doctor's offices, but one in ten rely on clinic-based settings.

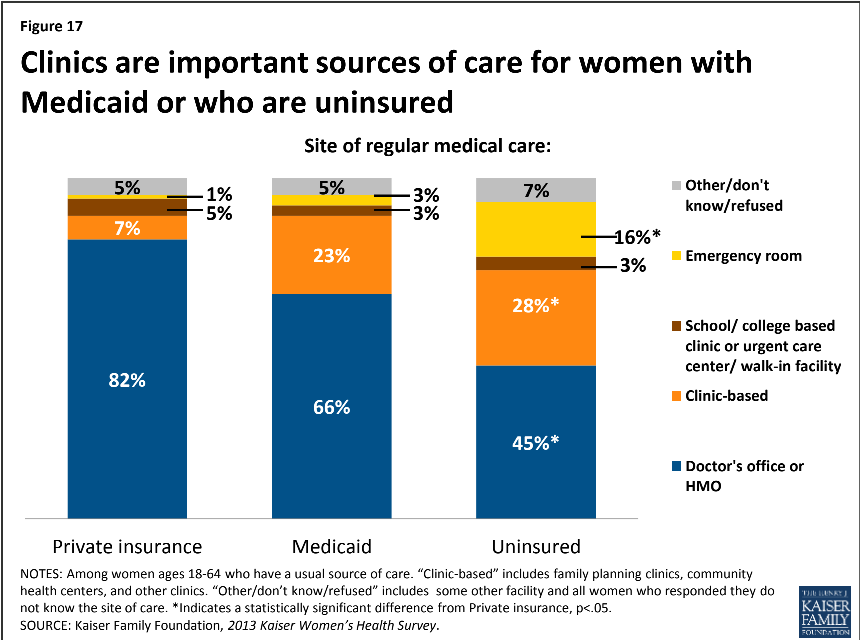
Among women who identify a routine setting, doctor's offices and HMOs are the most common site reported (**Figure 16**). Almost three in four women (73%) report that this is where they seek care. About one in ten women (13%) rely on a clinic setting and 3% report an emergency room as their routine source of care. A small fraction of women report that they rely on school based clinics or urgent care centers for their routine care. Women who use urgent centers and emergency rooms may be most at risk for receiving expensive, fragmented, and discontinuous care.



A sizable minority of women covered by Medicaid or who are uninsured rely on clinics for their care. For one in six uninsured women, emergency departments serve as their routine source of care.

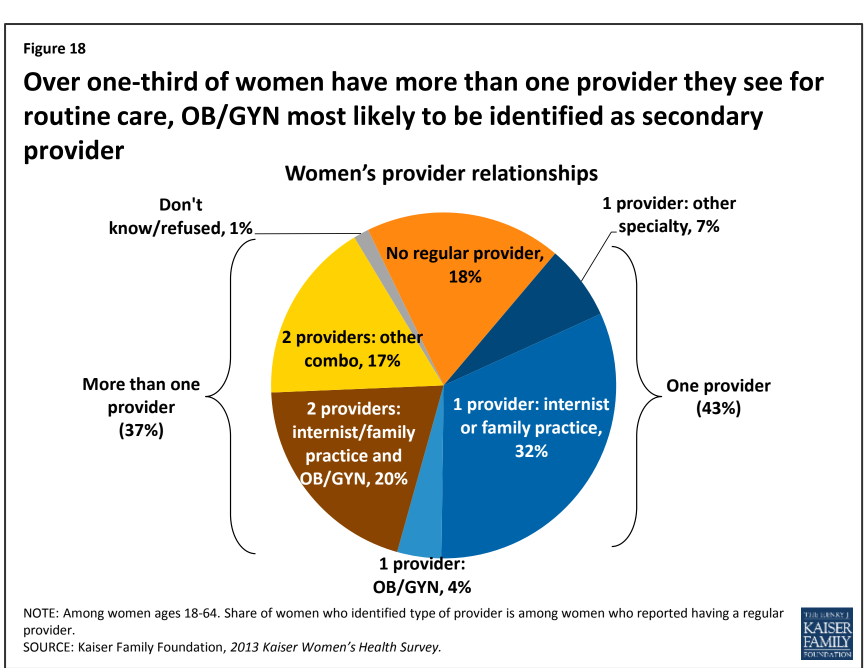
Differences in the types of settings that women with various types of insurance coverage rely on are notable (**Figure 17**). This variation reflects the networks of providers available to women through their plans and the long-standing role that safety net providers have filled in serving uninsured and low-income patients. While eight in ten women with private insurance (82%) go to a doctor's office for routine care, this share drops to two-thirds of women with Medicaid coverage (66%) and less than half of uninsured women (45%). There have

been historical challenges with physician participation in the Medicaid program, which is due in part to low provider reimbursement rates under the program. Medicaid beneficiaries (23%) and uninsured women (28%) have much higher use of clinics than privately-insured women (7%). Community health centers and public clinics were established to help care for low-income and underserved populations and play a major role serving these women. Of particular concern though, is that 16% of uninsured women say they usually seek care when they are sick or need medical advice in an emergency room, a rate considerably higher than their counterparts with Medicaid (3%) or private coverage (1%). As more women gain coverage under the ACA, they may also have better access to primary care and it is hoped that reliance on emergency departments for non-urgent care will fall. It is also not clear at this point, however, whether the provider networks under plans offered by state Marketplaces will include traditional safety-net providers, such as community health centers and family planning clinics.



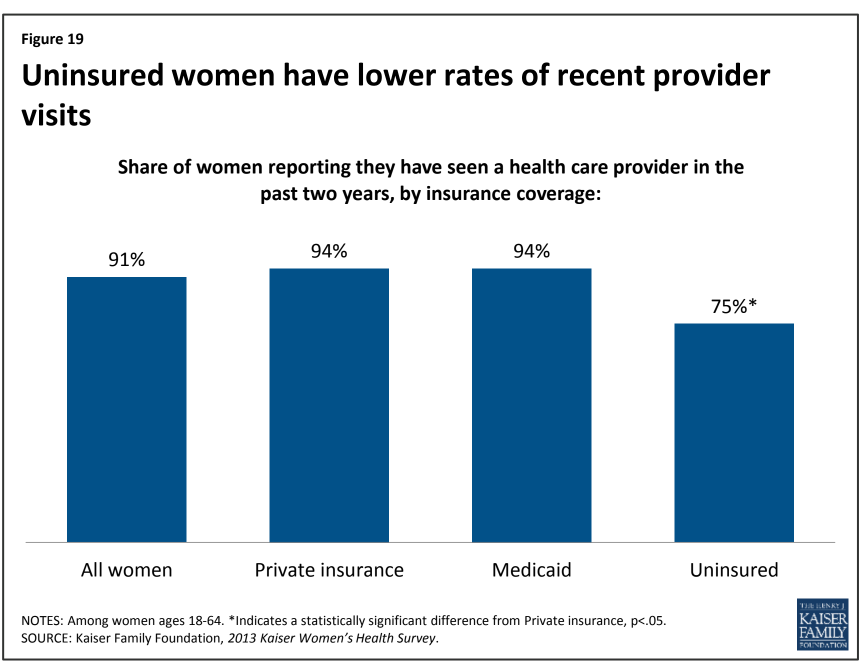
One-third of women report that they see more than more than one clinician for their routine care.

Over four in ten women (43%) report they see one provider regularly and one-third of women (37%) say they have multiple providers to address their basic health needs (compared to 18% of men). Family practitioners and internists are the most common provider types, and among those with multiple providers, Obstetrician-Gynecologists (Ob/Gyns) are the most commonly identified second provider. This is not surprising given women's reproductive and sexual health needs. Almost one in five women (18%) do not have a regular provider of any type (**Figure 18**).



Most women have had a recent health provider visit in the past two years, but uninsured women have the lowest rates.

Nine in ten adult women (91%) have seen a health care provider in the past two years compared to 75% of men. Hispanic women (84%) have a significantly lower rate than Black (91%) or White (93%) women of having a provider visit in the past two years. The largest difference is between women who are uninsured (75%), who have a significantly lower rate than women with private insurance or Medicaid (**Figure 19**). Designing a medical home for women is complicated by the traditional division of care that many women experience, with reliance on Ob/Gyns for reproductive care as well as primary care providers for other types of care. Among women with more complex and multiple medical conditions, similar challenges will arise. In designing programs and systems that encourage stable and comprehensive medical homes, the distinct needs of women are important considerations.



Most women use at least one prescription medication on an ongoing basis, and nearly one in ten take six or more medications on a regular basis.

Another important health access issue relates to women's use of prescription drugs. Over half of women (56%) take at least one prescription medicine on a regular basis compared to just over one-third of men (37%). Three in ten women say they take one or two prescription medications (31%), while nearly one in ten women (9%) report taking at least six different medicines on a regular basis. Use of prescription medications is driven in part by health needs as well as access to care. Use rises with age, partly due to the higher rates of chronic conditions among older women. Six in ten uninsured women report that they do not use a prescription medicine on a regular basis, compared to about four in ten women with private insurance (40%) and Medicaid (42%) (**Table 5**). This may be in part attributable to poorer access to care, undiagnosed conditions that could be managed with medication, and poorer ability to pay for medications since they do not have insurance. Almost one in five women covered by Medicaid (19%) take at least 6 medications on an ongoing basis, compared to 6% of women with private insurance. This difference may be explained by the poorer health status of women enrolled in Medicaid. Women with Medicaid coverage are disproportionately poor and some may qualify on the basis of their disability as well as their poverty status. Under the ACA, prescription medicines are one of the Essential Health Benefits (EHBs) that all new plans must now cover, but specific medicines and cost sharing requirements vary between plans.

Table 5: Prescription drug use by women, by age, race/ethnicity and insurance status									
	All Women	**Age Group**		**Race/Ethnicity**			**Insurance Status**		
Share of women reporting:		Ages 18-44	Ages 45-64	White	Black	Hispanic	Private	Medicaid	Uninsured
No Rx Use	44%	50%	37%*	39%	45%	60%*	40%	42%	61%*
1-2 Medicines	31%	36%	25%*	33%	28%	27%	36%	20%*	22%*
3-5 Medicines	16%	9%	23%*	18%	16%	8%*	17%	19%	8%*
6+ Medicines	9%	4%	15%*	10%	10%	5%	6%	19%*	7%

NOTE: Among women ages 18-64. *Indicates a statistically significant difference from ages 18-44, White, Private insurance, p<05.

SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Preventive Services

Clinical preventive care helps identify health problems earlier, allowing conditions to be treated or managed more effectively before they become more serious. The ACA prioritizes and promotes access to clinical preventive services by requiring that new private plans cover recommended clinical preventive services without cost sharing. The specific services that new plans must include are the ones that are recommended by:[2]

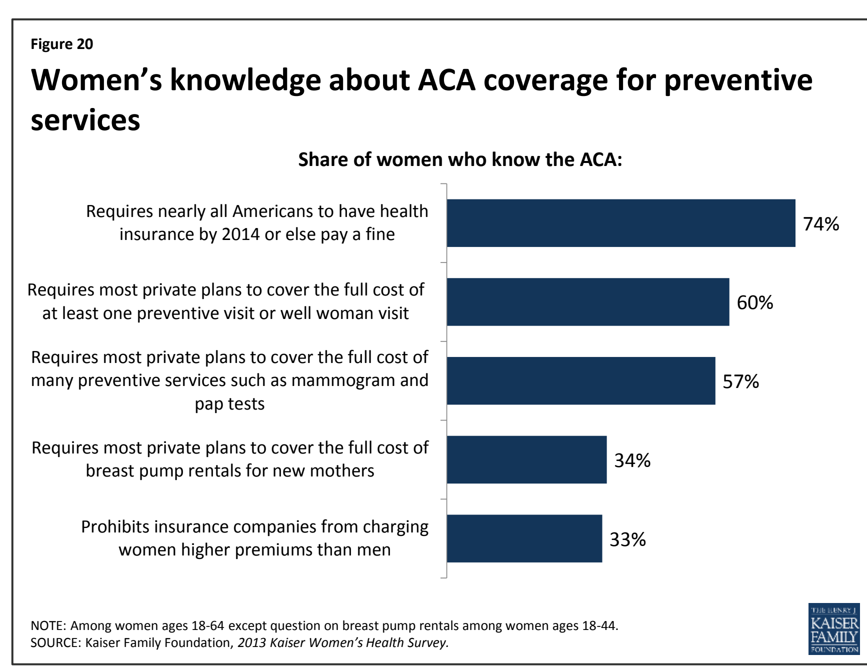
- the US Preventive Services Task Force (USPSTF), an independent body of clinicians and scientists that reviews the evidence of preventive health care services and develops recommendations for primary care providers and health care systems; services with grade A or B are covered under the ACA policy;[3]
- the Advisory Committee on Immunization Practices (ACIP), a group of medical and public health experts convened by the Centers for Disease Control and Prevention (CDC) that makes recommendations on vaccines for people of all ages;[4]
- the Health Resources and Services Administration's (HRSA) Bright Futures project for children, in partnership with the American Academy of Pediatrics provides recommendations to improve health of infants, children and adolescents;[5]
- the Health Resources and Services Administration, Office of Women's Health issued federal regulations for eight preventive care services for women based on recommendations from a committee of the Institute of Medicine (IOM).[6]

The combined roster of services recommended by these groups is extensive and can be classified into a few broad categories, including counseling and screening tests related to cancer, chronic conditions, mental health, health behaviors, and certain sexual and reproductive health services. For women, the law also requires no cost sharing for at least one annual "well woman" visit.

Knowledge and Understanding of the ACA Rules on Preventive Care

Women's awareness of the ACA requirements regarding no-cost coverage of preventive care is uneven.

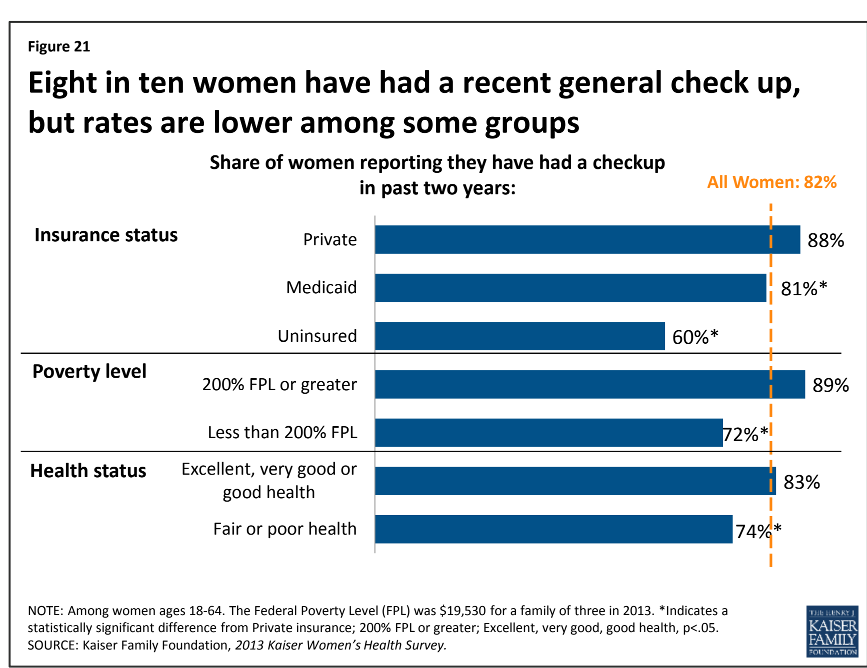
Coverage for preventive services without cost sharing is required in all new private plans, including employer-sponsored plans, individual market plans, and those in the new state marketplaces. While millions of women could potentially reap these benefits, many are unaware of ACA's coverage for preventive services (**Figure 20**). A sizable majority (74%) of women are aware of the ACA's requirement that individuals carry insurance, but fewer



know that at least one preventive visit for women must be covered (60%), or of the no-cost coverage for preventive services such as mammograms (57%). Knowledge is quite low even among subgroups that are most directly affected. For example, only 34% of women of reproductive age (ages 18 to 44) know of the coverage for breastfeeding supports including breast pump rental. Awareness of other benefits of particular relavence to women, such as the prohibition on insurers charging higher premiums for women over men, known as gender rating, is also low.

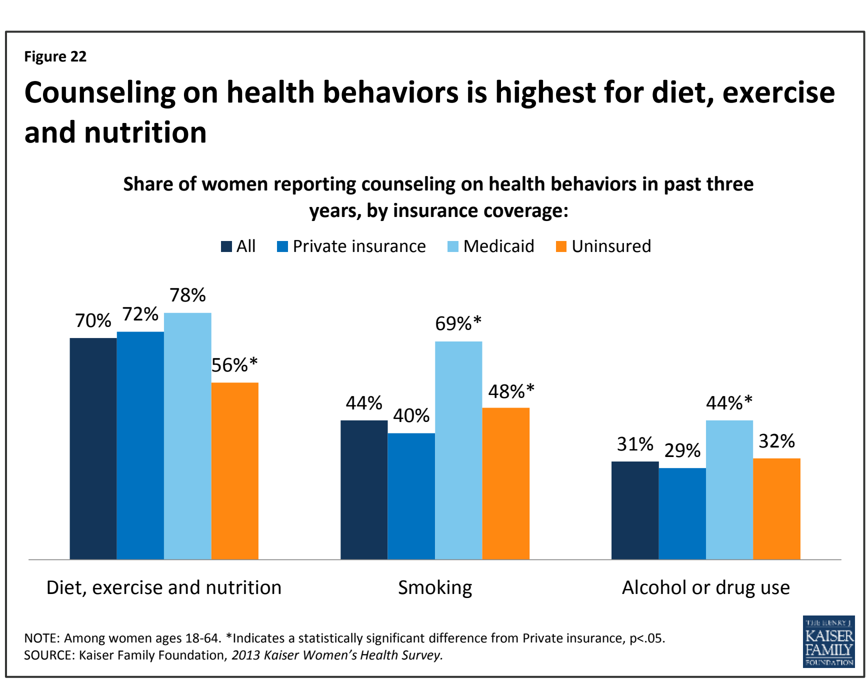
General Checkups and Provider–Patient Counseling

Provider visits can give women an opportunity to talk with clinicians about a broad range of issues, including preventing illness, the role of lifestyle factors, and management of chronic illnesses. Under the ACA, new plans must cover at least one annual "well woman visit," which the IOM Committee on Clinical Preventive Services for Women recommended could specifically cover a range of topics, such as assessment of diet and physical activity, history of pregnancy complications, mental health screenings for pregnant and post-partum women, screening for metabolic syndrome, preconception care, prenatal care, and screening for STIs.[7]



The majority of women have had a recent checkup with a provider.

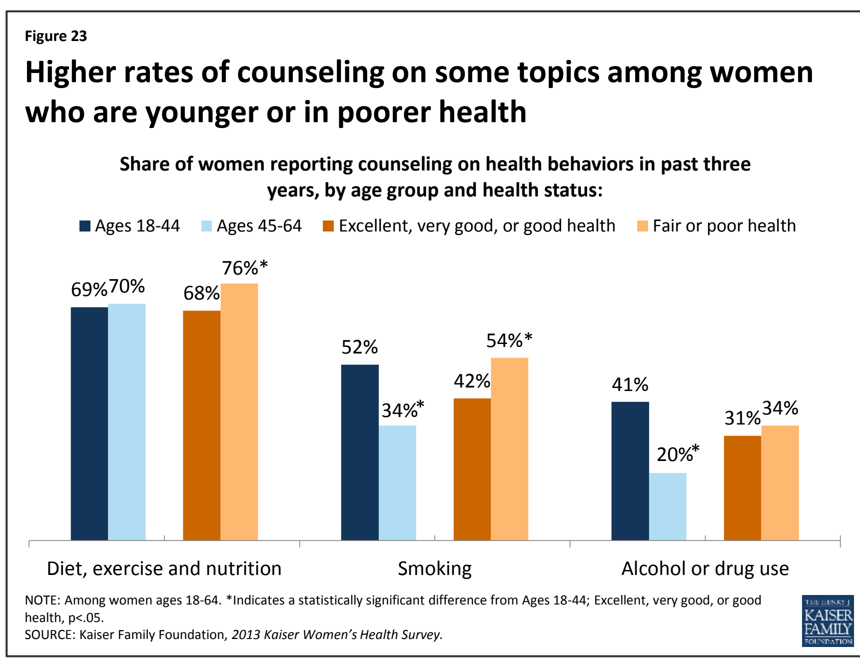
Eight in ten women (82%) have had a general checkup in the past two years (**Figure 21**). However, it is less common among uninsured women (60%), women with incomes less than 200% FPL (72%), and those with poorer health (74%). Rates are similar between women of different racial and ethnic groups, with about eight in ten White (83%), Hispanic (79%), and Black (88%) women reporting they have had a recent well woman visit.



In general, rates of counseling on healthy lifestyles are highest for diet, exercise, and nutrition.

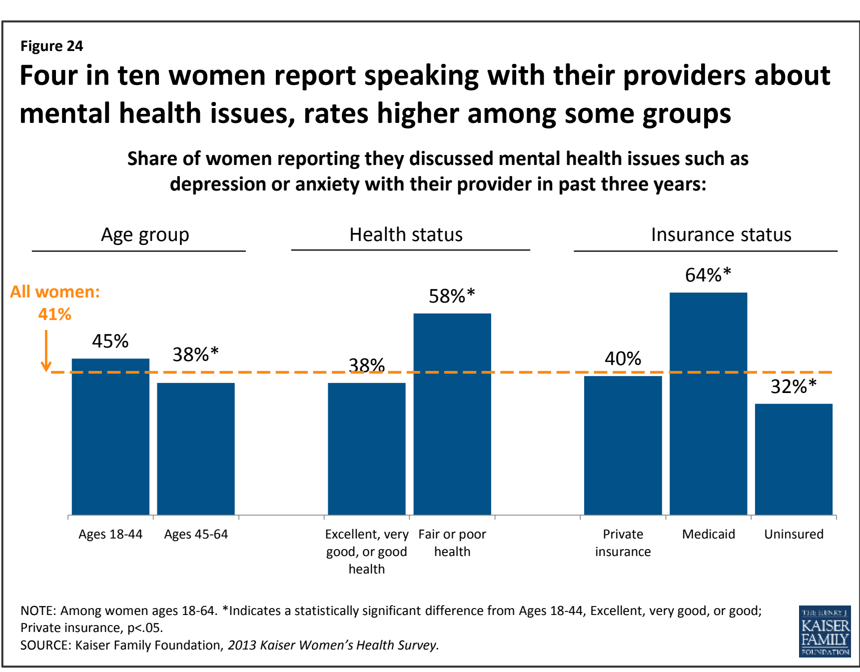
One component of preventive care that is now covered by plans without cost-sharing is provider counseling on health-related behaviors such as diet, smoking, and alcohol use, which have been shown to affect a wide range of health issues

including a woman's risk for chronic diseases. Consistent with other national trends, the highest rate of preventive counseling is on diet and nutrition, which 70% of women have discussed with a provider in the past three years (**Figure 22**). However, fewer than half of women have recently talked to a provider about other risk factors for chronic illnesses, such as smoking (44%) and alcohol or drug use (31%). Across the board, women covered by Medicaid have the highest rates of counseling. In addition, younger women and those in poorer health have higher counseling rates compared to their counterparts **(Figure 23)**.



Fewer than half of women have talked recently with a provider about mental health issues.

It is estimated that 21% of adult women are affected by some form of mental illness, such as depression, anxiety, trauma, eating disorders, or dementia.[8] Under the ACA, mental health services have been included as one of the ten Essential Health Benefits,[9] meaning that all new plans must cover this category, although coverage for specific services varies between plans. Depression and anxiety in particular present challenges to a disproportionate share of women over their lifetimes, and in response, the USPSTF recommends routine screenings. Four in ten (41%) women report having discussed a mental health issue such as anxiety or depression with a provider in the past three years (**Figure 24**). Mental health screening rates are similar between women of different racial and ethnic groups, with about four in ten White (42%), Hispanic (42%), and Black (39%) women reporting discussing with a provider. As with other counseling topics, the rate is higher among women who are younger, sicker, or covered by Medicaid.



Screening Tests

Rates of preventive screening tests are higher among women with insurance.

Use of preventive services can lead to early identification of conditions when they are most responsive to early interventions. This is especially true for some types of cancers and cardiovascular conditions. For example,

routine mammograms and pap tests, which are used to identify breast and cervical cancers respectively, are recommended by the USPSTF as necessary preventive services. The USPSTF also recommends regular screenings for elevated blood pressure and cholesterol levels because they are considered markers for cardiovascular conditions, including stroke and heart disease. These services are all now covered by new private plans under the ACA's preventive services coverage requirements.

Most women have received cancer and cardiovascular screening tests in the past two years, including mammograms (73%), pap tests (70%), and cholesterol tests (67%), with some variation by age group (**Table 6**). The rate of blood cholesterol tests varies significantly between younger women (58% for women ages 18 to 44) and older women (78% for women ages 45 to 64). Cholesterol tests are recommended for women older than 20 who are at increased risk for heart disease.[10] Rates of screening for colon cancer within the past two years are lower, with about four in ten (39%) women 50 and older reporting a recent colorectal screening. The USPSTF recommends three different methods with different intervals that are equally effective screenings for women between age 50 and 75 years: 1) annual high-sensitivity fecal occult blood testing, 2) sigmoidoscopy every 5 years combined with high-sensitivity fecal occult blood testing every 3 years, and 3) screening colonoscopy at intervals of 10 years.[11]

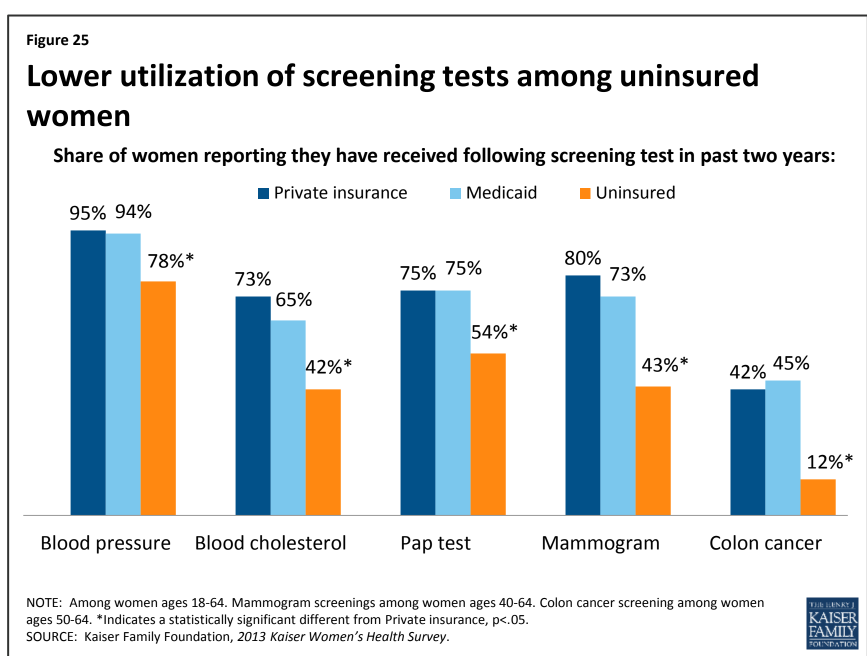
Table 6 : Rates of screening tests among women, by age and race/ethnicity

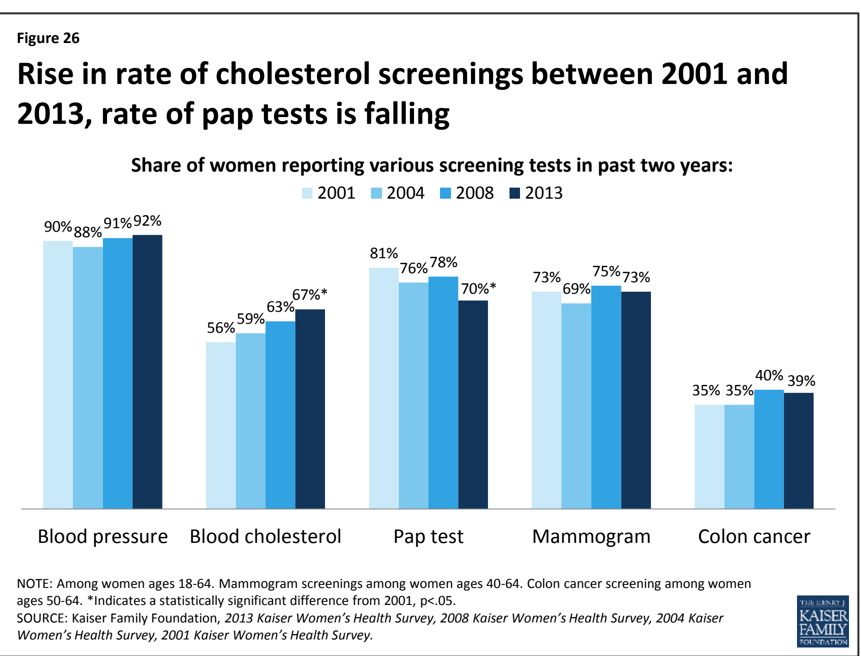
Preventive Screening	USPSTF Recommendation	Share of Women Reporting Screening Test in Past Two Years					
		All Women	Age Group		Race/Ethnicity		
			Ages 18-44	Ages 45-64	White	Black	Hispanic
Blood Pressure (Hypertension)	Screening for high blood pressure in adults age 18 and older.	92%	90%	94%*	94%	93%	83%*
Blood Cholesterol Test (Coronary Heart Disease)	Screening of women ages 20 and older who are at increased risk for coronary heart disease.	67%	58%	78%*	69%	66%	63%
Pap Test (Cervical Cancer)	A pap test every 3 years for women ages 21-65, or a combination of a pap test and HPV test every 5 years for women ages 30-65.	70%	72%	67%	71%	76%	72%
Mammogram (Breast Cancer)	Mammography screenings once every 1 to 2 years for women ages 40 and older.	73%	N/A	N/A	74%	79%	72%
Colonoscopy, Fecal Occult Blood test, Flexible Sigmoidoscopy (Colorectal Cancer)	1) Annual high-sensitivity fecal occult blood testing or 2) sigmoidoscopy every 5 years with high-sensitivity fecal occult blood testing every 3 years or 3) screening colonoscopy at 10 year intervals for adults ages 50 to 75.	39%	N/A	N/A	40%	35%	34%

NOTES: Among women ages 18-64, except mammogram (ages 40-64), and colorectal cancer (ages 50-64). The ACA requires coverage of mammogram services based on the USPSTF 2002 recommendation on breast cancer screening, which recommended screening every 1-2 years beginning at age 40. *Indicates a statistically significant difference from ages 18-44, White, p<.05.
SOURCE: U.S. Preventive Services Task Force, USPSTF A and B Recommendations; Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Women who are uninsured have consistently lower use of all screening tests. While 95% of privately-insured women have had a blood pressure check in the past two years, the rate is 78% among uninsured women (**Figure 25**). Just over half of uninsured women have had a recent pap test, compared to three in four women with private insurance or Medicaid. The differences are even larger for mammography, cholesterol and colon cancer screenings, which typically require that patients go to a lab or other facility to have blood drawn or obtain other costly testing procedures. Women with Medicaid coverage receive screening tests on a par with women who are privately insured.

Over the past decade, self-reported rates of screening tests have been fairly level, except for a rise in the rate of cholesterol screenings and a decline in the rate of pap testing between 2001 and 2013 (**Figure 26**). The latter may be related to changes in the recommendations and guidelines for cervical cancer screening over that time period, which reduced the frequency and narrowed the age group for testing compared to earlier guidelines.[12]





Reproductive and Sexual Health Services

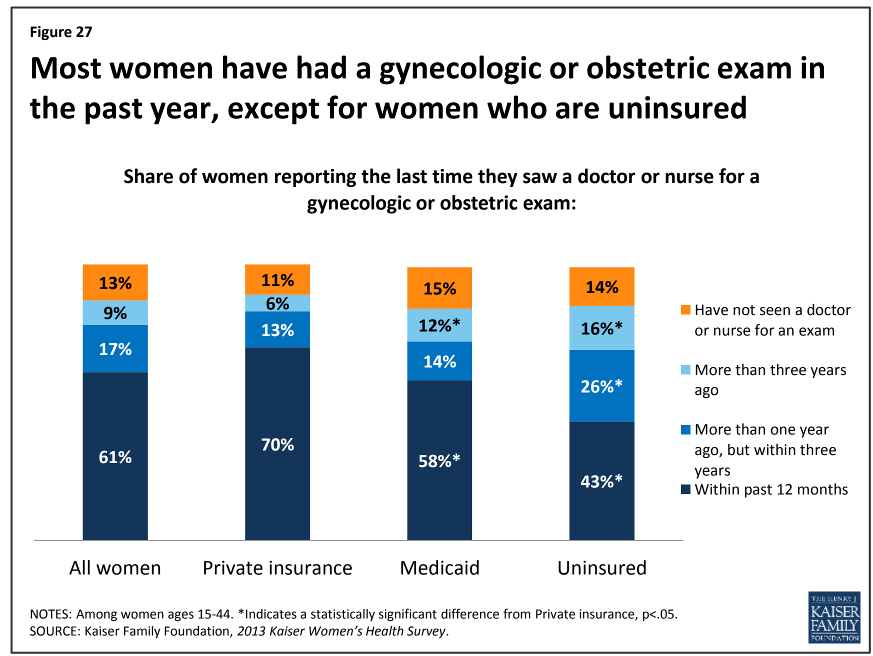
Reproductive and sexual health is an integral component of women's general health and well-being. The ACA makes many reforms to insurance coverage that may improve access to these important services for insured women, in addition to broadening the availability of coverage to uninsured individuals. The ACA's requirement for preventive services coverage without cost sharing includes a number of counseling services, screening tests, and supplies that could affect women's access to reproductive and sexual health services, such as contraceptives, screening tests for sexually transmitted infections (STIs) and HIV, and the Human Papilloma Virus (HPV) vaccine. They also include pregnancy-related services such as prenatal visits, folic acid supplements, screening tests, tobacco cessation, and breastfeeding supports. Notably, the law includes maternity care as an Essential Health Benefit category that all new health plans must cover in their policies.

The ACA's large coverage expansion to the uninsured may also make changes in the types of settings that women, particularly those who are newly insured, will use to obtain their reproductive care. This change in coverage patterns may have a disproportionate effect on family planning clinics and community health centers, who have long served low-income women, but may not be part of the health care provider networks contracting with the Marketplace plans. The ACA's extension of dependent coverage up to age 26 also extends a new coverage option to women at a peak time in their lives when they typically seek reproductive and sexual health care. The fact, however, that these adult children are part of their parents' insurance during this period also raises questions about privacy and confidentiality around the services they use when the primary policy holders are their parents. This section reports survey findings among women of reproductive age, 15 to 44 years old.

Use of Services

Most reproductive age women have had a gynecologic or obstetric visit in the past year.

The majority of women ages 15 to 44 report that they have had a gynecologic or obstetric visit in the past year (61%). Women with private insurance, however, have higher rates of a recent visit (within the past 12 months) for obstetric or gynecologic care (70%), compared to women with Medicaid (58%) and uninsured women (43%). A higher share of women covered by Medicaid (12%) and uninsured women (16%) reported that their last visit was over three years ago, more than twice the rate of women with private insurance (6%) (**Figure 27**). Just 13% of women ages 15 to 44 reported that they have never seen a provider for obstetric or gynecologic care and the rates were similar for all the insurance groups.



Most women (85%) report that their most recent sexual health visit was for gynecologic care and 14% report it was for prenatal care (**Table 7**). Almost one in four Hispanic women report that the reason was for pregnancy related care (23%), higher than for White (13%) and Black women (9%). Slightly more women ages 25 to 34 reported their most recent visit was for prenatal or pregnancy-related care (17%), and the shares of younger (12%) and older women (11%) were similar.

Table 7: Reason for most recent gynecologic visit, by age group, race/ethnicity, and poverty level

	All Women	Age Group			Race/Ethnicity			Poverty Level	
		15-24	25-34	35-44	White	Black	Hispanic	Less than 200% FPL	200% FPL or greater
Have had a gynecological or obstetric exam within the past year	61%	44%	74%*	64%	62%	70%	56%	56%*	68%
Reason for most recent visit									
Gynecologic care	85%	85%	82%	87%	86%	90%	75%*	79%*	90%
Prenatal/ Pregnancy Care	14%	12%	17%	11%	13%	9%	23%*	20%*	9%

NOTE: Reason for most recent visit among women ages 15-44 who have *ever* had an obstetric or gynecologic exam. Federal Poverty Level was $19,530 for a family of three in 2013. *Indicates a statistically significant difference from ages 15-24; White; 200% FPL or greater; p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Private doctors' offices and HMOs are the primary settings where women get gynecologic care, but family planning clinics and community health centers play a significant role for women who have Medicaid and women who are uninsured.

Among the group of women who said they have had a gynecologic exam (not for pregnancy related care) within the past three years, 73% report that their most recent exam was at a doctor's office or HMO (**Figure 28**). Among women who have a had a gynecologic exam in the past three years, nearly one in ten women (8%) report their most recent exam was at a community health center or public clinic. Fewer younger women sought care at a doctor's office or HMO (64%) than other women of reproductive age, with slightly more seeking care at school based clinics and urgent care centers/ walk-in facilities than other women **(Table 8)**. Not surprisingly, health care settings vary for women with different types of insurance coverage.

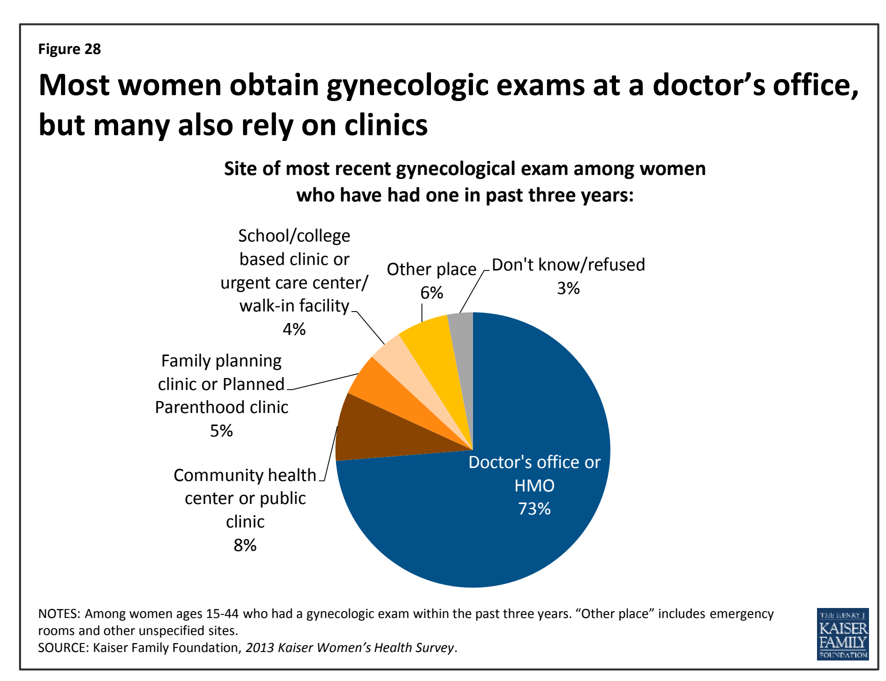


Table 8: Site of most recent gynecologic exam among women, by age and insurance coverage							
	All Women	Age Group			Insurance Coverage		
Site of most recent visit		15-24	25-34	35-44	Private Insurance	Medicaid	Uninsured
Doctor's office or HMO	73%	64%	72%	82%	84%	57%*	53%*
Community health center or public clinic	8%	9%	8%	7%	4%	13%	16%*
Family planning clinic or Planned Parenthood	5%	6%	5%	4%	2%	5%	16%*
School/college based clinic or urgent care center/ walk-in facility	4%	9%	3%	1%	4%	5%	5%
Other place	6%	6%	7%	4%	4%	13%	5%
Don't know/refused	4%	3%	5%	2%	1%	7%	3%

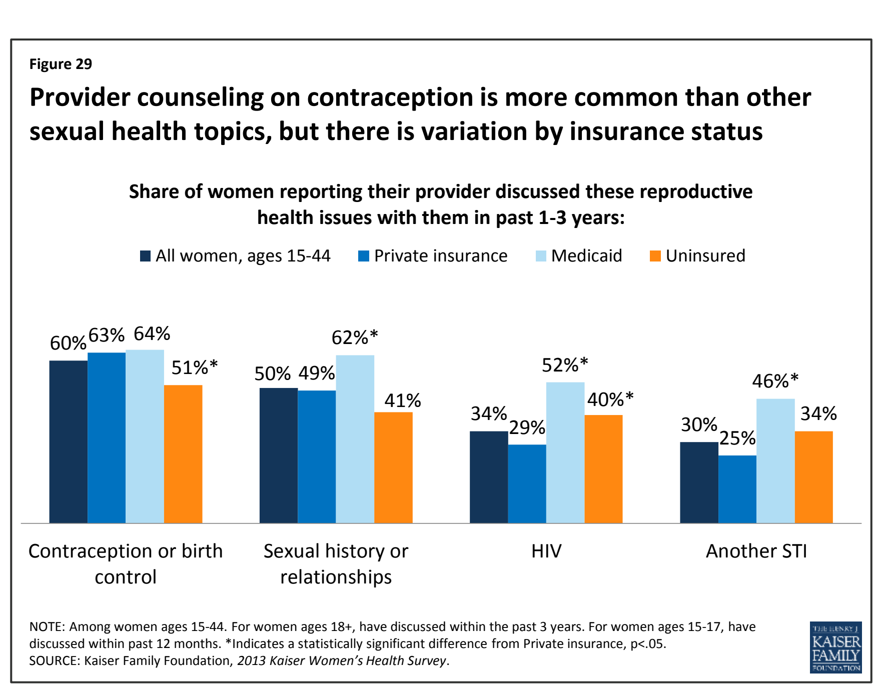
NOTE: Among women ages 15-44 who have had an exam in the past three years. Other place includes other types of clinics and other locations such as emergency departments. *Indicates a statistically significant difference from ages 35-44; Private Insurance; p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Women with private insurance overwhelmingly get their gynecologic care from private doctor's offices or HMOs. While just over half of women enrolled in Medicaid and uninsured women obtain care from a doctor's office/HMO, community health centers, family planning clinics and school based clinics play an important role for these groups. A larger portion of women covered by Medicaid (13%) seek care in another location, which includes emergency departments, compared to women with private insurance and uninsured women. A sizable share of private physicians limits their participation in Medicaid, and safety net providers play an important role serving low-income and uninsured women. As more women gain coverage under the ACA, especially through the subsidized private plans available on state Marketplaces, many of the women using these safety net providers could shift to private settings because their existing providers may not be in-network providers.

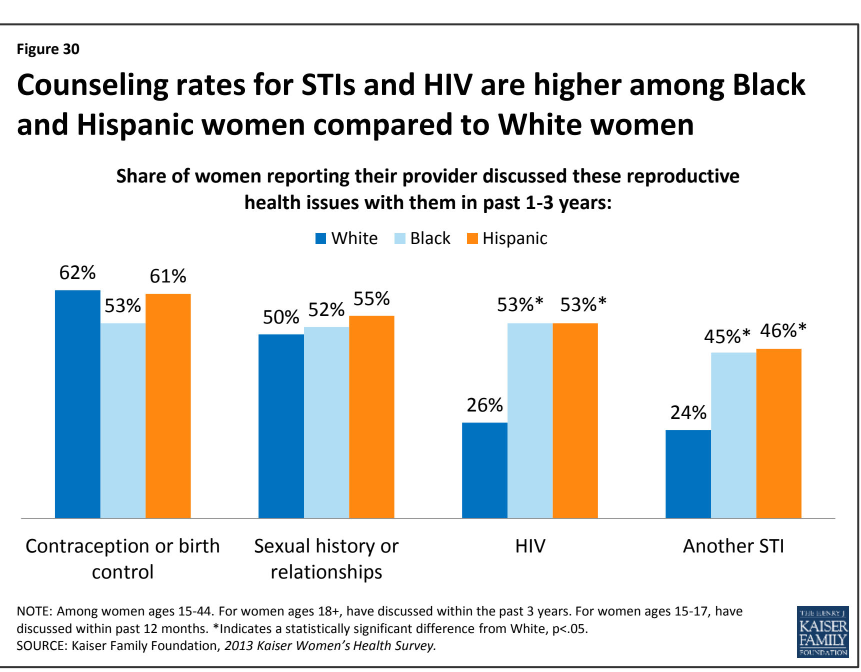
Counseling and Screening

Among reproductive health topics, counseling is more commonly reported for birth control than for other issues such as sexual history, sexually transmitted infections, and HIV.

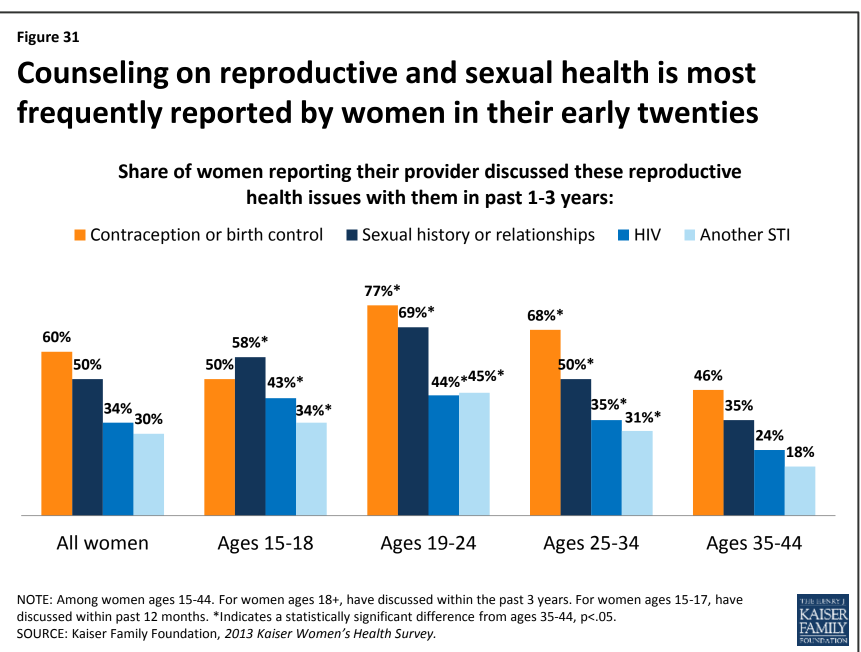
An important aspect of reproductive and sexual health care is the counseling and education that health care clinicians can offer patients. Counseling allows clinicians to provide patient education, screen for high-risk behaviors, and identify the need



for additional testing services. Providers can now be reimbursed when they provide counseling on a wide range of sexual health topics, because they are part of the preventive services that the ACA requires plans to cover without cost sharing. This is especially important because some of the health challenges women face during their reproductive years stem from sexual and reproductive health concerns. It is estimated that half of all pregnancies in the U.S. are unintended.[13] The CDC estimates approximately 19 million new cases of STIs, such as chlamydia, gonorrhea, and HPV, occur each year.[14] Approximately half of cases occur among young people ages 15 to 24, and disproportionately affect certain communities, with Black women at elevated risk for contracting an STI. Sex is also the major mode of transmission of HIV/AIDS among women, which has had a disproportionate impact on young women of color, particularly Black women.



Despite the high rates of STIs and unintended pregnancy, and the recommendations of professional groups, counseling on many of these topics is not routine among women of reproductive age (**Figure 29**). While most reproductive age women have had recent conversations with a provider about contraception (60%), the rate is much lower for other topics, including sexual history (50%), HIV (34%) and other STIs (30%). It is notable that women with Medicaid have significantly higher rates of counseling on most of these topics compared to women with private insurance. Women of color also report higher rates of counseling on HIV and other STIs, compared to White women (**Figure 30**). Women ages 19 to24 also have the highest rate of counseling from a health care provider on these topics (**Figure 31**).

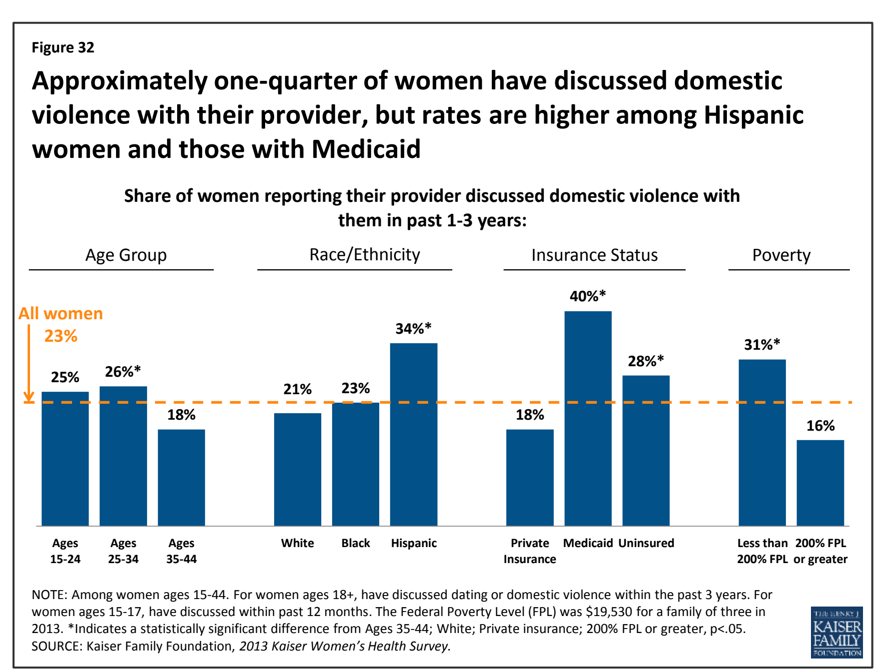


Despite the burden of sexual violence on women in the U.S., counseling on dating and domestic violence is particularly infrequent in a health setting.

More than 1 in 3 adult women in the United States (36%) have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.[15] Intimate partner violence (IPV), also called domestic or dating violence, can affect women at any point in their lives, but rates are highest among women in their reproductive years.[16] IPV can take many forms, including sexual violence, physical violence, and psychological

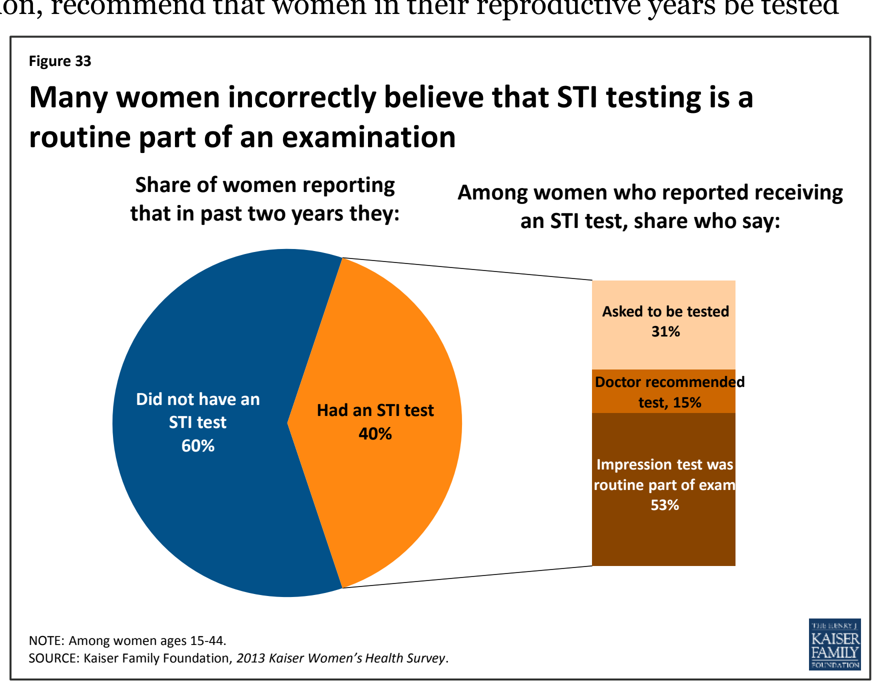
and emotional abuse. It has long been recognized that clinicians can play an important role in the identification and treatment of women who have suffered from violence. As with other sexual and reproductive health topics, counseling on domestic violence is highly sensitive and requires training, including special protections for patients' privacy, and knowledge of referrals so patients receive safe and effective follow up care and are protected from retaliation by perpetrators.

One of the preventive services for women that the ACA covers without cost sharing is provider counseling on IPV. While there have been advances in the health care system's handling of IPV and newly developed screening tools for providers to use, it is still far from routine for providers to raise the issue of violence with women. Nearly one-quarter of women ages 15 to 44 (23%) have discussed dating or domestic violence with a provider in the past three years (**Figure 32**). Compared to older women, provider-patient conversations about IPV are more common among women in their twenties and early thirties, but it is still not the norm. Counseling rates for IPV are also higher among Hispanic women, those who are low-income, and those covered by Medicaid.



Approximately four in ten women report recent screenings for HIV and other STIs, but many incorrectly assume they are being tested.

Several professional groups and government agencies, including the USPSTF, the Institute of Medicine, and the Centers for Disease Control and Prevention, recommend that women in their reproductive years be tested for sexually transmitted infections such as chlamydia, gonorrhea and HIV.[17,18,19] Knowing one's status is important to receive early treatment and prevent transmission to sexual partners. As with provider counseling, these tests are now covered without cost sharing in new private plans under the ACA's preventive services coverage requirements. They are also commonly included as part of family planning services under Medicaid.[20]



Approximately four in ten women report that they have had a test for HIV (44%) or other STIs (40%) in the past two years;

however, approximately half of these women assumed this test was a routine part of an examination—which it is not (**Figure 33**). Therefore, the actual screening rate is likely lower than the share of women who report being tested. This perpetuates the gap in knowledge of HIV status and other STIs that has been reported in other research and may cause women to believe they do not have an STI when in fact they have not actually been tested.

Screening rates for HIV and STIs are higher among low-income, Medicaid, uninsured, and minority women, particularly Black women (**Table 9**). Notably, there is a higher rate among some of these groups of women reporting that they requested their provider to conduct these tests; however, among all these groups, a substantial share also still incorrectly assume the test is routinely included in a health exam.

Table 9: Receipt of sexual health screening tests, by race/ethnicity, insurance status, poverty level

	All Women	Race/Ethnicity			Insurance Status			Poverty Level	
Reported having test in past 2 years		White	Black	Hispanic	Private	Medicaid	Uninsured	Less than 200% FPL	200% FPL or greater
HIV Test	**44%**	**35%**	**72%***	**60%***	**37%**	**59%***	**51%***	**54%***	**37%**
Thought test was routine part of Exam	56%	60%	48%	53%	56%	46%	61%	56%	55%
Doctor recommended test	14%	14%	7%	22%	16%	9%	13%	12%	18%
Asked to be tested	27%	23%	43%*	24%	27%	41%	22%	30%	26%
STI Test	**40%**	**33%**	**63%***	**50%***	**37%**	**55%***	**38%**	**47%***	**36%**
Thought test was routine part of exam	53%	55%	47%	54%	58%	35%	59%	50%	58%
Doctor recommended test	15%	11%	18%	21%	14%	15%	13%	14%	14%
Asked to be tested	31%	32%	35%	23%	28%	47%	27%	35%	27%

NOTE: Among women ages 15-44. Federal Poverty Level was $19,530 for a family of three in 2013. *Indicates a statistically significant difference from White; Private insurance; 200% FPL or greater; p<.05.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Use of Contraceptives

Nearly half of sexually active reproductive age women use at least one form of contraception, but approximately one in five sexually active women of reproductive age report that they do not use contraception despite reporting they do not want to get pregnant.

The vast majority of women who are of reproductive age (15 to 44 years) have been sexually active (81%) in the past year. Among sexually active women, one in ten are pregnant or trying to conceive, and one in five (20%) women report that they or their partners have had a sterilization procedure or cannot become pregnant. For women with reproductive capacity but who want to avoid an unintended pregnancy, contraception is an

essential health service. Some contraceptives also can reduce the risk of transmitting certain STIs (such as condoms) and in some cases can assist in managing other medical conditions (such as oral contraceptives). Among reproductive age women who have had sex in the past year, half (51%) report that they or their partners used at least one contraceptive method **(Figure 34)**. An estimated 19% of sexually active women ages 15 to 44 are at high risk for unintended pregnancy because they or their partners are not using contraception.

Figure 34

One in five sexually active women are at risk for unintended pregnancy because they are not using contraception

NOTES: Among women ages 15-44 who have had sex within the past 12 months. *Includes women who report that they or their partner have had a sterilization procedure or they have a medical condition that makes it impossible to get pregnant and are not using any contraception.
SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Condoms and birth control pills are the most commonly used forms of contraception.

While all forms of FDA approved contraception can reduce the risk of unintended pregnancy when used correctly, they vary in their use and effectiveness. Women are encouraged to consider a range of issues when choosing a contraceptive method in order to find the one that is most effective but also fits best within their beliefs and lifestyle. Condoms can protect against STIs and are widely available through many outlets without a prescription. Oral contraceptives, often referred to as the Pill, require prescriptions, are hormonal, and cannot be used or tolerated by all women. Other methods include injectables, implants, patches, and the vaginal ring, which deliver different doses of hormones. Intrauterine Devices (IUD) are devices that are inserted in a woman's uterus by a provider and some types also include hormones. They can last up to 5 years or longer and are among the most effective methods of reversible contraception but also have the highest up front cost. Under the ACA's preventive services provision, all new private plans are required to cover all FDA-approved methods of contraception as prescribed for women without cost sharing.

Table 10: Types of contraceptives used among sexually active women, by age and race/ethnicity

	All Women	Age Group			Race/Ethnicity		
Types of contraception used within the past 12 months		15-24	25-34	35-44	White	Black	Hispanic
Male condoms	63%	82%	60%*	41%	59%	78%*	59%
Oral contraceptives	48%	54%	44%	46%	53%	36%*	49%
IUD	19%	N/A	29%	22%	24%	10%*	17%
Injectables	7%	13%	6%	1%	3%	16%*	11%
Implants	6%	N/A	8%*	1%	6%	8%	8%
Other	12%	12%	14%	11%	12%	7%	17%

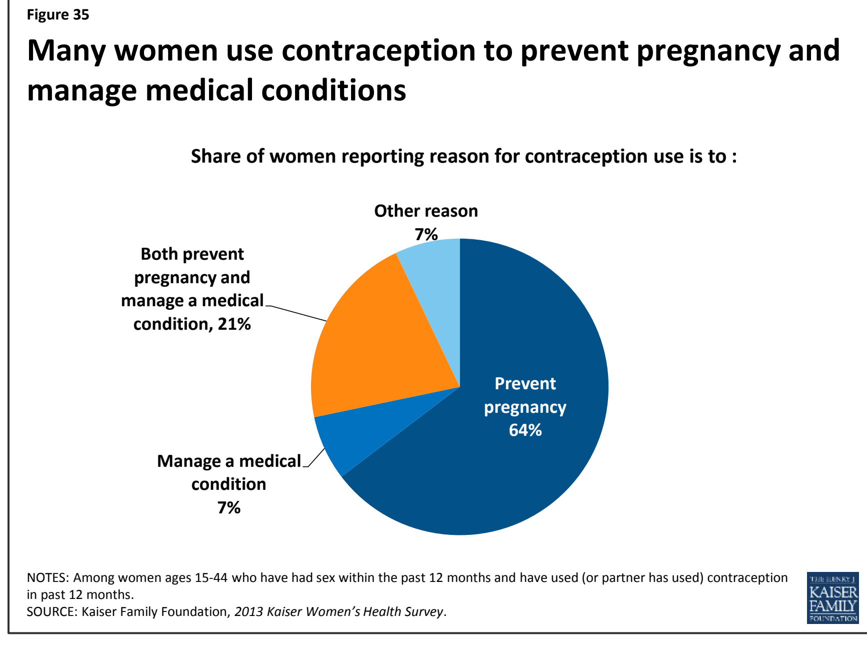
NOTES: Only includes women ages 15-44 who were sexually active in past year and used contraceptives in past year. Women may use more than one form of contraception. Oral contraceptives include birth control pills. IUD is an intrauterine device such as Mirena, Skyla, or Paragard. Injectables include Depo-Provera. Implants include Implanon or tubes in arm. Other methods include vaginal ring and the topical patch. N/A indicates data are not sufficient to meet criteria for statistical reliability. *Indicates a statistically significant difference from 35-44; White; p<.05.

SOURCE: Kaiser Family Foundation, *2013 Kaiser Women's Health Survey*.

Among sexually active women who use contraception, just over half (54%) rely on one method and just under half (45%) use more than one method. Women most frequently report that they have used condoms and birth control pills in the past year (**Table 10**). Nearly two-thirds (63%) of sexually active women who have used contraceptives in the past year report using male condoms, almost half have used birth control pills (48%), and about one in five (19%) use an IUD. Nearly one in four White women (24%) report that they are using an IUD. A larger share of Black women than White or Hispanic women use condoms. Black women also have higher usage of injectables than White or Hispanic women.

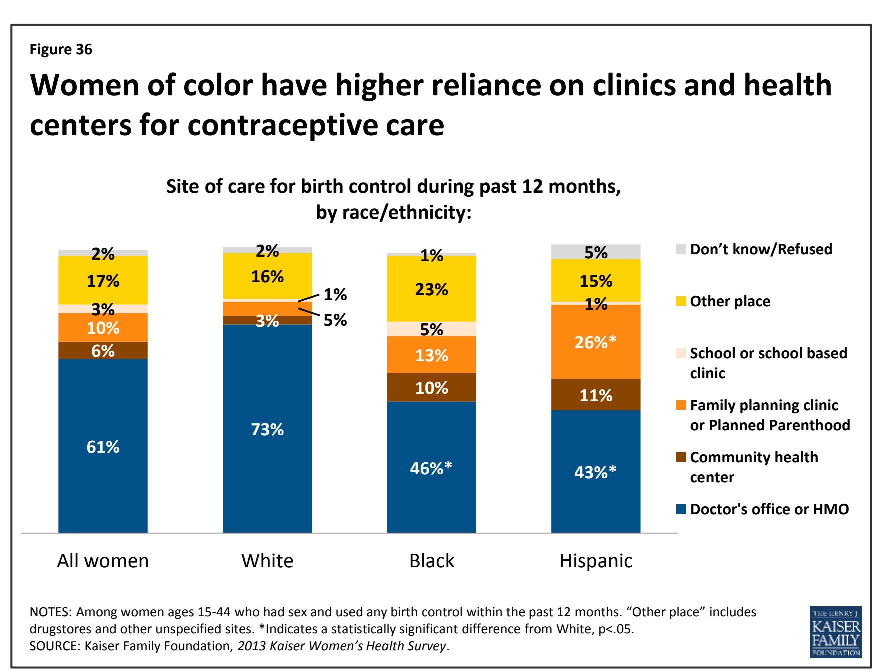
While preventing pregnancy is the leading reason for contraceptive use, a sizable fraction of women also use them to manage a medical condition.

While contraceptives are essential for preventing and spacing pregnancies, they can also aid in the management of a wide range of medical conditions such as endometriosis, irregular periods, and fibroids.[21,22] Not surprisingly, preventing pregnancy is the main reason for using contraceptives (64%), but a fair share of women (21%) state they use it to prevent pregnancy and manage a medical condition (**Figure 35**). This factor likely affects women's choices in the types of contraceptives they select.

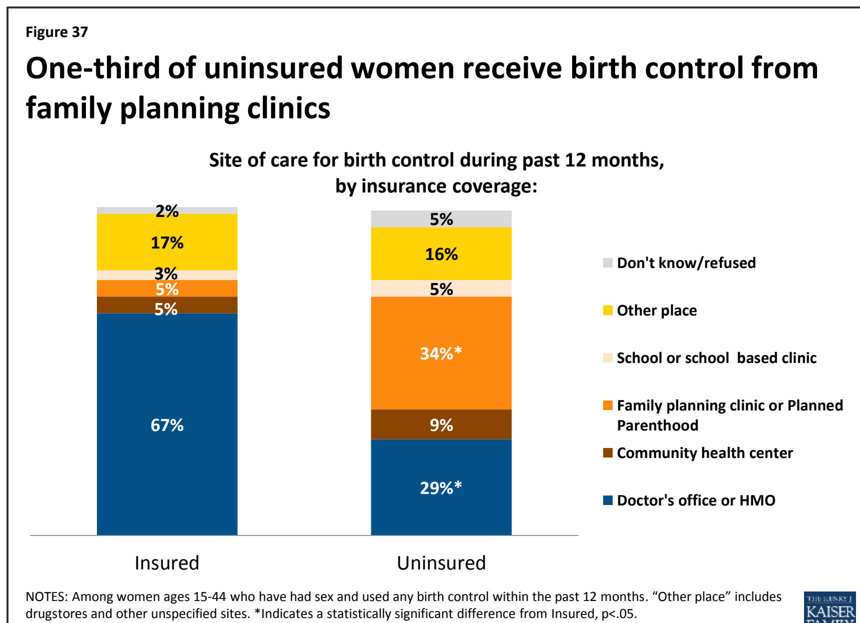


While most women get their contraceptives from a private physician or HMO, a significant minority get their contraceptives from a clinic-based provider.

Six in ten sexually active women who are using birth control report that they obtain contraceptives at a doctor's office or HMO (61%), one in ten (10%) obtain it at a family planning clinic, such as Planned Parenthood, and 6% from a community health center (**Figure 36**). Higher shares of women of color go to clinics for contraceptives though. Nearly three-fourths of White women report they obtained contraceptive care at a doctor's office or HMO, compared to less than half of Black (46%) and Hispanic (43%) women. Conversely, reliance on family planning clinics and community health centers is more than twice as high among women of color as for White women. This is the case for more than a third (37%) of Hispanic women, who also have the



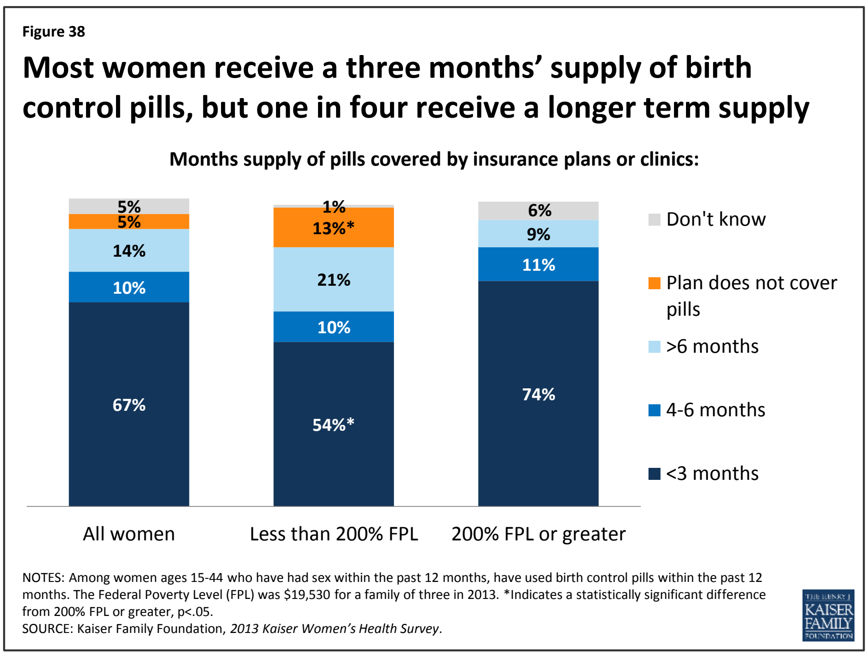
highest uninsured rate. Some of the differences in site of care are likely related to insurance status, which means that over time there could be changes in where women obtain care for contraceptives as the ACA moves forward and more women gain coverage. It is important to note that 17% of all women state they received contraceptives at "some other place," such as a drugstore where condoms can be purchased.



As with gynecologic exams, care seeking patterns differ between women with insurance and women who are uninsured, with uninsured women reporting much higher rates of obtaining contraceptives at family planning clinics such as Planned Parenthood (34%) compared to women with insurance (5%) (**Figure 37**). Only 29% of uninsured women receive birth control care from a doctor's office or HMO.

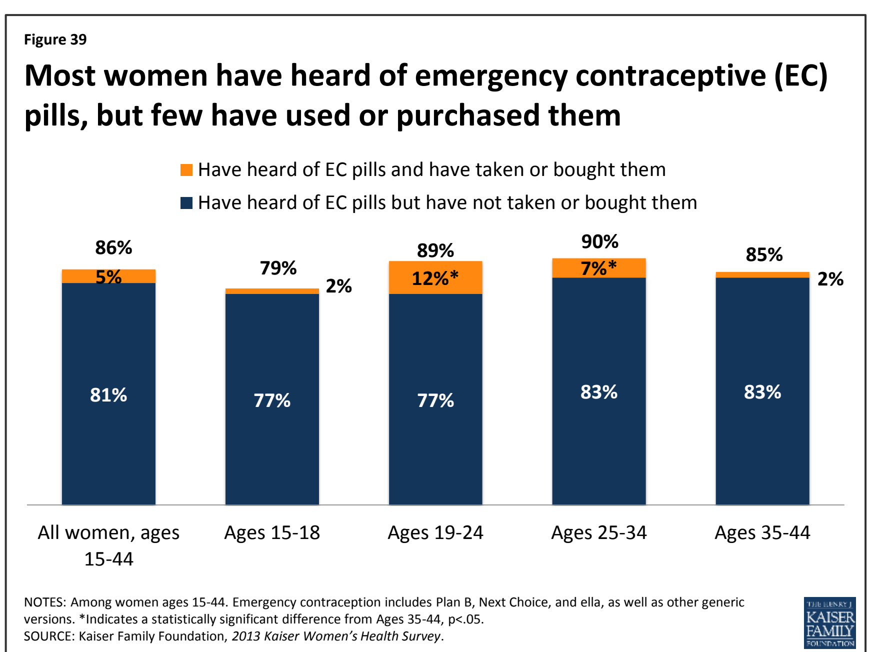
Among women who use oral contraceptives, most women typically receive 3 months' supply at a time.

Women who use oral contraceptives must take a pill every day; therefore having an adequate supply is important for consistent and effective use.[23] Nearly three in ten (28%) of those who take birth control pills report that they have missed a pill because they could not get next pack on time (data not shown). Among women who have used oral contraceptives in the past year, two-thirds (67%) reported their plan or clinic allows them to only get 3 months' supply or less at a time (**Figure 38**). A higher share of low-income women, however, say that their clinic or insurance covered a longer supply of oral contraceptives. At the same time though, more than one in ten low-income women (13%) also report that their plan did not cover birth control pills. The differences in dispensing patterns may be a result of differences in insurance coverage policies or practice variation between sites of care.



Awareness of the availability of emergency contraceptive (EC) pills is high, but only a fraction of women have purchased or used it.

Emergency contraception (EC), which is contraception that can be used after sex to prevent pregnancy, has been available in the U.S. since 1999. There are multiple forms, including the copper IUD, Plan B® pills, and more recently another form of EC pills, ella®, was approved by the FDA in 2010. Most forms require a prescription, except for Plan B®, which has been available without a prescription for women 17 and older since 2009. As with other contraceptives, new private plans are required to cover prescriptions for EC without cost sharing under the ACA's preventive services policy.

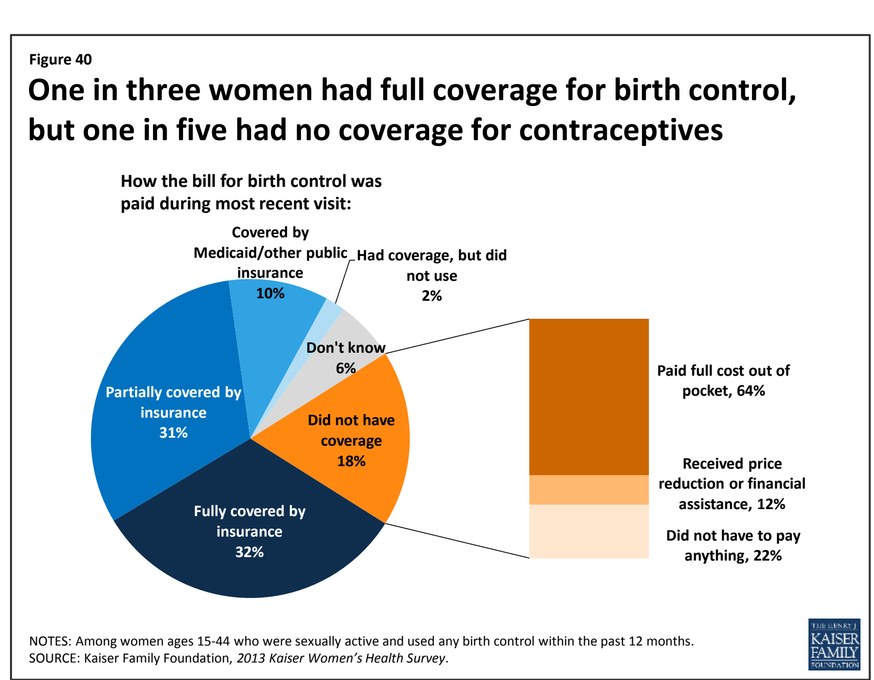


It has now been 15 years since EC pills were approved by the FDA and awareness of EC among women is very high. On average, 86% of women ages 15 to 44 report that they have heard of EC pills (**Figure 39**). Only a fraction of women (5%) have used or bought EC pills. Use is highest among women in their late teens and early twenties.

Contraceptive Coverage

Among sexually active women who used contraception in the past year, three-quarters say that their insurance or Medicaid paid for some or all of the costs. However, nearly one in five say they had no coverage for their contraceptives, and most of these women paid the full cost out of pocket.

One of the most publicized and discussed of the ACA's preventive services benefits is the requirement that most new private plans cover without cost sharing prescription contraceptive services and supplies. This policy went into effect August 2012.

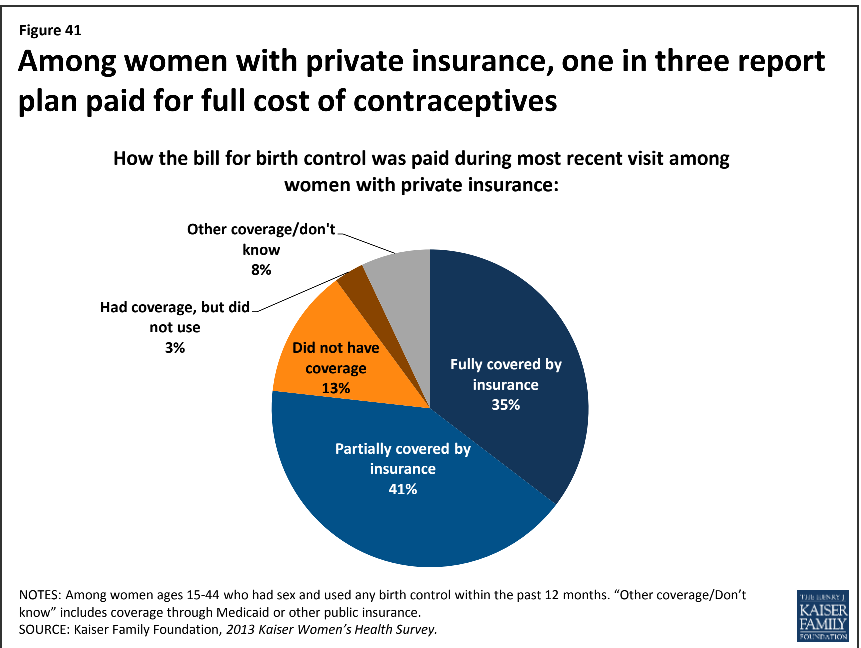


Among sexually active women who report using contraception in the last year, insurance covered the full cost for one-third (32%) of women (**Figure 40**). Almost another one-third of women (31%) reported that insurance covered part of the costs, which could be because they are

enrolled in an older private plan that is still "grandfathered" from ACA requirements or they used a particular contraceptive that is not covered by the requirement (such as condoms or a brand name drug), or they did not meet all the requirements (such as staying within the provider network). Family planning is a mandatory service under Medicaid and the program has covered contraceptives without cost sharing for decades. One in ten women who used birth control reported that Medicaid or another public program covered the costs of their contraceptives. Nearly one in five (18%) women reported they did not have any coverage for birth control, which could be due to lack of insurance or enrollment in a "grandfathered" plan (that does not have to cover preventive services). Among women without contraceptive coverage, nearly two-thirds (64%) paid the full cost out of pocket, 12% received a reduced price or financial assistance and 22% did not have to pay anything, presumably because they obtained free contraceptives at a clinic or through another assistance program.

About one in three women who use contraception and have private insurance say their plan covered the full cost of the contraceptives.

It is notable that by the end of 2013, just over one-third (35%) of sexually active women who use birth control reported that their insurance fully covered the cost of contraceptives. Another 41% of women who used contraceptives last year said that insurance covered part of the costs (**Figure 41**). Over one in ten (13%) report that they did not have any coverage for contraceptives under their insurance. Almost all women with insurance for contraceptives (97%, data not shown) report that they did not have trouble getting their insurance to cover the costs (fully or partially) for prescribed contraceptives. Only a small fraction of women (3%) had problems getting insurance to pay.

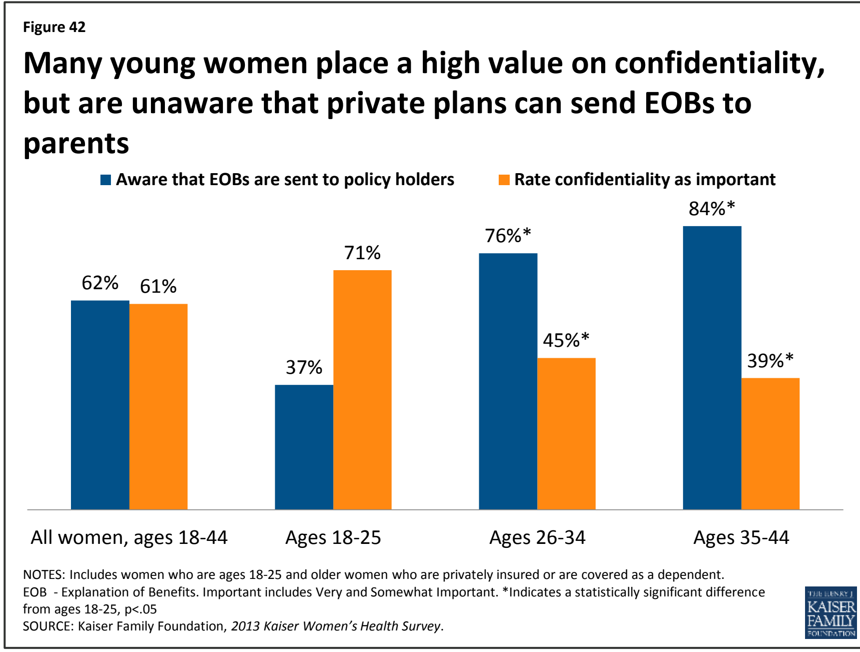


INSURANCE AND CONFIDENTIALITY

Women of all ages, but especially young women, value confidentiality. Many are not aware that private insurance plans can send documentation to the primary policy holder (such as a parent or spouse) that details the services they use.

Nearly half of women 18 to 25 (45%) with employer sponsored coverage are covered as dependents under their parents plan. Some of these women may have been able to obtain or keep private insurance through the ACA's extension of dependent coverage up to age 26. Because these individuals are adult children, the extension of coverage has raised concerns about maintaining privacy and confidentiality about use of health services. Overall, six in ten women 18 to 44 years old report that it is important to them that information about health care visits be kept confidential from a parent or spouse (**Figure 42**). However, it is a higher priority among young women, who also have the lowest awareness of the private insurance industry practice of sending documentation known as an explanation of benefits (EOB) with details about services and costs of services that were paid for by insurance to primary policy holders, often a parent or spouse. Among women 18 to 25, 71%

state that it is important to them that their use of health services, such as sexual or mental health care services, be kept confidential. Despite the importance of confidentiality, awareness of this practice was low among this age group, as only 37% of women knew that private insurers typically send an EOB to primary policy holders, often a parent. Awareness is even lower among teens ages 15 to 18, where only 24% reported knowing that EOBs were typically sent to the home (data not shown). Knowledge is considerably higher among women in older age groups, who likely have had greater experience with use of insurance plans.



Conclusions and Implications

The findings of this survey provide new information about the opportunities and ongoing challenges in women's health care and coverage in the early days of ACA implementation. The ACA includes reforms that could make coverage more affordable, accessible, and stable for many women in the years to come. The bans on pre-existing condition exclusions and gender-rating as well the requirement that plans now include maternity care and contraception could benefit many women, not just those who are uninsured. In the late fall and early winter of 2013 when this survey was conducted, there were still many gaps in coverage and access to care facing women. While the ACA can potentially fill some of these gaps, many challenges related to the law's implementation and other structural factors remain.

This report documents gaps in women access to care and identifies some of the barriers they experience including the need for affordable care and coverage options. It also highlights some of the distinct health concerns of women, especially the importance of reproductive and sexual health and the need for it to be addressed as part of women's basic care. Attention to these concerns will need to be part of the larger agenda to improve women's access to care and coverage, quality of care, and ultimately, their health and well-being.

Coverage

The health coverage expansion will affect many uninsured women. Gaps in coverage are experienced by a disproportionately high share of low-income women and women of color.

Uninsured women consistently reported barriers to care, lower use, and poorer access to care at much higher rates than women enrolled in Medicaid or private insurance. Millions of uninsured women could gain access to coverage that includes a wide range of benefits. The gaps in coverage are considerable for low-income women, with 4 in 10 reporting that they were uninsured at the end of 2013. The survey finds that Black and Hispanic women also bear a disproportionate burden of being uninsured. Eligibility for Medicaid and the subsidies in the form of tax credits are available to help many low-income women secure coverage under the ACA. While many may have enrolled in the state Marketplaces or in Medicaid during the open enrollment period, some of the poorest women will not qualify for assistance because they reside in a state that is not expanding Medicaid. Additionally, gaps will remain for some immigrant women because federal rules ban Medicaid coverage for new immigrants, and undocumented immigrants are not eligible for Medicaid and do not have access to the Marketplace plans.

Coverage under a parent's plan is now the leading way that women under age 26 get their coverage, highlighting the importance of confidentiality.

The ACA allows parents to keep their adult children enrolled in their plan until the age of 26. This age group had the highest uninsured rate of any age group before the law was passed. An issue related to this provision that has gotten less attention is confidentiality for this group. This stems from the practice of sending the Explanation of Benefits (EOB) to the principal policy holders, which in these cases is usually a parent of an adult child. The survey finds that most young women are not aware of this policy, but highly value their confidentiality. This is especially important when women see providers for sensitive services such as reproductive health and mental health care. While there are mechanisms available to protect confidentiality

and privacy in a health care setting, the receipt of an EOB signaling that an adult child has used services could violate that privacy.

Costs and Access

Many women, not just uninsured women, report they face cost related barriers to health care.

Between one-fifth and one-quarter of women report that they either postponed or went without care they felt they needed because of costs. While health costs are a major barrier to care for many uninsured women, women on Medicaid and privately insured women also report that out-of-pocket costs can limit access on a broad range of indicators. Out-of-pocket spending may still be a barrier to care for newly insured, low-income women despite the availability of subsidies and caps on spending under the ACA. A substantial share of women on Medicaid report that cost is a barrier, which could be attributable to Medicaid policy that permits nominal cost-sharing for some services and in some states limits on the number of visits, prescription drugs, or range of drugs the program will cover.

Medical bills are problems for nearly three in ten women and some are forced to make difficult trade-offs to meet these obligations.

Women report difficulties paying for medical bills at significantly higher rates than men. Not surprisingly, medical debt is a problem for a higher share of women who are low-income, uninsured, and even for women on Medicaid, who may also contend with bills for other family members who are uninsured. A substantial share of women with medical debt report they either used up most of their savings, had difficulty paying for basic necessities, or had to borrow money from friends or relatives to pay for their bills. The issue of medical debt could also be a consideration for women in the selection of a plan's metal tier available through the Marketplaces. Women choosing bronze plans with low premiums, but higher cost-sharing and deductibles could still face substantial out-of-pocket costs if they have a hospitalization, serious injury, or other medical condition that requires costly medical treatment.

Logistical barriers to care beyond coverage and affordability are challenges for many women.

Lack of flexibility at work, problems with childcare and difficulty securing transportation are reported by a sizable minority of women as a reason that they didn't get care they felt they needed in the past year. These challenges are more common among low-income women, but are also reported by some with higher incomes. Notably, one-quarter of all women, regardless of income, report that lack of time to go to the doctor is a reason they went without care. The survey suggests that factors such as work place flexibility, sick leave, and child care also could have implications for women's access to care.

Connections to Care

Expansions in coverage options and system reforms could result in more women having a stronger connection to health providers, but it is important that new models of care be gender sensitive.

While most women report that they have a specific place or provider for their routine care, a substantial share of women who are younger, Hispanic, low-income or uninsured lack this important connection to care. Sizable

shares of women also say they have more than one regular provider, typically a family physician/internist along with an Ob/Gyn. The ACA includes incentives to improve primary care and develop new models for patient centered medical homes. It will be important to examine how well these approaches address the diverse needs of women, including reproductive and sexual health care.

A network of safety-net clinics, including community health centers and family planning clinics, will still be needed by many women.

Safety-net providers including community health centers, public clinics, and family planning clinics play a significant role serving women, particularly those who are low-income, uninsured, or racial and ethnic minorities. While it is too soon to tell how these providers will fare as more people gain coverage and shift to private or Medicaid plans, many low-income women will remain reliant on these providers for their care.

Preventive Services

The ACA private plan coverage requirements may help improve the use of preventive services, yet awareness is still limited.

The new private plan coverage requirements in the ACA for well woman visits and for other preventive services could result in greater numbers of women receiving these services at recommended rates. However, public awareness of these insurance reforms is far from universal. In addition, while most women report a recent checkup or well woman visit, counseling and screening services are often not provided at recommended intervals. Gaps are especially notable among women who are low-income and uninsured.

Medicaid coverage of preventive services is an important benefit for low-income women.

Women with Medicaid coverage, despite their lower incomes and constrained provider options, obtain preventive screening and counseling services at rates that are on par with women with private coverage. The ACA includes a small financial incentive for state Medicaid programs to provide coverage of all services recommended by the USPSTF without cost sharing. In the coming years, we will track how many states take advantage of this option and broaden coverage of preventive care for women under Medicaid.

Sexual and Reproductive Health

There is considerable room for improvement in the rates of counseling on reproductive and sexual health services.

Among women of reproductive age, counseling rates fall far short of recommended levels. Screening rates for sensitive services are particularly low. Although nearly two-thirds of women have received some level of counseling for contraception, counseling on sexual history, HIV, and STIs is only provided to a fraction of reproductive age women. Many women are incorrectly under the impression that HIV and STI tests are routinely included as part of their gynecological exams. Therefore, the actual screening rate is likely lower than the share of women who report being tested. This mistaken assumption has implications for the treatment and prevention of transmission of these infectious diseases, especially given the high rates of STIs among young women and the disproportionate burden of HIV on Black women.

A substantial share of sexually active women is not using any contraception and consequently is at high risk for unintended pregnancy.

While the effectiveness of FDA approved contraceptives in preventing unintended pregnancy is widely known, many women are at very high risk for unintended pregnancy because they are not using any method. Among sexually active women who use reversible contraceptives, condoms are the most frequently reported followed by oral contraceptives, and a sizable share use more than one method. Condoms also offer important protection against certain STIs, but are not among the most effective methods for preventing pregnancy. It has now been 15 years since Plan B® emergency contraceptive (EC) pills were approved by the FDA and nearly 5 years since they became available without a prescription. Today, awareness of emergency contraceptive pills is quite high. However, a fraction of women report that they have used or purchased them to prevent unintended pregnancy in cases of contraceptive failure or as a backup method of contraception.

A sizable minority of women using contraception now rely on long acting reversible contraceptives (LARCs). Intrauterine devices (IUDs), sub-dermal implants and hormonal injections, considered to be LARCs, are among the most effective methods of birth control. The ACA includes provisions that require new plans to provide no-cost coverage for prescribed FDA-approved contraceptives and services for women (including insertion, removal and follow up care). This provision could expand access to highly effective and long lasting methods by eliminating costs as a barrier. In addition, coverage of family planning services without cost-sharing has long been a mandatory benefit under Medicaid. About half of the states also have special programs that provide coverage for family planning services to low-income women who do not qualify for full Medicaid, which has potentially expanded the pool of low-income women who can obtain LARCs without cost barriers. A recent study demonstrated that when financial barriers were removed, and women were counseled about all contraceptive methods, 75% of women chose LARCs. [24]

One in three women with private insurance report that their insurance plans covered the full cost of contraceptives.

Almost two years after the ACA contraceptive coverage rule took effect, among women with private insurance, one in three report that their insurance covered the costs of their contraceptive care in full. This provision only applies to "new" or "non-grandfathered" plans and over time it is anticipated that most women with private coverage will be enrolled in plans that offer this coverage. Still, four in ten say their insurance covered part of the costs and 13% reported that their plans did not cover contraceptives. While this provision has received much attention in the media, not all women are aware of this policy, which has the potential to broaden access to the most effective, but sometimes more costly, methods of contraceptives.

Family planning providers and community health centers play an important role providing contraceptive care for uninsured women and women of color.

Community health centers and family planning clinics were established to provide care to individuals regardless of their ability to pay. Title X, the federal planning program, and the Medicaid program are the leading sources of public funding for family planning services provided by clinics. As care systems under Medicaid increasingly shift to private managed care plans, and growing numbers of uninsured women are enrolled in private plans and Medicaid, it will be important to monitor how care changes for the women who have been relying on these clinics for their reproductive and sexual health care. In addition, there will still be gaps in coverage as many low-income women will either not qualify for coverage or may not be able to afford to

enroll. These low-income women will still need affordable sources of care if they are to have access to sexual and reproductive health services.

***

The findings of this survey provide new information about the opportunities and ongoing challenges in women's health care and coverage in the early days of ACA implementation. The ACA includes reforms that could make coverage more affordable, accessible, and stable for many women in the years to come. While the ACA can address some of these gaps, many challenges related to the law's implementation and other structural factors remain. Patient education, affordable care and coverage options, and integrated care systems that encompass the range of women's health needs, including reproductive and sexual health, will be critical issues to consider moving forward.

Endnotes

[1] Kaiser Family Foundation, Medical Debt Among People with Health Insurance, January 7, 2014.

[2] The Patient Protection and Affordable Care Act, Section 2713: Coverage of Preventive Health Services

[3] U.S. Preventive Services Task Force, USPSTF A and B Recommendations

[4] Centers for Disease Control and Prevention, Vaccine Recommendations of the ACIP

[5] Bright Futures and American Academy of Pediatrics, Recommendations for Preventive Pediatric Health Care

[6] Health Resources and Services Administration (HRSA), Women's Preventive Services Guidelines

[7] Health Resources and Services Administration, Women's Preventive Guidelines

[8] HHS, Substance Abuse and Mental Health Services Administration, Behavioral Health, United States, 2012

[9] HHS, Essential Health Benefits.

[10] U.S. Preventive Services Task Force, Screening for Lipid Disorders in Adults

[11] U.S. Preventive Services Task Force, Screening for Colorectal Cancer

[12] U.S. Preventive Services Task Force, Screening for Cervical Cancer

[13] Guttmacher Institute. (2013). Unintended Pregnancy in the United States.

[14] Centers for Disease Control and Prevention. (2013). Sexually Transmitted Infections Among Young Americans.

[15] Centers for Disease Control and Prevention. (2011). The National Intimate Partner and Sexual Violence Survey.

[16] Catalano, S. (2012). Intimate Partner Violence, 1993-2010. *U.S. Department of Justice, Office of Justice Programs*.

[17] U.S. Preventive Services Task Force. (2008). *Recommendations for STI Screening*.

[18] Centers for Disease Control and Prevention. (2014). Sexually Transmitted Diseases (STDs).

[19] The Institute of Medicine. (2011). Clinical Preventive Services for Women: Closing the Gaps.

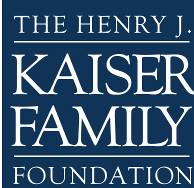
[20] Kaiser Family Foundation. (2012). State Coverage of Preventive Services for Women under Medicaid: Findings from a State-Level Survey.

[21] The American Congress of Obstetricians and Gynecologists. (2009). Hormonal Contraceptives Offer Benefits Beyond Pregnancy Prevention.

[22] Dayal, M & Barnhart, KT. (2001). Noncontraceptive benefits and therapeutic uses of the oral contraceptive pill. *Seminars in Reproductive Medicine* 19(4).

[23] Foster, D, et al. (2011). Number of oral contraceptive pill packages dispensed and subsequent unintended pregnancies. *Obstetrics & Gynecology* 117(3).

[24] Peipert, J.F., et al. (2012). Preventing unintended pregnancies by providing no-cost contraception. *Obstetrics and Gynecology* 120 (6).



THE HENRY J. KAISER FAMILY FOUNDATION

Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
Phone 650-854-9400 Fax 650-854-4800

Washington Offices and
Barbara Jordan Conference Center
1330 G Street, NW
Washington, DC 20005
Phone 202-347-5270 Fax 202-347-5274

www.kff.org

This publication (#8590) is available on the Kaiser Family Foundation's website at www.kff.org.

Filling the need for trusted information on national health issues, *the Kaiser Family Foundation is a nonprofit organization based in Menlo Park, California.*

GRIST Report: Updated COBRA model notices and guidance clarify ACA exchange options

By Leslie Anderson and Kaye Pestaina of Mercer's WRG
May 29, 2014

In This Article

Summary | Revisiting COBRA in light of ACA | New model COBRA notices, proposed regulations | COBRA, exchange enrollment, and subsidy eligibility | Unresolved issues | Next steps | Appendix: Effective date of exchange coverage after special enrollment

Summary

Federal guidance issued in May addresses the interaction of COBRA with the Affordable Care Act (ACA). The US Department of Labor (DOL) has updated its model COBRA general and election notices for employers to use; Spanish versions of the general and election notices are available as well. Accompanying DOL proposed regulations and interagency frequently asked questions (FAQs) explain that public exchanges may offer better coverage options than COBRA in some situations, and individuals need to understand the somewhat complex interaction of COBRA and exchange enrollment, including eligibility for exchange subsidies. Final rules published May 27 by the US Department of Health and Human Services (HHS) further clarify some of these issues. Under guidance from the Centers for Medicare and Medicaid Services (CMS), dropping COBRA coverage normally isn't an exchange special-enrollment event, but individuals who currently have or are eligible for COBRA coverage can enroll in federally run exchanges through a one-time special-enrollment period until July 1. This GRIST discusses the new guidance.

Revisiting COBRA in light of ACA

COBRA requires employers with 20 or more employees to offer continuation coverage for a limited period to employees and family members losing employer-provided health coverage under certain circumstances, known as "qualifying events." Individuals eligible for or enrolled in COBRA coverage are called "qualified beneficiaries." Qualifying events include loss of coverage caused by the employee's death, termination of employment, reduction in work hours, divorce, or child reaching the maximum age of coverage (GRIST #19990087, March 2, 1999). The maximum duration of COBRA coverage ranges from 18 to 36 months, depending on the qualifying event.

Employers can charge qualified beneficiaries electing COBRA coverage up to 102% of the total (employer and employee) cost — or 150% of the coverage cost during COBRA extensions based on a disability. Once an employer provides COBRA election notices, qualified beneficiaries have 60 days to decide whether to elect the coverage and 45 days from their election to make the initial payment. Individuals who don't timely elect COBRA don't have rights to elect it later. COBRA

coverage, if timely elected, is retroactive to the first day after the loss of coverage. (For a general discussion of COBRA qualifying events, see GRIST #19990092, March 4, 1999.)

ACA alters COBRA value for some

At the time of COBRA's enactment, the difficulties individuals faced obtaining or affording health insurance on their own provided the impetus for mandating an opportunity to extend employer-sponsored coverage. Under ACA, however, most US residents can now buy individual coverage on a guaranteed-issue basis — without the pre-existing condition exclusions and other constraints (such as individual rather than community ratings) that once limited access and affordability (GRIST #US20140038, March 18, 2014). Individuals buying public exchange coverage also may qualify for premium tax credits and cost-sharing reductions that can make this coverage less expensive than COBRA for some individuals (GRIST #20130093, May 14, 2013).

The recent agency guidance and revised model COBRA notices recognize that ACA has given employees and other qualified beneficiaries additional factors to consider in deciding whether to elect COBRA. Depending on an individual's age and eligibility for exchange subsidies, the cost and scope of employer coverage, and other factors, public exchanges may offer more cost-effective options than COBRA coverage. Because individuals electing COBRA tend to generate high claim expenses, many employers may want to encourage qualified beneficiaries to review other options — such as public exchange plans — when making COBRA decisions.

New model COBRA notices, proposed regulations

Although DOL modified its model COBRA election notice in May 2013 to mention ACA exchanges (GRIST #US20130121, July 2, 2013), the agency has now updated the model general notice and extensively revised the model election notice to give more details about coverage options. The agency also has proposed changing the COBRA notice regulations to eliminate the model notices from the appendices and instead supply current models on its COBRA website. According to DOL, this will reduce confusion as to the latest versions and facilitate future revisions. This simplified process presumably might allow DOL to update the notices more frequently. Regulators also have asked for comments by July 7 on the sufficiency of the notices and the need for mandatory language.

Timing for use of updated models

Use of the DOL models, appropriately completed, is not required but is good-faith compliance with content requirements until the revised COBRA notice rules are finalized. Although the proposed regulations do not specify an effective date, employers should either use the new models or update their versions of the COBRA notices to include the revised content as soon as administratively reasonable. Doing so not only ensures compliance but also informs qualified beneficiaries about other coverage options.

Employers don't have to provide updated versions to anyone who has already received a COBRA notice. But some employers may opt to send qualified beneficiaries an updated election notice or

COPYRIGHT 2014 MERCER LLC. ALL RIGHTS RESERVED.

some other communication describing exchange options — and perhaps including information about the one-time special-enrollment period for federally run exchanges (discussed below).

Updated content of models

While both of the DOL models have revised content, the model election notice has more significant changes.

General COBRA notice. Employers must provide a general notice of COBRA rights to all participants and their spouses when they first become covered by an employer-sponsored health plan. Two somewhat repetitive paragraphs added to DOL's model explain that individuals losing group health plan coverage may have options other than COBRA — such as coverage through a public exchange, a spouse, or Medicaid — which may be less expensive than COBRA.

COBRA election notice. The model COBRA election notice — which qualified beneficiaries must receive after a qualifying event — has extensive revisions, including the following:

- Explanation of the COBRA alternatives that may be available and cost less, such as coverage through a public exchange, special enrollment in a spouse's group plan, or Medicaid
- Information about how to enroll in and obtain more details on the public exchange
- Discussion of the need to evaluate multiple factors when deciding the best coverage option for an individual's situation, including:
  - Possible deductible to satisfy if COBRA isn't elected
  - Premium costs
  - Other cost sharing
  - Provider networks and drug formularies for patients currently getting care or treatment
  - Service areas
- Severance payments that might include employer-subsidized COBRA coverage (employees with severance packages are encouraged to contact DOL at 1-866-444-3272 to "discuss their options")
- Details on how COBRA eligibility and enrollment affects exchange enrollment and subsidy eligibility
- Elimination of some former content (for example, discussion of secondary qualifying events is replaced by link to a DOL webpage describing these events)

COPYRIGHT 2014 MERCER LLC. ALL RIGHTS RESERVED.

COBRA, exchange enrollment, and subsidy eligibility

The updated model COBRA election notice, final HHS rules, and recent CMS guidance summarize and clarify previously scattered pieces of information on the interaction of COBRA elections with exchange enrollment and subsidy rules. Because many individuals may not have fully grasped either the exchange options or their interaction with COBRA, CMS is allowing federally operated exchanges to offer COBRA qualified beneficiaries a one-time, special-enrollment period until July 1 — and is encouraging state-run exchanges to do the same.

Basics of exchange enrollment

Like many employer-sponsored plans, public exchanges hold an annual open-enrollment period for people to elect coverage for the upcoming year but permit special enrollment after certain qualifying events. For exchange coverage starting in 2015, open enrollment will run from Nov. 15, 2014–Feb. 15, 2015. For coverage starting in 2016 or later years, open enrollment will likely run from Oct. 7–Dec. 15 of the prior year. Outside of this annual open-enrollment period, an individual must experience a special-enrollment event to obtain exchange coverage.

For exchange coverage, special-enrollment events include the loss of other minimum essential coverage (MEC). Since all employer-provided coverage — other than excepted benefits, such as dental- or vision-only coverage — is MEC, most qualifying events triggering COBRA eligibility are also special-enrollment events for exchange coverage. Individuals experiencing exchange special-enrollment events generally have 60 days to enroll in exchange coverage, but this special-enrollment period can extend 60 days *before or after* the loss of MEC. As shown in the Appendix, the effective date of exchange coverage varies for different special-enrollment events, but after loss of MEC, the HHS final rules provide the following effective dates:

- If an exchange plan is selected on or before the date MEC is lost, exchange coverage is effective on the first of the month after the MEC loss.
- If an exchange plan is selected after MEC is lost, exchange coverage is effective on either the first of the first month starting after plan selection or, in some cases, the first of the second month starting after plan selection.

COBRA, exchange enrollment, and subsidy eligibility

The HHS final rules provide these general guidelines about COBRA's impact on exchange enrollment and eligibility for exchange subsidies:

- Loss of employer-sponsored MEC causing a COBRA qualifying event is also an exchange special-enrollment event. So individuals losing employer MEC can choose between electing COBRA or enrolling in public exchange coverage.
- Once the exchange special-enrollment period after loss of MEC has ended, individuals can't switch from COBRA to exchange coverage until the next exchange open-enrollment period,

COPYRIGHT 2014 MERCER LLC. ALL RIGHTS RESERVED.

unless they experience another exchange special-enrollment event before then. As a result, individuals wanting to change from COBRA coverage may be unable to obtain exchange coverage that's effective before the next Jan. 1 (the earliest effective date for exchange coverage obtained during open enrollment). Loss of COBRA caused by nonpayment of premiums is not a special-enrollment event. Exhaustion of COBRA is an exchange special-enrollment event, but the minimum duration of COBRA is 18 months.

- Mere eligibility for COBRA doesn't stop a qualified beneficiary from obtaining exchange coverage or subsidies. As long as qualified beneficiaries aren't actually enrolled in COBRA coverage, they can qualify for exchange subsidies. And qualified beneficiaries who do enroll in COBRA coverage can drop it at any time by not paying COBRA premiums. (However, proposed IRS rules treat *active* employees eligible for COBRA because of reduced hours — and their dependents — as still having access to employer-provided MEC, eliminating eligibility for exchange subsidies unless the employer coverage is unaffordable or lacks minimum value.) So most qualified beneficiaries can stop paying for COBRA and, if eligible, claim an exchange subsidy once they are able to enroll in exchange coverage (at open enrollment, on exhaustion of COBRA coverage, or after another special-enrollment event).

The examples below illustrate the interaction of these rules.

Example 1. Ann loses her job — with no advance notice — on July 31, 2014. Her employer-provided group health coverage (which is MEC) ends that day. She receives her COBRA election notice on Aug. 28. After reviewing the notice, her plan's terms and COBRA rates, and her exchange options, she decides to enroll in the exchange. She applies on Sept. 5, which falls within the exchange's 60-day special-enrollment period after her July 31 loss of employer-provided MEC. Ann's exchange coverage is effective Oct. 1 because — unlike COBRA — exchange coverage is not retroactive to the date of MEC loss. Ann therefore has a two-month gap in coverage. If Ann had advance notice of her termination, she could have enrolled in the exchange on or before July 31, with coverage effective Aug. 1.

Example 2. Harry terminates employment on Jan. 15, 2015. His employer-provided coverage will end on Jan. 31, so he enrolls in COBRA, effective Feb. 1. Because Harry stops paying his premiums, his COBRA coverage ends April 30, after the close of his 60-day exchange special-enrollment period. Unless he experiences another exchange special-enrollment event, he must wait until the exchange's open-enrollment period begins Oct. 7, 2015, to obtain exchange coverage effective Jan. 1, 2016. If he otherwise qualifies, Harry can receive a subsidy for his 2016 exchange coverage, even though he didn't exhaust his COBRA coverage.

Example 3. Same facts as above, except Harry marries Sally on April 1, 2015. Since marriage is an exchange special-enrollment event, Harry enrolls in exchange coverage on April 10 and stops paying for COBRA. His exchange coverage is effective May 1, and if he meets the eligibility criteria, he can receive exchange subsidies for that coverage.

COPYRIGHT 2014 MERCER LLC. ALL RIGHTS RESERVED.

Example 4. After her 2013 termination of employment, Flora elects COBRA. She exhausts her 18 months of COBRA coverage on March 31, 2015. This MEC loss due to COBRA exhaustion permits special enrollment for exchange coverage. If otherwise eligible, she can obtain exchange subsidies for this coverage.

One-time, exchange special enrollment for COBRA qualified beneficiaries

Recent COBRA qualified beneficiaries may not have understood their eligibility for public exchange coverage, the subsidies potentially available for that coverage, or their limited ability to switch from COBRA to exchange coverage before the next open-enrollment period. As a result, CMS guidance issued May 2 allows anyone currently enrolled in or eligible for COBRA to obtain coverage from a federally run exchange during a one-time, special-enrollment period that ends July 1. State-run exchanges are encouraged — but not required — to offer the same special-enrollment period. Individuals in states with federally operated exchanges can call 1-800-318-2596 to obtain information about their COBRA benefits and exchange coverage.

Employers don't have to tell COBRA qualified beneficiaries about this one-time enrollment option in federally run exchanges. However, some employers may want to provide this information, as switching to exchange coverage may prove more cost effective for both the employer and qualified beneficiaries.

Unresolved issues

The updated notices and guidance help clarify the coverage options available to COBRA qualified beneficiaries. But additional guidance would be welcome on some issues, such as possible gaps in coverage, the effect of employer-subsidized COBRA coverage on exchange enrollment, and the possibility of a special-enrollment event when someone becomes newly eligible for exchange subsidies.

Address possible coverage gap. While COBRA coverage, if elected, is retroactive to the loss of employer coverage, exchange coverage obtained through special enrollment after MEC loss often isn't effective until the first or second month starting after plan selection (see the Appendix). As illustrated in Example 1, this may result in a coverage gap for qualified beneficiaries who decide to enroll in the exchange rather than elect COBRA. The coverage gap can be eliminated or minimized if a qualified beneficiary anticipates and applies for exchange coverage on or before the MEC loss. However, individuals don't always have advance notice of a coverage loss, and those who do get advance notice may not know about their exchange special-enrollment rights.

Regulators could address this problem by making exchange coverage — like COBRA — retroactive to the date of MEC loss in this situation. Individuals choosing between COBRA and exchange coverage could select the better option without worrying about gaps in coverage. In the preamble to the final rules published May 27, HHS says qualified beneficiaries can avoid these gaps by timely electing *both* exchange coverage and COBRA coverage, then dropping COBRA once the exchange coverage is effective. This is a complex solution that requires a sophisticated

COPYRIGHT 2014 MERCER LLC. ALL RIGHTS RESERVED.

understanding of the exchange special-enrollment and COBRA election deadlines and coverage effective dates. The updated COBRA election notice certainly doesn't mention this strategy and offers little guidance beyond cautioning that switching from one option to another can be difficult. In addition, electing both COBRA and exchange coverage will sometimes result in unnecessary duplication of coverage for a limited period. Aligning the effective dates of COBRA and exchange coverage would be a much more straightforward way to eliminate coverage gaps for qualified beneficiaries.

Make loss of employer COBRA subsidies an exchange special-enrollment event. Some employers subsidize COBRA premiums for a portion — such as three or six months — of the maximum COBRA period. Under current guidance, former employees apparently can't drop COBRA when the employer subsidy ends and switch to public exchange coverage that may prove more affordable. (However, the revised model election notice encourages employees in this situation to call DOL to discuss their options.) Guidance permitting special enrollment in an exchange when employer-subsidized COBRA coverage ends would encourage employers to continue such practices.

Clarify special enrollment for COBRA qualified beneficiaries newly eligible for exchange subsidies. One exchange special-enrollment event occurs when someone with employer-provided coverage becomes newly eligible for exchange subsidies "based in part on a finding that such individual is ineligible for qualifying coverage in an eligible employer-sponsored plan." Unlike active employees (and their covered family members), COBRA qualified beneficiaries usually can drop MEC and, if otherwise eligible, claim exchange subsidies (unless the qualifying event was a reduction in hours, under proposed IRS rules). But it's unclear whether COBRA beneficiaries doing so have a special-enrollment right or must wait until the exchange's next open-enrollment period (or until COBRA coverage ends or another special-enrollment event occurs). Clarification of this issue would be welcome.

Next steps

Employers should consider several actions in response to the recent ACA/COBRA guidance, including the following:

- *Update COBRA general and election notices.* Employers that administer COBRA notices should begin using the new models or update their notices with the new content as soon as administratively reasonable. Employers outsourcing COBRA administration should confirm that their administrators are updating their notices to match the models.

- *Consider crafting communications about public exchanges' impact on COBRA decisions, including the one-time, exchange special-enrollment period ending July 1.* While employers don't have to send updated COBRA notices to anyone who received an earlier version, some employers might want to send updated election notices to individuals whose COBRA election period hasn't ended to help them better understand their options. In light of the potential

COPYRIGHT 2014 MERCER LLC. ALL RIGHTS RESERVED.

advantages to all parties, employers also might want to inform qualified beneficiaries about the one-time option to switch to coverage from a federally run exchange by July 1. Employers should carefully review the accuracy of such communications before distribution, given the complexity of the rules. For example, an important point to emphasize about the one-time, special-enrollment right is that it is optional for state-run exchanges.

- *Consider updating other plan communications or disclosures, such as summary plan descriptions (SPDs).* Many employers that choose to adopt DOL's model COBRA notices without modification may want to use other plan communications, such as SPDs, to further explain the COBRA alternatives created by ACA.

- *Consider interaction of employer-paid COBRA subsidies with exchange enrollment.* Employers offering COBRA subsidies should consider the potential dilemma they may create. Subsidized COBRA coverage initially may be the most attractive coverage option available to qualified beneficiaries, but if it ends midyear, former employees may be unable to obtain exchange coverage that's effective before Jan. 1 of the next calendar year. As a result, employers may want to consider alternatives, such as paying taxable compensation instead of COBRA subsidies or continuing regular coverage for the subsidized severance period and delaying the start of COBRA coverage until subsidies have ended. Any contemplated delay in the start of COBRA coverage should be reviewed with the carrier (if the coverage is insured) or any stop-loss carrier (if the coverage is self-funded).

- *Train — and caution — benefit staff on COBRA/exchange intricacies.* Individuals eligible for or enrolled in COBRA coverage are likely to contact their employer for information about their new choices. Staff handling these calls should be trained on the latest guidance but cautioned not to speculate in unclear or unusual situations. Bad advice could result in someone dropping COBRA and having to wait until the next open-enrollment period for exchange coverage. Individuals should be encouraged to confirm their enrollment options with public exchange staff.

COPYRIGHT 2014 MERCER LLC. ALL RIGHTS RESERVED.

Appendix: Effective date of exchange coverage after special enrollment

Under current HHS rules, 10 events permit special enrollment in exchange plans. The various events and the date coverage begins are listed in the table below. HHS may make additional changes to these rules.

Special-enrollment event	Effective date of ACA exchange coverage[1]
Losing minimum essential coverage (MEC)[2]	Plan selected on/before loss of MEC: • 1st of month after MEC loss Plan selected after loss of MEC: At exchange option, either: • 1st of month after plan selection • Regular effective date, which is 1st of month starting: – After plan selection, if choice made between 1st and 15th of month – After plan selection plus 1 full month, if choice made between 16th and last day of month
Gaining or becoming a dependent through marriage, birth, adoption, or placement for adoption or in foster care	For marriage: • 1st of month after date of marriage For birth, adoption, or placement for adoption or in foster care, either: • Date of event • Up to 1st of month after event, if exchange permits
Becoming a citizen or national or lawfully present in the US	Regular effective date
Enrolling or not enrolling in qualified health plan (QHP) because of exchange or HHS error, misrepresentation, or inaction	Appropriate date based on circumstances
QHP substantially violating material contractual obligation to enrollee	Appropriate date based on circumstances
Enrollee in employer-sponsored coverage becoming newly eligible for premium tax credits under certain circumstances[3]	Plan selected on or before loss of MEC: • 1st of month after MEC loss Plan selected after loss of MEC: At exchange option, either: • 1st of month after plan selection • Regular effective date
Gaining access to new QHP because of permanent move	Regular effective date
Indians (under Section 4 of Indian Health Care Improvement Act) or Alaska Natives enrolling in or changing coverage through monthly special enrollment	Regular effective date

COPYRIGHT 2014 MERCER LLC. ALL RIGHTS RESERVED.

Special-enrollment event	Effective date of ACA exchange coverage[1]
Experiencing other exceptional circumstances, as determined by exchange under HHS guidelines	Appropriate date based on circumstances
Not getting enrolled in any QHP, getting enrolled in incorrect QHP, or qualifying for but not receiving exchange subsidies as a result of misconduct by entity (other than exchange) that provided enrollment assistance	Appropriate date based on circumstances

[1] Different effective dates may apply to eligibility for premium subsidies or cost-sharing reductions. In some circumstances, an exchange, with HHS approval, can accelerate effective dates of coverage.

[2] Additional rules apply if the coverage lost is a noncalendar-year individual insurance policy or certain Medicaid coverage.

[3] Additional rules apply for QHP enrollees newly eligible or ineligible for exchange subsidies.

WRG only: US20140068

COPYRIGHT 2014 MERCER LLC. ALL RIGHTS RESERVED.

State and Consumer Initiatives

May 21, 2014

ACA and the Children’s Health Insurance Program

By Christine Vestal, Staff Writer

Follow on Twitter

The Children’s Health Insurance Program (CHIP) was enacted in 1997 to extend health coverage to children in poor families with modest incomes too high to qualify for Medicaid. The Affordable Care Act now offers many of those same families federal subsidies through the health insurance exchanges, calling into question whether the program should be continued over the long term.

Republican Pennsylvania Gov. Tom Corbett discusses the Children's Health Insurance Program at a library in Wilkes-Barre. Over the next five years, states will decide whether to continue running their CHIP programs or turn to new insurance subsidies for low-income families under the Affordable Care Act. (AP)

CHIP helped lower the uninsured rate among low-income American children from 25 percent in 1997 to 13 percent in 2012, and the program has strong bipartisan support at the state and federal level. Still, some states – particularly those that have opted to expand Medicaid to more low-income adults – may decide that families would be better served by enrolling everyone in the same insurance plan.

Following is a primer on CHIP and its evolving role under the ACA.

What is CHIP?

CHIP is a $13 billion federal-state partnership covering nearly 8 million kids in low-income families.

Under CHIP, the federal government bears a higher percentage of the overall cost than it does under Medicaid,

averaging 71 percent nationwide, compared to about 57 percent for Medicaid. Another difference between CHIP and Medicaid is that CHIP is a block grant, not an entitlement. That means states can create waiting lists for the program when state revenues run short. By contrast, states must provide Medicaid coverage to all eligible applicants, no matter the cost. (Under Medicaid, states can set their own income eligibility rules for non-disabled adults, but they must cover children, pregnant women and disabled adults up to federally specified income levels.)

Historically, CHIP has covered kids up to 19 years old with family incomes from 138 percent of the federal poverty level ($32,913 for a family of four) to as high as 405 percent ($96,592 for a family of four), depending on the state program. In families with incomes below 138 percent of poverty, young children from infancy to 6 years old are covered under Medicaid and, until this year, older children in families with the same income level were covered under CHIP.

How does the Affordable Care Act affect CHIP?

The Affordable Care Act (ACA) extends funding for CHIP through Sept. 30, 2015. At that time, the federal matching rate would increase by 23 percentage points to 94 percent, lowering the average state share of funding to 6 percent. But that’s only if Congress extends funding for the program beyond 2015.

Physicians, advocates for children and other groups recommend Congress extend funding to 2019, when the federal law gives states the option of dropping the program.

Currently, if a child qualifies for CHIP, the family cannot receive federal tax subsidies to cover the cost of including the child in their federally qualified health plan under the ACA. However, if a state decides to discontinue its CHIP program, families with children who were previously covered by the program could become eligible for federal tax subsidies to cover their children under one policy.

The ACA also required states to shift children ages 6 to 19 in families with incomes between the poverty level ($23,550 for a family of four) and 138 percent of poverty out of CHIP and into Medicaid by last Jan. 1. The rationale was that parents and children would be best served if they were covered by the same insurance plan, with the same doctors and hospitals and enrollment rules.

Since the federal health law assumed that all states would expand Medicaid to adults with incomes up to 138 percent of the poverty level, it made sense to cover the children in those families under the same program. Although nearly half of all states have chosen not to expand Medicaid to adults, children in those states ages 6 to 19 will still be moved into Medicaid. Nationwide, the transfer from CHIP to Medicaid will affect more than 1.5 million low-income children, an enrollment reduction of nearly 30 percent from the CHIP program.

Why would states eliminate CHIP?

Although states pay only a small share of the cost of CHIP, coverage of the same low-income families would be cost-free for states if they eliminated CHIP and directed families to the health insurance exchanges. In addition, some states may decide to dismantle CHIP to simplify public insurance options for families who may already have

members enrolled in Medicaid and private insurance on the exchanges.

However, states may choose to continue CHIP because of its bipartisan support and proven track record. In general, kids are cheap to cover because they are healthier than adults. States’ decisions on CHIP will rest in part on the relative success of insurance exchange policies at enrolling kids and keeping them healthy.

What other ACA provisions target children?

The ACA primarily aims to insure more adults, including parents. In the process, a substantial number of uninsured children are expected to get coverage as their parents learn more about federal and state subsidies.

According to a study by the Urban Institute, the federal health law could result in new coverage for as many as 3.2 million uninsured children because of tax credits offered on health insurance exchanges and overall outreach efforts. In addition, the law requires insurance companies to provide improved benefits for kids, including preventive, dental and vision care, and behavioral health services.

Does the ACA make it easier for low-income parents to get coverage for their kids?

Yes and no.

The ACA makes it easier for states to maintain or expand their CHIP programs by providing more federal funding. But what is considered an error in the law – the so-called “family glitch” – is expected to prevent as many as 56 percent of low-income families who qualify for CHIP from getting federal subsidies on health insurance exchanges if CHIP were to end.

Under the law, anyone who is offered “affordable” insurance by their employer is not eligible for federal tax credits. Affordable insurance is defined as coverage for an individual that does not exceed 9.5 percent of a worker’s income.

But there is no limit on the worker’s share of premiums for family coverage, which typically costs close to three times as much as individual coverage. That means workers who can’t afford employer-offered premiums for family coverage will have nowhere to go except CHIP or Medicaid.

Will exchange coverage cost families roughly the same as CHIP?

It is too soon to tell.

One state serves as an example. Arizona began dismantling its CHIP program in 2009, before the ACA was enacted. Most children were transferred to the state’s Medicaid program, but about 14,000 children whose families had incomes too high to qualify for Medicaid were directed to find alternative coverage this year.

It is not known how many of those families purchased policies on Arizona’s federally-run insurance exchange. But a new study from Georgetown University’s Center for Children and Families found that the federally subsidized policies they would have qualified for had substantially higher out-of-pocket expenses, including co-pays and deductibles, than CHIP coverage. Hardest hit, the researchers said, would be families with the lowest incomes and those with more than one child.

Costs for dental services were particularly high on the Arizona exchange, the study found, because the ACA requires insurance companies to include dental services for kids only if separate dental policies do not exist in the local market. For families in markets with stand-alone dental policies, the coverage represented a significant additional charge.

Whether the out-of-pocket costs for qualified insurance plans on the exchange will be more expensive than CHIP in 2019 is unknown. For that reason, advocates are urging states not to make hasty decisions about dropping CHIP coverage until exchange markets further develop and better enrollment and cost data is available.

Are benefits for exchange policies comparable to those for CHIP?

That is a question state health care officials are studying. The federal health law requires insurance companies to include benefits such as mental health, dental and vision care that theoretically would be similar to CHIP benefits. But individual insurance policy details such as how many mental health counseling visits are covered and whether dental coverage includes orthodontia and at what cost have not yet been analyzed.

Are all state CHIP programs the same?

No. The median income eligibility threshold for CHIP is 255 percent of poverty level which is $60,818 for a family of four, according to the Kaiser Family Foundation. But states vary widely, with New York offering coverage at the highest income level (405 percent of the federal poverty level or $96,592 for a family of four), followed by Iowa (380 percent), New Jersey (355 percent), the District of Columbia (324 percent), Connecticut and New Hampshire (323 percent) and Maryland (322 percent).

Nevada has the lowest income eligibility level at 175 percent of the poverty level ($41,738 for a family of four), followed by Idaho (190 percent), and Nevada, Utah, Virginia and Wyoming at 205 percent.

Nationally, 88 percent of eligible children were enrolled in either CHIP or Medicaid in 2012, compared to about 74 percent of adults who qualified for Medicaid, according to analysis from the Urban Institute. In 21 states, the participation rate was 90 percent or higher, while four states, Alaska, Montana, Nevada and Utah, signed up fewer than 80 percent of those eligible.

States also have leeway under federal rules to develop varying benefit packages and cost-sharing arrangements. A new study by the National Academy for State Health Policy found that, despite the flexibility, most state benefits were similar to those provided to children covered by Medicaid, and all states offered low or no premiums and other cost sharing.

Administration of the program also differs. When CHIP was launched, 21 states chose to create separate CHIP programs. The remaining states opted to cover children under an expanded Medicaid program. This year, two more states, California and New Hampshire, decided to merge their CHIP programs into Medicaid.

Share This With:

- State lawmakers
- Health care officials
- Advocates for children

TWITTER FACEBOOK

Issues: Health

States: National

Want to Republish our Stories?

New Rules Protect Navigators and Certified Application Counselors from Over-Reaching State Laws but Also Impose New Requirements

Posted on **May 21, 2014** by **CHIR Faculty**

Like Share g+1 Share Tweet Share

By Tricia Brooks, Georgetown University Center for Children and Families

Last week, CMS finalized rules that were proposed in March with a few modifications, some good and some not so good. The rules impact navigators, in-person assisters and certified application counselors (CACs) (collectively known as assisters) as summarized below.

1) ***Pre-empting certain aspects of state laws that restrict navigator and assisters.***States are not precluded from establishing or implementing state laws to protect consumers. However, the final regulations are the first attempt to define provisions of state laws that have overstepped their bounds and interfered with the operation of navigator and assister programs by marketplaces or inhibited assisters from doing what is required of them. While the proposed rule was not perfect and could have been strengthened, CMS is clear that it doesn't include all of the circumstances that later could be viewed as too restrictive or overruled by the courts. Here's the list of the state standards, which apply to all types of assisters, unless noted, that are not allowable. States cannot:

- Compel assisters to refer consumers to other entities that are not required to provide fair, accurate and impartial information.
- Prevent assisters from giving advice regarding substantive benefits or comparative benefits of different health plans.
- Require navigators to hold an agent or broker license (not applicable to in-person assisters and CACs). A proposed prohibition on requiring navigators to carry errors and omissions insurance was deleted from the final rule.
- Deem a health care provider to be ineligible to serve as an assister solely because it receives consideration from a health insurance issuer for health care services provided.

- Impose standards that would prevent the application of federal requirements applicable to assisters.
- Require assisters to maintain their principal place of business in the marketplace service area, although a physical presence is required.

2) ***Compensation***

- Assisters cannot charge any applicant or enrollee, or receive remuneration in any form from or on behalf of an applicant or enrollee, for application or other assistance.
- In federal marketplace states, no type of individual assister can be compensated on a per-application, per-individual-assisted, or per-enrollment basis effective November 15, 2014.
- To align requirements across assister types, CACs are not allowed to receive consideration directly from a health insurance or stop-loss issuer in connection with enrollment.

3) ***New standards prohibiting certain conduct.*** The proposed standards regarding providing gifts or promotional items, conducting "cold calling" type solicitation and using "robo" calling (automatic dialers) were finalized with some helpful clarifications.

- Gifts or promotional items, unless they are of nominal value, cannot be used as an "inducement for enrollment." However, the final rule clarifies that gifts, gift cards or cash exceeding a nominal value may be used to reimburse consumers for legitimate expenses incurred in their efforts to receive application assistance, such as, but not limited to, travel or postage expenses.
- Assisters are not allowed to solicit consumers for application or enrollment assistance by going door-to-door or through other unsolicited direct contact "unless the entity or individual has a pre-existing relationship with the consumer." The rule also clarifies that such outreach and education activities are allowed.
- Unless an assister organization has a relationship with the consumer, they are not allowed to initiate any telephone call to a consumer using an automated telephone dialing system, or artificial or recorded voice.

4) ***Consumer authorization***. All assisters must inform consumers about their functions and responsibilities. Additionally, assisters must secure an applicant's authorization, in a form and manner determined by the marketplace, before obtaining access to an applicant's personally identifiable information (PII). Such authorization does not expire but it can be revoked at any time. Assisters must minimally retain authorizations for a period of six years (not three years as proposed). The current model form provided in federal and partnership marketplace states includes information about how a consumers PII can be used, as well as an option for consumers to authorize follow-up contact. A similar form will be developed by CMS for in-person assisters.

5) ***Civil Monetary Penalties (CMP)***. The new rules subject assisters in federal or partnership marketplace states to two different sets of civil monetary penalties. The first is exclusive to assisters and assister entities who do not comply with applicable federal requirements. This rule allows HHS to permit an entity or individual issued a notice of CMP to enter into a corrective action plan instead of paying the CMP. The second rule more generically applies to the misuse or impermissible disclosure of PII.

All of these provisions warrant further discussion and explanation based on additional detail provided by CMS in response to comments received on the proposed rule. Stay tuned to future blogs that take a deeper dive into these provisions.

Editor's Note: This post originally appeared on the Georgetown University Center for Children and Families' Say Ahhh! Blog

Related posts:

1. Final Regulations on Navigators, In-Person Assisters and Certified Application Counselors
2. Answering Your Questions on Certified Application Counselors
3. HHS Proposes to Preempt Some State Navigator Laws; Lays Out Federal Enforcement Framework
4. Recommendations to Strengthen Navigator and Assister Programs

This entry was posted in **Implementing the Affordable Care Act** and tagged **aca implementation**, **affordable care act**, **certified application counselors**, **navigator** by **CHIR Faculty**. Bookmark the **permalink [http://chirblog.org/new-rules-protect-navigators-and-certified-application-counselors/]** .