COVERED CALIFORNIA

Reports and Research

Table of Contents

January 15, 2015 Board Meeting

- *The State of Health Insurance in California: Findings from the 2011/2012 California Health Interview Survey* – **UCLA Center for Health Policy Research**
  December 2014

- *Window Shopping on Healthcare.gov and State-Based Marketplaces: More Consumer Support is Needed* – **University of Pennsylvania's Leonard Davis Institute of Health Economics and Robert Wood Johnson Foundation**
  December 2014

- *Medicaid Moving Forward.* – **The Kaiser Family Foundation**
  January 2014

- *State-Based Marketplaces Using 'Clearinghouse' Plan Management Models Are Associated With Lower Premiums* – **Health Affairs**
  January 2015

Altarum Institute Survey of Consumer Health Care Opinions

Fall 2014

Wendy Lynch, PhD
Kristen Perosino, MPH
Michael Slover, MS

ALTARUM INSTITUTE
SYSTEMS RESEARCH FOR BETTER HEALTH

Table of Contents

Executive Summary

Altarum Institute conducts semiannual surveys to better understand consumer beliefs, practices, and preferences regarding health care. The fall 2014 *Altarum Institute Survey of Consumer Health Care Opinions* is the seventh in this ongoing series. Survey respondents included a nationally representative sample of 1,921 adults between the ages of 18 and 64 years old.

Key findings:

- **Consumers want the lead role in making decisions that affect their own health.** Two-thirds of consumers want to be in control of decisions concerning their health, and 28% prefer to make joint decisions with their doctors. Only 7% would like their doctor to be in charge.
- **Consumers remain concerned about health care costs but skeptical of their own ability to shop for high-value, low-cost care.** Consistently with previous findings, 90% of consumers are worried about paying medical bills, but only about half ever ask their doctors about the cost of care. Confidence in their own ability to affect the value of the care that they receive remains relatively low.
- **While only one-quarter of consumers have ever used a cost comparison tool, most found it to be helpful and would use the tool again.** Among consumers who have used a tool to compare health care prices, nearly all (91%) indicated that it was somewhat to very useful, and four out of five would use it again in the future. These results highlight a need for more widespread availability and use of transparency tools. As demonstrated in this study, such resources can provide valuable support to consumers and enable them to play an active role in their health.
- **Younger consumers and those with high deductibles are much more likely to compare costs.** Consumers in the youngest age group were nearly three times more likely to use a cost comparison tool than their older counterparts. Similarly, 60% of consumers with a $10,000 deductible have compared prices while less than 20% of those with low deductibles have done so. These findings suggest that consumers who assume greater financial risk (and incur lower out-of-pocket costs) exhibit more cost-conscious behavior.
- **Most consumers are committed to their current doctors but would likely switch if forced to pay more.** Almost 80% of consumers reported that it was important to them to keep their existing doctor. However, only 45% would pay an extra $25 per visit in order to keep seeing the same provider.
- **Most consumers place a great deal of trust in their doctors and believe that they would never deliver unnecessary or questionable care.** Nearly 9 out of 10 consumers indicated that they trust their doctors. Despite national estimates that one-third of all health care is wasteful or ineffective, 71% of consumers in this study reported that their doctors would not recommend a test or procedure unless it was necessary.
- **Consumers underestimate the extent of medical errors in the United States.** When asked how many deaths were caused by preventable hospital errors each year, only 8% of consumers selected the correct response of 400,000. More than 70% chose 10,000 or 50,000. Three out of five consumers also believed that car accidents were a more common cause of death, when in fact medical errors kill 10 times as many people. These findings underscore a

need to better educate consumers about medical errors, risk factors, and their own role in improving the safety and quality of care.

- **More than 40% of consumers have gotten unexpected medical bills from providers whom they have never met.** Fewer than half of these consumers received a good explanation. In most cases, the bill was only partially covered (59%) or not at all covered (13%) by insurance.
- **Consumers with high Altarum Consumer Engagement (ACE) Measure scores are more likely to compare health care costs.** Altarum recently launched the ACE Measure to assess levels of health engagement. Consumers with high ACE Measure scores in this survey were more likely to have used a cost comparison tool than those with low scores.

I. Introduction

The role of consumers in health care decisions and payments continues to expand. A decade after the introduction of Health Savings Accounts, there are more than 17 million account holders.[1] Four out of five large employers will offer consumer-directed health plans (CDHP) in 2015, and one-third of employers will offer a CDHP as the only choice for health benefits.[2] Additionally, consumers buying insurance through the Patient Protection and Affordable Care Act's federal and state exchanges are being advised to "shop around" for deals.[3] High deductible health plans are generally the lowest-cost options available to these consumers.[4]

These trends are part of a national movement encouraging people to take greater responsibility for their own health. Consumer engagement—in both health behaviors and health care decisions—is increasingly recognized as a key factor in maintaining good health and reducing unnecessary costs.[5] To support people in making decisions, transparency of price and quality information is slowly progressing and available through numerous vendors and health plans. A free online transparency tool is also expected to be released in 2015.[6]

As the nation continues to shift toward increased consumer engagement, we need to better understand the many factors that influence our health-related decisions. Since 2011, Altarum Institute has been administering semiannual surveys to examine consumer beliefs, practices, and preferences regarding health care. The fall 2014 *Altarum Institute Survey of Consumer Health Care Opinions* is the seventh in this ongoing series.

II. Decisions

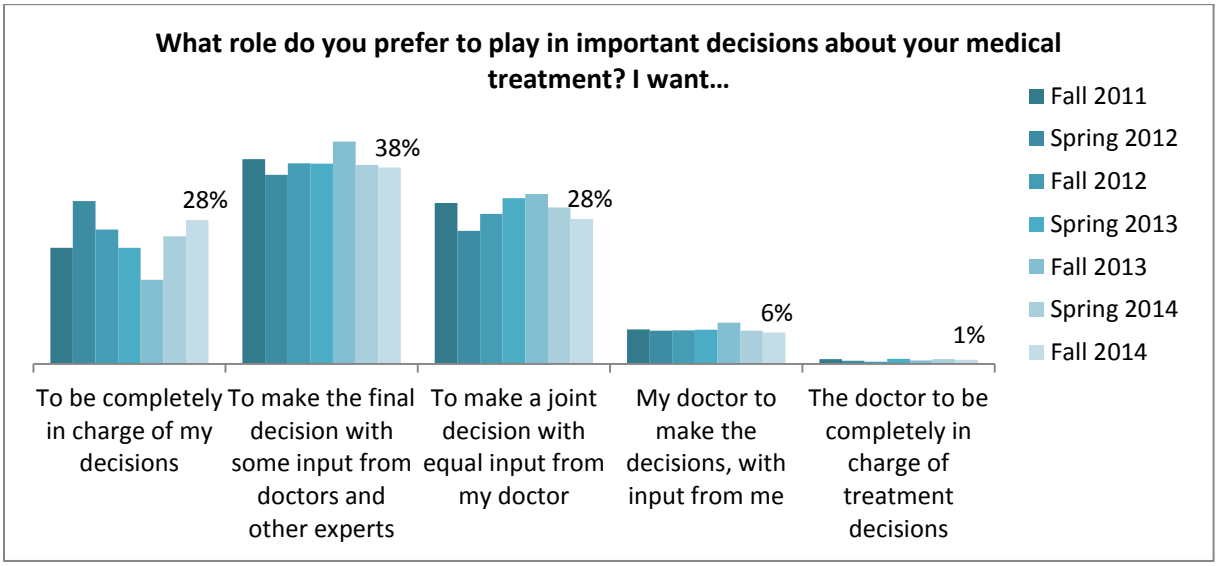
Preferred Role in Decisionmaking

Consumers were asked about their preferred level of involvement in decisions concerning their health. Three out of five reported that they prefer to take a lead role, 28% want to be completely in charge of decisionmaking, and 38% want to make the final decision with input from medical professionals. About 28% indicated that they prefer to make shared decisions with their doctors. A

[1] America's Health Insurance Plans, Center for Policy and Research. (2014, July). *January 2014 census shows 17.4 million enrollees in health savings account-eligible high deductible health plans*. Washington, DC: America's Health Insurance Plans.
[2] HealthDay News. (2014, August 15). *More employers moving to high-deductible health plans*. Retrieved from http://health.usnews.com/health-news/articles/2014/08/15/more-employers-moving-to-high-deductible-health-plans.
[3] New York Times. (2014, November 14). *Cost of coverage under Affordable Care Act to increase in 2015*. Retrieved from http://www.nytimes.com/2014/11/15/us/politics/cost-of-coverage-under-affordable-care-act-to-increase-in-2015.html?_r=0.
[4] Avalere. (2013, December 11). *Consumer deductibles vary significantly across exchange plans*. Retrieved from http://avalere.com/expertise/managed-care/insights/analysis-consumer-deductibles-vary-significantly-across-exchange-plans.
[5] James, J. (2013, February 14). Health policy brief: Patient engagement. *Health Affairs, 33*(6).
[6] Health Care Cost Institute. (2014, May 14). *Major U.S. health plans agree to give consumers free access to timely information about health care prices to foster greater transparency*. Retrieved from http://www.healthcostinstitute.org/news-and-events/major-us-health-plans-agree-give-consumers-free-access-timely-information-about-heal.

small minority of consumers want the doctor to be mostly (6%) or completely (1%) in charge of treatment decisions. Despite a few fluctuations, these percentages have remained relatively consistent since fall 2011.

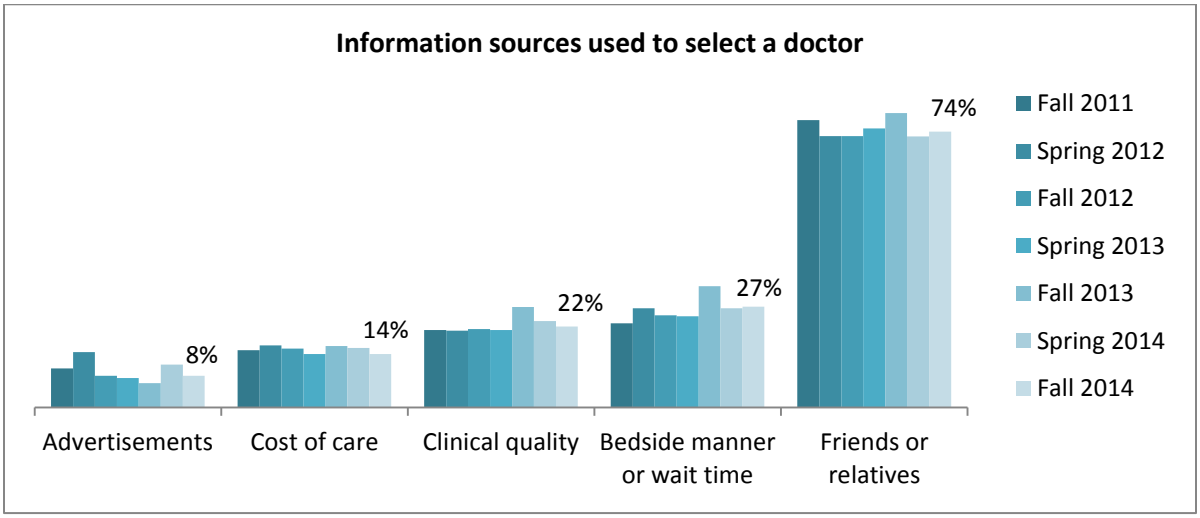
Exhibit 1: Role in Medical Decisions



Information Sources Used to Select a Doctor

When choosing a doctor, a majority of consumers (74%) continue to rely on the opinions and recommendations of friends and relatives. Only about one in four (27%) have used online ratings of a doctor's bedside manner or "wait time," and 22% have looked at online ratings of clinical quality to help them decide on a medical provider. Few consumers used data on the cost of care (14%) or selected a doctor based on newspaper, magazine, or television advertisements (8%).

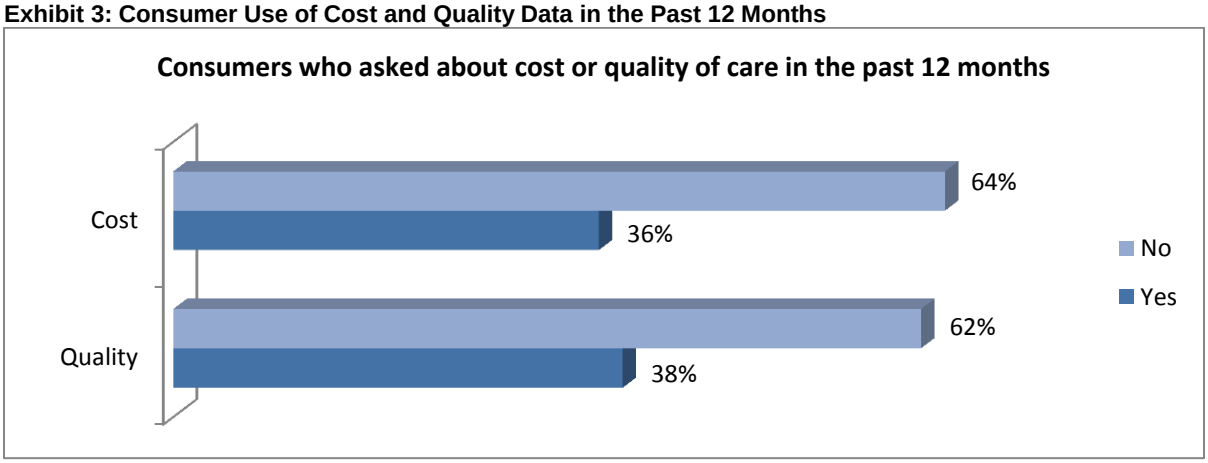
Exhibit 2: Information Sources Used to Select a Doctor



Evaluating the Cost and Quality of Care

Information about health care cost and quality is becoming increasingly available to consumers. However, survey findings show that fewer than two out of five consumers used price or quality data to inform their decisions in the past 12 months. Only 36% asked how much their health care visit would cost in advance, and 38% looked for health care quality ratings before they received services. These percentages are slightly lower than the spring 2014 survey (41% and 43%, respectively) but higher than survey results in 2011.

Exhibit 3: Consumer Use of Cost and Quality Data in the Past 12 Months



Of interest, almost one-quarter of consumers reported that they had used a cost comparison tool in the past. Of those who have used such a tool, 68% (17% out of 24%) found it to be useful or very useful. Another 23% found it to be somewhat useful. Furthermore, 77% reported that they would probably or definitely use the tool again.

Exhibit 4: Consumer Use of Cost Comparison Tool

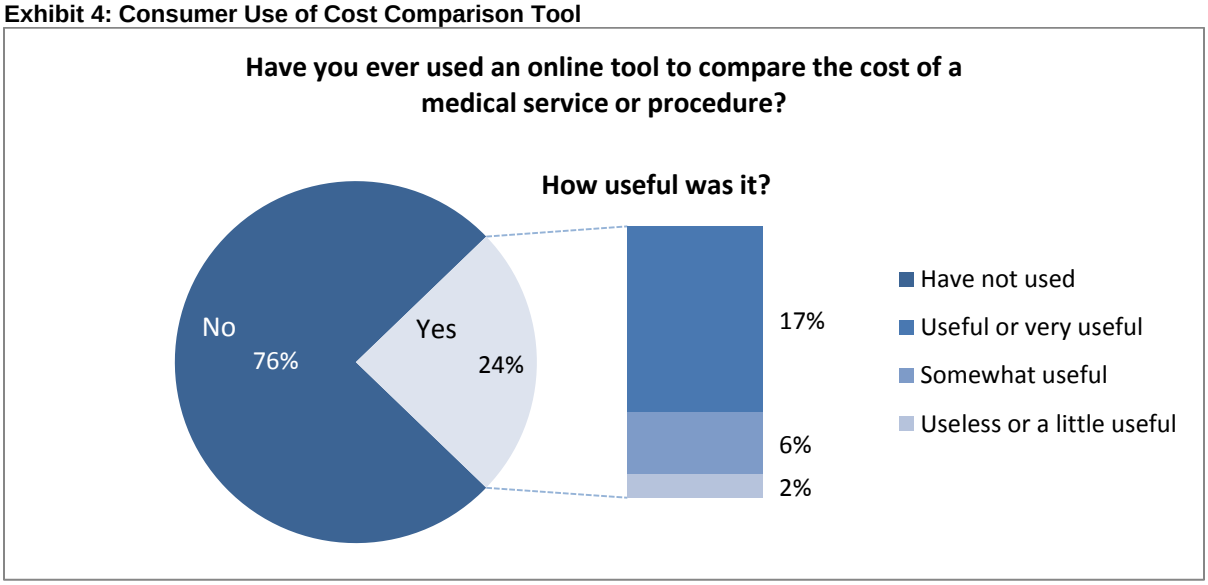
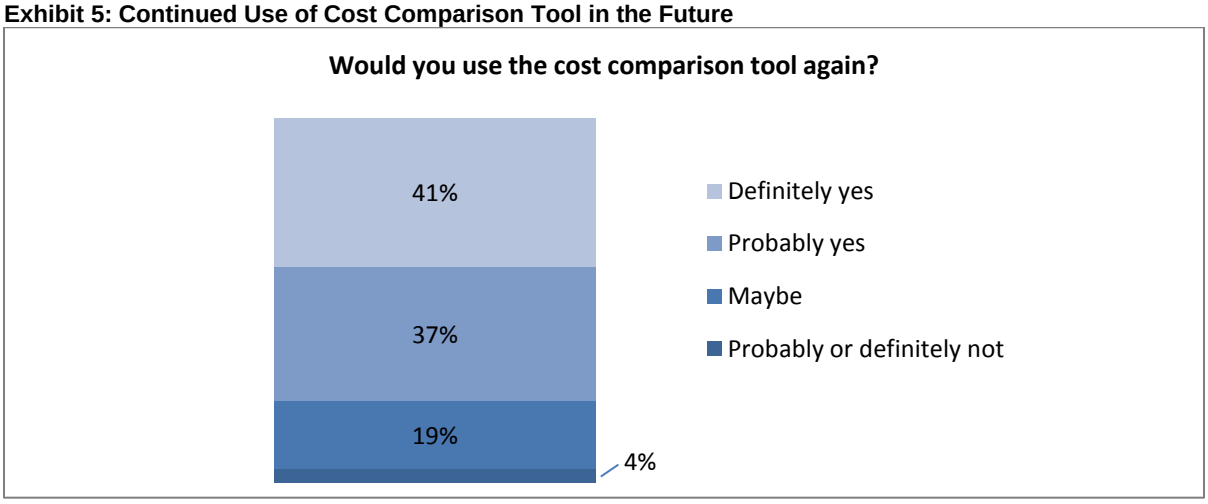
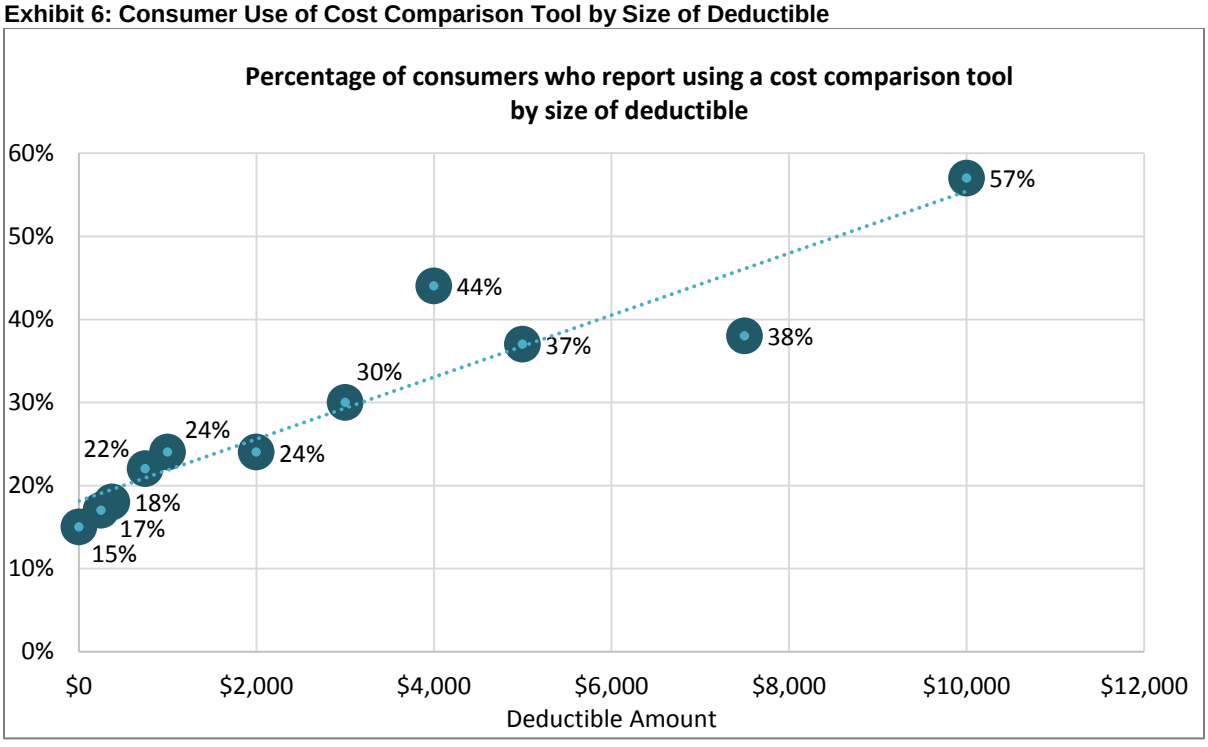


Exhibit 5: Continued Use of Cost Comparison Tool in the Future



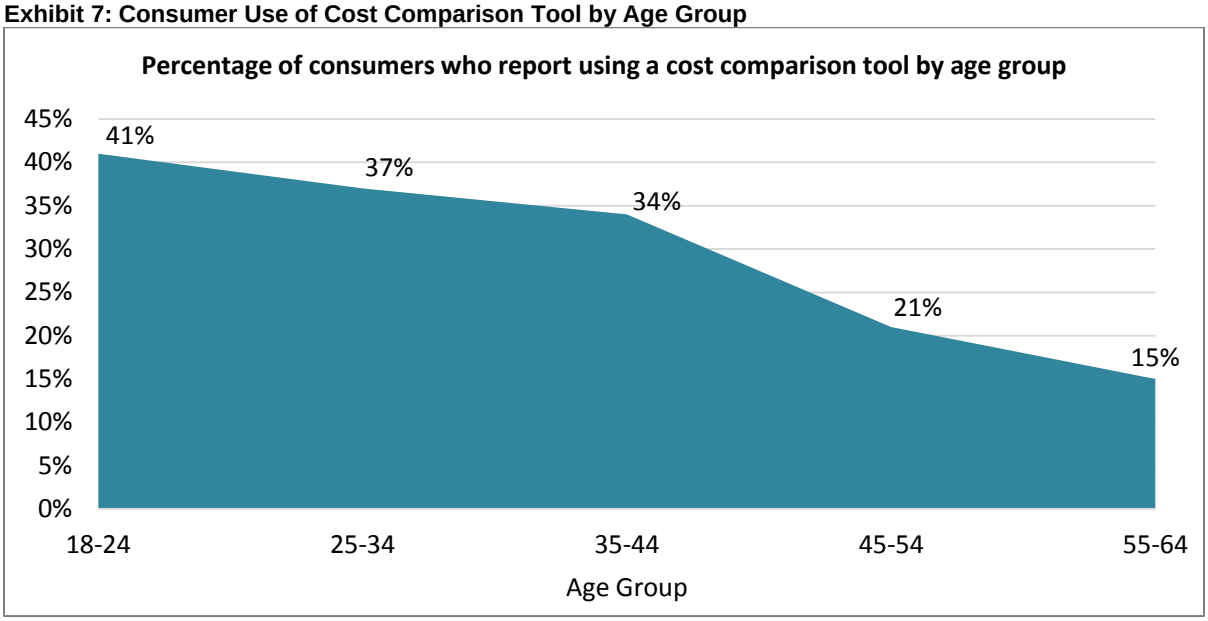
Reported use of a cost comparison tool was strongly related to the size of deductible the individual reported having in their health insurance coverage, suggesting a personal financial incentive to find savings. As shown, only 15%–18% of those with low deductibles had used a tool, while 30%–44% of those with deductibles between $3,000 and $8,000 had used a tool. Notably, almost 60% of those with a $10,000 deductible had compared prices.

Exhibit 6: Consumer Use of Cost Comparison Tool by Size of Deductible



Younger respondents were also most likely to report using a cost comparison tool. Consumers between the ages of 18 and 24 were nearly three times as likely (41%) to report using such tools as the oldest respondents (15%).

Exhibit 7: Consumer Use of Cost Comparison Tool by Age Group

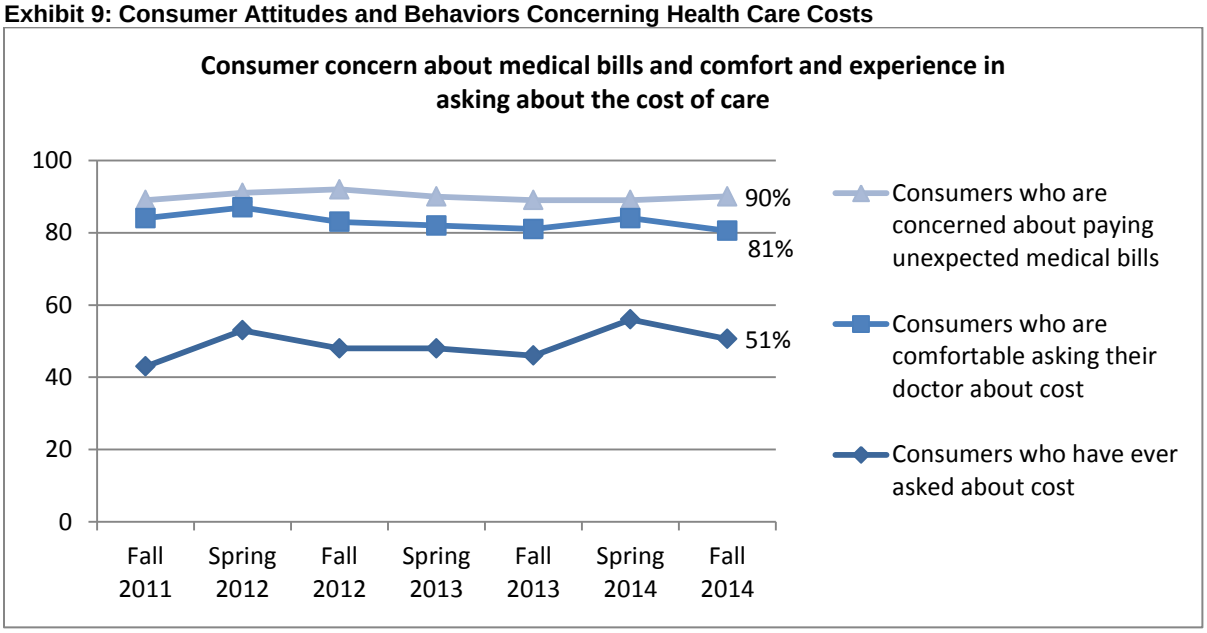


Despite positive experiences with the use of cost comparison tools, consumers generally remain skeptical of their ability to shop for high-value, low-cost health care. Consistent with previous findings, this survey found that only about one-third of consumers feel confident that they can shop for better health care prices, and around half of consumers believe that they can find better-qualified doctors by comparing performance results.

Exhibit 8: Confidence in Shopping for Better Care

Affordability of health care remains a concern for most consumers. The vast majority (90%) expressed some level of concern about their ability to pay for unexpected medical bills. Most (81%) reported that they would feel comfortable asking their doctors about the cost of health care services. Yet only 50% reported that they had ever made such inquiries. As seen by the longitudinal trends, consumers have been consistent in having a high level of concern but take action in asking questions about cost less often.

Exhibit 9: Consumer Attitudes and Behaviors Concerning Health Care Costs



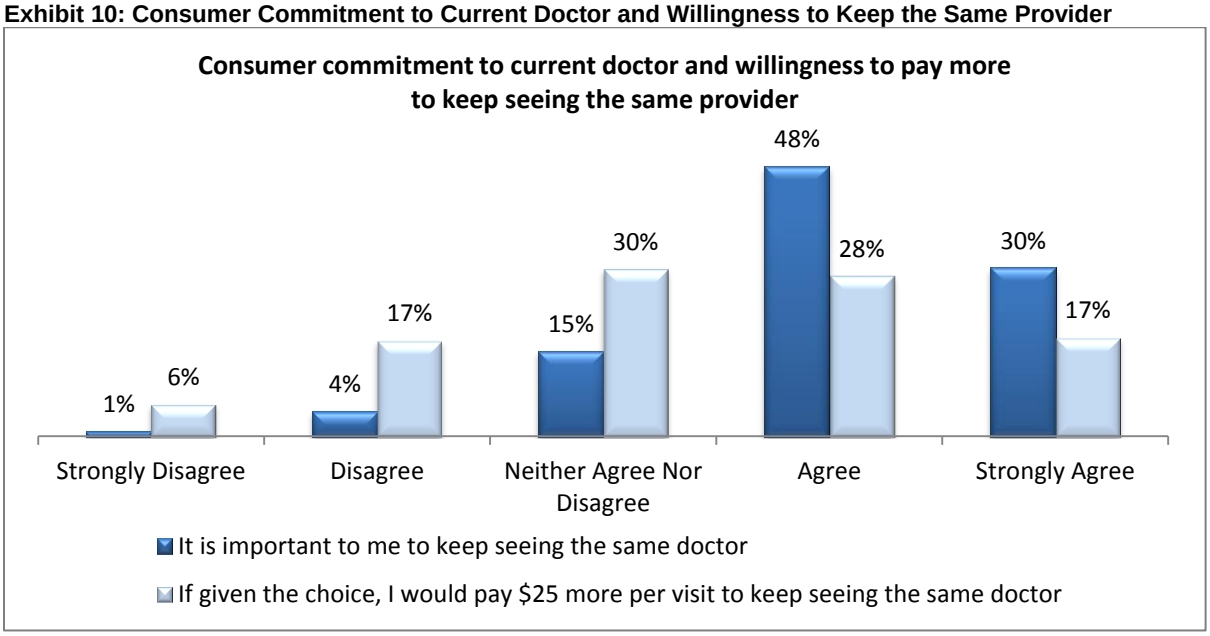
III. Opinions About Consumers' Own Doctors

Commitment to Existing Doctor

Some health insurance plans are designed to manage cost and quality of health care by narrowing consumers' options to a restricted list of providers (often called a network or narrow network). In some cases, consumers pay a higher fee or the full, undiscounted cost for seeing a provider outside their approved network. In this survey, consumers were first asked to rate their agreement with a statement about the importance of keeping their existing doctor. Almost 80% indicated that they were committed to their current provider.

These commitment levels shifted once consumers were faced with paying more. When asked whether they would be willing to pay an extra $25 per visit to keep their existing doctor, only 45% agreed or strongly agreed. When there is a cost to remaining loyal, a large portion of consumers indicate that they would switch rather than pay $25 per visit.

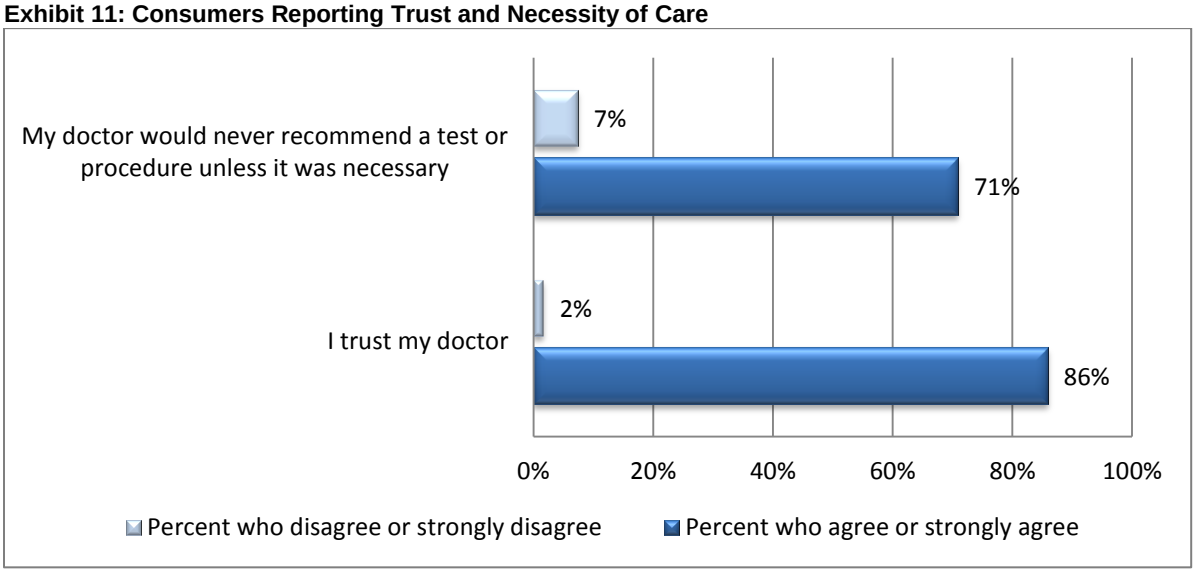
Exhibit 10: Consumer Commitment to Current Doctor and Willingness to Keep the Same Provider



Trust and Visit Dynamics

The vast majority of consumers (86%) reported trusting their doctors. This high level of trust may lead to a biased perception of the possibility that their doctor would ever deliver unnecessary care. Despite national estimates that approximately one-third of care is questionable or unnecessary,[7] only 7% of consumers disagreed with the statement, "My doctor would never recommend a test or procedure unless it was necessary."

Exhibit 11: Consumers Reporting Trust and Necessity of Care



[7] Institute of Medicine. (2012). *Best care at lower cost: The path to continuously learning health care in America*. Washington, DC: The National Academies Press.

Regarding their interactions with doctors during a visit, consumers described being largely content to let the doctor be in control (10%) or mostly take charge (51%). Only 39% reported coming prepared with questions and insisting on getting answers. Further, when asked specifically about aspects of their usual visits, more than 60% of consumers reported being asked their opinion in discussions with their doctor. Only 12% and 22% felt that they received too much or too little information from their doctor, respectively.

Exhibit 12: Likelihood of Asking Questions When Visiting the Doctor

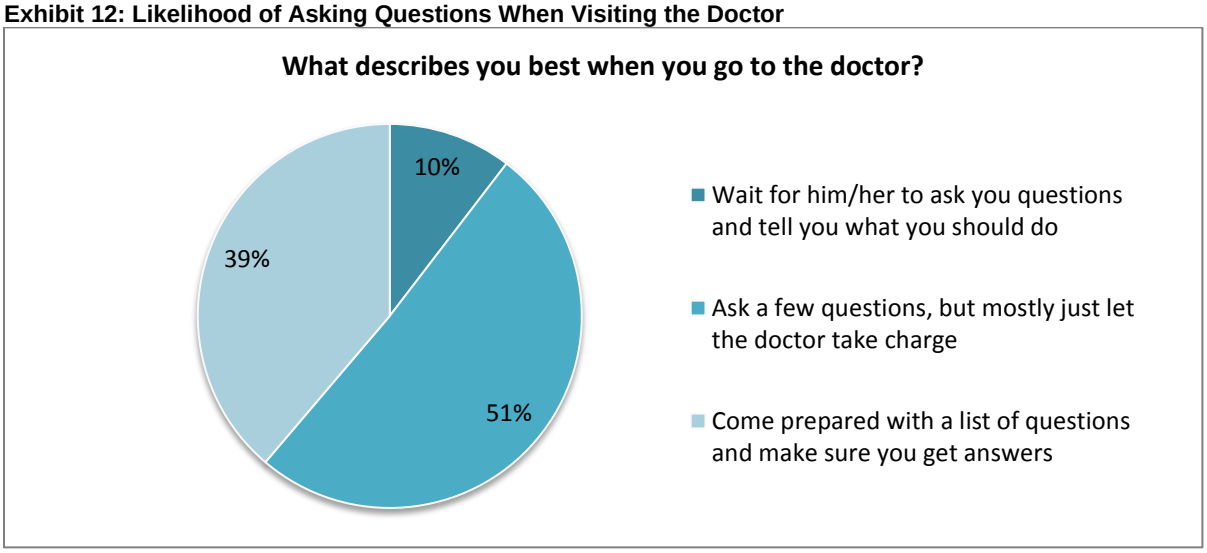
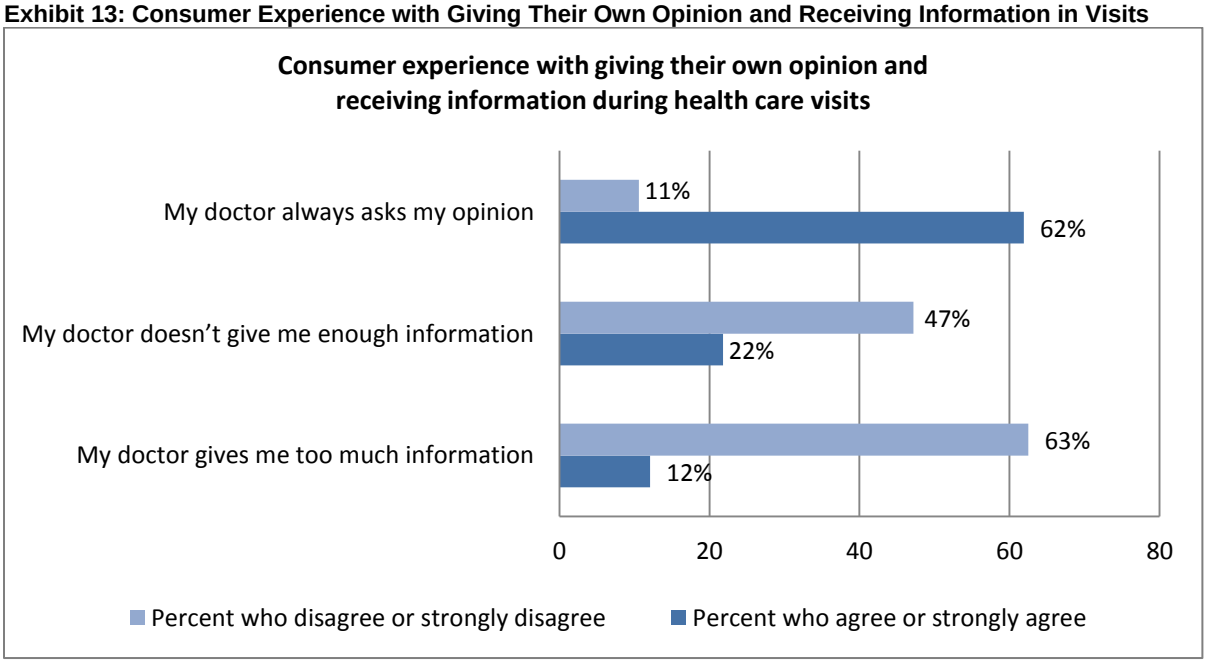


Exhibit 13: Consumer Experience with Giving Their Own Opinion and Receiving Information in Visits

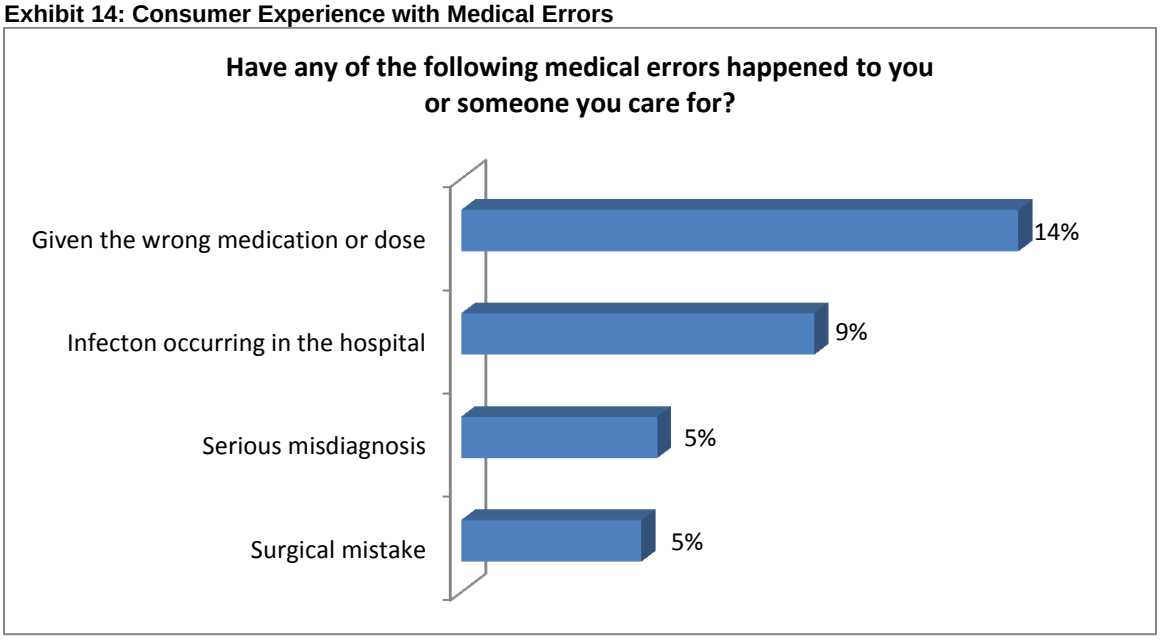


IV. Medical Errors and Perceptions of Safety

Experience with Medical Errors

Consumers were asked about their own experience with preventable medical errors, which claim the lives of an estimated 400,000 people each year.[8] One in seven (14%) reported that they or someone for whom they cared had been given the wrong medication or dosage. Others reported errors related to hospital-acquired infections (9%), serious misdiagnoses (5%), and surgical mistakes (5%). Overall, 31% of consumers had experienced an error on themselves or on a loved one.

Exhibit 14: Consumer Experience with Medical Errors

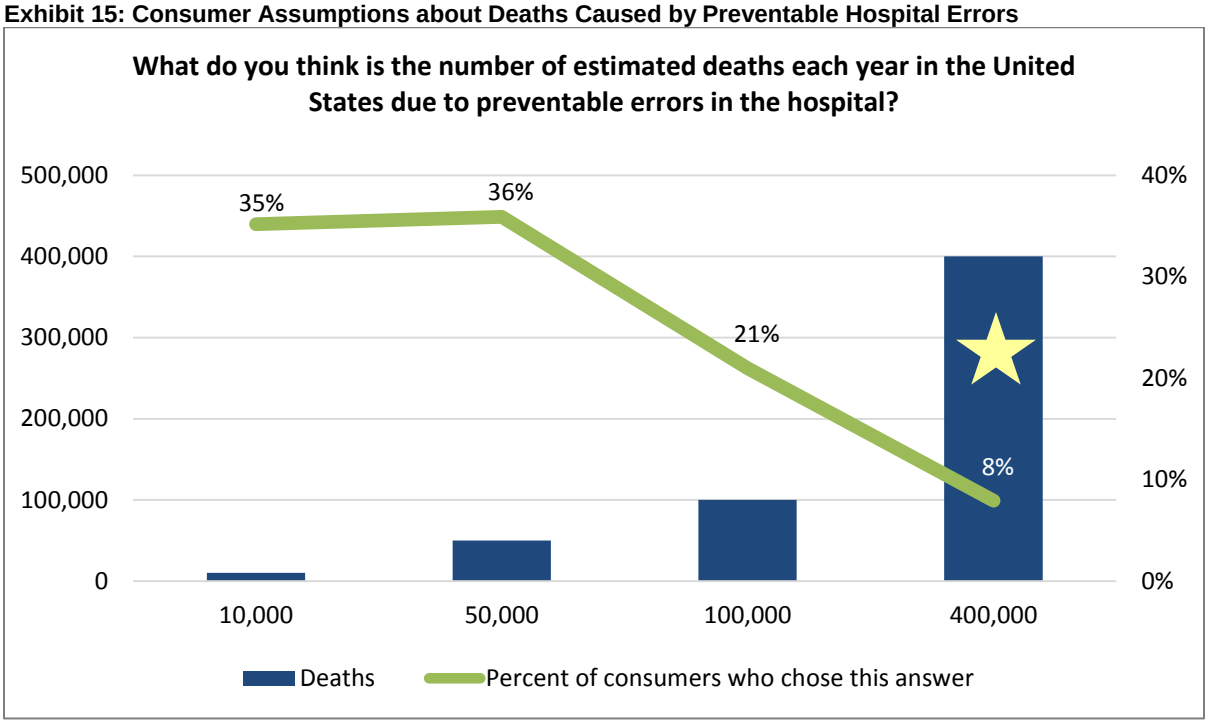


Knowledge of Medical Errors

To examine whether there is an awareness of the high rate of accidental, preventable deaths in hospital settings, consumers were asked to choose the actual death rate out of four responses. Options ranged from a low of 10,000 deaths per year to a high of 400,000 (the correct response). As shown, consumers were most equally likely (35% each) to choose the lowest two options (10,000 and 50,000). Only 8% selected the actual, highest option of 400,000.

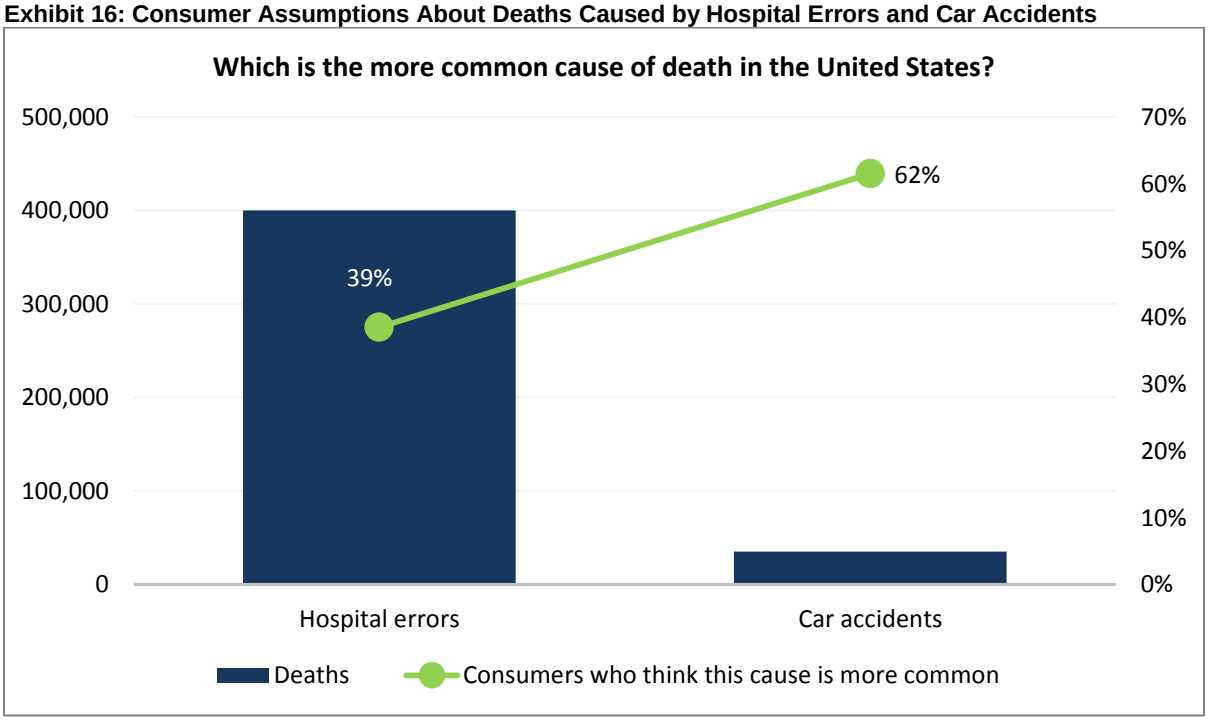
[8] James, J. (2013). A new, evidence-based estimate of patient harms associated with hospital care. *Journal of Patient Safety*, *9*(3), 122–128.

Exhibit 15: Consumer Assumptions about Deaths Caused by Preventable Hospital Errors



Additionally, the survey asked about the relative rates of death from car accidents and preventable hospital errors. Although more than 10 times as many people die each year from hospital errors, only 39% of respondents selected hospital errors as the more common cause of death.

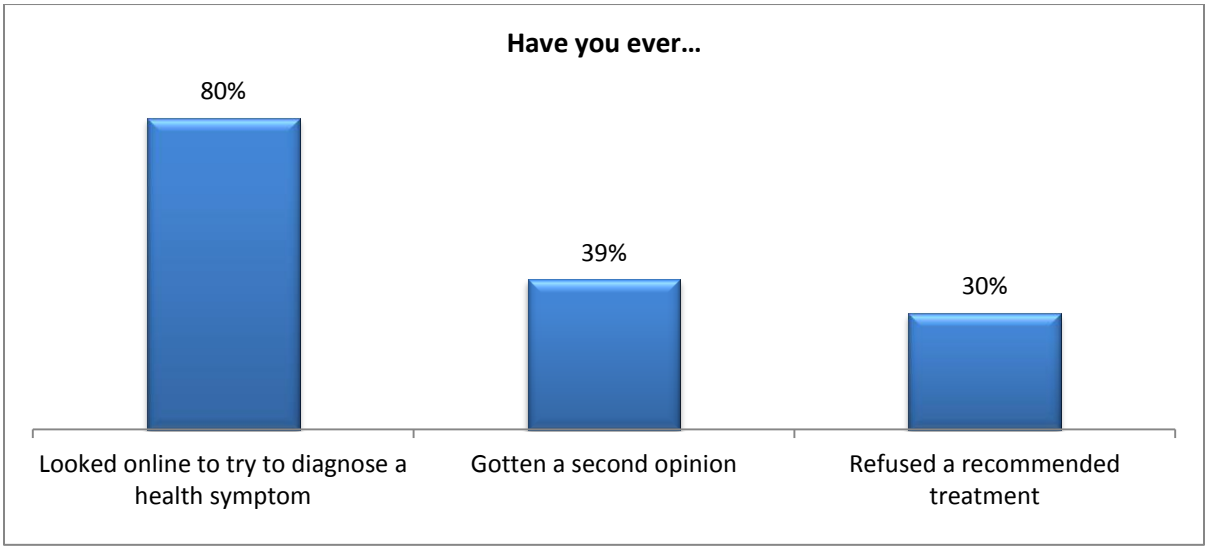
Exhibit 16: Consumer Assumptions About Deaths Caused by Hospital Errors and Car Accidents



Reducing the Risk of Medical Errors

Active and engaged consumers can take steps to protect against medical errors by seeking and sharing health information, asking questions, and consulting with various experts. This survey found that 80% of consumers have searched for information on the Internet about their health-related symptoms. About two out of five consumers (43%) have gone to more than one doctor to seek a second opinion on a diagnosis or treatment, and nearly one-third (30%) have refused a recommended treatment.

Exhibit 17: Health Care Behaviors That Can Minimize Risk of Medical Errors



V. Unexpected Medical Bills

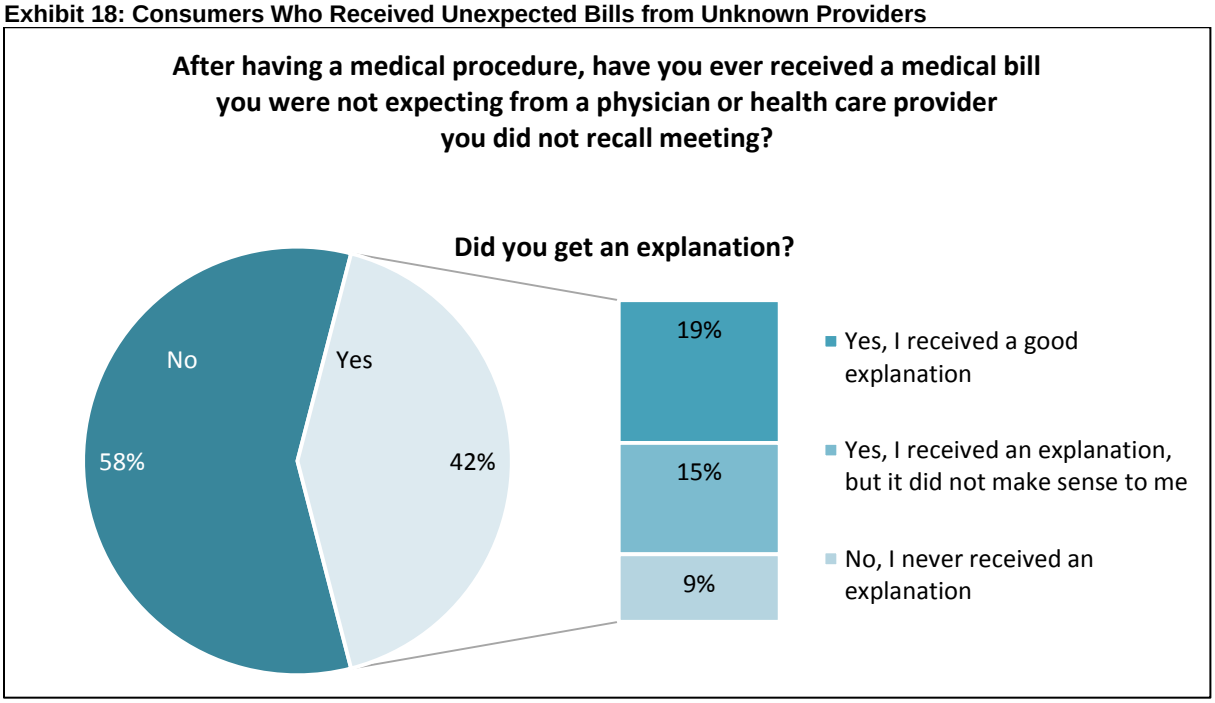
Experience with Unexpected Medical Bills

Since insurance and billing can be confusing, it is not uncommon for consumers to receive bills that they do not understand. Furthermore, a recent *New York Times* story[9] reported that patients often encounter "drive-by" fees from providers whom they did not know. To assess how commonly this occurs, the survey asked, "After having a medical procedure, have you ever received a medical bill you were not expecting from a physician or healthcare provider you did not recall meeting?"

More than 40% of respondents reported that they had received an unexpected bill. Of those, fewer than half had received a good explanation of the bill that they understood.

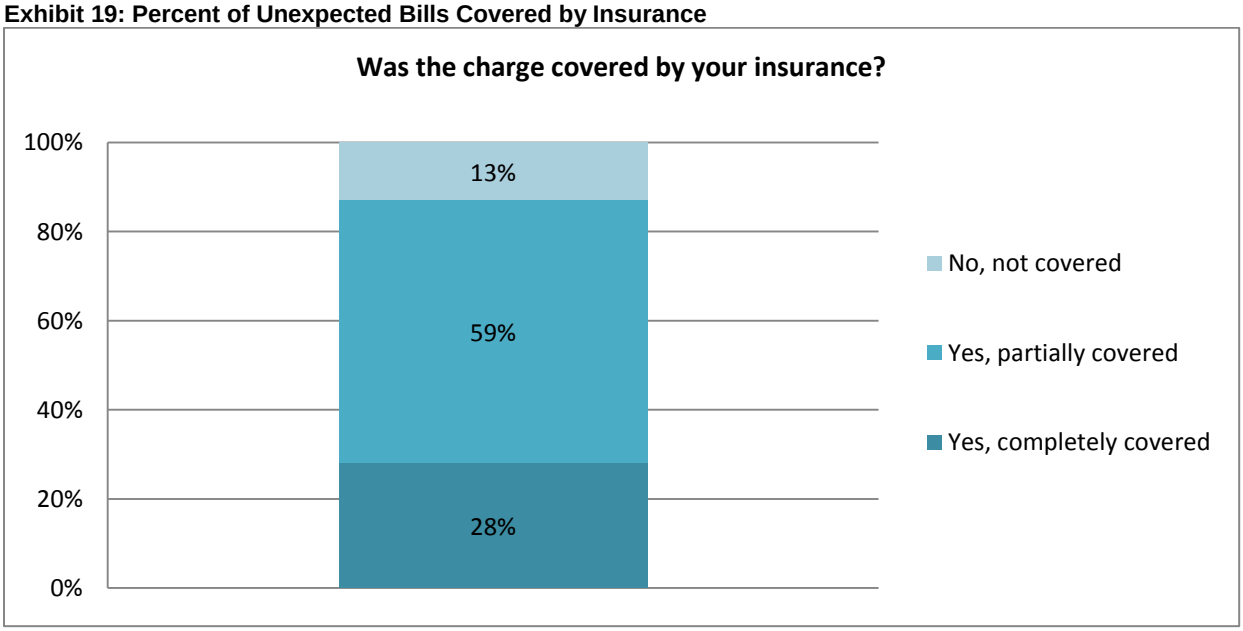
[9] Rosenthal, E. (2014, September 20). After surgery, surprise $117,000 medical bill from doctor he didn't know. *The New York Times*. Retrieved from http://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html?_r=1.

Exhibit 18: Consumers Who Received Unexpected Bills from Unknown Providers



Notably, less than one-third (28%) of the unexpected bills were covered in full by the person's health insurance. In most cases (59%), the bill was only partially covered.

Exhibit 19: Percent of Unexpected Bills Covered by Insurance



VI. Altarum Consumer Engagement (ACE) Measure

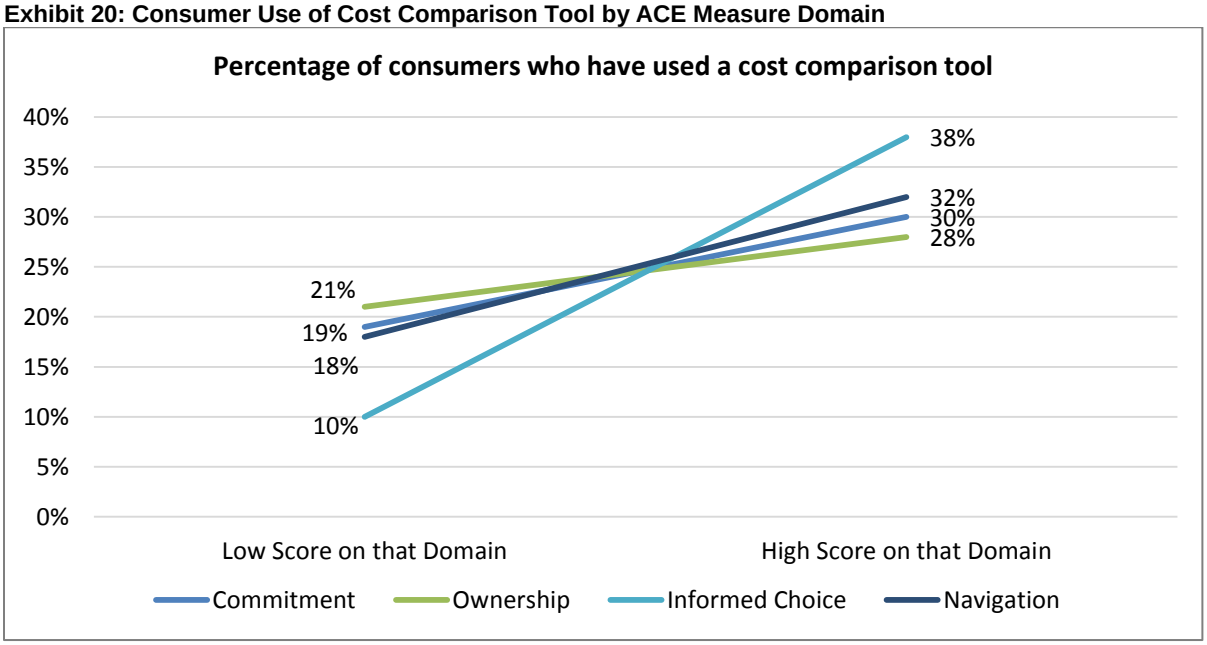
ACE Measure

In 2013, Altarum launched a tool to better understand the ways in which people engage in their health. The ACE Measure is a 21-item survey that assesses four domains of health engagement:

- The **ownership** domain assesses the extent to which a person feels responsible for his or her own health.
- The **commitment** domain measures a person's ability to manage his or her own health.
- The **informed choice** domain assesses the degree to which a person seeks and uses health-related information.
- The **navigation** domain measures how skilled a person is at using the health care system.

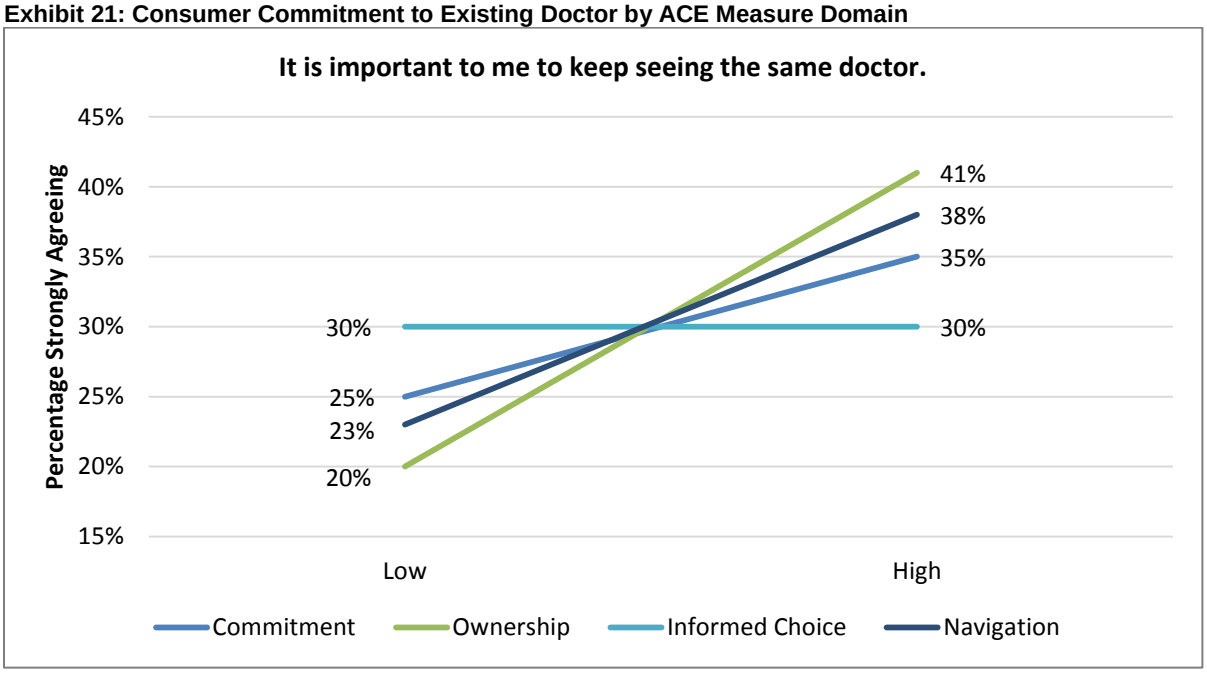
Consumers who took the fall 2014 *Altarum Institute Survey of Consumer Health Care Opinions* were also asked to respond to the ACE Measure questions. Respondents received a score for each domain, and these scores were split at the median to identify consumers with high and low levels of engagement. High scores in each domain were associated with a greater likelihood of having used a cost comparison tool. Notably, only 10% of those scoring low on the informed choice domain have used a tool, while 38% of those scoring high have done so. This may be expected as the informed choice domain measures information-seeking behavior.

Exhibit 20: Consumer Use of Cost Comparison Tool by ACE Measure Domain



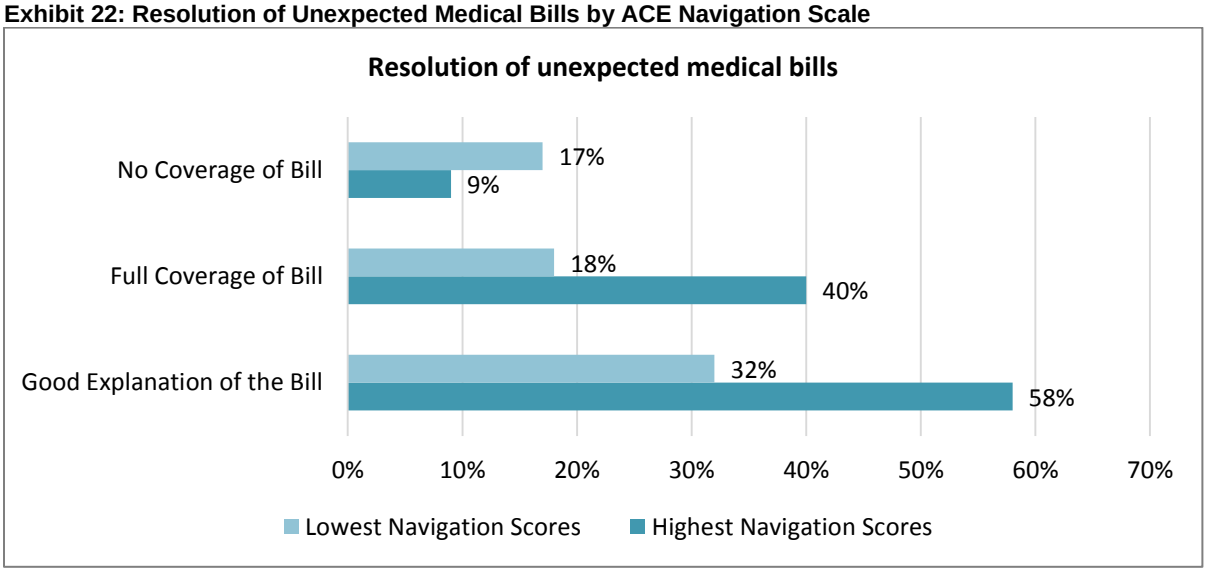
Some opinions also varied according to domain scores. Interestingly, when asked whether they agreed that it is important to keep seeing the same doctor, those scoring above the median in commitment, ownership, and navigation were more likely to agree strongly. However, consumers with both high and low informed choice scores did not differ in their agreement. This indicates that the information-seeking domain is less associated with physician loyalty than the other domains are.

Exhibit 21: Consumer Commitment to Existing Doctor by ACE Measure Domain



The navigation scale within the ACE measure indicates a person's degree of comfort and skills dealing with the health care system. This has practical application to the amount and quality of services the person receives. As an example, scores on the navigation domain influenced how likely the respondent was to have unexpected medical bills resolved.

Exhibit 22: Resolution of Unexpected Medical Bills by ACE Navigation Scale



Over 58% of those with the highest navigation scores received a good explanation of the bill and 40% had the bill fully covered by insurance. By comparison, among those with the lowest navigation scores, only 32% received a good explanation and only 18% (half as many) had the bill fully covered by insurance. While 17% of those with the lowest navigation scores received no insurance coverage for the bill, only half as many (9%) of those with high navigation scores received no coverage.

VII. Conclusion

The fall 2014 *Altarum Institute Survey of Consumer Health Care Opinions* finds that consumers have a high level of interest in being involved in their health and health care. Many consumers reported behaviors that reflect this desire to be engaged in their own health, such as playing a lead or shared role in decisions and asking questions about the price of services. Consistent with past survey findings, however, the majority most consumers are not using health care cost and quality data to influence decisions. Only one-quarter of respondents in this survey have used a cost comparison tool to look up the price of a health care services. Of those who did, the majority found it useful and would use it again.

Results of the survey suggest that consumers have very high levels of trust and are not aware of the risks in health care. While national experts estimate that one-third of health care services are unnecessary or redundant, only 7% of respondents believed that their own providers would provide unnecessary services. Furthermore, 92% underestimated the number of deaths due to hospital errors, most missing by a significant degree.

Lastly, this survey provides some illustrated examples using our measure of consumer engagement, the ACE, a tool that separates four independent domains of how consumers behave with regard to their health and health care. Elements of this measure are predictive of health behaviors and perceptions.

Appendix

Methodology

Survey respondents were paid participants from a nationwide panel maintained by Survey Sampling International, Inc. The survey was administered via the Internet in October 2014. Responses for any participant whose patterns indicated either a lack of understanding or hasty completion were dropped from the sample. This resulted in a total of 1,921 usable surveys.

Some questions are repeated in each semiannual survey. It should be noted that because different people respond to each survey, one cannot conclude with certainty that opinions have changed over time. However, consistent trends may be suggestive of a general shift in opinion.

Respondents

Survey respondents included a nationally representative sample of adults between the ages of 18 and 64 years old. More than half (59%) of all respondents were female. The majority (80%) identified themselves as White, 6% as African American, 6% as Hispanic, and 5% as Asian. About half were employed either full time (53%) or part time (12%), and 57% reported that they were married. Annual

household incomes ranged from less than $20,000 to more than $150,000, with a median income between $60,000 and $75,000.

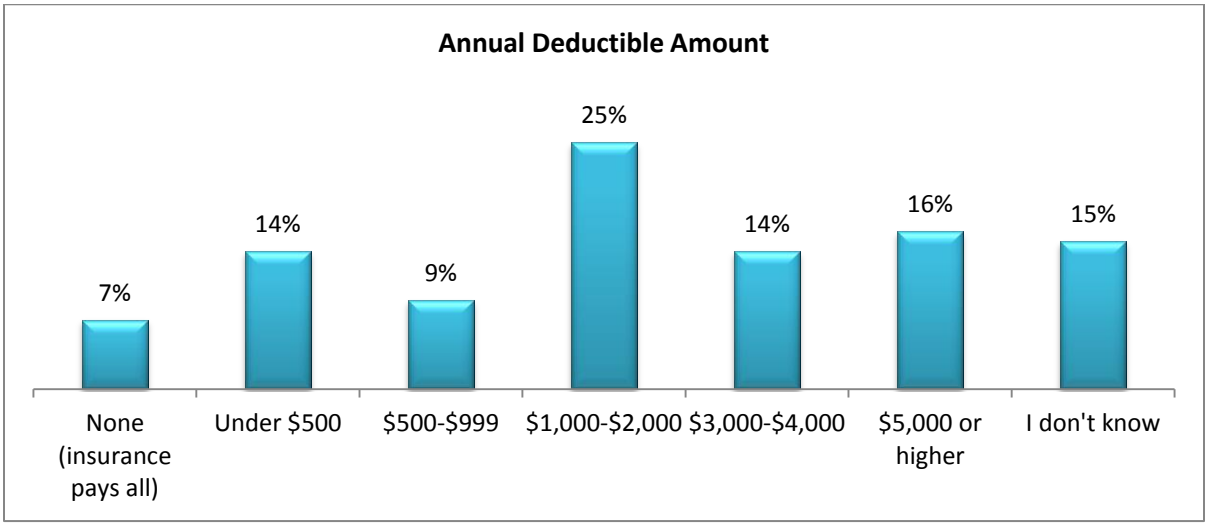
Exhibit 23: Demographic Characteristics of Survey Respondents

	Percentage		Percentage
Age Group (years)		**Income**	
18–24	7	Less than $20,000	4
25–34	22	$20,000–$29,999	7
35–44	18	$30,000–$39,999	11
45–54	20	$40-000–$49,999	9
55–64	33	$50,000–$59,999	13
		$60,000–$74,999	15
Gender		$75,000–$99,999	16
Male	41	$100,000–$149,999	14
Female	59	$150,000+	8
Education		**Race**	
Some high school	1	African American	6
High school	16	American Indian or Alaska Native	1
Some college	27	Asian American	5
College	34	Hispanic	6
Masters and postgraduate	18	White	80
Doctorate or professional	4	Other	2
Employment		**Marital Status**	
Full time	53	Married	63
Part time	12	Single	20
Unemployed	35	Separated/divorced/widowed	12
		Domestic partnership	5

Health Insurance Deductible Amounts

Annual health insurance deductibles varied from $0 to more than $10,000, with a median deductible between $1,000 and $2,000. Almost one in seven respondents reported a deductible above $5,000. About 15% of consumers reported that they did not know the amount of their health insurance deductible.

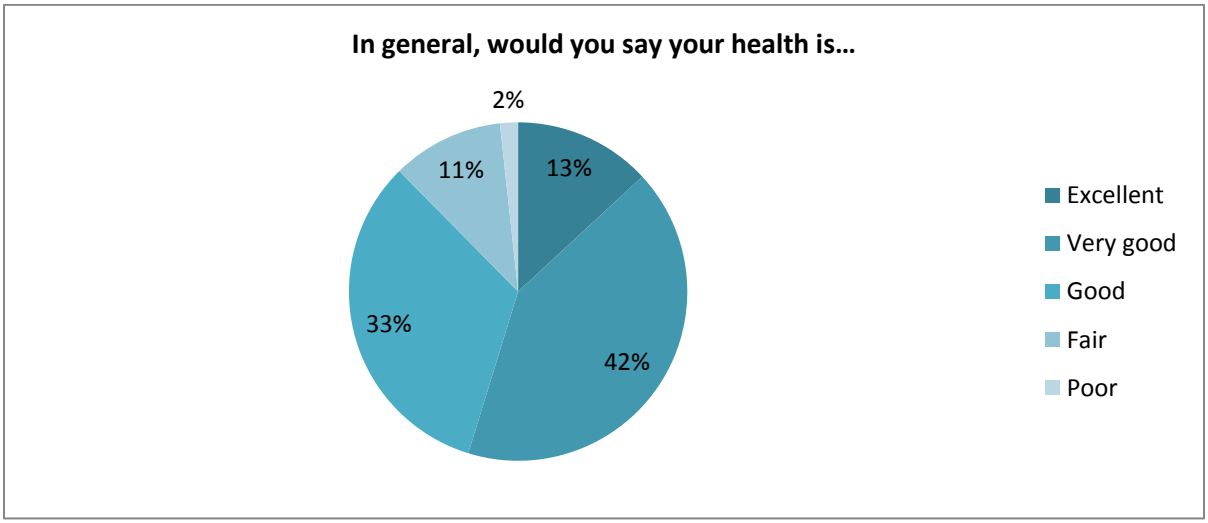
Exhibit 24: Annual Deductible Amount



Self-Rated Health Evaluation

Survey respondents were asked to rate the status of their own health on a scale from excellent to poor. About 13% perceived themselves to be in excellent health, and three-quarters reported themselves in very good (42%) or good (33%) health. About 13% rated their health as fair or poor.

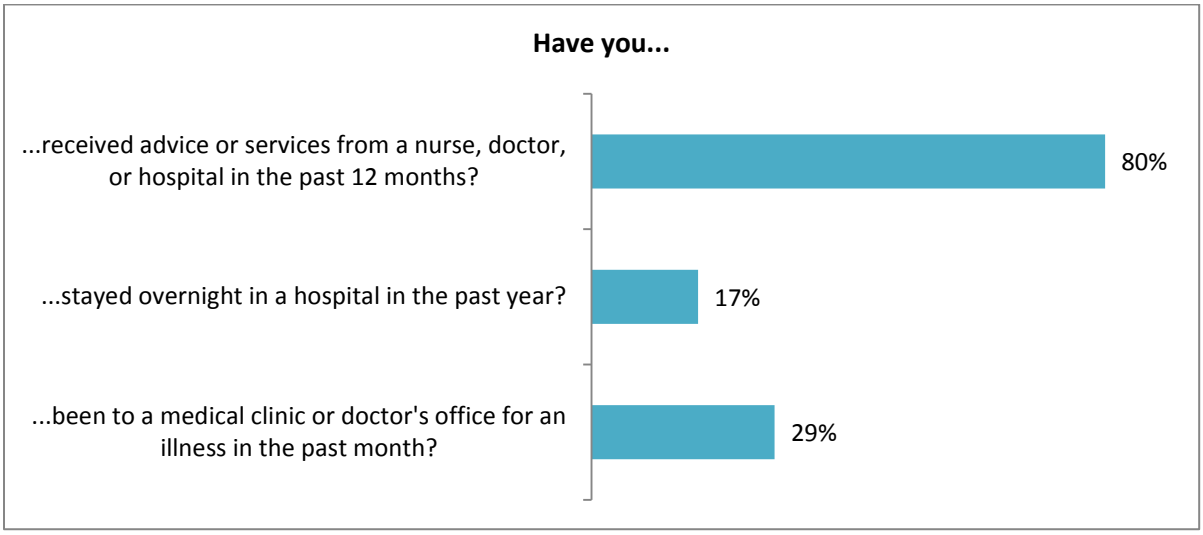
Exhibit 25: Self-Rated Health



Health Care Utilization

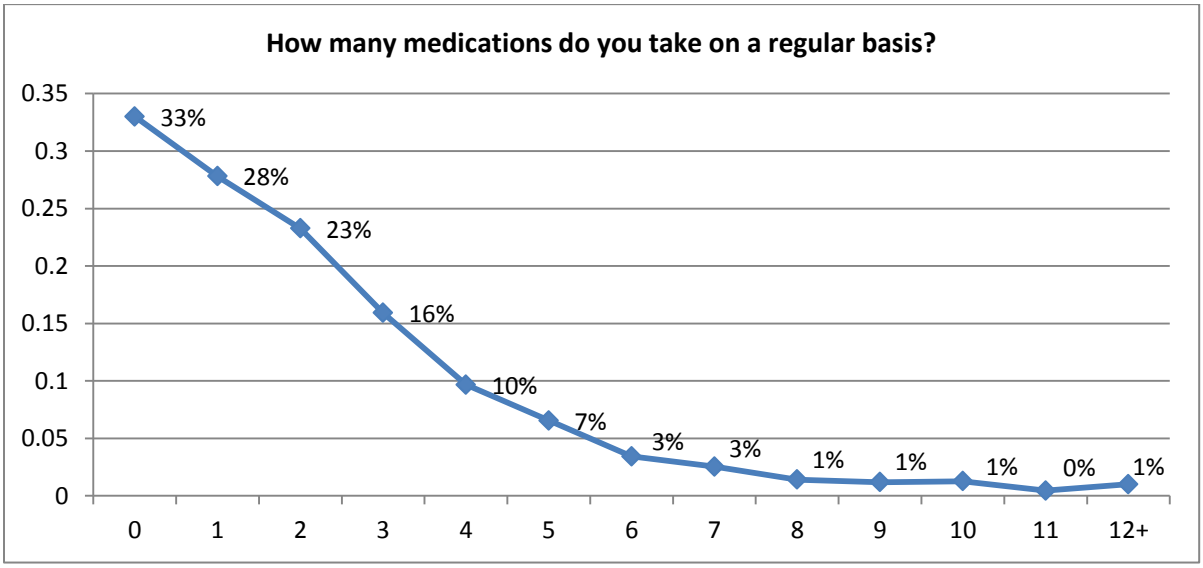
Over the past year, 80% of consumers received health care services, and 17% stayed overnight in a hospital. About 29% reported that they had visited a medical facility due to an illness within the past month.

Exhibit 26: Recent Health Care Utilization



Two-thirds of respondents take at least one medication prescribed by a doctor. Half of these individuals take one or two medications on a regular basis. Approximately 2% of respondents reported taking 10 medications regularly, and 1% reported taking 12 or more medications. Two out of five consumers (38%) reported that they sometimes forget to take their daily medicine. Within the past 2 weeks, 32% had forgotten to take their medication.

Exhibit 27: Number of Medications



NATIONAL HEALTH POLICY
FORUM

THE BASICS

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys:

Assessing Patient Experience

DECEMBER 18, 2014

In efforts to make health care more patient-centered, one approach is to give the patient more of a voice in evaluating the care he or she has received. Though the value and the mechanics of patient surveys and consumer comments via social media remain controversial, one set of survey instruments has established itself as a standard across a variety of public and private health programs: the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. These were developed in response to a growing conviction that information about the patient's experience of care is an essential tool when judging the performance of a health plan, organization, or provider.

HISTORY

The CAHPS program was created under the auspices of the federal Agency for Healthcare Research and Quality (AHRQ). For nearly 20 years, the agency has contracted with other organizations to produce CAHPS-related products, including surveys, evaluations, research studies, quality reporting formats, and quality improvement tools. The Centers for Medicare & Medicaid Services (CMS) is a federal partner. External organizations joining AHRQ and CMS to comprise the CAHPS Consortium overseeing CAHPS activity are the RAND Corporation, the Yale School of Public Health, and Westat.[1]

The initial CAHPS survey, released to the public in 1997 and fielded by CMS (then the Health Care Financing Administration, or HCFA) in 1998, focused on assessing the quality of health plans from their enrollees' perspective. (At that time, the HP in CAHPS stood for "health plan.") The scope has since broadened to include a range of health care settings and services.

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

National Health Policy Forum

2131 K Street, NW
Suite 500
Washington, DC 20037

T 202/872-1390
F 202/862-9837
E nhpf@gwu.edu
www.nhpf.org

The role initially envisioned for CAHPS data was to help consumers choose a health plan and to help plans and providers identify and carry out quality improvement initiatives. Over time, the data have also been incorporated in various pay-for-performance models; CAHPS data collection and reporting are required under some federal programs.

SURVEY DESIGN

According to AHRQ, CAHPS program goals are twofold:

- To develop standardized surveys that organizations can use to collect comparable information on patients' experience of care
- To generate tools and resources to support the dissemination and use of comparative survey results to inform the public and improve health care quality

Design principles underlying the surveys are:

- Focus on topics for which consumers are the best or only source of information
- Ask patients to report on their experience of care, as opposed to "satisfaction"; emphasize elements that patients view as most important
- Base questions, protocols, and reports on scientific development and testing
- Standardize questions and processes to ensure that data collection, analyses, and reports are consistent across the users of a given survey
- Reflect input from a broad spectrum of stakeholders
- Make surveys available in the public domain

Nearly all surveys are available in Spanish as well as English; guidelines exist for translation into other languages. CMS offers translations in several languages of the surveys it requires.

SURVEYS AVAILABLE FOR USE

CAHPS surveys most regularly in use are the health plan survey, the hospital survey (HCAHPS), and the clinician & group

survey (CG-CAHPS). Core questions in each include substantive items reflecting critical aspects of care, along with screening questions that allow respondents to skip questions not relevant to their experience (for example, pain control if they were not in pain), and demographic characteristics. Where appropriate, the surveys have adult (18 and over) and child versions, the latter meant to be completed by a parent. Supplemental question sets, such as for children with chronic conditions or people with mobility impairment, are available for users (see below) to add at their option.

The **health plan survey** solicits enrollees' experience in obtaining health care under commercial, Medicaid, Children's Health Insurance Program (CHIP), and Medicare Advantage plans, with somewhat different versions for each. Questions in this survey are clustered in the following categories:

- Getting needed care
- Getting care quickly
- How well doctors communicate
- Health plan information and customer service
- Rating the health plan[2]

HCAHPS asks patients about their experience with care delivered during an inpatient hospital stay in an acute care facility. HCAHPS categories are:

- Care from nurses
- Care from doctors
- The hospital environment
- The patient's experience in this hospital [relates to getting help with using the bathroom or a bedpan, understanding medication, pain control]
- When the patient left the hospital [discharge process]
- The patient's understanding of their care after leaving the hospital[3]
- Overall rating of the hospital

CG-CAHPS asks about patient experience with ambulatory care delivered by primary care or specialty physicians and their staffs. This survey has been adapted in cooperation with NCQA (National Committee for Quality Assurance) for use in its Patient-Centered Medical Home (PCMH) Recognition Program. CMS also uses a version specially geared to Accountable Care Organizations (ACOs). CG-CAHPS categories are:

- Getting timely appointments, care, and information
- How well providers communicate with patients
- Whether office staff are helpful, courteous, and respectful
- The patient's rating of the provider[4]

The CG-CAHPS survey has two core formats. One solicits a patient's ambulatory care experiences over the course of the previous 12 months; another focuses on the patient's most recent visit. A survey may incorporate PCMH-related items in addition to the core questions.

Other versions of CAHPS are tailored to home health care, in-center hemodialysis, nursing homes, surgical care, clinics delivering care to American Indians, dental plans, and mental and/or substance abuse services. CMS is testing versions for emergency departments and ambulatory surgical centers.

CAHPS USERS

Once released into the public domain by the CAHPS Consortium, CAHPS surveys may be used by any organization for its own purposes.[5] CAHPS materials include instructions on how to construct an appropriate sample frame. For each survey, a random sample is drawn from the relevant population: health plan enrollees, those discharged from a hospital or patients who have had at least one visit to the selected provider in the appointed time frame. Survey contractors (who must be approved by CMS under federal plans) are permitted a variety of administration options: mail, telephone, email, internet, or a combination.

Health plans or delivery systems may choose to survey their commercial members as well as those enrolled in a public plan, using results for quality improvement, provider selection or compensation, or assisting consumers to make choices. AHRQ

maintains a CAHPS database of survey data voluntarily submitted by users, which they may then access to compare their results to regional and national averages and other benchmarks. AHRQ also offers guidelines on how to communicate results to consumers and other stakeholders.

CMS, NCQA, the Veterans Health Administration (VHA), and the American Board of Medical Specialties (ABMS) are key users of CAHPS.

CMS incorporates CAHPS items in data analyzed and reported in a variety of programs. The health plan survey has been administered to Medicare beneficiaries since 1998; in addition to the fee-for-service program instrument, versions exist for Medicare Advantage (MA) and Prescription Drug Plans (PDPs). Results from the Medicare CAHPS surveys are published in the Medicare & You handbook and on the Medicare Options Compare Web site. MA and PDP data are part of the star ratings calculations for these plans. Many state Medicaid programs also employ this survey.

Hospitals subject to the Inpatient Prospective Payment System (IPPS) must collect and submit HCAHPS data in order to receive their full annual payment updates. (Non-IPPS hospital participation is voluntary.) CAHPS data is incorporated in the calculation of value-based incentive payment under the Hospital Value-Based Purchasing Program, and also forms part of the Hospital Compare information made available online to consumers. CMS is preparing to go farther by constructing a separate HCAHPS star rating system to add to Hospital Compare.[6]

ACOs in both the Pioneer and Shared Savings programs must report CAHPS data in the ACO format. Physicians and other eligible professionals must report CAHPS data under the Physician Quality Reporting System (PQRS); the data are also being incorporated along with other quality data in Physician Compare. Penalties for failure to report begin in 2015.

NCQA makes CAHPS information part of its accreditation and performance recognition programs. The **VHA** uses HCAHPS and CG-CAHPS to solicit patient experiences in VHA and contracted hospitals and clinics. The **ABMS** requires submission of "doctor communications" data as part of the maintenance of certification process.

ONGOING REFINEMENTS

Some providers continue to express reservations about a growing reliance on CAHPS data. Physicians, for example, have observed that pressure to keep their "scores" up may cause some to respond to patient desires even when these conflict with clinical best practice, such as prescribing antibiotics for viral ailments or opiates for moderate pain. Others suggest improvements to methodology or changes in the weighting of CAHPS measures vis-à-vis clinical quality measures in pay-for-performance reimbursement formulas.

The CAHPS Consortium continues to seek stakeholder input and to try to align and update the various surveys. For example, the Consortium recently has recommended that the CG-CAHPS 12-month survey be recast as a 6-month look-back to achieve consistency with versions being implemented by CMS for ACOs and in the PQRS. As pay-for-performance and value-based reimbursement models continue to gain traction, it seems certain that patient experience will remain an important component.

ENDNOTES

1. Agency for Healthcare Research and Quality, "CAHPS Glossary," https://cahps.ahrq.gov/about-cahps/glossary/index.html.

2. Full questionnaire available at https://cahps.ahrq.gov/surveys-guidance/survey5.0-docs/2151a_engadultcom_50.pdf.

3. Full questionnaire available at www.hcahpsonline.org/Files/Appendix%20D%20-%20CAHPS%20Hospital%20Survey%20%28English%29.pdf.

4. Full questionnaire available at https://cahps.ahrq.gov/Surveys-Guidance/CG/index.html.

5. Agency for Healthcare Research and Quality, "CAHPS: Assessing Health Care Quality from the Patient's Perspective, https://cahps.ahrq.gov/about-cahps/cahps-program/cahps_brief.html.

6. Centers for Medicare & Medicaid Services, "HCAHPS Star Ratings Technical Notes," www.hcahpsonline.org/StarRatings.aspx.

Prepared by Lisa Sprague, MBA.
Please direct questions to lsprague@gwu.edu.

VIEWPOINT

In Defense of the Employer Mandate
Hedging Against Uninsurance

John E. McDonough, DrPH, MPA
Department of Health Policy and Management, Center for Public Health Leadership, Harvard School of Public Health, Boston, Massachusetts.

Eli Y. Adashi, MD, MS
Warren Alpert Medical School, Brown University, Providence, Rhode Island.

After 2 delays, section 1513 of the Affordable Care Act (ACA)—shared responsibility for employers—is finally slated to go into effect on January 1, 2015.[1] The so-called employer mandate requires large employers to offer affordable "minimum-value" health insurance to full-time employees and their dependents (to age 26 years) or be subject to annual penalties if at least 1 employee receives premium tax credits for the purchase of individual health insurance via an exchange.[1] Designed to maintain employer-sponsored coverage and to offset the public cost of subsidies to eligible employees in need of health insurance, the employer mandate constitutes an important component of the ACA. However, in the wake of the recent midterm elections, this provision is likely to be singled out for repeal by the newly elected Republican-controlled Congress. In this Viewpoint, we trace the origins of the employer mandate provision, delineate its all-important rationale, and discuss the likelihood and consequences of its potential repeal.

> The core value undergirding the shared responsibility principle is the realization that all of the major stakeholders of the health care system must contribute something if comprehensive health care reform is to be accomplished.

How to engage employers in health care reform was the subject of heated debates during the drafting the ACA. For its part, the House of Representatives favored the notion termed *pay or play* wherein employers are required to offer health insurance to employees or be taxed to offset the public cost of subsidized alternatives. Opposed by business associations and deemed unpassable in the Senate, the pay or play model was not formally proposed. In its stead, the more acceptable notion of assessing employers only for employees in receipt of premium tax credits was adopted. The resultant "shared responsibility for employers" provision was crafted to reduce the likelihood that employers would stop offering to subsidize health insurance.[1]

As such, the provision (now part of the Internal Revenue Code) requires large employers (>100 full-time employees) to offer health insurance to 70% and 95% of their workforce in 2015 and 2016, respectively.[1] Employers with 50 to 99 full-time employees need not comply until 2016.[1] Failure to provide health insurance will result in an "employer shared responsibility payment" of $2000 for every full-time employee (beyond the first 30) when at least 1 obtains a subsidy toward the purchase of individual health insurance through an exchange.[1] Failure to provide affordable (≤9.5% of income) minimum-value (≥60% of total allowed costs) health insurance will be assessed at $3000 for each full-time employee in receipt of a subsidy.[1]

The core value undergirding the shared responsibility principle is the realization that all of the major stakeholders of the health care system must contribute something if comprehensive health care reform is to be accomplished. Stated differently, making the ACA work requires a measure of responsibility from consumers, hospitals, physicians, insurance companies, drug makers, medical device makers, home health agencies, labor, and—because of section 1513—large employers. This same notion proved essential in the passage of the 2006 Massachusetts Health Care Reform Act that served as a partial model for the ACA. Indeed, despite "employer shared responsibility payments" limited to $295 per uninsured employee per year, a far lower contribution than that required by the ACA, Massachusetts continues to lead the nation in the provision of employer-sponsored health insurance.[2] Without some form of shared responsibility, an important principle of health reform will be abandoned.

Shared responsibility is a public good, especially for employers who might otherwise be inclined to shift the cost of employer-sponsored health insurance onto the federal government and thereby the taxpayers. It follows that the employer mandate provision has a meaningful role to play in preserving employer-sponsored health insurance. In its absence, anywhere from 200 000 to 1 million individuals will lose employer-sponsored coverage per projections of the Urban Institute and the US Congressional Budget Office (CBO), respectively.[3,4] As such, these estimates are consistent with the findings of a 2014 survey of 2569 employers according to which 16%, 6%, and 4% of employers with 50 to 199, 200 to 499, and 500 or more employees are likely to terminate employer-sponsored health insurance within the next 5 years.[5] A 2011 survey of more than 1300 employers revealed that 30% of employers will cease offering employer-sponsored health insurance in the years past 2014.[6] The above notwithstanding, the ACA has not and will not forestall all erosion of employer-sponsored coverage. Still, what it will do is consistent with the stated prefer-

Corresponding Author: Eli Y. Adashi, MD, MS, Warren Alpert Medical School, Brown University, 101 Dudley St, Providence, RI 02905 (eli_adashi@brown.edu).

ence of the US public as evidenced by a 2013 Kaiser Tracking Poll wherein 57% of respondents were in support of an "employer mandate/penalty for large employers."[7]

The 10-year cost (2014-2024) of repealing the employer mandate is estimated by the CBO to approach $151 billion.[8] Finding $151 billion in federal "pay-fors" will constitute a serious challenge for the new Republican Congress. Moreover, Congress will need to consider the "opportunity cost" of yet other legislative priorities, the realization of which would be rendered more difficult by a potential repeal of the employer mandate. One recurrent example of a yet to be accomplished task is the repeal of the Sustainable Growth Rate (SGR) formula by March 31, 2015, at which point Medicare payments to physicians are projected to decrease by 21.2% unless Congress addresses the estimated $144 billion offset.[9] The choice between repealing the employer mandate or the SGR formula—both costly and thus likely mutually exclusive—is hardly a trivial one: eliminate the employer mandate at the risk of increasing the ranks of the uninsured or address the SGR formula with the welfare of Medicare beneficiaries in mind. Neither option is likely to be considered before the next congressional session begins in 2015.

At this time, the employer mandate provision is at an ironic and dichotomous juncture. On one hand, the delayed implementation of the employer mandate is the subject of a lawsuit (*US House of Representatives v Burwell*). A related earlier lawsuit by the Association of American Physicians and Surgeons (*AAPS v Koskinen*) has been dismissed. On the other hand, the employer mandate is being targeted for repeal. Suing to protest the "unilateral" delay of the implementation of the employer mandate while targeting it for repeal—at the same time—is a telling metaphor for the present state of health policy thinking on Capitol Hill. May cooler heads prevail.

ARTICLE INFORMATION

Published Online: December 18, 2014. doi:10.1001/jama.2014.17658.

Conflict of Interest Disclosures: The authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr McDonough has contributed to the reelection campaign of President Barack Obama. No other disclosures are reported.

REFERENCES

1. Internal Revenue Service. Questions and answers on employer shared responsibility provisions under the Affordable Care Act. May 13, 2014. http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act. Accessed December 3, 2014.

2. State Health Access Data Assistance Center. *State-Level Trends in Employer-Sponsored Health Insurance: A State by State Analysis*. Minneapolis: University of Minnesota; April 2013:47. http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf405434. Accessed December 3, 2014.

3. Jost T. Repeal, and replace, the employer mandate. *Health Affairs* blog. June 4, 2014. http://healthaffairs.org/blog/2014/06/04/repeal-and-replace-the-employer-mandate/. Accessed December 3, 2014.

4. Blumberg LJ, Holahan J, Buettgens M. *Why Not Just Eliminate the Employer Mandate?* Washington, DC: Urban Institute; May 2014. http://www.urban.org/UploadedPDF/413117-Why-Not-Just-Eliminate-the-Employer-Mandate.pdf. Accessed December 3, 2014.

5. Mercer. Modest health benefit cost growth continues as consumerism kicks into high gear. November 19, 2014. http://www.mercer.com/newsroom/modest-health-benefit-cost-growth-continues-as-consumerism-kicks-into-high-gear.html#10. Accessed December 3, 2014.

6. Singhal S, Stueland J, Ungerman D. *How US Health Care Reform Will Affect Employee Benefits*. McKinsey & Co; June 2011. http://www.mckinsey.com/insights/health_systems_and_services/how_us_health_care_reform_will_affect_employee_benefits. Accessed December 3, 2014.

7. Kaiser Family Foundation. Kaiser Health Tracking Poll. March 20, 2013. http://kff.org/health-reform/poll-finding/march-2013-tracking-poll/. Accessed December 3, 2014.

8. US Congressional Budget Office. *Insurance Coverage Provisions of the Affordable Care Act—CBO's February 2014 Baseline*. Washington, DC: US Congressional Budget Office; February 2014. http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2014-02-ACAtables.pdf. Accessed December 3, 2014.

9. US Congressional Budget Office. *Medicare's Payment to Physicians: The Budgetary Effects of Alternative Policies Relative to CBO's April 2014 Baseline updated for the Final Physician Fee Schedule Rule*. Washington, DC: US Congressional Budget Office; November 14, 2014. http://cbo.gov/sites/default/files/cbofiles/attachments/49770-SGR-Menu.pdf. Accessed December 3, 2014.

HealthAffairs | Robert Wood Johnson Foundation

Health Policy Brief

DECEMBER 22, 2014

Reenrollment. During the second round of open enrollment for the Affordable Care Act's insurance Marketplaces, insurers and policy makers have a new challenge: keeping last year's enrollees in the system.

WHAT'S THE ISSUE?

The first open enrollment period under the Affordable Care Act (ACA) was fraught with technical problems with the federal Marketplace, as well as many state-run exchanges. Despite these problems, just under seven million people purchased a health plan through one of the Marketplaces, making the first open enrollment period a qualified success. The first open enrollment focused on building awareness of the Marketplaces and the requirement to have health insurance, as well as getting people to apply and enroll in a plan.

During subsequent open enrollment periods, state and federal officials will devote more efforts to keeping people enrolled as well as trying to enroll hard-to-reach populations. Policies sold through the Marketplaces follow the calendar year and are set to terminate on December 31 unless they are renewed. The federal Marketplace and some state exchanges are automatically renewing policies for some enrollees unless they take action themselves.

This year open enrollment began November 15, allowing new customers to sign up for insurance and existing policyholders to change health plans, renew their existing plan, and request a redetermination on the amount of subsidy they received. The usability of HealthCare.gov and some of the state exchange websites has improved significantly from the early days of the 2013 open enrollment. Thus far, the open enrollment has had few technological glitches, including in the heavy traffic days leading up to December 15, the deadline before which consumers had to enroll in order for their 2015 coverage to take effect on January 1. Several states, including California, Idaho, Massachusetts, Minnesota, Rhode Island, and Washington, have extended the December 15 deadline or allowed consumers who had started the process by that date to complete their application and enroll in a plan with coverage still beginning on January 1.

In order to maximize policy renewals and continuity of coverage, the Department of Health and Human Services (HHS) issued regulations that allow the federally facilitated Marketplace to reenroll people automatically in their current plans unless they take action to change or terminate their coverage. State exchanges are allowed to do the same or adopt an alternative process to renew enrollees. A handful of states are following the federal lead, but others are making changes to the federal renewal process or choosing not to implement automatic renewal.

10.1377/hpb2014.26

95%

HHS estimates that about 95 percent of people who are enrolled through HealthCare .gov will be eligible for automatic renewal.

Looming over this year's open enrollment period is an air of uncertainty regarding the availability of premium subsidies in the federal Marketplace as a result of *King v. Burwell*, a case to be argued before the US Supreme Court in early 2015. Challengers in the case argue that the language of the ACA provides premium subsidies only in state-run exchanges. Some legal experts, the Internal Revenue Service (IRS), and several courts have found that the intent of the law is for all eligible people to receive federal assistance regardless of how the Marketplace is run.

Other legal experts and a three-judge panel of the US District Court of Appeals for the District of Columbia have supported the view of the challengers. The US Supreme Court has agreed to hear this case in its next session, instead of waiting for a decision by the full US District Court of Appeals for the District of Columbia. While this decision likely will not affect premium subsidies for 2015, it will have significant consequences in the future.

WHAT'S THE BACKGROUND?

People often cycle or "churn" on and off coverage as their income, family situation, or employment status changes. Churning is common not only in other public programs, such as Medicaid and the Children's Health Insurance Program (CHIP), but also in the individual health insurance market. In some sense, the individual market is a residual market—primarily attracting those not offered or eligible for employer-based insurance, Medicare, Medicaid, or CHIP. As a result, churning in the federal and state Marketplaces is to be expected. Colorado estimates it will lose 30 percent of its 2014 enrollment by the end of the year through attrition.

Over the past decade a number of states began to use automatic renewals for their Medicaid and CHIP programs to reduce churning. By 2012 twenty Medicaid programs and sixteen CHIP programs allowed families without changes in circumstances to renew their eligibility automatically. In 2014 automatic renewal became mandatory for all Medicaid programs. For the most part, enrollment in Medicare plans, employer-sponsored plans, and plans sold on the individual market are automatically renewed each year unless enrollees actively terminate or change their plan. In this sense, HHS policy allowing automatic renewals is following standard practice.

For the 2015 calendar year, open enrollment runs from November 15 to February 15, half as long as the initial open enrollment period. In order to have coverage that begins on January 1, 2015, and avoid a gap in insurance, current enrollees must have signed up or renewed their policy by December 15, 2014, putting pressure on the federal Marketplace and state exchanges and adding to the importance of automatic renewals.

States want to maximize enrollment in their exchanges not only to reduce the number of uninsured in their state but to help finance the operating expenses of their exchanges. Beginning in 2015 state exchanges must be self-financing. The state-based exchanges collectively received hundreds of millions of dollars in planning and establishment grants, which helped support them leading up to and through 2014. Media reports indicate that at least four states have asked HHS for a no-cost extension to continue to use their establishment grants through 2015, and others are considering doing so.

Even with extensions for the use of existing grants, states must have strategies in place to cover exchange operating costs. Many states are relying on user fees added on to premiums in order to finance their exchanges. As a result, exchanges are dependent on having adequate enrollment to generate sufficient operating funds.

WHAT'S IN THE LAW?

The ACA gives the secretary of HHS wide latitude to establish redetermination and reenrollment procedures with the goals of making the insurance buying process easier and encouraging continuity of coverage. HHS established an automatic reenrollment process for the 2015 benefit year through regulation. Marketplaces can use the redetermination process outlined in federal law, an alternative process offered through federal guidance, or create another process which HHS will approve if it facilitates continuity of care and provides clear information to enrollees while maintaining program integrity.

The federal Marketplace is using the alternative approach outlined through HHS guidance. The approach provided under regulation is similar to that provided in guidance with a few nuances. The alternate approach requires the Marketplace to obtain updated information from only the enrollees who received a premium subsidy or cost-sharing reduction,

rather than from all people who initially requested an eligibility determination. In addition, the alternative approach uses only tax information obtained from the IRS rather than information from the IRS, Social Security Administration, and other data sources.

Upon making a redetermination on eligibility and providing notices, HHS is reenrolling eligible people in their existing plan, assuming it is available, unless the consumers take action. HHS estimates that about 95 percent of people who are enrolled through HealthCare.gov will be eligible for automatic renewal. Most insurers favor automatic reenrollment because it helps maintain existing enrollment, reduces costs, and avoids some of the technical problems associated with the initial enrollment.

"A handful of states are following the federal lead, but others are choosing not to implement automatic renewal."

Automatic reenrollment avoids the need for almost seven million people already enrolled in a qualified health plan to flood HealthCare.gov and state exchanges during the short open enrollment period and ensures continuity of coverage. But it also may discourage consumers from going to the Marketplace to shop for coverage that better fits their needs and to get a more accurate determination of eligibility for subsidies.

According to a paper by Georgetown University researchers that reviewed six state-run exchanges, these states are taking a number of different strategies with renewals in their exchanges. Although some state-run exchanges are implementing the federal rule, the paper highlights four states (California, Colorado, Kentucky, and Washington) that are implementing automatic renewals but are adjusting the subsidies based on updated data such as the 2015 benchmark plan.

One of the studied states (Maryland) is automatically renewing coverage but not providing premium assistance unless consumers revisit the state's website and update their information. Maryland adopted this approach because a change in vendors prohibits it from transferring last year's information to this year. Finally, another state studied (Rhode Island) is not implementing automatic renewal in part because it did not obtain consent from applicants to use enrollees' income information for the 2015 redetermination process.

WHAT'S THE DEBATE?

Automatic enrollment is easy for consumers, but it may cost them. Premiums for 2015 vary widely by market and issuer. In some markets, issuers are submitting rates 30 percent higher than their 2014 rates, while in other markets issuers are showing little change or decreasing their 2015 rates. In many markets, these premium changes mean that the benchmark plan in 2015 will be different from 2014. Premium changes affect consumers' level of financial assistance because advance premium tax credits are determined based on a formula that includes family income and the premium of the second-lowest-cost silver plan.

People with incomes of 100 – 400 percent of the federal poverty level are required to pay a sliding scale premium of 2.0 – 9.5 percent of their income for the second-lowest-cost silver plan (known as the benchmark plan). Consumers are not required to enroll in the benchmark plan—they can enroll in a more expensive plan and pay the difference, or enroll in a cheaper plan (such as the lowest-cost silver plan or another cheaper plan) and have their premium lowered accordingly.

According to HHS data, people in the Marketplace are very price-sensitive. Across all plan tiers—bronze, silver, gold, platinum, and catastrophic—64 percent of all enrollees selected the lowest- or second-lowest-cost plan for 2014. People who are automatically enrolled may no longer be in one of the two lowest-cost silver plans because of changes in premiums or because new, less costly plans have entered the market. According to an analysis by the Kaiser Family Foundation of plans in sixteen cities, the majority had both a different benchmark plan and a different lowest-cost silver plan in 2015 than in 2014.

Wide swings in Marketplace premiums may be expected for the first few years of the ACA. Issuers did not know what to expect when setting their 2014 rates in terms of who would enroll, how many would enroll, and what their health status and claims experience would be. One year later, issuers know a little more, but given that many had to submit their rates over the summer, issuers still did not have much claims experience for the majority of their enrollees.

One piece of information issuers had for setting rates in 2015 is how they stacked up against their competition, since they knew their competitors' 2014 premiums. Some issuers may be keeping their premiums steady or lowering them in order to gain market share. The Kaiser analysis showed that the average premium for the benchmark plan in the sixteen cities increased an average of less than 1

64%

Across all plan tiers, 64 percent of all enrollees selected the lowest- or second-lowest-cost plan for 2014.

percent. This is good news overall for consumers, but as a result of changes in the benchmark plan and the overall ranking of plans, consumers who are automatically enrolled in their current plan may face a substantially higher premium.

Consumer advocates and HHS recommended that everyone shop around before being automatically reenrolled in their plan. Even if a plan's premium goes down or remains relatively unchanged in 2015, the cost to enrollees could still be higher once the revised subsidy is calculated because of the change in the benchmark plan. Comparison shopping is particularly important for people receiving premium tax credits or cost-sharing reductions, because of their price sensitivity. The savings achieved by selecting a new plan in the market or a plan with a much lower premium than in 2014 may be even greater because of the relationship of the premium tax credit to the benchmark plan.

According to the Georgetown study, the wide swings in premiums are one of the reasons behind not implementing automatic renewals in Maryland and Rhode Island. In addition, officials in Colorado, Kentucky, and Washington are telling consumers that active shopping for plans may be in their best interest. In fact, Colorado and Washington officials shifted their messages more in this direction after obtaining information on the changes in benchmark plans.

Consumers who decide to change plans may be double billed. If consumers change plans during open enrollment, they must tell their old plans that they are disenrolling. Otherwise, their old plan may continue to bill them. Initially, the federally facilitated Marketplace stated that it was not providing issuers with a termination notice when consumers disenrolled. HHS planned to send enrollment files to issuers on December 15 that would allow plans to reconcile their records. HHS said that plans can assume an enrollee's coverage ends on December 31 unless they are notified otherwise. Recently, HHS changed course, providing guidance in early December that created an "enrollee switched list." This electronic file was sent daily through December 15 to each issuer, notifying them if one of their enrollees switched to a plan offered by another issuer.

In determining eligibility for financial assistance, the federally facilitated Marketplace and state exchanges following the same approach may be using outdated information. When consumers first applied for Marketplace coverage, they had the option to allow the exchanges access to their tax filings for purposes of making future redeterminations. For people who provided this authorization, the exchanges accessed income information from their 2013 tax filings, determined how much financial assistance enrollees were eligible for, and provided written notice of the redetermination by November 15.

The notice included a request for any updated information. If people do not respond to the request for updated information by going back to HealthCare.gov, the 2015 premium tax credit will be the same dollar amount as their 2014 premium tax credit. As a result, HHS estimates that most people who do not provide updated information will receive a lower advance premium tax credit in 2015 than they are due. Although they will receive a refund of any underpayment from the government when filing their taxes in early 2016, this will make their premiums higher in the short term and could make insurance coverage unaffordable.

For consumers who did not give HHS authority to access their tax records, HHS will provide a notice informing them that unless they revisit the Marketplace and update their information, their premium subsidy will terminate on December 31, 2014. If they continue to be eligible for a premium subsidy, they will still receive it when they file their taxes, but they will not receive an advance payment. If experience in Medicaid is any indicator, few people will respond to these notices and submit requests for redeterminations based on updated information. However, people may request redeterminations once they are faced with higher-than-expected premiums.

Enrollees could also receive higher advance premium tax credits than they are due because of the change in the benchmark plan. If an enrollee's income remains the same in 2015 but the benchmark plan premium decreases, enrollees will receive a higher premium tax credit than the amount due and will be required to pay it back at tax time.

The standard notice to consumers used by the federally facilitated Marketplace did not provide the net amount owed for their 2015 premium, after taking the subsidy into account, for the plan in which they will be automatically reenrolled. If enrollees end up paying a higher premium in 2015 because their subsidy is the same as their 2014 subsidy or because the plan they were automatically

"Looming over this year's open enrollment period is an air of uncertainty regarding the availability of premium subsidies in the federal Marketplace."

reenrolled in is substantially more expensive in 2015 (whether because the plan raised its premium or because of changes to the benchmark plan), they may be more likely to let their policy lapse during the year because it is no longer affordable.

This runs counter to the goal of auto-reenrollment, which is to maintain continuous coverage. Several states hope to improve on the redetermination process by strongly encouraging consumers to update their information. Furthermore, the Georgetown study found that the four study states using automatic reenrollment (California, Colorado, Kentucky, and Washington) have the ability to include the 2015 benchmark premium in the redetermination and to make other updates, making the premium subsidy more accurate even if people do not update their information.

Technology challenges are not a thing of the past. Automatic renewals may decrease Web traffic during open enrollment, but if consumer advocates are successful in getting people to shop around and enrollees respond to changes in premiums, traffic during the open enrollment period may still be heavy. The short time people have to act in order to maintain continuous coverage may result in heavy traffic during the first month, and insurers and consumer advocates are worried that the websites may not be capable of handling it.

At least one state, California, was able to get ahead of the curve by allowing people to renew their plans starting in mid-October. In another effort to improve the functionality of HealthCare.gov, HHS has streamlined the online application. Officials estimate that 70 percent of new customers will be able to use the shorter, simpler form. Despite these changes, it is probably naïve to believe that this year's open enrollment will be free of technological glitches.

WHAT'S NEXT?

Open enrollment began November 15 and thus far has been going much more smoothly than the first open enrollment. People who want to change their plan must have done so by December 15 in order to avoid any gap in coverage. Enrollees who do not shop around and are automatically renewed may be surprised with their new premium. People in states using the federally facilitated Marketplace or following its procedures, whose income or family situation has changed since their 2013 tax filing but who have not requested a redetermination with the new information, may find the size of their premium tax credit covers a smaller portion of their premium than in 2014. There may be backlash from people who find themselves paying more for the same plan and who are not receiving the full subsidy for which they are eligible.

In recognition of the price sensitivity of enrollees, HHS is rethinking the automatic reenrollment process for future open enrollment periods. In the recently released proposed rule on benefit and payment parameters, HHS stated that it is exploring alternative automatic reenrollment scenarios in which premiums would be taken into account.

One possible approach discussed in the proposed rule would allow consumers at the time of initial enrollment to opt in to an automatic reenrollment hierarchy. For example, enrollees may be reenrolled in their current plan if their premiums did not increase by more than 5 percent but would be reenrolled in another low-cost plan if premiums did increase above that threshold. This process is still in the exploratory stage, and HHS is requesting comments on how best to implement a policy that respects the value consumers place on price. HHS notes that this change in reenrollment would not apply until the 2016 open enrollment period for plan year 2017.

On the legal front, the US Supreme Court has decided to take up the *King v. Burwell* case in its current term and should issue a decision no later than June 2015. Although the ruling likely will not affect 2015 enrollment, it may leave doubt in the minds of potential enrollees and angst among states not running their own exchanges about the long-term availability of premium subsidies in the federal Marketplace. ■

About Health Policy Briefs

Written by
Sarah Goodell
Health Policy Consultant

Editorial review by
Jack Hoadley
Research Professor
Health Policy Institute
Georgetown University

Sandy Ahn
Research Fellow
Center on Health Insurance Reforms
Health Policy Institute
Georgetown University

Timothy Jost
Robert L. Willett Family Professor of Law
Washington and Lee University
School of Law

Rob Lott
Deputy Editor
Health Affairs

Tracy Gnadinger
Assistant Editor
Health Affairs

Health Policy Briefs are produced under a partnership of *Health Affairs* and the Robert Wood Johnson Foundation.

Cite as:
"Health Policy Brief: Reenrollment," *Health Affairs*, December 22, 2014.

Sign up for free policy briefs at:
www.healthaffairs.org/healthpolicybriefs

RESOURCES

Avalere Health, Exchange Plan Renewals: Many Consumers Face Sizeable Premium Increases in 2015 Unless They Switch Plans (Washington, DC: Avalere, June 26, 2014).

Kyle Cheney and Sarah Wheaton, "States Want More Time on ACA Funds," *Politico*, July 25, 2014.

Sabrina Corlette, Jack Hoadley, and Sandy Ahn, Marketplace Renewals: State Efforts to Maximize Enrollment into Affordable Health Plan Options (Washington, DC: Georgetown University, Center on Health Insurance Reforms, December 2014).

Cynthia Cox, Larry Levett, Gary Claxton, Rosa Ma, and Robin Duddy-Tenbrunsel, Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces (Menlo Park, CA: Kaiser Family Foundation, November 17, 2014).

Department of Health and Human Services, "Patient Protection and Affordable Care Act; Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges," *Federal Register* 79, no. 172 (2014):52994–53006.

Paul R. Houchens and Susan E. Pantely, The Proposed Federal Exchange Auto-Enrollment Process: Implications for Consumers and Insurers (Seattle, WA: Milliman, July 28, 2014).

Julia Lerche and Aree Bly, Addressing the Financial Impact of Renewals: Why Many Enrollees Could Benefit from Shopping (Clearwater, FL: Wakely Consulting Group, August 2014).

ASPE
ISSUE BRIEF

HEALTH INSURANCE MARKETPLACE 2015 OPEN ENROLLMENT PERIOD: DECEMBER ENROLLMENT REPORT

For the period: November 15, 2014 – December 15, 2014[1]

December 30, 2014

The Health Insurance Marketplace ("the Marketplace") plays a critical role in achieving one of the Affordable Care Act's goals of reducing the number of uninsured Americans by creating a market for affordable, high-quality health insurance for individual and small group consumers. This report provides preliminary data for enrollment-related activity in the individual Marketplace during the first month of the 2015 Open Enrollment period for all 50 states and the District of Columbia.

Section I of the report focuses on the 37 states that are using the HealthCare.gov platform for 2015 (also known as "HealthCare.gov states") for the first month of the 2015 Open Enrollment (generally for the period 11-15-2014 to 12-15-2014).[1] The 37 HealthCare.gov states include 35 states that are states that used the HealthCare.gov platform in both 2014 and 2015 and Oregon and Nevada, which are new to the HealthCare.gov platform in 2015. These 37 states accounted for 68 percent of total Marketplace plan selections in 2014.[2] The data available for these states includes Marketplace plan selections for new consumers and consumers reenrolling in Marketplace coverage – including consumers who are actively reenrolling in Marketplace coverage (people who return to the Marketplace to select a new plan or actively renew their existing plan), but *not* consumers who are being automatically reenrolled into coverage ("automatic reenrollees" – people who retain coverage without returning to the Marketplace and selecting a plan). The reporting period for HealthCare.gov states in this report (through 12-15-14) differs from the reporting period (through 12-26-14) in the most recent weekly enrollment snapshot published by the Centers for Medicare & Medicaid Services (CMS).[3]

[1] Most of the data in this report are for the 11-15-14 to 12-15-14 reporting period with the following exceptions: Marketplace plan selection data for most of the 14 states that are using their own Marketplace platforms are for 11-15-14 to 12-13-14 (with the exception of California, which is reporting data for 11-15-14 to 12-14-14); and data on website visits and call center volume for states that are using the HealthCare.gov platform are for 11-15-14 to 12-20-14.

[2] For more information about data on Marketplace plan selections for the 2014 coverage year, please see the Marketplace Summary Enrollment Report, which can be accessed at http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf.

[3] The Centers for Medicare & Medicaid Services has released a weekly snapshot for Open Enrollment Week 6: December 20 - December 26, 2014 which states that nearly 6.5 million consumers have selected 2015 Marketplace plans in the states that are using the HealthCare.gov platform through 12-26-14, including data for automatic reenrollments. The weekly Open Enrollment snapshots provide preliminary point-in-time estimates for weekly data that could fluctuate based on consumers changing or

The most recent Weekly Enrollment Snapshot included a summary of enrollment activity in the 37 HealthCare.gov states showing that from November 15th to December 26th, nearly 6.5 million consumers selected a 2015 Marketplace plan or were automatically reenrolled in those states. As noted above, this report includes data for the HealthCare.gov states through 12-15-14, as well as for other states that are using their own Marketplace platforms (as discussed below). However, neither the most recent Weekly Enrollment Snapshot, nor this report fully capture the total number of plan selections for coverage beginning January 1st (see Appendix Table C1 for additional information on how the data in this report compare with the data in the most recent Weekly Enrollment Snapshot). This report also includes data relating to completed applications, eligibility determinations, and website visits, and call center activity for the HealthCare.gov states; as well as data on the overall distribution of Marketplace plan selections in these states by gender, age, metal level, financial assistance status, race/ethnicity, and rural status.

Section II of the report focuses on the 14 states (including the District of Columbia) that are operating their own Marketplace platform for 2015 (see page 10). Most of the 14 states include activity for the period 11-15-2014 to 12-13-2014 (however data for California are through 12-14-14). These 14 states accounted for 32 percent of Marketplace plan selections in 2014. The data available for these states includes new consumers, consumers who are actively reenrolling in Marketplace coverage (except for two states, New York and California), and automatic reenrollees in 5 states (Connecticut, Idaho, Kentucky, Vermont, and Washington).

Because complete data are not yet available, this report does not provide a comprehensive estimate of the total number of Marketplace plan selections, including both new consumers and consumers reenrolling in Marketplace coverage, for all states for coverage beginning on January 1, 2015. *(Please see Appendix Table C2 for additional information on the Marketplace plan selection data that are available for various states).*

canceling plans or having a change in status such as a new job or marriage; data revisions may mean that the weekly totals from the snapshots may not sum to the cumulative numbers. The weekly snapshots can be accessed at http://www.hhs.gov/healthcare/facts/blog/index.html.

Key Highlights:

Preliminary national plan selection data available to date show that as of December 15th, more than 4.0 million Americans had selected new coverage or been reenrolled in 2015 health insurance coverage through the Marketplace for coverage beginning January 1st (see Appendix Table B1). In detail:

- 3.4 million people have selected 2015 Marketplace plans in the 37 states that are using the HealthCare.gov platform in 2015 as of December 15th, including plan selections by new consumers and consumers who are actively reenrolling in Marketplace coverage (excluding automatic reenrollees); and
- Over 600,000 people have selected 2015 Marketplace plans in the 14 states (including DC) that are using their own Marketplace platforms in 2015, based on data that generally run through December 13th. Depending on the state, these data may reflect new consumers only, or both new consumers and consumers reenrolling in Marketplace coverage (including, in some states, automatic reenrollees).

SECTION I. DATA FOR THE 37 STATES USING THE HEALTHCARE.GOV PLATFORM

- ***The Marketplaces in HealthCare.gov States are Succeeding in Reaching People Who Do Not Currently have Marketplace Coverage.***

  3.4 million individuals have already selected 2015 Marketplace plans as of 12-15-14 in HealthCare.gov states, including new consumers, and consumers who are reenrolling in Marketplace coverage (see Table 1). Of that total, 52 percent (1.8 million) are plan selections by new consumers who did not have a Marketplace plan selection as of November 2014, and 48 percent (1.6 million) are plan selections from consumers who are reenrolling in Marketplace coverage (excluding automatic reenrollees).

Table 1

2015 Marketplace Plan Selections in States Using the HealthCare.gov Platform By Enrollment Type	Cumulative 11-15-14 to 12-15-14	
	Number	% of Total
Total 2015 Marketplace Plan Selections in HealthCare.gov States (1)	3.42 million	100%
New Consumers	1.77 million	52%
Consumers Reenrolling in Marketplace Coverage (2)	1.64 million	48%

Notes: Numbers may not add to totals due to rounding
(1) Total 2015 Marketplace Plan Selections represents cumulative data on the number of unique individuals who have selected a 2015 Marketplace medical plan for enrollment through the individual market Marketplaces (with or without the first premium payment having been received directly by the Marketplaces or the issuer). This is also known as pre-effectuated enrollment. These data do not include: cancellations and terminations; a count of the number of individuals who have selected a standalone dental plan; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been granted a Special Enrollment Period (SEP).
(2) Consumers reenrolling in Marketplace coverage includes data for consumers who are actively reenrolling in Marketplace coverage, but does not include data for automatic reenrollees.
Source: Centers for Medicare & Medicaid Services, as of 12-23-14.

- ***Interest in the Marketplaces in HealthCare.gov States is High*** – During the first month of the 2015 Open Enrollment period:
  - 14.7 million visits were made to the HealthCare.gov and CuidadoDeSalud.gov websites;
  - 6.8 million calls were made to the Marketplace call center for the HealthCare.gov states;
  - 3.4 million completed applications for 2015 coverage were submitted; and
  - 5.0 million people were included in these completed applications.

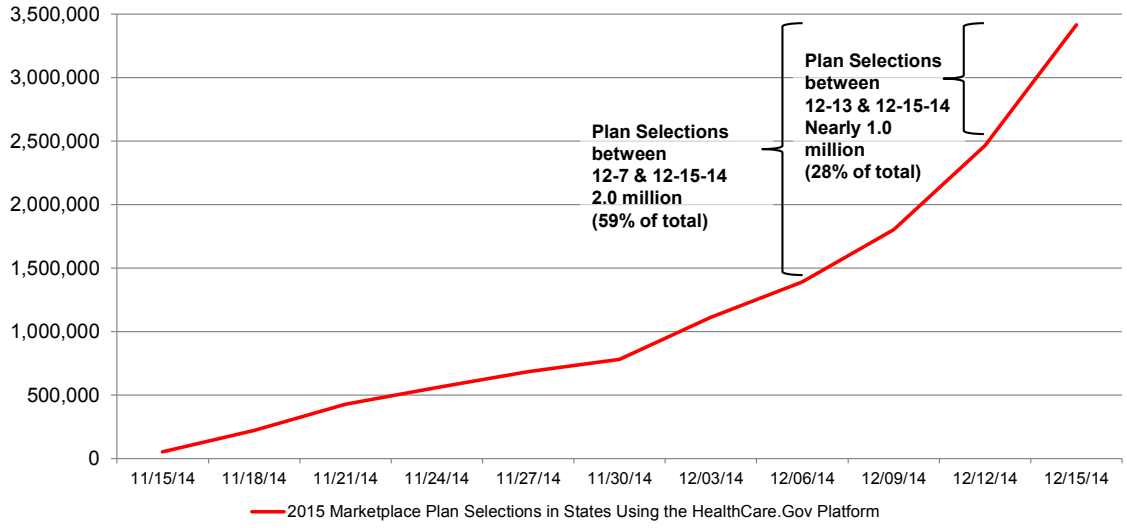
- ***Two-Thirds of the Consumers Who Submitted Applications to the Marketplaces in the HealthCare.gov States Have Already Selected Marketplace Plans*** – Most of the people who applied for coverage through the Marketplace during the first month of the 2015 Open Enrollment period in the HealthCare.gov states have already received an eligibility determination and/or selected a plan (see Appendix Table B2):
    - 97 percent of applicants have received an eligibility determination.[4]
    - Two-thirds (68 percent) of those applying have already selected a 2015 Marketplace plan; and
    - 9 percent of applicants have been determined or assessed eligible for Medicaid/CHIP.
- ***People Responded to the December 15th Deadline for Marketplace Coverage Beginning on January 1, 2015 in HealthCare.gov States***
    - 2.0 million people selected a 2015 Marketplace plan in the 37 HealthCare.gov states between 12-7-14 and 12-15-14 (59 percent of the 3.4 million people who selected a plan during the first month of the 2015 Open Enrollment period) (see Figure 1); and
    - Nearly 1.0 million people selected a 2015 Marketplace plan on 12-13-14, 12-14-14 or 12-15-14, which is 28 percent of the total number of people selecting a plan during the first month of the open enrollment period.

[4] The number of applicants who have received an eligibility determination includes both those who have been determined eligible to enroll in a plan through the Marketplaces, and those who have been determined or assessed eligible for Medicaid/CHIP by the Marketplaces.

Figure 1

Trends in the Cumulative Number of Individuals Who Selected a Marketplace Plan in States Using the HealthCare.gov Platform, 11-15-14 to 12-15-14

3.4 million people selected 2015 Marketplace plans in HealthCare.gov states during the first month of the open enrollment period, including 28% during the last 3 days



Notes: Represents the cumulative number of unique individuals who have been determined eligible to enroll in a plan through the states using the HealthCare.gov platform, and have actively selected a plan (with or without the first premium payment having been received by the issuer). Number of states using the HealthCare.gov platform: 37 states during the 2015 coverage year.

Source: Centers for Medicare & Medicaid Services, as of 12-23-14

Characteristics of 2015 Marketplace Plan Selections

In the HealthCare.gov states, the socio-demographic characteristics of people who selected 2015 Marketplace plans during the first month of the 2015 Open Enrollment period are generally similar to those of people who selected Marketplace plans during the early months of the 2014 Open Enrollment period (see Table 2).[5]

- **Young People**: The 2014 Open Enrollment period showed that the proportion of young people (ages 0 to 34) selecting plans increased over time as the period progressed. For example, the proportion of 0 to 34 year olds who selected a Marketplace plan during the early months of the 2014 Open Enrollment period (29 percent for 10-1-13 to 12-28-13)[6] grew to 35 percent by the end of the open enrollment period. For the 2015 Open

[5] The number and composition of the HealthCare.gov states has changed slightly between the 2014 coverage year, when there were 36 HealthCare.gov states, and the 2015 coverage year, when 37 states are using the HealthCare.gov Marketplace platform

[6] For additional information on Marketplace plan selection data for 10-1-13 to 12-28-13, please see the "Health Insurance Marketplace: January 2014 Enrollment Report," which can be accessed at http://www.aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib_2014jan_enrollment.pdf

Enrollment period, the information to date suggests a slightly higher rate of plan selections by this age group at this early point than for 2014 (33 percent versus 29 percent in the early months of the 2014 Open Enrollment period). However, it is important to note that because it is early in the open enrollment period, the age distribution of the 2015 plan selections could change. This is especially the case because the data for automatic reenrollees have not yet been incorporated into the analysis.

- **Race/Ethnicity**: The self-reported Marketplace data on race/ethnicity should be used with caution due to the high proportion of plan selections with unknown race/ethnicity (nearly a third both in 2014 and thus far in 2015). The proportions of plan selections by race/ethnicity in the early months of the 2014 Open Enrollment Period[7] are similar to those for the first month of 2015 with the following exceptions: the proportion of Latino plan selections is slightly higher than in 2014 (8 percent in 2015 compared with 7 percent in 2014), and for African-Americans the share is slightly lower in 2015 (11 percent in 2015 compared to 14 percent in 2014).

- **Financial Assistance**: Similarly, the proportion of people who selected Marketplace plans with financial assistance (including premium tax credits and/or cost-sharing subsidies) grew during the 2014 Open Enrollment Period. For example, the proportion selecting plans with financial assistance grew from 80 percent during the early months of the 2014 Open Enrollment period (10-1-13 to 12-28-13) to 86 percent by the end of the open enrollment period. For the 2015 Open Enrollment period, the proportion who selected a plan with financial assistance is 87 percent to date compared with 80 percent in the early months of the 2014 Open Enrollment period.

- **Gender**: For the 2015 Open Enrollment period, the proportion of males who have selected a Marketplace plan is 44 percent to date compared to 45 percent in the early months of the 2014 Open Enrollment period (10-1-13 to 12-28-13). As this pattern suggests, the same holds true for women (56 percent vs. 55 percent).

- **Rural Status**: Approximately one-fifth (18 percent) of the people who selected a 2015 Marketplace plan in the HealthCare.gov states between 11-15-14 and 12-15-14 live in rural ZIP Codes.

[7] Data on the race/ethnicity distribution of Marketplace plan selections during the early months of the 2014 Open Enrollment Period are for 10-1-13 to 2-1-14, the earliest period for which these data are available.

Table 2

Comparison of Selected Characteristics of Marketplace Plan Selections in States Using the HealthCare.gov Platform	**2014 Open Enrollment Period (2)** *(36 States)*	**2015 Open Enrollment Period (3)** *(37 States)*
	10-1-13 to 12-28-13 (4)	**11-15-14 to 12-15-14 (5)** *(not including automatic reenrollments)*
Total Number of Individuals Who Have Selected a Marketplace Plan (1)	1,196,430	3,416,023
Males who have selected a Marketplace plan (6)	*45%*	*44%*
Females who have selected a Marketplace plan (6)	*55%*	*56%*
0 to 34 year olds who have selected a Marketplace plan (6)	*29%*	*33%*
18 to 34 year olds who have selected a Marketplace plan (6)	*23%*	*24%*
Individuals who have selected a Silver Marketplace plan (6)	*61%*	*68%*
Individuals who have selected a Marketplace plan with Financial Assistance (6)	*80%*	*87%*
African-Americans who have selected a Marketplace plan (6)	*14%*	*11%*
Latinos who have selected a Marketplace plan (6)	*7%*	*8%*
Whites who have selected a Marketplace plan (6)	*71%*	*70%*
Individuals in ZIP Codes designated as Rural who have selected a Marketplace Plan (6)	*N/A*	*18%*

(1) Represents cumulative data on the number of unique individuals who have selected a 2015 Marketplace medical plan for enrollment through the individual market Marketplaces (with or without the first premium payment having been received directly by the Marketplaces or the issuer). This is also known as pre-effectuated enrollment. These data do not include: cancellations and terminations; a count of the number of individuals who have selected a standalone dental plan; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been granted a Special Enrollment Period (SEP). See Appendix C for additional technical notes.

(2) During the 2014 Marketplace coverage year, there were a total of 36 states using the HealthCare.gov platform, including one state (Idaho) that switched from using the HealthCare.gov platform in 2014 to using its own Marketplace platform in 2015.

(3) During the 2015 Marketplace coverage year, there were a total of 37 states using the HealthCare.gov platform, including 35 states that are states that used the HealthCare.gov platform in both 2014 and 2015, and two states which are new to the HealthCare.gov platform in 2015 (Oregon and Nevada).

(4) Most of the data for the early months of the 2014 Open Enrollment period are for 10-1-13 to 12-28-13. However, the race/ethnicity data are for 10-1-13 to 2-1-14 (the earliest period for which these data are available).

(5) Data for the HealthCare.gov states for the first month of the 2015 Open Enrollment Period only include plan selections for

individuals who are new consumers or who have actively reenrolled in Marketplace coverage during the reference period. These data do not include automatic reenrollments.

(6) Percentages shown in this table are based on the total number of active Marketplace plan selections for which the applicable data are available, excluding plan selections with unknown data for a given metric (e.g., age, gender, race/ethnicity, etc.) Additional information on the number of plan selections with missing data for each metric can be found in Appendix Table A.

Source: Centers for Medicare & Medicaid Services, as of 12-23-14.

Other Data on Marketplace Enrollment-Related Activity in the HealthCare.gov States

Interest in the Marketplaces in HealthCare.gov states has been high during the first month of the 2015 Open Enrollment period, with 14.7 million visits on the Marketplace websites, 6.8 million calls to the Marketplace call center, and 3.4 million completed applications in the HealthCare.gov states (see Table 3).

Table 3

Cumulative Marketplace Enrollment-Related Information in States Using The HealthCare.gov Platform	**Reporting Period: First Month of the 2015 Open Enrollment Period (1)** *(not including automatic reenrollments)*
Visits to the Marketplace Websites (2)	14,658,020
Calls to the Marketplace Call Centers (3)	6,827,704
Number of Completed Applications	3,392,182
Number of Individuals Included in Completed Applications	4,990,439
Number of Individuals Determined Eligible to Enroll in a 2015 Marketplace Plan	4,376,414
Number of Individuals Who Have Selected a 2015 Marketplace Plan (4)	3,416,023

Notes:

(1) Most of the data in this table are for the 11-15-14 to 12-15-14 reporting period with the following exceptions: the data on website visits and call center volume are for 11-15-14 to 12-20-14.

(2) Visits on the Marketplace Websites includes 14,161,103 unique visitors on HealthCare.gov and 496,917 unique visitors on CuidadoDeSalud.gov between 11-15-14 and 12-20-14. Visitors to the Marketplace Websites is the sum of monthly data and has been deduplicated to the extent possible.

(3) Total Calls to the Marketplace call centers includes 501,614 calls with Spanish-speaking representatives and 6,326,090 other calls between 11-15-14 and 12-20-14.

(4) Total 2015 Marketplace Plan Selections represents cumulative data on the number of unique individuals who have selected a 2015 Marketplace medical plan for enrollment through the individual market Marketplaces (with or without the first premium payment having been received directly by the Marketplaces or the issuer). This is also known as pre-effectuated enrollment. These data do not include: cancellations and terminations; a count of the number of individuals who have selected a standalone dental plan; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been granted a Special Enrollment Period (SEP). See Appendix C for technical notes.

Source: Centers for Medicare & Medicaid Services, as of 12-23-2014.

SECTION II. DATA FOR THE 14 STATES USING THEIR OWN MARKETPLACE PLATFORMS

Initial data indicate that over 600,000 individuals have selected 2015 Marketplace plans in the 14 states (including DC) that are using their own Marketplace platforms for the 2015 coverage year. This includes:

- 161,752 Marketplace plan selections in two states reporting only data for new consumers (California and New York);
- 153,011 Marketplace plan selections in seven states reporting data on new consumers and consumers actively reenrolling in Marketplace coverage (Colorado, District of Columbia, Hawaii, Maryland, Massachusetts, Minnesota, and Rhode Island); and
- 318,075 Marketplace plan selections in five states reporting data on new enrollees, consumers actively reenrolling in Marketplace coverage, and automatic reenrollees (Connecticut, Idaho, Kentucky, Vermont, and Washington).

Data on consumers reenrolling in Marketplace coverage are not yet available for all 14 of these states, nor is a complete breakdown of new consumers versus consumers reenrolling in Marketplace coverage available. Several states could not separate out data for new consumers compared to consumers reenrolling in Marketplace coverage due to system vendor changes or other information technology system issues. Also, five states initiated automatic reenrollment prior to 12-14-2014 and these reenrollments are included in their plan selection data.

SECTION III. METHODOLOGICAL OVERVIEW

The data reported here have been obtained from the information systems of the Centers for Medicare & Medicaid Services (CMS), based on information collected for 37 states using the HealthCare.gov platform. We also obtained more limited data reported to CMS by the 14 states (including DC) that are using their own Marketplace platform. Data for the Small Business Health Options Program (SHOP) Marketplaces are not included in this report.

This report includes data that are currently available on enrollment-related activity for the first month of the open enrollment period – which generally corresponds with data from 11-15-14 to 12-15-14 for the 37 HealthCare.gov states, and from 11-15-14 to 12-13-14 for most of the states that are using their own Marketplace platforms for the 2015 coverage (see Table 4 below).

Table 4

Marketplace Type	Reporting Period
States Using the HealthCare.gov Marketplace Platform (37 states)	11-15-14 to 12-15-14*
States Using Their Own Marketplace Platform (14 states)	
California	11-15-14 to 12-14-14
Other 13 States (including DC)	11-15-14 to 12-13-14

*Data for call center and website visits are for 11-15-2014 – 12-20-2014

Data for certain metrics are not yet available for several of the states that are using their own Marketplace platforms. Additionally, some states (Connecticut, Idaho, Kentucky, Vermont, and Washington) initiated automatic reenrollments prior to 12-14-2014; automatic reenrollments are included in these states' plan selection data. This report does not include complete data on the number of individuals with 2014 Marketplace coverage who have selected health insurance coverage through the Marketplace that can begin on January 1, 2015 because the automatic reenrollments were not completed during the one-month period this report examines. In addition, some states extended their deadline for plan selection for January 1 coverage or offered special enrollment periods to consumers experiencing longer than normal wait times or other challenges.[8] [9]

It is important to note that data for the 14 states that are using their own Marketplace platforms include new consumers but not all states are reporting reenrollments (California and New York are only reporting data for new consumers) and some states are not separately reporting data for new consumers and consumers who are reenrolling in Marketplace coverage. Most of the 14 states include activity through 12-13-14 (however data for California are through 12-14-14), ending prior to the surge associated with the deadlines for January 1st coverage.[10] Please refer to Appendix C for additional technical notes.

This report also includes data on the characteristics of persons who have selected a Marketplace plan through the 37 states that are using the HealthCare.gov platform for 2014. In some cases, the data for certain characteristics of Marketplace plan selections are not yet available in selected states.

We believe that the information contained in this issue brief provides the most systematic summary of enrollment-related activity in the Marketplaces for the first month of the 2015 Open Enrollment period because the data for the various metrics are counted using comparable definitions for data elements across states and Marketplace types.

[8] For example, in the HealthCare.gov states, the deadline for Marketplace coverage beginning on January 1st was 12-15-14. However, consumers in these states who experienced longer than normal wait times or other challenges as a result of increased website and call center activity near the December 15th deadline will be eligible for a Special Enrollment Period.
[9] Dan Mangan, "More Extensions as Obamacare Deadline Looms," accessed at http://www.cnbc.com/id/102269082#.
[10] In the States that are using their own Marketplace platform, the deadline for Marketplace coverage beginning on January 1st varies. The deadline in the District of Columbia and Kentucky was December 15th, but some states have announced later deadlines. For example, the deadline in Maryland was December 18th; the deadline for Connecticut was December 19th; the deadline in New York and Idaho was December 20th; the deadline in California was December 21st; the deadline in Massachusetts, Rhode Island, and Washington was December 23rd; and the deadline in Hawaii, Minnesota and Vermont is December 31st. Additionally, Connect for Health Colorado has offered to work with people who started the process before the December 15th deadline, but were not able to finish enrolling, to complete their application for January coverage.

SECTION IV: APPENDICES

APPENDIX TABLE A

Marketplace Plan Selections by Gender, Age, Metal Level, Financial Assistance Status, Race/Ethnicity, and Rural Status, in States Using the HealthCare.gov Platform, 11-15-14 to 12-15-14 (1)		
Characteristics	**States Using the HealthCare.gov Platform for the 2015 Coverage Year** *(37 States)*	
	Number 11-15-14 to 12-15-14 *(not including automatic reenrollments)* **(2)**	**% of Available Data, Excluding Unknown (3)**
Total Who Have Selected a Marketplace Plan		
Total Number of Individuals Who Have Selected a Marketplace Plan	3,416,023	n/a
By Gender		
Female	1,896,562	56%
Male	1,518,929	44%
Subtotal: Plan Selections With Available Data on Gender	3,415,491	100%
Unknown Gender	532	n/a
By Age		
Age < 18	308,507	9%
Age 18-25	333,360	10%
Age 26-34	488,825	14%
Age 35-44	520,425	15%
Age 45-54	732,671	21%
Age 55-64	1,016,196	30%
Age ≥65	16,038	0%
Subtotal: Plan Selections With Available Data on Age (2)	3,416,022	100%
Unknown Age	n/a	n/a
Ages 18 to 34	822,185	24%
Ages 0 to 34	1,130,692	33%
By Metal Level		
Bronze	706,150	21%
Silver	2,321,915	68%
Gold	265,657	8%

Marketplace Plan Selections by Gender, Age, Metal Level, Financial Assistance Status, Race/Ethnicity, and Rural Status, in States Using the HealthCare.gov Platform, 11-15-14 to 12-15-14 (1)		
Characteristics	**States Using the HealthCare.gov Platform for the 2015 Coverage Year** *(37 States)*	
	Number 11-15-14 to 12-15-14 *(not including automatic reenrollments)* **(2)**	**% of Available Data, Excluding Unknown (3)**
Platinum	103,330	3%
Catastrophic	23,697	1%
Subtotal: Plan Selections With Available Data on Metal Level (4)	3,416,023	100%
Standalone Dental	521,784	n/a
Unknown Metal Level	0	n/a
By Financial Assistance Status		
With Financial Assistance	2,985,989	87%
Without Financial Assistance	430,033	13%
Subtotal: Plan Selections With Available Data on Financial Assistance (2)	3,416,022	100%
Unknown Financial Assistance Status	N/A	n/a
By Self-Reported Race/Ethnicity		
American Indian / Alaska Native	9,367	0%
Asian	211,701	9%
Native Hawaiian / Pacific Islander	1,749	0%
African-American	253,132	11%
Latino	200,407	8%
White	1,659,111	70%
Multiracial	30,117	1%
Subtotal: Plan Selections With Available Data on Self-Reported Race/Ethnicity	2,365,584	100%
Unknown Race/Ethnicity	1,050,439	n/a
By Rural Status		
In ZIP Codes Designated as Rural	605,733	18%
In ZIP Codes Designated as Urban	2,810,163	82%

Marketplace Plan Selections by Gender, Age, Metal Level, Financial Assistance Status, Race/Ethnicity, and Rural Status, in States Using the HealthCare.gov Platform, 11-15-14 to 12-15-14 (1)		
Characteristics	**States Using the HealthCare.gov Platform for the 2015 Coverage Year** *(37 States)*	
	Number 11-15-14 to 12-15-14 *(not including automatic reenrollments)* **(2)**	**% of Available Data, Excluding Unknown (3)**
Subtotal: Plan Selections With Available Data on Rural Status	3,415,896	100%
Unknown Rural Status	127	n/a

Notes:

Percentages in this table have been rounded. Some numbers may not add to totals due to rounding.

(1) Unless otherwise noted, the data in this table represent cumulative data on the number of unique individuals who have been determined eligible to enroll in a Marketplace plan, and have selected a Marketplace medical plan (with or without the first premium payment having been received by the issuer). These data do not include: cancellations and terminations; a count of the number of individuals who have selected a standalone dental plan; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been granted a Special Enrollment Period (SEP). For additional technical notes, please refer to Appendix C of this report.

(2) For each metric, the data represent the total number of "Individuals Applying for 2015 Coverage in Completed Applications" who have selected a 2015 medical Marketplace plan for enrollment through the Marketplace (with or without the first premium payment having been received directly by the Marketplaces or the issuer) during the reference period, excluding plan selections with unknown data for a given metric. This is also known as pre-effectuated enrollment.

(3) In some cases, the data for certain characteristics of Marketplace plan selections are not yet available. For this reason, for each metric, we have calculated the comparable percentages based on the number of plan selections with known data for that metric.

(4) The subtotals for each metal tier type do not sum to the total number due to a small number of individuals (0.1%) who have have multiple 2015 Marketplace plan selections in the system that will be resolved through data cleanup processes (including some people who may have records in multiple states). Data for standalone dental plan selections are shown separately in this section, but are not included in any of the other metrics in this table.

Source: Centers for Medicare & Medicaid Services, as of 12-23-2014.

APPENDIX TABLE B1

Marketplace Plan Selection by Enrollment Type, Marketplace Type and State, 2015 (1) *11-15-2014 to 12-13-2014 (for State-Based Marketplaces Using Their Own Platforms), and 11-15-2014 to 12-15-2014 (for States Using the HealthCare.gov Platform)*			
Description	**Total Number of Individuals Who Have Selected a 2015 Marketplace Plan (1)**	**Distribution By Enrollment Type (2)**	
		New Consumers (3)	**Consumers Reenrolling in Marketplace Coverage (4)**
	Number	**% of Total**	**% of Total**
State-Based Marketplaces (SBMs) Using Their Own Marketplace Platforms			
California (5) (6)	118,770	N/A*	N/A
Colorado (7)	36,238	N/A	N/A
Connecticut (7) (8)	77,042	N/A	N/A
District of Columbia (7)	2,069	N/A	N/A
Hawaii (7)	1,903	N/A	N/A
Idaho (8) (9)	73,262	N/A	N/A
Kentucky (8)	82,651	9%	91%
Maryland (9)	50,742	N/A	N/A
Massachusetts (9)	32,266	N/A	N/A
Minnesota (7)	17,446	N/A	N/A
New York (6) (10)	42,982	N/A*	N/A
Rhode Island	12,347	20%	80%
Vermont (7) (8)	21,709	N/A	N/A
Washington (8)	63,411	20%	80%
TOTAL - SBMs Using Their Own Marketplace Platforms	**632,838**	**14%**	**86%**
States Using the HealthCare.gov Platform (11)			
State-Based Marketplaces (SBMs) Using the HealthCare.gov Platform (12)			
Nevada (13)	40,285	100%	0%
New Mexico	17,556	59%	41%
Oregon (13)	73,152	100%	0%
Subtotal - SBMs Using the HealthCare.gov Platform	**130,993**	**95%**	**5%**
Federally-Facilitated Marketplace (FFM) States			
Alabama	64,926	47%	53%
Alaska	9,325	39%	61%
Arizona	72,932	47%	53%
Arkansas	19,900	50%	50%
Delaware	8,956	56%	44%
Florida	673,255	49%	51%
Georgia	187,654	55%	45%
Illinois	121,243	54%	46%
Indiana	88,733	52%	48%
Iowa	18,913	49%	51%

Marketplace Plan Selection by Enrollment Type, Marketplace Type and State, 2015 (1) *11-15-2014 to 12-13-2014 (for State-Based Marketplaces Using Their Own Platforms), and 11-15-2014 to 12-15-2014 (for States Using the HealthCare.gov Platform)*			
Description	**Total Number of Individuals Who Have Selected a 2015 Marketplace Plan (1)**	**Distribution By Enrollment Type (2)**	
		New Consumers (3)	**Consumers Reenrolling in Marketplace Coverage (4)**
	Number	**% of Total**	**% of Total**
Kansas	39,023	53%	47%
Louisiana	56,651	51%	49%
Maine	36,132	39%	61%
Michigan	123,208	53%	47%
Mississippi	28,452	58%	42%
Missouri	102,087	50%	50%
Montana	22,618	42%	58%
Nebraska	32,213	52%	48%
New Hampshire	23,210	41%	59%
New Jersey	105,306	43%	57%
North Carolina	249,784	44%	56%
North Dakota	8,528	39%	61%
Ohio	88,927	48%	52%
Oklahoma	44,129	55%	45%
Pennsylvania	180,046	53%	47%
South Carolina	75,075	57%	43%
South Dakota	8,817	51%	49%
Tennessee	87,137	49%	51%
Texas	379,525	54%	46%
Utah	49,740	50%	50%
Virginia	164,884	54%	46%
West Virginia	12,283	54%	46%
Wisconsin	92,398	42%	58%
Wyoming	9,020	49%	51%
TOTAL – States Using the HealthCare.gov Platform	**3,416,023**	**52%**	**48%**
MARKETPLACE TOTAL	**4,048,861**	**50%**	**50%**

Notes:

"N/A" means that the data for the respective metric are not yet available for a given state.

* Indicates that the data reported for the current month only include new consumers, and exclude reenrollees.

(1) Unless otherwise noted, the data in these tables represent cumulative data on the number of unique individuals who have selected a 2015 Marketplace medical plan for enrollment through the Marketplaces (with or without the first premium payment having been received directly by the Marketplaces or the issuer). This is also known as pre-effectuated enrollment. These data do not include: cancellations and terminations; standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been granted a Special Enrollment Period (SEP). This table only reflects data for the individual market Marketplaces. For additional technical notes, please refer to Appendix C of this report.

(2) "Distribution by Enrollment Type" represents the percentage of plan selections with available data on enrollment type that are new consumers vs. consumers reenrolling in Marketplace coverage.

(3) "New Consumers" are those individuals who selected a 2015 Marketplace medical plan (with or without the first premium payment having been received directly by the Marketplaces or the issuer) as of the reporting date, and did not have a Marketplace

plan selection as of November 2014. These data do not include: cancellations and terminations; standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been granted a Special Enrollment Period (SEP). 3 SBM states that are using their own Marketplace platforms are reporting this metric.

(4) "Consumers Reenrolling in Marketplace Coverage" are those individuals who had a Marketplace plan selection as of November 2014, and have either actively submitted a 2015 application and selected a 2015 Marketplace medical plan or in applicable states using their own Marketplace platforms (Connecticut, Idaho, Kentucky, Vermont, and Washington), are being automatically reenrolled in Marketplace coverage – with or without the first premium payment having been received directly by the Marketplaces or the issuer). These data do not include: cancellations and terminations; standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been granted a Special Enrollment Period (SEP). 3 SBM states that are using their own Marketplace platforms are reporting this metric.

(5) California: The data that are being reported for California are for the following reporting period: 11-15-14 to 12-14-14. In a recent press release, Covered California recently stated that the comparable number as of 12-15-14 is 144,178 (see http://news.coveredca.com/2014/12/covered-california-and-department-of.html).

(6) California and New York only reported data on 2015 Marketplace plan selections by new consumers; data on the number of 2015 Marketplace plan selections by consumers reenrolling in Marketplace coverage are not yet available for these states.

(7) Several states have reported data on 2015 Marketplace plan selections that include plan selections by new consumers and plan selections by consumers reenrolling in Marketplace coverage, but have not yet reported any data on the distribution of Marketplace plan selections by enrollment status (new consumers vs. consumers reenrolling in Marketplace coverage for 2015).

(8) Several states (Connecticut, Idaho, Kentucky, Vermont, and Washington) initiated automatic reenrollment prior to 12-14-2014, and these numbers are included in their plan selection data.

(9) Idaho is an SBM that changed Marketplace platforms for the 2015 coverage year (Idaho transitioned from using the HealthCare.gov platform to using its own platform). Additionally, Massachusetts and Maryland changed their eligibility and enrollment system vendors for the 2015 coverage year. All of the plan selections for these states are being treated as new consumers for operational enrollment and reporting purposes.

(10) New York is currently unable to distinguish between Marketplace plan selections for the 2014 coverage year and Marketplace plan selections for the 2015 coverage year. Therefore, the plan selection data that are reported by New York may include a small number of plan selections from new consumers who were approved for a special enrollment period for 2014 Marketplace coverage between 11-15-14 and 12-15-14.

(11) For the HealthCare.gov states, the data on 2015 Marketplace plan selections includes data for new consumers and consumers who are actively reenrolling in Marketplace coverage, but does not include data for consumers who are being automatically reenrolled into coverage.

(12) Nevada, New Mexico, and Oregon are using the HealthCare.gov platform for 2015.

(13) Nevada and Oregon changed Marketplace platforms in 2015. Therefore, their 2015 Marketplace plan selections are generally being classified as new consumers for operational enrollment and reporting purposes. However, a small number of 2015 plan selections in these states may be classified as consumers reenrolling in Marketplace coverage in cases where an individual who had an active 2014 Marketplace plan selection in a HealthCare.gov state signs up for 2015 coverage in Oregon or Nevada.

Source: Centers for Medicare & Medicaid Services, as of 12-23-2014.

APPENDIX TABLE B2

Total Completed Applications and Individuals Who Completed Applications in States Using the HealthCare.gov Platform, By State, 2015
11-15-2014 to 12-15-2014

Description	Total Number of Completed Applications for 2015 Coverage (2)	Total Individuals Applying for 2015 Coverage in Completed Applications (3)	Individuals Applying for 2015 Coverage in Completed Applications By Status			
			Have Selected a 2015 Marketplace Plan (4)	Have Been Determined Eligible to Enroll, but Have Not Selected a 2015 Marketplace Plan (5)	Have Been Determined or Assessed Eligible for Medicaid/CHIP (6)	Pending / Other (7)
	Number	Number	% of Total	% of Total	% of Total	% of Total
States Using the HealthCare.gov Platform						
State-Based Marketplaces (SBMs) Using the HealthCare.gov Platform (8)						
Nevada	40,737	62,168	65%	14%	21%	0%
New Mexico	19,468	28,175	62%	18%	19%	1%
Oregon	97,115	144,520	51%	12%	19%	18%
Subtotal - SBMs Using the HealthCare.gov Platform	**157,320**	**234,863**	**56%**	**14%**	**20%**	**11%**
Federally-Facilitated Marketplace (FFM) States						
Alabama	70,021	96,948	67%	25%	4%	5%
Alaska	8,650	12,715	73%	17%	8%	1%
Arizona	67,729	112,752	65%	20%	15%	0%
Arkansas	28,426	41,211	48%	17%	18%	17%
Delaware	8,948	13,638	66%	17%	16%	1%
Florida	635,946	884,010	76%	18%	6%	0%
Georgia	183,868	273,616	69%	23%	8%	0%
Illinois	124,630	182,770	66%	17%	16%	0%
Indiana	92,144	135,405	66%	18%	16%	0%
Iowa	21,175	30,424	62%	18%	19%	1%
Kansas	36,262	54,899	71%	22%	7%	0%
Louisiana	60,006	79,306	71%	23%	3%	2%
Maine	30,420	45,236	80%	15%	5%	0%
Michigan	123,508	185,745	66%	14%	19%	0%
Mississippi	34,829	44,163	64%	28%	7%	0%
Missouri	98,530	145,940	70%	21%	9%	0%

Total Completed Applications and Individuals Who Completed Applications in States Using the HealthCare.gov Platform, By State, 2015
11-15-2014 to 12-15-2014

Description	Total Number of Completed Applications for 2015 Coverage (2)	Total Individuals Applying for 2015 Coverage in Completed Applications (3)	Individuals Applying for 2015 Coverage in Completed Applications By Status			
			Have Selected a 2015 Marketplace Plan (4)	Have Been Determined Eligible to Enroll, but Have Not Selected a 2015 Marketplace Plan (5)	Have Been Determined or Assessed Eligible for Medicaid/CHIP (6)	Pending / Other (7)
	Number	Number	% of Total	% of Total	% of Total	% of Total
Montana	20,268	30,235	75%	19%	3%	3%
Nebraska	26,288	43,641	74%	18%	8%	1%
New Hampshire	22,616	33,210	70%	14%	15%	1%
New Jersey	119,433	179,170	59%	17%	12%	12%
North Carolina	227,103	328,173	76%	18%	6%	0%
North Dakota	6,510	11,350	75%	13%	11%	0%
Ohio	94,358	139,786	64%	17%	19%	0%
Oklahoma	41,064	62,652	70%	22%	8%	0%
Pennsylvania	211,638	295,846	61%	15%	11%	13%
South Carolina	75,454	102,849	73%	20%	6%	0%
South Dakota	8,546	13,400	66%	25%	9%	0%
Tennessee	104,975	150,531	58%	24%	8%	10%
Texas	358,779	569,431	67%	25%	3%	5%
Utah	37,044	74,817	66%	19%	15%	0%
Virginia	145,093	224,808	73%	20%	6%	0%
West Virginia	12,970	18,803	65%	17%	8%	10%
Wisconsin	89,885	126,164	73%	15%	6%	6%
Wyoming	7,746	11,932	76%	18%	6%	0%
TOTAL – States Using the HealthCare.gov Platform	**3,392,182**	**4,990,439**	**68%**	**19%**	**9%**	**3%**

Notes:

"N/A" means that the data for the respective metric are not yet available for a given state.

(1) Unless otherwise noted, the data in this table represent cumulative Marketplace enrollment-related activity for 11-15-14 to 12-15-14. These data also do not include any enrollment-related activity relating to individuals who may have applied for and/or selected a 2014 Marketplace plan during the reporting period, as a result of having been granted a Special Enrollment Period (SEP). This table only reflects data for the individual market Marketplaces. For additional technical notes, please refer to Appendix C of this report.

(2) "Completed Applications for 2015 Coverage" represents the total number of electronic and paper applications that were submitted to the Marketplace during the reference period with sufficient information to begin performing eligibility determinations for enrollment in a plan through the Marketplace and, if appropriate, sufficient information to begin performing eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions, and eligibility assessments or determinations for Medicaid and CHIP.

(3) "Individuals Applying for 2015 Coverage in Completed Applications" represents the total number of individuals included in Completed Applications that were submitted to the Marketplaces during the applicable reference period. This number does not include individuals applying through the SHOP.

(4) "Has Selected a 2015 Marketplace Plan" represents the percentage of "Individuals Applying for 2015 Coverage in Completed Applications" who have selected a 2015 Marketplace medical plan for enrollment through the Marketplaces (with or without the first premium payment having been received directly by the Marketplaces or the issuer) during the reference period. This is also known as pre-effectuated enrollment. These data do not include: cancellations and terminations; standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been granted a Special Enrollment Period (SEP).

(5) "Has Been Determined Eligible to Enroll, But Has Not Selected a 2015 Marketplace Plan" represents the percentage of "Individuals Applying for 2015 Coverage in Completed Applications" who have been determined eligible to enroll in a 2015 Marketplace plan, but have not yet selected a 2015 Marketplace medical plan.

(6) "Has Been Determined or Assessed Eligible for Medicaid / CHIP" represents the percentage of "Individuals Applying for 2015 Coverage in Completed Applications" who have been determined or assessed by the Marketplace as eligible for Medicaid or CHIP, based on their modified adjusted gross income (MAGI). In some states, completed applications for individuals, whom the Marketplace has assessed as potentially eligible for Medicaid or CHIP based on MAGI, are transferred to the relevant state agency for a final eligibility determination. In these "assessment states" the data include those accounts where a final decision is pending. In other states, the Marketplace has been delegated the final Medicaid/CHIP eligibility determination responsibility for these individuals. Thus, this data element includes FFM determinations and assessments, regardless of the state Medicaid/CHIP agency's final eligibility determination, if applicable. These data may vary from accounts transferred via "flat file" to states by the FFM. Quality assurance continues on Medicaid assessments and determinations. Note: Marketplace Medicaid/CHIP eligibility determination and assessment data in this report cannot be added to eligibility determination data in the most recent monthly Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment report (available on Medicaid.gov), which covers data from October 2014. In the Marketplaces, some of the individuals assessed or determined eligible for Medicaid or CHIP by the Marketplace and reported in this report may also be reported in the monthly Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Report when the state has made an eligibility determination based on the information provided by the Marketplace. Total Medicaid & CHIP enrollment is reported in the monthly Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Report, and is a point-in-time count of total enrollment in the Medicaid and CHIP programs at the end of the monthly reporting period.

(7) "Pending/Other" is a derived estimate representing the percentage of "Individuals Applying for 2015 Coverage in Completed Applications" who either: 1) have a pending eligibility determination or assessment for a Marketplace plan or Medicaid/CHIP coverage; 2) have a completed eligibility determination or assessment for a Marketplace plan or Medicaid/CHIP coverage that is not captured in the relevant column in this table for a given state due to system issues; or 3) have been deemed ineligible for Marketplace plan coverage. The Pending/Other totals shown in this table are based on the sums of the corresponding state-level Pending/Other counts, which may differ slightly from the difference between the total number of individuals applying for coverage in completed applications and the total number of individuals with processed eligibility determinations.

(8) Nevada, New Mexico, and Oregon are using the HealthCare.gov platform for 2015.

Source: Centers for Medicare & Medicaid Services, as of 12-23-2014.

APPENDIX TABLE B3

Total Marketplace Eligibility Determinations, and Marketplace Plan Selections in States Using the HealthCare.gov Platform, By State, 2015 (1) *11-15-2014 to 12-15-2014*				
State Name	**Number of Individuals Determined Eligible to Enroll through the Marketplace for 2015 Coverage**		**Number of Individuals Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace (4)**	**Number of Individuals With 2015 Marketplace Plan Selections** *(not including automatic reenrollments)* **(5)**
	Total Eligible to Enroll in a Marketplace Plan (2)	**Eligible to Enroll in a Marketplace Plan with Financial Assistance (3)**		
	Number	**Number**	**Number**	**Number**
States Using the HealthCare.gov Platform				
State-Based Marketplaces (SBMs) Using the HealthCare.gov Platform (6)				
Nevada	48,812	42,381	13,066	40,285
New Mexico	22,748	17,479	5,249	17,556
Oregon	91,179	73,149	28,043	73,152
Subtotal - SBMs Using the HealthCare.gov Platform	**162,739**	**133,009**	**46,358**	**130,993**
Federally-Facilitated Marketplace (FFM) States				
Alabama	88,942	68,026	3,434	64,926
Alaska	11,536	9,637	1,069	9,325
Arizona	95,610	75,403	16,809	72,932
Arkansas	26,790	22,194	7,347	19,900
Delaware	11,303	8,970	2,219	8,956
Florida	833,380	721,666	48,812	673,255
Georgia	250,766	200,426	22,298	187,654
Illinois	152,589	121,063	29,565	121,243
Indiana	112,811	93,994	22,201	88,733
Iowa	24,432	20,305	5,780	18,913
Kansas	50,871	38,039	3,912	39,023
Louisiana	74,992	60,664	2,341	56,651
Maine	42,945	36,040	2,194	36,132
Michigan	149,270	129,927	36,015	123,208
Mississippi	40,985	33,002	3,092	28,452
Missouri	133,171	106,847	12,560	102,087

Total Marketplace Eligibility Determinations, and Marketplace Plan Selections in States Using the HealthCare.gov Platform, By State, 2015 (1)
11-15-2014 to 12-15-2014

State Name	Number of Individuals Determined Eligible to Enroll through the Marketplace for 2015 Coverage		Number of Individuals Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace (4)	Number of Individuals With 2015 Marketplace Plan Selections *(not including automatic reenrollments)* (5)
	Total Eligible to Enroll in a Marketplace Plan (2)	Eligible to Enroll in a Marketplace Plan with Financial Assistance (3)		
	Number	Number	Number	Number
Montana	28,444	23,485	759	22,618
Nebraska	40,095	33,285	3,315	32,213
New Hampshire	28,022	19,939	5,005	23,210
New Jersey	136,612	107,585	21,093	105,306
North Carolina	307,667	261,605	20,079	249,784
North Dakota	10,021	8,713	1,279	8,528
Ohio	113,208	93,341	26,263	88,927
Oklahoma	57,763	44,512	4,741	44,129
Pennsylvania	224,707	177,085	31,328	180,046
South Carolina	96,032	77,154	6,647	75,075
South Dakota	12,170	10,072	1,181	8,817
Tennessee	123,419	90,362	11,943	87,137
Texas	523,441	401,973	18,211	379,525
Utah	63,619	55,029	11,025	49,740
Virginia	209,955	159,679	14,377	164,884
West Virginia	15,446	12,597	1,512	12,283
Wisconsin	111,434	97,436	7,590	92,398
Wyoming	11,227	9,458	672	9,020
TOTAL – States Using the HealthCare.gov Platform	**4,376,414**	**3,562,522**	**453,026**	**3,416,023**

Notes:
"N/A" means that the data for the respective metric are not yet available for a given state.

(1) Unless otherwise noted, the data in this table represent cumulative Marketplace enrollment-related activity for 11-15-14 to 12-15-14. These data also do not include any enrollment-related activity relating to individuals who may have applied for and/or selected a 2014 Marketplace plan during the reporting period, as a result of having been granted a Special Enrollment Period (SEP). This table only reflects data for the individual market Marketplaces. For additional technical notes information, please refer to Appendix C of this report.

(2) "Individuals Determined Eligible to Enroll in a Plan Through the Marketplace" (i.e., enrollment through the Marketplaces for a 2015 Marketplace plan) represents the total number of individuals for whom a Completed Application has been received for the 2015 plan year (including any individuals with active 2014 Marketplace enrollments who returned to the Marketplaces and updated their information), and who are determined to be eligible for plan enrollment through the Marketplaces during the reference period, whether or not they qualify for advance payments of the premium tax credit or cost-sharing reductions. These individuals may or may not have enrolled in coverage by the end of the reference period. Individuals who have been determined or assessed eligible for Medicaid or CHIP are not included.

(3) "Individuals Determined Eligible to Enroll in a Plan Through the Marketplace with Financial Assistance" (i.e., enrollment through the Marketplace for a 2015 Marketplace plan with Financial Assistance) represents the total number of individuals determined eligible to enroll through the Marketplace in a Marketplace plan who qualify for an advance premium tax credit (APTC), with or without a cost-sharing reduction (CSR) for the 2015 plan year (including any individuals with active 2014 Marketplace enrollments who returned to the Marketplace and updated their information). These individuals may or may not have enrolled in coverage by the end of the reference period.

(4) "Individuals Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace" represents the number of individuals who have been determined or assessed by the Marketplace as eligible for Medicaid or CHIP based on their modified adjusted gross income (MAGI). In some states, completed applications for individuals, whom the Marketplace has assessed as potentially eligible for Medicaid or CHIP, based on MAGI, are transferred to the relevant state agency for a final eligibility determination. In these "assessment states" the data include those accounts where a final decision is pending. In other states, the Marketplace has been delegated the final Medicaid/CHIP eligibility determination responsibility for these individuals. Thus, this data element includes FFM determinations and assessments, regardless of the state Medicaid/CHIP agency's final eligibility determination, if applicable. These data may vary from accounts transferred via "flat file" to states by the FFM. Quality assurance continues on Medicaid assessments and determinations. Note: Marketplace Medicaid/CHIP eligibility determination and assessment data in this report cannot be added to eligibility determination data in the most recent monthly Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment report (available on Medicaid.gov) which covers data through October 2014. In the Marketplaces, some of the individuals assessed or determined eligible for Medicaid or CHIP by the Marketplace and reported in this report may also be reported in the monthly Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Report when the state has made an eligibility determination based on the information provided by the Marketplace. Total Medicaid/CHIP enrollment is reported in the monthly Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Report, and is a point-in-time count of total enrollment in the Medicaid and CHIP programs at the end of the monthly reporting period.

(5) "Individuals With 2015 Marketplace Plan Selections" represents the total number of individuals determined eligible to enroll in a plan through the marketplace" who have selected a 2015 Marketplace medical plan for enrollment through the Marketplaces or, after December 15, have been automatically reenrolled in Marketplace coverage (with or without the first premium payment having been received directly by the Marketplace or the issuer) during the reference period. This is also known as pre-effectuated enrollment. These data do not include: cancellations and terminations; a count of the number of individuals who have selected a standalone dental plan; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been granted a Special Enrollment Period (SEP).

(6) Nevada, New Mexico, and Oregon are using the HealthCare.gov platform for 2015.

Source: Centers for Medicare & Medicaid Services, as of 12-23-2014.

APPENDIX TABLE B4

Marketplace Plan Selections by Financial Assistance Status in States Using the HealthCare.gov Platform, By State (1) *11-15-14 to 12-15-14*				
Description	**Total Number of Individuals Who Have Selected a 2015 Marketplace Plan (2)**	**Plan Selections With Available Data on Financial Assistance Status (3)**	**By Financial Assistance Status** *(% of Available Data, Excluding Unknown)*	
			With Financial Assistance	**Without Financial Assistance**
	Number	**Number**	**%**	**%**
States Using the HealthCare.gov Platform (4)				
State-Based Marketplaces (SBMs) Using the HealthCare.gov Platform (5)				
Nevada	40,285	40,285	90%	10%
New Mexico	17,556	17,556	73%	27%
Oregon	73,152	73,152	79%	21%
Subtotal - SBMs Using the HealthCare.gov Platform	**130,993**	**130,993**	**82%**	**18%**
Federally-Facilitated Marketplace (FFM) States				
Alabama	64,926	64,926	91%	9%
Alaska	9,325	9,325	91%	9%
Arizona	72,932	72,932	77%	23%
Arkansas	19,900	19,900	89%	11%
Delaware	8,956	8,956	83%	17%
Florida	673,255	673,255	94%	6%
Georgia	187,654	187,654	89%	11%
Illinois	121,243	121,243	80%	20%
Indiana	88,733	88,733	88%	12%
Iowa	18,913	18,913	86%	14%
Kansas	39,023	39,023	80%	20%
Louisiana	56,651	56,651	91%	9%
Maine	36,132	36,132	89%	11%
Michigan	123,208	123,208	89%	11%
Mississippi	28,452	28,452	95%	5%
Missouri	102,087	102,087	89%	11%
Montana	22,618	22,618	85%	15%
Nebraska	32,213	32,213	88%	12%
New Hampshire	23,210	23,210	69%	31%
New Jersey	105,306	105,306	82%	18%
North Carolina	249,784	249,784	92%	8%
North Dakota	8,528	8,528	88%	12%
Ohio	88,927	88,927	85%	15%
Oklahoma	44,129	44,129	82%	18%
Pennsylvania	180,046	180,046	79%	21%
South Carolina	75,075	75,075	88%	12%
South Dakota	8,817	8,817	88%	12%

Marketplace Plan Selections by Financial Assistance Status in States Using the HealthCare.gov Platform, By State (1) *11-15-14 to 12-15-14*				
Description	**Total Number of Individuals Who Have Selected a 2015 Marketplace Plan (2)**	**Plan Selections With Available Data on Financial Assistance Status (3)**	**By Financial Assistance Status** *(% of Available Data, Excluding Unknown)*	
			With Financial Assistance	**Without Financial Assistance**
	Number	**Number**	**%**	**%**
Tennessee	87,137	87,137	83%	17%
Texas	379,525	379,524	86%	14%
Utah	49,740	49,740	89%	11%
Virginia	164,884	164,884	83%	17%
West Virginia	12,283	12,283	85%	15%
Wisconsin	92,398	92,398	90%	10%
Wyoming	9,020	9,020	92%	8%
TOTAL – States Using the HealthCare.gov Platform	**3,416,023**	**3,416,022**	**87%**	**13%**

Notes:

"N/A" means that the data for the respective metric is not yet available for a given state. Percentages in this table have been rounded. Some numbers may not add to totals due to rounding.

(1) Unless otherwise noted, the data in this table represent cumulative data on the number of unique individuals who have been determined eligible to enroll in a Marketplace plan, and have selected a Marketplace medical plan (with or without the first premium payment having been received by the issuer). These data do not include: cancellations and terminations; a count of the number of individuals who have selected a standalone dental plan; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been granted a Special Enrollment Period (SEP). For additional technical notes, please refer to Appendix C of this report.

(2) For each metric, the data represent the total number of "Individuals Applying for 2015 Coverage in Completed Applications" who have selected a 2015 medical Marketplace plan for enrollment through the Marketplace (with or without the first premium payment having been received directly by the Marketplaces or the issuer) during the reference period, excluding plan selections with unknown data for a given metric. This is also known as pre-effectuated enrollment.

(3) In some cases, the data for certain characteristics of Marketplace plan selections are not yet available. For this reason, for each metric, we have calculated the comparable percentages based on the number of plan selections with known data for that metric.

(4) For the HealthCare.gov states, the data on 2015 Marketplace plan selections includes data for new consumers and consumers who are actively reenrolling in Marketplace coverage, but does not include data for consumers who are being automatically reenrolled into coverage.

(5) Nevada, New Mexico, and Oregon are using the HealthCare.gov platform for 2015.

Source: Centers for Medicare & Medicaid Services, as of 12-23-2014.

APPENDIX C: TECHNICAL NOTES

We believe that the information contained in this issue brief provides the most systematic summary of enrollment-related activity in the Marketplaces through the first month of the 2015 Open Enrollment period because the data for the various metrics are counted using comparable definitions for data elements across states, and Marketplace platforms. However, data for certain metrics may not be available (including in states that changed their Marketplace platform between the 2014 and 2015 coverage years) due to information system issues. **It is also important to note that the data that are included in this report may differ slightly from comparable data that are included in the weekly enrollment updates that are published by CMS (also known as the Weekly Enrollment Snapshots) because that data may be based on different time periods and/or reporting dates than those that are used in this report.**

The following section provides additional information about the metrics used in this enrollment report, in addition to the information that is included elsewhere in the footnotes of the tables in this report.

Additional Information About the Metrics Used in this Marketplace Summary Enrollment Report

Reporting of Data on Activity Relating to the 2015 Marketplace Coverage Year – Except where otherwise noted, this report includes enrollment-related data on activity related to the 2015 Marketplace coverage year. The data that are being reported for 11-15-14 to 12-15-14 do not include activity associated with individuals who may have applied for and/or qualified for a Special Enrollment Period for 2014 Marketplace coverage.

Reporting Period – This report includes data that are currently available on enrollment-related activity for the first month of the 2015 Open Enrollment period – which generally corresponds with data from 11-15-14 to 12-15-14 for the 37 HealthCare.gov states, and from 11-15-14 to 12-13-14 for most of the states that are using their own Marketplace platforms for the 2015 coverage. The following table shows how the reporting periods for the data in this report compare with those for the most recent Weekly Enrollment Snapshot.

Appendix Table C1

Marketplace Type	Reporting Period	
	December Monthly Enrollment Report	Week 6 Weekly Enrollment Snapshot
States Using the HealthCare.gov Marketplace Platform (37 states)	11-15-14 to 12-15-14*	11-15-14 to 12-26-14
States Using Their Own Marketplace Platform (14 states)		
California	11-15-14 to 12-14-14	Not included
Other 13 States (including DC)	11-15-14 to 12-13-14	Not included

*Data for call center and website visits are for 11-15-2014 – 12-20-2014

2015 Marketplace Plan Selections – Represents cumulative data on the number of unique individuals who have selected a 2015 Marketplace plan for enrollment through the Marketplaces (with or without the first premium payment having been received directly by the Marketplaces or the issuer) during the reference period. This is also known as pre-effectuated enrollment. These data represent the number of individuals with active plan selections for a Marketplace medical plan as of the reporting date (excluding cancellations and terminations), and do not include stand-alone dental plan selections. These data also do not include any individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been granted a Special Enrollment Period (SEP). This table only reflects data for the individual market Marketplaces.

We are using the term "active Marketplace plan selections" to signify that the total number of Individuals Who Have Selected a Marketplace Plan that is reported in the monthly Marketplace enrollment reports excludes data for plan selections that have been cancelled or terminated. For example, if an individual selected a Marketplace plan during the first week of the open enrollment period, but selected a different plan during the third week of the open enrollment period, the active plan selections total would only include data for the most recent plan selection. This is consistent with the way that the Marketplace plan selection data were reported in the previous monthly enrollment reports for the 2014 Open Enrollment period.

Definitions of "New" and "Reenrolling" Consumers – The monthly enrollment reports for the 2015 Open Enrollment period distinguish plan selections by new consumers from plan selections by those who are reenrolling in Marketplace coverage:

- ***"New Consumers"*** are those individuals who selected a 2015 Marketplace plan (with or without the first premium payment having been received directly by the Marketplaces or the issuer) and did not have a Marketplace plan selection as of November 2014. These data do not include: cancellations and terminations; standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been granted a Special Enrollment Period (SEP). Additionally, some states are generally classifying all of their plan selections as new consumers for operational enrollment and reporting purposes due to changes in Marketplace platform (e.g., Idaho switched to using its own Marketplace platform in 2015, while Nevada and Oregon switched to using the HealthCare.gov platform in 2015), or changes in system vendors (Maryland and Massachusetts).

- ***"Consumers Reenrolling in Marketplace Coverage"*** are those individuals who had Marketplace plan selection as of November 2014, and have either actively submitted a 2015 application and selected a 2015 Marketplace medical plan, or in applicable states using their own Marketplace platforms (Connecticut, Idaho, Kentucky, Vermont, and Washington), are being automatically reenrolled in Marketplace coverage – with or without the first premium payment having been received directly by the Marketplaces or the issuer. These data do not include: cancellations and terminations; standalone dental plan selections; or individuals who may have selected a 2014 Marketplace plan during the reporting period, as a result of having been granted a Special Enrollment Period (SEP). This category is consistent with the "consumers renewing coverage" category

that is included in the HHS Weekly Enrollment Snapshots. Consumers Reenrolling in Marketplace Coverage includes the following two categories:

- ***Consumers who are Actively Reenrolling in Marketplace Coverage*** – People who had a Marketplace plan selection as of November 2014, and return to the Marketplace to select a new plan or actively renew their existing plan; and

- ***Consumers who are being Automatically Reenrolled into Marketplace Coverage (also known as "Automatic Reenrollees")*** – People who had a Marketplace plan selection as of November 2014, and retain coverage without returning to the Marketplace and selecting a plan.

The categories of Marketplace plan selection data for the first month of the 2015 Open Enrollment period that are included in this report vary by Marketplace type and state:

Appendix Table C2

Enrollment Type	**States Using Their Own Marketplace Platforms** *(14 states including DC)*	**States Using the HealthCare.gov Platform** *(37 states)*
New Consumers	Included in this report	Included in this report
Consumers Who Are Actively Reenrolling in Marketplace Coverage	Included in this report for the following 12 states: CO, CT, DC, HI, ID, KY, MD, MA, MN, RI, VT, and WA* *[Not included for CA and NY]*	Included in this report**
Consumers Who Are Being Automatically Reenrolled into Marketplace Coverage	Included in this report for the following five states: CT, ID, KY, VT, and WA	Not included in this report

* Some states that are using their own Marketplace platforms are generally classifying all of their plan selections as new consumers for operational enrollment and reporting purposes due to changes in Marketplace platform (e.g., ID, which switched to using its own Marketplace platform in 2015), or changes in eligibility and enrollment system vendors (MD and MA).
** Some HealthCare.gov states are generally classifying all of their plan selections as new consumers for operational enrollment and reporting purposes due to changes in Marketplace platform (e.g., NV and OR, which switched to using the HealthCare.gov platform in 2015).

Categories for Reporting State-Level Marketplace Data – The Health Insurance Marketplace includes the Marketplaces established in each of the states (and the District of Columbia) and run by the state or the federal government. This report addresses the individual market Marketplaces that are using their own Marketplace platforms for the 2015 coverage year, as well as the individual market Marketplaces that are using the HealthCare.gov Marketplace platform for eligibility and enrollment for the 2015 coverage year (data for the small group Marketplace, also known as SHOP, is not included in this report).

Marketplace enrollment-for the 2015 Open Enrollment period, will be reported based on the

following two major categories:

- **State-Based Marketplaces (SBMs) Using Their Own Marketplace Platform** – 14 states (including DC):

  California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, and Washington.

- **States Using the HealthCare.gov Platform** – 37 states, including:

  - ***State-Based Marketplaces Using the HealthCare.gov Platform*** – 3 states

    Nevada, New Mexico, and Oregon *(Note: one of these states (New Mexico) also used the HealthCare.Gov platform during the 2014 Open Enrollment period; however, Nevada and Oregon switched to using the HealthCare.gov platform for the 2015 Open Enrollment period).*

  - ***Federally-Facilitated Marketplaces*** – 34 states

    Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming. *(Note: all of these states also used the HealthCare.Gov platform during the 2014 Open Enrollment period).*

Notes on Changes in Marketplace Platforms – The following states changed their Marketplace eligibility and enrollment platform between the 2014 and 2015 coverage years:

- Nevada and Oregon switched from using their own Marketplace eligibility and enrollment platforms in 2014 to using the HealthCare.gov platform for eligibility and enrollment for 2015 (as a consequence, all people who select 2015 Marketplace plans in NV and OR are treated as new consumers for operational enrollment and reporting purposes because the system cannot identify or automatically reenroll persons who previously had 2014 Marketplace coverage in these states); and

- Idaho switched from using the HealthCare.gov platform for 2014 to using its own Marketplace platform for 2015.

Additionally, Maryland and Massachusetts are continuing to use their own Marketplace platforms, but have implemented new eligibility and enrollment systems for the 2015 Open Enrollment period, and as a result, the Marketplaces in these states are unable to distinguish between new consumers and consumers reenrolling in Marketplace coverage for plan year 2015. Individuals who have 2014 Marketplace coverage in these states will need to return to the Marketplace to reenroll in coverage for 2015.

Idaho, Nevada, Oregon, Maryland and Massachusetts are generally classifying all of their plan selections as new consumers for operational enrollment and reporting purposes due to their changes in Marketplace platform (e.g., ID, NV and OR) or eligibility and enrollment system vendors (MD and MA).

Data on Total Number of Completed Applications and Total Individuals Applying for Coverage in Completed Applications – We are showing data on the number of completed applications and the total number of individuals applying for coverage in the completed applications in this report.

Data on Characteristics of Marketplace Plan Selections by Metal Level – The subtotals for each metal tier type do not sum to the total number of Plan Selections with Available Data on Metal Level due to a small number of individuals (0.1%) who have multiple 2015 Marketplace plan selections in the system that will be resolved through data cleanup processes (including some people who may have records in multiple states). Data for standalone dental plan selections are shown separately.

Standalone Dental Plan Selections – Individuals who are shopping for health insurance coverage in the Marketplace have the choice of selecting:

- A medical Marketplace plan with integrated dental coverage,
- A medical Marketplace plan without integrated dental coverage, or
- A medical Marketplace plan and a separate standalone dental plan (it is not possible to select a standalone dental plan without also selecting a medical plan).

Individuals who have selected both a medical Marketplace plan and a standalone dental plan are only counted once in the total Marketplace plan selections metric. However, we report data on total standalone dental plan selections separately for the 37 states that are using the HealthCare.gov platform, including combined data for both the "High" and "Low" standalone dental plan metal tier types (see Appendix Table A).

Data on Additional Characteristics of Marketplace Plan Selections – This report also includes data on the characteristics of persons who have selected a Marketplace plan in the 37 states that are using the HealthCare.gov platform by Race/Ethnicity and Rural Status. In some cases, the data for certain characteristics of Marketplace plan selections are not yet available. For this reason, for each metric, we have calculated the comparable percentages based on the number of plan selections with known data for that metric.

- ***Race/Ethnicity –*** The application for Marketplace coverage in the states using the HealthCare.gov platform contains questions on race and on ethnicity, which are both marked as optional. The share of unknown race/ethnicity in Marketplace plan selection data for HealthCare.gov states is higher than in federal survey data,[11] but lower than that

[11] The main Census surveys have missing data on 3 to 5 percent of respondents, and the National Health Interview Survey has missing information for about 5 percent of respondents. (Source: ASPE correspondence with U.S. Census and the National

reported in administrative data sources in the healthcare industry.[12] Thus, while this information is provided for transparency purposes, its quality is low and its use should be limited. For example, it is also important to note that the racial/ethnic makeup of the persons with unknown race and ethnicity who selected a Marketplace plan in the HealthCare.gov states may differ substantially from that among those who reported race and ethnicity. For example, if racial and ethnic minorities are more likely to skip the optional questions, they would be disproportionately under-reported in the overall totals.[13]

- ***Rural Status*** **–** The proportion of Marketplace plan selections in rural areas was derived by aggregating data for Marketplace plan selections with valid ZIP Code information based on the HHS Office of Rural Health Policy's (ORHP) most current list of Rural Designated ZIPs, which has been updated using the 2010 Census data.

Number of Individuals Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace **–** Marketplace Medicaid & CHIP eligibility determination and assessment data in this report cannot be added to eligibility determination data in the most recent monthly Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment report (available on www.Medicaid.gov), which covers data through October 2014. Some of the individuals assessed or determined eligible for Medicaid or CHIP by the Marketplace and reported in this report may also be reported in the monthly Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Report when the state has made an eligibility determination based on the information provided by the Marketplace. Total Medicaid & CHIP enrollment is reported in the monthly Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Report, and is a point-in-time count of total enrollment in the Medicaid and CHIP programs at the end of the monthly reporting period.

Effectuated Enrollment – Data on effectuated enrollment for the 2015 Open Enrollment period are not yet available.

Center for Health Statistics regarding the American Community Survey, the Current Population Survey, and the National Health Interview Survey; February 2014.)

[12] For example, a study of administrative data from the Department of Veterans Affairs found that race/ethnicity information was missing from files for 36 percent of patients. Additionally, as of 2008, commercial plans that collected race and ethnicity data only had information for about 40 percent of their members. The health insurance company Aetna, which began collecting data on race and ethnicity for all its members in 2002 via enrollment forms, currently has information on race/ethnicity for about 35 percent of its membership. (Sources: Nancy R. Kressin, Bei-Hung Chang, Ann Hendricks, and Lewis E. Kazis, "Agreement between administrative data and patients' self-reports of race/ethnicity," American Journal of Public Health, vol. 93, no. 10 (2003), p. 1734-1739); José J. Escarce, Rita Carreón, German Veselovskiy, and Elisa H. Lawson, "Collection of race and ethnicity data by health plans has grown substantially, but opportunities remain to expand efforts," Health Affairs, vol. 30, no. 10 (2011); and Aetna, "Aetna's Commitment," accessed April 25, 2014. Available at: http://www.aetna.com/about-aetna-insurance/initiatives/racial-ethnic-equality/index.html.

[13] For additional information on the methodology that was used to analyze the characteristics of individuals who selected a Marketplace plan in the HealthCare.gov states by race/ethnicity, please refer to Appendix C in the 2014 Marketplace Summary Enrollment Report, which can be accessed at http://www.aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf.

Additional Data Validation – CMS has been taking steps to enhance the processes for generating and validating Marketplace data. As such, some of the numbers in this report could be updated in future reports.

McKinsey&Company

McKinsey Center for U.S. Health System Reform

Intelligence Brief

Exchanges year 2: New findings and ongoing trends

The open enrollment period (OEP) for year 2 of the individual exchanges is officially under way, having begun on November 15th. To understand how the products being offered this year differ from those offered during the 2014 OEP, the McKinsey Center for U.S. Health System Reform expanded its database to include all of the 335 carriers[1] participating on the 2015 exchanges and all of the products they are offering there. This year, we were able to obtain data at a deeper level than we did last year (i.e., we were able to obtain 2014 and 2015 data for each county, not just each rating area). Thus, our database contains information on more than 223,000 ACA-compliant on-exchange products from both years, including premiums, benefit design, and network design. As a result, we were able to compare year-over-year carrier, product, and premium changes across the market as a whole. In addition, for each product offered in 2014 that was re-filed in 2015, we linked the data from both years so that we could understand the specific changes that 2014 exchange enrollees are seeing during the 2015 OEP.[2]

We elicited five key observations from our analyses:

- *Competition and choice are increasing nationwide.* In most counties, consumers shopping for coverage on the 2015 public exchanges have more carriers and more products from which to choose. Nationwide, the number of carriers participating on the exchanges has increased 19 percent since the 2014 OEP, and the number of products has increased 27 percent.

---

[1] The carrier count represents the number of unique carriers offering products in at least one county within a state (not all carriers offer products in every county within a state). Carrier count is as it appears to consumers shopping on exchanges. Specifically, the count is the number of carriers that offer products in each state, i.e., a carrier that offers products in 3 states is counted 3 times, a carrier that offers products under 2 different carrier names in one state is counted 2 times, a carrier that offers one or more products in 1 state under 1 carrier name is counted only once.

[2] Complete details about our methodology can be found in the Appendix.

- *Gross premium prices are rising, especially for PPO and broad-network products.* Between the 2014 and 2015 OEPs, gross premiums of the lowest-price exchange products rose by a median of 6 percent across metal tiers.[3] Among the lowest-price 2014 exchange products re-filed for 2015, the median gross premium increase is 10 percent. Premiums for re-filed products built on health maintenance organizations (HMOs), narrowed networks, or both increased much less than did the premiums for products based on preferred provider organizations (PPOs) or broad networks.
- *Switching products would minimize or eliminate premium increases in many cases, but would not always lower overall costs.* We estimate close to three-quarters of 2014 exchange enrollees have access this year to a product that is within the same metal tier as the product they bought last year but priced below the 2015 premium of last year's plan. Often, however, the lower-premium products have higher deductibles.[4]
- *Net premiums for subsidy-eligible consumers have often risen.* Net premiums for the lowest-price silver products have increased for nearly three-quarters of those eligible for subsidies,[5] but in most cases the increases are less than 10 percent.
- *Recent and new entrants are often price leaders.* Just over half of new price leaders are either recent or new entrants (i.e., carriers that entered the individual exchange market in one or more states last year or this year). In many counties, there is a significant change in competitive price positions.

Competition and choice are increasing nationwide

Across the U.S., the number of carriers operating on the individual exchanges has increased 19 percent since the 2014 OEP (*Exhibit 1*). Seventy new carriers[6] entered the 2015 exchanges, and 17 withdrew.[7] Two-thirds of the new entrants are carriers that had offered individual products in 2013 but sat out the exchanges in their markets in 2014. One or more new carriers entered the exchanges in 59 percent of counties, which collectively contain 70 percent of the eligible population. In the other 41 percent of counties, there are no new carriers.

---

[3] Median of the percentage change between the lowest-price 2014 product in each tier and the lowest-price 2015 product in the same tier in each county (calculated for all counties and all tiers).

[4] All products in a given metal tier should have a similar actuarial value, and thus the average consumers would be expected to pay should be similar. In addition to deductible, a range of other factors, including co-payments and the services to which the deductible is applied, influence the eventual amount a consumer must pay.

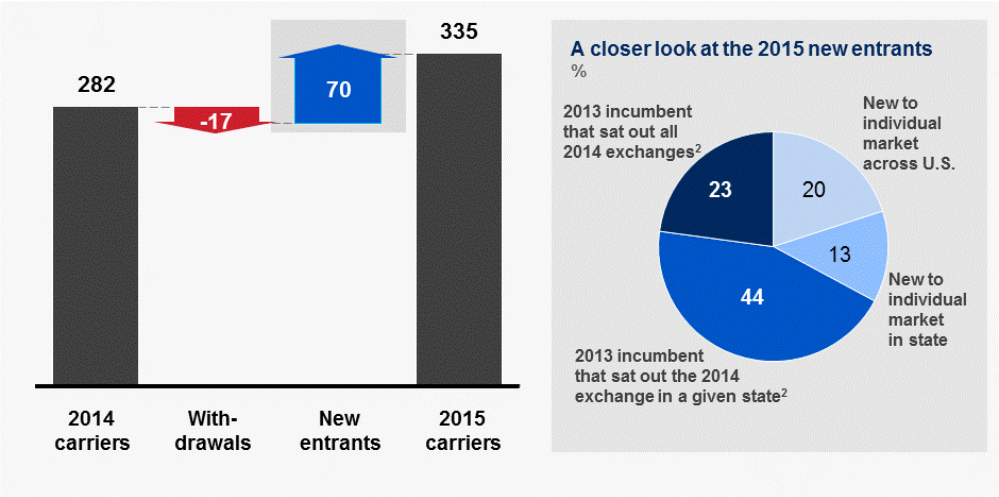
[5] Sixty-nine percent of the QHP-eligible population are eligible for subsidies; how many of these consumers will actually enroll is not yet known. Among 2014 exchange enrollees, 85 percent were determined to be eligible for subsidies. (ASPE Research Brief. "Health plan choice and premiums in the 2015 health insurance marketplace." December 2014.)

[6] Only 14 of the 70 new entrants are truly new to the individual insurance market. Forty of the new entrants participated in the 2014 OEP in some states but expanded into other states for 2015. The remaining 16 new entrants operated off-exchange in a given state but did not participate in that state's 2014 OEP.

[7] Seventeen is the number of withdrawals as it appears on the exchanges to consumers. Seven of the carriers had filed under two different legal-entity names in a given state during the 2014 OEP and then withdrew one of those names for 2015. (They stayed in the state under the other name.) As a result, the 17 withdrawals represent 10 unique carriers.

EXHIBIT 1

New carrier growth is driven in large part by re-entry of 2013 incumbents



1 Based on the number of carriers that offer plans in each state, i.e., carrier that offers plans in 3 states is counted 3 times, and a carrier that offers plans under 2 different carrier names in 1 state is counted 2 times
2 These carriers offered insurance in the off-exchange individual market prior to entering the exchange market in 2015.

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of November 19, 2014 across all states in the U.S.

With the exception of Blues carriers,[8] which were already available to 98 percent of exchange consumers in 2014, all carrier types increased their market presence in 2015 (*Exhibit 2*). National carriers[9] not participating in some or all of the 2014 exchanges are the most common type of new 2015 entrant and have the largest "footprint" expansion (i.e., increase in the number of consumers who can access their products on the exchanges).[10] Provider-based new entrants[11] have also expanded their footprint and remain the third most common carrier type after Blues and nationals.

8 Anthem is included in the category of Blues carriers. Because Anthem added a few new counties for the 2015 OEP, the Blues' market presence expanded slightly (from 97.7 percent in 2014 to 97.8 percent in 2015).

9 A commercial payor with a presence in more than 4 states that has filed on the exchanges (specifically, Assurant, Aetna/Coventry, Cigna, Humana, and UnitedHealthcare).

10 This expansion is primarily driven by UnitedHealthcare and Assurant, which expanded into 20 and 16 new markets, respectively.

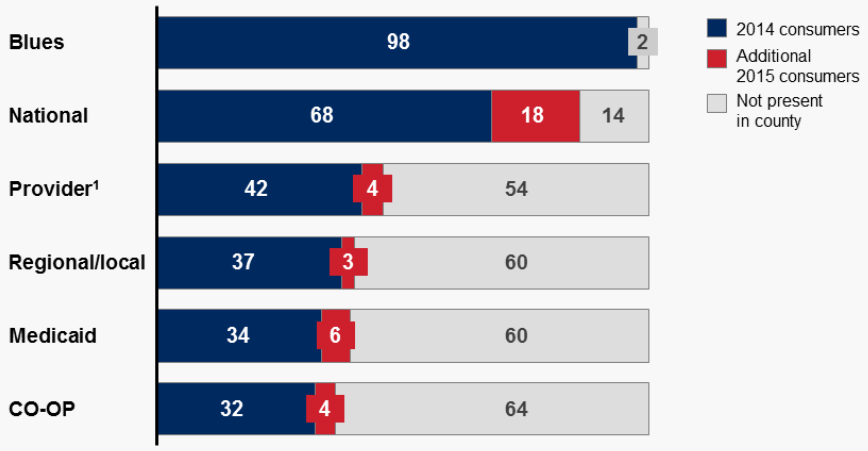
11 A carrier that also operates as a provider/health system. Note: Last year, we characterized provider-based entrants who also offered Medicaid as Medicaid entrants; however, this year we define these carriers as provider-based.

EXHIBIT 2

Many carriers have increased market penetration

Carrier types' market penetration across the U.S.

% of QHP-eligible consumers



1 Thirty percent of the provider-based new entrants also offer Medicaid products. If these new entrants are included with other Medicaid carriers, provider-based carriers expanded their footprint to 29% in 2015, from 22% in 2014

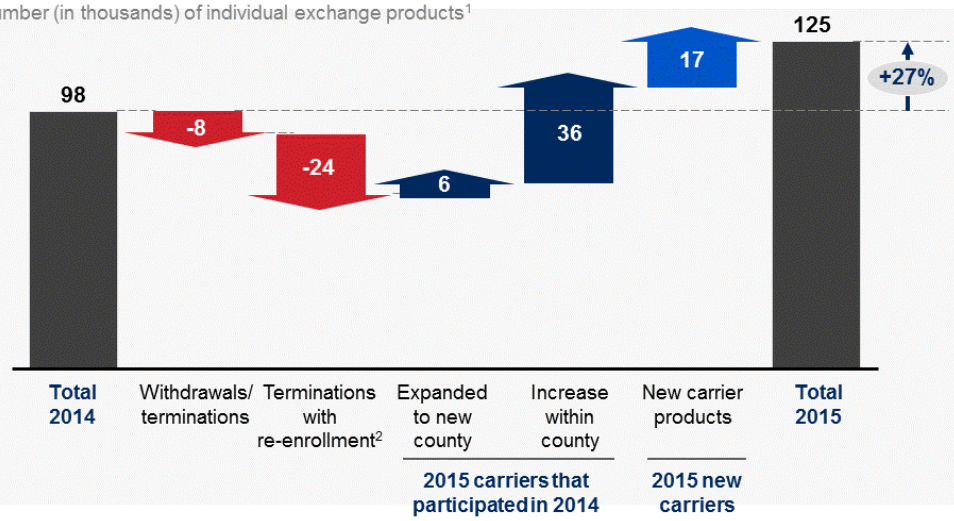
SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of November 19, 2014 across all states in the U.S.

EXHIBIT 3

27% more products are being offered on the public exchanges this year

Product expansion from 2014 to 2015 across the U.S.

Number (in thousands) of individual exchange products[1]



1 Products counted as unique at the county level
2 Products that have a new designated 2015 plan into which enrollees will be auto-enrolled, as identified by the CMS Plan ID Crosswalk Public Use File

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of November 19, 2014 across all states in the U.S.

Product choice for consumers has also increased—nationwide, there are 27 percent more products this year (*Exhibit 3*). New products were introduced in all metal tiers and at all price levels. In each county, anywhere between 6 and 160 products are being offered; the average is 40 (compared with 31 in the 2014 OEP).

Existing carriers (2014 OEP participants that are on the exchanges again in 2015) introduced 71 percent of the new products. On average, these carriers are offering nearly 1.7 times more products in each county than are the new entrants. Providers and consumer-operated-and-oriented plans (CO-OPs) had the highest rates of new product introductions.

Few patterns emerged among the carriers exiting the exchanges or among the products that were withdrawn. All carrier types terminated products, and none of them terminated an unusually high number of products. Furthermore, all carrier types introduced new products at rates that equaled or exceeded the number of products withdrawn.

Gross premium prices[12] are rising, especially for PPO and broad-network products

Between the 2014 and 2015 OEPs, gross premiums (the amount charged by carriers before subsidies are considered) rose by a median of 6 percent among the lowest-price exchange products in all metal tiers.[13] Among the lowest-price 2014 products re-filed for 2015, the median gross-premium increase is 10 percent.

Our estimates suggest that if all 2014 exchange enrollees (not just those who bought the lowest-price products) were to renew the product they purchased last year, 85 percent of them would have higher gross premiums this year (*Exhibit 4*). Gross premiums would decrease for 10 percent of these enrollees. The remaining 5 percent cannot renew their 2014 products because those products were withdrawn. If all of the exchange enrollees who could renew their 2014 products did so, the weighted-average gross-premium increase would be 9 percent.

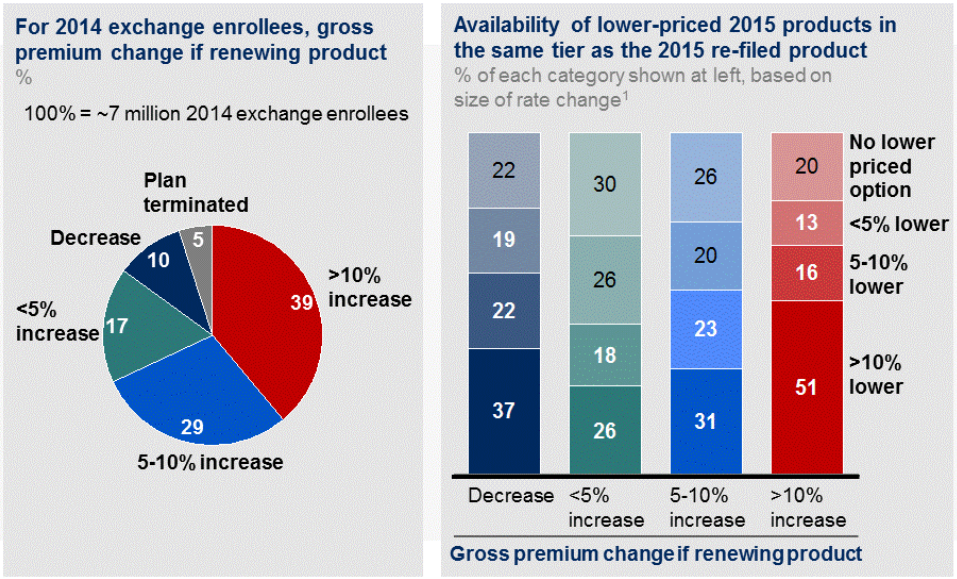
---

[12] Subsidies are only available for consumers with incomes under 400 percent FPL who are not eligible for Medicaid. These individuals do not face the full impact of the increases in gross premiums reported here. For consumers with incomes above 400 percent FPL, net premium equals gross premium. (See the next section. The Appendix describes the methods used to estimate the premium changes we report throughout this Intelligence Brief.)

[13] Median of the percentage change between the lowest-price 2014 product in each tier and the lowest-price 2015 product in the same tier in each county (calculated for all counties and all tiers).

EXHIBIT 4

Most enrollees face higher renewal premiums but have cheaper options



1 Consumers whose plans were terminated are excluded

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of November 19, 2014 across all states in the U.S.

Across metal tiers, the price changes range from a decrease of 48 percent to an increase of 88 percent. In most cases, the highest increases are found on last year's lowest-price products—for example, a median increase of 8 percent for the lowest-price silver products (equal to a $20 monthly increase for a 40-year-old nonsmoker). In contrast, the highest-price 2014 silver products re-filed for 2015 have a median premium increase of just 2 percent ($7 monthly for that same person). Accordingly, premium price dispersion among re-filed products is decreasing.

Nevertheless, price dispersion is considerably larger among 2015 products (from both existing and new carriers) than it was in 2014. The net result is that consumers are facing an overall wider, rather than a narrower, band of premiums among all 2015 products. For about half of all consumers this year, the price differential between the least and most expensive products within the same metal tier in a given county is greater than 50 percent. However, the gap between the lowest- and second-lowest-price silver plans has narrowed.

HMO products experienced much smaller year-over-year median gross premium increases than PPO products did (*Exhibit 5*). Similarly, products configured around narrowed networks had smaller rate increases than broader-network products did.[14] We found the lowest median

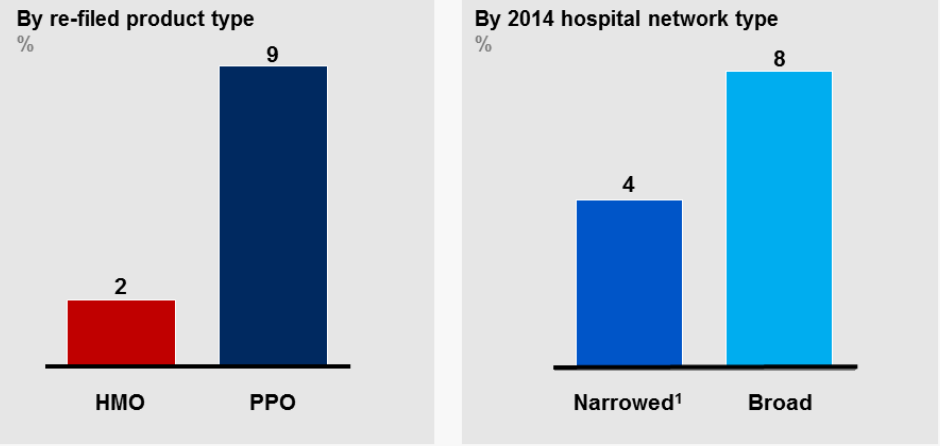
[14] Narrow networks cover 31 to 70 percent of the hospitals in their markets. Ultra-narrow networks cover 30 percent or less of those hospitals. Tiered networks group hospitals based on differences in co-payments. (For information on how network breadth correlated with 2014 product pricing, see the Intelligence Brief, McKinsey Center for U.S. Health System Reform. "Hospital networks: Updated national view of configurations on the exchanges." June 2014.)

gross premium increases in HMO products configured around narrowed networks (1 percent, compared with a 10-percent increase for PPO products configured around broad networks).

EXHIBIT 5

HMOs and narrowed networks had the lowest premium increases

Median premium increases among re-filed 2014 products



1 Includes narrow, ultra-narrow, and tiered networks

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of November 19, 2014 across all states in the U.S.

Our analysis also showed that HMO products now comprise a greater percentage of all lowest-price products, as well as of all products priced within 10 percent of those products. For example, 47 percent of the lowest-price silver products in 2015 are HMOs, compared with 32 percent last year. We are in the midst of conducting a detailed analysis of the relationship between the network breadth of 2015 products and their pricing; results will be reported in an upcoming Intelligence Brief.

Switching products would minimize or eliminate premium increases in many cases, but would not always lower overall costs

We estimate that close to three-quarters of 2014 exchange enrollees have access this year to a product that is within the same metal tier as the product they bought last year but priced below the 2015 premium of last year's plan. For about 55 percent, the gross premium decrease is likely to be more than 5 percent; for close to 40 percent, the decrease could be above 10 percent *(see Exhibit 4)*.

Premium differences of this magnitude may induce some consumers to switch to new products. However, individuals need to evaluate this carefully because a decrease in premium price will not always result in a decrease in an individual's out-of-pocket costs. For some 2014 enrollees who have a lower-premium option this year, the lower-premium 2015 product has a deductible higher than the one associated with renewing their 2014 product. However, a range of other factors, including co-payments and the services to which the deductible is applied, influence the eventual amount a consumer must pay. Furthermore, all products in a given metal tier should have a similar actuarial value, and thus the average consumers would be expected to pay should be similar.

Presently, we cannot predict how many consumers will switch to a new product to lower their premiums. Our research suggests that premium increases of 10 percent or higher may induce consumers to shop for a new product.[15] A switch to a product with a lower premium may not always be cost-minimizing, as it will depend on any change in benefit design of the new lower-premium product, as well as the specific types and amounts of services utilized. The extent to which individuals fully understand this trade-off is unclear.

Net premiums for many subsidy-eligible consumers will rise

To understand how premium changes affect affordability, we analyzed the change in net premium (the amount individuals have to pay after subsidies) between the lowest-price silver products in 2014 and 2015. Our calculations suggest that 73 percent of all QHP-eligible consumers—including 71 percent of those eligible for subsidies—appear to be subject to a net premium increase (*Exhibit 6)*. For 38 percent of subsidy-eligible consumers, the increase is less than 10 percent (a weighted average of $7 per member per month) (*Exhibit 7*). For 33 percent of the subsidy-eligible, the increase is over 10 percent (a weighted average of $22 PMPM). In contrast, 28 percent of subsidy-eligible consumers appear to have a decrease in net premiums; 10 percent are seeing a decrease greater than 10 percent (a weighted average of $18 PMPM).[16]

---

[15] In our recent consumer survey ("On the Eve of Open Enrollment 2015"), 70 percent of consumers reported that they would consider switching products if the premium for their 2014 plan rose by 10 percent or more; some were sensitive to as low as a 5-percent difference. In the 2014 OEP, however, strong brands were able to offset the price advantage and retain strong share in many geographies.

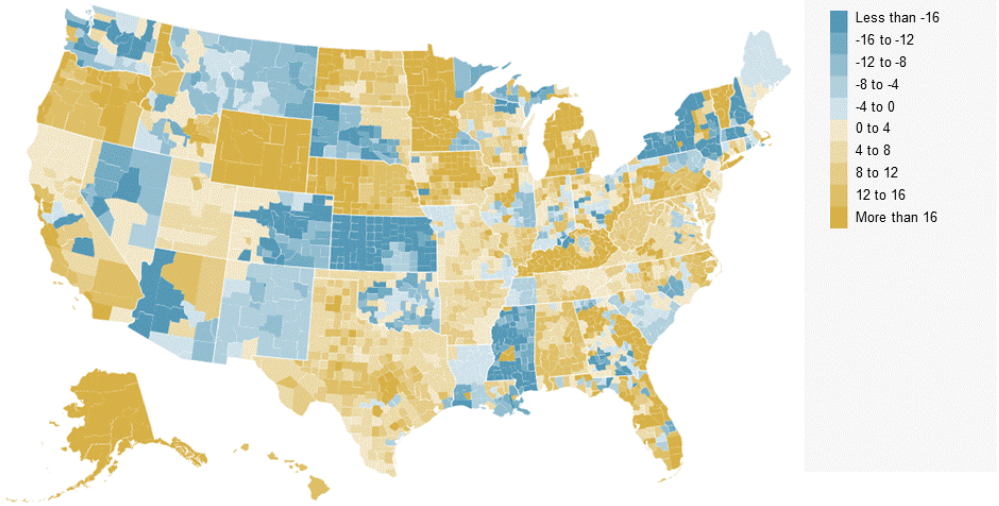
[16] For 1 percent of subsidy-eligible consumers, net premiums remained the same between 2014 and 2015.

EXHIBIT 6

Net premiums are often rising, but increases are low for most consumers

Net premium change between 2014 lowest-price silver and 2015 lowest-price silver

$ PMPM premium change for all QHP-eligible consumers



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of November 19, 2014 across all states in the U.S.

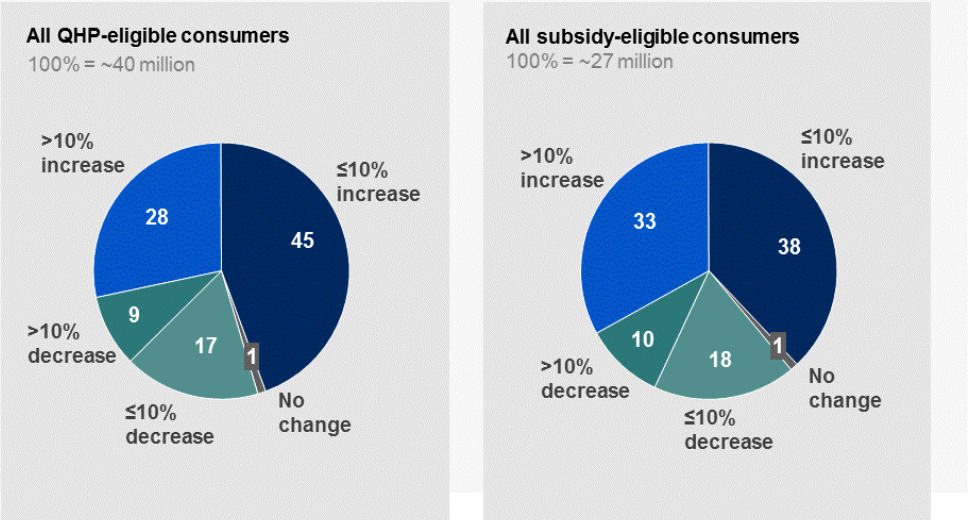
Nationwide, the relative increase in net premiums for the lowest-price silver products decreases as income levels rise (it is a weighted average of 15 percent for those with incomes below 200 percent of the federal poverty level (FPL), 5 percent for those with incomes between 200 and 400 percent FPL, and 3 percent for those with incomes above 400 percent FPL). In absolute terms, the reverse is true (it is a weighted average of $6 PMPM for those with incomes below 200 percent FPL vs. $9 PMPM for those with incomes above 400 percent FPL). Early exchange filings, which we analyzed in our September 2014 Intelligence Brief,[17] suggested that individuals at the high end of subsidy eligibility (200 to 400 percent FPL) might be disproportionately affected by net premium increases. This finding did not persist when we looked at the full set of exchange filings, largely because of differences among the states in the magnitude of the weighted-average net premium increases. Those increases are highest in Alaska and Michigan and lowest in Arizona and New Hampshire.

[17] McKinsey Center for U.S. Health System Reform. "2015 OEP: Emerging trends on the individual exchanges." September 2014.

EXHIBIT 7

Most enrollees face higher renewal premiums but have cheaper options

Net premium change in lowest-price silver products from 2014 to 2015



SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of November 19, 2014 across all states in the U.S.

The changes in net premiums for the lowest-price silver products also vary by market type. In general, urban markets are seeing close to twice the weighted-average net premium increases than rural markets. Markets in which CO-OPs are the predominant carrier type are seeing less than one-third the increases of other markets.

To fully understand the impact of premium increases on low-income consumers, we also estimated the number of consumers having access to zero-net-premium products. We found a 10-percent decrease in the number of persons with access to zero-net-premium bronze products (from 6.0 million in 2014 to 5.4 million in 2015). Most (95 percent) of the consumers having access to zero-net-premium bronze products have incomes below 250 percent FPL, qualifying them for cost-sharing subsidies should they select a silver product. The number of people with access to zero-net premium silver product decreased from about 912,000 in 2014 to just over 420,000 in 2015.

Recent and new entrants are often price leaders

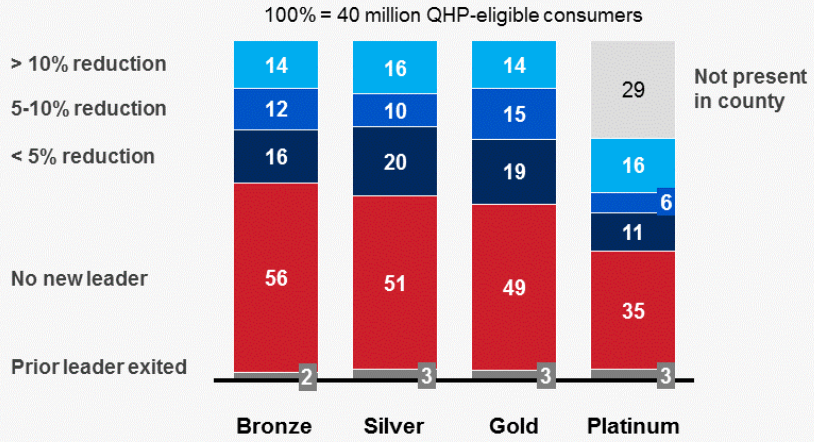
Price leaders (the carriers offering the lowest-premium product in each metal tier) are changing in at least one tier in 77 percent of counties across the U.S. Within the silver tier, there is a new price leader in 45 percent of counties, which together contain 49 percent of the consumers shopping on the 2015 exchanges (*Exhibit 8*). Over half of these new silver-tier price leaders entered the individual market within the past year: 32 percent were new to the overall individual market in their states in 2014, and another 26 percent are new entrants to the exchanges in one or more states in 2015.

EXHIBIT 8

One-third of QHP-eligible consumers have a new price leader in 2015

Change in price leadership

% of QHP-eligible consumers seeing a change in price leadership by the size of the price differential[1]



1 2015 price leader compared to 2014 price leader's 2015 rate

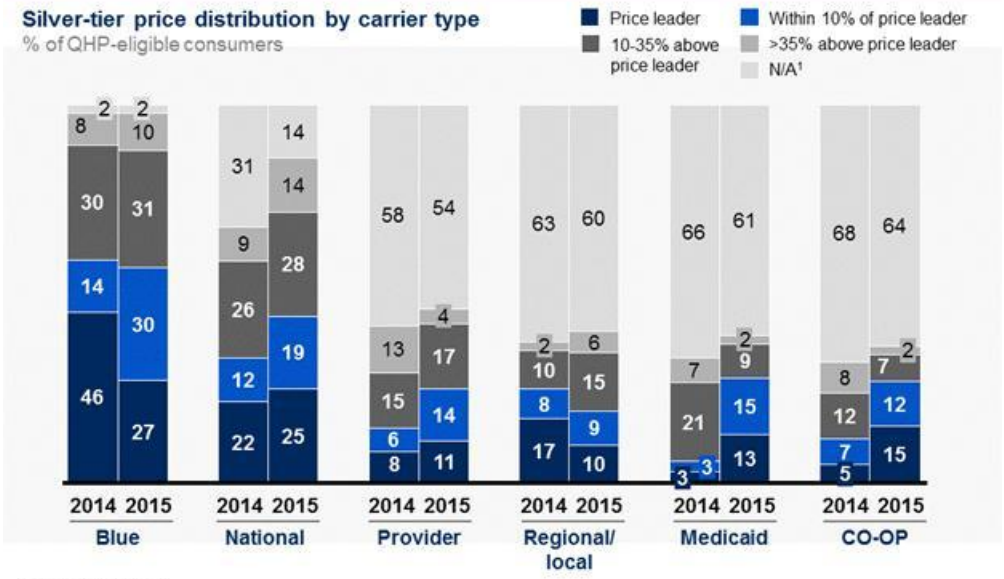
SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of November 19, 2014 across all states in the U.S.

Frequently, the new price leaders undercut the 2014 price leaders by a significant amount. For 16 percent of all consumers shopping on the 2015 exchanges, the new lowest-premium silver product is priced more than 10 percent below the 2015 premium of last year's silver-tier price leader. For 17 percent of consumers, the price of the 2015 lowest-premium silver product is below that of last year's lowest-premium silver product.

The carrier types capturing the greatest increase in silver-tier price-leadership positions in 2015 are CO-OPs and Medicaid (*Exhibit 9*). In contrast, the Blues and regional/local carriers are most frequently ceding price-leadership positions. Nevertheless, the Blues remain price leaders for 27 percent of 2015 consumers, a larger percentage than any other carrier type.

EXHIBIT 9

Many consumers are finding new price leaders



1 Not present in county

SOURCE: McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information as of November 19, 2014 across all states in the U.S.

The changes in price-leadership positions are having a dampening effect on overall premium increases. In the counties with a new price leader in the silver tier, gross premiums for the lowest-price silver products increased at a lower rate than in counties where the 2014 price leader remained unchanged (a median of 1 percent compared with 7 percent). Counties in which CO-OPs were the new price leader experienced a median rate decrease of 1 percent.

□ □ □

The emerging trends presented in this Intelligence Brief help to inform changes in the competitive landscape on the 2015 exchanges as compared to 2014 exchanges. Data on the changes in competitors, product offerings, and prices provide insight into potential implications for market volatility, product affordability, member retention, and overall market growth. However, the findings in this Intelligence Brief are directional indicators only. As the 2015 OEP progresses, we will continue to analyze trends across both offerings (including exchange network detail) and consumer behavior.

Jason Bello, Erica Coe, Kija Kari, Jim Oatman, Suzanne Rivera

The authors would like to thank Brock Mark and Brendan Murphy for their support.

Appendix

Additional background on the underlying research

The analyses supporting this Intelligence Brief are informed by a McKinsey Health Systems and Services Practice asset that has been developed jointly by the Center for U.S. Health System Reform (the Reform Center) and McKinsey Advanced Healthcare Analytics (MAHA). This tool offers a real-time view of comprehensive 2014 and 2015 individual exchange offerings.

Additional Reform Center/MAHA tools can compare a range of topics, including a) individual and small-group rates and filings, b) pre- to post-ACA trends, c) pricing across product types by consumer characteristics, d) exchange network trends, e) predictions of market share (based on rates, filings, and consumer-predicted dynamics), and f) benefit designs across carrier types and metal tiers.

Please contact reformcenter@mckinsey.com with any inquiries.

Methodology

Data sources and analyses:

The major analyses in this Intelligence Brief are based on publicly available information about exchange product offerings.

2014 and 2015 exchange offerings database: We developed a county-level database of all products offered in all metal tiers on the 2014 and 2015 individual exchanges across the United States. It includes details about premiums, carriers, cost-sharing provisions, product type design, and network design.

McKinsey Predictive Agent-based Coverage Tool (MPACT): This model provides specific county-level demographic details about the QHP-eligible population in 2014. These details are attained by merging county- and state-level data from the U.S. Census Bureau, Small Area Health Insurance Estimates (SAHIE), American Community Survey (ACS), Centers for Medicare and Medicaid Services (CMS), and Health and Human Services (HHS). They have been reconciled with publicly reported enrollment information to date for 2014 (i.e., exchange enrollment, Medicaid enrollment). This granular and dynamic behavioral simulation model also has details about all other lines of insurance business and projects these details forward to show the impact of health reform over time on the coverage decisions of consumers, payors, and employers. However, for the purposes of this Intel Brief, we are not using the projection aspect of this model, just the 2014 baseline information.

Approach to analyses:

Carrier exchange participation: To understand how carrier participation is changing competitive dynamics on the exchanges, we compared the number of carriers competing on the exchanges in 2014 and 2015. The carrier count is based on what consumers see when they shop on the exchanges; thus, it represents the number of unique carriers offering products in at least one county within a state (not all carriers offer products in every county

within a state). Specifically, the count is the number of carriers that offer products in each state, i.e., a carrier that offers products in 3 states is counted 3 times, a carrier that offers products under 2 different carrier names in one state is counted 2 times, a carrier that offers one or more products in 1 state under 1 carrier name is counted only once.

Exchange product offerings: To understand how consumers' choice of products is changing, we compared the number of exchange products offered in 2014 and 2015. Products were counted uniquely at a county-area level (i.e., each product in each county area counts as one). To look at product offerings from the consumer's perspective, we counted two otherwise identical products offered by the same parent company as separate products if they are sold under two different names.

Gross premium changes in the market as a whole: To understand gross premium changes in the market as a whole, we compared the lowest-price products in each tier at the county level between 2014 and 2015. We calculated the percentage change between each 2014 and 2015 lowest-price product by tier and calculated a median of all percentage changes.

We focused many of our analyses on exchange silver products for three reasons. First, 65 percent of all exchange enrollees bought silver products in the 2014 OEP. Second, all carriers are required to offer a silver product to compete on the exchanges. Third, the silver tier is the only tier for which income-eligible consumers can receive both federal premium and cost-sharing subsidies.

Gross premium change for 2014 exchange enrollees: To understand the specific changes that 2014 exchange enrollees are seeing during the 2015 OEP, we linked data for all 2014 products that were re-filed in 2015. To do this, we started with the full set of 2014 exchange products across all counties. For each product, we identified whether it was terminated, withdrawn from the market (if the carrier withdrew), or re-filed in 2015. For states using the Federally Facilitated Marketplace (FFM), we referenced the CMS "Plan ID Crosswalk Public Use File" released in November 2014 to identify both terminated products for which consumers are auto-enrolled into a new product and terminated products that do not include auto-enrollment. For the state-based marketplaces (SBMs), we defined terminated products as any 2014 product that did not have an equivalent 2015 product, based on matching HIOS ID or other key identifying product features.

Using this linked data, we then calculated the weighted-average gross premium changes for re-filed 2014 exchange products to understand the changes that 2014 exchange enrollees would face if they were to re-enroll in the same plan. First, we established the distribution of 2014 exchange enrollment at a county level by price position within metal tier across ages. To do this, we used HHS-reported enrollment, specifically zip-code level enrollment for FFM states and state-level enrollment for SBM states, both as of April 19, 2014 (end of the 2014 OEP), since more recent granular market-level enrollment figures have not yet been released. We then leveraged our McKinsey MPACT model (based on public sources such as CMS, HHS, Census, ACS, and SAHIE) to inform current exchange enrollment since the April-released numbers. We then determined enrollment by price position within tier (lowest,

second-lowest, all others), based on HHS-reported national enrollment by price position.[18] We assumed that the price position distribution remained constant at a national level. We used McKinsey's MPACT model (reconciled with HHS-reported enrollment demographics) to determine age distribution at a county level. For the distribution of price positions for products above second-lowest, we assumed a geometric distribution across the remaining products.

Then, we combined this 2014 exchange enrollment distribution at a product level with actual 2014 exchange products that were filed again in 2015. To estimate premiums, we assumed that each exchange enrollee purchased an individual policy, as contract size was not reported. We used the median age factor for each age bucket, and then calculated rates for each year and rate changes for every product. Then, we calculated the weighted-average rate changes across the U.S.

Net premium change for QHP-eligible individuals: To understand the net premium changes that QHP-eligible individuals will face, we calculated the population weighted-average change in net premiums between 2014 and 2015 for the lowest-price silver product in each county. We assumed that subsidy eligibility will be re-determined for all individuals in 2015. First, we established a distribution of QHP-eligible individuals (at a household level) in each county, using McKinsey's MPACT model. Next, we combined this population distribution with data about 2014 and 2015 lowest-price silver product net premiums, calculating per-member-per-year net premiums at a household level. To estimate net premiums, we used income level and household size to determine the relative premium cap for each household unit. Then, we calculated the second-lowest-price silver premium based on the median age for each age bucket combined with household size to determine the relative subsidy, and applied that to the lowest-price silver product to calculate the net premium of the lowest-price silver product. Finally, we used the 2014 and 2015 net premiums to calculate weighted-average rate changes.

Using this net premium calculation to understand how premium price changes affect affordability for subsidy-eligible individuals after subsidies are applied, we analyzed, in each county, the interactions between the 2014 to 2015 changes in the price of the second-lowest-price silver product (the benchmark product against which subsidies are set) and the lowest-price silver product.[19]

---

[18] ASPE Research Brief. "Premium, affordability, competition, and choice in the health insurance marketplace, 2014." June 2014.

[19] The change in the benchmark plan's premium relative to change between 2014 and 2015 in the price of the lowest-price silver product has the greatest impact on affordability for subsidy-eligible individuals (specifically, whether they will see an increase or decrease in their net 2015 premium for the lowest-price silver plan). Our calculations show this change accounts for about two-thirds of the differences in net 2015 premiums for the lowest-price silver product among subsidy-eligible individuals. Only one-third of the net premium changes are driven by changes in the indexed definitions of the federal poverty level and the indexed premium caps set by the Affordable Care Act.

Classifications for carriers

The criteria we used to classify payors are summarized below.

- Blues: a Blue Cross Blue Shield payor; includes Anthem, HCSC, Regence
- Consumer-operated-and-oriented plan (CO-OP): a recipient of federal CO-OP grant funding that was not a commercial payor before 2014
- Medicaid: a carrier that offered only Medicaid insurance in the past; includes Molina and Centene, along with regional/local Medicaid carriers
- National: a commercial payor with a presence in more than four states that has filed on exchanges (specifically, Aetna/Coventry, Assurant, Cigna, Humana, UnitedHealthcare)
- Provider-based: a carrier that also operates as a provider/health system
- Regional/local: a commercial payor with a presence in four or fewer states (most often, just one state) that has filed on the exchanges

Obtaining previous Intelligence Briefs and Reform Center infographics

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

- "On the eve of the OEP" (November 2014)
- "2015 OEP: Emerging trends in the individual exchanges" (September 2014)
- "Hospital networks: Updated national view of configurations on the exchanges" (June 2014)
- "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)

December 2014

THE HENRY J. KAISER FAMILY FOUNDATION

Filling the need for trusted information on national health issues...

December 2014 | Issue Brief

Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S.

Usha Ranji, Adara Beamesderfer, Jen Kates, and Alina Salganicoff

Executive Summary

Lesbian, gay, bisexual, and transgender (LGBT) individuals often face challenges and barriers to accessing needed health services and, as a result, can experience worse health outcomes. These challenges can include stigma, discrimination, violence, and rejection by families and communities, as well as other barriers, such as inequality in the workplace and health insurance sectors, the provision of substandard care, and outright denial of care because of an individual's sexual orientation or gender identity.[1,2,3]

While sexual and gender minorities have many of the same health concerns as the general population, they experience certain health challenges at higher rates, and also face several unique health challenges. In particular, research suggests that some subgroups of the LGBT community have more chronic conditions as well as higher prevalence and earlier onset of disabilities than heterosexuals. Other major health concerns include HIV/AIDS, mental illness, substance use, and sexual and physical violence. In addition to the higher rates of illness and health challenges, some LGBT individuals are more likely to experience challenges obtaining care. Barriers include gaps in coverage, cost-related hurdles, and poor treatment from health care providers.

Several recent changes within the legal and policy landscape serve to increase access to care and insurance for LGBT individuals and their families. Most notably the implementation of the Affordable Care Act (ACA), the Supreme Court's overturning of a major portion of the Defense of Marriage Act (DOMA), the subsequent legalization of same-sex marriage in many states, as well as recent steps taken by the Obama Administration to promote equal treatment of LGBT people and same-sex couples in the nation's health care system have reshaped policy affecting LGBT individuals and their families. The ACA expands access to health insurance coverage for millions, including LGBT individuals, and includes specific protections related to sexual orientation and gender identity. The Supreme Court ruling on DOMA resulted in federal recognition of same-sex marriages for the first time and paved the way for recognition in many more states which also serves to provide new health insurance coverage options.[4]

This issue brief provides an overview of what is known about LGBT health status, coverage, and access in the United States, and reviews the implications of the ACA, the overturning of DOMA, and other recent policy developments for LGBT individuals and their families going forward.

The LGBT Community

While there is no single definition of the "LGBT community" – indeed, it is a diverse and multidimensional group of individuals with unique identities and experiences, and variations by race/ethnicity, income, and other characteristics – LGBT individuals share the common experience of often being stigmatized due to their sexual orientation, gender identity, and/or gender expression.[5] In its landmark 2011 report, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding,* the Institute of Medicine defines *sexual orientation* as "an enduring pattern of or disposition to experience sexual or romantic desires for, and relationships with, people of one's same sex, the other sex, or both sexes."[6] This definition incorporates elements of attraction, behavior, and identity. It is important to note that for some individuals, their sexual identity does not necessarily fall into any specific category but, rather, exists along a spectrum. In addition, not all persons who engage in same-sex behavior or experience same-sex attraction identify as lesbian, gay, or bisexual.

Gender Identity refers to "an individual's internal sense of being male, female, or something else. Since gender identity is internal, one's gender identity is not necessarily visible to others."[7] Additionally, *gender expression* and *gender role conformity* further describe the extent to which a person does or does not adhere to expected gender norms and roles. *Transgender* refers to individuals whose sex at birth is different from their identity as male, female, or elsewhere along the gender spectrum. People who identify as transgender may live their lives as the opposite gender, and may seek prescription pharmacologic therapy and/or surgical transformation. Transgender people may identify as heterosexual, lesbian, gay, or bisexual, or somewhere else along the spectrum of sexual identity.

Lastly, while sexual orientation and gender identity are important aspects of an individual's identity, they interact with many other factors, including sex, race/ethnicity, and class. The intersection of these characteristics helps to shape an individual's health, access to care, and experience with the health care system.

Population Characteristics

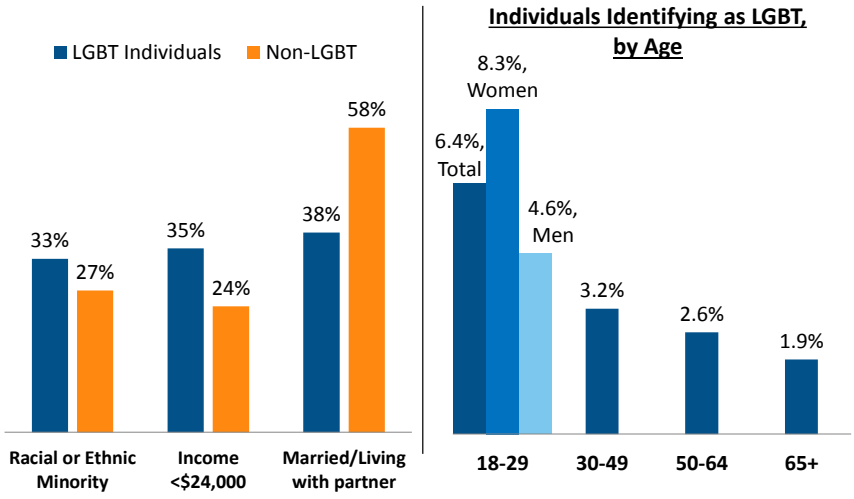
Assessing the health needs and barriers to care of the LGBT population has been challenging due to the historical lack of data collection on sexual orientation and gender identity. While some health surveys have asked about sexual orientation, it has not been routine to collect and analyze data on sexual orientation and gender identity in many major health surveys, particularly nationally representative ones, meaning that much of the data available to date have been from smaller, non-representative studies and convenience samples. Where data have been collected, they have mostly focused on same-sex couples using data systems that collect information on relationship status.[8] In addition, where data are available for individuals, there is more information about lesbian, gay, and bisexual persons than transgender individuals. There has been growing recognition of the need for research focused on the LGBT community, and the ACA has new data collection requirements on disparities, which include sexual orientation and gender identity (described below). The National Health Interview Survey (NHIS), the principal source of information on the health of the U.S. population, began including a question on sexual orientation in its 2013 survey and findings were released in July 2014.

Many data sources are used to make inferences about the LGBT population and estimates on the size of the LGBT population vary:

- Data on the size of the LGBT population in the United States range. The latest data from the National Health Interview Survey (NHIS), a nationally representative survey of the U.S. population on health issues which now includes questions on sexual orientation, indicate that 2.3% of adults ages 18 and older in the U.S. identify as lesbian, gay, or bisexual, equating to more than 5.2 million people.[9] Gallup poll data have found that between 3.4% and 3.6% of Americans ages 18 and older identify as LGBT, or about 9 million people.[10,11,12,13] Estimates may vary due to differing methodologies for data collection. Most of these surveys include only those who self-identify as LGB[14] and do not include those who may have engaged in same-sex behavior or have same-sex attraction but do not identify as gay, lesbian, or bisexual. Other studies have looked beyond self-identification, to include behavior and attraction, and obtained higher estimates, including one that found that 10% of adults reported experience with same-sex partners.[15] In addition, a recent analysis indicates that standard survey measures appear to significantly underestimate non-heterosexual identity and same-sex sexual experiences.[16]
- Data on those who identify as transgender are limited but a recent study found that an estimated 0.3% of the U.S. population is transgender, equating to approximately 700,000 people.[17]
- Estimates of self-identified LGBT individuals also vary by state. According to a 2012 Gallup poll, the share of adults who identify as LGBT ranges from a low of 1.7% in North Dakota to a high of 10% in the District of Columbia.[18] This range could reflect local policies and societal attitudes regarding LGBT equality, which may be correlated with an individual's willingness to self-identify as LGBT or live in a certain locale.
- Racial and ethnic minorities, young people, and women are more likely than their counterparts to identify as LGBT **(Figure 1)**.[19]
- One in five (20%) LGBT individuals indicate they are married, and an additional 18% are in a domestic partnership or living with a partner (some of whom could be in heterosexual marriages or domestic partnerships).[20]
- According to the 2012 American Community Survey, a smaller share of same-sex couples is raising children compared to both married and unmarried heterosexual couples.[21] Just over 40% of married and unmarried heterosexual couples are raising children, compared to 18% of same-sex couples, 11% of male same-sex couples and 24% of female same-sex couples.
- Compared to the general population, sexual and gender minorities are disproportionately poor overall, but there is variation between

Figure 1

Demographic Characteristics Among Adults Ages 18-64



SOURCE: Gates, G., Newport, F. (2013). *Gallup poll Special Report: 3.4% of U.S. Adults Identify as LGBT.*

subgroups. A recent Pew Research poll of LGBT individuals found that about 4 in 10 (39%) earned $30,000 or less per year, compared to 28% of the U.S. population overall.[22] Poverty rates on average are higher among lesbian and bisexual women, young people, and African Americans.[23] According to an analysis of the 2006-2010 National Survey of Family Growth, more than one-quarter (28%) of lesbian and bisexual women are poor, compared with 21% of heterosexual women. Just over 1 in 5 gay and bisexual men (23%) are poor, compared to 15% of heterosexual men. However, when comparing couples, lesbian couples have the highest poverty rates, followed by heterosexual couples and male same-sex couples. Further, a recent survey of more than 6,400 transgender people from across the U.S. found that the transgender population is approximately 4 times as likely as the non-transgender population to have an annual income of less than $10,000.[24]

Health Challenges

Health is shaped by a host of social, economic, and structural factors.[25] For LGBT individuals, these factors include the experience and impact of discrimination, stigma, and ostracism which affect health outcomes, access, and experience with health care.[26, 27, 28] Research available to date finds that while sexual and gender minorities have many of the same health concerns as the general population, they experience some health challenges at higher rates, and face several unique health challenges.

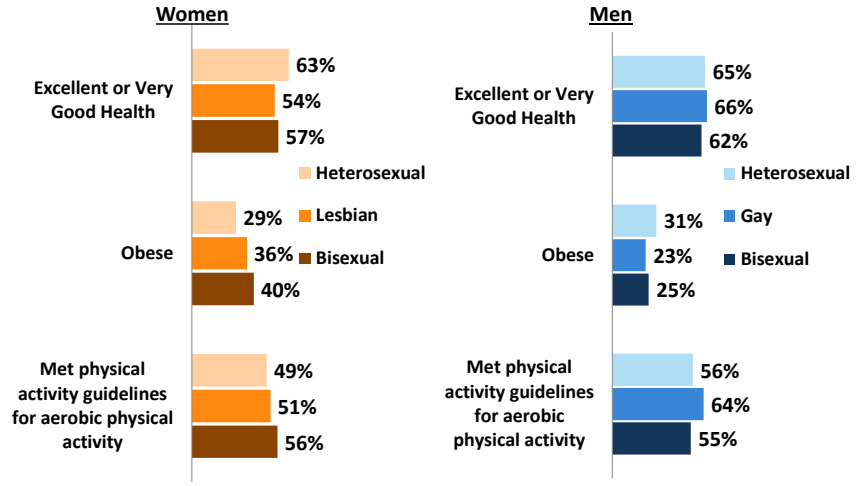
Chronic Conditions

Studies have found that sexual and gender minorities experience worse physical health compared to their heterosexual and non-transgender counterparts.[29, 30]

- A recent literature review found that self-identified LGB individuals are more likely than heterosexuals to rate their health as poor, have more chronic conditions, and have higher prevalence and earlier onset of disabilities. Overall, LGB people report more asthma diagnoses, headaches, allergies, osteoarthritis, and gastro-intestinal problems than heterosexual individuals.[31]
- Additionally, there are differences between subgroups within the LGBT community. Lesbian and bisexual women report poorer overall physical health and higher rates of asthma, urinary tract infections, and Hepatitis B and C than heterosexual women. Lesbian and bisexual women also report heightened risk for and diagnosis of some cancers and higher rates of cardiovascular disease diagnosis. Similarly, gay and bisexual men report more cancer diagnoses and lower survival rates, higher rates of cardiovascular disease and risk factors, as well as higher total numbers of acute and chronic health conditions such as headaches and urinary incontinence

Figure 2

Health Status Indicators Among Women and Men in the U.S., by Sexual Orientation, 2013



NOTES: Among adults ages 18-64.
SOURCE: Centers for Disease Control and Prevention, National Health Statistics Reports. (July 2014). Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey, 2013.

than heterosexual men.[32]

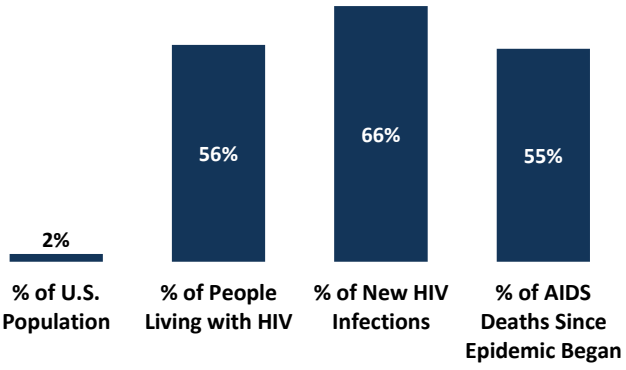
- According to newly released data from the NHIS, fewer lesbian and bisexual women reported excellent or very good health compared to heterosexual women. There were no health status differences between men by sexual orientation **(Figure 2)**.[33]
- LGB individuals on average have higher rates of some risk factors for chronic illnesses. Obesity rates are higher among lesbian and bisexual women compared to heterosexual women, but are lowest among gay men. However, there were no significant differences by sexual orientation for women or men in rates of meeting physical activity guidelines.
- According to a study of Massachusetts residents, transgender persons are the least likely among LGBT individuals to self-report their health as *Excellent* or *Very Good* (67% vs. 79%) and are twice as likely to report limitations in daily activities due to impairment of health problems (33% vs. 16%).[34]

HIV/AIDS and Sexually Transmitted Infections (STIs)

One of the most significant health challenges facing the LGBT community has been the HIV/AIDS epidemic's impact on gay and bisexual men, and there are increasing data on the disproportionate impact of HIV on transgender women. After experiencing a dramatic rise in new infections in the 1980s, efforts by the gay community and public health officials helped to bring HIV incidence down; however, in recent years, new infections among gay and bisexual men in the U.S. have been on the rise, the only group for which infections are increasing **(Figure 3).**

Figure 3

Impact of HIV on Gay and Bisexual Men in the U.S.



NOTE: Includes Men who have sex with men (MSM) and Men who have sex with men and inject drugs (MSM/IDU).
SOURCES: CDC, Fact Sheet: "HIV Among Gay, Bisexual, and Other Men Who Have Sex With Men"; CDC, Diagnoses of HIV Infection in the United States and Dependent Areas, 2011; HIV Surveillance Report, Volume 23; CDC, Estimated HIV Incidence in the United States, 2007–2010, HIV Supplemental Surveillance Report, Volume 17, No. 4.

- In 2010, gay and bisexual men and other men who have sex with men (MSM), while representing an estimated 2% of the U.S. population, accounted for more than half (56%) of all people living with HIV in the United States, and two-thirds (66%) of new HIV infections.[35]
- Between 2008 and 2010, the rate of new HIV infections among young black MSM increased by 20%, the highest increase among all sub-populations. Black MSM accounted for 36% of new HIV infections in 2010.[36]
- The CDC recommends that gay and bisexual men be tested for HIV at least once every year (and more frequently for those who are sexually active), but according to a new nationally representative survey conducted by the Kaiser Family Foundation, many do not meet this level. While seven in ten gay and bisexual men say they have gotten an HIV test at some point in their lives, just 30 percent say they were tested within the past year. Three in ten (30%) say they have never been tested for HIV, rising to 44% of

those under age 35. The leading reason that men give for not having had a recent test is that they do not consider themselves at risk for HIV.[37]

- Access to medical care is critical for the health of people with HIV. Among MSM diagnosed with HIV in 2010, approximately three-fourths received medical care within three months of their diagnosis, but only half (51%) were retained in treatment over the course of the year. Rates were lowest among younger men and Black men.[38] In addition, according to the Kaiser survey, three in ten (31%) gay and bisexual men either say they don't have a regular place to go for medical care or they don't have a regular physician. These men (who tend to be younger, lower-income, and more racially diverse) are also less likely to report discussing HIV with doctors or getting tested for HIV.
- Transgender women, particularly transgender women of color, are also at high risk of HIV. Studies have found that more than one in four (28%) are HIV positive,[39] and a majority are unaware that they are infected.
- To date, there has only been one likely case of female-to-female sexual transmission of HIV in the United States.[40] However, HIV is an issue that affects lesbians as well as bisexual women, since individuals who identify as lesbian may still have sexual relationships with men, and lesbians and bisexual women are also at risk of HIV via transmission modes that do not involve sexual contact (such as injection drug use).
- STI rates are higher among some LGB groups than heterosexuals, and rates have been increasing for some infections. For example, MSM account for more than seven in ten (72%) new syphilis cases, an alarming increase that has re-emerged during the last several years.[41] MSM also account for 15% to 25% of all new Hepatitis B infections.[42] Given the strong interaction between HIV and other STIs, this is a particular concern for MSM.
- Human Papillomavirus (HPV) is the most common STI and is a major cause of cervical, anal, and mouth cancers.[43] MSM are 17 times more likely to develop anal cancer than men who only have sex with women.[44] The HPV vaccine, which protects against certain strains of the virus that are associated with anal cancer, could reduce anal cancer rates among future generations of MSM.

Behavioral and Mental Health

Research has found that LGBT individuals are at elevated risk for some mental health and behavioral health conditions, with studies finding that they are two and a half times more likely to experience depression, anxiety, and substance misuse.[45,46] The history of discrimination and stigma contributes to higher rates of mental illness.[47] In fact, until the 1970s, homosexuality was considered a mental illness in the Diagnostic and Statistical Manual (DSM) of Mental Disorders and by various professional organizations. The diagnosis "gender dysphoria," which has replaced the transgender diagnosis in the DSM, is intended to communicate the emotional distress that transgender people may experience as well as promote insurance coverage of services related to gender transition, such as counseling or hormone therapy, that typically have not been covered by insurance plans.[48] Still, stigma and prejudice against sexual and gender minorities remain pervasive and continue to have negative consequences for the mental health of the LGBT population.[49]

LGBT adults experience higher rates of mental illness, substance abuse, and discrimination compared to heterosexual and non-transgender adults. Additionally, lack of acceptance from family members is correlated with higher rates of mental illness and substance use among the LGBT population. [50]

- The recent NHIS provides the first national comparisons of gay, lesbian and bisexual adults to heterosexual adults on alcohol consumption, smoking status, and one measure of mental health status **(Table 1)**.
  - Consuming five or more alcoholic beverages in one day was reported by more bisexual (40%) and gay or lesbian (33%) adults than heterosexual adults (22%). Rates among men of all sexual orientations were substantially higher than for women.
  - Smoking rates were higher among bisexual and lesbian women compared to heterosexual women, but did not vary by sexual orientation for men. A separate meta-analysis of several studies found that overall, LGBT people smoke cigarettes at 1.5 to 2.5 times the rate of heterosexual and non-transgender people.[51]
  - One in ten bisexual women experienced serious psychological distress in the past 30 days, more than twice the rate of lesbian and heterosexual women. Approximately 3% of heterosexual men reported experiencing serious psychological distress, and data were unavailable for bisexual and gay men.

Table 1: Alcohol Use, Cigarette Use, and Serious Psychological Distress Among Bisexual, Gay or Lesbian, and Heterosexual Adults ages 18–64, 2013

Five or more alcoholic drinks in 1 day at least once in past year	Bisexual	Gay or Lesbian	Heterosexual
All adults	41.5%	35.1%	26.0%
Women	34.9%	27.7%	17.2%
Men	56.3%	41.8%	35.1%
Current cigarette smoker	**Bisexual**	**Gay or Lesbian**	**Heterosexual**
All adults	29.5%	27.2%	19.6%
Women	29.4%	27.2%	16.9%
Men	29.6%	27.2%	22.3%
Experienced serious psychological distress in past 30 days	**Bisexual**	**Gay or Lesbian**	**Heterosexual**
All adults	11.0%	5.0%	3.9%
Women	10.8%	N/A	4.5%
Men	N/A	N/A	3.3%
All adults	41.5%	35.1%	26.0%

NOTE: N/A– data not available due to unreliability.
SOURCE: Centers for Disease Control and Prevention, National Health Statistics Reports. (July 2014). Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey, 2013.

- Other studies have used state-level data or sample populations to identify mental health trends among LGBT individuals. Nearly one fifth (19%) of bisexual adults in Massachusetts report they had recently seriously considered suicide, compared to 4% of lesbian and gay adults and 3% of heterosexuals.[52] There are notable differences between subgroups, with the rate highest among bisexual women (26%), followed by bisexual men (11%), gay men (6%), and approximately 3% among all other subgroups. Another nationwide study found a reported 41% prevalence of suicide attempts among the transgender population.[53]
- Research suggests that MSM have higher use of certain substances. One study has estimated that MSM are more than 12 times as likely to use amphetamines and almost 10 times as likely to use heroin as heterosexual men. However, it's important to note that research in this field is older and data are not necessarily comparable to the heterosexual population.[54]

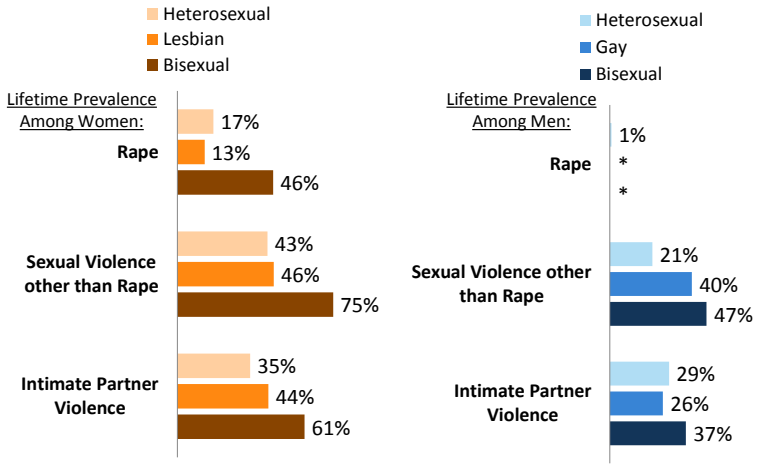
Sexual Assault and Physical Violence

Sexual assault and physical violence can have lasting consequences for victims, families, and communities.[55]

LGBT individuals experience higher rates of sexual and physical violence compared to heterosexual and non-transgender individuals. Violence toward LGBT people has inspired public policy responses. For example, federal legislation as well as some state laws allow for the classification of violence based on gender identity or sexual orientation bias as a "hate crime," which has implications for penalties as well as funding to states and locales for deterrence and surveillance of these crimes.[56] Key statistics include the following:

- A recent poll of LGBT adults found that two thirds had experienced some form of discrimination because of their sexual orientation or gender identity, including subjection to slurs, rejection by a friend or family member, being physically threatened or attacked, receiving poor service at a place of business or treated unfairly by an employer, or made to feel unwelcome at a place of worship; a full 30% said they had been physically threatened or attacked.[57]
- Many women and men have experienced some form of sexual violence, but the rates are significantly higher among some LGBT groups. It is estimated that almost half (46%) of bisexual women have been raped, as have 17% of heterosexual and 13% of lesbian women. More than four in ten heterosexual and lesbian women and the majority (75%) of bisexual women have experienced other forms of sexual violence, such as coercion or harassment. Six in ten (61%) bisexual women have encountered intimate partner violence (IPV), as have 44% of lesbian and 35% of heterosexual women (**Figure 4**).[58]

Figure 4
Sexual Violence, by Sexual Orientation, 2010



Sexual Violence other than rape includes being made to penetrate, sexual coercion, unwanted sexual contact, and non-contact unwanted sexual experiences. Perpetrator can include an Intimate Partner.
Intimate Partner Violence includes physical and sexual violence, threats of physical or sexual violence, stalking, and psychological aggression by a current or former intimate partner.

NOTE: *Sample size too small for estimate. Among adults 18 and older.
SOURCE: CDC. (2013). The National Intimate Partner and Sexual Violence Survey: 2010 Findings on Victimization by Sexual Orientation.

- While sexual violence rates are higher among women overall, bisexual and gay men experience significantly higher rates than heterosexual men. Four in ten gay men and nearly half of bisexual men have encountered sexual violence other than rape. More than one-third (37%) of bisexual men have faced partner violence. For both men and women, the perpetrators were predominantly male.
- Anti-LGBT bias also puts LGBT people at risk for physical violence. According to the FBI's crime reporting surveillance, one in five hate crimes was due to sexual orientation bias.[59] Studies using convenience samples have shown a significant number of LGBT individuals have been victims of physical and verbal assaults, as well as personal property damage, due to their sexual orientation or gender identity.[60] One recent nationally representative study examined self-reported experiences with physical violence due to sexual orientation among gay men, lesbian women, and bisexual individuals, and found almost 8% of individuals have experienced physical violence once and 5.5% have experience physical violence at least twice. Gay men were the most likely to experience physical violence due to their sexual orientation.[61] Transgender people, particularly transgender women and transgender people of color, are also at particular risk of physical violence.[62] Statistics from the National Coalition of Anti-Violence Programs indicate that half of the victims

of anti-LGBT bias-motivated murders in 2012 were transgender women and the majority were also people of color.[63]

Adolescent and Young Adult Health

Adolescence and young adulthood are often times when individuals begin to identify as LGBT.[64] While these times can be challenging for many individuals, they are often especially so for LGBT youth. Despite growing societal acceptance and understanding, some young people still suffer discrimination at the hands of their family and friends and in their schools and communities, experiences which can lead to serious challenges, such as housing problems, that affect health. There is growing awareness about bullying and violence affecting LGBT youth. These include efforts to promote greater attention to fostering inclusive school climates, teaching youth about online safety, establishment of reporting processes in schools and communities when violence or bullying occur, and referring young people for professional mental and behavioral health services when needed. Key statistics include the following:

- Like their adult counterparts, youth who identify as a sexual and/or gender minority experience higher rates of mental illness, substance abuse, violence, and discrimination compared to the general population. Additionally, LGBT youth are more likely to be homeless and live in poverty than non-LGBT youth. Research has found that parental rejection can increase the likelihood that an LGBT youth will suffer from depression, attempt suicide, use illegal drugs, and/or engage in risky sexual behaviors.[65]
- Approximately 40% of homeless youth are LGBT, and the leading reasons for homelessness among this group are due to family rejection.[66]
- Almost two thirds (64%) of LGB students and 4 out of 10 (44%) transgender students report feeling unsafe at school because of their sexual orientation or gender identity.[67]
- LGB youth are four times more likely to attempt suicide than heterosexual youth.[68]
- Three times as many LGB youth report ever being raped compared to their heterosexual peers (16% vs. 5%).[68]

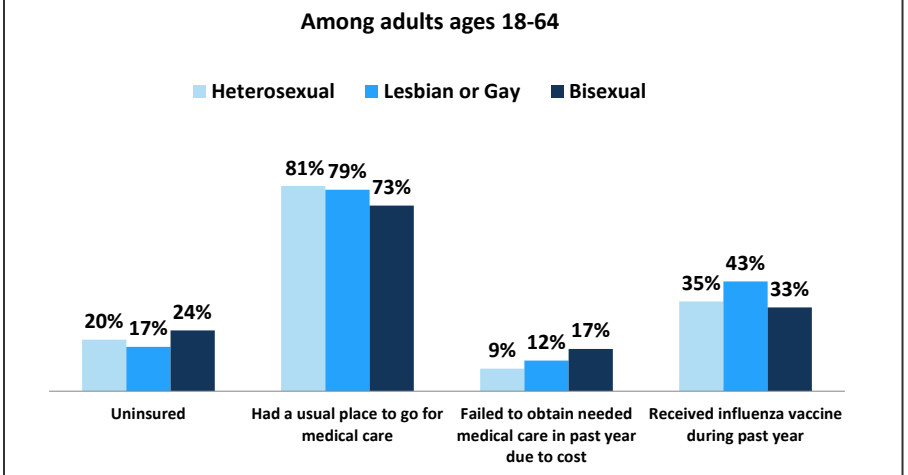
Insurance Coverage and Access to Care

Research has shown that LGBT populations have different patterns of health coverage and utilization of services and has begun to document gaps within the delivery system in meeting the needs of the LGBT population.

- Until recently, the available research on LGBT people has often been limited to couples or combines lesbian, gay, and bisexual people while excluding transgender people. Studies that have stratified between

Figure 5

Access to Care and Utilization of Services in the U.S., by Sexual Orientation, 2013



NOTES: Among adults ages 18-64.
SOURCE: Centers for Disease Control and Prevention, National Health Statistics Reports. (July 2014). Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey, 2013.

these different groups suggest that there are important differences in access that are often masked in more aggregated studies. In particular, new research finds that on some measures, bisexual individuals have more limited access to care while lesbian and gay individuals have rates comparable to heterosexual adults **(Figure 5)**. According to the 2013 NHIS, the uninsured rate is similar between lesbian and gay adults (17%), heterosexual (20%), and bisexual adults (24%). However, on other measures of access, including a usual place to go for medical care and going without medical care due to cost, bisexual adults fared poorer than other groups.

- A 2013 survey found that, of the close to 5.5 million LGBT individuals estimated to have incomes under 400% of the federal poverty level (FPL), one in three were uninsured at the time of the survey and more than two-thirds of these individuals had been uninsured for more than two years.[69] Among this group, LGBT individuals with insurance were less likely than individuals in the general population to get insurance through their employer and more likely to be enrolled in Medicaid. Additionally, almost 4 in 10 had medical debt and more than 4 in 10 reported postponing medical care due to costs. [70,71]
- Research studies on same-sex couples find that LGB individuals have higher rates of unmet medical need because of cost and are less likely to have a regular provider. Research has also found that women in same-sex couples are less likely than heterosexual married women to have received timely medical care for both primary and specialty services. Among men in couples, gay men are three times as likely as their heterosexual counterparts to report delays in obtaining needed prescription medicines.[72]
- Some studies have found that lesbian women in couples have lower rates of breast and cervical cancer screenings than married heterosexual women.[73] In addition to lower mammography rates, lesbian women on average have higher rates of some risk factors for breast cancer, including greater alcohol use and lower likelihood of childbearing. [74,75]
- The transgender population is much more likely to live in poverty and less likely to have health insurance than the general population. Research reflects the impact of these barriers. In one survey of transgender individuals, nearly half (48%) of respondents postponed or went without care when they were sick because they could not afford it.[76] In addition, many health plans include transgender-specific exclusions that deny transgender individuals coverage of services provided to non-transgender individuals, such as surgical treatment related to gender transition, mental health services, and hormone therapy.[77]
- An individual's relationship with providers is another important component of access to care. Significant shares of LGBT individuals report negative experiences when seeking care, ranging from disrespectful treatment from providers and staff, to providers' lack of awareness of specific health needs. In a survey of LGB people, more than half of all respondents reported that they have faced cases of providers denying care, using harsh language, or blaming the patient's sexual orientation or gender identity as the cause for an illness.[78] Fear of discrimination may lead some people to conceal their sexual orientation or gender identity from providers or avoid seeking care altogether.
- For transgender persons, discrimination may be as personal as refusing to use the patient's chosen name or as structural as providers' lack of knowledge about how to provide appropriate care to transgender people. For example, most transgender men still have a cervix and should be screened for cervical cancer, which requires a sensitive approach.[79] Studies of the transgender community show that up to 39% of transgender people have faced some type of harassment or discrimination when seeking routine health care, and many report being denied care outright or encountering violence in health care settings.[80,81]

- Medical education does not routinely encompass LGBT health issues. More than half of medical schools and public health school curricula lack instruction about the health concerns of LGBT people beyond work related to HIV/AIDS.[82,83] However, the medical community's awareness of LGBT health needs has grown. Several professional medical societies have formed policies and guidance that advocate on behalf of fair treatment and access for LGBT patients and health providers.[84] For example, the American Medical Association (AMA) has issued an explicit nondiscrimination policy as well as numerous other statements that recognize prior discriminatory practices in the medical setting, the importance of better understanding and addressing LGBT health needs, the impact of discrimination on health and well-being, and the need to include sexual orientation in research.
- The World Professional Association for Transgender Health also maintains a set of standards and principles to guide health care professionals in providing health care to transgender people.[85] Additionally, in 2011, the Joint Commission, an independent non-profit national organization that accredits and certifies more than 20,000 health care organizations and programs in the U.S., began to require that hospitals prohibit discrimination based on sexual orientation, gender identity and gender expression in order to be accredited.[86]

Impact of Policies on Coverage and Access to Care

In addition to specific health needs, the health of and access to care for LGBT communities is shaped by federal and state policies on insurance, compensation and benefits, and marriage. In 2010, President Obama asked the Secretary of Health and Human Services (HHS) to identify steps to improve the health and well-being of LGBT individuals, families, and communities, which resulted in a series of recommended actions that are now being implemented.[87] Additionally, the passage of the ACA in 2010 and the overturning of DOMA in 2013 affect access to care and coverage for LGBT individuals and their families, expand nondiscrimination protections, increase data collection requirements, and support family caregiving. Finally, states and private organizations have also moved to add nondiscrimination protections and enhance coverage for LGBT individuals.

Impact of the ACA

The ACA makes far-reaching changes in health coverage and delivery of care for all Americans. For LGBT populations, three major areas are of particular saliency: 1) expanded access to coverage and insurance market reforms, 2) new "nondiscrimination" protections, and 3) requirements for data collection and research.

Coverage

- The ACA will extend coverage to millions of uninsured persons through the expansion of Medicaid in some states, as well as the creation of new federally subsidized health insurance marketplaces. In states that expand their Medicaid programs, Medicaid eligibility will be based solely on income, and will be available to most individuals with incomes below 138% FPL regardless of their family status or disability. Uninsured individuals who are not eligible for Medicaid can purchase coverage in insurance marketplaces, with subsidies available to many individuals with incomes below 400% FPL to help offset the costs of premiums. It is estimated that nearly 390,000 uninsured LGBT individuals could qualify for Medicaid in states that plan to expand Medicaid, and that approximately 1.12 million uninsured LGBT individuals could receive subsidies to help with the cost of coverage in insurance marketplaces.[88]

- As of January 2014, individuals can no longer be denied insurance due to a pre-existing condition, such as HIV infection, mental illness, or a transgender medical history. Additionally, new private plans are now required to cover recommended preventive services without cost sharing. This includes screenings for HIV, STIs, depression, and substance use. And, those who gain coverage through Medicaid or in the state marketplaces will have coverage for a set of essential health benefits, including prescription drugs and mental health services.

Nondiscrimination Protections

- As described above, bias and discrimination in the health care system have been an unfortunate reality for many LGBT people.[89] In addition to provider level discrimination, some policies in the insurance and financing system have disproportionately affected LGBT people, including pre-existing condition clauses permitting plans to deny insurance to people with conditions such as HIV, mental illness, or to transgender individuals, who may require specific health care services.[90] Furthermore, some plans have interpreted these exclusions broadly and used them to deny transgender people coverage for services that are not related to gender transition.[91]
- Section 1557 of the ACA prohibits discrimination based on sex, defined to include gender identity and sex stereotypes (but not sexual orientation), in any health program receiving federal funds (such as Medicaid, Medicare, and providers who receive federal funds). Separate federal regulations issued by the Department of Health and Human Services governing the health insurance marketplaces and plans offering the essential health benefits bar discrimination in insurance provisions based on sexual orientation and gender identity.[92] In addition to the new federal law, several states have nondiscrimination policies. Eight states (CA, CO, DE, IL, ME, OR, VT, WA) plus DC prohibit discrimination based on sexual orientation and gender identity.[93] Additionally, eight states (CA, CN, CO, IL, MA, OR, VT, WA) and DC prohibit transgender exclusions in health insurance through legislation or regulation.[94]

Data Collection

- The ACA calls for the inclusion of routine data collection and surveillance on health disparities, which HHS and many other groups have recognized includes LGBT populations. National health care surveys will include questions on sexual orientation within the next couple of years so that analysis can be conducted specifically on LGB populations; efforts to develop questions on gender identity for national surveys are underway as well. Research on LGBT health has increased over time, and HHS has sponsored efforts to collect and report data on LGBT health, as evidenced with the inclusion of LGBT-specific data in publications such as the National Healthcare Disparities Report, the addition of Healthy People 2020 goals to increase routine data collection efforts on LGBT populations, and early efforts of collection and surveillance on sexual orientation and gender identity in national health care surveys.[95] As mentioned above, as of 2013, the NHIS includes a question on sexual orientation. In addition, several agencies within HHS have taken steps toward broader data collection. For example, the CDC has approved sexual orientation and gender identity questions that can be used on the state-administered Behavioral Risk Factor Surveillance System surveys and the Substance Abuse and Mental Health Services Administration is considering adding questions to its National Survey on Drug Use and Health. However, it is still not routine for researchers and health data systems to collect and report data by individuals' sexual orientation and gender identity.
- At the provider and patient level, some groups advocate for clinicians to collect patient information on sexual orientation and gender identity to better understand an individual's health profile and needs. Some

providers have expressed discomfort with and inadequate knowledge on soliciting this information. Advocates' recommendations include being direct with patients about why questions on sexual orientation and gender identity are being asked, ensuring that confidentiality will be maintained, informing patients of the right to opt-out, and asking multiple questions to assess both sexual orientation and gender identity.[96] In particular, the IOM recommends collecting such data in electronic medical records (EMRs), which are growing in use.[97]

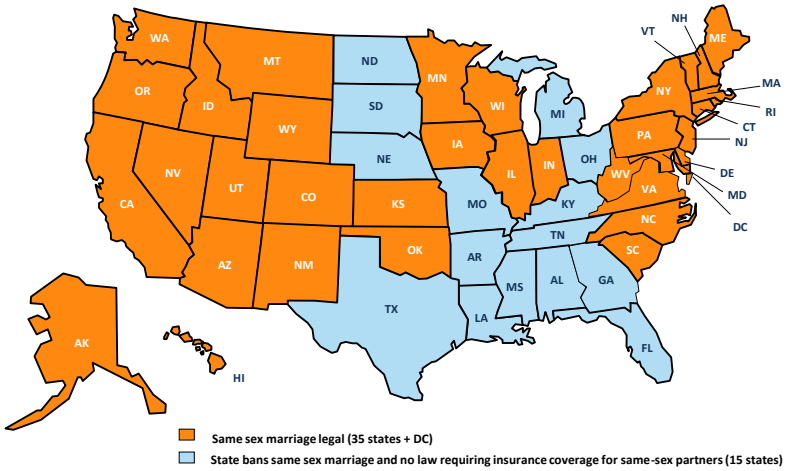
Impact of DOMA Ruling

Spousal coverage is an important pathway to insurance for millions of people, particularly in the context of employer-sponsored health insurance. Until recently, the federal government did not recognize same-sex marriage due to DOMA, which therefore limited LGB individuals' access to a wide range of benefits, including health coverage as a dependent spouse. In June 2013, the Supreme Court issued a ruling in *United States v. Windsor* that overturned a portion of DOMA and requires the federal government to recognize legal same-sex marriages. The DOMA ruling and subsequent Agency policy interpretations and guidance have resulted in expanded access for some LGB families to a range of benefits, including dependent health coverage and family and medical leave. For more information on the impact of federal policy changes, please refer to **Table 2**.

- The Supreme Court decision has prompted federal agencies to reverse previous limitations on spousal benefits in some federal programs. For example, all federal employees who are legally married now have the same eligibility for dependent spousal health coverage in the Federal Employees Health Benefits Program (FEHBP) as well as other dependent benefits, such as dental and vision insurance, long-term care insurance, and flexible spending accounts.[98] The Department of Labor has also clarified that employers must now recognize married same-sex couples for federally required benefits such as COBRA, the program that offers employees and their families a temporary extension of group health coverage in the event that an employee loses his or her job.[99]
- In the wake of the 2013 DOMA ruling, bans on same sex marriage have been overturned in several states and as of December 2014, 35 states and the District of Columbia recognize same-sex marriages.[100] In these states, employees' same-sex spouses should have the same eligibility as opposite sex spouses for dependent health coverage **(Figure 6)**. More broadly, spousal coverage for same sex spouses is not just limited to states that have legalized same sex marriage. According to CMS regulations, health plans in the individual and group markets that offer coverage to opposite-sex spouses must also offer coverage to same-sex spouses (based on "state of celebration," regardless of whether or not the couple lives in

Figure 6

Relationship Recognition and Insurance Coverage Policies for Same-Sex Partners, by State



NOTE: Under the ACA and Supreme Court Ruling on DOMA, states that recognize same-sex marriages are required to provide insurance parity to same-sex couples.
SOURCES: Human Rights Campaign Marriage Center; GRIST InDepth: Employee benefits for same-sex spouses and other life partners – 2012 update, Survey by Mercer; National Conference of State Legislatures.

a state that recognizes same-sex marriage).[101] This applies to individual and group plans. However, with respect to employer coverage, it is important to note that this regulation only applies to health plan issuers; employers in turn have discretion as to what benefits they offer their employees. Thus, in non-marriage equality states, employers could still choose not to offer spousal coverage to same sex partners even though issuers are required to cover it.

- In addition to marriage recognition laws, 19 states and DC have passed separate measures that require fully insured employers in the state to cover same-sex spouses. These insurance parity measures also encourage employers to extend benefits to those in civil unions and domestic partnerships. While same sex marriage is now legal in most states, of the 15 states that still prohibit it, none have an insurance parity requirement.
- Nationally, four in ten (39%) firms that offered health insurance provided benefits to unmarried same-sex domestic partners in 2014, up from 21% in 2009. This varies by firm size, region, and industry, with larger companies, those in the Northeast, and manufacturing field most likely to offer coverage to same-sex partners **(Table 3)**.

- More broadly, as a result of the Supreme Court ruling, the Internal Revenue Service (IRS) has ruled that it now recognizes all legally married couples (based on "state of celebration,") and that they can file federal taxes as "married," which affects a number of health-related financial issues such as the taxes they pay on health benefits.[102] For example, dependent coverage, including spousal coverage, is excluded from an employee's taxable income. However, prior to the Supreme Court ruling, coverage for a domestic partner was considered taxable income, which raised taxes for those who received this coverage. The Supreme Court decision means that married same-sex couples no longer face this higher tax burden at the federal level.[15]

- The DOMA decision also affects LGB individuals' eligibility for assistance under the ACA's coverage expansions, which is based in part on applicants' family structure and incomes. Federal regulations have clarified that insurance marketplaces will recognize same-sex marriages and base eligibility for tax credits on couples' income.[103] The federal government is encouraging states to recognize same-sex marriages for the purpose of determining Medicaid income eligibility, but the ultimate determination is under state jurisdiction since Medicaid is a federal-state partnership.[104] Additionally, certain elements of Medicaid eligibility may be impacted when a marriage is recognized and income and assets are counted jointly.

- In addition, the DOMA decision has resulted in expanded access to Medicare for some same sex couples. First, an individual in a same sex marriage is now eligible for free (in marriage recognition states) or reduced (in non-recognition states) Medicare Part A (hospital) premiums if their spouse has sufficient work history to qualify for Medicare benefits, even if they themselves do not.[105] In addition, a special enrollment period (SEP) for Medicare Part B (and Premium Part A) is available for an individual who gains and then loses insurance coverage related to spousal employment without facing a penalty, based on state of celebration of marriage.[106] As with Medicaid, eligibility for some means tested Medicare programs may be impacted when a marriage is recognized and income and assets are counted jointly.
- A recent development occurred in May 2014, when HHS invalidated a 1981 rule that allowed Medicare to deny coverage for transsexual surgery. [107] As a result, insurance plans are no longer able to use this rule to deny claims related to transsexual surgery, although they may still use alternate rationale to deny these claims. Several employers have also moved to make their plan offerings more comprehensive by removing exclusions for transgender health services. Among major U.S. employers, there has been a five-fold increase

in the number of businesses offering at least one health plan that includes coverage of transgender services such as counseling, hormone therapy, and surgical procedures.[108]

Family Caregiving Issues

Caring for ill family members is another area of policy that has been evolving in recent years for LGBT people and their families. The Family Medical Leave Act (FMLA) provides workplace protections to employees if they take time off to care for a family member in the event of illness or birth of a child. Under DOMA, LGB individuals were not afforded the law's protections to care for a spouse because the federal government did not recognize same-sex marriages; however, the Supreme Court's decision extends the law to all legally married individuals at qualifying employers. While this is an important step, it does not cover all workers. Additionally there are still other barriers that can limit the reach of these new policies.

- The Department of Labor (DOL) expanded FMLA in 2013 after the ruling on DOMA to include same-sex spouses married and residing in states that recognized same-sex marriage.[109] In June 2014, the DOL proposed rules to further expand FMLA to include same-sex couples based on state of celebration, regardless of their state of residence.[110]
- Paid sick leave is another important benefit that many workers do not have. Because it is legal in more than half the states to fire employees based on their sexual orientation or gender identity, LGBT employees without paid leave may be more reluctant to take time off when they or their family members are sick.[111]
- In addition to workplace protections, visiting loved ones in the hospital or another health care setting has not always been guaranteed for LGBT people. However, federal regulations in effect since 2011 require hospitals participating in Medicare and Medicaid (virtually all hospitals in the U.S.) to adopt written policies and procedures regarding a patient's rights to visit his or her same-sex partner and state explicitly that discrimination based on sexual orientation and gender identity are prohibited.[112]
- Providers must sometimes communicate information or discuss medical decisions on a patient's behalf with a patient "representative," who is often a spouse. If finalized, Federal regulations proposed in 2014 would require that providers and suppliers, such as hospitals, hospices, community mental health centers, and laboratories, that participate in Medicare and Medicaid must recognize same sex spouses (marriage legalized based on state of celebration) as patient representatives.[113]
- Concerns have also been raised about discrimination against older LGBT individuals and their families in long-term care facilities. Recent federal regulations now provide residents of long-term care facilities, such as nursing homes, the right to have visitors of their choice, including same-sex spouses and domestic partners.[114]

***

A number of health challenges disproportionately affect LGBT communities, particularly the HIV/AIDS epidemic, stigma and violence, substance abuse, negative experiences in the health care system, and lack of insurance coverage. In addition to health outcomes, access to care has been a concern and intersects with many broader issues, including relationship recognition, legal identity recognition policies for transgender individuals, training and cultural competency of health professionals, as well as overarching societal and cultural issues, particularly a long history of stigma and discrimination. Recent policy and legal changes will serve to mitigate some of these challenges. In particular, the years ahead will see both the full implementation

of the ACA as well as the full effects of overturning elements of DOMA, and for the first time in the nation's history, same-sex marriage is legal in the majority of states. This convergence of policy and legal breakthroughs holds promise for broader access to health services, coverage, and benefits for LGBT communities.

The authors thank Kellan Baker of the Center for American Progress and Sean Cahill of the Fenway Institute for their thoughtful review and comments.

Table 2: Impact of Selected Federal Policy Changes on Coverage and Access to Care for LGBT Communities	
Policy	**Key Provisions and Impact**
The Patient Protection and Affordable Care Act (ACA)[115]	• Broadens federal nondiscrimination in health care programs receiving federal funds and prohibits basing coverage eligibility, insurance premium pricing, benefit design, or any other aspect of coverage on sex, gender identity, or sex stereotyping. • Explicitly prohibits state insurance marketplaces and plans offering the essential health benefits from discriminating based on sexual orientation or gender identity. • Promotes data collection and analysis on sexual orientation and gender identity through federally-sponsored surveys and programs. • Individuals will no longer be denied coverage due to a pre-existing condition, such as HIV/AIDS, mental illness, or a transgender medical history. • New private plans are required to cover USPSTF recommended preventive services without cost sharing. Includes screenings for HIV, STIs, depression, and substance misuse. • Expands coverage to many uninsured persons through Medicaid and state-based health insurance marketplaces. Medicaid, in states that expand, will base eligibility solely on income (no categorical requirement) and tax credits are available to help subsidize the cost of coverage in marketplaces for low income individuals.

United States v. Windsor **– Overturn of Federal Defense of Marriage Act (DOMA)**	• Overturned Section 3 of the Defense of Marriage Act, which limited marriage to persons of the opposite sex. Treats legal marriages between same-sex individuals the same as marriages between opposite sex individuals with regard to federal law.
	• **Department of Health and Human Services**[116]
	  ○ Guarantees that same-sex married beneficiaries in Medicare Advantage plans who both need care in a skilled nursing facility can receive care at same facility.
	• **Center for Consumer Information and Insurance Oversight (CCIIO) Guidance on IRS Ruling 2013-17 and Eligibility for Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions**
	  ○ All Health Insurance Marketplaces are to recognize legal same-sex marriages when determining eligibility for Premium Assistance and Tax Credits.[117]
	• **Centers for Medicare and Medicaid Services (CMS) Guidance to advise of the implications of the Windsor decision for Medicaid and CHIP**[118]
	  ○ Allows states to decide whether to recognize same-sex marriages when determining Medicaid eligibility.
	• **Internal Revenue Service (IRS) Ruling 2013-17**[119]
	  ○ Ruled that same-sex couples legally married will be treated as married for federal tax purposes, regardless of whether the couple lives in a jurisdiction that recognizes same-sex marriage or not ("state of celebration" takes precedent). Allows couples to file taxes as "married" and thus treats same-sex spousal health coverage as tax exempt for purposes of determining federal income tax.
	  ○ If same-sex spouse received employer-based dependent insurance, the employee may apply for refund of excess federal income taxes paid on the value of the coverage for past 2-3 years.
	• **Department of Labor Technical Release Number 2013-04**[120]
	  ○ Requires all ERISA plans to include legally married same-sex couples in the definition of "spouse" and "marriage," opening the door for broader dependent coverage of same-sex spouses.
	• **Department of Defense Memorandum Subject: Extending Benefits to the Same-Sex Spouses of Military Members**[121]

	○ Legally married spouses eligible for dependent health coverage of service members and DOD civilian employees. • **Department of Justice Letter to The Honorable John Boehner**[122] ○ Extends VA and DOD spousal benefits to same-sex spouses by no longer enforcing Title 38 of the U.S. Code, which had previously limited benefits to opposite-sex marriages only. • **Department of Labor, Wage and Hour Division- The Family and Medical Leave Act,** ○ As a result of the DOMA ruling, the DOL expanded the definition of spouse under FMLA to include same-sex couples residing in a state that legally recognized same-sex marriage.[123] ○ **Notice of Proposed Rulemaking**[124]**:** In 2014, DOL proposed a further expansion of the definition of "spouse" to include all legally married same-sex couples.
Other	• **Presidential Memorandum- Hospital Visitation**[125] ○ Executive order in 2010 stating hospitals that receive funds from Medicaid and Medicare are to respect the rights of patients to designate visitors, including those designated by legally valid advance directives. ○ Hospitals may not deny visitation privileges on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity, or disability. ○ Guidance issued in November 2010 supports enforcement of the right of patients to designate the person of their choice, including a same-sex partner, to make medical decisions on their behalf should they become incapacitated. • **Centers for Medicare and Medicaid Services Memorandum 13-42-NH: Reminder- Access and Visitation Rights in Long Term Facilities**[126] ○ LTC facilities must ensure that all individuals seeking to visit a resident be given full and equal visitation privileges, consistent with resident preferences within reasonable restrictions that safeguard residents. • **Centers for Medicare and Medicaid Services- Medicaid Spousal Impoverishment Protections**[127] ○ Protections have been extended to include same-sex spouses. This allows a spouse living in the community to maintain a certain level of assets when institutional expenses (usually a nursing home) threaten to deplete all resources and impoverish the community-based spouse. • **National Institutes of Health- LGBT Research Coordinating Committee**[128] ○ This committee was formed to consider recommendations of the Institute of Medicine's study *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* and to suggest strategies for how the NIH can support research.

Table 3: Among Firms Offering Health Benefits, Distribution of Whether Employers Offer Health Benefits to Unmarried Same-Sex Domestic Partners, by Firm Size, Region, Industry, 2014			
	Offer Health Coverage to Same-sex Partners	Do Not Offer Health Coverage to Same-sex Partners	Not Encountered
Firm Size			
All Small Firms(3-199 Workers)	39%	19%*	42%*
All Large Firms (≥200 Workers)	49%*	45%*	5%*
Region			
Northeast	60%*	21%	19%*
Midwest	28%	24%	47%
South	25%*	22%	53%
West	48%	11%	41%
Industry			
Manufacturing	69%*	20%	12%*
Wholesale	38%	36%	25%
Retail	25%	12%	63%
Finance	55%	22%	23%
State/ Local Government	16%*	27%	57%
All Firms	**39%**	**20%**	**41%**

* Estimate is statistically different from estimate for all firms not in the indicated size, region, or industry category ($p<.05$).
NOTE: The response option "not encountered" captures the number of firms that report not having a policy on the issue. This response is distinguished from firms that report "no" since those firms have a set policy on the issue.
SOURCE: Kaiser/HRET, Employer Health Benefits Survey, 2014.

ENDNOTES

[1] Institute of Medicine. (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*.

[2] Healthy People 2020: Lesbian, Gay, Bisexual, and Transgender Health.

[3] Agency for Healthcare Research and Quality. (2012). *2012 National Healthcare Disparities Report*.

[4] DHHS. (2013). "HHS LGBT Issues Coordinating Committee 2013 Report."

[5] Institute of Medicine. (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*.

[6] Ibid.

[7] National Center for Transgender Equality. (2009). *Transgender Terminology*.

[8] Gates, G. (March 22, 2010). LGBT Demographics: Presentation to the Institute of Medicine.

[9] Centers for Disease Control and Prevention, National Health Statistics Reports. (July 2014). Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey, 2013.

[10] Gallup Politics. (October 18, 2012). Special Report: 3.4% of U.S. Adults Identify as LGBT.

[11] Gates, G. (2011). How many people are lesbian, gay, bisexual, and transgender? *The Williams Institute*.

[12] Gallup Politics. (July 30, 2014). LGBT Americans Continue to Skew Democratic and Liberal.

[13] Gates, G. (2014). LGB/T Demographics: Comparisons among population-based surveys. The Williams Institute.

[14] Where data do not include transgender individuals, LGB (lesbian, gay, bisexual) is used.

[15] Institute of Medicine. (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*.

[16] Coffman, KB, Coffman, LC & Marzilli Ericson, KM. (2013). The Size of the LGBT Population and the Magnitude of Anti-Gay Sentiment are Substantially Underestimated, NBER Working Paper No. 19508.

[17] Gates, G. (2011). How many people are lesbian, gay, bisexual, and transgender? *The Williams Institute*..

[18] Gallup Politics. (February 15, 2013). LGBT Percentage Highest in D.C., Lowest in North Dakota.

[19] Gallup Politics. (October 18, 2012). Special Report: 3.4% of U.S. Adults Identify as LGBT.

[20] Ibid.

[21] United States Census Bureau. (2012). Same-Sex Couples Main- Characteristics of Same-Sex Couple Households: 2012.

[22] Pew Research Center (June 2013). A Survey of LGBT Americans Attitudes, Experiences and Values in Changing Times.

[23]Badgett, M.V., Durso, L.E. & Schneebaum, A. (2013). New Patters of Poverty in the Lesbian, Gay, and Bisexual Community. *The Williams Institute*.

[24] Grant JM, Mottet LA, Tanis J, Harrison J, Herman JL, Keisling M. (2011). Injustice at Every Turn: A Report of the National Transgender Discrimination Survey. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force.

[25] Agency for Healthcare Research and Quality. (2012). *2012 National Healthcare Disparities Report*.

[26] Institute of Medicine. (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*.

[27] Healthy People 2020: Lesbian, Gay, Bisexual, and Transgender Health.

[28] Agency for Healthcare Research and Quality. (2012). *2012 National Healthcare Disparities Report*.

[29] Lick, D., Durso, L.E., & Johnson, K.L. (2013). Minority Stress and Physical Health Among Sexual Minorities. *Pers on Psychological Sci 8*(5): 521-548.

[30] Denney, J.T., Gorman, B.K. & Barrera, C.B. (2013). Families, Resources, and Adult Health: Where do Sexual Minorities Fit? *Journal of Health and Social Behavior 54*(1): 46-63.

[31] Lick, D., Durso, L.E., & Johnson, K.L. (2013). Minority Stress and Physical Health Among Sexual Minorities. *Pers on Psychological Sci 8*(5): 521-548.

[32] Ibid.

[33] Centers for Disease Control and Prevention, National Health Statistics Reports. (July 2014). Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey, 2013.

[34] Massachusetts Department of Public Health. (2009). The Health of Lesbian, Gay, Bisexual, and Transgender (LGBT) Persons in Massachusetts.

[35] Centers for Disease Control and Prevention. (2013). HIV Among Gay, Bisexual, and Other Men Who Have Sex With Men.

[36] Centers for Disease Control and Prevention. (2013). HIV Among Black/African American Gay, Bisexual, and Other Men Who Have Sex With Men.

[37] Kaiser Family Foundation, HIV/AIDS In The Lives Of Gay And Bisexual Men In The United States, 2014.

[38] Singh, S., et al. (2014). Men Living with Diagnosed HIV Who Have Sex with Men: Progress Along the Continuum of HIV Care – U.S., 2010. *MMWR*.

[39] Centers for Disease Control and Prevention. (2013). HIV Among Transgender People.

[40] Centers for Disease Control and Prevention. (2014). Likely Female-to-Female Sexual Transmission of HIV- Texas, 2012.

[41] Centers for Disease Control and Prevention. (2010). Syphilis & MSM- CDC Fact Sheet.

[42] Centers for Disease Control and Prevention. (2012). Viral Hepatitis and Men Who Have Sex With Men.

[43] Centers for Disease Control and Prevention (2013). HPV-Associated Cancers Statistics.

[44] Centers for Disease Control and Prevention. (2012). HPV and Men- Fact Sheet.

[45] Lick, D., Durso, L.E., & Johnson, K.L. (2013). Minority Stress and Physical Health Among Sexual Minorities. *Pers on Psychological Sci 8*(5): 521-548.

[46] Cochran, S.D., Sullivan, J.G. & Mays, V.M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among Lesbian, Gay, and Bisexual adults in the United States. *Journal of Consulting and Clinical Psychology* 71(1): 53-61.

[47] Institute of Medicine. (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*.

[48] Ford, Z. (December 3, 2012). APA Revises Manual: Being Transgender is no Longer a Mental Disorder. *Think Progress*.

[49] Lick, D., Durso, L.E., & Johnson, K.L. (2013). Minority Stress and Physical Health Among Sexual Minorities. *Pers on Psychological Sci 8*(5): 521-548.

[50] Substance Abuse and Mental Health Services Administration. (2012). Top Health Issues for LGBT Populations: Information & Resources Kit.

[51] Lee J, Griffin G, Melvin C (2009). Tobacco use among sexual minorities in the USA, 1987 to May 2007: a systematic review. *Tob Control*. 18:275-282.

[52] Cochran, S.D., Sullivan, J.G. & Mays, V.M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among Lesbian, Gay, and Bisexual adults in the United States. *Journal of Consulting and Clinical Psychology* 71(1): 53-61.

[53] Grant JM, Mottet LA, Tanis J, Harrison J, Herman JL, Keisling M. (2011). Injustice at Every Turn: A Report of the National Transgender Discrimination Survey. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force.

[54]Ostrow, D.G. & Stall, R. (2008) Alcohol, tobacco, and drug use among gay and bisexual men. In Wolitski, R.J., Stall, R., & Valdiserri, R.O., *Unequal opportunity: Health disparities affecting gay and bisexual men in the United States*. New York: Oxford University Press.

[55] Centers for Disease Control and Prevention. (2009). Sexual Violence: Consequences.

[56] Human Rights Campaign, (2011). A Guide to State Level Advocacy Following Enactment of the Matthew Shepard and James Byrd, Jr. Hate Crimes Prevention Act.

[57] Pew Research Center (June 2013). A Survey of LGBT Americans Attitudes, Experiences and Values in Changing Times.

[58] Centers for Disease Control and Prevention. (2013). The National Intimate Partner and Sexual Violence Survey: 2010 Findings on Victimization by Sexual Orientation.

[59] U.S. Department of Justice Federal Bureau of Investigation, (2012). Hate Crime Statistics 2011.

[60] Herek, G.M. (2009). Hate Crimes and Stigma-Related Experiences Among Minority Adults in the United States: Prevalence Estimates from a National Probability Sample. *Journal of Interpersonal Violence*.

[61] Ibid.

[62] Lombardi E, et al. (2002). Gender violence: Transgender experiences with violence and discrimination. *J Homosex* 42(1).

[63] National Coalition of Anti-Violence Programs. (2013). Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-Affected Hate Violence in 2012.

[64] Human Rights Campaign. (2012). National Coming Out Day Youth Report.

[65] Centers for Disease Control and Prevention. (2011). Lesbian, Gay, Bisexual, and Transgender Health: Youth.

[66] The Williams Institute. (2012). Serving Our Youth: Findings from a National Survey of Service Providers Working with Lesbian, Gay, Bisexual, and Transgender Youth who are Homeless or At Risk of Becoming Homeless.

[67] Gay, Lesbian & Straight Education Network. (2012). 2011 National School Climate Survey.

[68] Centers for Disease Control and Prevention. (2011). Sexual Identity, Sex of Sexual Contacts, and Health Risk Behaviors Among Students in Grades 9-12: Youth Risk Behavior Surveillance, Selected Sites, United States, 2001-2009.

[69] Personal communication with Kellan Baker, Center for American Progress, December 6, 2013.

[70] Perry Undem Research/Communication, LGBT Community and the ACA, Presentation September 12, 2013.

[71] Center for American Progress. (2013). LGBT Communities and the Affordable Care Act: Findings from a National Survey.

[72] Clift, J & Kirby J. (2012). Health care access and perceptions of provider care among individuals in Same-Sex Couples: Findings from the Medical Expenditure Panel Survey (MEPS). *Journal of Homosexuality 59*(6): 839-850.

[73] Buchmueller, T.& Carpenter C. (2010). Disparities in health insurance coverage, access, and outcomes for individuals in same-sex versus different-sex relationships, 2000-2007. *American Journal of Public Health* 100(3): 489-495.

[74]Kerker, B.D., Mostashari, F. & Thorpe, L. (2006). Health care access and utilization among women who have sex with women: Sexual behavior and identity. *Journal of Urban Health* 83(5): 970-979.

[75] Cochran, SD, et al. (2001). Cancer-related risk indicators and preventive screening behaviors among lesbians and bisexual women. *American Journal of Public Health 91*(4): 591-597.

[76] National Center for Transgender Equality and National Gay and Lesbian Task Force. (2011). Injustice at Every Turn: A Report of the National Transgender Discrimination Survey.

[77] Center for American Progress. (2012). FAQ: Health Insurance Needs for Transgender Americans.

[78] Lambda Legal, "When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV".

[79] The Fenway Institute. (2008). *The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health*.

[80] Lambda Legal, "When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV".

[81] Movement Advancement Project. (2009). Advancing Transgender Equality.

[82] Tesar, C. & Rovi, S. (1998). Survey on Curriculum on Homosexuality/ Bisexuality in Departments of Family Medicine. *Fam Medicine* 30(4): 283-287.

[83] Corliss, H.L., Shankle, M.D. & Moyer, M.B. (2007). Research, Curricula, and Resources Related to Lesbian, Gay, Bisexual, and Transgender Health in U.S. Schools of Public Health. *American Journal of Public Health* 97(6): 1023-1027.

[84] GLMA, Health Professionals Advancing LGBT Equality. (2013). Compendium of Health Profession Association LGBT Policy & Position Statements.

[85] World Professional Association for Transgender Health (2012). Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People.

[86] The Joint Commission. (2010). Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals.

[87] DHHS. (2013). "HHS LGBT Issues Coordinating Committee 2013 Report".

[88] Center for American Progress. (2013). How New Coverage Options Affect LGBT Communities.

[89] Lambda Legal, "When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV".

[90] Baker, K. & Cray, A. (2012). Ensuring Benefits Parity and Gender Identity Nondiscrimination in Essential Health Benefits.

[91] Human Rights Campaign. Health Insurance Discrimination for Transgender People.

[92] Department of Health and Human Services. Federal Register 77(59): March 27, 2012.

[93] Movement Advancement Project. Non-Discrimination Laws.

[94] Ibid.

[95] Department of Health and Human Services. (2013). HHS LGBT Issues Coordinating Committee 2013 Report.

[96] The Fenway Institute. (2012). Policy Focus: How to gather data on sexual orientation and gender identity in clinical settings.

[97] Institute of Medicine. (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*.

[98] U.S. Office of Personnel Management, Guidance on the Extension of Benefits to Married Gay and Lesbian Federal Employees, Annuitants, and their Families, June 28, 2013.

[99] Department of Labor, Technical Release No. 2013-04, September 18, 2013.

[100] Human Rights Campaign, Marriage Center.

[101] Department of Health and Human Services. Centers for Medicaid and Medicare Services. Frequently Asked Questions on Coverage of Same-Sex Spouses . March 14, 2014.

[102] Internal Revenue Service, Rev.Rul.2013-17.

[103] Department of Health and Human Services, Guidance on Internal Revenue Ruling 2013-17 and Eligibility for Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions , September 27, 2013.

[104] Department of Health and Human Services, State Health Officer # 13-006, September 27, 2013.

[105]Social Security Administration. Program Operations Manual System (POMS): GN 00210.002 Same-Sex Marriage - Determining Marital Status for Title II and Medicare Benefits. TN 10 (06-14). Social Security Administration. Program Operations Manual System (POMS): GN 00210.706 Same-Sex Marriage – HI Premium Reduction for Aged and Disabled Individuals. TN 8 (05-14).

[106]Social Security Administration. Program Operations Manual System (POMS): GN 00210.700 Same-Sex Marriage - Eligibility for Medicare Special Enrollment Period (SEP). TN 6 (04-14).

[107] Department of Health and Human Services, Departmental Appeals Board, Appellate Division. NCD 140.3, Transsexual Surgery, Docket No. A-13-87, Decision No. 2576, May 30, 2014.

[108] Human Rights Campaign. (2013). Corporate Equality Index.

[109] Department of Labor, Wage and Hour Division, Fact Sheet #28F: Qualifying Reasons for Leave under the Family and Medical Leave Act, August 2013.

[110] Department of Labor, Wage and Hour Division. Federal Register 79(124): June 27, 2014.

[111] National Gay and Lesbian Task Force, Nondiscrimination Laws Map, June 21, 2013.

[112] Department of Health and Human Services, Medicare finalizes new rules to require equal visitation rights for all hospital patients, November 17, 2010.

[113] Centers for Medicare and Medicaid Services. (2014). Medicare and Medicaid Program Revisions to Certain Patient's Rights of Conditions of Participation and Conditions for Coverage.

[114] Centers for Medicare and Medicaid Services. (2013). Reminder: Access and Visitation Rights in Long Term Care (LTC) Facilities.

[115] Department of Health and Human Services. Federal Register 77(59): March 27, 2012.

[116] Department of Health and Human Services, HHS announces first guidance implementing Supreme Court's decision on the Defense of Marriage Act, August 29, 2013.

[117] Department of Health and Human Services, Guidance on Internal Revenue Ruling 2013-17 and Eligibility for Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions, September 27, 2013.

[118] Department of Health and Human Services, State Health Officer # 13-006, September 27, 2013.

[119] U.S. Department of the Treasury, All Legal Same-Sex Marriages Will be Recognized for Federal Tax Purposes, August 29, 2013.

[120] Department of Labor, Technical Release No. 2013-04, September 18, 2013.

[121] Secretary of Defense, Extending Benefits to Same-Sex Spouses of Military Members, August 13, 2013.

[122] Department of Justice, Attorney General Holder Announces Move to Extend Veterans Benefits to Same-Sex Married Couples, September 4, 2013.

[123] Department of Labor, Wage and Hour Division, Fact Sheet #28F: Qualifying Reasons for Leave under the Family and Medical Leave Act, August 2013.

[124] Department of Labor, Wage and Hour Division. Federal Register 79(124): June 27, 2014.

[125] Office of the Press Secretary, Presidential Memorandum- Hospital Visitation, April 15, 2010.

[126] Centers for Medicare and Medicaid Services. (2013). Details for Title: Reminder: Access and Visitation Rights in Long Term Care (LTC) Facilities.

[127] Centers for Medicare and Medicaid Services. (2013). Spousal Impoverishment.

[128] National Institutes of Health. (January 4, 2013). *Statement by NIH Director Francis S. Collins, M.D., Ph.D., on opportunities for advancing LGBT health research*.

The COMMONWEALTH FUND

Realizing Health Reform's Potential

DECEMBER 2014

Implementing the Affordable Care Act: State Approaches to Premium Rate Reforms in the Individual Health Insurance Market

Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette

Abstract The Affordable Care Act protects people from being charged more for insurance based on factors like medical history or gender and establishes new limits on how insurers can adjust premiums for age, tobacco use, and geography. This brief examines how states have implemented these federal reforms in their individual health insurance markets. We identify state rating standards for the first year of full implementation of reform and explore critical considerations weighed by policymakers as they determined how to adopt the law's requirements. Most states took the opportunity to customize at least some aspect of their rating standards. Interviews with state regulators reveal that many states pursued implementation strategies intended primarily to minimize market disruption and premium shock and therefore established standards as consistent as possible with existing rules or market practice. Meanwhile, some states used the transition period to strengthen consumer protections, particularly with respect to tobacco rating.

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

For more information about this brief, please contact:

Justin Giovannelli, J.D., M.P.P.
Research Fellow
Center on Health Insurance Reforms
Georgetown University Health Policy Institute
jmg298@georgetown.edu

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

Commonwealth Fund pub. 1795
Vol. 34

OVERVIEW

Before the Affordable Care Act, insurance companies in most states were free to charge consumers a higher price for coverage based on many factors, including health status, gender, and occupation.[1] Relatively few states had legal standards that limited these rating practices in the individual (also known as "nongroup") insurance market, meaning that most people looking to buy an individual policy faced highly variable and often unaffordable premiums.[2]

The health law reforms rate-setting by limiting the factors that insurers can consider when pricing coverage. No longer may carriers charge more to a person with a preexisting condition. Instead, premiums must be the same for everyone community-wide, adjusted only for: 1) whether the plan covers an individual or family, 2) age, 3) tobacco use, and 4) where people live.[3]

These federal reforms apply nationwide and, in conjunction with other provisions of the law, aim to make health coverage more accessible and affordable.[4] At the same time, the states retain primary responsibility for regulating their health insurance markets and have significant flexibility when implementing the federal provisions.[5] Consequently, state officials continue to play an essential role in shaping the legal and regulatory landscape in which health coverage is bought and sold.[6]

This brief examines state rating standards in the first year of full implementation of reform. We identify the new federal rules governing age, tobacco, and geographic rating and analyze variation in state approaches to implementation of these factors. Drawing on interviews with state insurance regulators, we also explore some of the critical considerations weighed by policymakers as they determined how to implement the ACA's requirements for 2014.

FINDINGS

Age Rating

Federal Standard. The ACA permits insurers to adjust premiums according to an enrollee's age, but limits the overall magnitude of the variation.[7] To implement this requirement, federal regulations construct standard age brackets, also called bands, for children, adults, and older adults and an "age-rating curve" that specifies the annual rate at which premiums may rise as enrollees grow older (Exhibit 1).[8] States must use the federally defined age bands but may establish their own uniform age curve or a narrower rating ratio.[9]

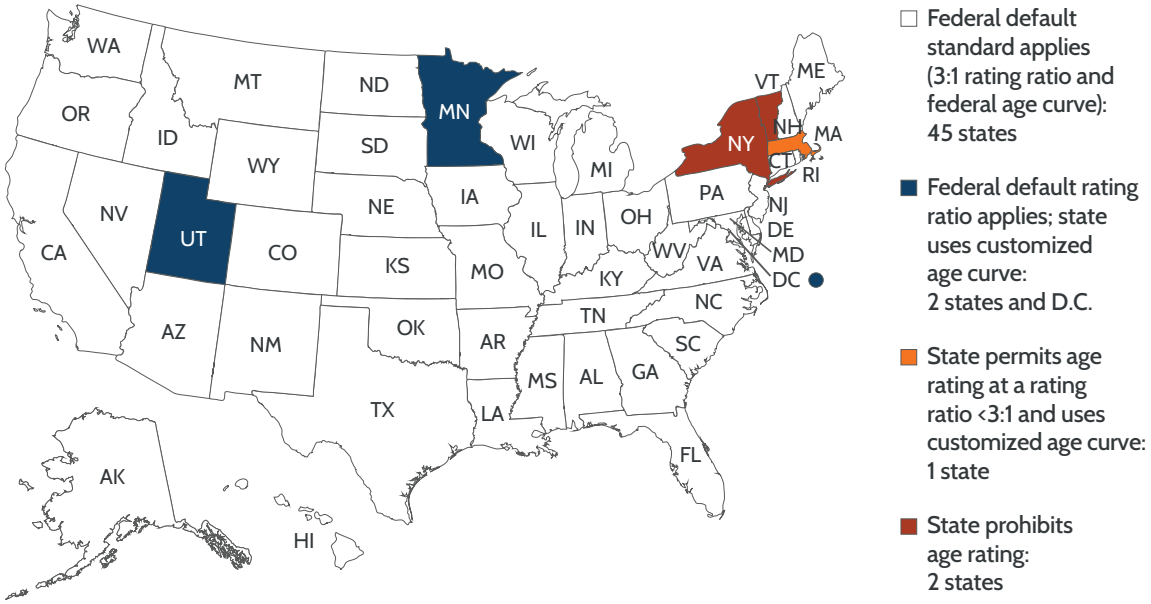
Exhibit 1. Federal Age-Rating Methodology

Age band category	Description
Children	A single band covers children ages 0 through 20. All children within the age band pay the same age-based premium rate.
Adults	Separate one-year age bands cover adults ages 21 through 63. All adults within a given age band (i.e., all 30-year-olds) pay the same age-based premium rate, but premiums may rise from one band to the next, according to a standard age curve (Appendix Table 1).[a] This variation is limited to a ratio of 3:1, meaning that an older adult, ages 64 and older, cannot be charged more than three times the age rate of a 21-year-old.
Older adults	A single age band covers adults ages 64 and older. All older adults within the age band pay the same age-based premium rate.

Note: An enrollee's age for purposes of applying a rating adjustment is determined at the time of policy issuance or renewal.
[a] The single-year adult age bands and uniform age curve are designed to mitigate premium disruption as enrollees age, as well as improve the accuracy of risk adjustment and make it easier for consumers to compare competing plans.
Source: 45 C.F.R. § 147.102(a)(1)(iii) & (d).

State Flexibility. Five states and the District of Columbia implemented state-specific age-rating standards. Massachusetts, New York, and Vermont further restricted age rating by reducing or eliminating the maximum rating ratio—meaning, for example, that New Yorkers cannot be charged different prices for coverage depending on their age—while the District of Columbia, Massachusetts, Minnesota, and Utah created unique age-rating curves that regulate, at the state level, the rate at which consumers' premiums may increase due to age each year. In the remaining 45 states, federal minimum requirements govern without modification (Exhibit 2).

Exhibit 2. State Standards for Age Rating in the Individual Market (2014)



Source: Authors' analysis.

Most states approached implementation of the age-rating ratio with the goal of minimizing market disruption. Before reform, only six states imposed a ratio equal to or narrower than the ACA's 3:1 maximum.[10] Thirty-eight had not established any explicit limitation on age rating in the individual market. Since, for most states, adopting the federal requirements created a substantial shift in rate regulation, policymakers in these jurisdictions were disinclined to require their markets to undergo still greater changes. One interviewee expressed concern that any further compression of the rating ratio might discourage younger, healthier individuals from enrolling, thereby undercutting efforts to expand coverage and producing an older, more expensive mix of enrollees in carriers' risk pools.

The few states that previously adopted strict age-based rate restrictions were similarly motivated to preserve market stability and thus tended to maintain their rules for 2014. New York and Vermont continued prohibitions on age rating and Massachusetts retained its 2:1 ratio, partly to avoid a potential rate spike for older individuals, which may have occurred had the state relaxed its ratio to match the federal minimum.[11]

Forty-seven states are using the federal age curve, with interviewees generally noting they lacked either the data to justify a deviation, or the time—during a tight implementation period—to explore state-specific alternatives. One of the exceptions, Utah, created a customized curve to reflect the health costs of its state population, which includes a comparatively high percentage of younger, larger families.[12]

Tobacco Rating

Federal Standard. The health law allows insurers to vary nongroup premiums based on whether an enrollee uses tobacco, up to a maximum ratio of 1.5:1.[13] Significantly, and in contrast to rate adjustments on the basis of age or geography, federal default rules require consumers who use tobacco to bear the full, unsubsidized cost of any tobacco-related surcharge (Exhibit 3).[14] Among other options, states may require insurers to calculate the surcharge based on the subsidized premium, reduce

the rating ratio, adopt a narrower definition of tobacco use, or implement a combination of these alternatives.[15]

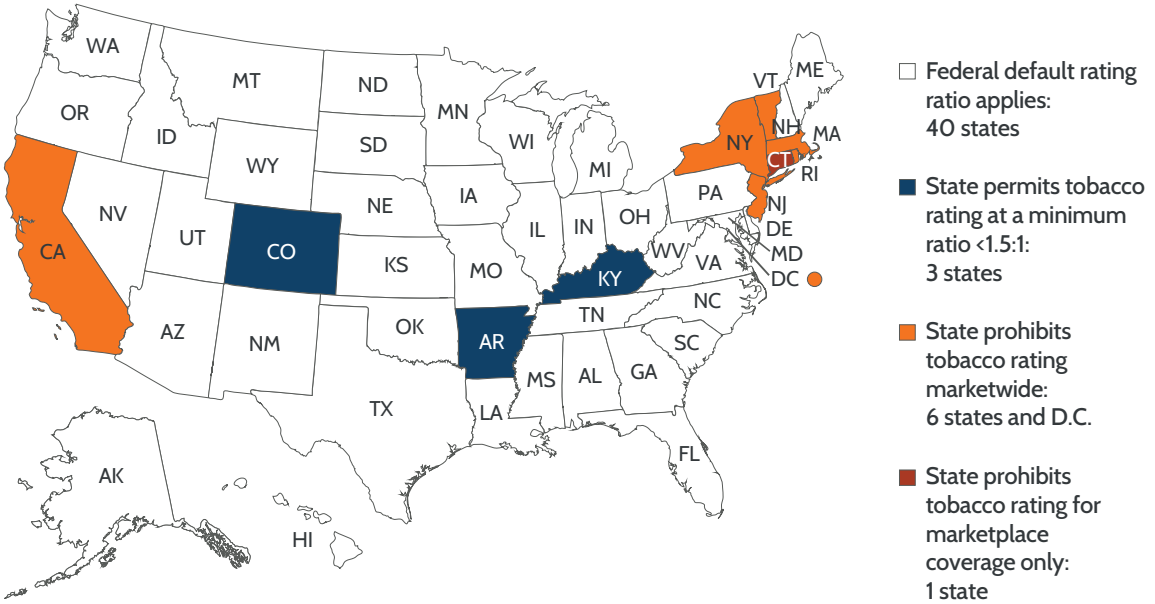
Exhibit 3. Impact of Tobacco Rating on Annual Premiums, After Tax Credits

Income[a]	Annual premium excluding tobacco rating		Annual premium including 50% tobacco surcharge	
	Premium	Premium as a percent of income	Premium	Premium as a percent of income[c]
150% FPL ($17,235)	$689	4.0%	$2,657	15.4%
250% FPL ($28,725)	$2,312	8.05%	$4,280	14.9%
350% FPL ($40,215)	$3,820	9.5%	$5,788	14.4%
444% FPL ($51,016)[b]	$3,936	7.7%	$5,904	11.6%

Notes: FPL refers to federal poverty level. Calculations based on an annual, unsubsidized premium of $3,936 for one enrollee. This value constitutes the weighted average annual premium of the second-lowest-cost silver plan offered in the marketplaces of 48 states during the open enrollment period for policy year 2014, as estimated by the Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Health Policy (ASPE). (Excluded from the ASPE estimate are the states of Hawaii, Kentucky, and Massachusetts, for which ASPE lacked premium data.) In general, premium tax credits are available on a sliding scale to individuals with incomes between 100 percent and 400 percent of the federal poverty level who purchase coverage through their insurance marketplace.
[a] Dollar values reflect federal poverty guideline data for 2013, the baseline used to calculate subsidy eligibility for the 2014 policy year.
[b] Income level equals the national median household income in 2012.
[c] Under the Affordable Care Act, an individual is deemed to lack access to "affordable" insurance if her required share of the premium for self-only coverage is greater than 8 percent of income. To the extent a consumer's coverage options (including those at metal tiers other than silver) exceed this threshold because of application of the tobacco surcharge, she would be exempt from the health law's coverage mandate tax penalty.
Source: Authors' analysis.

State Flexibility. Nine states and the District of Columbia chose to further limit the effect of tobacco rating by reducing or eliminating the 1.5:1 rating ratio marketwide, while Connecticut prohibited the use of the rating factor for coverage offered through the state's marketplace (Exhibit 4).[16] In addition, Maryland's marketplace, which is using Connecticut's technology platform in 2015, also adopted the restriction on tobacco rating for the coming year.[17]

Exhibit 4. State Standards for Tobacco Rating in the Individual Market (2014)



Source: Authors' analysis.

No state altered the federal definition of tobacco use, nor has any required the factor to be calculated from subsidized premiums—a step that would reduce the magnitude of the surcharge, especially for consumers with lower incomes (Exhibit 5).

Exhibit 5. Impact of Alternative Tobacco Rating Standards on Annual Premiums, After-Tax Credits

	Annual premium including 50% tobacco surcharge (default standard: surcharge applied to unsubsidized premium)		Annual premium including 50% tobacco surcharge (surcharge applied to subsidized premium)		Annual premium including 20% tobacco surcharge (surcharge applied to subsidized premium)	
Income[a]	Premium	Premium as a percent of income	Premium	Premium as a percent of income	Premium	Premium as a percent of income
150% FPL ($17,235)	$2,657	15.4%	$1,034	6.0%	$827	4.8%
250% FPL ($28,725)	$4,280	14.9%	$3,468	12.1%	$2,774	9.7%
350% FPL ($40,215)	$5,788	14.4%	$5,730	14.2%	$4,584	11.4%
444% FPL ($51,016)[b]	$5,904	11.6%	$5,904	11.6%	$4,723	9.3%

Notes: FPL refers to federal poverty level. Calculations based on an annual, unsubsidized premium of $3,936 for one enrollee. This value constitutes the weighted average annual premium of the second-lowest-cost silver plan offered in the marketplaces of 48 states during the open enrollment period for policy year 2014, as estimated by ASPE. (Excluded from the ASPE estimate are the states of Hawaii, Kentucky, and Massachusetts, for which ASPE lacked premium data.) In general, premium tax credits are available on a sliding scale to individuals with incomes between 100 percent and 400 percent of the federal poverty line who purchase coverage through their insurance marketplace. No state has adopted a rating standard whereby the tobacco adjustment is calculated based on an enrollee's subsidized premium. Three states permit tobacco rating at a ratio that is narrower than the federal default of 1.5:1, including Arkansas, which allows a 20 percent surcharge.
[a] Dollar values reflect federal poverty guideline data for 2013, the baseline used to calculate subsidy eligibility for the 2014 policy year.
[b] Income level equals the national median household income in 2012.
Source: Authors' analysis.

States considered a range of factors when implementing the tobacco rating provision, with a desire for market stability a high priority. Before reform, all but five states permitted individual market insurers to charge higher premiums for tobacco use.[18] For 2014, most states adhered to federal minimum requirements to allow carriers rating flexibility as consistent as possible with past practice. For similar reasons of continuity, four states that previously banned tobacco rating to broaden risk-sharing—New Jersey, New York, Rhode Island, and Vermont—maintained the prohibition, with interviewees noting little appetite for movement away from the existing consumer-protective framework.

In addition to their interest in maintaining stability, states grappled with competing views on the efficacy of tobacco rating. Officials recognized that tobacco use is a voluntary behavior associated with higher health costs but also acknowledged that it is highly addictive and difficult to influence. Policymakers thus debated how to allocate the risk of increased costs between tobacco users and the broader enrollee pool.[19] Kentucky, for example, imposed a tobacco rate restriction that is tighter than both the federal default and the state's requirements before reform. However, because regulators were concerned that completely phasing out the rating factor might negatively affect the premiums of nonusers, officials permitted a surcharge of 40 percent.[20] Wariness about imposing a potentially punitive charge on consumers with addiction weighed on policymakers in the District of Columbia, who chose to prohibit the rating practice in its entirety.[21] Meanwhile, several states considered

whether the tobacco surcharge would make coverage unaffordable for many consumers, particularly those with lower incomes.[22] These concerns—about whether the surcharge would ultimately increase the number of uninsured and encourage adverse selection against the marketplace—helped prompt California's legislature to eliminate the rating factor.[23]

Geographic Rating

Federal Standard. The ACA allows insurers to vary premiums based on where an individual lives within a state (Exhibit 6).[24] States have wide discretion to develop geographic rating areas and may also limit the magnitude of the premium variation between their highest- and lowest-cost regions.[25]

Exhibit 6. Geographic Rating Concepts

Key concept	Description
Rating area	States may establish one or more rating areas based on existing geographic divisions including counties, three-digit zip codes, or urban and rural regions. Within a rating area, all enrollees receive the same geographic rate, but insurers may adjust premiums based on geography from one area to the next.
Federal default approach	If a state declines to establish its own rating areas, federal rules specify that the state must have one rating area for each of its metropolitan statistical areas (MSAs) and one additional area combining all non-MSAs.
Rating band	In contrast to the ACA's rules for age and tobacco use, which do not allow rates to fluctuate beyond a maximum ratio, federal law does not limit the degree to which premiums may vary across geographic rating areas. States retain authority to impose such restrictions if they choose.

Source: 45 C.F.R. § 147.102(a)(1)(ii) & (b).

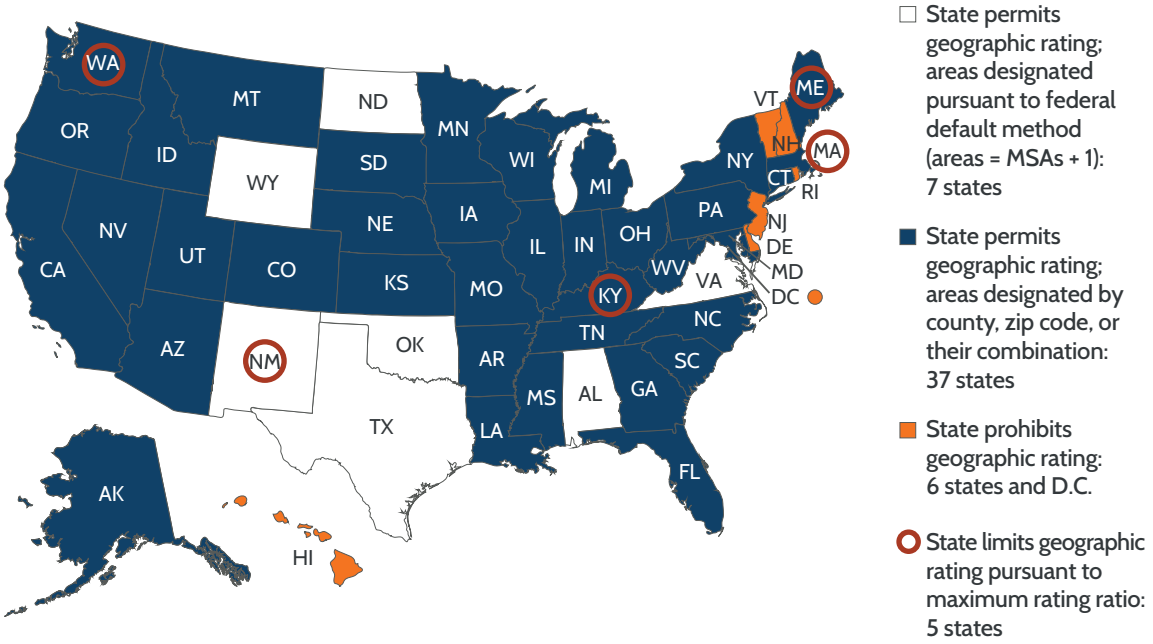
State Flexibility. All but seven states designated rating areas based on classifications that diverged from the federal default (Appendix Table 2).[26] Six states and the District of Columbia banned geographic rating by establishing a single rating area for the entire jurisdiction, while five states that permit the factor's use blunted its impact by limiting variation to a prescribed ratio (Exhibit 7).

States attempted to minimize disruption to their markets when implementing the geographic rating standards, frequently setting rating areas to align with existing regulatory requirements. New Jersey, for example, created a single rating area for its individual market pursuant to prevailing state law, while Florida and South Carolina adopted the largest number of rating areas nationwide (67 and 46, respectively), corresponding to the single-county areas each had established before reform.[27]

In some states, strict replication of past practice was either impossible, because that practice was not previously defined through state action, or undesirable, because additional analysis suggested alternatives. Policymakers in these states struggled to craft rating areas that reflected existing regional differences in health costs but that did not entrench pricing mechanisms that could systematically disadvantage particular subpopulations. One interviewee noted that his state did not adopt as many rating areas as allowed under federal rules in part because regulators did not want to segment the market too finely. Doing so, they worried, could make it easier for insurers to isolate communities with greater health needs and charge them higher rates, a practice that would undermine the federal law's protections against discrimination based on health status.

In general, however, regulators from states that perceived substantial geographic variation in the cost of care expressed caution about adopting relatively few rating areas, fearing that such

Exhibit 7. State Standards for Geographic Rating in the Individual Market (2014)



Notes: In Kentucky, state law establishes a combined maximum rating ratio for all "case characteristics" including geographic area and age. In New Mexico, state law imposes a similar requirement, and the state's insurance marketplace places additional limits on the differential between the highest and lowest rated areas.
Source: Authors' analysis.

limitations might lead to sharp increases in premiums for many residents.[28] Colorado officials, for example, worried that having too few rating areas might cause carriers to exit the market in expensive regions—depressing competition and raising prices there—while also producing significantly higher rates for low-cost areas that would now have to share risk more broadly.[29] These concerns led the state to design a framework with a greater number of rating areas than allowed by federal default rules to reflect the perceived regional differences in costs.[30] Colorado's method for delineating regions proved controversial, however, especially among residents of high-cost rating areas, where unsubsidized premiums were among the steepest in the country.[31] This backlash spurred the state to reassess its approach, leading to a decision to reduce the number of rating areas for 2015.[32]

Still other states sought to strike a balance between rating flexibility and risk-sharing by other means, including allowing geographic variation within prescribed bounds. Thus, Washington prohibited nongroup insurers from imposing a geographic adjustment of more than 15 percent, a limit that reflects the rating variation observed in the state's small-group market prior to reform.[33]

DISCUSSION

Prior to health reform, the individual market was marked by dysfunction, providing coverage that, for many, was difficult to access and hard to afford.[34] The ACA seeks to remedy these shortcomings, in part by placing limits on the factors that insurers can consider when setting premiums. The law's rating reforms require that everyone be charged the same price for the same coverage, adjusted only for an enrollee's family size, age, tobacco use, and geographic location.

Our findings reveal that—within the bounds set by the federal government— most states customized at least some aspect of their individual market rating requirements.[35] States varied in the standards they set, but most often were motivated by a common goal: to minimize market disruption.

In general, states pursued continuity to encourage carrier participation in as many service areas as possible and to reduce the risk of premium shocks for consumers.

For age and tobacco rating, most states chose to adhere to federal minimum requirements. Most interviewees viewed the default rules as the best option for facilitating a smooth transition from the pre-reform period—where restrictions on these rating factors were looser or nonexistent—to the present.[36] A few states, however, like Arkansas, California, and Connecticut, went further and reduced or eliminated tobacco rating in their nongroup markets to help ensure affordable coverage options for residents. Meanwhile, others left development of customized standards for the future and prioritized simpler approaches, given the significant time pressure to implement the new requirements.

For geographic rating, desire to prevent rate shock frequently led states to maximize carriers' flexibility to adjust rates across regions. Thus, most states established rating areas that corresponded to pre-reform rating patterns or that equaled the maximum number of areas allowed under federal regulations.[37] In a number of states, this market segmentation revealed significant differences in premiums from one rating area to the next. While these disparities often existed historically, several interviewees noted that the ACA's new rating framework and insurance marketplaces have made the variation more transparent. Increased awareness has already contributed to regulatory changes in Colorado, and seems likely to prompt fresh debates about the appropriate number of geographic areas and the possibility of establishing limits on geographic rating variation elsewhere.

As state officials continue to manage the transition and receive feedback from consumers and other stakeholders, states likely will diverge with increasing frequency from federal minimum requirements. This brief provides a baseline for evaluating future developments and suggests that continued monitoring of state action will be essential to understanding how the ACA is affecting the affordability of coverage.

Notes

[1] S. Corlette, J. Volk, and K. Lucia, *Real Stories, Real Reforms* (Princeton, N.J.: Robert Wood Johnson Foundation, Sept. 2013).

[2] See, for example, D. Goin and S. Long, *Prior Experience with the Nongroup Health Insurance Market: Implications for Enrollment under the Affordable Care Act* (Washington, D.C.: The Urban Institute, Jan. 2014); S. Collins, R. Robertson, T. Garber et al., *Gaps in Health Insurance: Why So Many Americans Experience Breaks in Coverage and How the Affordable Care Act Will Help* (New York, N.Y.: The Commonwealth Fund, April 2012); R. McDevitt, J. Gabel, R. Lore et al., "Group Insurance: A Better Deal for Most People than Individual Plans," *Health Affairs*, Jan. 2010 29:156-64; N. Turnbull and N. Kane, *Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market* (New York, N.Y.: The Commonwealth Fund, Feb. 2005).

[3] Public Health Service Act § 2701 (codified at 42 U.S.C. § 300gg).

[4] The ACA addresses shortcomings in the availability and affordability of individual market coverage through an interrelated and interdependent set of reforms. In addition to the rating protections discussed in this brief, the law requires insurers to provide guaranteed access to coverage and creates a tax penalty for Americans who can afford to get insurance but decline to do so. Public Health Service Act §§ 2702 (codified at 42 U.S.C. § 300gg-1); Pub. L. 111-148, 124 Stat. 782 (2010) § 1501(b) (codified at 26 U.S.C. § 5000A). The ACA also extends financial relief, in the form of premium tax credits and reduced exposure to out-of-pocket expenses, to defray the costs of coverage for low- and middle-income Americans. Pub. L. 111-148, 124 Stat. 782 (2010) §§ 1401-02 (codified at 26 U.S.C. § 36B; 42 U.S.C. § 18071).

[5] See, generally, T. S. Jost, "The Regulation of Private Health Insurance" (Washington, D.C.: National Academy of Social Insurance, National Academy of Public Administration; Princeton, N.J.: Robert Wood Johnson Foundation, Jan. 2009).

[6] J. Giovannelli, K. Lucia, and S. Corlette, *Implementing the Affordable Care Act: State Action to Reform the Individual Health Insurance Market* (New York, N.Y.: The Commonwealth Fund, July 2014); K. Keith and K. Lucia, *Implementing the Affordable Care Act: State of the States* (New York, N.Y.: The Commonwealth Fund, Jan. 2014).

[7] Public Health Service Act § 2701(a)(1)(A)(iii) (codified at 42 U.S.C. § 300gg(a)(1)(A)(iii)).

[8] 45 C.F.R. § 147.102(a)(1)(iii), (d) & (e).

[9] 45 C.F.R. § 147.103; Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review; Final Rule, 78 Fed. Reg. 13406, 13412 (Feb. 27, 2013) (the "ACA Market Reform Final Rule").

[10] The six states that maintained age-rating restrictions, prior to reform, that were at least as stringent as current ACA standards were Maine, Massachusetts, Minnesota, New Mexico, New York, and Vermont.

[11] N.Y. Ins. Law §§ 3231, 4317, 4328; Vt. Stat. Ann. tit. 33, § 1811; Mass. Gen. Laws Ann. ch. 176J, § 3.

[12] Utah Insurance Department, "Bulletin 2013-4: Health Benefit Plan Market Transition," March 28, 2013, https://insurance.utah.gov/health/documents/bulletin20134Signed.pdf.

[13] Public Health Service Act § 2701(a)(1)(A)(iv) (codified at 42 U.S.C. § 300gg(a)(1)(A)(iv)). Federal regulations define "tobacco use" as the use of any tobacco product on average four or more times per week within the last six months. 45 C.F.R. § 147.102(a)(1)(iv). This definition is described as "transitional" and federal regulators suggest a "more evidence-based definition" may be provided in future rulemaking. ACA Market Reform Final Rule 78 Fed. Reg. 13406, 13414 (Feb. 27, 2013). For purposes of the definition as it stands, "tobacco use" does not include the religious or ceremonial use of tobacco. 45 C.F.R. § 147.102(a)(1)(iv). Consumers must self-report whether they meet the definition of tobacco use when enrolling in coverage. An insurer may retroactively apply the appropriate tobacco rating surcharge to an individual who misrepresents her tobacco use on her application, but it may not rescind coverage on that basis. ACA Market Reform Final Rule, 78 Fed. Reg. 13406, 13414 (Feb. 27, 2013).

[14] See 26 C.F.R. § 1.36B-3(e) (stating that premium subsidy amounts are based on plan premiums calculated prior to the application of any tobacco rating factor).

[15] 45 C.F.R. § 147.103; ACA Market Reform Final Rule, 78 Fed. Reg. 13406, 13414 (Feb. 27, 2013).

[16] Connecticut Health Insurance Exchange, "Amendment to: Initial Solicitation to Health Plan Issuers for Participation in the Individual and Small Business Health Options Program (SHOP) Exchanges," http://www.ct.gov/hix/lib/hix/040613_FINAL_AMENDMENT_QHP_SOLICITATION_12_13_12.pdf.

[17] Maryland Health Benefit Exchange Board of Trustees, "April 15, 2014 Board Meeting Minutes," http://marylandhbe.com/wp-content/uploads/2014/05/MHBE-Board-Meeting-Minutes-04-15-14.pdf.

[18] The five states that prohibited tobacco rating prior to the ACA were: New Jersey, New York, Oregon, Rhode Island, and Vermont.

[19] Multiple interviewees—including one from a state that prohibits tobacco rating and several from states that do not—expressed doubt about whether the rating factor could be administered fairly or reliably, given that its application is based solely on the self-attestation of enrollees.

[20] Kentucky Department of Insurance, "Affordable Care Act Implementation Update, May 22, 2013," https://insurance.ky.gov/Documents/acaimpfaq2_052313.pdf; M. Burchett, "State health-insurance exchange plans to make smokers pay 40 percent more for coverage; varied interests, observers object," *Kentucky Health News*, Sept. 9, 2013, accessed April 10, 2014, http://kyhealth-news.blogspot.com/2013/09/state-health-insurance-exchange-plans.html.

[21] District of Columbia Health Benefit Exchange Authority, "Resolution: To prohibit tobacco use as a rating factor," http://hbx.dc.gov/sites/default/files/dc/sites/Health%20Benefit%20Exchange%20Authority/publication/attachments/Resolution-ProhibitiononTobaccoUseRating.pdf; District of Columbia Health Benefit Exchange Authority, "Standing Advisory Board Meeting Minutes, March 27, 2013," http://hbx.dc.gov/sites/default/files/dc/sites/Health%20Benefit%20Exchange%20Authority/publication/attachments/AdvisoryBoardMinutes3-27-13_0.pdf.

[22] District of Columbia Health Benefit Exchange Authority, "Tobacco Rating," March 20, 2013, http://hbx.dc.gov/sites/default/files/dc/sites/Health%20Benefit%20Exchange%20Authority/publication/attachments/TobaccoRating.pdf; D. Dillon, "Report on Tobacco Rating Issues in Arkansas Under the Affordable Care Act," Lewis and Ellis, Inc., Feb. 2013, https://static.ark.org/eeuploads/hbe/Feb-2013-Tobacco-Plan.pdf; North Carolina Department of Insurance Market Reform Technical Advisory Group, "In-Person Meeting #9: Notes," Oct. 17, 2012, http://www.ncdoi.com/lh/Documents/HealthCareReform/ACA/TAG%209%20Meeting%20Notes.pdf; R. Curtis and E. Neuschler, "Tobacco Rating Issues and Options for California under the ACA," Institute for Health Policy Solutions, June 21, 2012, http://www.ihps.org/pubs/Tobacco_Rating_Issue_Brief_21June2012.pdf.

[23] California State Assembly Committee on Health, "Bill Analysis: Senate Bill 2," http://leginfo.ca.gov/pub/13-14/bill/sen/sb_0001-0050/sbx1_2_cfa_20130308_164138_asm_comm.html. These same concerns also formed the basis for opposition to the tobacco use surcharge by consumer organizations like the American Cancer Society and the American Lung Association. American Cancer Society Cancer Action Network, "Insurance Market Reform Rule Comment Letter," Dec. 20, 2012, http://www.acscan.org/content/wp-content/uploads/2012/12/Ins-Mkt-Ref-comment-ltr-FINAL-Dec-20-2012.pdf; American Lung Association, "Tobacco Surcharges," 2013, http://www.lung.org/stop-smoking/tobacco-control-advocacy/reports-resources/2013/factsheet-tobacco-surcharges-v2.pdf.

[24] Public Health Service Act § 2701(a)(1)(A)(ii) (codified at 42 U.S.C. § 300gg(a)(1)(A)(ii)); 45 C.F.R. § 147.102(a)(1) (ii) & (b).

[25] State-selected rating areas that are uniform for the entire state and adhere to the geographic divisions described in Exhibit 6 are presumed by federal regulators to be adequate, provided: (1) they were established as of January 1, 2013; or (2) they are no greater in number than the total number of MSAs in the state plus one. If a state proposes rating areas that, in number, exceed the limit specified by this safe harbor, federal officials will review the state's plan to assess whether the proposed areas are actuarially justified, are not unfairly discriminatory, and reflect significant differences in health care unit costs, among other considerations. 45 C.F.R. § 147.102(b).

[26] Most interviewees expressed that it was important for states to retain primary control over rating area selection to manage their markets and seek premium stability for consumers. One interviewee in a state that set areas using counties saw value in the flexibility to deviate from the federal default approach, in particular. He noted that his state's rural regions displayed relatively substantial cost variation and would not have been well-served by a single, aggregated non-MSA rating area.

[27] N.J. Stat. Ann. §§ 17B:27A2 & A-6; Florida Office of Insurance Regulation, "State of Florida Geographical Rating Areas," Letter to the Honorable Kathleen Sebelius, March 21, 2013, http://www.floir.com/siteDocuments/FLGeoRatingAreas.pdf; South Carolina Department of Insurance, "Bulletin Number 2013-01: Rate Filing Procedures for Health Insurance Rate Change Requests, Rate Filing Procedures for New Products, and Other Rating Factors," April 5, 2013, http://www.doi.sc.gov/DocumentCenter/View/2699. Florida and South Carolina were two of only four states—the others, Colorado and Connecticut—to implement rating areas that were greater in number than the federal default maximum based on the number of MSAs in the state plus one. Connecticut also received approval to implement single-county areas (it established eight), while Colorado created 11 areas (reduced to nine beginning in 2015) consisting of a mix of MSAs and non-MSAs. See Department of Health and Human Services, "Sub-Regulatory Guidance Regarding Age Curves, Geographical Rating Areas and State Reporting," Feb. 25, 2013, http://www.cms.gov/CCIIO/Resources/Files/Downloads/market-reforms-guidance-2-25-2013.pdf. ; 3 Code Colo. Regs. § 702-4-2-39.

[28] California and North Carolina are but two examples. California Department of Insurance, "SBX1-2 (Hernandez): Health Care Coverage—Oppose unless Amended," Letter to Senator Ed Hernandez, Feb. 13, 2013, http://www.insurance.ca.gov/0400-news/0100-press-releases/2013/upload/statement017HernandezLtr.pdf; North Carolina Department of Insurance, "State Rating Requirements Disclosure Form—Second Submission," Letter to the Honorable Kathleen Sebelius, March 28, 2013, http://www.ncdoi.com/HealthCareReform/Documents/HealthCareReform/Sebelius28March2013.pdf.

[29] Colorado Division of Insurance, "Fact Sheet: Colorado Geographic Rating Requirements in Mountain Resort Counties," Oct. 25, 2013.

[30] Ibid.

[31] K. McCrimmon, "Remote care, monopolies and pricey injuries hike resort, rural health costs," *Health News Colorado*, Jan. 29, 2014, accessed April 18, 2014, http://www.healthnewscolorado.org/2014/01/29/remote-care-monopolies-and-pricy-injuries-hike-resort-rural-health-costs/; J. Rau, "The 10 Most Expensive Insurance Markets In The U.S.," *Kaiser Health News*, Feb. 3, 2014, accessed April 18, 2014, http://www.kaiserhealthnews.org/Stories/2014/February/03/most-expensive-insurance-markets-obamacare.aspx.

[32] Colorado Division of Insurance, "U.S. Health & Human Services Approves Division of Insurance Shift on Geographic Rating Areas for 2015," May 19, 2014; see also M. Brown, G. Blobaum, and S. Loudon, "Colorado Total Health Cost and Geographic Study," Miller & Newberg Consulting Actuaries, May 2, 2014.

[33] Wash. Admin. Code 284-170-250.

[34] See, for example, D. Goin and S. Long, *Prior Experience with the Nongroup Health Insurance Market*, 2014; S. Collins, R. Robertson, T. Garber et al., *Gaps in Health Insurance*, 2012.

[35] Only six states—Alabama, North Dakota, Oklahoma, Texas, Virginia, and Wyoming—followed federal default rating standards in their individual markets.

[36] Similarly, pursuit of stability—and resistance to perceived backsliding on existing protections—prompted some states with already robust age or tobacco restrictions to maintain them.

[37] For 2014, 29 states established (or defaulted to) the maximum number of areas allowed under the federal safe harbor—a value equal to the number of MSAs in the state plus one. Compare The Center for Consumer Information & Insurance Oversight, "Market Rating Reforms: State Specific Geographic Rating Areas," http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-gra.html; with Department of Health and Human Services, "Sub-Regulatory Guidance Regarding Age Curves, Geographical Rating Areas and State Reporting," 2013.

Appendix Table 1. Federal Default Standard Age Curve (2014)

Age	Premium ratio	Age	Premium ratio	Age	Premium ratio
0-20	0.635	35	1.222	50	1.786
21	1.000	36	1.230	51	1.865
22	1.000	37	1.238	52	1.952
23	1.000	38	1.246	53	2.040
24	1.000	39	1.262	54	2.135
25	1.004	40	1.278	55	2.230
26	1.024	41	1.302	56	2.333
27	1.048	42	1.325	57	2.437
28	1.087	43	1.357	58	2.548
29	1.119	44	1.397	59	2.603
30	1.135	45	1.444	60	2.714
31	1.159	46	1.500	61	2.810
32	1.183	47	1.536	62	2.873
33	1.198	48	1.635	63	2.952
34	1.214	49	1.706	64 and older	3.000

Source: The Center for Consumer Information and Insurance Oversight.

Appendix Table 2. State Geographic Rating Areas in the Individual Market (2014)

State	Number of rating areas (geographic division)	State	Number of rating areas (geographic division)
Alabama	13 (MSAs/non-MSAs)	Montana	4 (counties)
Alaska	3 (zip codes)	Nebraska	4 (zip codes)
Arizona	7 (counties)	Nevada	4 (counties)
Arkansas	7 (counties)	New Hampshire	1 (statewide)
California	19 (combination of zip codes and counties)	New Jersey	1 (statewide)
Colorado	11 (counties)*	New Mexico	5 (MSAs/non-MSAs)
Connecticut	8 (counties)	New York	8 (counties)
Delaware	1 (statewide)	North Carolina	16 (counties)
District of Columbia	1 (statewide)	North Dakota	4 (MSAs/non-MSAs)
Florida	67 (counties)	Ohio	17 (counties)
Georgia	16 (counties)	Oklahoma	5 (MSAs/non-MSAs)
Hawaii	1 (statewide)	Oregon	7 (counties)
Idaho	7 (zip codes)	Pennsylvania	9 (counties)
Illinois	13 (counties)	Rhode Island	1 (statewide)
Indiana	17 (counties)	South Carolina	46 (counties)
Iowa	7 (counties)	South Dakota	4 (counties)
Kansas	7 (counties)	Tennessee	8 (counties)
Kentucky	8 (counties)	Texas	26 (MSAs/non-MSAs)
Louisiana	8 (counties)	Utah	6 (counties)
Maine	4 (counties)	Vermont	1 (statewide)
Maryland	4 (counties)	Virginia	12 (MSAs/non-MSAs)
Massachusetts	7 (zip codes)	Washington	5 (counties)
Michigan	16 (counties)	West Virginia	11 (counties)
Minnesota	9 (counties)	Wisconsin	16 (counties)
Mississippi	6 (counties)	Wyoming	3 (MSAs/non-MSAs)
Missouri	10 (counties)		

Note: MSAs refers to metropolitan statistical areas.
* Colorado will have nine rating areas, based on counties, beginning in 2015.
Source: The Center for Consumer Information & Insurance Oversight.

About the Authors

Justin Giovannelli, J.D., M.P.P., is a research fellow at the Georgetown University Health Policy Institute's Center on Health Insurance Reforms. His research focuses primarily on the implementation of the Affordable Care Act's market reforms and health insurance exchanges at the federal and state levels. Giovannelli received his law degree from the New York University School of Law and his master's degree in public policy from Georgetown's Public Policy Institute.

Kevin W. Lucia, J.D., M.H.P., is a senior research fellow at the Georgetown University Health Policy Institute's Center on Health Insurance Reforms. He focuses on the regulation of private health insurance, with an emphasis on analyzing the market reforms implemented by federal and state governments in response to the Affordable Care Act. Lucia received his law degree from the George Washington School of Law and his master's degree in health policy from Northeastern University.

Sabrina Corlette, J.D., is a senior research fellow at the Georgetown University Health Policy Institute's Center on Health Insurance Reforms. Her areas of focus include state and federal regulation of private health insurance plans and markets, and implementation of new rules for insurance markets under the Affordable Care Act. She serves as a consumer representative to the National Association of Insurance Commissioners, and was appointed to its Consumer Information Workgroup. She received her law degree from the University of Texas at Austin.

Acknowledgments

The authors thank the federal and state officials who shared their time and valuable insights with us. We are also grateful to Ashley Williams for providing research support.

Editorial support was provided by Deborah Lorber.

The
COMMONWEALTH
FUND

www.commonwealthfund.org

INSIGHT on the Issues

Monitoring the Impact of Health Reform on Americans 50–64: Medicaid Expansion and Marketplace Implementation Increased Health Coverage

Adam L. Weiss, Timothy A. Waidmann, and Kyle J. Caswell
Urban Institute

A survey conducted by the Urban Institute and AARP shows that the share of 50- to 64-year-olds without health insurance fell between December 2013 and March 2014. In states that expanded their Medicaid programs, a greater share of previously uninsured adults gained coverage, particularly among groups that have traditionally faced barriers to obtaining it. The survey also found that the newly insured differed in key ways from those who reported being insured for all of the past 12 months. On average, more were low income, and more reported that they had had trouble paying medical bills.

This paper is part of a series that looks at the experience of 50- to 64-year-olds during the first open enrollment period of the Affordable Care Act (ACA).

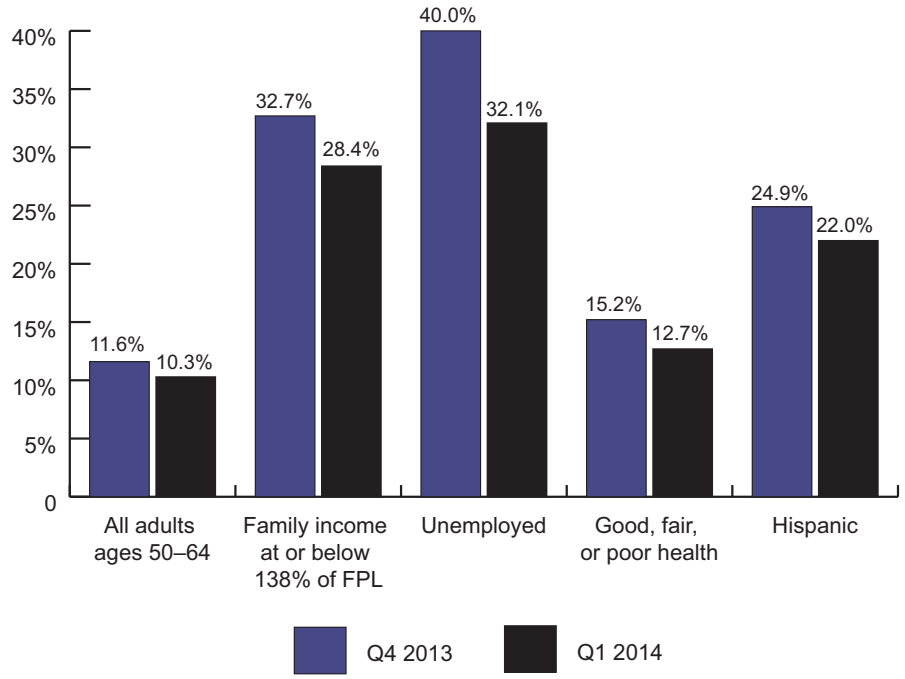
ACA Health Coverage Goals Address Unique Needs of Americans Ages 50–64

Health insurance access is a common concern for Americans ages 50 to 64, a population that has a high need for medical care but that has traditionally faced difficulties obtaining coverage. Those without coverage from an employer have often faced barriers, including (a) limited access to public insurance for poor adults without children and (b) difficulty buying comprehensive coverage in the private health insurance market because of preexisting conditions and cost. As a result, coverage options for many Americans in that age bracket were limited to expensive nongroup (individual) insurance, COBRA, high-risk pools, and plans that provided catastrophic coverage.

The Affordable Care Act (ACA) makes health insurance more accessible and affordable for the 50- to 64-year-old population through a number of changes designed to expand coverage. Those changes include (a) guaranteeing that individuals will have access to private insurance regardless of their medical history; (b) banning the use of health status in setting insurance rates; (c) limiting the amount that insurers can charge older people relative to the amount they can charge younger people; (d) extending the availability of Medicaid to poor, childless adults; and (e) subsidizing the cost of private nongroup coverage bought through new health insurance Marketplaces.

This paper provides data on the effect of the ACA in the first few months of implementation (between December 2013 and March 2014) and reports on changes in health insurance coverage among individuals ages 50 to 64. The data were collected from the Urban Institute's

Figure 1
Changes in the Uninsurance Rate for Select Groups among Adults 50–64 between December 2013 and March 2014



Source: HRMS-AARP, quarter 4 2013 and quarter 1 2014.
Note: FPL = federal poverty level. Estimated changes from quarter 4 2013 to quarter 1 2014 differ significantly from zero at at least the 5 percent level, using a two-tailed test.

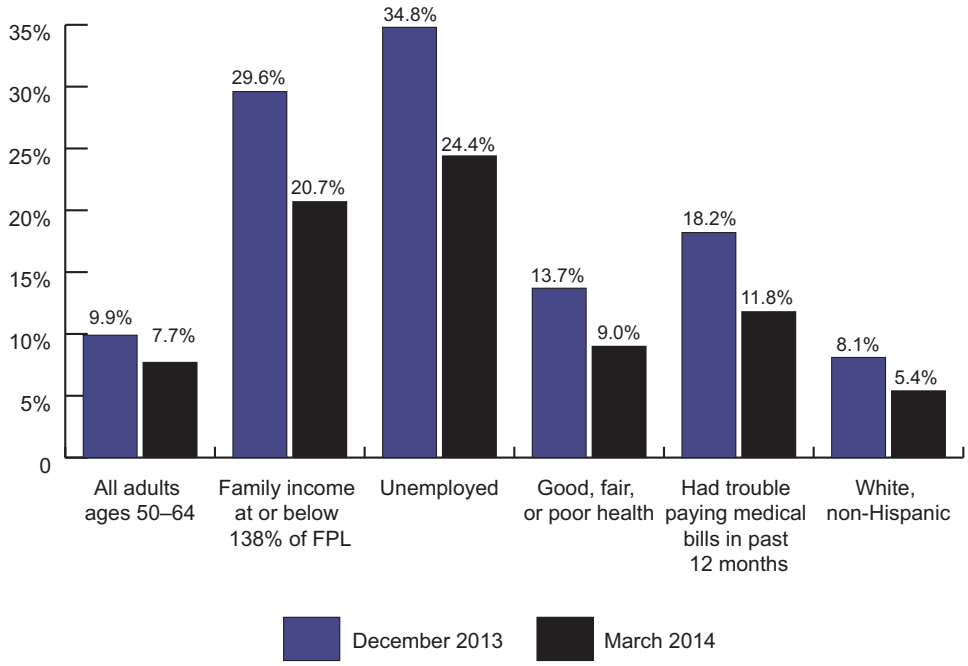
Health Reform Monitoring Survey that compared the coverage type reported by survey respondents in the fourth quarter of 2013 (largely December 2013) with that reported by survey respondents in the first quarter of 2014 (largely during the first three weeks of March 2014). More information about the Health Reform Monitoring Survey is presented in the box at the end of this paper.

Uninsurance Rates Fell among 50- to 64-Year-Olds in the First Months of 2014

In December 2013, 11.6 percent of all adults ages 50 to 64 reported being uninsured. Between December 2013 and March 2014, that rate fell to 10.3 percent. Some groups within the 50–64 population experienced more pronounced declines in the percentage without insurance. Table 1 in the appendix shows how declines varied across different groups. The following are some highlights (also see figure 1):

- For individuals with family incomes at or below the Medicaid expansion threshold of 138 percent of the federal poverty level (FPL), the share without insurance fell from 32.7 percent to 28.4 percent. (For those at or above 400 percent of poverty level, it dropped from 2.2 percent to 1.4 percent.)
- The share of uninsured among the unemployed[1] fell from 40.0 percent to 32.1 percent.
- Among individuals reporting worse health ("poor," "fair," or "good" as opposed to "very good" or "excellent"), the share of uninsured fell from 15.2 percent to 12.7 percent.

Figure 2
Changes in the Uninsurance Rate between December 2013 and March 2014 in Medicaid Expansion States



Source: HRMS-AARP, quarter 4 2013 and quarter 1 2014.
Note: FPL = federal poverty level. Estimated changes from quarter 4 2013 to quarter 1 2014 differ significantly from zero at at least the 5 percent level, using a two-tailed test.

- The share of Hispanics without health insurance fell from 24.9 percent to 22.0 percent.

State Medicaid Expansion Boosted Coverage Gains[2]

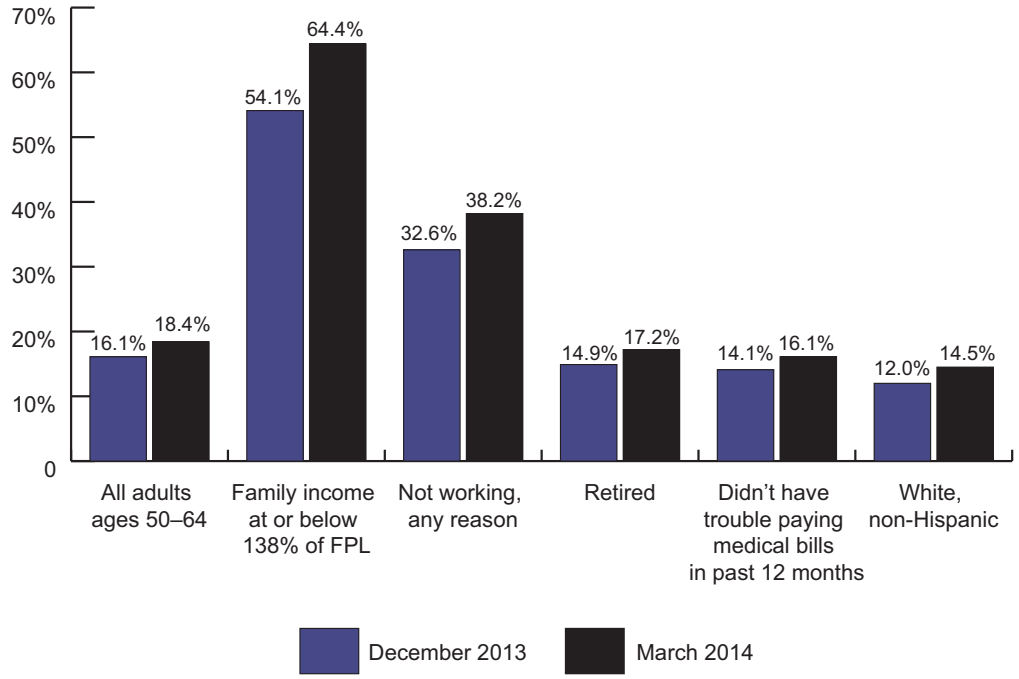
Survey data show pronounced differences between states that chose to expand their Medicaid programs under the ACA and those that did not (appendix tables 2 and 3). The percentage of uninsured adults in Medicaid expansion states declined, while the percentage with public coverage[3] increased, especially among groups that experience barriers to coverage (figures 2 and 3). States that did not expand Medicaid showed more limited declines in the percentage of uninsured and no gains in public coverage.

Expansion States

The following are findings from states that expanded Medicaid:

- Among all adults ages 50 to 64 in Medicaid expansion states, the percentage of those without health insurance fell from 9.9 percent to 7.7 percent, and the public coverage rate increased from 16.1 percent to 18.4 percent.
- Among individuals with family incomes within the Medicaid expansion threshold, the percentage of uninsured fell from 29.6 percent to 20.7 percent, and the percentage of those with public coverage increased from 54.1 percent to 64.4 percent. The survey team did not observe statistically significant changes in the shares of uninsured and publicly

Figure 3
Changes in the Public Insurance Rate between December 2013 and March 2014 in Medicaid Expansion States



Source: HRMS-AARP, quarter 4 2013 and quarter 1 2014.
Note: FPL = federal poverty level. Estimated changes from quarter 4 2013 to quarter 1 2014 differ significantly from zero at at least the 5 percent level, using a two-tailed test. Public insurance includes Medicaid, medical assistance, CHIP, any kind of state or other government-sponsored assistance plan based on income or disability, or Medicare.

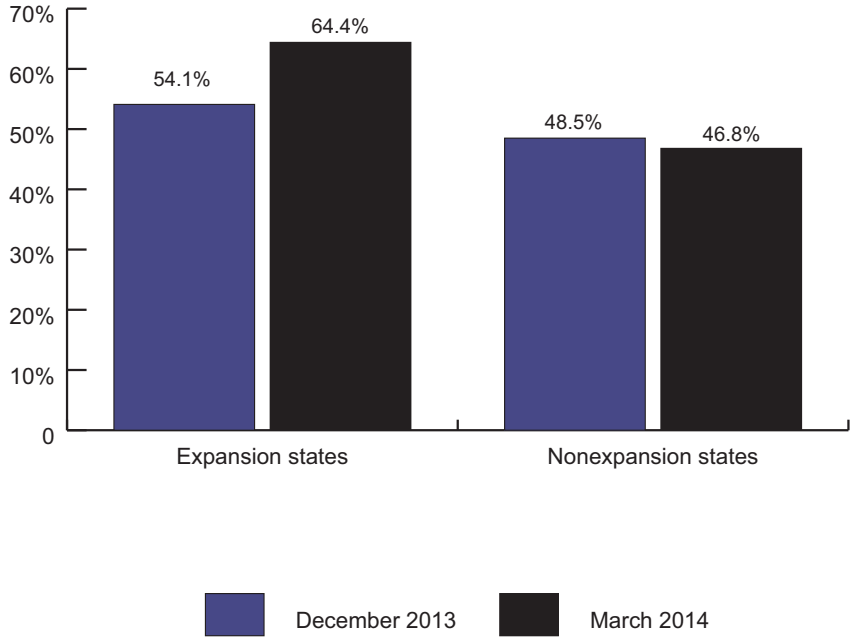
insured among 50- to 64-year-olds with higher incomes.

- Among individuals who were unemployed, the percentage of uninsured fell from 34.8 percent to 24.4 percent. Among working individuals, the percentage of uninsured declined from 8.2 percent to 6.6 percent. The percentage of those groups with public coverage rose but not at a statistically significant level. The increase in public coverage was significant across all nonworkers and among retirees.
- The percentage of individuals who were without insurance and who reported worse health ("poor," "fair," or "good") fell from 13.7 percent to 9.0 percent.
- The uninsured rate among individuals who reported problems paying medical bills in the past 12 months dropped from 18.2 percent to 11.8 percent. Individuals who did not report problems paying medical bills in the past 12 months experienced a smaller decline in the percentage without insurance.
- Among white, non-Hispanic individuals, the percentage of those without health insurance declined from 8.1 percent to 5.4 percent, and the percentage with public coverage rose from 12.0 to 14.5 percent.

Nonexpansion States

Although nonexpansion states saw no significant change in the percentage of adults who had incomes within the Medicaid threshold and who had pub-

Figure 4
Changes in the Public Insurance Rate between December 2013 and March 2014 among Adults 50–64 at or below 138% of FPL in Expansion vs. Nonexpansion States



Source: HRMS-AARP, quarter 4 2013 and quarter 1 2014.
Note: FPL = federal povertly level. Estimated changes from quarter 4 2013 to quarter 1 2014 differ significantly from zero at at least the 5 percent level, using a two-tailed test. Estimated change in the nonexpansion states does not differ significantly.

lic coverage, the share of low-income adults with public insurance rose from 54.1 percent to 64.4 percent in the expansion states (figure 4).

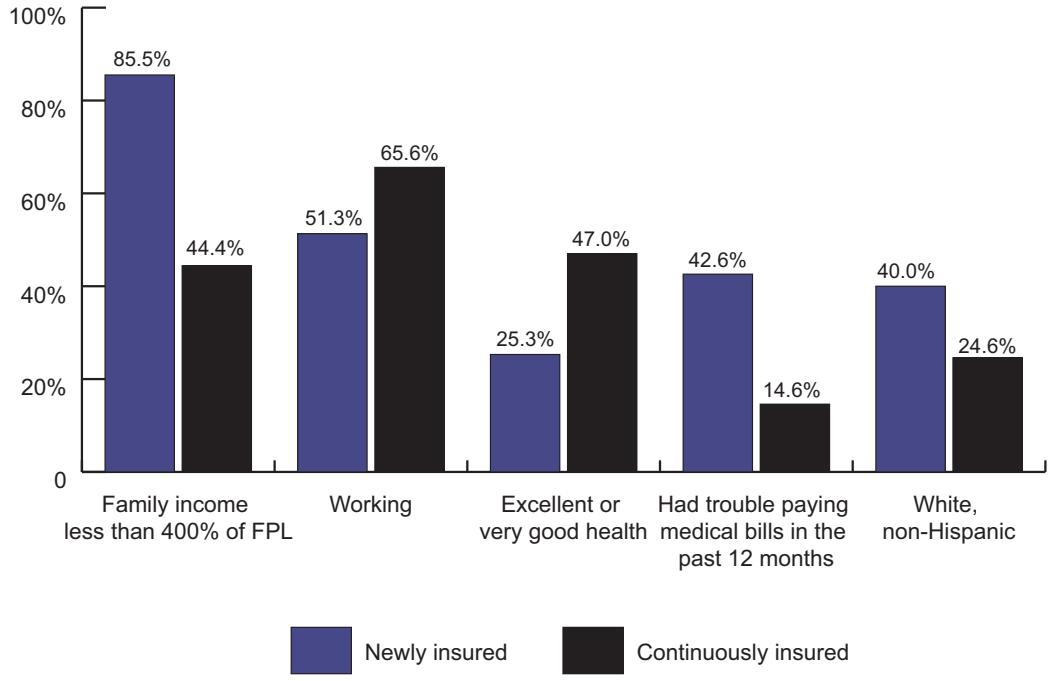
Unlike expansion states, states that did not expand Medicaid did not experience a statistically significant change in the percentage of all adults ages 50–64 who were uninsured.[4] The significant changes in the share of uninsured adults observed in nonexpansion states occurred among those with high family incomes, among Hispanics, and among those who did not have trouble paying medical bills.

Newly Insured Are More Likely to Be Lower Income, Unemployed

In addition to observing changes in coverage between the December 2013 and March 2014 survey samples, the survey included questions about an individual's health coverage for the past 12 months, thereby providing a longitudinal look at coverage during ACA implementation.

Those data reveal socioeconomic, demographic, and health care characteristics of the newly insured and continuously insured. Respondents who reported being newly insured in March 2014—that is, being uninsured for some period of time in the past 12 months and immediately prior to obtaining their current coverage—differed in key ways from those who reported being insured for all of the past 12 months (figure 5). Compared with those who were continuously insured, the newly

Figure 5
Characteristics of the Newly Insured and Continuously Insured in March 2014



Source: HRMS-AARP, quarter 4 2013 and quarter 1 2014.
Note: FPL = federal poverty level. "Newly insured" respondents are those that reported being uninsured for some period of time in the past 12 months and immediately prior to their current coverage. "Continuously insured" respondents are those that reported being insured for the past 12 months. Percentages may not add up to 100 percent due to rounding. Estimates for the newly insured differ significanly from those for the continuously insured from zero at at least the 5 percent level, using a two-tailed test.

insured, on average, have the following characteristics:

- Lower income. Of the newly insured, 41.7 percent reported family incomes that are less than or equal to 138 percent of the federal poverty level (FPL), and 85.5 percent reported family incomes less than 400 percent of FPL. Only 12.6 percent of the continuously insured reported family incomes less than 138 percent of FPL, and 44.4 percent reported family incomes less than 400 percent of FPL.
- More likely to be unemployed or out of the labor force. Of the newly insured, 51.3 percent worked, compared with 65.6 percent of the continuously insured.
- In worse health. Of the newly insured, 25.3 percent reported being in excellent or very good health, compared with 47.0 percent of the continuously insured.
- More likely to report trouble paying medical bills in the past 12 months. Of the newly insured, 42.6 percent reported trouble, compared with 14.6 percent of the continuously insured.
- More likely to be ethnic or racial minorities. Of the newly insured, 40.0 percent are nonwhite, compared with 24.6 percent of the continuously insured.

More Research Is to Come about Americans Ages 50–64

Analysis of HRMS-AARP survey data suggests that the ACA decreased the

percentage of uninsured persons ages 50–64 nationally. Moreover, it appears that state Medicaid expansion had a big effect on decreasing the share of 50- to 64-year-olds without health insurance, particularly among groups that may have had difficulty accessing insurance before the ACA was passed. Other provisions of the ACA, such as limiting variation in premiums for age and guaranteeing that people with preexisting health conditions have access to insurance, have likely also had an effect on coverage among older adults.

Most recent findings have continued to show increases in coverage for the population as a whole, suggesting that adults ages 50 to 64 have had a similar experience (Long et al. 2014; Clemans-Cope et al. 2014). Additional research is needed to assess the effect of coverage on this group, including the incidence of financial hardship from high medical spending, access to health care, and health outcomes.

This work is based on the Health Reform Monitoring Survey's oversample of individuals ages 50 to 64, which is referred to as the HRMS-AARP and was from December 2013 and March 2014. The Health Reform Monitoring Survey is a quarterly Internet survey of individuals ages 18 to 64 that is designed to produce rapid feedback on ACA implementation before the federal government's survey data are available (Long et al. 2013). It was developed by the Urban Institute (hrms.urban.org); fielded by GfK (www.gfk.com); and jointly funded by the Robert Wood Johnson Foundation (www.rwjf.org), the Ford Foundation (www.fordfound.org), and the Urban Institute (www.urban.org). AARP funded the 50- to 64-year-old oversample, which is designed to produce nationally representative statistics of individuals ages 50 to 64. The December 2013 survey includes approximately 8,200 respondents, most of whom completed the survey in the first three weeks of December 2013.

The March 2014 survey includes approximately 8,759 respondents, the majority of whom completed the survey in the first three weeks of March 2014. Because most responses to the first quarter survey were collected in the first three weeks of March, those data may not capture all nongroup and Medicaid expansion coverage obtained in the first Marketplace open enrollment period. For more information on the survey instrument, go to http://hrms.urban.org/survey-instrument/index.html.

References

Clemans-Cope, Lisa, Michael Karpman, Adam Weiss, and Nathaniel Anderson. 2014. "Increase in Medicaid under the ACA Reduces Uninsurance, According to Early Estimates." Policy Briefs Series about Health Reform Monitoring Survey. Washington, DC: Urban Institute. http://hrms.urban.org/briefs/Increase-in-Medicaid-under-the-ACA-reduces-uninsurance.html.

Long, Sharon K., Genevieve M. Kenney, Stephen Zuckerman, Dana E. Goin, Douglas Wissoker, Fredric Blavin, Linda J. Blumberg, Lisa Clemans-Cope, John Holahan, and Katherine Hempstead. 2013. "The Health Reform Monitoring Survey: Addressing Data Gaps to Provide Timely Insights into the Affordable Care Act." *Health Affairs* 3 (1): 161–67.

Long, Sharon K., Genevieve M. Kenney, Stephen Zuckerman, Douglas Wissoker, Adele Shartzer, Michael Karpman, and Nathaniel Anderson. 2014. "Quicktake: Number of Uninsured Adults Continues to Fall under the ACA: Down by 8.0 Million in June 2014." Policy Briefs Series about Health Reform Monitoring Survey. Washington, DC: Urban Institute. http://hrms.urban.org/quicktakes/Number-of-Uninsured-Adults-Continues-to-Fall.html.

Endnotes

[1] "Unemployed" individuals reported that they either were looking for work or were temporarily laid off.

[2] States that expanded Medicaid before April 1, 2014, are AZ, AR, CA, CO, CT, DE, DC, HI, IL, IA, KY, MD, MA, MN, NV, NJ, NM, NY, ND, OH, OR, RI, VT, WA, and WV.

[3] Public coverage includes Medicaid, medical assistance, CHIP, Medicare, and any kind of state or other government-sponsored assistance plan that was based on income or disability.

[4] Statistically significant at the 5 percent level, using a two-tailed test.

Appendix

Table 1
Percentage-Point Change in the Uninsurance Rate for Adults 50–64 between December 2013 and March 2014

	Q4 2013 (percent)	Q1 2014 (percent)	Percentage-point change
All adults ages 50–64	11.6	10.3	–1.3**
Family income			
At or below 138% of FPL	32.7	28.4	–4.3*
139–399% of FPL	13.6	13.0	–0.6
400% of FPL or higher	2.2	1.4	–0.7*
Work status			
Working	10.1	9.2	–0.9*
Employed	8.0	7.2	–0.8
Self-employed	23.1	21.3	–1.8
Not working, any reason	14.2	12.4	–1.7*
Retired	8.4	6.4	–1.9*
Disabled	6.5	4.8	–1.6
Unemployed	40.0	32.1	–7.9**
Other	20.2	21.5	1.3
Health			
Excellent or very good health	7.7	7.1	–0.6
Good, fair, or poor health	15.2	12.7	–2.5**
Financial trouble in past 12 months			
Had trouble paying medical bills	20.4	19.0	–1.4
Didn't have trouble paying medical bills	9.4	8.2	–1.2**
Race or ethnicity			
White, non-Hispanic	9.5	8.0	–1.5**
Nonwhite, non-Hispanic	12.5	13.1	0.6
Hispanic	24.9	22.0	–2.9*

Source: HRMS-AARP, quarter 4 2013 and quarter 1 2014.
Note: Estimated change is significantly different from zero, using a two-tailed test. Significance level: * = 5 percent, ** = 1 percent.

Table 2
Percentage-Point Change in the Uninsurance Rate between December 2013 and March 2014, by State Medicaid Expansion Status

	Expansion states			Nonexpansion states		
	Q4 2013 (percent)	Q1 2014 (percent)	Percentage-point change	Q4 2013 (percent)	Q1 2014 (percent)	Percentage-point change
All adults ages 50–64	9.9	7.7	–2.2**	13.5	13.1	–0.4
Family income						
At or below 138% of FPL	29.6	20.7	–8.9**	35.4	34.8	–0.5
139–399% of FPL	13.1	11.4	–1.7	14.1	14.4	0.4
400% of FPL or higher	1.9	1.4	–0.5	2.5	1.5	–1.0*
Work status						
Working	8.1	6.6	–1.5**	12.3	12.0	–0.3
Employed	6.3	5.0	–1.4**	9.8	9.6	–0.2
Self-employed	18.6	16.6	–2.0	28.5	26.3	–2.2
Not working, any reason	13.0	9.8	–3.2**	15.3	15.0	–0.3
Retired	6.1	4.6	–1.5**	10.8	8.4	–2.4
Disabled	7.3	2.7	–4.6*	5.8	6.5	0.7
Unemployed	34.8	24.4	–10.5**	47.4	42.4	–5.0
Other	17.2	17.9	0.7	23.2	25.2	2.0
Health						
Excellent or very good health	6.2	5.9	–0.3	9.5	8.7	–0.8
Good, fair, or poor health	13.7	9.0	–4.6**	16.7	16.2	–0.5
Financial trouble in past 12 months						
Had trouble paying medical bills	18.2	11.8	–6.4**	22.2	24.5	2.3
Didn't have trouble paying medical bills	8.0	6.7	–1.3*	10.9	9.8	–1.1*
Race/ethnicity						
White, non-Hispanic	8.1	5.4	–2.8**	10.9	10.7	–0.2
Nonwhite, non-Hispanic	10.8	10.0	–0.8	14.0	15.7	1.7
Hispanic	20.0	19.1	–0.9	31.0	25.8	–5.1*

Source: HRMS-AARP, quarter 4 2013 and quarter 1 2014.
Note: Estimated change is significantly different from zero, using a two-tailed test. Significance level: * = 5 percent, ** = 1 percent.

Table 3
Percentage-Point Change in the Public Insurance Rate between December 2013 and March 2014, by State Medicaid Expansion Status

	Expansion states			Nonexpansion states		
	Q4 2013 (percent)	Q1 2014 (percent)	Percentage-point change	Q4 2013 (percent)	Q1 2014 (percent)	Percentage-point change
All adults ages 50–64	16.1	18.4	2.3**	18.0	17.4	–0.6
Family income						
At or below 138% of FPL	54.1	64.4	10.3*	48.5	46.8	–1.7
139–399% of FPL	16.2	18.5	2.3	15.6	16.4	0.8
400% of FPL or higher	4.3	3.7	–0.6	5.7	4.0	–1.6
Work status						
Working	6.5	7.5	1.1	4.4	4.7	0.3
Employed	6.0	7.0	1.0	4.3	4.4	0.1
Self-employed	9.5	11.0	1.5	5.2	6.8	1.6
Not working, any reason	32.6	38.2	5.6**	39.2	38.5	–0.7
Retired	14.9	17.2	2.4*	20.8	18.1	–2.6
Disabled	79.3	85.4	6.2*	80.6	81.8	1.2
Unemployed	16.8	22.3	5.5	6.4	10.4	4.0
Other	18.0	23.4	5.4*	21.1	12.8	–8.3*
Health						
Excellent or very good health	7.6	8.8	1.2	8.1	7.2	–0.9
Good, fair, or poor health	24.5	26.8	2.3	26.3	24.6	–1.7
Financial trouble in past 12 months						
Had trouble paying medical bills	25.7	31.0	5.3	28.7	24.9	–3.8
Didn't have trouble paying medical bills	14.1	16.1	2.0*	15.1	15.5	0.3
Race/ethnicity						
White, non-Hispanic	12.0	14.5	2.5*	13.1	13.0	–0.1
Nonwhite, non-Hispanic	21.4	23.5	2.1	30.7	30.3	–0.4
Hispanic	35.0	35.5	0.6	30.2	25.0	–5.2

Source: HRMS-AARP, quarter 4 2013 and quarter 1 2014.
Note: Estimated change is significantly different from zero, using a two-tailed test. Significance level: * = 5 percent, ** = 1 percent.

Table 4
Characteristics of the Continuously Insured and Newly Insured in March 2014

	Insured for all of past 12 months (percent)	Newly insured (percent)
Income (% in each category)		
At or below 138% of FPL	12.6	41.7**
139–399% of FPL	31.8	43.9*
400% of FPL or higher	55.6	14.5**
Work status (% in each category)		
Working	65.6	51.3**
Employed	58.0	41.3**
Self-employed	7.5	9.9
Not working, any reason	34.4	48.7**
Retired	14.1	8.7**
Disabled	11.9	14.3
Unemployed	3.1	16.1**
Other	5.3	9.6*
Health (% in each category)		
Excellent or very good health	47.0	25.3**
Good, fair, or poor health	52.8	73.7**
Financial trouble in past 12 months (% in each category)		
Had trouble paying medical bills	14.6	42.6**
Didn't have trouble paying medical bills	85.0	57.3**
Race/ethnicity (% in each category)		
White, non-Hispanic	75.4	59.9**
Nonwhite, non-Hispanic	16.4	21.6
Hispanic	8.2	18.4

Source: HRMS-AARP, quarter 1 2014.

Note: Among respondents, 43 indicated they were insured but did not indicate either the number of months out of the past 12 month that they were insured or whether they were uninsured immediately prior to having their current coverage. Estimated change is significantly different from zero, using a two-tailed test. Significance level: * = 5 percent, ** = 1 percent.

Insight on the Issues 95, December 2014

Written by Adam L. Weiss, Timothy A. Waidmann, and Kyle J. Caswell
AARP Public Policy Institute
601 E Street, NW, Washington, DC 20049
www.aarp.org/ppi
202-434-3890, ppi@aarp.org

RESEARCH REPORT

Racial/Ethnic Differences in Uninsurance Rates under the ACA

Are Differences in Uninsurance Rates Projected to Narrow?

Lisa Clemans-Cope
Matthew Buettgens
Hannah Recht

December 2014

URBAN INSTITUTE · ELEVATE · THE · DEBATE

ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector.

The Urban Institute is a nonprofit policy research organization. It has been incorporated and is operated as a public charity. It has received official IRS recognition of its tax-exempt status under sections 501(c)(3) and 509(a)(2) of the Internal Revenue Code. The Institute's federal ID number is 52-0880375. Donations will be tax deductible and may be disclosed to the IRS and the public, unless given anonymously. We are committed to transparent accounting of the resources we receive. In addition to required tax filings, a copy of the Urban Institute's audited financial statement is available to anyone who requests it.

ABOUT THE FUNDER

The Low-Income Working Families project builds on more than a decade of research under the Assessing the New Federalism project, which followed struggling families as many left welfare.

The Low-Income Working Families (LIWF) project tracks the well-being of low-income families over time and analyzes the risks these families face. Our researchers identify the factors that contribute to poor outcomes for these families and policy options that would reduce barriers and promote meaningful work for adults and positive outcomes for children.

This project is made possible through generous funding from the Annie E. Casey Foundation. Any opinions and conclusions expressed herein are those of the authors and do not necessarily represent the views of the Annie E. Casey Foundation or the Urban Institute and its sponsors or trustees.

Contents

Acknowledgments

This report is part of the Urban Institute's Low-Income Working Families project, a multiyear effort that focuses on the private- and public-sector contexts for families' success or failure. Both contexts offer opportunities for better helping families meet their needs. The Low-Income Working Families project is currently supported by the Annie E. Casey Foundation. Any opinions and conclusions expressed herein are those of the authors and do not necessarily represent the views of the Annie E. Casey Foundation or the Urban Institute and its sponsors or trustees.

The nonpartisan Urban Institute publishes studies, reports, and books on timely topics worthy of public consideration. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders.

The authors would like to thank the Low Income Working Families project and the Annie E. Casey Foundation for their generous support of this project; the working-group participants who graciously shared their time and insights; and Mary Howard, John Keating, and Rachel Langford for their careful review.

This report has benefited from the helpful comments of Margaret Simms, Genevieve Kenney, and Stephen Zuckerman. The authors thank Dean Resnick and Victoria Lynch of the Urban Institute's Health Policy Center for their assistance in developing data used in the Health Insurance Policy Simulation Model–American Community Survey.

Executive Summary

This report is the first state-level examination of how the Affordable Care Act (ACA) is projected to change uninsurance rates for five major racial/ethnic groups: whites, Latinos, blacks, Asian/Pacific Islanders, and American Indian/Alaska Natives. The Urban Institute's Health Insurance Policy Simulation Model–American Community Survey microsimulation projects large percentage reductions in uninsurance rates for all racial and ethnic groups under the ACA with Medicaid expansion decisions as of December 2014. We project even larger reductions under the ACA with Medicaid expansion in all states ("full Medicaid expansion"). In a more detailed subgroup examination by origin (i.e., identity relating to family ancestry or birthplace), we also find large reductions for all Latino-origin groups, all Asian/Pacific Islander–origin groups, and all American Indian/Alaska Natives tribes.

According to our projections, the ACA with current Medicaid expansion decisions can substantially narrow differences in uninsurance rates between whites and all racial/ethnic minorities, except blacks, who disproportionately live in nonexpansion states. Dramatic reductions are projected for the American Indian/Alaska Natives uninsurance rate: a decrease from 25.7 percent to 13.0 percent, or a 49.5 percent reduction that translates to 600,000 gaining coverage. Latinos have a projected decrease in the uninsurance rate from 31.2 percent to 19.0 percent: a 39.2 percent reduction that translates to 6.6 million gaining coverage. Both groups' projections lead to a narrowing of the difference in their uninsurance rates compared with whites.

Under the ACA with full Medicaid expansion, uninsurance rates are projected to fall further for all racial and ethnic groups. Compared with projections using the ACA with current Medicaid expansion decisions, dramatic uninsurance rate reductions are projected for blacks were all states to expand Medicaid: from 11.3 percent with current expansion decisions to 7.2 percent with full expansion. This is because over half of all blacks are living in states not expanding Medicaid in 2014; 1.4 million uninsured blacks are in the eligibility gap. These 1.4 million constitute 23.1 percent of the black adult uninsured adult population nationwide. Because of tribe members' locations, four American Indian/Alaska Natives tribes (Eskimo, Cherokee, Sioux, and Lumbee) are also projected to experience dramatic gains under the ACA with full Medicaid expansion compared with current expansion decisions.

Even with current Medicaid expansion decisions, the ACA is projected to shrink many of the long-standing racial/ethnic differences in health insurance coverage. Medicaid expansion in all states shows the potential for further reductions in uninsurance rates and, in contrast with projections of current Medicaid expansion decisions, would reduce racial differences in coverage between whites and blacks.

State outreach and enrollment efforts will be crucial in (1) raising enrollment rates in Medicaid and CHIP among eligible individuals and (2) increasing Marketplace enrollment among those who are eligible for, but are not using, the subsidies available in the insurance Marketplaces.

Introduction

The Affordable Care Act's (ACA's) coverage provisions are reducing uninsurance rates: initial estimates suggest reductions may be particularly marked among blacks and Latinos.[1] Several ACA provisions have contributed to this coverage expansion. The law's Medicaid expansion provision set a nationwide eligibility standard: adults with family income up to 138 percent of the federal poverty level (FPL). This Medicaid expansion was made a state option by the US Supreme Court's 2012 decision. As of December 2014, 27 states and the District of Columbia had expanded Medicaid or planned to expand by January 2015 ("expansion states").[2]

In addition to the Medicaid expansion, the ACA includes other provisions designed to increase rates of health insurance coverage: (1) state-based health insurance Marketplaces offering coverage starting in 2014; (2) health insurance market reforms that have been phasing in since the law passed in 2010; (3) premium subsidies for many with income below 400 percent of FPL, available through both the federal and state health insurance Marketplaces;[3] and (4) a requirement that all individuals obtain health insurance coverage.

Many nonelderly adults (ages 19 to 64) with income below 138 percent of FPL who live in states that have not chosen to expand Medicaid by January 2015 ("nonexpansion states") fall into the "coverage gap": they are not eligible for Medicaid under their states' eligibility rules but are also ineligible for Marketplace premium subsidies.[4] Because racial and ethnic compositions vary across states, these state policy decisions can have a major effect on the racial/ethnic composition of poor individuals in the Medicaid coverage gap (Kenney et al. 2012).

In addition, the ACA excludes particular immigrant groups from new coverage options. Undocumented immigrants are prohibited from enrolling in Medicaid or purchasing coverage through the Marketplaces. Undocumented immigrants are projected to compose approximately one-quarter of the uninsured population after the ACA's major provisions are implemented, including states' Medicaid expansions (as those expansion decisions stand in December 2014).[5] Further, the ACA options available to lawfully residing immigrants vary depending on the number of years they have lived in the United States.

This study builds on a previous national analysis (Clemans-Cope et al. 2012) and is the first state-level analysis to project coverage gains for detailed racial/ethnic groups and subgroups by origin (i.e., identity relating to family ancestry or birthplace) under the ACA. Three coverage projection scenarios are compared. Each scenario projects outcomes as of 2016, at which time the current provisions of the

ACA are assumed to be fully implemented. The first scenario projects uninsurance rates in 2016 if the ACA had not been passed. The second scenario projects uninsurance rates in 2016 under the states' Medicaid expansion decisions as of December 2014. The third scenario projects uninsurance rates in 2016 if all states were to implement the ACA's Medicaid expansion.

These findings shed light on whether specific state Medicaid expansions and outreach and enrollment efforts could affect coverage gains among different racial and ethnic groups.

Methods

We use microsimulation to examine projected coverage changes for different racial and ethnic groups in 2016. We compare projected coverage in 2016 across three scenarios: (1) had the ACA not been passed, (2) the ACA with current Medicaid expansion decisions, and (3) the ACA with Medicaid expansion in all states ("full Medicaid expansion"). Comparing the second and third scenarios with projected baseline coverage in 2016 had the ACA not been passed allows us to estimate racial/ethnic coverage effects of the alternative ACA scenarios.[6]

The Microsimulation Model

The projections are based on the Urban Institute's Health Insurance Policy Simulation Model–American Community Survey (HIPSM-ACS) (Buettgens et al. 2013). This model uses ACS data from 2009, 2010, and 2011 to obtain representative samples of nonelderly populations (ages 0 to 64) both by state and by pre-ACA insurance coverage. All estimates and projections presented in this report refer to the nonelderly population. The Health Insurance Policy Simulation Model simulates individual and family health insurance enrollment under the ACA by using 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] Estimates based on previous versions of HIPSM differ slightly because of revisions and updated regulations.[8] Eligibility for subsidized marketplace coverage is determined by considering (1) state decisions to expand Medicaid under the ACA and (2) access to employer-sponsored insurance coverage.

We model eligibility status for Medicaid and the Children's Health Insurance Program and subsidized coverage in the Marketplaces, and then use the HIPSM to simulate the decisions of employers, families, and individuals to offer or enroll in health insurance coverage. We then map those results to the ACS, using regression modeling to assign probabilities of take-up. To calculate the effects of reform options, the HIPSM uses a microsimulation based on the relative desirability (utility) of the health insurance options available to each individual and family under reform,[9] considering people's current choices as reported in the survey data.[10] The resulting health insurance decisions made by individuals, families, and employers are calibrated to findings in the empirical economics literature (including, importantly, the price elasticities for employer-sponsored insurance and nongroup coverage).

Defining Racial/Ethnic Groups

We start by examining coverage changes for five major racial/ethnic groups:[11]

1. White non-Latino ("white")
2. Latino
3. Black non-Latino ("black")
4. Non-Latino Asian/Pacific Islander ("Asian/Pacific Islander" or "A/PI")
5. American Indian/Alaska Native ("AI/AN")

We classify people as uninsured without the ACA if they did not report health insurance. Also, we do not count the Indian Health Service as health insurance coverage because of limitations in its scope of available services and in the geographic reach of its facilities (Turner and Boudreaux 2010). In this approach we follow previous research (Clemans-Cope et al. 2012). Because the data are collected continuously over a 12-month period, our coverage estimates represent an average day in the calendar year.

We then examine three racial/ethnic groups in additional detail. We analyze subgroups by origin for the Latino and Asian/Pacific Islander groups because they have relatively high proportions of foreign-born individuals compared with the three other racial/ethnic groups. We analyze American Indian/Alaska Natives subgroups by tribe. The racial/ethnic subgroups are as follows:

1. The 11 largest Latino-origin groups (Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, Colombian, Honduran, Ecuadorian, Spaniard, and Peruvian) and three other categories (other South American, other Central American, and other Latino not specified).
2. The five largest A/PI-origin groups (Chinese, Indian, Filipino, Vietnamese, and Korean) and all other Asian/Pacific Islanders (including those reporting multiple subgroups).
3. The nine largest identifiable AI/AN subgroups by tribe (Navajo, Cherokee, Sioux, Chippewa, Choctaw, Apache, Lumbee, Pueblo, and Eskimo), with all other American Indian/Alaska Natives (including those of mixed race and multiple tribes) grouped into an "all other American Indian/Alaska Natives" category. Because nearly three-quarters of American Indian/Alaska Natives reported either no tribal affiliation or multiple races in the ACS, and because our estimates for the individual tribes include only those who reported a sole tribal affiliation and no other race/ethnicity, we undercount the number in each tribal group gaining coverage, but not the total number of American Indian/Alaska Natives.

Latino-origin, A/PI-origin, and American Indian/Alaska Native tribes are based on self-reported answers to detailed questions on racial identity relating to family ancestry or birthplace. See appendix A for more details on race, ethnicity, tribe, and origin classification.

Assigning Undocumented Immigrant Status

The imputation process assigns undocumented status as follows: Noncitizens are those without US citizenship, including both lawfully present immigrants—some of whom are legal permanent residents—and undocumented immigrants. An undocumented immigrant is a foreign national who entered the United States either with a visa as a temporary resident, then overstaying the visa or engaging in activities forbidden by the visa, or without a visa.[12] We impute documentation status for noncitizens in each year in two stages, using both individual and family characteristics, based on an imputation methodology originally developed by Jeffrey Passel for the Current Population Survey Annual Social and Economic Supplement.

An estimated one-sixth of Latinos are undocumented, accounting for 69.7 percent of all undocumented immigrants.[13] A forthcoming brief details coverage changes for Latinos by documentation status, which varies by origin group (Clemans-Cope et al., forthcoming).

Measures of Projected Coverage Changes by Racial/Ethnic Group

Absolute and Relative Changes in Uninsurance Rates by Race/Ethnicity Nationally

For each racial/ethnic group, we assess how uninsurance rates are projected to change at the national level under each of the three scenarios. We examine absolute difference and percent difference in the uninsurance rate for each racial/ethnic group, comparing the uninsurance rate without the ACA to those under the ACA with current Medicaid expansion decisions and those under the ACA with full Medicaid expansion for each racial/ethnic group.

The simplest method of comparing how the ACA affects different racial and ethnic groups' coverage is to examine the difference in uninsurance rates between groups. We find racial/ethnic uninsurance rate differences by subtracting the rate of uninsurance for one racial/ethnic group from

that of another, providing percentage-point differences in uninsurance rates between racial/ethnic group pairs. Whites, whose uninsurance rates are lowest in the baseline scenario, are the reference group for these differences (thus, for example, we will assess the black-white difference in uninsurance rates).[14]

Assessing Whether Differences in Uninsurance Rates Could Narrow by Race/Ethnicity Nationally

Though we assess the absolute and relative differences in uninsurance rates between whites and other racial/ethnic groups, that assessment may not always be sufficient to determine whether the underlying differences in health coverage between racial/ethnic groups have narrowed.[15] Absolute and relative differences in uninsurance rates between groups provide different types of information and may lead to different conclusions. Moreover, as uninsurance rates for all groups decline, the relative difference between the groups will tend to increase (all other factors remaining equal).[16] For example, the absolute percentage-point difference in uninsurance rates between blacks and whites is smaller under the ACA with current Medicaid expansion decisions than without the ACA (a difference of 5.0 percentage points versus a difference of 6.5 percentage points; see table 1 on page 12), suggesting that the differences in health coverage rates narrowed. But the percentage decrease in the uninsurance rate is larger for whites than for blacks under the ACA with current Medicaid expansion decisions (51.6 percent versus 42.3 percent), suggesting that differences in health coverage between blacks and whites did not narrow.[17]

To draw conclusions about changes in health coverage differences between racial/ethnic minorities and whites, we compute an additional metric that has advantageous properties not shared by measures that rely on absolute risk differences. Several metrics have been developed that avoid the problems of simpler measures of absolute or relative difference. The metric we use is similar to measures of association, such as relative risk, and we use it here to quantify the size of the difference in coverage rates between two groups and assess whether differences have narrowed. We calculate this metric for each racial/ethnic minority group as the correlation between two binary variables (also known as an "effect size"): being uninsured and being of a particular racial/ethnic minority group. We compute four metrics for the four race/ethnicity group pairs (black versus white, Latino versus white, American Indian/Alaska Native versus white, and Asian/Pacific Islander versus white) using whites as the reference group in each pair (table B.13). To compute this metric, we used a standard measure of association for two binary variables: the φ statistic based on the χ-squared test:18

$$\varphi = \sqrt{\frac{\chi^2}{N}}$$

where N is the weighted number of people in our dataset. If there were no differences in health coverage between whites and a given racial/ethnic group, this statistic would be 0. In this report, under all scenarios this statistic is greater than 0 for all racial/ethnic group pairs, meaning that differences in health coverage exist in all scenarios. For all racial/ethnic group pairs, we compute the statistic without the ACA, under the ACA with current state Medicaid expansion decisions, and under the ACA with all states expanding Medicaid. If the statistic for a given group relative to whites is lower under the ACA than without the ACA, we can conclude that the underlying difference in health coverage has narrowed.

State Changes in Uninsurance Rates by Race/Ethnicity and by Origin Group

For each racial/ethnic group, we assess how uninsurance rates are projected to change at the state level under the three projected scenarios. For the third such scenario, ACA with full Medicaid expansion, we assess how geographically concentrated the projected coverage gains would be for each racial/ethnic group. (See tables B.1–B.12 for further state-level detail.) We also produced estimates of the uninsured for each racial/ethnic group for the smallest statistically representative geographic area on the ACS.[19] Additional estimates and maps are available in a *Metro Trends* blog post.[20] For three detailed subgroups (Latino-origin, Asian/Pacific Islander–origin, and American Indian/Alaska Native tribe) we compare projected percentage reductions in uninsurance rates.

Projected Uninsured Rate Reductions by Racial or Ethnic Group

In this section, we assess how uninsurance rates for each racial/ethnic group are projected to change nationally under each of the three scenarios. We analyze whether racial/ethnic differences in uninsurance rates are projected to narrow under each scenario.

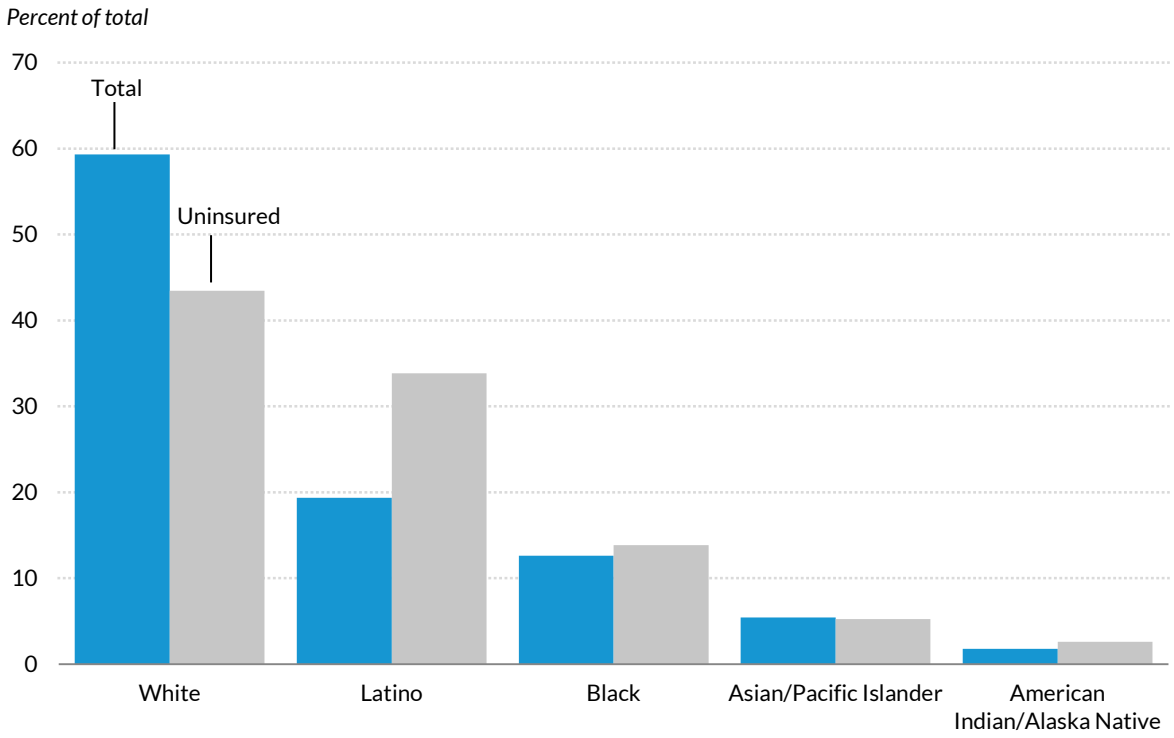
Latinos, Blacks, and American Indian/Alaska Natives Are Overrepresented among the Uninsured at Baseline without the ACA

Without the ACA, blacks make up make up 13.8 percent of the uninsured but only 12.6 percent of the nonelderly population (figure 1). Latinos make up 33.8 percent of the uninsured but only 19.4 percent of the population. American Indian/Alaska Natives make up 2.6 percent of the uninsured but only 1.8 percent of the population. Whites, Asian/Pacific Islanders, and other non-Latinos, in contrast, have lower uninsurance rates than their representation in the population.

FIGURE 1

Uninsured Nonelderly Population Compared with Total Nonelderly Population without the ACA, by Racial/Ethnic Group

Latinos are 19 percent of the population but 34 percent of the uninsured; whites are 59 percent of the population but 43 percent of the uninsured.



Source: HIPSM-ACS 2014.
Notes: "Others" (not shown here) compose 1.5 percent of the nonelderly population and 1.1 percent of the uninsured without the ACA. These data are projections for 2016 as described in the Methods section of this report.

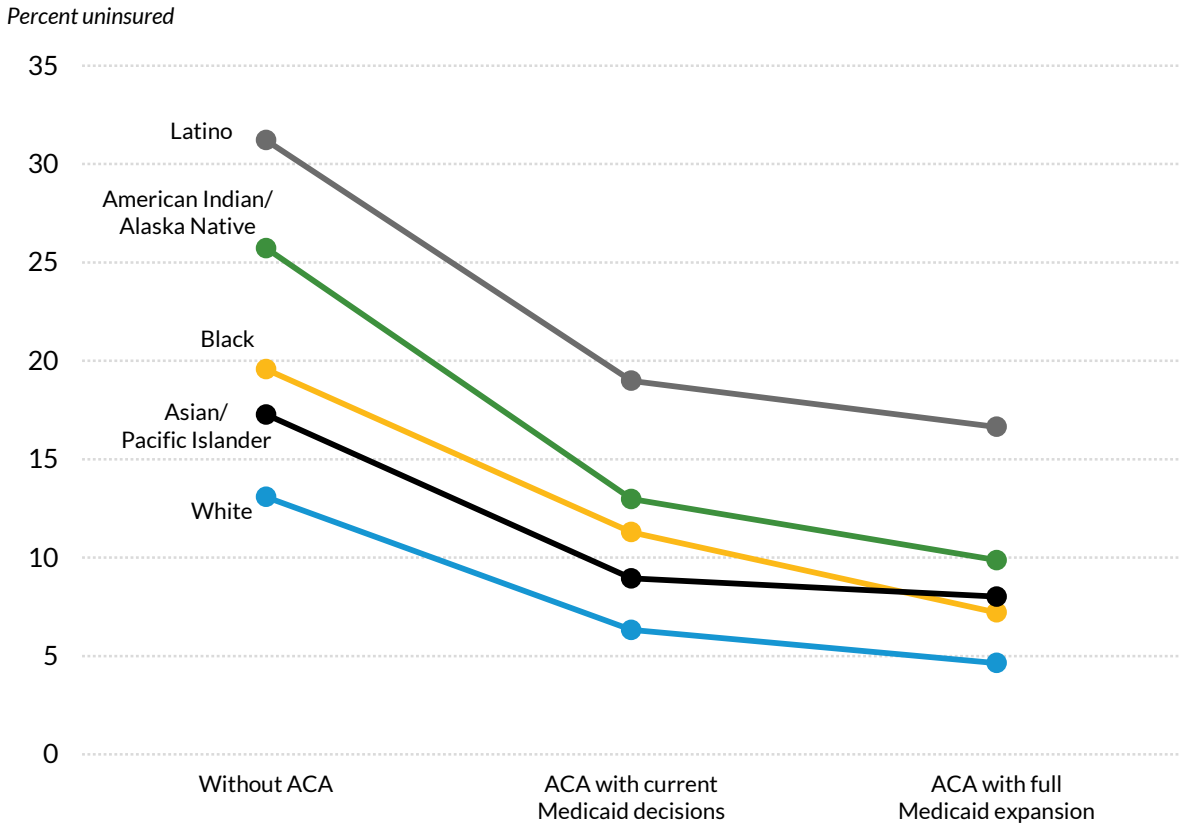
Uninsurance Rates Projected to Fall for all Racial/Ethnic Groups under the ACA with Current Medicaid Expansion Decisions

Without the ACA, Latinos are projected in 2016 to have the highest uninsurance rate (31.2 percent), followed by American Indian/Alaska Natives (25.7 percent), blacks (19.6 percent), and Asian/Pacific Islanders (17.3 percent; see figure 2). Whites have the lowest uninsurance rate without the ACA at 13.1 percent. The ACA with current Medicaid expansion decisions is projected to lead to large reductions in uninsurance rates for all racial/ethnic groups examined. The rank order of uninsurance rates across

racial/ethnic groups is projected to be unchanged: Latinos still with the highest (19.0 percent), followed by American Indian/Alaska Natives (13.0 percent) and blacks (11.3 percent); the lowest uninsurance rates are still projected to be among Asian/Pacific Islanders (8.9 percent) and whites (6.3 percent).

FIGURE 2

Projected Uninsurance Rates by Racial/Ethnic Group under Three ACA Scenarios



Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

The largest absolute reductions in uninsurance rates under the ACA with current Medicaid expansion decisions are projected to be among minority groups, especially American Indian/Alaskan Natives (a 12.7 percentage-point drop) and Latinos (a 12.2 percentage-point drop).[21] The absolute reduction is somewhat less for blacks and Asian/Pacific Islanders (an 8.3 percentage-point drop for both). In comparison, the uninsurance rate among whites is expected to fall 6.8 percentage points, smaller than the drops projected for minority groups.

Uninsurance rates vary greatly by race and ethnicity in the "without ACA" scenario. Thus, the racial/ethnic groups with the largest percentage-point drops in the uninsurance rate do not correspond

to the largest relative reductions in uninsurance levels. For example, though Latinos are projected to have the largest percentage-point decrease in the uninsured rate, they also had the highest rate of uninsurance at the baseline. Consequently, the relative reduction in the uninsured rate for Latinos is projected to be smaller than for all other racial/ethnic groups.

Important projected changes in coverage under the ACA with current Medicaid expansion decisions compared to the "without ACA" scenario include the following (table 1):[22]

- The uninsurance rate for whites would decrease 51.6 percent from 13.1 percent without ACA to 6.3 percent under the ACA with current Medicaid expansion decisions: 11.1 million would gain coverage. Whites would account for 48.9 percent of all coverage gains nationwide.
- For Latinos, the ACA with current Medicaid expansion decisions is projected to reduce the uninsured rate 39.2 percent compared to the "without ACA" scenario from 31.2 percent to 19.0 percent: an estimated 6.6 million Latinos would gain coverage. Although this group would still have the highest uninsurance rate of all racial and ethnic groups, its coverage gains would constitute 28.9 percent of all coverage gains.
- The uninsurance rate for blacks would decrease 42.3 percent from 19.6 percent to 11.3 percent: 2.9 million would gain coverage. Blacks would account for 12.8 percent of all coverage gains.
- The uninsurance rate for Asian/Pacific Islanders would decrease 48.2 percent from 17.3 percent to 8.9 percent: 1.3 million would gain coverage. Asian/Pacific Islanders would account for 5.5 percent of all coverage gains.
- Dramatic rate reductions are projected for American Indian/Alaska Natives, for whom the uninsurance rate is projected to decrease 49.5 percent from 25.7 percent to 13.0 percent: 600,000 would gain coverage. American Indian/Alaska Natives would account for 2.8 percent of all coverage gains.

TABLE 1

Selected Characteristics and Projected Uninsurance Rates under Three ACA Scenarios, by Race/Ethnicity

				Without ACA		ACA with Current Medicaid Expansion Decisions		ACA with Full Medicaid Expansion	
Race/ethnicity	Total nonelderly (millions)	Living in nonexpansion states (%)	Undocumented immigrants (%)	Uninsured (millions)	Uninsurance rate (%)	Decrease relative to without ACA (%)	Uninsurance rate (%)	Decrease relative to without ACA (%)	Uninsurance rate (%)
White	164.3	42.3	0.7	21.5	13.1	51.6	6.3	64.5	4.6
Latino	53.6	38.1	16.4	16.7	31.2	39.2	19.0	46.7	16.6
Black	35.0	54.9	1.7	6.8	19.6	42.3	11.3	63.2	7.2
Asian/PI	15.0	22.9	12.1	2.6	17.3	48.2	8.9	53.6	8.0
AI/AN	5.0	44.4	N/A	1.3	25.7	49.5	13.0	61.6	9.9
All	277.0	41.9	4.5	49.5	17.9	45.9	9.7	57.6	7.6

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

Notes: PI = Pacific Islander; AI/AN = American Indian/Alaska Native; N/A = not applicable. Population is all nonelderly. Cells marked "not applicable" had too small of a sample size to provide meaningful data. "All" includes a residual racial/ethnic category: those who selected "some other race" as their racial category or selected multiple races and are not Latino or American Indian/Alaska Native. Because of the small samples and heterogeneous nature of this group, this category is not analyzed. See appendix A for additional details on racial/ethnic categories.

Are Differences in Uninsurance Rates Projected to Narrow under the ACA with Current Medicaid Expansion Decisions?

Yes—in most cases the differences in uninsurance rates between racial/ethnic minority groups and whites are projected to narrow under the ACA with current Medicaid expansion decisions.

First, we examine the projected absolute percentage-point differences in uninsurance. Compared to without the ACA, the uninsurance rate difference with whites drops for all groups under the ACA with current Medicaid expansion decisions:[23]

- The black-white difference in uninsurance rates is projected to fall from 6.5 percentage points to 5.0 percentage points.
- The Latino-white difference is projected to fall from 18.1 percentage points to 12.7 percentage points.
- The Asian/Pacific Islander–white difference is projected to fall from 4.2 percentage points to 2.6 percentage points.
- The American Indian/Alaskan Native–white difference is projected to fall from 12.6 percentage points to 6.7 percentage points.

To assess whether these changes signify a narrowing of the relative difference in uninsurance rates among the groups, we examine an additional statistic, effect size, to quantify the size of the difference in coverage rates between two groups (as described in the methods section). For Latinos and American Indian/Alaska Natives, the difference in uninsurance rates with whites is projected to narrow under the ACA with current Medicaid expansion decisions compared with uninsurance rates without the ACA since the statistic is smaller under the latter scenario (table B.13). In addition, the difference between Asian/Pacific Islanders' uninsurance rates and whites' rates, which started out small, is projected to narrow slightly under the ACA with current Medicaid expansion decisions. For blacks, however, the difference between their uninsurance rates and whites' rates is projected to narrow under the ACA with current Medicaid expansion decisions *only in Medicaid expansion states*. Across all states, the difference in uninsurance rates between blacks and whites is projected to stay approximately the same both under the ACA with current Medicaid expansion decisions and without the ACA.

Under the ACA with Full Medicaid Expansion, Uninsurance Rates Are Projected to Fall Further for All Racial/Ethnic Groups, Particularly for Blacks

Uninsurance rates are projected to fall further for all groups under the ACA with full Medicaid expansion compared with rates under the ACA with current Medicaid expansion decisions. Under both ACA scenarios, Latinos, American Indian/Alaska Natives, and blacks would have the largest absolute reductions in uninsurance rates.[24] The effects on uninsurance rates under the ACA with full Medicaid expansion are particularly strong for groups with a high share of potential Medicaid eligibles because the nonexpansion states tended to have lower Medicaid eligibility rules before the ACA than the expansion states. Blacks are projected to have the largest decreases in uninsurance rates under full Medicaid expansion: a drop from 11.3 percent (projected with current expansion decisions) to 7.2 percent (see figure 2 and table 1).

These results are driven in part by how many uninsured in each racial/ethnic group fall into the "coverage gap" in nonexpansion states. As a share of the adult uninsured population in nonexpansion states, a disproportionate share of blacks falls into the coverage gap (37.6 percent for blacks compared with 28.7 percent for whites; data not shown). Accordingly, blacks are projected to have particularly large gains from additional Medicaid expansions.

Are Differences in Uninsurance Rates Projected to Narrow under the ACA with Full Medicaid Expansion?

Yes—in most cases differences in uninsurance rates between racial/ethnic minority groups and whites are projected to narrow under the ACA with full Medicaid expansion relative to differences without the ACA.

We first examine the projected absolute percentage-point differences in uninsurance. Compared to the "without ACA" scenario, the uninsurance rate difference with whites drops for all groups under ACA with full Medicaid expansion:[25]

- The Latino-white difference is projected to fall from 18.1 percentage points to 12.0 percentage points.

- The black-white difference in uninsurance rates is projected to fall from 6.5 percentage points to 2.6 percentage points, thus the black-white difference shrinks more under the ACA with full Medicaid expansion than under the ACA with current Medicaid expansion decisions.
- The Asian/Pacific Islander–white difference is projected to fall from 4.2 percentage points to 3.4 percentage points—a smaller decrease than under the ACA with current Medicaid expansion decisions.
- The American Indian/Alaskan Native–white difference is projected to fall from 12.6 percentage points to 5.2 percentage points.

As above, to assess whether these changes signify a narrowing of the relative difference in uninsurance rates among the groups, we examine the effect size (table B.13). In contrast to the ACA with current Medicaid expansion decisions, the national difference in uninsurance rates between blacks and whites is projected to narrow under the ACA with full Medicaid expansion as compared with the "without ACA" scenario. This is because the coverage gap in nonexpansion states contains a large numbers of blacks.

For Latinos and American Indian/Alaska Native groups, the difference in uninsurance rates with whites is also projected to narrow under the ACA with full Medicaid expansion. Coverage rates for whites are affected more than coverage rates for Latinos in a given nonexpansion state if that state were to expand; this is because a small but significant share of poor uninsured Latinos in nonexpansion states is undocumented and therefore ineligible for Medicaid. For American Indian/Alaska Natives, the sizable narrowing of the coverage difference with whites is caused by additional enrollment in nonexpansion states if those states were to expand. For Asian/Pacific Islanders, who started out with a small coverage difference with whites, the differential is not projected to narrow under the ACA with full Medicaid expansion.

Small Groups of States Account for Most Projected Coverage Gains by Racial or Ethnic Group

A different group of states accounts for disproportionate gains for each racial/ethnic group under the ACA with full Medicaid expansion. These findings are driven by the underlying distribution of residence for each group. We first identify the states with the highest potential effect on coverage gains for each group; we then examine whether these states are Medicaid expansion states or nonexpansion states.[26]

Whites (Tables B.3 and B.4)

- Under the ACA with full Medicaid expansion, 11 states are found to account for half (6.8 million) of coverage gains for whites. In descending order of size of gain, these states are California, Florida, Texas, Ohio, Pennsylvania, Michigan, Georgia, North Carolina, Indiana, Illinois, and New York.
- Because 6 of these 11 states (California, Ohio, Michigan, Illinois, New York, and Pennsylvania) have expanded Medicaid, coverage gains caused by Medicaid expansion are already included in projections that use current Medicaid expansion decisions.
- If the remaining five (Florida, Texas, Georgia, North Carolina, and Indiana) were to expand Medicaid, the number of whites projected to gain coverage nationwide would increase 25.1 percent (3.3 million) compared with the number of whites projected to gain coverage under the ACA with current Medicaid expansion decisions.

Latinos (Tables B.5 and B.6)

- Under the ACA with full Medicaid expansion, just two states (California, which expanded Medicaid, and Texas, which has not expanded Medicaid) are projected to account for half (3.4 million) of coverage gains for Latinos.

- If Texas expands Medicaid, the number of Latinos projected to gained coverage nationally would increase 11.3 percent (0.7 million) compared with the number of Latinos projected to gain coverage under the ACA with current Medicaid expansion decisions.

Blacks (Tables B.7 and B.8)

- Under the ACA with full Medicaid expansion, seven states are projected to account for half (2.2 million) of coverage gains for blacks. In descending order of size of gain, these states are Florida, Georgia, Texas, North Carolina, Louisiana, California, and Illinois.
- Because only two of these seven states (California and Illinois) have expanded Medicaid, a small share of potential coverage gains is projected to occur under the ACA with current Medicaid expansion decisions.
- If the remaining five states (Florida, Georgia, Texas, North Carolina, and Louisiana) were to expand Medicaid, the number of blacks projected to gain coverage nationwide would increase 30.2 percent (0.9 million) compared with the number of blacks projected to gain coverage under the ACA with current Medicaid expansion decisions.

Asian/Pacific Islanders (Tables B.9 and B.10)

- Under the ACA with full Medicaid expansion, three states (California, Texas, and New York) are projected to account for half (0.7 million) of coverage gains for Asian/Pacific Islanders. California would account for 35.9 percent of all national gains.
- If Texas were to expand Medicaid, coverage gains for Asian/Pacific Islanders nationwide would increase by 3.6 percent (46,000) compared with the number of Asian/Pacific Islanders projected to gain coverage under the ACA with current Medicaid expansion decisions.

American Indian/Alaska Natives (Tables B.11 and B.12)

- Under the ACA with full Medicaid expansion, seven states are projected to account for half (0.4 million) of coverage gains for American Indian/Alaska Natives. In descending order of coverage gain, these are California, Oklahoma, Arizona, New Mexico, Texas, Alaska, and North Carolina.
- If the four nonexpansion high-impact states (Oklahoma, Texas, Alaska, and North Carolina) were to expand Medicaid, coverage gains for American Indian/Alaska Natives nationally are projected to increase 11.8 percent (75,000) compared with the number of American Indian/Alaska Natives projected to gain coverage under the ACA with current Medicaid expansion decisions.

Projected Uninsured Rate Reductions by Racial and Ethnic Subgroups

We provide more disaggregated information for three detailed subgroups: Latino-origin, Asian/Pacific Islander–origin, and American Indian/Alaska Native tribe.

For Latino-Origin Groups, Uninsurance Rates Are Projected to Decrease

Changes under the ACA with current Medicaid expansion decisions and with full Medicaid expansion vary widely by Latino-origin group and are driven largely by three factors: rates of uninsurance without the ACA, state of residence, and the prevalence of undocumented immigrants.

As shown in table 1, compared with other racial/ethnic groups, Latinos have the highest rate of uninsurance without the ACA: 31.2 percent. Latino uninsurance rates vary by origin without the ACA and are estimated to range from 15.2 percent for those of Puerto Rican origin to 49.0 percent for those of Honduran origin (table 2).

Overall, the ACA with current Medicaid expansion decisions is projected to decrease uninsurance rates 39.2 percent for all Latinos, leaving 19.0 percent uninsured. Wide differences are projected to remain across Latino-origin groups. The Honduran-origin and Guatemalan-origin populations, approximately one-third of whom are undocumented, would still have the highest rates of uninsurance: 35.6 percent and 32.0 percent, respectively. Those two populations are also projected to have the smallest percentage decreases in uninsurance rate of all Latino-origin groups. The Dominican-origin population, among those with the lowest uninsurance rate without the ACA, would have among the largest percentage decrease in uninsurance rate across Latino-origin groups: from 22.9 percent to 13.1 percent uninsured, a 42.8 percent drop.

State of residence is also an important factor in projected changes in coverage under the ACA for Latino-origin groups. Though 27 states and the District of Columbia will expand Medicaid by January 2015, 38.1 percent of Latinos live in states that are not currently planning to expand Medicaid.

Consequently, the uninsurance rate for Latinos would decrease 39.2 percent under the ACA with current Medicaid expansion decisions; this decrease would be 46.7 percent with full expansion. Thus, the ACA with current Medicaid expansion decisions would lead to 1.3 million fewer insured Latinos than with full Medicaid expansion. State decisions' effect on coverage varies by Latino-origin group location. For example, four out of five uninsured Cubans live in Florida, which is not expanding Medicaid as of January 2015 (data not shown). If Florida were to expand Medicaid, an additional 73,000 Cubans would gain coverage. Nationwide, only 13.3 percent of all Cubans would remain uninsured if all states expanded Medicaid; 17.8 percent would remain uninsured with current Medicaid expansion decisions.

Under the ACA with full Medicaid expansion, 16.6 percent of Latinos would remain uninsured, a reduction of 46.7 percent compared with the project uninsurance rate without the ACA. The resulting uninsurance rates, however, would still vary among Latino-origin groups. The difference between the ACA with current expansion decisions and with full expansion would be particularly large for those of Cuban origin, over three-quarters of whom live in states that will not be expanding Medicaid by January 2015. For those of Mexican origin and several other Latino-origin groups, the difference in projected uninsurance rates between the two ACA scenarios is lessened by the prevalence of undocumented immigrants among the uninsured. See a forthcoming brief by Clemans-Cope and colleagues for more details regarding the effect of undocumented immigrants on coverage rates for Latino-origin groups (Clemans-Cope et al., forthcoming).

TABLE 2

Selected Characteristics and Projected Uninsurance Rates for Latinos by Origin under Three ACA Scenarios

				Without ACA		ACA with Current Medicaid Expansion Decisions		ACA with Full Medicaid Expansion	
Latinos by origin	Total nonelderly (millions)	Living in nonexpansion states (%)	Undocumented immigrants (%)	Uninsured (millions)	Uninsurance rate (%)	Decrease relative to without ACA (%)	Uninsurance rate (%)	Decrease relative to without ACA (%)	Uninsurance rate (%)
Mexican	35.2	38.2	17.8	11.8	33.4	39.1	20.3	46.5	17.8
Puerto Rican	4.9	30.2	N/A	0.7	15.2	50.3	7.6	61.0	5.9
Salvadoran	2.0	33.2	28.1	0.8	40.0	35.6	25.8	40.1	24.0
Cuban	1.8	77.1	12.6	0.5	28.9	38.2	17.8	54.0	13.3
Dominican	1.6	16.8	9.2	0.4	22.9	42.8	13.1	47.9	11.9
Guatemalan	1.2	31.6	32.8	0.6	47.2	32.3	32.0	35.3	30.5
Colombian	1.0	48.6	20.1	0.3	28.7	40.0	17.3	48.3	14.9
Honduran	0.7	57.3	34.5	0.4	49.0	27.3	35.6	34.7	32.0
Ecuadorian	0.7	17.8	21.5	0.2	35.4	34.6	23.2	37.4	22.2
Spaniard	0.6	32.4	3.1	0.1	15.4	51.0	7.6	60.5	6.1
Peruvian	0.6	37.6	24.7	0.2	31.6	35.2	20.5	40.1	18.9
Other S. Am.	0.9	50.4	25.3	0.2	28.0	36.0	17.9	43.6	15.8
Other C. Am.	0.8	48.9	17.4	0.2	30.2	38.5	18.5	48.6	15.5
Other Latino, n.s.	1.6	33.8	3.4	0.3	20.7	50.4	10.3	60.8	8.1
All Latino	53.6	38.1	16.4	16.8	31.2	39.2	19.0	46.7	16.6

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

Notes: S. Am. = South American; C. Am. = Central American; n.s. = not specified. See appendix A for additional details on race/ethnicity and origin categories.

For Asian/Pacific Islander–Origin Groups, Uninsurance Rates Are Projected to Decrease, but Wide Differences Remain

Though the overall uninsurance rate for Asian/Pacific Islanders without the ACA is projected to be 17.3 percent, lower than that of all other race/ethnic groups except whites, uninsurance rates are projected to differ widely by Asian/Pacific Islander–origin groups (table 3). Those of Korean origin are projected to have the highest uninsurance rate without the ACA, 29.9 percent, followed by those of Vietnamese origin at 21.5 percent. Those of Indian origin and those of Filipino origin are projected to have much lower uninsurance rates without the ACA: 13.1 percent and 12.4 percent, respectively.

Over three-quarters of Asian/Pacific Islanders live in states that are expanding Medicaid, the highest rate of any racial/ethnic group. Under the ACA with current Medicaid expansion decisions, uninsurance rates for Asian/Pacific Islanders are projected to decrease 48.2 percent, falling from 17.3 percent to 8.9 percent. If all states expanded Medicaid, an additional 139,200 Asian/Pacific Islanders would gain coverage. More than one-quarter of these additional gains would come from those of Vietnamese origin: 34.5 percent live in states that are not currently expanding Medicaid. Additionally, this group is projected to experience the largest percentage decrease in uninsurance of any Asian/Pacific Islander–origin group under the ACA with full expansion: 60.3 percent. Because a large majority of Chinese-, Asian Indian–, Filipino-, and Korean-origin groups live in states that decided to expand Medicaid by January 2015, only marginal gains would be made with additional expansions.

TABLE 3

Selected Characteristics and Projected Uninsurance Rates for Asian/Pacific Islanders by Origin under Three ACA Scenarios

				Without ACA		ACA with Current Medicaid Expansion Decisions		ACA with Full Medicaid Expansion	
Asian/Pacific Islanders by origin	Total nonelderly (millions)	Living in nonexpansion states (%)	Undocumented immigrants (%)	Uninsured (millions)	Uninsurance rate (%)	Decrease relative to without ACA (%)	Uninsurance rate (%)	Decrease relative to without ACA (%)	Uninsurance rate (%)
Chinese	3.4	16.5	11.4	0.6	16.5	47.5	8.7	50.8	8.1
Asian Indian	2.9	28.3	17.4	0.4	13.1	44.2	7.3	49.9	6.6
Filipino	2.4	16.0	10.3	0.3	12.4	49.4	6.3	52.2	5.9
Vietnamese	1.6	34.5	6.5	0.4	21.5	50.0	10.7	60.3	8.5
Korean	1.4	23.1	15.3	0.4	29.9	51.1	14.6	55.0	13.4
All other A/PI	3.2	23.9	10.8	0.6	17.7	47.6	9.3	54.1	8.1
All A/PI	15.0	22.9	12.1	2.6	17.3	48.2	8.9	53.6	8.0

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

Notes: A/PI = Asian/Pacific Islander. See appendix A for additional details on racial/ethnic and origin categories.

For American Indian/Alaska Native Tribes, Uninsurance Rates Are Projected to Decrease, but Wide Differences Remain because of State Expansion Decisions

Without the ACA, uninsurance rates are projected to vary widely for American Indian/Alaska Natives by tribe, from 24.4 percent for Chippewa to 34.2 percent for Navajo (table 4). Under the ACA with current Medicaid expansion decisions, uninsurance rates are projected to fall substantially for all American Indian/Alaska Native groups. Approximately 633,000 American Indian/Alaska Natives are projected to gain coverage. Over two-thirds (68.2 percent) of American Indian/Alaska Natives projected to gain coverage under the ACA with current Medicaid expansion decisions do not report membership in only a single tribe and thus fall into the "All Other AI/AN" category.[27]

Only one-quarter of American Indian/Alaska Natives report only one tribal affiliation and no additional races. And though potential underreporting of tribal membership and small samples limit detail on inter-tribal differences, some findings are clear. American Indian/Alaska Natives who report only one tribal affiliation and no additional races are concentrated in states with tribal jurisdictions; those reporting no tribe, multiple tribes, or multiple races are much less geographically concentrated.[28] Consequently, differences in coverage gains across tribes are largely based on state Medicaid expansion decisions.

Thus, though just 13.0 percent of all American Indian/Alaska Natives are projected to be uninsured under the ACA with current Medicaid expansion decisions, rates vary based on state of residence. Navajos and Pueblos, with fewer than 10 percent of members living in nonexpansion states, are projected to have uninsurance rates of 11.8 percent and 11.9 percent, respectively. Lumbees and Eskimos, with nearly all residents living in nonexpansion states (North Carolina and Alaska, respectively) are projected to have uninsurance rates of 17.5 percent and 16.3 percent, respectively.

If all states expanded Medicaid, the uninsurance rate among all American Indian/Alaska Natives would drop to 9.9 percent, a decrease of 61.6 percent compared with projections without the ACA. The projected uninsurance rates with full expansion would range from 8.7 percent for the Cherokee to 11.7 percent for Pueblos. Eskimos, 9.0 percent of whom would remain uninsured, would see the largest percentage decrease in uninsurance: 72.7 percent if all states (including Alaska) expanded Medicaid.

TABLE 4

Uninsurance Rates and Decreases for American Indian/Alaska Natives by Tribe

American Indian/ Alaska Natives by tribe	Total nonelderly (thousands)	Living in nonexpansion states (%)	Without ACA		ACA with Current Medicaid Expansion Decisions		ACA with Full Medicaid Expansion	
			Uninsured (thousands)	Uninsurance rate (%)	Decrease relative to without ACA (%)	Uninsurance rate (%)	Decrease relative to without ACA (%)	Uninsurance rate (%)
Navajo	347.2	9.9	118.7	34.2	65.6	11.8	68.3	10.8
Cherokee	283.4	68.9	70.1	24.7	43.4	14.0	64.7	8.7
Sioux	141.4	68.3	44.2	31.3	41.4	18.3	67.3	10.2
Chippewa	130.6	24.2	31.9	24.4	56.7	10.6	61.2	9.5
Choctaw	89.1	79.5	24.8	27.9	46.1	15.0	64.3	9.9
Apache	76.9	17.8	23.5	30.5	57.0	13.1	65.0	10.7
Lumbee	76.4	96.3	20.3	26.5	34.1	17.5	65.9	9.0
Pueblo	68.0	5.4	21.8	32.1	63.0	11.9	63.6	11.7
Eskimo	66.8	94.5	22.0	33.0	50.5	16.3	72.7	9.0
All other AI/AN	3,688.5	44.0	900.7	24.4	48.0	12.7	59.7	9.9
All AI/AN	4,968.2	44.4	1,278.0	25.7	49.5	13.0	61.6	9.9

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

Note: AI/AN = American Indian/Alaska Native. Population is all nonelderly. See appendix A for additional details on racial/ethnic categories.

Conclusions

This study is the first state-based examination of how the ACA is projected to change uninsurance rates for five major racial and ethnic groups: whites, blacks, Latinos, Asian/Pacific Islanders, and American Indian/ Alaska Natives. The Urban Institute's HIPSM-ACS microsimulation model projects large reductions in uninsurance rates for all racial/ethnic groups under the ACA with Medicaid expansion decisions as of December 2014. We project even larger reductions under the ACA with full Medicaid expansion. In a more detailed subgroup examination by origin, we also find large reductions for each Latino-origin group, Asian/Pacific Islander–origin group, and American Indian/Alaska Natives tribe examined.

According to our projections, the ACA with current Medicaid expansion decisions could substantially narrow differences in uninsurance rates between whites and all racial/ethnic minorities except blacks, who disproportionately live nonexpansion states. In particular, dramatic reductions are projected for American Indian/Alaska Natives, with a projected decrease in the uninsurance rate from 25.7 percent to 13.0 percent—a 49.5 percent reduction that translates to 600,000 gaining coverage. Latinos would see a projected decrease in the uninsured rate from 31.2 percent to 19.0 percent—a 39.2 percent reduction, translating to 6.6 million gaining coverage. Both groups would see a narrowing of the differences in uninsurance rates with whites.

Under the ACA with Medicaid expansion in all states, uninsurance rates are projected to fall further for all racial/ethnic groups. Compared to projections with current Medicaid expansion decisions, dramatic uninsurance rate reductions are projected for blacks were all states to expand Medicaid: from 11.3 percent with current decisions to 7.2 percent with full expansion. Given that over half of all blacks are living in states not expanding Medicaid in 2014, 1.4 million uninsured blacks are in the eligibility gap. These 1.4 million constitute 23.1 percent of the black adult uninsured adult population nationwide. Overall, 2.7 million whites, 13.8 percent of the white adult uninsured population, falls into this gap. Because of tribe members' locations, four American Indian/Alaska Natives tribes (Eskimo, Cherokee, Sioux, and Lumbee) are also projected to experience dramatic gains under the ACA with full Medicaid expansion as compared with current expansion decisions.

Even with current Medicaid expansion decisions, the ACA is projected to shrink many of the persistent racial and ethnic differences in health insurance coverage. The ACA with Medicaid expansion in all states shows the potential for further reductions in uninsurance rates and, in contrast with projections of current Medicaid expansion decisions, would substantially narrow racial/ethnic

differences in coverage between whites and blacks. Thus, the promise of reducing long-standing racial/ethnic differences in access to health care and health status likely depends in part on the expansion decisions of the remaining 23 states.

Even so, state outreach and enrollment efforts will be important to (1) raise enrollment rates among eligibles in Medicaid and the Children's Health Insurance Program and (2) increase the number of eligible people who purchase subsidized coverage through the new insurance Marketplaces:

- Further coverage gains among Latinos will depend heavily on reaching Latinos in California (a Medicaid expansion state), many of whom are immigrants with limited English proficiency; those gains will also depend on Medicaid expansion decisions in Texas and Florida.
- California will also be pivotal for Asian/Pacific Islanders, many of whom have limited English proficiency, and for low-income whites, for whom low health insurance literacy may be the most important obstacle.
- Further coverage gains among blacks will depend on effective Medicaid and Marketplace outreach and enrollment efforts in California and Illinois (also a Medicaid expansion state) and Medicaid expansion decisions in Florida, Georgia, Texas, North Carolina, and Louisiana.
- Further coverage gains for American Indian/Alaska Natives will depend heavily on outreach and enrollment efforts in Oklahoma and Alaska, which have not expanded Medicaid, as well as California, Arizona, and New Mexico, which expanded Medicaid in 2014.
- Further coverage gains for whites will depend on outreach and enrollment in California, Ohio, and Pennsylvania (three Medicaid expansion states), and Florida and Texas (two nonexpansion states). Those gains also depend on Medicaid expansion decisions in Florida, Texas, Georgia, North Carolina, and Indiana.

The extent to which these high-impact states are maximizing outreach and enrollment efforts across racial/ethnic groups is unknown.[29] But four lessons for racial/ethnic group enrollment identified during the first open enrollment season may be instructive. First, an effective enrollment process requires enrollment assistance for those with limited English proficiency. This includes high-quality translations of print materials, greater availability of one-on-one in-person assistance, and a well-functioning website with culturally and linguistically appropriate versions languages besides English (Brooks 2014). Translation services are particularly important for those with limited English proficiency (Jahnke, Siddiqui, and Andrulis 2014). Second, the identity verification process posed problems. The process relied heavily on whether an individual could provide a Social Security number and answer

'identity proofing' questions drawn from credit history.[30] The process was cited as a barrier for many immigrant families and those with limited credit history during the first open enrollment season (Kanchinadam and Jee 2014).[31] Third, improving health insurance literacy is likely to improve enrollment. Health insurance literacy is low among those who are eligible for Medicaid. This impedes enrollment, and some racial/ethnic groups, such as Latinos, face larger health insurance literacy gaps than other groups (Long and Goin 2014). Lastly, effective outreach will likely require more communication at the community level, such as through partnerships with local ethnic media and through work with trusted individuals in the community who can address misperceptions and misinformation around the ACA.[32]

Appendix A. Racial and Ethnic Classifications

Changes in coverage were examined for six racial/ethnic categories based on the combined responses to two questions on the ACS. Racial groups were identified using responses to the ACS question, "What is Person X's race?" There were 15 response selections, including "some other race" (the complete question and response choices are provided in this appendix). Responses were then grouped into six categories, more than one of which could be true for a respondent: White, Black, American Indian or Alaska Natives, Asian, Pacific Islander, and Other. Latino ethnicity was identified using responses to the ACS question, "Is Person X of Hispanic, Latino, or Spanish origin?" The racial/ethnic categories used in this report are as follows:

1. **White, non-Latino**, referred to as "white," includes those who are not Latino and who selected only "white" as their race.
2. **Latino** includes those of Hispanic, Latino, or Spanish origin who are of any race or multiple races, and not American Indian/Alaska Natives.
3. **Black, non-Latino**, referred to as "black," includes those who are not Latino and who selected only "black, African Am., or negro" as their race.
4. **Asian/Pacific Islander, non-Latino**, referred to as "Asian/Pacific Islander," includes those who are not Latino and who selected only Asian or Pacific Islander racial subcategories (Asian Indian, Japanese, Native Hawaiian, Chinese, Korean, Guamanian or Chamorro, Filipino, Vietnamese, Samoan, other Asian, or other Pacific Islander).
5. **American Indian/Alaska Natives** includes all those who selected American Indian or Alaska Natives as their race, regardless of ethnicity or additional races identified.

A residual racial/ethnic category includes those who selected "some other race" as their racial category or selected multiple races and are not Latino or American Indian/Alaska Natives. Because of the small samples and heterogeneous nature of this group, this category is not analyzed.[33]

We then examine three racial/ethnic groups in additional detail. We analyze subgroups by origin for the Latino and Asian/Pacific Islander groups, since they have a relatively high proportion of foreign-born compared to the three other racial/ethnic groups. We analyze American Indian/Alaska Natives subgroups by tribe.

1. The 11 largest Latino-origin groups (Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, Colombian, Honduran, Ecuadorian, Spaniard, and Peruvian) and three other categories (Other South American, Other Central American, and Other Latino not specified). Classifications are based on responses given to Question 5 below.
2. The five largest Asian/Pacific Islander–origin groups (Chinese, Indian, Filipino, Vietnamese, and Korean) and all other Asian/Pacific Islanders (including those reporting multiple subgroups). Classifications are based on responses to in Question 6 below, with those selecting multiple Asian/Pacific Islander subgroups included in the "all other Asian/Pacific Islander" category.
3. The nine largest identifiable tribes as self-identified in Question 6 below. All other American Indian/Alaska Natives, including those of mixed race and multiple or unspecified tribes, are included in the "all other American Indian/Alaska Natives" subcategory.

American Community Survey Questions, 2009.[34]

5. Is Person 1 of Hispanic, Latino, or Spanish origin?

☐ **No,** not of Hispanic, Latino, or Spanish origin

☐ Yes, Mexican, Mexican Am., Chicano

☐ Yes, Puerto Rican

☐ Yes, Cuban

☐ Yes, another Hispanic, Latino, or Spanish origin -- *Print origin, for example, Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, and so on.* ____

6. What is Person 1's race? *Mark (X) one or more boxes.*

☐ White

☐ Black, African Am., or Negro

☐ American Indian or Alaska Natives -- *Print name of enrolled or principal tribe.* _____

☐ Asian Indian	☐	Japanese	☐	Native Hawaiian			
☐ Chinese	☐	Korean	☐	Guamanian or Chamorro			
☐ Filipino	☐	Vietnamese	☐	Samoan	☐	Other	

Asian -- *Print race, for example, Hmong, Laotian, Thai, Pakistani, Cambodian, and so on.* _____

☐ Other Pacific Islander -- *Print race, for example, Fijian, Tongan, and so on.* ____

☐ Some other race -- *Print race.* ____

Appendix B. Additional Tables

TABLE B.1

Projected Number of Nonelderly Uninsured without ACA, with ACA and Current Medicaid Expansion Decisions, and with ACA and Full Medicaid Expansion (Nonexpansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions			ACA with Full Medicaid Expansion		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Alabama	681.7	489.1	192.6	28.3	264.8	416.9	61.2
Alaska	140.9	73.5	67.4	47.8	50.5	90.4	64.1
Florida	4,153.1	2,592.3	1,560.7	37.6	1,621.3	2,531.7	61.0
Georgia	1,967.8	1,369.3	598.5	30.4	856.4	1,111.4	56.5
Idaho	271.6	174.7	96.9	35.7	103.8	167.8	61.8
Indiana	939.1	614.4	324.6	34.6	344.1	595.0	63.4
Kansas	380.3	258.5	121.8	32.0	160.6	219.7	57.8
Louisiana	820.3	557.5	262.8	32.0	301.1	519.1	63.3
Maine	143.5	81.2	62.3	43.4	52.1	91.4	63.7
Mississippi	531.0	367.3	163.7	30.8	191.9	339.1	63.9
Missouri	815.9	538.8	277.1	34.0	296.0	519.9	63.7
Montana	190.3	110.3	80.1	42.1	61.2	129.2	67.9
Nebraska	222.1	141.0	81.1	36.5	91.0	131.1	59.0
North Carolina	1,612.3	1,007.9	604.4	37.5	623.5	988.8	61.3
Oklahoma	706.6	464.6	242.0	34.3	300.1	406.5	57.5
South Carolina	805.3	543.0	262.3	32.6	327.2	478.2	59.4
South Dakota	107.1	67.1	40.0	37.3	35.5	71.7	66.9
Tennessee	951.2	624.2	327.0	34.4	385.6	565.6	59.5
Texas	6,287.8	4,333.9	1,953.9	31.1	2,932.1	3,355.7	53.4
Utah	436.4	272.6	163.8	37.5	183.2	253.1	58.0
Virginia	1,009.3	683.6	325.7	32.3	436.9	572.4	56.7
Wisconsin[a]	537.0	221.5	315.5	58.7	199.5	337.6	62.9
Wyoming	88.1	50.9	37.2	42.2	32.5	55.6	63.2
All nonexpansion states	23,798.7	15,637.2	8,161.4	34.3	9,850.9	13,947.8	58.6

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

[a] Although Wisconsin has not accepted the ACA Medicaid expansion, adults with incomes up to 100 percent of the federal poverty level are now eligible for Medicaid and can enroll. Before 2014, there was a limited benefits program for low-income adult nonparents, but enrollment closed.

TABLE B.2

Projected Number of Nonelderly Uninsured without ACA and with ACA and Current Medicaid Expansion Decisions, (Expansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Arizona	1,191.5	488.0	703.4	59.0
Arkansas	503.7	194.8	308.9	61.3
California	7,456.5	3,069.6	4,386.9	58.8
Colorado	821.0	382.4	438.6	53.4
Connecticut	330.7	166.0	164.7	49.8
Delaware	89.1	47.9	41.2	46.2
District of Columbia	48.9	23.9	25.0	51.0
Hawaii	104.4	42.4	61.9	59.3
Illinois	1,767.0	749.5	1,017.5	57.6
Iowa	279.3	116.2	163.1	58.4
Kentucky	636.6	232.6	404.0	63.5
Maryland	651.0	331.2	319.8	49.1
Massachusetts	306.7	143.6	163.1	53.2
Michigan	1,219.2	436.7	782.5	64.2
Minnesota	490.9	242.5	248.4	50.6
Nevada	627.8	304.7	323.1	51.5
New Hampshire	139.8	49.1	90.6	64.8
New Jersey	1,250.6	632.3	618.2	49.4
New Mexico	455.1	207.6	247.6	54.4
New York	2,435.1	1,364.9	1,070.2	43.9
North Dakota	69.4	25.2	44.2	63.7
Ohio	1,384.2	479.4	904.8	65.4
Oregon	656.6	281.2	375.3	57.2
Pennsylvania	1,302.3	495.4	806.9	62.0
Rhode Island	127.2	57.8	69.4	54.5
Vermont	57.0	27.4	29.7	52.0
Washington	997.4	450.3	547.1	54.9
West Virginia	274.1	91.4	182.7	66.6
All expansion states	25,673.0	11,134.2	14,538.8	56.6

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

TABLE B.3

Projected Number of Uninsured Whites without ACA, with ACA and Current Medicaid Expansion Decisions, and with ACA and Full Medicaid Expansion (Nonexpansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions			ACA with Full Medicaid Expansion		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Alabama	360.8	244.6	116.3	32.2	123.9	236.9	65.7
Alaska	63.9	31.7	32.2	50.4	22.9	41.0	64.1
Florida	1,632.8	1,016.0	616.8	37.8	579.7	1,053.1	64.5
Georgia	768.0	486.3	281.7	36.7	262.1	505.9	65.9
Idaho	194.5	117.9	76.6	39.4	62.0	132.5	68.1
Indiana	665.8	412.8	253.0	38.0	213.4	452.5	68.0
Kansas	225.1	142.1	83.0	36.9	75.6	149.5	66.4
Louisiana	376.5	239.1	137.4	36.5	131.9	244.6	65.0
Maine	134.4	75.9	58.5	43.5	47.8	86.6	64.5
Mississippi	247.9	159.6	88.3	35.6	86.8	161.1	65.0
Missouri	578.2	367.6	210.6	36.4	194.8	383.4	66.3
Montana	140.8	80.2	60.6	43.0	43.1	97.7	69.4
Nebraska	139.8	81.5	58.3	41.7	45.4	94.4	67.5
North Carolina	762.5	467.9	294.6	38.6	260.0	502.5	65.9
Oklahoma	370.7	233.4	137.3	37.0	138.9	231.8	62.5
South Carolina	401.7	248.5	153.2	38.1	143.3	258.4	64.3
South Dakota	66.0	40.1	25.9	39.2	21.7	44.3	67.1
Tennessee	596.1	361.9	234.2	39.3	206.9	389.2	65.3
Texas	1,578.4	965.2	613.2	38.8	569.7	1,008.7	63.9
Utah	251.1	138.1	113.0	45.0	76.5	174.6	69.5
Virginia	452.8	282.5	170.3	37.6	153.9	298.9	66.0
Wisconsin[a]	356.4	137.8	218.6	61.3	120.4	236.0	66.2
Wyoming	66.1	37.1	28.9	43.8	22.8	43.3	65.5
All nonexpansion states	10,430.3	6,367.9	4,062.4	38.9	3,603.3	6,827.0	65.5

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

[a] Although Wisconsin has not accepted the ACA Medicaid expansion, adults with incomes up to 100 percent of the federal poverty level are now eligible for Medicaid and can enroll. Before 2014, there was a limited benefits program for low-income adult nonparents, but enrollment closed.

TABLE B.4

Projected Number of Uninsured Whites without ACA and with ACA and Current Medicaid Expansion Decisions (Expansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Arizona	421.7	139.5	282.3	66.9
Arkansas	325.9	106.1	219.8	67.4
California	1,643.0	577.4	1,065.6	64.9
Colorado	407.6	146.6	261.0	64.0
Connecticut	156.2	62.3	93.9	60.1
Delaware	47.3	21.2	26.1	55.1
District of Columbia	10.3	4.5	5.8	56.3
Hawaii	29.2	9.8	19.4	66.5
Illinois	718.4	267.9	450.5	62.7
Iowa	210.2	75.9	134.2	63.9
Kentucky	507.9	169.3	338.7	66.7
Maryland	219.0	85.0	134.0	61.2
Massachusetts	177.5	69.7	107.7	60.7
Michigan	822.8	276.0	546.7	66.5
Minnesota	322.8	141.5	181.2	56.1
Nevada	229.5	80.6	148.8	64.9
New Hampshire	122.1	40.1	82.0	67.1
New Jersey	416.3	159.8	256.6	61.6
New Mexico	101.6	36.4	65.2	64.2
New York	869.3	426.6	442.7	50.9
North Dakota	48.3	16.8	31.5	65.2
Ohio	1,013.7	334.0	679.7	67.0
Oregon	428.0	145.8	282.2	65.9
Pennsylvania	874.4	298.7	575.7	65.8
Rhode Island	70.2	22.7	47.4	67.6
Vermont	51.6	24.6	27.1	52.4
Washington	563.3	205.4	357.9	63.5
West Virginia	250.4	81.6	168.9	67.4
All expansion states	11,058.4	4,025.9	7,032.5	63.6

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

TABLE B.5

Projected Number of Uninsured Latinos without ACA, with ACA and Current Medicaid Expansion Decisions, and with ACA and Full Medicaid Expansion (Nonexpansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions			ACA with Full Medicaid Expansion		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Alabama	77.9	65.6	12.3	15.8	58.7	19.2	24.6
Alaska	7.5	5.1	2.4	32.2	4.1	3.4	45.4
Florida	1,583.8	977.3	606.4	38.3	692.1	891.7	56.3
Georgia	435.1	355.5	79.6	18.3	314.2	120.9	27.8
Idaho	60.5	46.1	14.4	23.7	35.6	24.9	41.1
Indiana	122.5	98.3	24.3	19.8	75.2	47.3	38.6
Kansas	94.6	74.1	20.5	21.7	59.9	34.7	36.7
Louisiana	70.1	54.9	15.2	21.7	46.1	23.9	34.2
Maine	2.0	N/A	N/A	N/A	N/A	N/A	N/A
Mississippi	32.6	26.5	6.1	18.8	22.8	9.8	30.0
Missouri	64.0	49.1	14.9	23.3	36.9	27.1	42.3
Montana	7.6	5.1	2.5	32.6	4.3	3.3	43.7
Nebraska	51.1	39.8	11.2	22.0	33.0	18.1	35.4
North Carolina	366.4	231.0	135.4	37.0	199.8	166.6	45.5
Oklahoma	123.0	94.5	28.5	23.2	79.5	43.5	35.4
South Carolina	107.0	88.2	18.9	17.6	79.8	27.3	25.5
South Dakota	4.3	3.2	1.1	25.9	2.5	1.8	42.0
Tennessee	125.4	104.3	21.1	16.8	94.6	30.8	24.6
Texas	3,751.2	2,732.5	1,018.7	27.2	1,994.8	1,756.4	46.8
Utah	147.6	109.2	38.4	26.0	92.3	55.3	37.4
Virginia	209.5	166.2	43.3	20.7	149.1	60.4	28.8
Wisconsin[a]	92.7	47.8	44.8	48.4	45.0	47.6	51.4
Wyoming	13.4	7.9	5.5	41.3	6.3	7.1	53.1
All nonexpansion states	7,549.8	5,383.6	2,166.2	28.7	4,128.0	3,421.8	45.3

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

Notes: N/A = not applicable. Cells marked "not applicable" had too small of a sample size to provide meaningful data.

[a] Although Wisconsin has not accepted the ACA Medicaid expansion, adults with incomes up to 100 percent of the federal poverty level 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.

TABLE B.6

Projected Number of Uninsured Latinos without ACA and with ACA and Current Medicaid Expansion Decisions (Expansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Arizona	580.9	281.5	299.4	51.5
Arkansas	68.3	49.9	18.3	26.8
California	4,414.2	1,955.2	2,459.0	55.7
Colorado	320.1	195.5	124.6	38.9
Connecticut	108.3	70.2	38.1	35.2
Delaware	19.2	14.9	4.3	22.4
District of Columbia	10.1	7.2	2.9	28.8
Hawaii	9.6	3.8	5.9	61.0
Illinois	589.9	304.9	285.0	48.3
Iowa	40.2	28.1	12.1	30.1
Kentucky	46.3	33.9	12.4	26.8
Maryland	159.3	124.2	35.1	22.0
Massachusetts	65.8	40.5	25.2	38.4
Michigan	102.0	57.4	44.5	43.7
Minnesota	71.1	53.5	17.6	24.7
Nevada	288.6	178.8	109.7	38.0
New Hampshire	8.2	4.2	4.0	49.0
New Jersey	507.2	320.7	186.5	36.8
New Mexico	248.6	134.3	114.4	46.0
New York	834.8	513.0	321.8	38.5
North Dakota	2.5	N/A	N/A	N/A
Ohio	90.5	43.4	47.1	52.1
Oregon	151.6	103.3	48.2	31.8
Pennsylvania	159.3	89.0	70.3	44.1
Rhode Island	38.9	25.5	13.4	34.5
Vermont	1.3	N/A	N/A	N/A
Washington	247.3	161.4	85.9	34.7
West Virginia	4.3	1.8	2.6	59.2
All expansion states	9,188.4	4,797.5	4,390.9	47.8

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.
Notes: N/A = not applicable. Cells marked "not applicable" had too small of a sample size to provide meaningful data.

TABLE B.7

Projected Number of Uninsured Blacks without ACA, with ACA and Current Medicaid Expansion Decisions, and with ACA and Full Medicaid Expansion (Nonexpansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions			ACA with Full Medicaid Expansion		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Alabama	218.9	161.8	57.1	26.1	70.6	148.3	67.8
Alaska	3.5	2.4	1.1	30.8	1.8	1.7	49.3
Florida	731.0	476.5	254.5	34.8	270.8	460.2	63.0
Georgia	635.1	441.9	193.2	30.4	220.9	414.2	65.2
Idaho	1.9	N/A	N/A	N/A	N/A	N/A	N/A
Indiana	110.9	78.0	32.9	29.6	38.9	72.0	64.9
Kansas	28.9	20.8	8.2	28.2	10.7	18.3	63.2
Louisiana	335.4	236.9	98.5	29.4	105.9	229.5	68.4
Maine	1.0	N/A	N/A	N/A	N/A	N/A	N/A
Mississippi	233.0	169.4	63.6	27.3	74.1	158.9	68.2
Missouri	130.8	92.6	38.2	29.2	45.8	85.0	65.0
Montana	1.1	N/A	N/A	N/A	N/A	N/A	N/A
Nebraska	14.0	8.9	5.2	36.8	5.4	8.6	61.4
North Carolina	377.3	243.8	133.4	35.4	123.9	253.4	67.2
Oklahoma	52.7	35.7	17.0	32.3	18.2	34.5	65.5
South Carolina	266.8	187.1	79.7	29.9	90.9	175.9	65.9
South Dakota	2.0	1.0	1.0	49.0	N/A	N/A	N/A
Tennessee	191.1	131.8	59.3	31.0	66.0	125.0	65.4
Texas	616.1	414.6	201.5	32.7	216.9	399.2	64.8
Utah	4.9	3.9	1.0	21.1	2.6	2.3	46.6
Virginia	241.9	164.4	77.6	32.1	83.6	158.3	65.4
Wisconsin[a]	48.2	18.9	29.3	60.8	17.4	30.7	63.8
Wyoming	N/A	N/A	N/A	N/A	N/A	N/A	N/A
All nonexpansion states	4,247.1	2,892.8	1,354.3	31.9	1,466.6	2,780.5	65.5

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

Notes: N/A = not applicable. Cells marked "not applicable" had too small of a sample size to provide meaningful data.

[a] Although Wisconsin has not accepted the ACA Medicaid expansion, adults with incomes up to 100 percent of the federal poverty level 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.

TABLE B.8

Projected Number of Uninsured Blacks without ACA and with ACA and Current Medicaid Expansion Decisions (Expansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Arizona	40.3	14.0	26.3	65.2
Arkansas	84.2	27.1	57.2	67.9
California	336.0	117.7	218.3	65.0
Colorado	34.8	14.6	20.2	58.0
Connecticut	40.6	19.0	21.7	53.3
Delaware	17.0	8.9	8.0	47.2
District of Columbia	25.9	11.0	14.9	57.5
Hawaii	1.0	N/A	N/A	N/A
Illinois	336.8	123.9	212.9	63.2
Iowa	13.6	4.1	9.5	69.8
Kentucky	63.3	21.5	41.8	66.0
Maryland	207.3	88.1	119.2	57.5
Massachusetts	28.6	13.2	15.4	53.9
Michigan	225.7	75.4	150.4	66.6
Minnesota	41.6	20.7	20.9	50.1
Nevada	43.7	15.1	28.6	65.4
New Hampshire	2.5	1.2	1.3	52.8
New Jersey	171.9	70.4	101.5	59.1
New Mexico	5.1	2.1	3.0	59.6
New York	390.4	224.7	165.6	42.4
North Dakota	1.7	N/A	N/A	N/A
Ohio	224.5	79.4	145.1	64.6
Oregon	11.8	3.5	8.3	70.3
Pennsylvania	187.0	69.8	117.2	62.7
Rhode Island	9.2	4.8	4.4	47.4
Vermont	N/A	N/A	N/A	N/A
Washington	39.3	18.1	21.2	53.9
West Virginia	11.7	5.0	6.8	57.8
All expansion states	2,596.4	1,054.9	1,541.5	59.4

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.
Notes: N/A = not applicable. Cells marked "not applicable" had too small of a sample size to provide meaningful data.

TABLE B.9

Projected Number of Uninsured Asian/Pacific Islanders without ACA, with ACA and Current Medicaid Expansion Decisions, and with ACA and Full Medicaid Expansion (Nonexpansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions			ACA with Full Medicaid Expansion		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Alabama	10.2	7.2	2.9	28.8	5.5	4.7	45.7
Alaska	11.4	6.5	4.9	42.9	4.8	6.6	57.8
Florida	116.9	69.1	47.7	40.9	45.3	71.6	61.3
Georgia	92.3	61.2	31.1	33.7	43.3	49.0	53.1
Idaho	3.2	2.1	1.1	33.5	1.3	1.8	57.6
Indiana	19.1	12.6	6.5	34.0	10.0	9.1	47.7
Kansas	12.0	8.3	3.7	30.7	6.2	5.9	48.9
Louisiana	20.5	14.5	6.0	29.1	9.9	10.6	51.8
Maine	2.2	N/A	N/A	N/A	1.0	1.2	55.1
Mississippi	8.0	5.3	2.7	33.7	4.2	3.8	47.3
Missouri	15.7	10.6	5.1	32.6	7.9	7.8	49.9
Montana	1.8	N/A	N/A	N/A	N/A	N/A	N/A
Nebraska	5.3	4.1	1.2	23.1	3.2	2.1	39.3
North Carolina	41.7	24.7	17.0	40.7	16.9	24.8	59.5
Oklahoma	14.8	9.6	5.2	35.1	6.8	8.1	54.5
South Carolina	15.0	10.0	5.0	33.6	8.1	6.9	45.8
South Dakota	1.0	N/A	N/A	N/A	N/A	N/A	N/A
Tennessee	18.1	12.4	5.7	31.3	9.3	8.8	48.7
Texas	227.2	146.3	80.9	35.6	100.8	126.5	55.6
Utah	13.1	9.2	3.8	29.5	5.7	7.3	56.3
Virginia	74.4	50.0	24.4	32.8	36.8	37.6	50.6
Wisconsin[a]	17.6	8.1	9.4	53.7	7.8	9.8	55.9
Wyoming	N/A	N/A	N/A	N/A	N/A	N/A	N/A
All nonexpansion states	741.8	475.5	266.2	35.9	336.3	405.5	54.7

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

Notes: N/A = not applicable. Cells marked "not applicable" had too small of a sample size to provide meaningful data.

[a] Although Wisconsin has not accepted the ACA Medicaid expansion, adults with incomes up to 100 percent of the federal poverty level 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.

TABLE B.10

Projected Number of Uninsured Asian/Pacific Islanders without ACA and with ACA and Current Medicaid Expansion Decisions (Expansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Arizona	30.4	15.0	15.4	50.7
Arkansas	11.0	5.0	6.0	54.9
California	833.6	334.8	498.9	59.8
Colorado	26.1	12.1	14.0	53.6
Connecticut	16.2	9.5	6.7	41.4
Delaware	2.5	1.5	1.0	38.6
District of Columbia	1.8	N/A	N/A	N/A
Hawaii	45.5	22.8	22.7	50.0
Illinois	95.7	42.5	53.3	55.6
Iowa	5.8	3.2	2.6	44.6
Kentucky	7.6	3.7	3.9	51.1
Maryland	48.4	25.6	22.7	47.0
Massachusetts	21.9	13.3	8.6	39.2
Michigan	33.6	15.6	18.0	53.5
Minnesota	25.8	13.7	12.1	46.9
Nevada	41.2	20.6	20.6	49.9
New Hampshire	4.0	2.5	1.4	36.2
New Jersey	117.7	59.8	57.9	49.2
New Mexico	5.2	2.7	2.5	47.3
New York	272.8	162.5	110.3	40.4
North Dakota	N/A	N/A	N/A	N/A
Ohio	27.0	12.2	14.7	54.6
Oregon	29.3	14.8	14.5	49.5
Pennsylvania	55.1	27.1	28.0	50.8
Rhode Island	4.8	3.0	1.9	38.5
Vermont	1.8	N/A	N/A	N/A
Washington	85.6	41.2	44.4	51.9
West Virginia	1.8	N/A	N/A	N/A
All expansion states	1,852.9	868.5	984.4	53.1

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.
Notes: N/A = not applicable. Cells marked "not applicable" had too small of a sample size to provide meaningful data.

TABLE B.11

Projected Number of Uninsured American Indian/Alaska Natives without ACA, with ACA and Current Medicaid Expansion Decisions, and with ACA and Full Medicaid Expansion (Nonexpansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions			ACA with Full Medicaid Expansion		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Alabama	10.1	7.1	3.0	30.1	4.7	5.4	53.8
Alaska	53.3	27.3	26.0	48.8	16.6	36.7	68.9
Florida	42.9	26.5	16.4	38.2	15.7	27.2	63.4
Georgia	19.0	12.4	6.6	34.7	8.4	10.6	55.8
Idaho	10.5	7.1	3.4	32.7	4.1	6.5	61.4
Indiana	11.2	6.8	4.4	39.2	3.7	7.5	67.2
Kansas	15.8	10.5	5.2	33.1	6.7	9.1	57.8
Louisiana	13.2	9.1	4.1	31.3	5.8	7.5	56.5
Maine	3.7	1.6	2.1	57.3	1.4	2.3	62.4
Mississippi	7.5	5.2	2.3	30.7	3.1	4.5	59.4
Missouri	19.1	13.1	6.0	31.3	7.7	11.5	60.0
Montana	37.8	22.5	15.3	40.6	12.1	25.7	67.9
Nebraska	9.2	5.8	3.5	37.6	3.2	6.0	64.8
North Carolina	50.6	32.2	18.3	36.3	18.1	32.5	64.2
Oklahoma	139.7	87.4	52.3	37.4	54.1	85.7	61.3
South Carolina	7.0	5.2	1.8	25.9	2.6	4.4	62.7
South Dakota	33.8	22.3	11.4	33.8	10.1	23.6	70.0
Tennessee	12.9	9.1	3.8	29.6	5.8	7.1	54.7
Texas	77.7	52.0	25.8	33.1	35.2	42.5	54.7
Utah	15.9	9.5	6.4	40.2	4.5	11.4	71.7
Virginia	14.9	9.8	5.1	34.0	6.8	8.1	54.5
Wisconsin[a]	16.6	7.0	9.6	57.8	6.7	9.9	59.6
Wyoming	7.1	4.6	2.5	35.4	2.9	4.2	59.0
All nonexpansion states	629.5	394.1	235.5	37.4	239.8	389.7	61.9

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

[a] Although Wisconsin has not accepted the ACA Medicaid expansion, adults with incomes up to 100 percent of the federal poverty level 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.

TABLE B.12

Projected Number of Uninsured American Indian/Alaska Natives without ACA and with ACA and Current Medicaid Expansion Decisions (Expansion States)

	Without ACA	ACA with Current Medicaid Expansion Decisions		
	Uninsured (thousands)	Uninsured (thousands)	Reduction in uninsured (thousands)	Decrease (%)
Arizona	107.8	34.3	73.5	68.2
Arkansas	11.1	5.2	6.0	53.7
California	144.5	54.1	90.4	62.5
Colorado	24.6	10.5	14.1	57.4
Connecticut	3.5	1.5	1.9	56.4
Delaware	2.0	N/A	N/A	N/A
District of Columbia	N/A	N/A	N/A	N/A
Hawaii	2.4	N/A	N/A	N/A
Illinois	13.0	5.1	7.9	60.8
Iowa	7.0	3.9	3.1	44.5
Kentucky	6.7	2.7	4.0	59.8
Maryland	8.0	4.2	3.8	47.2
Massachusetts	3.5	1.6	1.9	53.8
Michigan	21.1	7.7	13.4	63.5
Minnesota	21.5	9.8	11.7	54.4
Nevada	15.5	5.5	10.0	64.7
New Hampshire	1.6	N/A	N/A	N/A
New Jersey	17.4	11.9	5.5	31.8
New Mexico	93.0	31.3	61.7	66.3
New York	29.9	15.7	14.2	47.4
North Dakota	15.8	6.3	9.5	59.9
Ohio	12.9	4.4	8.5	66.0
Oregon	27.3	10.9	16.4	59.9
Pennsylvania	9.6	3.1	6.5	67.6
Rhode Island	1.6	N/A	N/A	N/A
Vermont	1.0	N/A	N/A	N/A
Washington	41.9	16.3	25.6	61.1
West Virginia	4.0	1.5	2.6	63.6
All expansion states	648.5	250.8	397.7	61.3

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.
Notes: N/A = not applicable. Cells marked "not applicable" had too small of a sample size to provide meaningful data.

TABLE B.13

Projected Statistic (Effect Size) to Assess Whether Coverage Rates for Racial/Ethnic Minority Groups Narrow Compared with White Coverage Rates under the ACA

	Black	Latino	Asian/Pacific Islander	American Indian/ Alaska Native
All states				
Without ACA (A)	0.071	0.205	0.034	0.063
ACA with current Medicaid decisions (B)	0.073	0.187	0.029	0.045
ACA with full Medicaid expansion (C)	0.044	0.195	0.043	0.041
Difference (narrowing coverage differential with white is negative; widening is positive)				
Without ACA vs. ACA with current Medicaid decisions (B minus A)	0.002	-0.019	-0.005	-0.017
Without ACA vs. ACA with full Medicaid decisions (C minus A)	-0.026	-0.010	0.009	-0.021
Medicaid expansion states				
Without ACA (A)	0.051	0.193	0.041	0.060
ACA with current Medicaid decisions (B)	0.041	0.177	0.048	0.039
Relative differences (narrowing is negative; widening is positive)				
Without ACA vs ACA with current Medicaid decisions (B minus A)	-0.010	-0.016	0.007	-0.021
Nonexpansion states				
Without ACA (A)	0.079	0.230	0.039	0.065
ACA with current Medicaid decisions (B)	0.080	0.213	0.034	0.051
ACA with full Medicaid expansion (C)	0.044	0.224	0.043	0.044
Relative differences (narrowing is negative; widening is positive)				
Without ACA vs. ACA with current Medicaid decisions (B minus A)	0.001	-0.016	-0.005	-0.013
Without ACA vs. ACA with full Medicaid decisions (C minus A)	-0.035	-0.005	0.004	-0.021

Source: HIPSM-ACS 2014. ACA simulated as fully implemented in 2016.

Note: The statistic presented is an "effect size" as described in the methods section.

Notes

1. Robin A. Cohen and Michael E. Martinez, "Health Insurance Coverage: Early Release of Quarterly Estimates from the National Health Interview Survey, January 2010–March 2014," National Center for Health Statistics, accessed November 21, 2014, http://www.cdc.gov/nchs/data/nhis/earlyrelease/quarterly_estimates_2010_2014Q11.pdf.
2. "State Medicaid and CHIP Income Eligibility Standards," Centers for Medicare and Medicaid Services, accessed November 21, 2014. In addition, Pennsylvania is slated to expand Medicaid eligibility in January 2015. See Marilyn Tavenner, letter to Secretary Mackereth, August 28, 2014, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/pa-healthy-ca.pdf.
3. Those whose incomes are between 100 and 400 percent of FPL, who are not eligible for any public coverage program such as Medicaid, who are legally present in the United States, and who do not have an affordable offer of coverage from an employer are eligible for subsidized private coverage in the health insurance Marketplaces. This means that in a state that has expanded Medicaid eligibility, subsidy eligibility ends at 138 percent of FPL. Legally present immigrants who do not qualify for Medicaid because they have not been residing in the United States for five years are also eligible for subsidized coverage, even if their incomes are below 100 percent of FPL.
4. Also, many adults with family income between 100 and 138 percent of FPL who live in expansion states and would have been eligible for Medicaid are barred from subsidized Marketplace coverage because of an offer of employer-sponsored insurance coverage to a family member. If any family member is offered single coverage for which his or her share of the premium is less than 9.5 percent of family income, then the entire family is ineligible for subsidized coverage.
5. Authors' tabulations using HIPSM-ACS, 2014.
6. "State Medicaid and CHIP Income Eligibility Standards," Centers for Medicare and Medicaid Services. In addition, Pennsylvania is slated to expand Medicaid eligibility in January 2015. See Marilyn Tavenner, letter to Secretary Mackereth, August 28, 2014, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/pa-healthy-ca.pdf.
7. For an overview of HIPSM, see Urban Institute (2010). For more information about methodology, see "Further Methodological Information for 'Tax Preparers Could Help Most Uninsured Get Covered,'" Urban Institute, accessed November 11, 2014, http://www.urban.org/health_policy/health_care_reform/taxfilingmethodology.cfm.
8. Previous estimates based on HIPSM (e.g., Holahan et al. 2012) differ slightly, particularly in the estimate of potential new Medicaid eligibles. Our current estimates take into account final HHS and Treasury regulations on how Medicaid eligibility should be computed under the ACA. In addition, previous estimates were based on the 2010 ACS, while the current estimates are based on three years of the ACS aged to 2016. Further, the number of uninsured has declined since 2010, disproportionately reducing the number of very low income uninsured, and economic conditions and thus the underlying income distribution have also changed since 2010.
9. The approach allows new coverage options to be assessed without simply extrapolating from historical data. It considers such factors as affordability (premiums and out-of-pocket health care costs for available insurance products), health care risk, whether the individual mandate would apply, and family disposable income.
10. For example, if someone is currently eligible for Medicaid but not enrolled, he or she (or his or her parents) have shown a preference against Medicaid. He or she will be less likely to enroll in Medicaid under the ACA than a similar person who becomes newly eligible for Medicaid and thus has not had a chance to express a preference. We use such preferences to customize individual utility functions so that people's current choices score the highest among their current coverage choices, and these preferences affect their behavior under the ACA.
11. See appendix A for classification details. The 4.1 million nonelderly adults in the "other non-Latino" racial/ethnic category are not discussed in this paper because that category combines heterogeneous groups. Overall, findings for the "other non-Latino" group largely mirror findings for whites.

12. "Summary of Immigrant Eligibility Restrictions under Current Law," Assistant Secretary for Planning and Evaluation, last modified April 28, 2011, accessed November 24, 2014, http://aspe.hhs.gov/hsp/immigration/restrictions-sum.shtml.

13. For comparison, the second-largest concentration of undocumented individuals is among Asians and Pacific Islanders. Fully 14.4 percent of the undocumented are estimated to be Asians and Pacific Islanders. Undocumented individuals are estimated to make up 12.1 percent of Asians and Pacific Islanders.

14. Percentage-point differences are not shown in the tables; computations are based on projections in the tables.

15. James P. Scanlan, "How Measures Are Affected by the Prevalence of an Outcome," letter in response to Clemans-Cope et al. (2012), http://content.healthaffairs.org/content/31/5/920.full/reply#healthaff_el_476249.

16. When two groups differ in their uninsurance rate, if the overall uninsurance rate (i.e., the rate of uninsurance across both groups) decreases without any change in the underlying difference between the groups, then (1) the relative difference in uninsurance rates between the groups tends to be greater, and (2) the relative difference in rates of having health coverage tends to be smaller.

17. If the relative changes in both the uninsured and insured rates are consistent—either larger or smaller for one group compared to another group—we can conclude that the difference in health coverage between the two groups has narrowed (or widened).If the relative changes in the uninsured and insured rates are not in the same direction, however, we cannot draw conclusions about relative differences in uninsurance rates between groups without additional information. In all cases presented here, the relative changes in the uninsured and insured rates were not consistent, suggesting that computation of a measure such as "effect size" was necessary.

18. For general information on the measure computed here, effect size, see Harper and Lynch (2005). Also see Scanlan (2013).

19. The Public Use Microdata Areas are the smallest statistically representative geographic area on the ACS.

20. Lisa Clemans-Cope, Hannah Recht, and Anna Spencer, "Racial/Ethnic Differences in Uninsurance Rates under the ACA: Where You Live Matters," *MetroTrends* (blog), December 16, 2014, http://blog.metrotrends.org/2014/12/racialethnic-differences-uninsurance-rates-aca-live-matters.

21. Calculations based on table 1.

22. Estimates include calculations based on table 1.

23. Calculations based on table 1.

24. Calculations based on table 1.

25. Calculations based on table 1.

26. Although we define high-impact states as those that together account for half the projected coverage gains under the ACA with full Medicaid expansion, the actual proportions are slightly over 50 percent because of the need to include whole states. High-impact states make up 50.6 percent (black) to 54.0 percent (Latino) of coverage gains by race.

27. Calculations based on table 9.

28. The share of American Indian/Alaska Natives in the "All other Asian/Pacific Islander" category is low for several states. In four states, the share of American Indian/Alaska Natives in the "All other Asian/Pacific Islander" category is less than half (19 percent in New Mexico, 21 percent in South Dakota, 36 percent in North Dakota, and 46 percent in Arizona). In another five states, the share in the "All other Asian/Pacific Islander" category is less than the national average (52 percent in North Carolina, 53 percent in Utah, 54 percent in Minnesota, 56 percent in Alaska, and 59 percent in Mississippi). See appendix A for details on race and tribe classification.

29. For example, California recently turned down an offer from the California Endowment of $6 million toward the renewal process for those newly enrolled in Medi-Cal, a decision that has led to some criticism, given the backlog of Medi-Cal applicants. See Anna Gorman, "Advocates Say California Is Rejecting 'Free Money' to Renew Poor People's Insurance," *Kaiser Health News,* July 4, 2014,

http://capsules.kaiserhealthnews.org/index.php/2014/07/advocates-say-california-is-rejecting-free-money-to-renew-poor-peoples-insurance/

30. Consumer Reports, "Having trouble proving your identity to HealthCare.gov?" December 18, 2013, http://www.consumerreports.org/cro/news/2013/12/how-to-prove-your-identity-on-healthcare-gov/index.htm.

31. See also Sonya Schwartz, "We Can Fix This, People! More than Half of Uninsured Parents Are Latino," *CHIRblog,* September 12, 2014, http://chirblog.org/we-can-fix-this-people-more-than-half-of-uninsured-parents-are-hispanic; and "Improving the Road to ACA Coverage: Lessons Learned on Outreach, Education, and Enrollment for Asian American, Native Hawaiian, and Pacific Islander Communities," Asian & Pacific Islander American Health Forum, September 2014, accessed November 24, 2014, http://www.apiahf.org/resources/resources-database/improving-road-aca-coverage-lessons-learned-outreach-education-and-enro.

32. "Improving the Road to ACA Coverage," September 2014.

33. This group of 4.1 million nonelderly who selected neither American Indian/Alaska Native as a race nor Latino as an ethnicity is made up of 3.6 million who selected multiple races and 566,000 nonelderly respondents who selected only "other race."

34. "Questions on the Form and Why We Ask," US Census Bureau, accessed November 24, 2014, http://www.census.gov/acs/www/about_the_survey/questions_and_why_we_ask/.

References

Brooks, Tricia A. 2014. "Open Enrollment, Take Two." *Health Affairs* 33 (6): 927–30.

Buettgens, Matthew, Dean Resnick, Victoria Lynch, and Caitlin Carroll. 2013. *Documentation on the Urban Institute's American Community Survey-Health Insurance Policy Simulation Model (ACS-HIPSM).* Washington, DC: Urban Institute. http://www.urban.org/publications/412841.html.

Clemans-Cope, Lisa, Genevieve M. Kenney, Matthew Buettgens, Caitlin Carroll, and Fredric Blavin. 2012. "The Affordable Care Act's Coverage Expansions Will Reduce Differences in Uninsurance Rates by Race and Ethnicity." *Health Affairs* 31 (5): 920–30. http://content.healthaffairs.org/cgi/content/abstract/31/5/920?ijkey=to7RiPsbOigAQ&keytype=ref&siteid=healthaff.

Clemans-Cope, Lisa, Genevieve M. Kenney, Matthew Buettgens, and Hannah Recht. Forthcoming. *Coverage Gains under the Affordable Care Act for Latino-Origin Groups Impacted by Undocumented Immigrants and State of Residence.* Washington, DC: Urban Institute.

Harper, Sam, and John Lynch. 2005. *Methods for Measuring Cancer Disparities: Using Data Relevant to* Healthy People 2010 *Cancer-Related Objectives.* NCI Cancer Surveillance Monograph Series, no 6. NIH Publication No. 05-5777. Bethesda, MD: National Cancer Institute. http://seer.cancer.gov/archive/publications/disparities/measuring_disparities.pdf.

Jahnke, Lauren R., Nadia J. Siddiqui, and Dennis P. Andrulis. 2014. *Marketplace Consumer Assistance Programs and Promising Practices for Enrolling Racially and Ethnically Diverse Communities.* Austin: The Texas Health Institute. http://www.texashealthinstitute.org/uploads/1/3/5/3/13535548/thi-tsff_aca_marketplace_equity_report_05.22.2014.pdf.

Kanchinadam, Keerti, and Joanne Jee. 2014. *Early State Experiences with the First Open Enrollment under the Affordable Care Act.* Princeton, NJ: Robert Wood Johnson Foundation. http://www.maxenroll.org/files/maxenroll/resources/early.state.experiences.with.first.open.enrollment.under.ACA.pdf.

Kenney, Genevieve M., Stephen Zuckerman, Lisa Dubay, Michael Huntress, Victoria Lynch, Jennifer Haley, and Nathaniel Anderson. 2012. *Opting In to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?* Washington, DC: Urban Institute. http://www.urban.org/publications/412630.html.

Long, Sharon K., and Dana Goin. 2014. *Large Racial and Ethnic Differences in Health Insurance Literacy Signal Need for Targeted Education and Outreach.* Washington, DC: Urban Institute. http://hrms.urban.org/briefs/literacy-by-race.html.

Scanlan, James P. 2013. "Measuring Health and Healthcare Disparities." 2013 Research Conference of the Federal Committee on Statistical Methodology. http://fcsm.sites.usa.gov/files/2014/05/J4_Scanlan_2013FCSM.pdf.

Turner, Joanna, and Michel Boudreaux. 2010. "Health Insurance Coverage in the American Community Survey: A Comparison to Two Other Federal Surveys." In *Databases for Estimating Health Insurance Coverage for Children: A Workshop Summary.* Washington, DC: National Academies Press.

Urban Institute. 2010. *The Urban Institute's Health Microsimulation Capacities.* Washington, DC: Urban Institute. http://www.urban.org/publications/412154.html.

About the Authors

Lisa Clemans-Cope is a senior research associate in the Health Policy Center at the Urban Institute. Her areas of expertise include health insurance reform legislation and regulation, Medicaid and the Children's Health Insurance Program (CHIP), dual health spending, access to and use of health care, private insurance, eligibles health-related survey data, and Medicaid claims data. Her current work includes quantitative and qualitative analyses of federal and state implementation of the Affordable Care Act, and an evaluation of children's access to and use of health services in CHIP. Clemans-Cope has a BA in economics from Princeton University and a PhD in health economics from the Johns Hopkins Bloomberg School of Public Health.

Matthew Buettgens is a senior research analyst in the Health Policy Center at the Urban Institute, where he is the mathematician leading the development of Urban's Health Insurance Policy Simulation Model (HIPSM). The model is currently being used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington as well as to the federal government. His recent work includes a number of research papers analyzing various aspects of national health insurance reform, both nationally and state-by-state. Research topics have included the costs and coverage implications of Medicaid expansion for both federal and state governments; small firm self-insurance under the Affordable Care Act and its effect on the fully insured market; state-by-state analysis of changes in health insurance coverage and the remaining uninsured; the effect of reform on employers; the affordability of coverage under health insurance exchanges; and the implications of age rating for the affordability of coverage. Buettgens was previously a major developer of the Health Insurance Reform Simulation Model—the predecessor to HIPSM—used in the design of the 2006 Roadmap to Universal Health Insurance Coverage in Massachusetts.

Hannah Recht is a research assistant in the Health Policy Center at the Urban Institute, where she works with the Health Insurance Policy Simulation Model to predict and analyze the effects of the Affordable Care Act. Her recent work has included providing technical assistance for New York State, state-level analysis of the current uninsured, an examination of children in complex coverage situations, and the implications of

Medicaid expansion. Recht received her BA in mathematics and statistics from the University of Rochester.

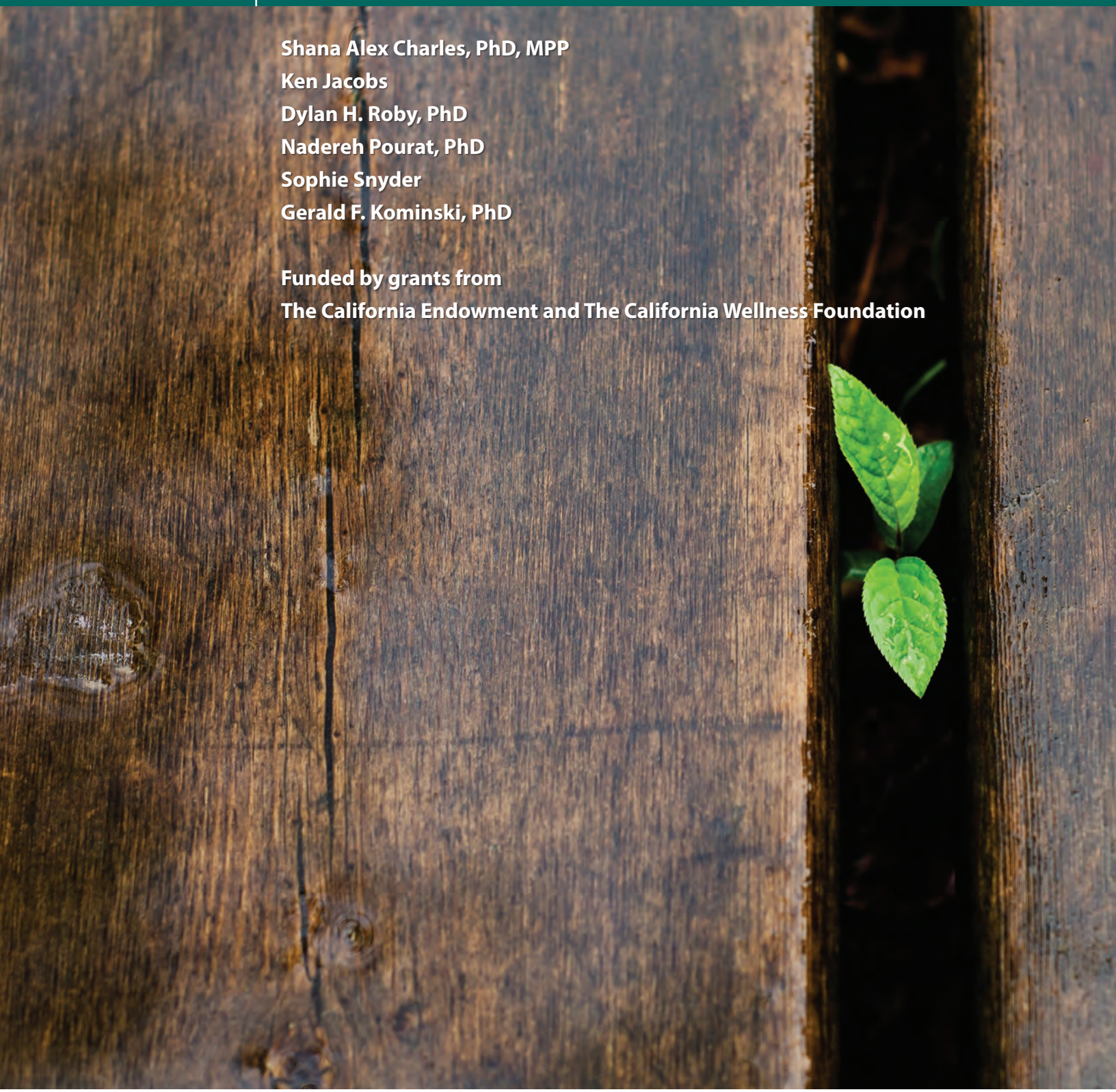
2100 M Street NW
Washington, DC 20037

www.urban.org

December 2014

The State of Health Insurance in California:

Findings from the 2011/2012 California Health Interview Survey



Shana Alex Charles, PhD, MPP
Ken Jacobs
Dylan H. Roby, PhD
Nadereh Pourat, PhD
Sophie Snyder
Gerald F. Kominski, PhD

Funded by grants from
The California Endowment and The California Wellness Foundation

UCLA CENTER FOR HEALTH POLICY RESEARCH

December 2014

The State of Health Insurance in California:

Findings from the 2011/2012 California Health Interview Survey

Shana Alex Charles, PhD, MPP
Ken Jacobs
Dylan H. Roby, PhD
Nadereh Pourat, PhD
Sophie Snyder
Gerald F. Kominski, PhD

The UCLA Center for Health Policy Research is based in the UCLA School of Public Health and affiliated with the UCLA Luskin School of Public Affairs.

www.healthpolicy.ucla.edu

Funded by grants from The California Endowment and The California Wellness Foundation

The views expressed in this report are those of the authors and do not necessarily represent the UCLA Center for Health Policy Research, the Regents of the University of California, The California Endowment, or The California Wellness Foundation.

Suggested Citation:
Charles SA, Jacobs K, Roby DH, Pourat N, Snyder S, Kominski GF. The *State of Health Insurance in California: Findings from the 2011/2012 California Health Interview Survey*. Los Angeles, CA: UCLA Center for Health Policy Research, 2014.

CHIS california health interview survey

www.chis.ucla.edu

This study and report were funded by grants from The California Endowment and The California Wellness Foundation. The report is based on data from the 2011/2012 California Health Interview Survey, which was supported by funds received from The California Department of Health Care Services; The California Department of Public Health; The California Endowment; First 5 California; the California Department of Mental Health; the California Office of the Patient Advocate; Kaiser Permanente; the San Diego County Health and Human Services Agency; the Blue Shield of California Foundation; the California Wellness Foundation; the Archstone Foundation; the Centers for Disease Control; and the United American Indian Involvement, Inc./CA Indian Health Services.

UCLA CENTER FOR HEALTH POLICY RESEARCH

The UCLA Center for Health Policy Research is based in the UCLA School of Public Health and affiliated with the UCLA Luskin School of Public Affairs.

www.healthpolicy.ucla.edu

Foreword

Ninez Ponce

The implementation of the Patient Protection and Affordable Care Act of 2010 (ACA) signifies a historic period in this country. Social and economic swings have affected coverage trends throughout the years, but the shift that is occurring under the ACA's mandate that all citizens obtain health care coverage is a massive one. The implications of the law will be personal, economic, social, and societal, from our individual health and health care spending, to public health, to funding for government programs, to coverage for those who have previously lacked health insurance.

Since 2001, this biennial report has documented the challenges facing Californians in securing health care insurance for themselves and their families. During the compilation of this year's report, California has been implementing this major shift in health care policy, the many effects of which will play out over years. There will be short-term implications in the number of people able to seek care, but coverage is only one piece of the overall puzzle. Millions of newly insured people need access to health care services, and states must find the workforce to meet this increased demand and facilitate timely access to services.

Both the intended and unintended consequences of the law will unfold over time. Whether the long-term goals of a healthier nation and lower heath care spending are met will take years to track and understand.

In this respect, the *2011-2012 State of Health Insurance in California (SHIC)* report is our most important volume yet. The data from this report will serve as the baseline against which we will measure the change – and ultimately the success or failure – of state policies specifically, and of the ACA in general. New programs have been rolled out across the U.S. as well as here in California, but over several years there may be minor adjustments or major policy changes as new challenges created by the law are identified, along with new ways to meet the ultimate goal of better health and health care for everyone. It is therefore critical that we have a good foundation and a valuable instrument for trending the changes over time at a granular level in order to understand what works and what does not, and which populations may be lagging behind in realizing the benefits of health care coverage.

While the California Health Interview Survey (CHIS) was born of the desire to have better health insurance coverage estimates at the local level and for ethnic subgroups, this rich data source captures critical information not available anywhere else. While institutional data are wonderful for understanding the needs of people who have received treatment or preventive measures, survey data are needed to identify those who are still not receiving medical attention, as well as to illuminate the reasons for delayed or forgone care. Health insurance coverage for all is a major advancement in public health. Nevertheless, it is only when all Americans take advantage of prevention programs, seek medical attention when they first need it, and can afford to utilize ongoing management programs that we can truly improve our global health ranking.

Building on a Foundation

We begin this report, the foundation of our future evaluations of the ACA, with a memorial to our founder, Dr. E. Richard Brown, who passed away suddenly in April 2012. In addition to his sought-after expertise in teaching, research, and policy analysis, his vision for engaging the public and policymakers in health care reform fueled his creation of the UCLA Center for Health Policy Research, the California Health Interview Survey, and this report. He set a high standard for quality data and information to drive evidence-based policy aimed at improving the health of all Californians. The authors of this report are proud to build on his legacy.

Table of Contents

List of Exhibits

EXECUTIVE SUMMARY

Chapter 1: Health Insurance Prior to the Affordable Care Act Expansions

The health insurance trends in 2011/12 were illustrative of a unique transition period between the Great Recession and the Patient Protection and Affordable Care Act (ACA). During these years, many individuals remained uninsured or dependent on employment-based insurance coverage. Insurance coverage patterns were distinct across age groups and regions in California. Notably, a major health insurance expansion provision of the ACA was enacted early on: the ACA enabled young adults up to age 26 to enroll in a parent's private plan as a dependent. This early enactment gave rise to noticeable changes in coverage within this age group that signify the impact of the ACA.

- Employment-based coverage insured just under half of all nonelderly adults and children (49.1%, or 15.96 million) in 2012. Employment-based insurance among young adults ages 19-26 jumped from 23.2% in 2009 to 27.1% in 2012. This age group also experienced the largest drop in the uninsurance rate, from 28.9% in 2009 to 26% in 2012.
- More than one in five nonelderly Californians were uninsured for all or part of the past year (21.3%, or 6.91 million) in 2012; nearly half of the uninsured were in full-time working families. Latinos remain the group with the highest rate of uninsurance (28.4%) and the lowest rate of job-based coverage (33.9%).
- Medi-Cal, combined with Healthy Families, insured one-fifth of all nonelderly Californians in 2012 (19.7%, or 6.41 million).
- Los Angeles County continues to be home to the highest number of uninsured in the state, with 2.13 million nonelderly residents uninsured for all or part of the year in 2012.

Chapter 2: Employment-Based Coverage and the Individual Market

Employment-based coverage remains the central source of coverage for Californians under the age of 65; however, fewer individuals had coverage through their employer in 2012 than in 2009. The decline in employment-based coverage (both own and dependent coverage) varied by age, race, citizenship status, education, family income, and hourly wage. The rate of job-based coverage also varied by region of the state and firm size.

Several ACA provisions are expected to influence rates of employment-based and non-group insurance coverage. In 2014, low-income families without

an affordable offer of employment-based coverage became eligible for premium subsidies in the individual market. Also, insurance companies could no longer discriminate against individuals based on health status or pre-existing conditions. Finally, small businesses gained the option of purchasing coverage through the SHOP (Small Business Health Options Program) exchange.

- In 2012, 63.6% of full-time workers had employment-based coverage, compared to 66.5% in 2009. Part-time workers also experienced a decline in coverage, from 41.8% in 2009 to 39.6 % in 2012.
- An estimated 16.6% of workers with family incomes below 138% of the Federal poverty level (FPL) had coverage through their own employer, compared to 62.7% of those with family incomes above 400% of the FPL.
- Employer-based dependent coverage rose between 2009 and 2012 for 19-25-year-olds (from 13.6% to 16.7%), but fell for all other age groups.
- Workers in large firms (1,000 or more employees) were more likely to have employment-based coverage than those in firms with 10 to 50 employees (80.2%, compared to 46.1%) in 2012. About 38% of workers in the smallest firms were uninsured for all or part of the year, and 10.0% were enrolled in Medi-Cal or Healthy Families.
- Most Californians who did not take up offers of employment-based coverage had coverage through another source (52.1%).
- Self-employed individuals were the most likely to purchase coverage in the individual market (15%), and they were more likely to be uninsured (40%) than those who worked for an employer.

Chapter 3: Transitions in Medi-Cal, Healthy Families, and Medicare

Public insurance in California changed considerably in 2011 and 2012, facilitated by: 1) partial implementation of the Affordable Care Act (ACA), and 2) movement to Medi-Cal managed care plans for seniors and persons with disabilities in 16 counties. In this section, we focus on the changes in public insurance coverage and characteristics that occurred in 2012, while also looking forward to expected changes related to the ACA and other reforms to the state's health care system.

- In 2012, 34.4% of children were enrolled in Medi-Cal for the entire year, compared to 26.7% in 2009. The percentage of children who were uninsured for all or part of the year fell by 15% between 2009 and 2012, from 9.9% to 8.6%.
- The most rural areas of the state, including the Central Valley, Northern Sierras, and Imperial County, had the highest proportion of nonelderly people in Medi-Cal or Healthy Families, with more than 27% of the nonelderly population enrolled all year. Coastal areas had lower levels of enrollment, with San Luis Obispo and Orange counties and the Bay Area having the lowest rates (less than 15% of the nonelderly population).
- Latinos comprised more than two-thirds of the children enrolled in Medi-Cal, with other non-white minorities representing 18.9% of child beneficiaries. However, the adult Medi-Cal population had a much higher proportion of non-Latino whites (20.7% ages 19-64, and 26.6% ages 65 and over).
- Fully 23.1% of elderly adult Medi-Cal beneficiaries were Asian or Pacific Islander, more than twice the Asian/PI percentage in the nonelderly adult population and three times the percentage in the child population.

- Almost two-thirds of the Medicare beneficiary population ages 65 and over were non-Latino white, with only 15.9% Latino, 10.2% Asian/PI, and 5.8% African-American. As the near-elderly population ages and demographic shifts occur throughout the next decade, it is likely that Latinos will become a larger part of the Medicare population.

Chapter 4: The Role of Insurance in Access to Care

Access to care varies by type of insurance due to variations in benefits and cost-sharing levels. Health insurance is associated not only with higher rates of important preventive services such as flu shots, but also with higher rates of emergency room (ER) use. Preventive services and visits also vary by whether or not an individual has a high-deductible plan. Racial/ethnic disparities in access frequently persist despite having health insurance.

Some of the challenges due to variations in insurance coverage will be addressed by provisions of the ACA. Starting in 2014, all plans in California, including high-deductible plans, must have standard benefits and cover preventive care and some primary care services without applying either a copayment or deductible, in compliance with the ACA.

- Among adults, those who were uninsured all year (52%) were most likely to be without a usual source of care in 2012, and those with employment-based coverage all year (8.6%) were least likely to be without a usual source of care.
- Among adults, the rates of emergency room visits in 2012 were lowest for those uninsured all year (12.1%) and highest for those with Medi-Cal or Healthy Families (32.3%).
- Adults without insurance all year (19.7%) were most likely to report having forgone or delayed needed medical care due to cost or lack of insurance, followed by adults who were uninsured part of the year (23.8%) in 2012.
- Among adults with employment-based coverage, Latino (10.6%) and Asian American/Pacific Islander adults (10.3%) reported no usual source of care more frequently than white adults (7.2%) in 2012.

1 Health Insurance Prior to the Affordable Care Act Expansions

Shana Alex Charles

With the Great Recession ending, California saw two years of strong employment growth in 2011 and 2012. In January 2011, the unemployment rate peaked at 12.5%.[1] By December 2012, the unemployment rate had declined markedly, to 9.8%.[2] Clearly, the job market was enabling more families to go back to work. However, data from the 2011/12 California Health Interview Survey (CHIS) indicate employment-based coverage insured just under half of all nonelderly adults and children (49.1%, or 15.96 million; Exhibit 1), and more than one in five nonelderly Californians were uninsured for all or part of the past year (21.3%, or 6.91 million). This snapshot of health insurance patterns in 2011/12, prior to the Patient Protection and Affordable Care Act (ACA) expansions of 2014, underscores the very real needs that existed under a mainly employment-based coverage system that had reached its limits.

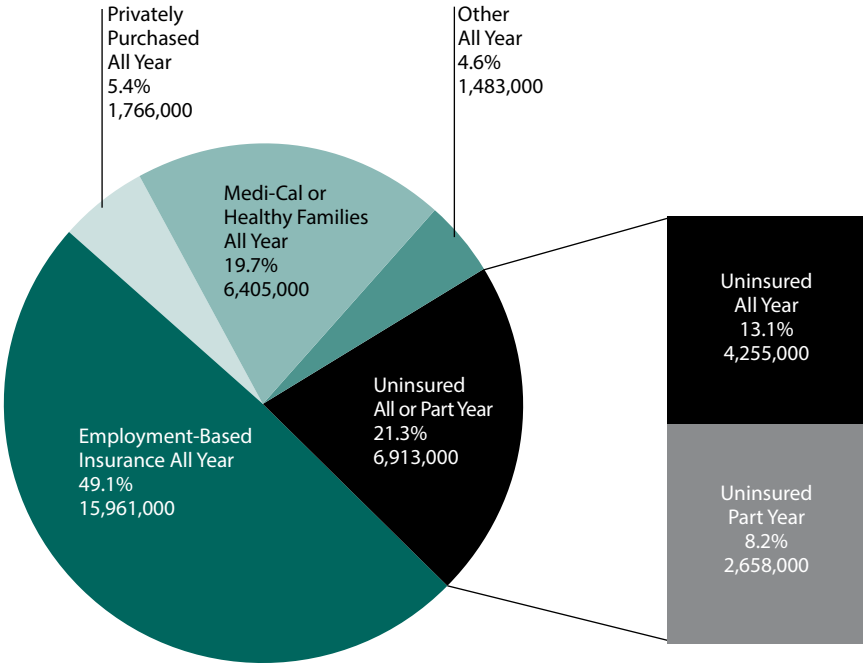
Prior to the expansion of Medi-Cal to include low-income nonelderly adults without children, the program, combined with Healthy Families, already insured one-fifth of all nonelderly Californians in 2012 (19.7%, or 6.41 million; Exhibit 1). Other types of public coverage accounted for 4.6% (1.48 million) of nonelderly adults and children. The individually purchased market languished at only 5.4% (1.77 million) of the total nonelderly population.

Without access to either private or public coverage, 21.3% of nonelderly Californians, or 6.91 million people, were uninsured at some point in 2012 (Exhibit 1). This included the 13.1% (4.26 million) who had no coverage for all of the year, and the additional 8.2% (2.66 million) who had coverage for only part the year.

1 California Employment Development Division (EDD) data. Accessed at *www.edd.ca.gov*, on 3/19/14.

2 California EDD, 2014.

Exhibit 1.
Health Insurance Coverage During Last 12 Months Among Nonelderly Persons, Ages 0-64, California, 2012



Notes: "Other All Year" includes public health insurance programs that are not Medi-Cal or Healthy Families (including Access for Infants and Mothers {AIM} and Medicare, for example) and any combination of insurance types during the past year without a period of uninsurance.

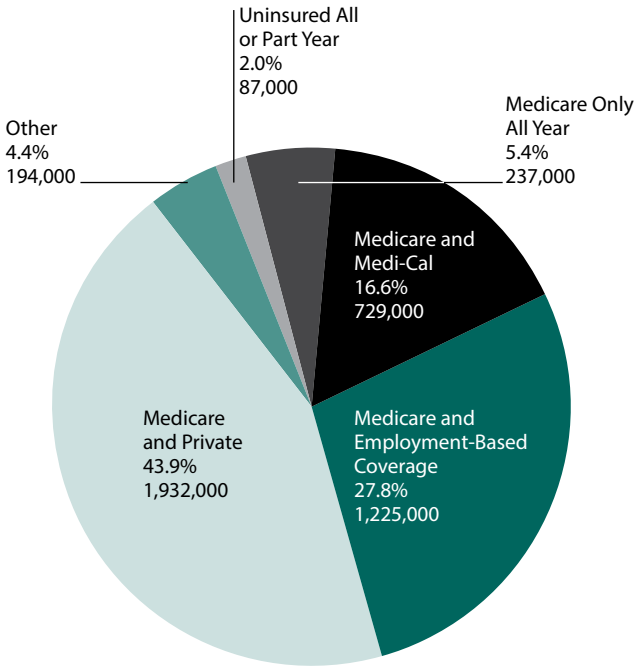
Numbers may not add up to 100% because of rounding.

Source: 2011/12 California Health Interview Survey

Health insurance patterns among adults ages 65 and older starkly contrast with patterns among their younger counterparts, with only 2% (87,000) of older adults experiencing uninsurance for some part of 2012 (Exhibit 2). Fully 94% of all elderly persons in California had some form of Medicare, ranging from 5% (237,000) with only Medicare coverage to 44% (1.93 million) with both Medicare and private supplemental coverage.

"Medicare and Private" also includes those who were enrolled in a Medicare HMO through Medicare Part C, also called the Medicare Advantage program, along with those who had a private Medicare supplement. About one-sixth of the elderly (17%, or 729,000) were dually enrolled in both Medicare and Medi-Cal due to living in a low-income household, and an additional one-quarter (28%, or 1.23 million) had coverage through both Medicare and their own or a spouse's employment.

Exhibit 2.
Type of Medicare Coverage During Last 12 Months Among Elderly Adults, Ages 65 and Older, California, 2012



Notes: "Other All Year" includes public health insurance programs that are not Medi-Cal or Healthy Families (including Access for Infants and Mothers {AIM} and the Managed Risk Medical Insurance Program {MRMIP}, for example) and any combination of insurance types during the past year without a period of uninsurance.

Numbers may not add up to 100% because of rounding.

Source: 2011/12 California Health Interview Survey

Young Adults Gained Job-Based Health Insurance from 2009 to 2012

The Affordable Care Act (ACA) enabled young adults up to age 26 to enroll in a parent's private plan as a dependent, regardless of student status or whether they lived in the same household. This key health insurance expansion provision took effect for new policies after September 2010, six months after the ACA was signed into law.

The early effects of allowing dependent enrollment of young adults in their parents' plans could already be seen by 2012. Employment-based insurance among young adults ages 19-26 jumped from 23.2% in 2009 to 27.1% in 2012 (Exhibit 3), corresponding to an increase of 254,000 insured people. In stark contrast, no other age group had any gains in employment-based coverage. In fact, significant drops in employment-based coverage could be seen among those ages 0-11 (44.7% to 40.0%), ages 40-54 (49% to 45.4%), and ages 55-64 (55.2% to 50.4%; Exhibit 3). Young adults ages 19-26 experienced the largest drop in the uninsurance rate, from 28.9% in 2009 to 26% in 2012.

Exhibit 3.
Health Insurance Coverage During Last 12 Months by Age Among Nonelderly Persons, Ages 0-64, California, 2012

		HEALTH INSURANCE STATUS DURING PREVIOUS 12 MONTHS							
Age Group (In Years)	**Year**	**Uninsured All Year**	**Uninsured Part Year**	**Uninsured All or Part Year**	**Employment-Based Coverage All Year**	**Privately Purchased All Year**	**Medi-Cal or Healthy Families All Year**	**Other All Year**	**Total**
0 - 11	**2009**	157,000 2.3%	344,000 5.0%	501,000 7.3%	3,083,000 44.7%	251,000 3.6%	2,261,000 32.8%	302,000 4.4%	6,899,000 100.0%
	2012	130,000 2.0%	308,000 4.8%	438,000 6.8%	2,576,000 40.0%	197,000 3.1%	2,598,000 40.3%	198,000 3.1%	6,445,000 100.0%
12-18	**2009**	221,000 4.7%	322,000 6.8%	543,000 11.4%	2,151,000 45.4%	216,000 4.6%	1,111,000 23.4%	179,000 3.8%	4,743,000 100.0%
	2012	185,000 5.0%	215,000 5.8%	400,000 10.7%	1,712,000 45.8%	224,000 6.0%	1,287,000 34.4%	113,000 3.0%	3,736,000 100.0%
19-26	**2009**	833,000 14.3%	855,000 14.6%	1,688,000 28.9%	1,356,000 23.2%	397,000 6.8%	410,000 7.0%	305,000 5.2%	5,844,000 100.0%
	2012	831,000 14.0%	710,000 12.0%	1,541,000 26.0%	1,610,000 27.1%	380,000 6.4%	576,000 9.7%	285,000 4.8%	5,933,000 100.0%
27-39	**2009**	1,162,000 13.8%	784,000 9.3%	1,947,000 23.1%	3,377,000 40.0%	281,000 3.3%	562,000 6.7%	323,000 3.8%	8,436,000 100.0%
	2012	1,238,000 14.5%	715,000 8.4%	1,953,000 22.9%	3,275,000 38.4%	295,000 3.5%	803,000 9.4%	239,000 2.8%	8,518,000 100.0%
40-54	**2009**	1,254,000 12.8%	541,000 5.5%	1,795,000 18.3%	4,819,000 49.0%	441,000 4.5%	635,000 6.5%	341,000 3.5%	9,826,000 100.0%
	2012	1,311,000 13.9%	505,000 5.4%	1,816,000 19.3%	4,279,000 45.4%	391,000 4.1%	781,000 8.3%	350,000 3.7%	9,433,000 100.0%
55-64	**2009**	436,000 9.4%	162,000 3.5%	598,000 13.0%	2,545,000 55.2%	306,000 6.6%	280,000 6.1%	287,000 6.2%	4,614,000 100.0%
	2012	561,000 11.3%	204,000 4.1%	765,000 15.4%	2,508,000 50.4%	280,000 5.6%	361,000 7.3%	298,000 6.0%	4,977,000 100.0%

Notes: "Other All Year" includes public health insurance programs that are not Medi-Cal or Healthy Families (including Access for Infants and Mothers {AIM} and the Managed Risk Medical Insurance Program {MRMIP}, for example) and any combination of insurance types during the past year without a period of uninsurance.

Numbers may not add up to 100% because of rounding.

Data from 2009 have been adjusted to match the CHIS 2011/12 cell phone/landline household sampling frame, in order to increase comparability of the point estimates.

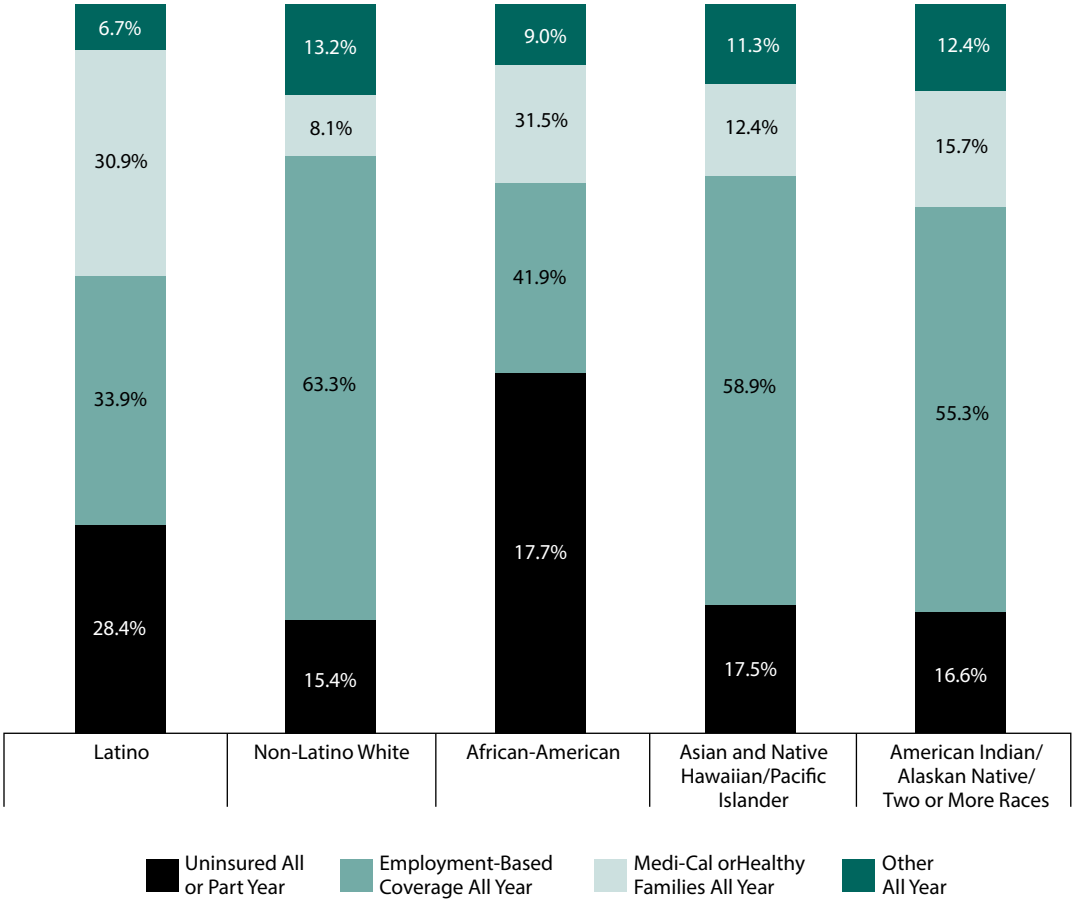
Source: 2011/12 California Health Interview Survey, adjusted 2009 California Health Interview Survey

More nonelderly Californians qualified for public programs due to ongoing loss of household income, which led to increases in Medi-Cal or Healthy Families coverage in every age group between 2009 and 2012 (Exhibit 3). Young children had the largest increase in public coverage, from 32.8% in 2009 to 40.3% in 2012. These data underscore the fundamental importance of public programs as a safety net in hard economic times, as these gains occurred prior to the expansion of Medi-Cal in 2014 (see Exhibit 8, below) to all households with incomes below 138% of the Federal poverty level (FPL).[3]

When we examine health insurance coverage by racial and ethnic group, Latinos remained the group with the highest rate of uninsurance (28.4%) and the lowest rate of job-based coverage (33.9%; Exhibit 4). Latinos' rate of public coverage (30.9%) was similar to that of African-Americans (31.5%), but nearly four times that of the non-Latino white population (8.1%).

3 In 2014, the federal poverty level was $11,670 for a one-person household, $15,730 for a two-person household, $19,790 for a three-person household, and so forth.

Exhibit 4.
Health Insurance Coverage During Last 12 Months by Race/Ethnicity Among Nonelderly Persons, Ages 0-64, California, 2012



Notes: The category "Other Single or Multiple Race" has been omitted from the exhibit.

Numbers may not add up to 100% because of rounding.

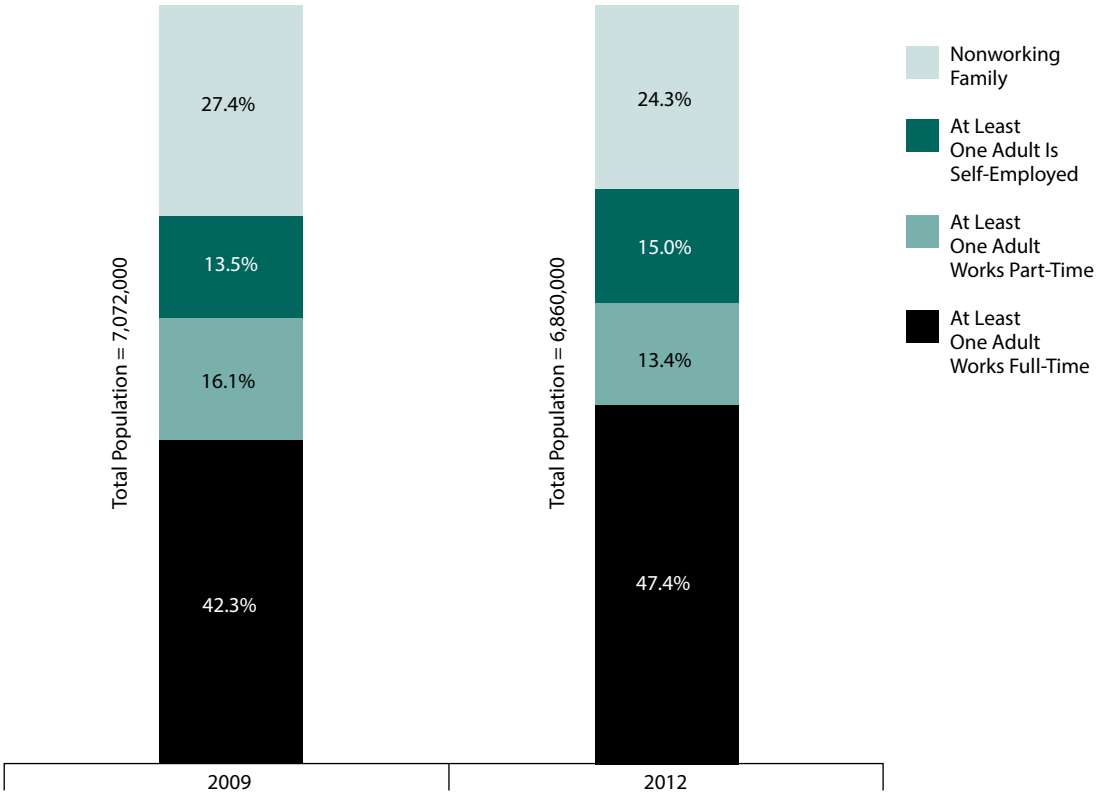
Source: 2011/2012 California Health Interview Survey

Nearly Half of the Uninsured in 2012 Were in Full-Time Working Families

The increase from 2009 to 2012 in employment-based insurance among young adults stands in contrast to the increasing rate of full-time workers among the uninsured. While many people returned to work by the end of 2012,[4] the jobs that returned did not necessarily bring health insurance benefits along with them. In 2009, roughly 4 in 10 nonelderly uninsured (42.3%) were in families that had at least one full-time worker (Exhibit 5). In 2012, nearly half of the uninsured were in full-time working families (47.4%). The percentage of the uninsured in nonworking families dipped to 24.3% in 2012, down from 27.4% in 2009 (Exhibit 5).

4 Unemployment declined to 9.8% by December 2012, according to California Employment Development Division (EDD) data. Accessed at *www.edd.ca.gov* on 3/19/14.

Exhibit 5.
Family Work Status Among Nonelderly Persons Who Were Uninsured During the Past 12 Months, Ages 0-64, California, 2009-2012



Notes: Data from 2009 have been adjusted to match the CHIS 2011/12 cell phone/landline household sampling frame in order to increase comparability of the point estimates.

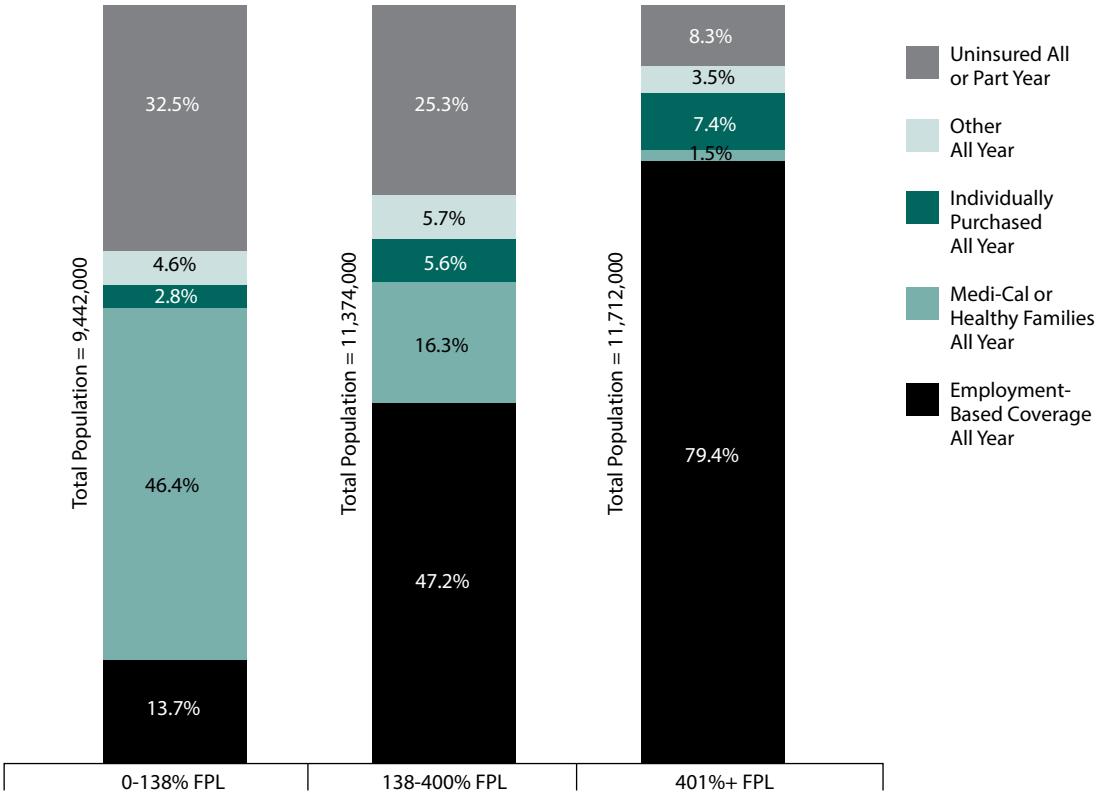
Numbers may not add up to 100% because of rounding.

Source: 2011/12 California Health Interview Survey, adjusted 2009 California Health Interview Survey

Nearly 6 Million Low- and Middle-Income Californians Were Uninsured in 2012

The Medi-Cal expansion will help a wide swath of the 9.44 million low-income nonelderly Californians, as one-third remained uninsured in 2012 (32.5%; Exhibit 6). Less than half of California's low-income nonelderly population were eligible for and enrolled in either Medi-Cal or the Healthy Families program (46.4%). Only 13.7% of this group had health insurance through their own, a parent's, or a spouse's employment.

Exhibit 6.
Health Insurance Coverage During Last 12 Months by Federal Poverty Level Among Nonelderly Persons, Ages 0-64, California, 2012



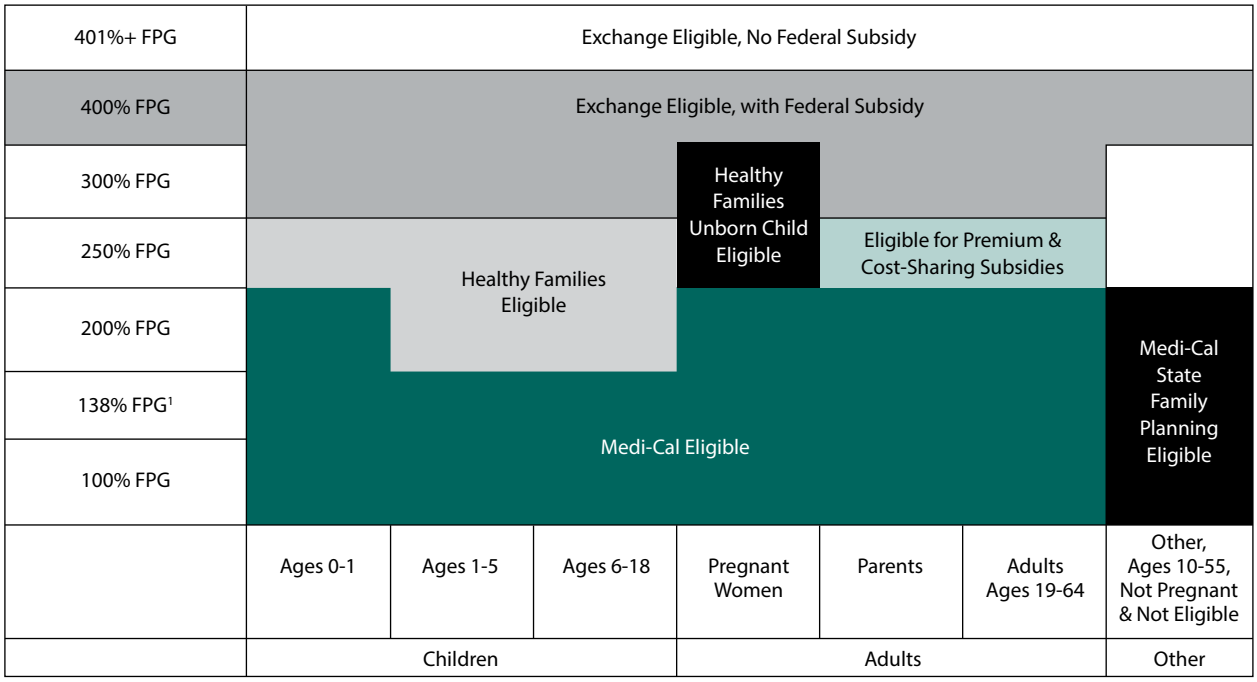
Notes: "Other All Year" includes public health insurance programs that are not Medi-Cal or Healthy Families (including Access for Infants and Mothers {AIM} and the Managed Risk Medical Insurance Program {MRMIP}, for example) and any combination of insurance types during the past year without a period of uninsurance.

Numbers may not add up to 100% because of rounding.

Source: 2011/12 California Health Interview Survey

About 11.4 million nonelderly Californians had household incomes at 138-400% FPL in 2012 (Exhibit 6). After the ACA health insurance expansions in 2014, individuals in this income group are potentially able to purchase health insurance through the new marketplace, Covered California, with a federal subsidy to help them buy coverage (Exhibit 7). Of this middle-income group, nearly half (47.2%) had employment-based insurance in 2012. One-quarter (25.3%) of the group had been uninsured for all or part of the past year (Exhibit 6).

Exhibit 7.
Medi-Cal, Healthy Families, and Exchange Eligibility According to the ACA as a Percent of Federal Poverty Guidelines (FPG), California, 2014



Note: FPG = Federal Poverty Guidelines. The poverty guidelines are a simplified version of the federal poverty thresholds used for administrative purposes—for instance, determining financial eligibility for certain federal programs.

1 There is a 5% income disregard, so the effective calculation is 138% FPG. However, 133% is the cutoff specified in the ACA.

Medi-Cal = "full scope" Medi-Cal only, excluding eligibility for the share-of-cost program.

When the health insurance expansions of 2014 are in place, millions of low- and middle-income uninsured Californians will have new options for health insurance coverage. As of April 2014, enrollment data from Covered California indicated that almost 1.4 million people had enrolled in the new private plan options, either with or without federal subsidy assistance. Additionally, nearly 2.0 million had enrolled in the newly expanded Medi-Cal program.[5]

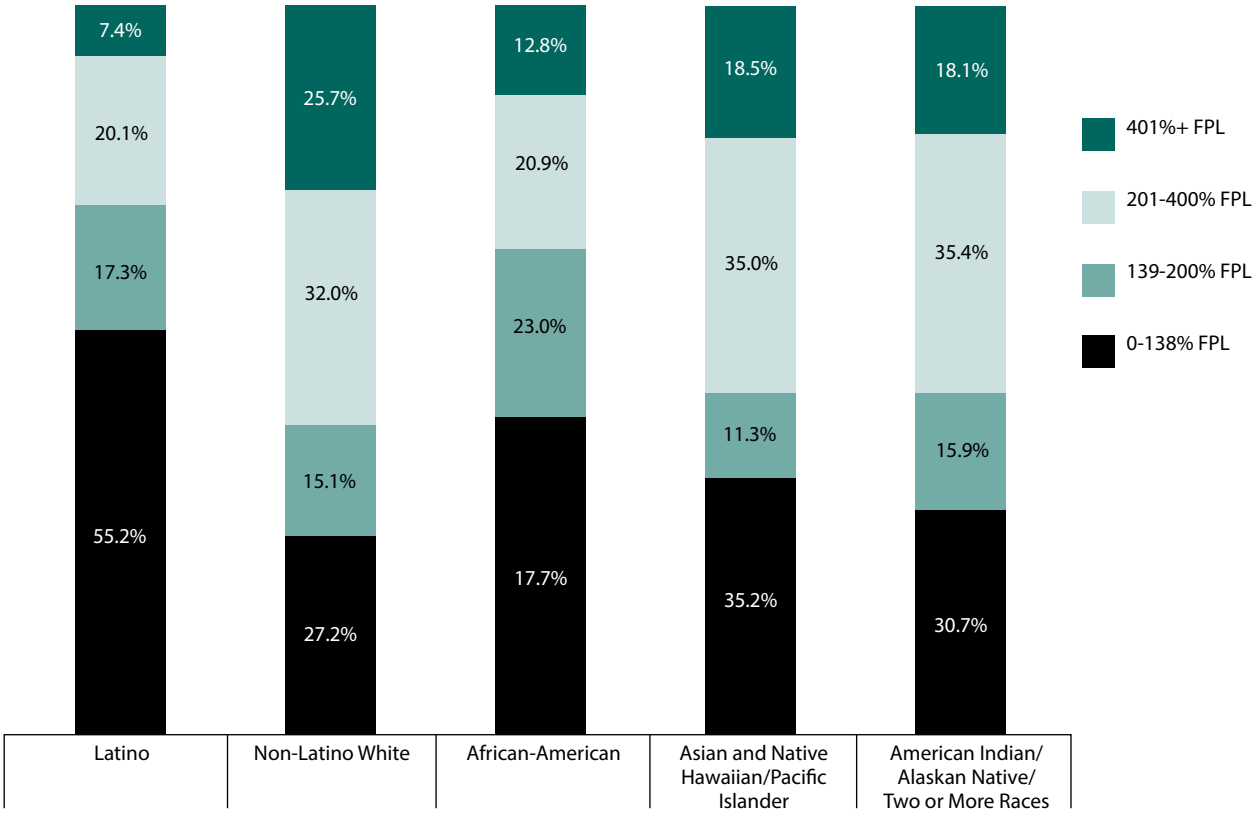
5 Covered California (2014).

Covered California's Historic First Open Enrollment Finishes with Projections Exceeded; Agents, Counselors, Community Organizations and County Workers Credited as Reason for High Enrollment in California. Covered California, Department of Health Care. Posted April 17, 2014, at *http://news.coveredca.com/2014/04/covered-californias-historic-first-open.html*.

The major expansion of public health insurance could potentially impact racial and ethnic group health disparities among the uninsured. Among uninsured Latinos in fair or poor health, 55.2% had household incomes below 138% FPL (Exhibit 8). More than four in ten (43.3%) uninsured African-Americans in fair or poor health also had household incomes that would qualify them for the Medicaid expansion. Health insurance coverage would go far to improve their access to health care and, hopefully, improve their health status over time.

Exhibit 8.

Race and Ethnicity by Poverty Level Among Nonelderly Uninsured All or Part Year and in Fair or Poor Health, Ages 0-64, California, 2012

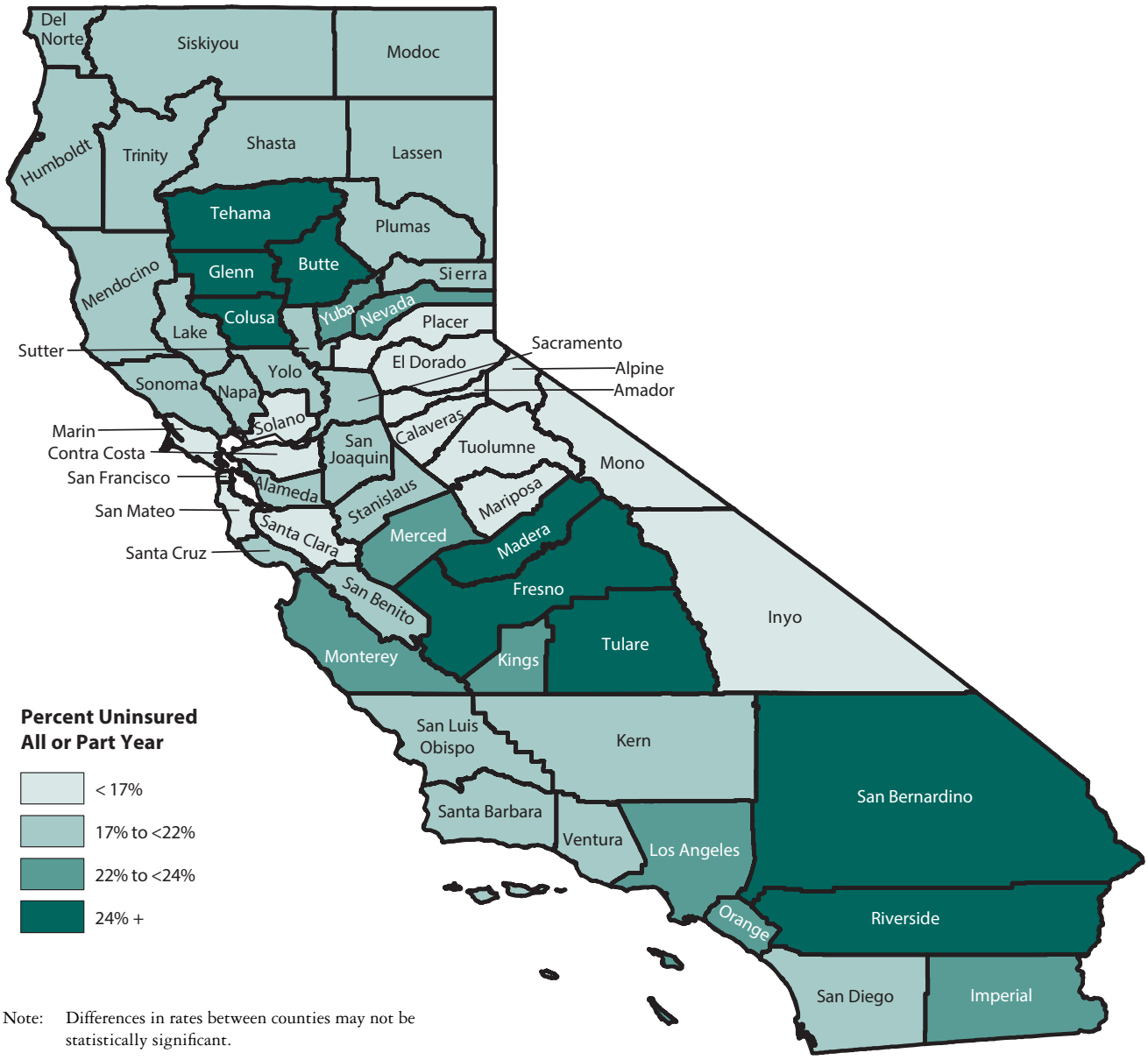


Notes: The category "Other Single or Multiple Race" has been omitted from the exhibit.

Numbers may not add up to 100% because of rounding

Source: 2011/2012 California Health Interview Survey

Exhibit 9.
Percent Uninsured by County Among Nonelderly Persons, Ages 0-64, California, 2012



Note: Differences in rates between counties may not be statistically significant.

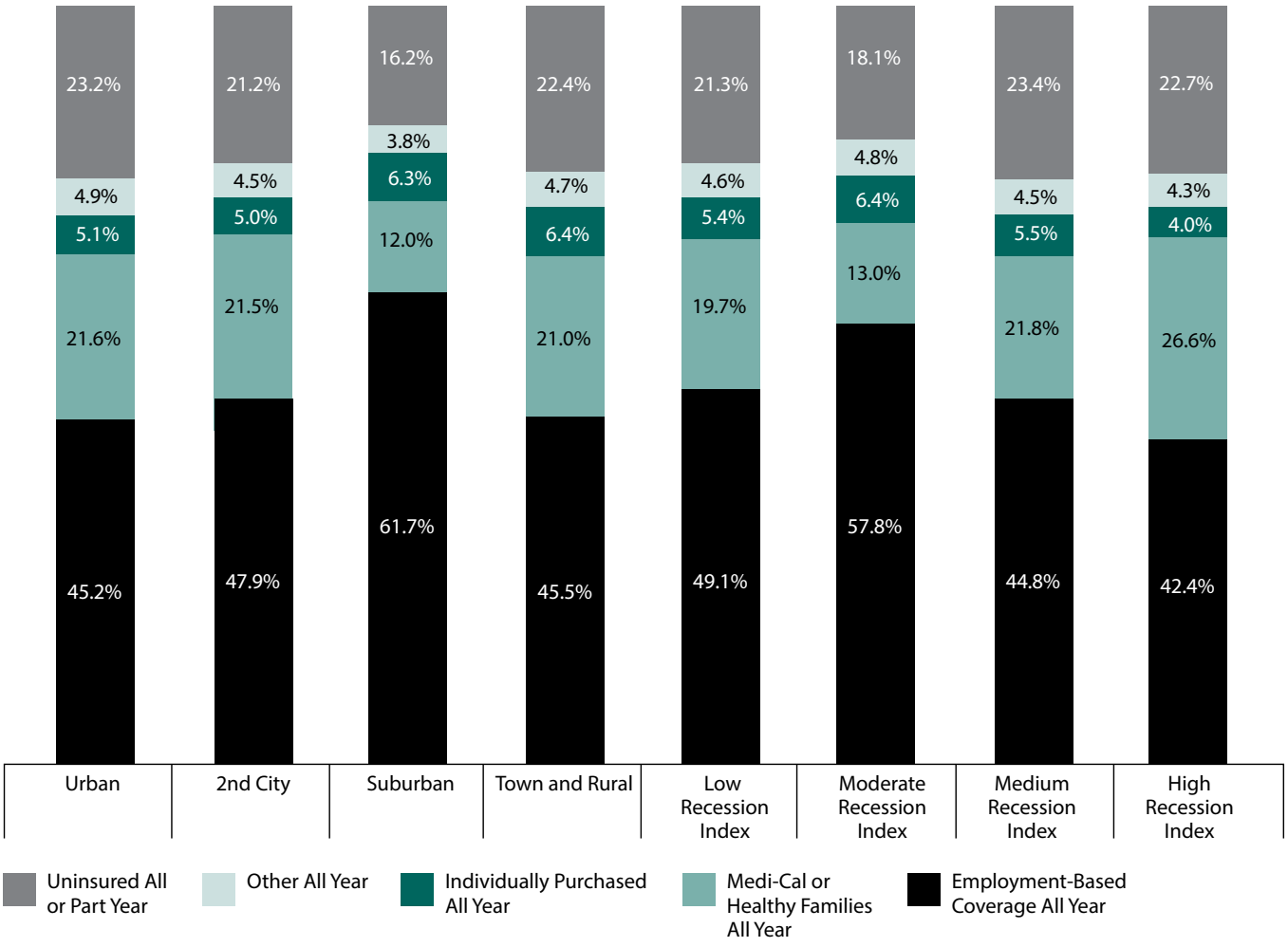
Source: 2011/12 California Health Interview Survey

High Uninsured Rates Were Spread Throughout California

Pockets of high uninsurance rates persisted throughout low-income areas of California, including Riverside and San Bernardino counties in the southern Inland Empire, Fresno and surrounding counties in the Central Valley, and Butte and nearby counties in the Northern and Mountain regions (Exhibit 9). In these counties, the number of uninsured rose to one-quarter of the nonelderly population in 2009 (data not shown) and remained at that level throughout the recession. While the Bay Area retained its status as having the lowest rates of uninsurance, the overall rates there were still higher than they had been prior to the start of the recession. Los Angeles County still had the highest number—although not the highest rate—of uninsured, with 2.13 million nonelderly residents uninsured for all or part of the prior year (data not shown).

Comparing different geographic levels of urbanization in California, suburban areas had a much higher rate of employment-based coverage (61.7%) and a lower rate of uninsurance (16.2%) than any other area (Exhibit 10). Public coverage in suburban areas was also markedly lower (12%) than in other areas, indicating that this type of coverage was not contributing to the overall lower uninsurance rate (unlike trends for the entire population across the state; see Exhibit 3 in this chapter). Health insurance coverage in suburban California stood in sharp contrast to the health insurance patterns in urban, rural, or second-city areas (i.e., an area that is less densely populated than a nearby city but still a city hub).

Exhibit 10.
Health Insurance Coverage During Last 12 Months by Urban/Rural and Recession Index Areas Among Nonelderly Persons, Ages 0-64, California, 2012



Notes: "Other All Year" includes public health insurance programs that are not Medi-Cal or Healthy Families (including Access for Infants and Mothers {AIM} and the Managed Risk Medical Insurance Program {MRMIP}, for example) and any combination of insurance types during the past year without a period of uninsurance.

Numbers may not add up to 100% because of rounding.

Source: 2011/12 California Health Interview Survey

Conclusions

Although hiring had increased by the end of 2012, the unemployment rate still remained four percentage points higher than the rate prior to the Great Recession. In addition, our data show that the jobs that returned did not necessarily bring health insurance rates back, as the overall employment-based coverage rate languished at below 50% and the percentage of the uninsured in working families increased. Among low-income nonelderly Californians, uninsurance remained at one-third of the population in 2012, regardless of the increases in public coverage as more families fell below the poverty line. California exhibits divisions along geographic lines, with suburban areas having strikingly different health insurance patterns than both the urban and rural areas of the state.

However, the data also show the clear early impact of the ACA. A single provision allowing young adults (through age 25) to either remain on a parent's coverage after graduation or to re-enroll as a dependent enabled hundreds of thousands of Californians to gain or keep health insurance. This group had the largest reduction in uninsurance compared to all other nonelderly age groups, and the change is directly attributable to the ACA.

This early success portends the changes in health insurance that will surely be seen in future CHIS data, following the ACA expansions that began in January 2014. The snapshot of health insurance in California in 2012 provided here shows just how far we have to go before the nonelderly population can reach the 2% level of uninsurance enjoyed by those ages 65 and older because of the nearly universal eligibility for Medicare among seniors.

2 Employment-Based Coverage and the Individual Market

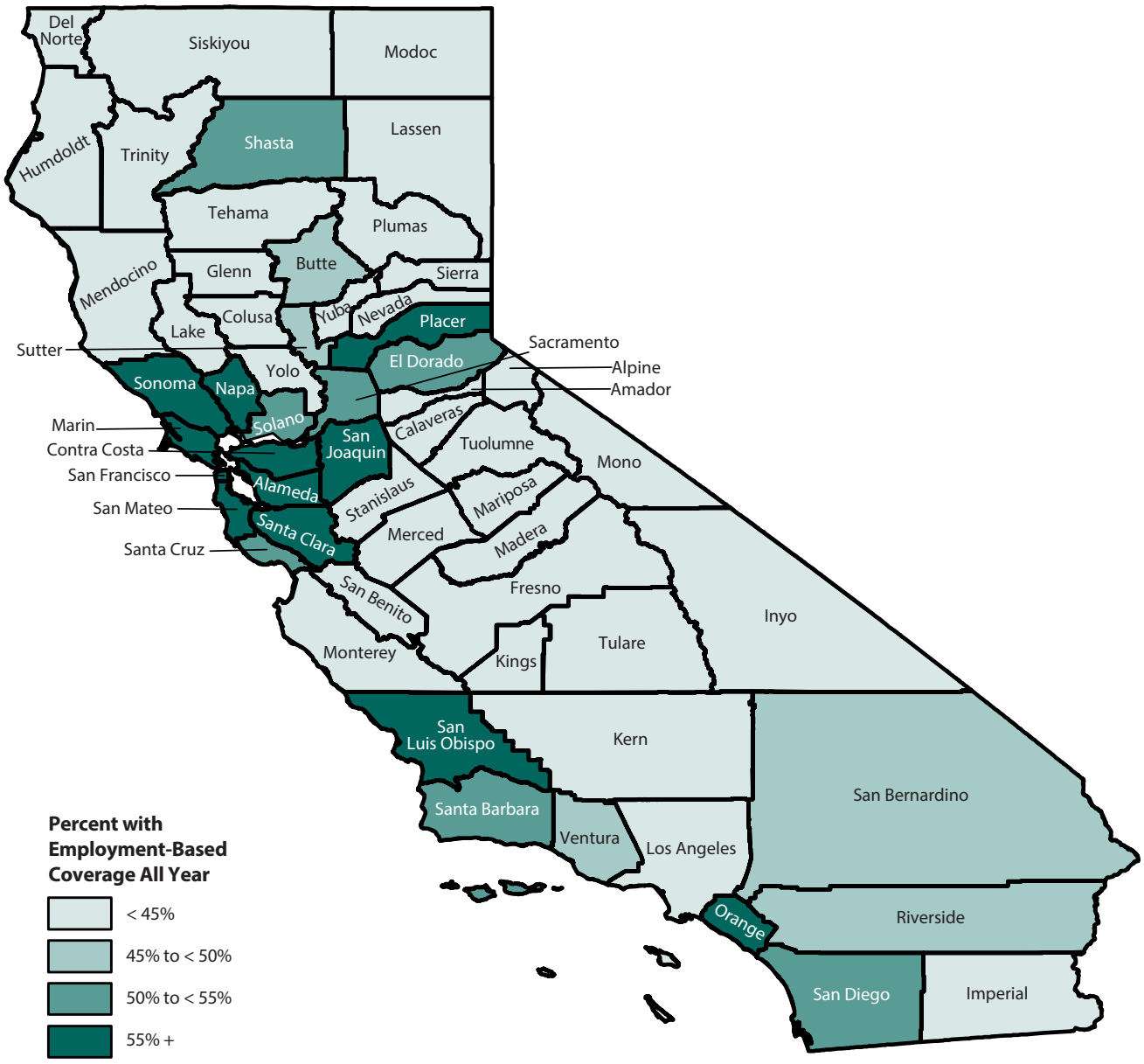
Ken Jacobs

While employment-based coverage has declined over the last decade, it remains the central source of coverage for Americans under the age of 65. As we saw in chapter 1, in 2012, 15.9 million (49.1%) Californians under the ages of 65 were covered through their own or a family member's plan throughout the entire year. This compares to the 1.8 million Californians (5.4%) who were covered by individually purchased plans.

The share of individuals with job-based coverage varied throughout the state (Exhibit 11). Coverage rates were highest in the Greater Bay Area, where more than 55% of individuals had an employment-based plan year-round in all but Solano County. Coverage rates were lowest in rural Northern and Central California counties, Los Angeles County, and the Imperial Valley, all of which had coverage rates below 45%. The county with the highest rate of individuals with year-round employment-based coverage was San Mateo, with 70.7%. The lowest rate was in Lake County, with only 26.9%. Comparing the labor markets of these two counties reveals that Lake has double the unemployment rate of San Mateo, a much smaller labor pool, and an economy that is heavily dependent on the service industry.[6]

6 California Employment Development Department (2014). Labor market statistics found at *http://www.labormarketinfo.edd.ca.gov/*, accessed on August 4, 2014.

Exhibit 11.
Percent with Employment-Based Coverage Among Nonelderly Persons, Ages 0-64, California, 2012



Note: Differences in rates between counties may not be statistically significant.

Source: 2011/2012 California Health Interview Survey

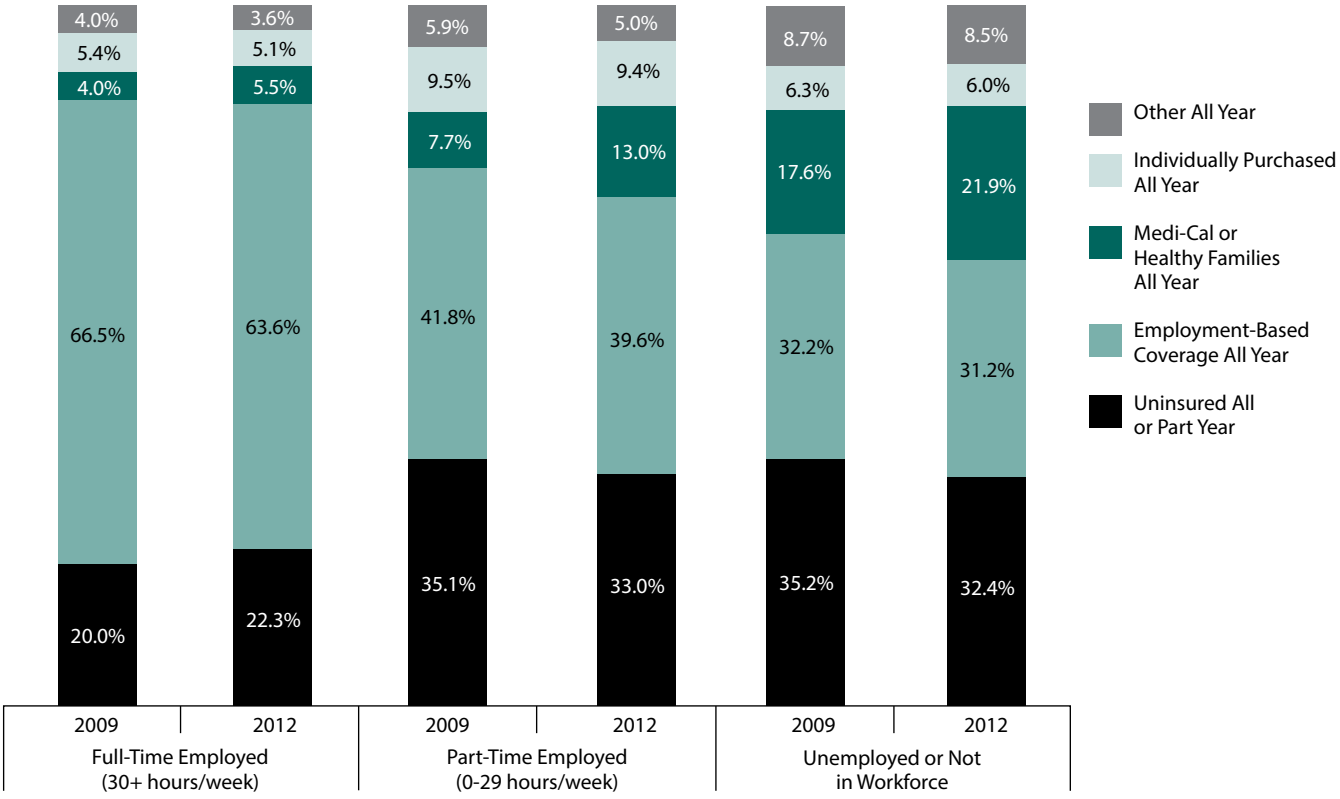
Job-Based Coverage Fell for Both Full- and Part-Time Workers

Even as the economic recovery picked up between 2009 and 2012, the share of workers with employment-based coverage declined (Exhibit 12). The decline was consistent among full-time workers, part-time workers, and the unemployed. In 2012, 63.6% of full-time workers had employment-based coverage, compared to 66.5% three years earlier. Part-time workers experienced a similar decline in coverage, from 41.8% in 2009 to 39.6 % in 2012.

While there is considerable debate on the issue, most analysts anticipate that the ACA will have a modest impact on the overall share of individuals with coverage through an employer. Coverage sources are expected to change most for lower-income workers, who will have access to significant subsidies through the new marketplaces. It will be important to measure any change against this pre-existing trend of declining job-based coverage.

On the eve of implementation of the new health insurance marketplaces under the ACA, the share of workers with individually purchased coverage remained stable, with slightly over 5% for full-time workers and 9.5% for part-timers. Part-time workers were more likely to have individually purchased coverage than adults who were unemployed or not in the workforce. The share of full-time workers uninsured all or part of the year rose from 20% to 22.3%; uninsurance among part-time workers fell from 35.1% to 33%, due mainly to increased enrollment in Medi-Cal.

Exhibit 12.
Employment-Based and Individually Purchased Insurance by Full- and Part-Time Work Status Among Nonelderly Adults, Ages 19-64, California, 2009 and 2012



Notes: Data from 2009 have been adjusted to match the CHIS 2011/12 cell phone/landline household sampling frame, in order to increase comparability of the point estimates.

Numbers may not add up to 100% because of rounding.

Sources: 2011/12 California Health Interview Survey, adjusted 2009 California Health Interview Survey

Own-Employer Coverage Rates Declined Most for Single Parents, Latinos, and Older Workers

In 2012, 7.53 million working Californians ages 19 to 64 had job-based coverage through their own employer for the full year (46.4%), compared to 7.76 million (48.2%) in 2009 (Exhibit 13). The decline in coverage varied by age, race, citizenship status, education, family income, and hourly wage, which are all strong predictors of a worker's having coverage through his/her own employer (Exhibit 13). However, it must be noted that some of the cells in this table have very small sample sizes, which could contribute to a trend's appearing larger than it actually was due to high variation in the sample.

Own-employer coverage fell among all age groups except those ages 19-25, who were much less likely to have employment-based coverage in the first place. While 56.8 % of workers ages 55-64 had coverage through their own employer in 2012, this was true of only 24.4% of workers ages 19-25.

Latino workers were significantly less likely to have coverage through their own employer (35.4%; Exhibit 13) than white (52.7%), Asian (54.1%) or African-American (55%) workers.[7] Latinos also experienced the largest drop in own-employer coverage of all racial and ethnic groups during this period. A similar story can be seen when looking at immigration status, with the largest declines in coverage between 2009 and 2012 among noncitizens.

Own-employer coverage varied significantly by educational attainment. The coverage gap between workers with a four-year college degree and the rest of the workforce grew larger. While 60.1% of individuals with a college degree had coverage through an employer in 2012, essentially unchanged from three years prior, this was true of only 26.1% of those without a high school diploma, down from 30.9% in 2009 (Exhibit 13). The employment-based health coverage advantage for those with some college compared to those with only a high school diploma disappeared. The advantage for those with a vocational education or associate degree narrowed: while the share of workers with a high school diploma who were covered on the job remained stable at 39.7%, coverage rates fell by 3 and 4 percentage points for the latter two groups, respectively.

7 Own-employer coverage rates among African-Americans have been relatively volatile in CHIS. Both CHIS and the Current Population Survey showed sharply declining coverage rates during the 2000s. Further research is warranted.

Exhibit 13.
Employment-Based Insurance, Own Coverage All Year: Rates by Demographics Among Working Nonelderly Adults, Ages 19-64, California, 2009 and 2012

	2009	2012
All Workers	48.2%	46.4%
Age		
19-25	21.4%	24.4%
26-34	47.7%	45.8%
35-44	51.6%	49.6%
45-54	54.9%	51.1%
55-64	57.6%	56.8%
Race and Ethnicity		
White	53.6%	52.7%
Latino	38.8%	35.4%
African-American	43.6%	55.0%
Asian/Native Hawaiian/Pacific Islander	54.1%	54.1%
American Indian/Alaskan Native/Two or More Races	52.5%	37.4%
Family Composition		
Single Adult	43.5%	40.8%
Single Parent	45.0%	34.0%
Married without Children	55.7%	55.3%
Married with Children	48.4%	49.9%
Citizenship and Immigration Status		
U.S. Citizen	51.6%	50.4%
Non-Citizen with a Green Card	35.2%	33.5%
Non-Citizen without a Green Card	24.8%	19.9%
Highest Level of Education		
Less Than High School	30.9%	26.1%
High School Graduate	39.6%	39.7%
Some College	42.5%	39.5%
Vocational School, AA, AS	47.7%	42.0%
College Graduate or Higher	60.9%	60.1%
Federal Poverty Level		
Less than 138% FPL	17.4%	16.6%
139-200% FPL	33.6%	29.4%
201-400% FPL	49.5%	47.2%
400%+ FPL	61.8%	62.7%
Hourly Wage		
Less than $9.00	22.0%	22.1%
$9.00-$12.99	35.9%	33.4%
$13.00-$14.99	43.9%	35.9%
$15.00-$18.99	47.7%	50.9%
$19.00-$23.99	62.5%	58.0%
$24.00 +	65.0%	65.7%

Notes: Data from 2009 have been adjusted to match the CHIS 2011/12 cell phone/landline household sampling frame, in order to increase comparability of the point estimates.

Sources: 2011/12 California Health Interview Survey, adjusted 2009 California Health Interview Survey

Family income is the strongest predictor of own-employer coverage. An estimated 16.6% of workers with family incomes below 138% of the federal poverty level (FPL) had coverage through their own employer, while 62.7% of those with family incomes above 400% of the FPL had employer-based insurance (Exhibit 13). Own-employer coverage fell the most between 2009 and 2012 for families with incomes between 138% and 400% of the FPL. As of 2014, families in this income range without an affordable offer of employment-based coverage are eligible for premium subsidies in the individual market through the ACA. Since subsidies are greatest for those with incomes below 200% of the FPL, we would expect any declines in employer-based coverage resulting from the ACA to be concentrated in this group.

Hourly wage is also a strong predictor of own-employer coverage. Only 22.1% of workers earning less than $9 per hour reported having coverage through their own employer in 2012, compared to 65.7% of those with wages above $24 an hour (Exhibit 13). Own-employer coverage rates were stable among the lowest and highest wage groups between 2009 and 2012, while falling for those in between. The biggest decline (8 percentage points) was for workers earning between $13.00 and $14.99 an hour (in 2012 dollars).

Family status was also associated with own-employer coverage. Individuals who were married without children had the highest rates of coverage through their own employer (55.3%; Exhibit 13), while single parents reported the lowest rates of own-employer coverage (34%). Coverage rates for single parents fell considerably between 2009 and 2012, from 45% to 34%.

Employment-Based Dependent Coverage Rose for 19-25-Year-Olds and Fell for All Other Age Groups

Under the ACA, adults under the age of 26 were able to stay on a parent's plan starting in 2010, regardless of whether or not they were attending college or were financially dependent on their parents. In 2009, 13.6% of those between the ages of 19 and 25, or slightly under half a million young adults, had coverage through a parent or spouse. By 2012, this percentage had increased to 16.7%, or 646,000 people (Exhibit 14). During the same time period, dependent coverage declined among all other age groups. As a result, dependent employment-based coverage through a parent or spouse fell for working-age Californians (16-64), from 13.3% to 12.2%.

As with own-employer coverage, dependent coverage varies by age, race, citizenship status, education, and family income. Non-Latino white Californians were nearly three times as likely to have coverage through a parent or spouse (17.7%; Exhibit 14) than African-Americans (6.2%) or Latinos (7.3%). Dependent coverage rates for Asians and Pacific Islanders (14.5%) were twice as high as for Latinos. U.S. citizens were much more likely to be on dependent coverage (13.1%) than non-citizens either with or without a green card (10.8% and 2.3%, respectively).

Those with a college degree or higher were much more likely to have dependent coverage (16.8%; Exhibit 14) than those with less than a high school education (4.6%). Individuals in families with incomes above 400% of the FPL were more than five times as likely to have coverage through a parent or spouse than those with incomes below 138% of the FPL (21.8% compared to 3.8%).

Exhibit 14.
Employment-Based Dependent Coverage All Year: Rates by Demographics Among Nonelderly Persons, Ages 0-64, California, 2009 and 2012

	2009	2012
All Workers	13.3%	12.2%
Age		
19-25	13.6%	16.7%
26-34	11.1%	9.0%
35-44	17.6%	15.5%
45-54	18.0%	16.0%
55-64	17.7%	16.6%
Race and Ethnicity		
White	15.9%	17.7%
Latino	6.8%	7.3%
African-American	6.7%	6.2%
Asian/Native Hawaiian/Pacific Islander	13.1%	14.5%
American Indian/Alaskan Native/Two or More Races	8.1%	6.2%
Family Composition		
Single Adult	7.9%	7.9%
Single Parent	1.2%	1.9%
Married without Children	24.3%	22.8%
Married with Children	11.4%	14.8%
Citizenship and Immigration Status		
U.S. Citizen	11.8%	13.1%
Non-Citizen with a Green Card	13.1%	10.8%
Non-Citizen without a Green Card	2.0%	2.3%
Highest Level of Education		
Less Than High School	5.1%	4.6%
High School Graduate	11.6%	10.3%
Some College	12.5%	13.3%
Vocational School, AA, AS	12.0%	14.3%
College Graduate or Higher	13.3%	16.8%
Federal Poverty Level		
Less than 138% FPL	3.0%	3.8%
139-200% FPL	7.0%	7.5%
201-400% FPL	12.1%	13.0%
400%+ FPL	17.5%	21.2%

Note: Data from 2009 have been adjusted to match the CHIS 2011/12 cell phone/landline household sampling frame, to increase comparability of the point estimates.

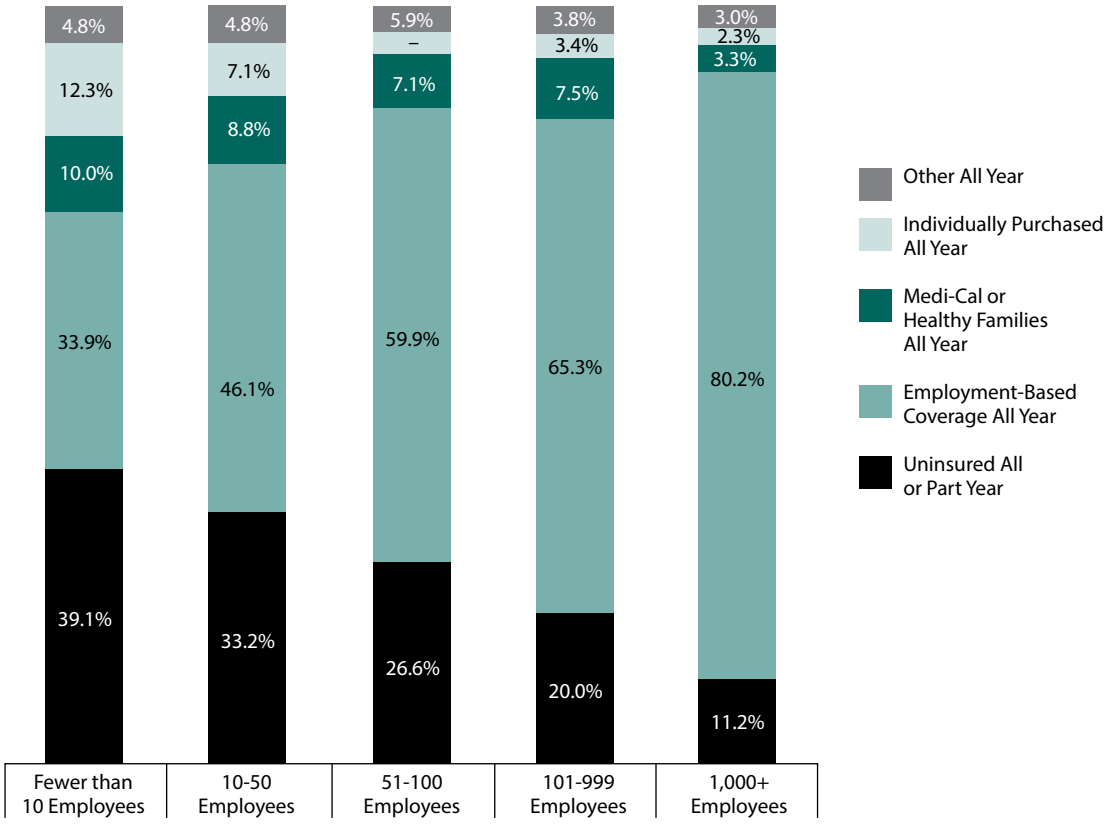
Sources: 2011/12 California Health Interview Survey, adjusted 2009 California Health Interview Survey

Older Workers and Workers in Large Firms Were Much More Likely to Have Employment-Based Coverage

There is a direct and strong correlation between firm size and source of coverage. Individuals who work in the largest firms are much more likely to have coverage through an employer—either their own employer or that of a parent or spouse—than individuals who work in smaller firms. More than 80% of workers in firms of 1,000 or more employees had coverage through an employer, compared to less than half of those in firms with 10 to 50 employees (46.1%; Exhibit 15) and slightly more than a third (33.9%) of those in firms with fewer than 10 employees.

Conversely, those working in smaller firms were much more likely to be uninsured, receive Medi-Cal, or purchase coverage through the individual market. Of the workers in firms of 1,000 or more, only 2.3% purchased coverage in the individual market, 3.3% were enrolled in Medi-Cal or Healthy Families, and 11.2% went without coverage during the year (Exhibit 15). This compares to 39.1% of those in the smallest firms who were uninsured for all or part of the year, 10.0% who were enrolled in Medi-Cal

Exhibit 15.
Health Insurance Coverage During Last 12 Months of Employed Adults by Firm Size, Ages 19-64, California, 2012



– Data are unstable due to coefficient of variation above 30%.

Notes: "Other All Year" includes public health insurance programs that are not Medi-Cal or Healthy Families (including Access for Infants and Mothers {AIM} and the Managed Risk Medical Insurance Program {MRMIP}, for example) and any combination of insurance types during the past year without a period of uninsurance.

Numbers may not add up to 100% because of rounding.

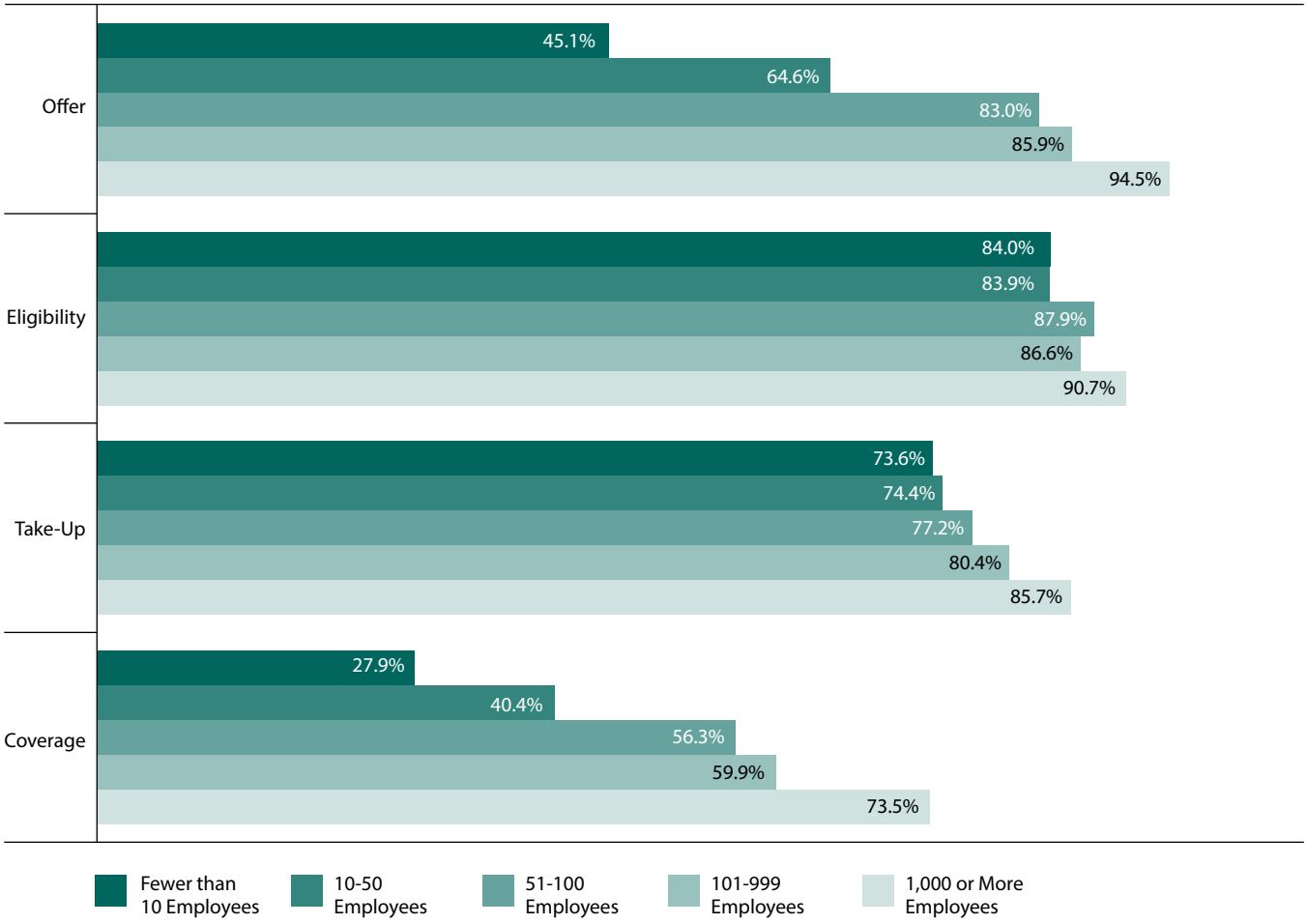
Source: 2011/2012 California Health Interview Survey

or Healthy Families, and 12.3 % who purchased coverage in the individual market.

Coverage rates are a product of the share of workers who are in firms that offer coverage to employees, the share of the employees in offering firms who are eligible for that coverage, and the share of employees who choose to take up the coverage offered to them. Several factors affect eligibility rates in offering firms. Employers are less likely to offer coverage to part-time workers, and they also usually have waiting periods before employees are eligible for coverage. In high-turnover industries, longer waiting periods will result in a lower share of workers who are eligible for coverage at any one time.

The share of workers with coverage through an employer varied significantly by firm size. While nearly three-quarters (73.5%; Exhibit 16) of employees in firms of 1,000 or more had coverage through an employer, the

Exhibit 16.
Rates of Offer, Eligibility, Take-Up, and Coverage of Employment-Based Coverage by Firm Size Among Working Nonelderly Adults, Ages 19-64, California, 2012



Notes: Offer rate = The total number of employees working for employers that offer health insurance, divided by the total number of employees.

Eligibility rate = The total number of employees eligible for their employer's plan, divided by the total number of employees working for employers that offer health insurance.

Take-up rate = The total number of people who accepted insurance, divided by the total number of employees with access to their employer's plan.

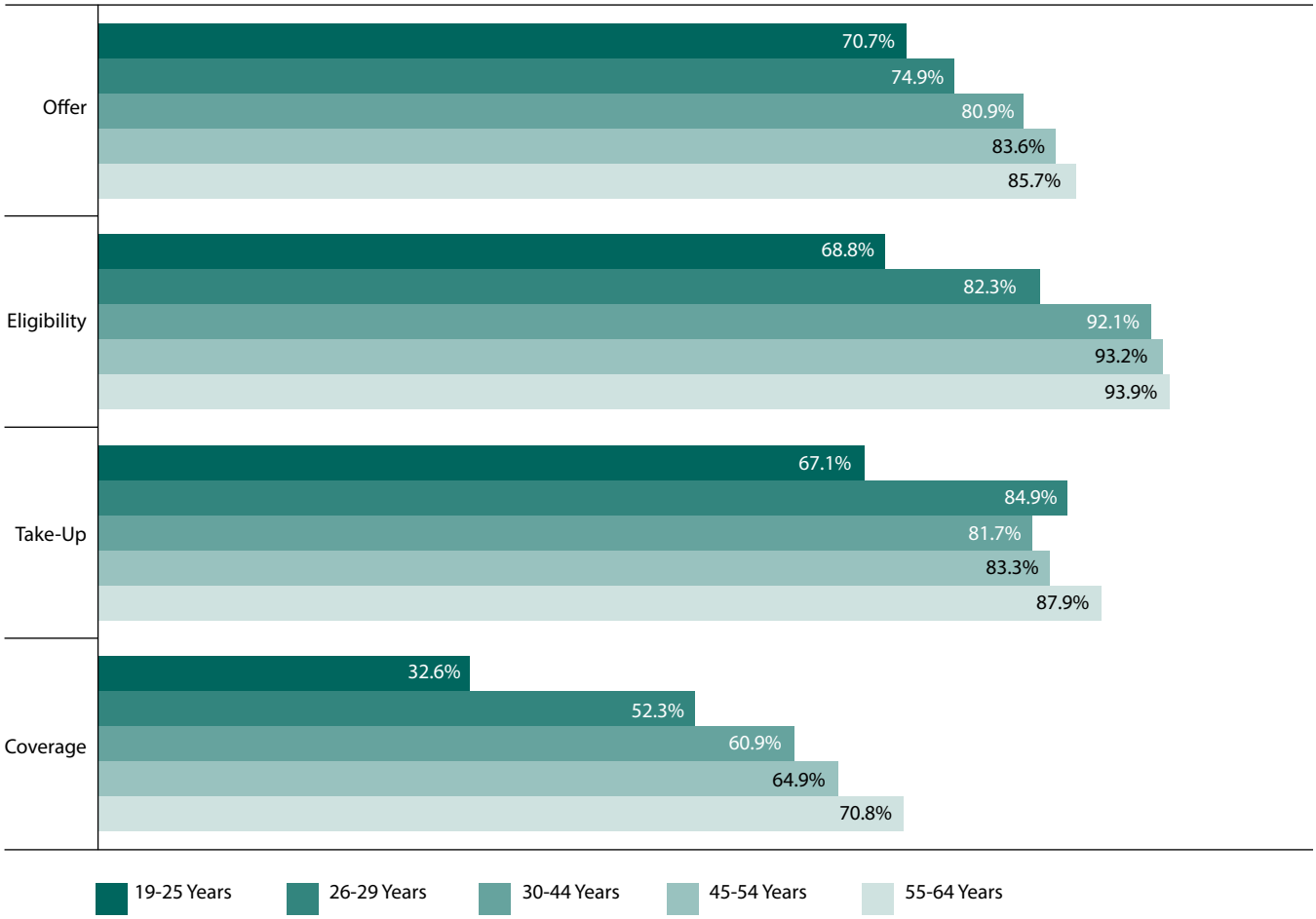
Coverage rate = The product of the offer, eligibility, and take-up rates. The population analyzed excludes self-employed individuals who are in firms with fewer than 10 employees.

Source: 2011/2012 California Health Interview Survey

same was true for only 27.9% of employees in firms with fewer than 10 employees and 40.4% of those in firms with 10 to 50 employees.

In 2012, 94.5% of workers in firms of 1,000 or more worked for an employer who offered coverage, compared to only 45.1% of workers in firms with fewer than 10 employees and 64.6% in firms with 10 to 50 employees (Exhibit 16). Eligibility rates also varied by firm size, but the variation was much less than that of offer rates: 84% of workers in firms with 50 or fewer employees that offered coverage were eligible for that coverage, compared to 90.7% of those who worked for the largest firms. Take-up rates were also higher in large firms, with 85.7% compared to 73.6% among the smallest firms. While there was great variation by industry, workers in larger firms generally both paid lower shares of premium costs and earned higher wages than those in small firms, with both factors possibly contributing to the higher take-up rates.

Exhibit 17.
Rates of Offer, Eligibility, Take-Up, and Coverage of Employment-Based Coverage by Age Among Working Nonelderly Adults, Ages 19-64, California, 2012



Notes: Offer rate = The total number of employees working for employers that offer health insurance, divided by the total number of employees.

Eligibility rate = The total number of employees eligible for their employer's plan, divided by the total number of employees working for employers that offer health insurance.

Take-up rate = The total number of people who accepted insurance, divided by the total number of employees with access to their employer's plan.

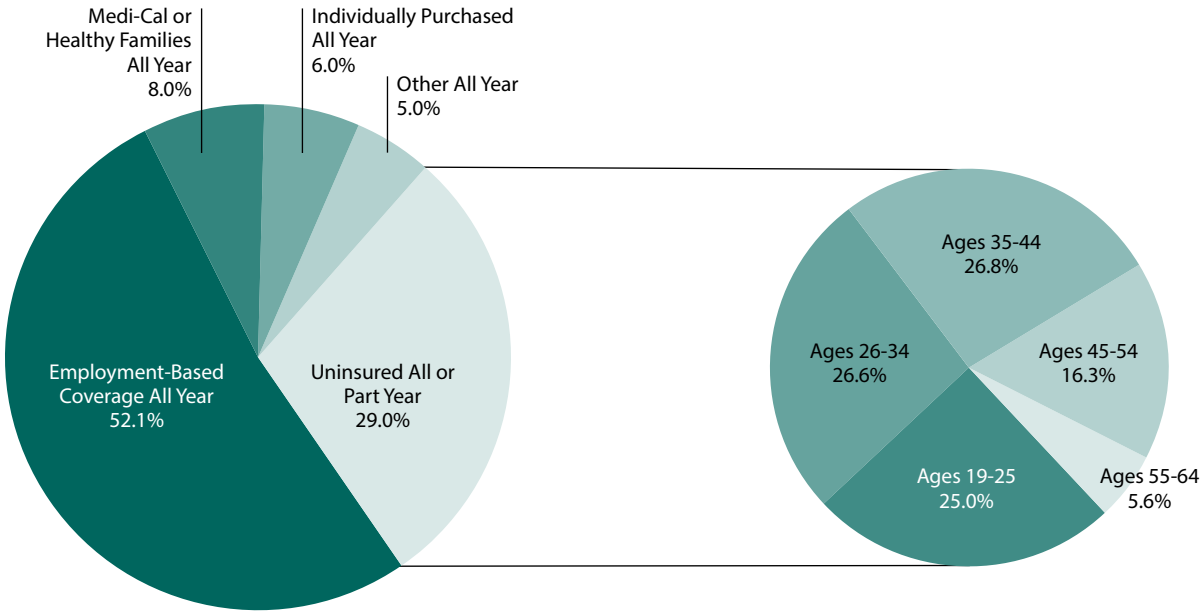
Coverage rate = The product of the offer, eligibility, and take-up rates. The population analyzed excluded self-employed individuals in firms with fewer than 10 employees.

Source: 2011/2012 California Health Interview Survey

Most Californians Who Did Not Take Up Offers of Employment-Based Coverage Had Coverage Through Another Source

Of the 1,783,000 Californians who were offered but did not take up employment-based coverage in 2012, more than half (52.1%; Exhibit 18) had coverage through another employer, either directly or through a spouse's or parent's employer. Smaller shares had coverage through a public source (8.0%) or purchased coverage on the individual market (6.0%). Less than a third (29.0%) were uninsured. As seen in Exhibit 18, the shares of individuals who declined job-based coverage and remained uninsured were spread surprisingly evenly among the age bands under the age of 44. Unsurprisingly, few workers over 55 declined to take up job-based coverage when they did not have another source of coverage.

Exhibit 18.
Type of Health Insurance Coverage Among Working Nonelderly Adults Who Declined Own Employment-Based Coverage, Ages 19-64, California, 2012



Notes: "Employment-Based Coverage All Year" refers to coverage through an employer other than one's own (e.g., a parent's or spouse's employer). "Other All Year" includes public health insurance programs that are not Medi-Cal or Healthy Families (including Access for Infants and Mothers [AIM] and the Managed Risk Medical Insurance Program [MRMIP], for example) and any combination of insurance types during the past year without a period of uninsurance.

Numbers may not add up to 100% because of rounding.

Source: 2011/2012 California Health Interview Survey

The Individual (Non-Group) Market Prior to Implementation of the ACA

Overall, in 2012, 1.7 million Californians had year-round coverage through the individual market. Starting in January 2014, insurance companies could no longer discriminate against individuals based on health status or pre-existing conditions. Costs could vary only by age and geography (smoking status has been legally disallowed as a reason for varying the premiums in California). Low- and moderate-income families without an affordable offer of coverage on the job became eligible for premium subsidies.

Nonelderly Californians ages 19-64 with individually purchased coverage were younger than those who were covered in the small- and large-group markets (Exhibit 19). While one out of four (25.1%) of those individually purchasing coverage were between the ages of 19 and 25, that was true of only 14% of those in the small-group market and 9.8% of those in the large-group market. Citizenship and immigration status was relatively stable across the three markets.

Individuals purchasing coverage directly were more likely to report that they were in excellent or very good health (65.1%) than those in the small-group market (60.8%), and less likely to report fair or poor health (9.7%) than those in the small-group market (12.2%). In the large-group market, 64% reported excellent or very good health, and 8.6% reported fair or poor health.

Individuals purchasing coverage directly were significantly less likely to have high blood pressure or to be overweight or obese than those covered through the small- or large-group markets. Smoking rates were similar across the three groups.

A majority (55.9%) of those with individually purchased coverage worked full-time, while an additional 14.2% worked part-time. More than half of those who worked were self-employed (39.9%) or non-self-employed (12.2%) and working in firms of 10 or fewer. Slightly more than one-quarter (25.5%) worked for firms of 50 or more, the cutoff for the employer mandate under the ACA.

Exhibit 19.

Demographics of Individuals with Individually Purchased, Small-Group, or Large-Group Coverage Among Nonelderly Adults, Ages 19-64, California, 2012

	Individually Purchased	Small-Group	Large-Group
All Nonelderly Adults			
Age			
19-25	25.1	14.0	9.8
26-29	11.8	6.3	7.6
30-44	20.0	34.0	37.8
45-54	22.3	25.6	26.6
55-64	20.8	20.2	18.2
Total	100.0%	100.0%	100.0%
Citizenship and Immigration Status			
U.S.-Born or Naturalized Citizen	90.5	87.0	91.4
Non-Citizen with Green Card	6.7	9.4	6.3
Non-Citizen without Green Card	2.9	3.6	2.3
Total	100.0%	100.0%	100.0%
Health Status			
Excellent or Very Good	65.1	60.8	64.0
Good	25.3	27.0	27.4
Fair or Poor	9.7	12.2	8.6
Total	100.0%	100.0%	100.0%
Chronic Conditions			
Currently Has Asthma	8.2	7.6	7.4
Diabetes Prevalence	3.6	4.6	5.0
Heart Disease	2.1	2.8	2.9
High Blood Pressure	13.9	18.0	20.5
Current Smoker	11.6	11.8	11.4
Overweight or Obese	42.7	57.9	60.0
Federal Poverty Level			
Less Than 138% FPL	17.0	10.5	5.9
139%-200% FPL	6.0	8.3	5.7
201%-400% FPL	27.5	26.0	23.9
400%+ FPL	49.4	55.2	64.5
Total	100.0%	100.0%	100.0%
Work Status			
Full-Time	55.9	82.4	93.7
Part-Time	14.2	15.7	5.5
Employed, Not at Work	–	–	–
Unemployed, Looking for Work	7.8	0.9	0.1
Unemployed, Not Looking for Work	21.9	–	0.5
Total	100.0%	100.0%	100.0%
All Working Adults			
Firm Size			
Self-Employed and < 10 Employees	39.9	26.6	–
Not Self-Employed and < 10 Employees	12.7	23.8	–
10-50 Employees	21.9	49.6	–
51-99 Employees	3.0	–	8.1
100-999 Employees	7.4	–	19.7
1,000 or More Employees	15.1	–	72.2
Total	100.0%	100.0%	100.0%

Note: Numbers may not add up to 100% because of rounding. Source: 2011/2012 California Health Interview Survey

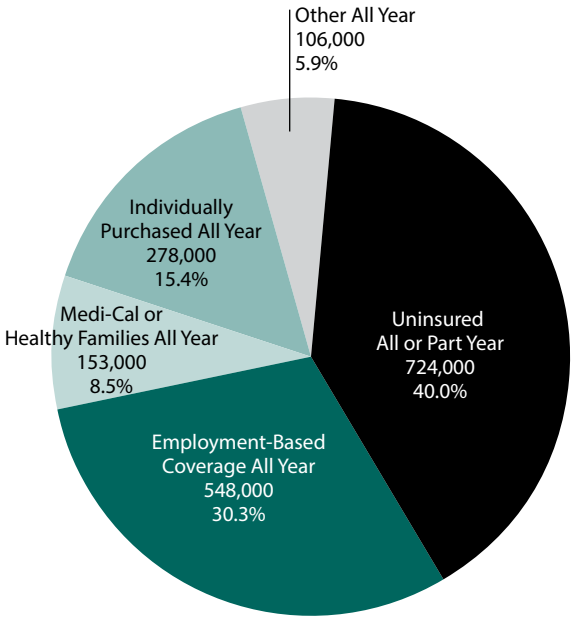
Self-Employed Most Likely to Purchase Coverage in the Individual Market

The United States has one of the lowest rates of self-employment among advanced democracies, and difficulty securing health insurance is an often cited reason.[8]

The self-employed are much more likely to be uninsured than those who work for an employer or own a larger business. In 2012, 1.8 million Californians reported that they were self-employed and worked in a firm with fewer than three employees. Of those, 40% reported that they had been uninsured for all or part of the year, 30% had coverage through an employer, and 15% were covered through the individual market (Exhibit 20). The ACA is likely to impact the number of people who choose to work for themselves or to open small businesses by paying for coverage, affecting the sources of coverage for those groups.

8 John Schmitt and Nathan Lane. *An International Comparison of Small Business Employment*. Center for Economic and Policy Research, 2009. *http://www.cepr.net/documents/publications/small-business-2009-08.pdf*

Exhibit 20.
Health Insurance Coverage During Last 12 Months of Self-Employed Adults in Businesses with Fewer than Three Employees, Ages 19-64, California, 2012



Total Population: 1,809,000

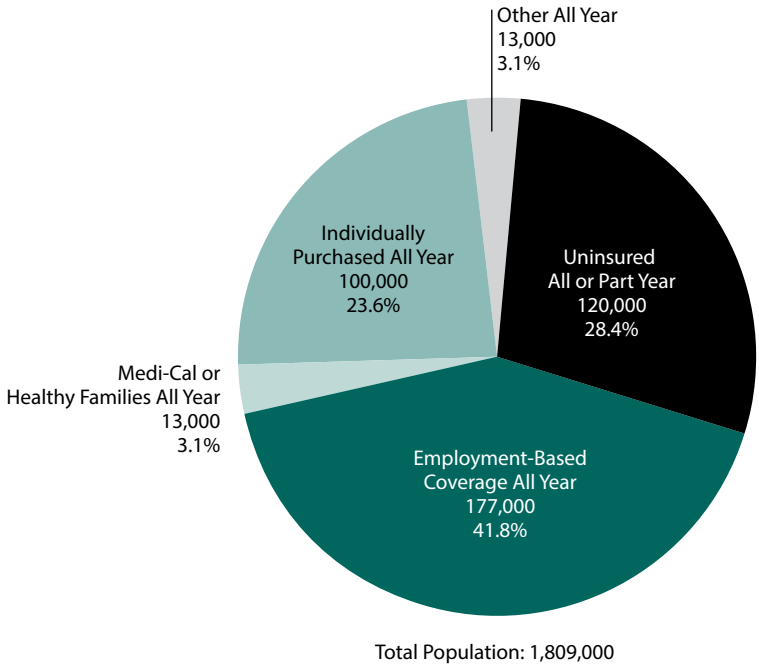
Notes: "Other All Year" includes public health insurance programs that are not Medi-Cal or Healthy Families (including Access for Infants and Mothers {AIM} and the Managed Risk Medical Insurance Program {MRMIP}, for example) and any combination of insurance types during the past year without a period of uninsurance.

Numbers may not add up to 100% because of rounding.

Source: 2011/2012 California Health Interview Survey

The picture for owners of small businesses with three to nine employees was similar, but with a smaller share going without insurance (28.4%; Exhibit 21) and a larger share purchasing coverage in the individual market (23.6%). Starting in 2014, small businesses have the option of purchasing coverage through the SHOP (Small Business Health Options Program) exchange, while individual workers will be able to purchase coverage through Covered California.

Exhibit 21.
Health Insurance Coverage During Last 12 Months of Self-Employed Adults in Businesses with Three to Nine Employees, Ages 19-64, California, 2012



Notes: "Other All Year" includes public health insurance programs that are not Medi-Cal or Healthy Families (including Access for Infants and Mothers {AIM} and the Managed Risk Medical Insurance Program {MRMIP}, for example) and any combination of insurance types during the past year without a period of uninsurance.

Numbers may not add up to 100% because of rounding.

Source: 2011/2012 California Health Interview Survey

Conclusions

There was a marked decline in the share of Californians with employment-based coverage between 2009 and 2012. Coverage rates fell among both full- and part-time workers. The largest declines in own-employer coverage were among Latinos, noncitizens, workers with less than a college education, and workers in families with incomes between 139% and 400% of the FPL. Dependent coverage rose for young adults between the ages of 19 and 25, who can now stay on a parent's plan, but fell for other age groups. The share of Californians under the age of 65 with employer-based coverage varied considerably across the state, with a high of 70.7% in San Mateo County and a low of 26.9% in Lake County.

In 2012, 14.0 million Californians had coverage through an employer. The share of Californians with job-based coverage—either their own or as a dependent—varied significantly by age, race, citizenship status, educational attainment, family income, and firm size. An estimated 35% of Latino workers had coverage through their own employer for a full year in 2012, compared to more than 50% of white, Asian, and African-American workers. Workers who graduated from college were more than twice as likely to have coverage through their work than those without a high school diploma. While 62.7% of workers in families with incomes above 400% of the FPL reported year-round coverage on the job, this was true for only 16.6% of those with incomes below 138% of the FPL.

There is considerable debate over what the eventual impact of the ACA will be on job-based coverage after full implementation. Most analysts anticipate a small net decline in the share of individuals with employment-based coverage as a result of the law.[9] Job-based coverage rates actually rose in Massachusetts following implementation of that state's earlier reforms.[10]

The law affects job-based coverage in several important ways. First, the individual mandate will increase employee demand for coverage. Second, starting in 2015, employers who have 100 or more full-time equivalent workers and who do not make an affordable offer of coverage will face penalties; in 2016, the penalties will apply to firms of 50 or more. The individual and employer mandates could increase take-up rates and result in offers of coverage or expanded eligibility for coverage by firms that would not have done so in the absence of the policy change.

Third, the expansion of Medicaid and the availability of subsidies for low- and middle-income families to purchase coverage through the new marketplaces will create a viable alternative to job-based coverage for a part of the workforce and could lead certain employers to drop coverage. Since the employer penalty only applies to employees working 30 hours or more in larger firms, coverage is most likely to decline for part-time workers and among smaller firms. Some firms may also reduce work hours to avoid the penalty. Finally, new plan standards will raise the cost of coverage for firms that previously offered plans below these standards.

9 Thomas Buchmueller, Colleen Carey, and Helen G. Levy. Will Employers Drop Health Insurance Coverage Because of the Affordable Care Act? *Health Affairs* 32 (9) (2013): 1522-1530.

10 Lisa Dubay, Sharon K. Long, and Emily Lawton. *Will Health Reform Lead to Job Loss? Evidence from Massachusetts Says No*. Urban Institute, 2012.

On the eve of full implementation of the new coverage options in the ACA, the individually purchased market in California remained relatively small, with just 1.7 million individuals under the age of 65 enrolled in nongroup plans. The nongroup market will see the largest changes under the ACA, as the combination of guaranteed issue and community rating along with subsidies to purchase coverage through the new marketplaces is anticipated to significantly expand it.

An estimated 25% of those purchasing coverage in the individual market prior to 2014 were expected to be eligible to receive premium subsidies in California.[11] For those not eligible for subsidies, the impact on price was mixed, depending on age, health status, geography, and the plan in which they had been previously enrolled, among other factors. The demographics of the nongroup market will change as more of the uninsured enroll in coverage. This will in turn affect the risk mix in the pool and the cost of coverage.

The difficulty in obtaining individual coverage is commonly considered to have served as a drag on self-employment and small business creation in the United States. In 2012, 1.8 million workers reported that they were self-employed and worked in firms of fewer than three employees; 15% had purchased coverage through the individual market, while 40% went without coverage. The ACA may influence both the share of workers who are self-employed and whether and how they purchase coverage.

Changes in employer offers and individual decisions of whether, and where, to take up coverage are not likely to take place immediately, but such shifts will occur over time. These changes need to be understood not only in relationship to current rates of employer offer, eligibility, take-up, and coverage, but also as they relate to the existing trend of declining job-based coverage. This chapter provides a baseline from which to measure these changes in the future.

11 *CalSIM Version 1.91 Statewide Data Book 2015-2019*. Available at: *http://healthpolicy.ucla.edu/publications/Documents/PDF/2014/calsimdatabook-may2014.pdf*

3 Transitions in Medi-Cal, Healthy Families, and Medicare

Dylan Roby

The public insurance landscape in California changed considerably in 2011 and 2012, facilitated by the partial implementation of the Affordable Care Act (ACA) and decisions by the state legislature and governor to rely on Medi-Cal managed care plans to administer health care benefits to seniors and persons with disabilities in 16 counties. Further changes were implemented in 2013 with the transition of the Healthy Families population into Medi-Cal, and in 2014 with the implementation of both the ACA's optional Medicaid expansion for childless adults and the Cal Medi-Connect program targeting dually eligible Medicare and Medi-Cal beneficiaries in selected counties. In this section, we focus on the changes in public insurance coverage and characteristics that occurred in 2012, while also looking forward to expected changes related to the ACA and other reforms to the state's health care system.

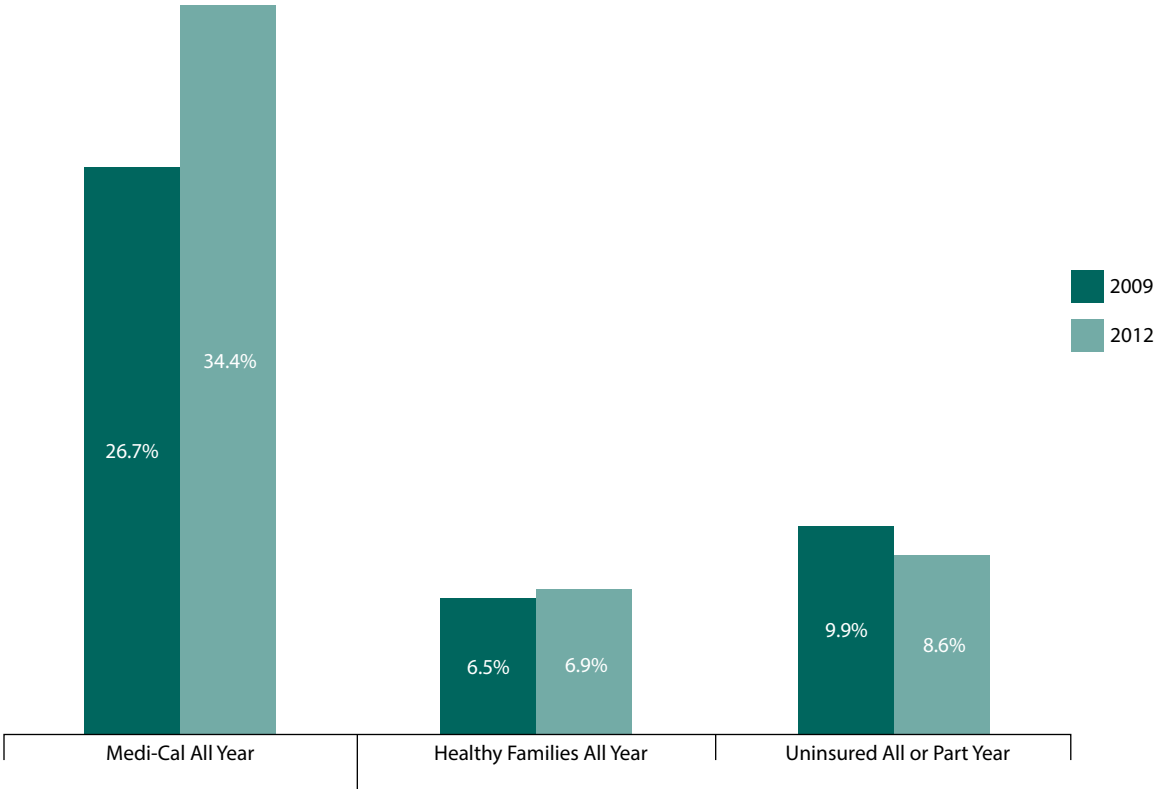
Public insurance coverage is comprised of multiple federal, state, and local programs.[12] In all, these programs insure 12.4 million Californians. Public sources of insurance coverage often have age, citizenship, income, and categorical restrictions on eligibility. For example, Medicare is only available to adults who are 65 or older or to people who are blind or disabled. In 2012, Medi-Cal was a program designed for low-income citizens, lawful permanent-resident children and their caretaker parents, seniors, and persons with disabilities. While these categorical criteria may not act as barriers to Medi-Cal enrollment currently, those policies were in effect in 2012 and influenced whether low-income adults had access to public insurance coverage. While Medi-Cal provides insurance coverage to low-income families and individuals with medical needs or disabilities, Healthy Families is California's Children's Health Insurance Program (CHIP). CHIP programs were implemented to cover children and adolescents ages 0 through 18 whose families earn too much to qualify for Medi-Cal but still cannot afford insurance coverage. People over 18 are not eligible for Healthy Families, regardless of family status. As designed, Healthy Families eligibility covers the gap between Medi-Cal's income threshold for each age group up to 250% of the federal poverty level (FPL). Like Medi-Cal, a portion of the funding for Healthy Families comes from the federal government. The delivery system for Healthy Families is managed-care based, while a significant portion of Medi-Cal during 2012 was delivered in a fee-for-service environment. As with Medi-Cal, there is diversity among the children participating in Healthy Families in terms of race/ethnicity, language, and other characteristics. This is important information for managed care plans that provide services to Healthy Families beneficiaries, and it is also important for understanding the impact of the transition of Healthy Families beneficiaries into Medi-Cal managed care plans in 2013.

12 Other Public Coverage is defined as Medicare Only, Medicare and Medicaid, Medicare and Employer-Based insurance, Medicaid only, CHIP/Healthy Families, VA, TriCare, and Other Public sources of insurance for Californians of all ages.

The Employment Situation Improved, but the Burden on Public Programs Continued

Despite the recent economic recovery in California, the rate of employment-based insurance coverage continued to decline between 2009 and 2012, from 52.1% to 49.1% of the nonelderly population. The fact that unemployment declined during the same period indicates that the majority of Californians could not rely on employers to provide insurance benefits, resulting in a reliance on public programs such as Medi-Cal, Healthy Families, and other government programs to provide coverage and protect individuals and families from unforeseen health care costs. In 2012, the Medi-Cal rules were still based on categorical and income-related eligibility, making children with household incomes up to 250% of the federal poverty level (FPL) likely to qualify for Medi-Cal or Healthy Families. 34.4% of children were enrolled in Medi-Cal for the entire year, compared to 26.7% in 2009 (Exhibit 22). The percentage of children who were uninsured for all or part of the year fell by 15% between 2009 and 2012, from 9.9% to 8.6%. Given the high income eligibility limit for children in Medi-Cal and Healthy Families, it is still troubling that almost 9% of children remained uninsured in California in 2012. The reasons for this could include lack of information, churning in and out of coverage due to income changes or paperwork barriers, or immigration status.

Exhibit 22.
Percent of Children in Medi-Cal or Healthy Families or Who Were Uninsured All or Part Year, Ages 0-18, California, 2009 and 2012



Notes: "Medi-Cal" is comprised of Medi-Cal Only All Year, Medi-Cal and Employment-Based Insurance All Year, Medi-Cal and Other, and Medi-Cal and Healthy Families All Year.

Differences are not significant at the 95% confidence level.

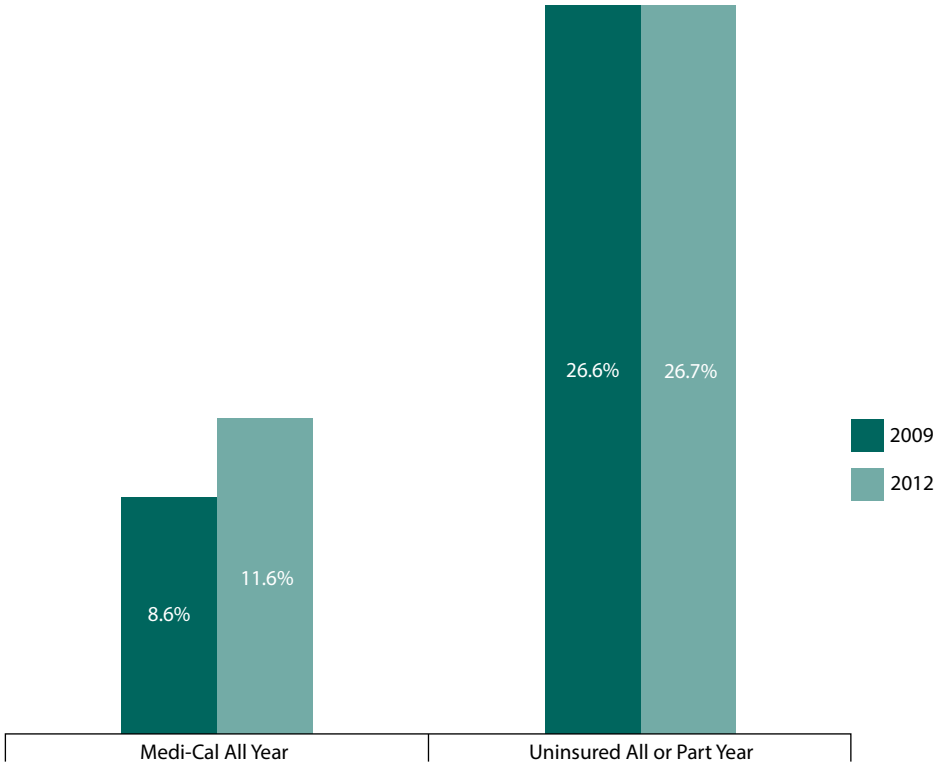
Sources: 2009 and 2011/2012 California Health Interview Surveys

Medi-Cal and Healthy Families continued to grow in importance for children, offsetting the decline in employer-based insurance. While adult parents and childless adults do not qualify for Healthy Families, Medi-Cal eligibility in 2012 allowed for enrollment of low-income parents (earning up to 106% FPL). The percentage of Medi-Cal enrolled adults increased in 2012 (Exhibit 23). However, the rate of adults who were uninsured all or part year had not changed since 2009, with adults being three times more likely than children to be uninsured all or part of the year.

Medi-Cal Coverage Is Concentrated in Certain Areas of the State

Medi-Cal and Healthy Families enrollment prior to 2014 was multifaceted due to the categorical, income, and age-based eligibility rules. The most rural areas of the state, including the Central Valley, Northern Sierras, and Imperial County, had the highest proportions of nonelderly people in Medi-Cal or Healthy Families, with more than 27% of the nonelderly population enrolled all year (Exhibit 24). Coastal areas had lower levels of enrollment, with San Luis Obispo and Orange counties and the Bay Area having the lowest rates (less than 15% of the nonelderly population). Due to the categorical nature of Medi-Cal and Healthy Families eligibility, the areas with proportionately higher enrollment in the state are likely to have more children and low-income parents. In addition, counties with significant levels of undocumented immigrants may have lower Medi-Cal and Healthy Families participation because legal residence is required for children and parents to fully enroll in the two programs.

Exhibit 23.
Percent of Adults with Medi-Cal Coverage All Year or Uninsured All or Part Year, Ages 19-64, California, 2009 and 2012

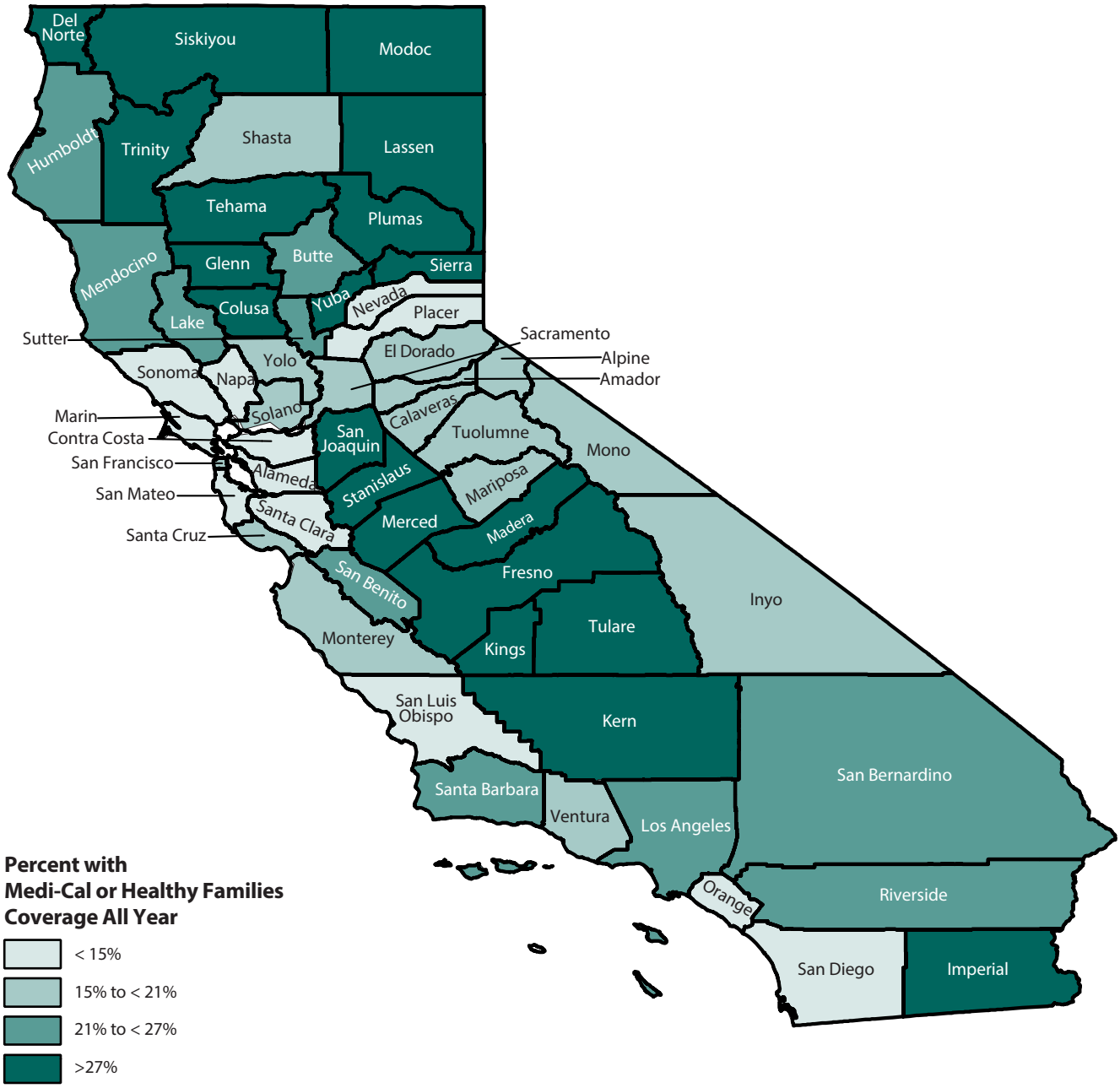


Notes: "Medi-Cal" is comprised of Medi-Cal Only All Year, Medi-Cal and Employment-Based Insurance All Year, Medi-Cal and Other, and Medi-Cal and Healthy Families All Year.

Differences are not significant at the 95% confidence level.

Sources: 2009 and 2011/2012 California Health Interview Surveys

Exhibit 24.
Percent of Adults with Medi-Cal Coverage All Year or Uninsured All or Part Year, Ages 19-64, California, 2009 and 2012



Note: Differences in rates between counties may not be statistically significant.

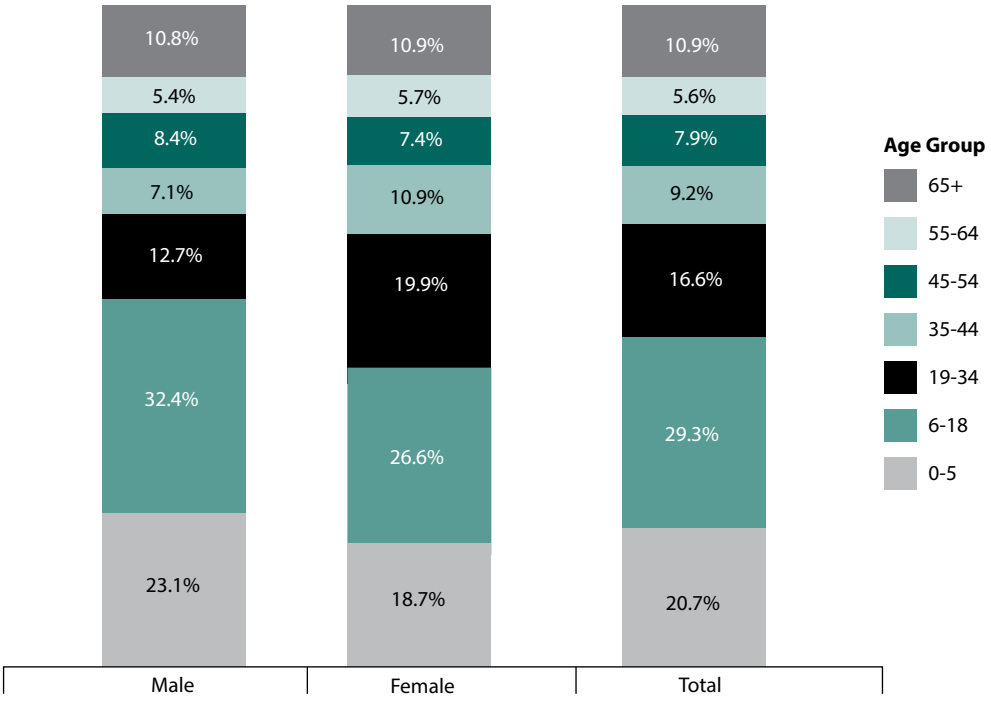
Source: 2011/2012 California Health Interview Survey

Characteristics of Medi-Cal Beneficiaries

Children ages 0-18 represented half of all Medi-Cal beneficiaries across the state, which is likely to change in future years. In 2013, the Healthy Families transition to Medi-Cal resulted in more children entering the program. However, in 2014, a substantial number of adults entered via the Medi-Cal expansion funded by the ACA. The 19-64 population represented more than 60% of Californians, but only 39.3% of the Medi-Cal beneficiary population (Exhibit 25). In addition, because people over the age of 65 are very likely to have either Medicare or Medi-Cal or to be dually enrolled in both, it is apparent that those in the childless adult population between the ages of 35 and 64 are not only most at risk of being uninsured, but they are also the least likely group to qualify for Medi-Cal coverage. This is expected to change in 2014, as mentioned in chapter 1, due to California's expansion of Medi-Cal to individuals earning up to 138% of FPL.

The majority of Medi-Cal beneficiaries in 2012 were female (54.8%). Several differences appear when gender is compared to age for Medi-Cal beneficiaries. While male children ages 0 to 5 (23.1%) and 6 to 18 (32.4%) made up a larger portion of the overall male Medi-Cal enrolled population than their female counterparts (18.7% ages 0 to 5, and 26.6% ages 6 to 18), females made up a larger share of Medi-Cal enrollment than males when comparing adult age groups. For example, among those ages 19 to 34, the number of female Medi-Cal enrollees was 57% higher than the number of male enrollees in the same age group, due mainly to the requirement of being a custodial parent in order to be eligible for coverage.

Exhibit 25.
Medi-Cal Beneficiaries During Last 12 Months by Gender and Age, All Ages, California, 2012



Notes: "Medi-Cal Beneficiaries" are individuals who have Medi-Cal Only All Year, Medi-Cal and Employment-Based Insurance All Year, Medi-Cal and Other All Year, Medi-Cal and Healthy Families All Year, Medicare + Medi-Cal + Employer-Paid All Year and Medicare + Medi-Cal All Year.

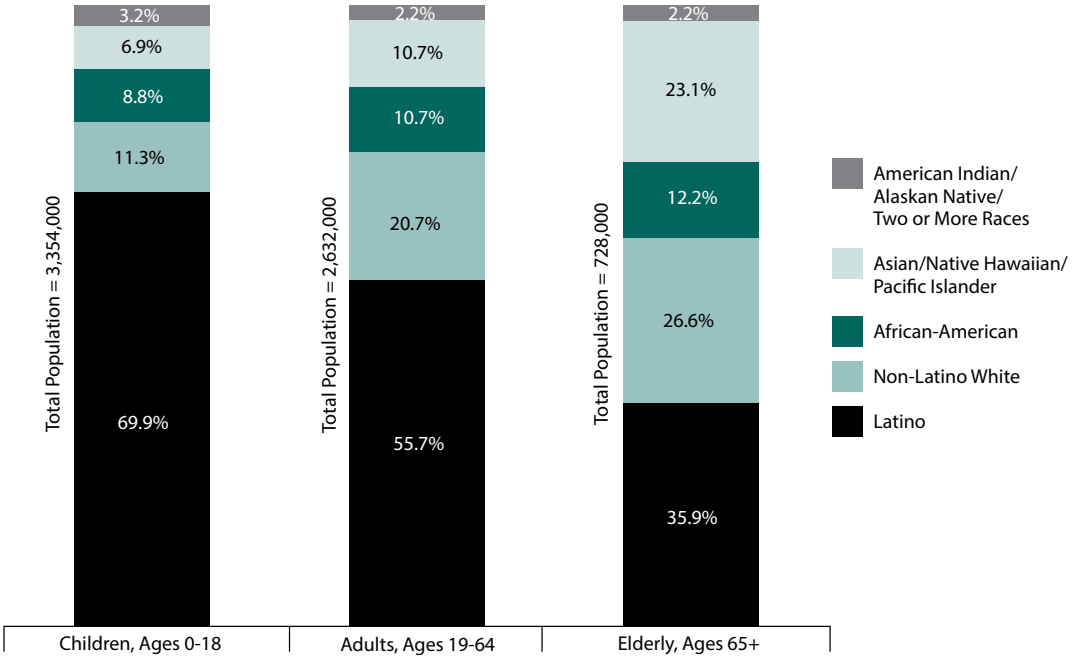
Numbers may not add to 100% due to rounding.

Source: 2011/2012 California Health Interview Survey

The population of Medi-Cal beneficiaries in California is quite diverse, with Latinos making up more than two-thirds of the children enrolled in the program in 2012, and other non-white minorities representing 18.9% of beneficiaries (Exhibit 26). However, the adult population had a much higher proportion of non-Latino whites (20.7% ages 19-64 and 26.6% ages 65 and over). Showing the demographic shift occurring in California, Latinos made up more than half of all nonelderly Medi-Cal beneficiaries, but 35.9% of the elderly Medi-Cal beneficiary population. Interestingly, 23.1% of elderly adult Medi-Cal beneficiaries were Asian or Pacific Islander —more than twice the percentage of Asian/PI in the nonelderly adult population, and three times the percentage in the child population.

Language diversity is a well-known characteristic of California's population as a whole, and this is no different in the Medi-Cal program. Due to the high Latino enrollment in Medi-Cal, a substantial percentage of the beneficiary population spoke Spanish (59% of children and 47.3% of nonelderly adults). The majority of Spanish speakers reported a lack of English proficiency, but the vast majority (64.1%) of Medi-Cal beneficiaries spoke English (Exhibit 26). The highest rate of English proficiency was in the elderly population enrolled in Medi-Cal.

Exhibit 26.
Medi-Cal Beneficiaries by Race/Ethnicity, All Ages, California, 2012



Notes: "Medi-Cal Beneficiaries" are individuals who have Medi-Cal Only All Year, Medi-Cal and Employment-Based Insurance All Year, Medi-Cal and Other All Year, Medi-Cal and Healthy Families All Year, Medicare + Medi-Cal + Employer-Paid All Year, and Medicare + Medi-Cal All Year.

Numbers may not add up to 100% because of rounding.

Source: 2011/2012 California Health Interview Survey

Exhibit 27.

Languages Spoken Among Medi-Cal Beneficiaries, All Ages, California, 2012

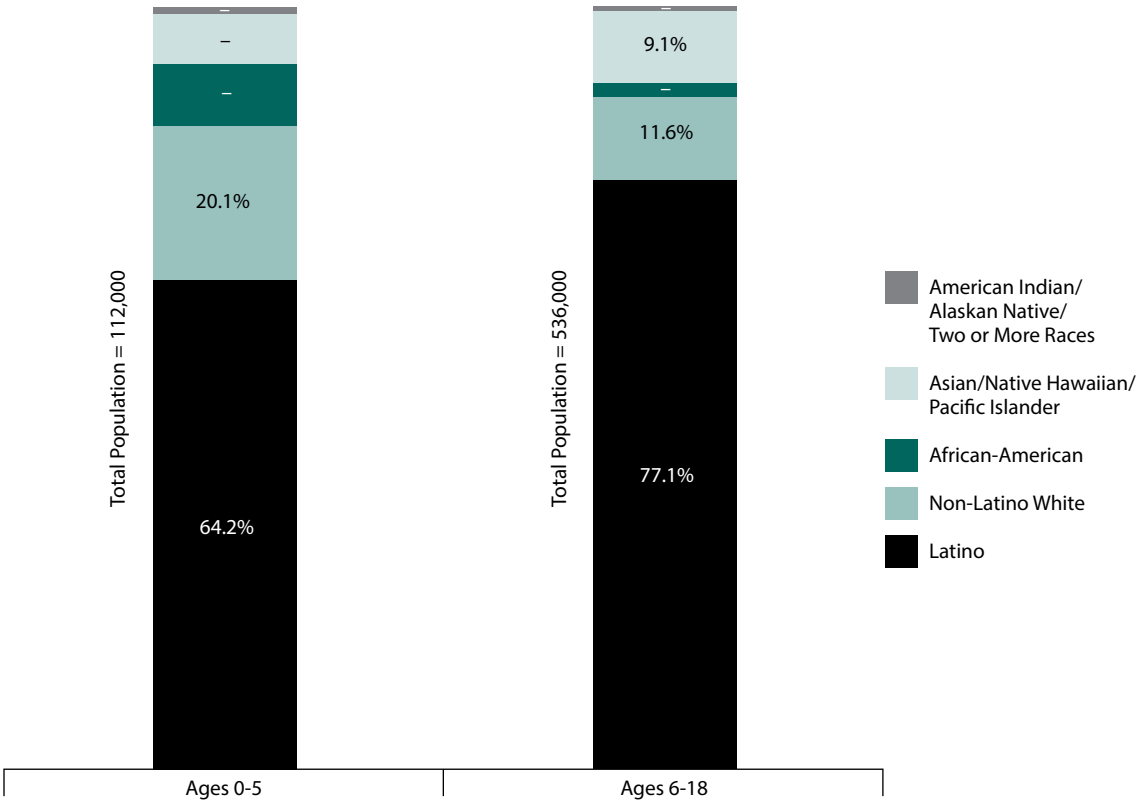
	Children 0-18	Adults 19-64	Elders 65+	Total Population
English Speaking	32.2%	39.6%	41.2%	2,418,000
Spanish Speaking - English Proficient	23.2%	21.9%	10.9%	1,431,000
Spanish Speaking - Not English Proficient	35.8%	25.4%	21.6%	2,023,000
Asian Language - English Proficient	3.0%	4.1%	3.7%	236,000
Asian Language - Not English Proficient	2.6%	4.0%	16.3%	309,000
Other Language - English Proficient	2.7%	3.5%	3.6%	210,000
Other Language - Not English Proficient	0.5%	1.5%	2.7%	74,000
Total Percent	**100.0%**	**100.0%**	**100.0%**	**-**
Total Population	**3,340,000**	**2,632,000**	**729,000**	**6,701,000**

Note: "Medi-Cal" coverage for children and adults is comprised of Medi-Cal only, Medi-Cal and Employment-Based Insurance, Medi-Cal and Other, and Medi-Cal and Healthy Families. "Medi-Cal" coverage for the elderly is comprised of Medicare and Medi-Cal and Employer-Paid All Year, and Medicare and Medi-Cal All Year. "Spanish Speaking" includes: Spanish Only, and English and Spanish. "Asian Language" includes: Chinese, Vietnamese, Korean, Other Asian Language, English and Chinese, and English and Another Asian Language. "Other Language" includes: Other Non-Asian Language, English and European Language, English and One Other Language, and Other Languages. Children's type of language is identified by the parent (ages 0-11); teens report for themselves (ages 12-17).

Source: 2011/2012 California Health Interview Survey

Exhibit 28.

Children with Healthy Families by Race/Ethnicity, Ages 0-18, California, 2012



Notes: "Healthy Families" is comprised of Healthy Families Only All Year, Healthy Families and Employment-Based Insurance All Year, and Healthy Families and Other All Year.

Numbers may not add up to 100% because of rounding.

– Unstable estimate due to coefficient of variation greater than 30%.

Source: 2011/2012 California Health Interview Survey

Characteristics of Healthy Families Beneficiaries

Similar to the Medi-Cal enrollees ages 0-18, Healthy Families enrollees in 2012 were also largely Latino—64.2% between the ages of 0 and 5, and 77.1% ages 6 to 18 (Exhibit 28). Non-Latino whites were the next largest group, representing less than one-fifth of Healthy Families enrollees. Among the largely Latino Healthy Families enrollees ages 6 to 18, the rate of English proficiency was also fairly low. Only 54.7% of Healthy Families enrollees ages 6 to 18 were English proficient, in contrast with 73.2% of children ages 0 to 5 from English-only households (Exhibit 29).

Exhibit 29.
Languages Spoken Among Healthy Families Children, Ages 0-18, California, 2012

	Ages 0-5	Ages 6-18	Total Population
English Only	32.9%	18.7%	136,000
Spanish Speaking - English Proficient	29.7%	27.9%	181,000
Spanish Speaking - Not English Proficient	22.7%	41.3%	245,000
Asian Language - English Proficient	2.1%	5.2%	30,000
Asian Language - Not English Proficient	4.2%	3.5%	24,000
Other Language - English Proficient	8.5%	2.9%	25,000
Other Language - Not English Proficient	-	0.3%	2,000
Total Percent	100.0%	100.0%	–
Total Population	163,000	471,000	643,000

Notes: "Healthy Families" is comprised of Healthy Families Only All Year, Healthy Families and Employment-Based Insurance All Year, and Healthy Families and Other All Year.

Numbers may not add up to 100% because of rounding.

– Unstable estimate due to coefficient of variation greater than 30%.

Source: 2011/2012 California Health Interview Survey

The Remaining Uninsured Prior to the ACA: Why Didn't People Enroll?

Despite the passage of the Affordable Care Act in 2010, the Medi-Cal expansion and creation of Covered California (the state Health Benefit Exchange) had not yet occurred in 2012. Restricted eligibility criteria for Medi-Cal and Healthy Families can certainly serve as a barrier for childless adults or higher-income parents who cannot qualify for either program. However, it is important to understand the reasons why those eligible for Medi-Cal or Healthy Families in 2012 did not enroll. Among those adults and children who were eligible for Medi-Cal, more than one-quarter reported that they did not know about the program. Almost 11% reported being ineligible due to citizenship status; 5.4% already had existing insurance coverage; and 10.3% did not want to sign up despite their eligibility, not wanting the coverage due to perception (Exhibit 30). The reasons were substantially different among those children who did not enroll in Healthy Families, despite being eligible. Only 11.2% of children had parents that did not know about the program, while 11.5% reported ineligibility due to citizenship status, and 14.2% already had other coverage. In 2014, the clearer eligibility guidelines and "no-wrong-door" eligibility called for by the ACA is expected to have removed some of the barriers around income, knowledge of the program, and paperwork. It appears that response to the Medi-Cal expansion has been high during the first open enrollment period for Covered California. However, there are still problems to be dealt with both in the state and nationally with regard to redeterminations of eligibility, data systems, and knowledge of the program. It is still likely that a portion of Medi-Cal eligibles will continue to be uninsured, despite the individual mandate, Medi-Cal expansion, and the creation of Covered California.

Exhibit 30.
Reasons for Not Having Medi-Cal or Healthy Families Among Those Who Were Eligible, Ages 0-64, California, 2012

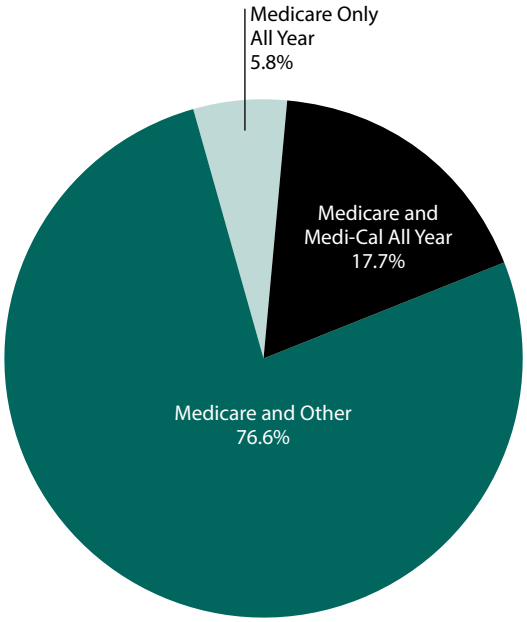
	Medi-Cal All Year	Healthy Families All Year
Didn't Know If Eligible/It Existed	25.8%	11.2%
Other, Not Eligible	20.5%	20.8%
Ineligible Due to Income	15.2%	21.6%
Ineligible Due to Citizenship/Immigration Status	10.6%	11.5%
Do Not Believe In or Didn't Like or Want Welfare	10.3%	4.2%
Has Not Applied/Doesn't Know How to Apply	7.1%	5.7%
Already Has Insurance/Thought Was Insured	5.4%	14.2%
Paperwork Too Difficult	2.9%	5.6%
Too Expensive	2.2%	5.0%

Source: 2011/2012 California Health Interview Survey

Medicare's Contribution to Insuring Californians

In addition to Medi-Cal and Healthy Families, the other major public program that provides coverage to Californians is Medicare. Medicare is designed for the elderly (ages 65 and over), but it also covers individuals with federally recognized disabilities. As described in the previous section, low-income Medicare beneficiaries may also qualify and enroll in Medi-Cal so that they are covered by both programs ("dual-eligible"). Similarly, retirees and current members of the workforce may also carry dual coverage with Medicare and their existing employment-based policy. Except in certain circumstances, Medicare acts as the primary payer in using and paying for health services when an individual has both Medicare and another source of coverage. More than 4 million elderly Californians had some Medicare coverage in 2012 (94.7%), often combined with supplemental coverage offered by private insurers, employers, or Medi-Cal. Almost 6% of Medicare beneficiaries did not have additional coverage and instead relied on Medicare for all of their health care needs, making them more financially vulnerable to out-of-pocket costs. 17.7% were dually eligible and were enrolled in both Medicare and Medi-Cal. More than three-quarters were covered by both Medicare and another private source of coverage (Exhibit 31).

Exhibit 31.
Medicare Coverage During Last 12 Months and Additional Insurance Coverage Among Elderly Adults, Ages 65 and Older, California, 2012



Notes: "Medicare and Medi-Cal All Year" is comprised of Medicare + Medi-Cal + Employer-Paid All Year and Medicare + Medi-Cal All Year. "Medicare and Other" is comprised of Medicare + Employment-Based Coverage All Year, Medicare + Employment-Paid Medigap or HMO All Year, Medicare + Privately Purchased Medigap or HMO All Year, and Medicare + Medigap or HMO, Unknown Payer All Year.

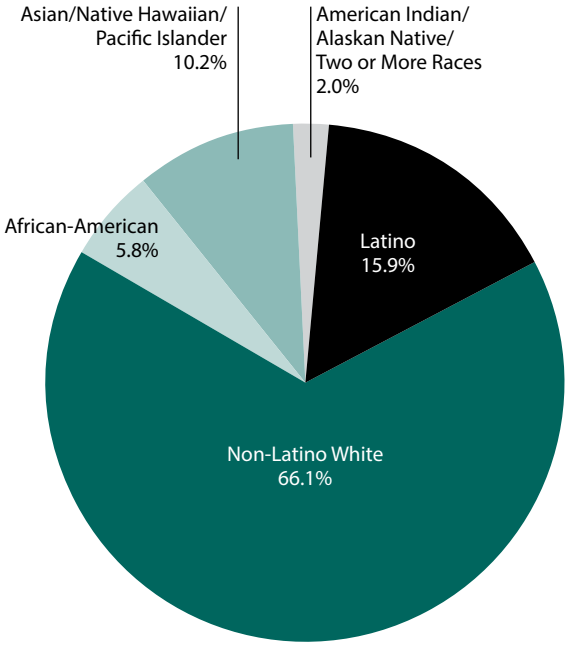
Numbers may not add up to 100% because of rounding.

Source: 2011/2012 California Health Interview Survey

Characteristics of Medicare Beneficiaries

Unlike the situation with Medi-Cal, the elderly demographic and the nature of Medicare as a social insurance, non-means-tested program indicate that the majority of beneficiaries were non-Latino whites. Almost two-thirds of the Medicare beneficiary population ages 65 and over were non-Latino white, with only 15.9% Latino, 10.2% Asian/PI, and 5.8% African-American (Exhibit 32). As the near-elderly population ages and demographic shifts occur throughout the next decade, it is likely that Latinos will become a larger part of the Medicare population. However, it is unlikely that Latino enrollment in Medicare will mirror the enrollment in Medi-Cal. Data showed the Medicare beneficiary population to be less diverse than the Medi-Cal population—73.4% of Medicare beneficiaries spoke English only, and only 6.7% spoke Spanish and reported not being English proficient (Exhibit 33).

Exhibit 32.
Race and Ethnicity of Medicare Beneficiaries, Ages 65 and Older, California, 2012



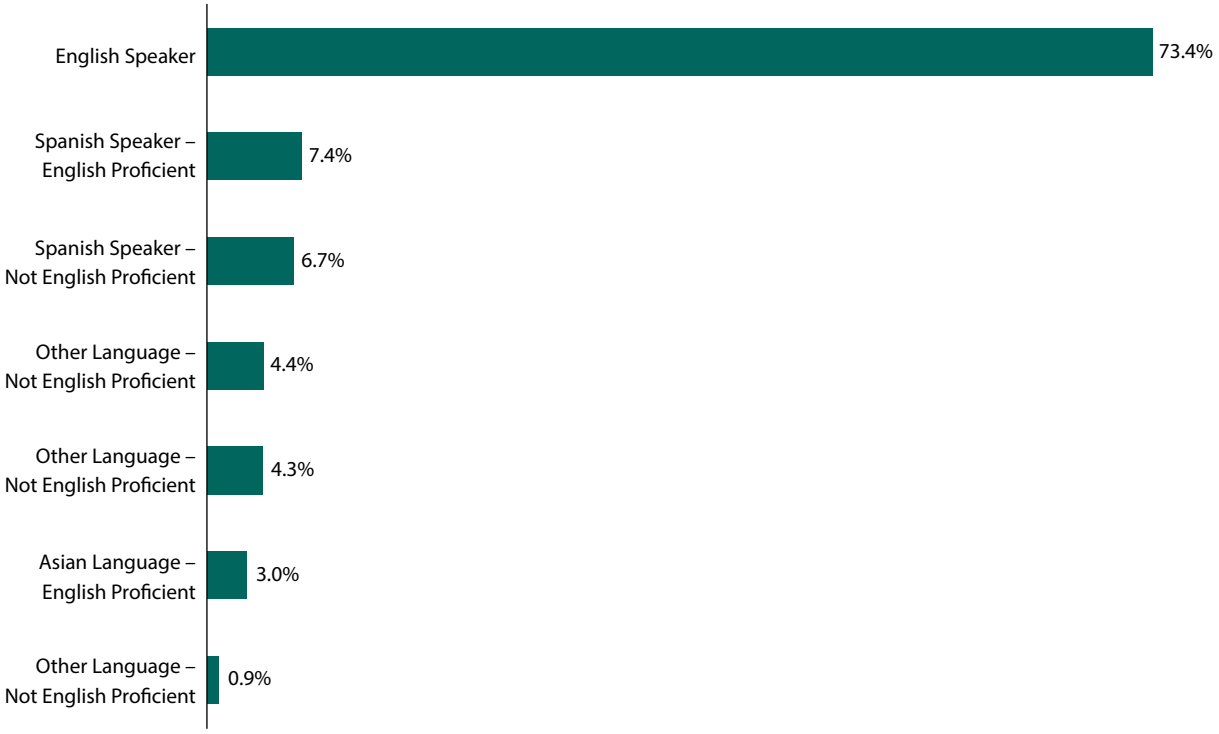
Notes: Medicare is comprised of Medicare Only All Year, Medicare and Medi-Cal and Employer-Paid All Year, Medicare and Medi-Cal All Year, and Medicare and Employment-Based Coverage All Year, Medicare + Employment-Paid Medigap or HMO All Year, Medicare + Privately Purchased Medigap or HMO All Year, and Medicare + Medigap or HMO, Unknown Payer All Year.

Numbers may not add to 100% due to rounding.

Source: 2011/2012 California Health Interview Survey

Exhibit 33.

Languages Spoken and English Proficiency of Medicare Beneficiaries, Ages 65 and Older, California, 2012



Notes: Medicare is comprised of Medicare Only All Year, Medicare and Medi-Cal and Employer-Paid All Year, Medicare and Medi-Cal All Year, and Medicare and Employment-Based Coverage All Year, Medicare + Employment-Paid Medigap or HMO All Year, Medicare + Privately Purchased Medigap or HMO All Year, and Medicare + Medigap or HMO, Unknown Payer All Year.

"Spanish Speaking" includes: Spanish Only, and English and Spanish. "Asian Language" includes: Chinese, Vietnamese, Korean, Other Asian Language, English and Chinese, and English and Another Asian Language. "Other Language" includes: Other Non-Asian Language, English and European Language, English and One Other Language, and Other Languages.

Numbers may not add to 100% due to rounding.

Source: 2011/2012 California Health Interview Survey

Health Needs and Characteristics of the Medicare Beneficiary Population

There are far fewer elderly individuals in California who remain uninsured when compared to the non-elderly population, because Medicare acts as primary coverage for millions of people in the state. However, those in the elderly population who are covered by Medicare are also more likely to report being in fair or poor health status or having a chronic illness. In addition, differences exist in health status, chronic illness, usual source of care, delays, and ER use among the elderly, even among those who are enrolled in Medicare. More than half (50.3%) of dually eligible Medicare/Medi-Cal beneficiaries reported fair or poor health status, in contrast to the 22.1% with Medicare and other private insurance or the 23.4% who had Medicare only (Exhibit 34). Although the rate of diabetes was 7 to 10 percentage points higher among the dually eligible population, the rate of chronic illness for Medicare beneficiaries was comparable across all three groups. It seems that the self-reported fair and poor health status for the dual-eligible population was not necessarily linked to the overall chronic illness burden in the population, but generally to poor health and disability, coupled with lower incomes.

The highest rates of having no usual source of care (9.2%), facing delays in obtaining prescription drugs (9.7%), and needing to use the ER (29.1%) in the past 12 months were found in the dual-eligible population, which makes sense, given their perceived health status and chronic illness burden. However, the fact that people with Medicare Only (who did not have secondary employer-based or Medigap coverage) faced significant delays in getting medications (9.1%), needed to use the ER (25.7%), and lacked a usual source of care (7.5%) may be indicative of problems with access and affordability in Medicare, given the high costs of deductibles, coinsurance, and lack of out-of-pocket spending caps.

Exhibit 34.

Health Care Needs and Status of All Publicly Insured Elderly Adults, Ages 65 and Older, California, 2012

	Medicare	Medicare and Medi-Cal	Medicare and Other
Health Status			
Excellent or Very Good	39.8%	23.2%	47.5%
Good	36.8%	26.5%	30.4%
Fair or Poor	23.4%	50.3%	22.1%
Total	100.0%	100.0%	100.0%
Chronic Conditions			
Asthma	5.4%	9.5%	8.4%
Heart Disease	22.1%	20.8%	21.7%
High Blood Pressure	67.0%	66.8%	60.3%
Diabetes	20.2%	27.7%	17.3%
Usual Source of Care			
Doctor's Office/HMO/Kaiser	70.3%	71.8%	86.8%
Community or Hospital Clinic	20.7%	18.4%	9.7%
Emergency Room/Urgent Care	-	-	-
Other Place/No One Place	-	-	0.5%
No Usual Source of Care	7.5%	9.2%	2.8%
Delays in Health Care			
Had Delay in Getting Any Care	6.0%	6.2%	6.0%
Had Delay in Getting Medicine	9.1%	9.7%	7.9%
Emergency Room Visits			
At Least One ER Visit in the Past 12 Months	25.7%	29.1%	23.4%

Notes: "Medicare and Medi-Cal All Year" is comprised of Medicare + Medi-Cal + Employer-Paid All Year and Medicare + Medi-Cal All Year. "Medicare and Other" is comprised of Medicare + Employment-Based Coverage All Year, Medicare + Employment-Paid Medigap or HMO All Year, Medicare + Privately Purchased Medigap or HMO All Year, and Medicare + Medigap or HMO, Unknown Payer All Year.

Numbers may not add to 100% due to rounding.

– Unstable estimate due to coefficient of variation greater than 30%.

Source: 2011/2012 California Health Interview Survey

Conclusions

As the reliance on public programs grows, those same programs face barriers in providing care to their beneficiaries due to payment reductions, higher out-of-pocket costs, and the greater cost of health care in general.

Many changes nationally and statewide will alter the landscape in public coverage, to be noted in the next SHIC report. Starting in January of 2013, the Healthy Families program was transitioned to Medi-Cal, so that children ages 0-18 with family incomes up to 250% FPL were moved into Medi-Cal managed care products or fee-for-service in rural counties. Then, in January of 2014, Medi-Cal expanded to the childless adult population earning up to 138% FPL (and parents earning 106% to 138% FPL), and all full-scope Medi-Cal beneficiaries were concurrently transitioned into managed care in all counties. The number of enrollees in Medi-Cal will surge due to both changes, and the impact of Medi-Cal provider networks, reimbursement, and benefits will be important to monitor.

Public coverage from Medi-Cal, Healthy Families, and Medicare covers a large proportion of Californians, with more than 12 million relying on these state and federal programs to care for their health needs. It is evident that the populations enrolled in Medicare, Medi-Cal, and Healthy Families are some of the more vulnerable groups within the state: children and mothers from low-income families, the elderly and disabled, and children whose parents cannot afford coverage on their own.

The burden on public programs, especially Medi-Cal and Healthy Families, initially increased due to the recession of 2008 and the stagnant employment market that has decreased the number of full-time, commercially insured workers. However, even as the unemployment rate has declined, it still appears that job-based health coverage for dependents and parents has not improved as hoped. The state received additional funding to operate these programs via federal stimulus dollars, but that money is no longer available to support the program as the economy recovers. The ACA's Medicaid expansion will pay for the full cost of the Medi-Cal expansion from 2014 to 2016, and it will continue to contribute at least 90% in 2020 and beyond. However, the existing Medi-Cal enrollee population will continue to receive only a partial match from the federal government.

These programs will be bolstered by new investment in 2014 and beyond, with the ACA extending the life of Medicare through payroll tax increases for higher-income workers and providing more support for states to operate both Medicaid and their Children's Health Insurance Programs. As Medi-Cal becomes a larger source of public coverage, there are opportunities and risks. The strengthening of Medi-Cal via additional matching funds, the addition of newly insured individuals in 2014, and coordination through private managed care plans should alleviate pressure from other parts of the safety net, including public hospitals and community health centers that provide the bulk of care for the uninsured and low-income populations. However, there are risks related to provider reimbursement, capacity, and sustainability in the face of federal budget pressures that could undermine this investment in public programs by the ACA.

4 The Role of Insurance in Access to Care

Nadereh Pourat

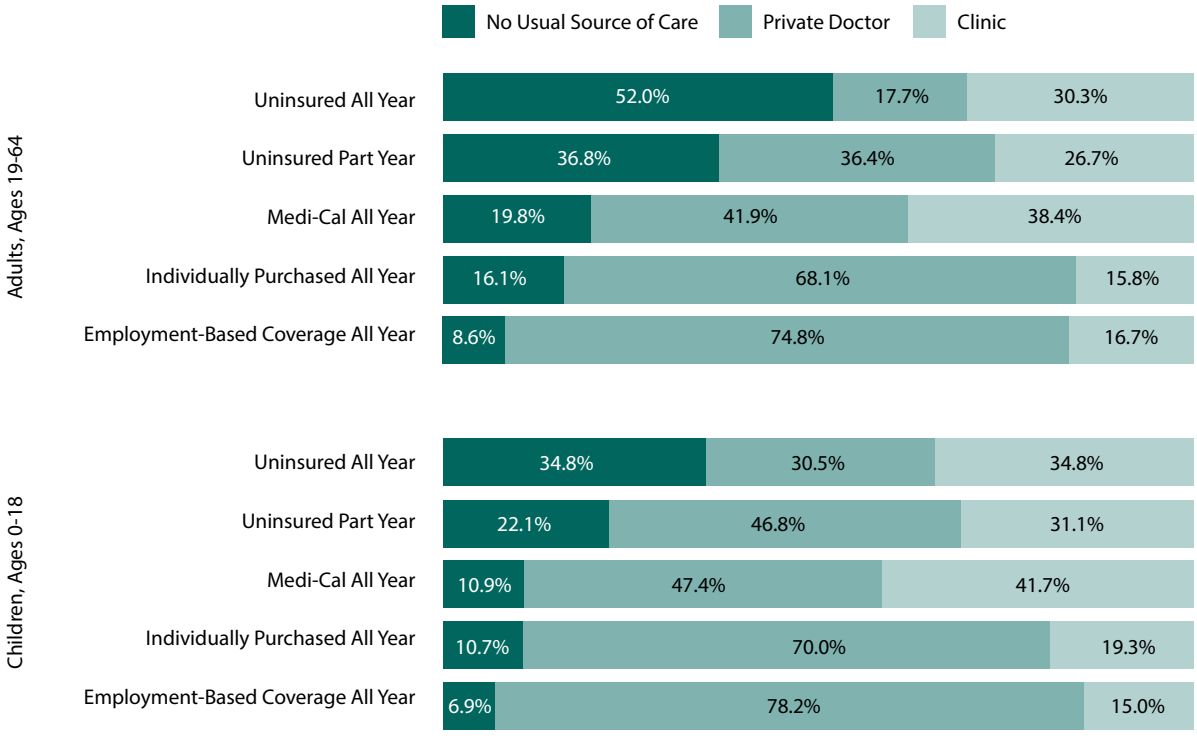
Health insurance is a significant determinant of access to care because it reduces financial barriers to the use of essential health care services, including primary care and emergency services. Individuals with health insurance coverage have better access to primary care providers who serve as the first point of contact with the health care system, manage the patient's preventive and chronic health care needs, and coordinate patient care with specialists and other providers. Individuals with health insurance coverage are also empowered to use health care as needed, and they have more options in their choice of providers. Access to care varies by type of insurance due to variations in benefits and cost-sharing levels, although some of the challenges resulting from these variations will be addressed by provisions of the Patient Protection and Affordable Care Act (ACA) that took effect in January 2014.

Health Insurance Improves Access to Primary Care Providers

Insurance allows individuals to establish relationships with primary care providers who are the first point of contact when care is needed and who improve continuity of care. According to data from the 2011-2012 California Health Interview Survey (CHIS), insurance type continues to be associated with having a usual source of care and with the setting in which the usual provider operates. Among adults, those who were uninsured all year (52%) were most likely to be without a usual source of care, and those with employment-based coverage all year (8.6%) were least likely to be without a usual source of care (Exhibit 35). Individuals with employment-based coverage more frequently reported using office-based private doctors for their usual source of care (74.8%) than did those with individually purchased all-year coverage (68.1%).

In contrast, adults with Medi-Cal all year most frequently reported a clinic as their usual source of care (38.4%; Exhibit 35). In addition, many individuals who were uninsured all or part of the year also reported using clinics as their main usual source of care (30.3% and 26.7%, respectively). The role of insurance coverage in having a usual source of care and the setting of the providers was similar among children and adults, with one notable difference: among those who were uninsured all year, a smaller proportion of children than adults reported no usual source of care (34.8% and 52%, respectively; Exhibit 35).

Exhibit 35.
Health Insurance Coverage During Last 12 Months by Usual Source of Care Among Nonelderly Adults and Children, Ages 0-64, California, 2012



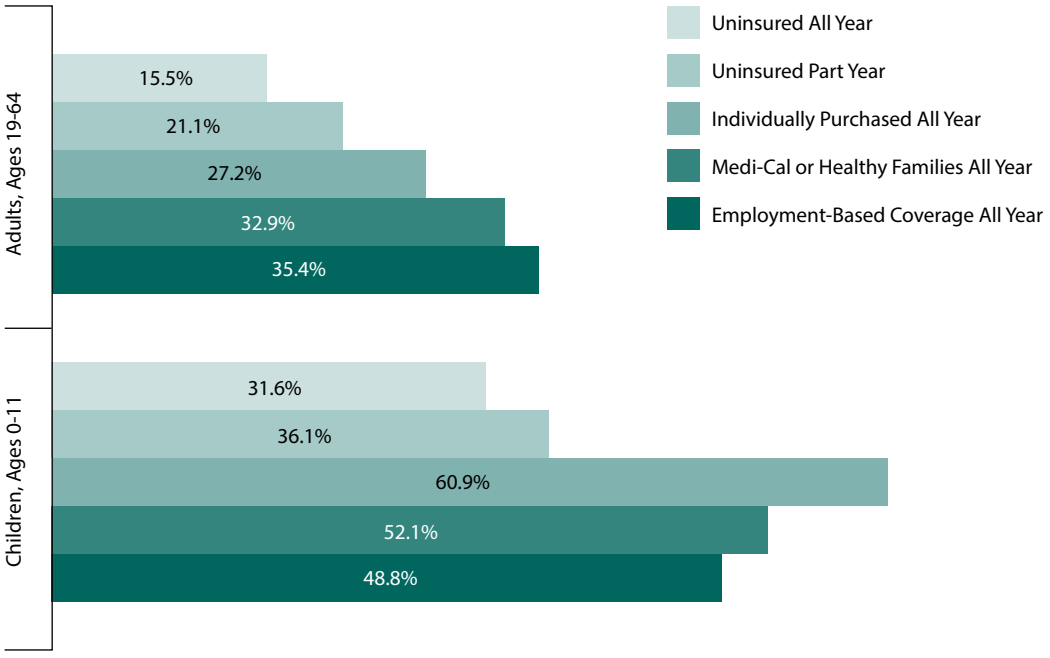
Note: Numbers may not add up to 100% because of rounding.

Source: 2011/2012 California Health Interview Survey

Health Insurance Improves Receipt of Preventive, Primary, and Urgent Care

Health insurance is associated with important preventive services, such as flu shots. The rates of flu shots were generally higher among children ages 0-11 than adults (Exhibit 36). Among children, those with employment-based coverage all year (48.8%), individually purchased coverage all year (60.9%), and Medi-Cal all year (52.1%) had the highest rates of flu shots, while those uninsured all year (31.6%) or part year (36.1%) had the lowest rates. A similar pattern was observed among adults: the insured were more likely to receive flu shots than the uninsured. However, adults with individually purchased insurance all year (27.2%) were less likely than adults with employment-based coverage all year (35.4%) or Medi-Cal all year (32.9%) to have received a flu shot.

Exhibit 36.
Flu Shot Rates by Health Insurance Coverage During Last 12 Months Among Nonelderly Adults, Ages 19-64, and Children, Ages 0-11, California, 2012

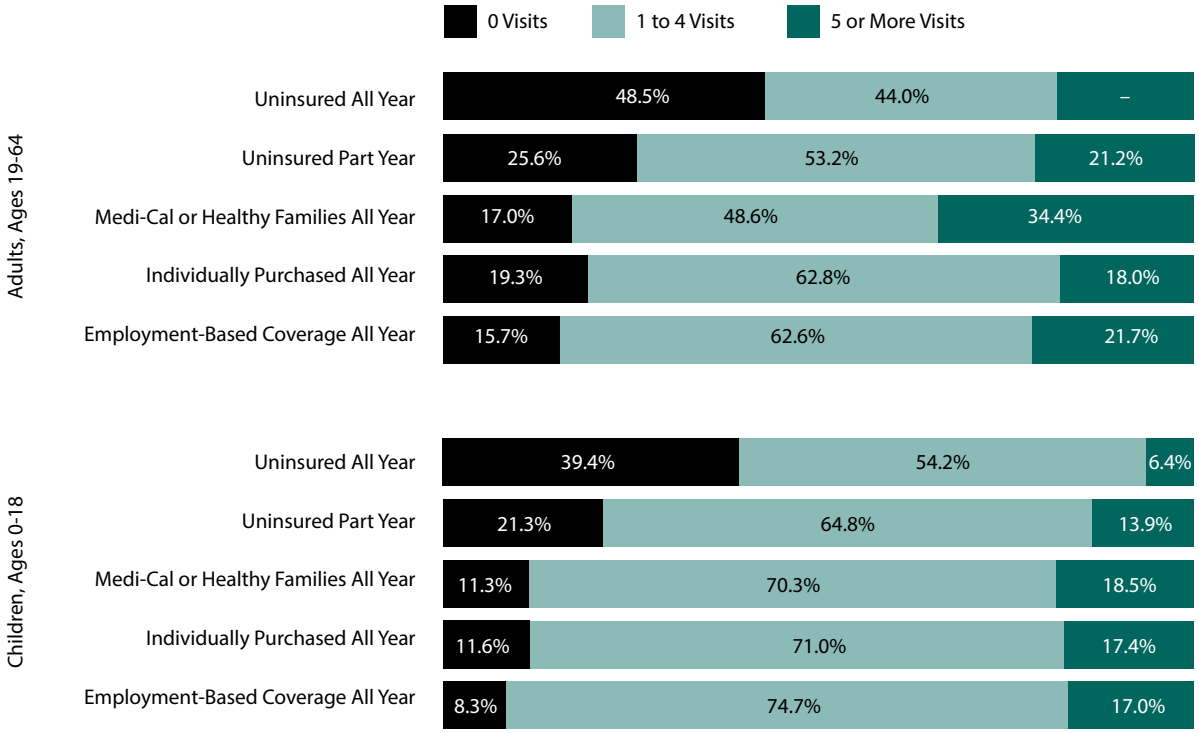


Note: Data for ages 12-17 were not available in CHIS 2011/2012.

Source: 2011/2012 California Health Interview Survey

Health insurance is also associated with a higher likelihood of outpatient visits. Among adults, those uninsured all year (48.5%) were most likely to have had no doctor visits, while adults with employment-based coverage were least likely to have had no doctor visits (15.7%; Exhibit 37). Among adults with any doctor visits, those with employment-based and individually purchased coverage (62.8%) were most likely to have had between one and four visits. The patterns of visits given the type of insurance coverage were similar among children and adults, although the overall proportions without any doctor visits were lower among children than adults.

Exhibit 37.
Health Insurance Coverage During Last 12 Months by Number of Doctor Visits Among Nonelderly Persons, Ages 0-64, California, 2012



-Unstable estimate due to coefficient of variation greater than 30%.

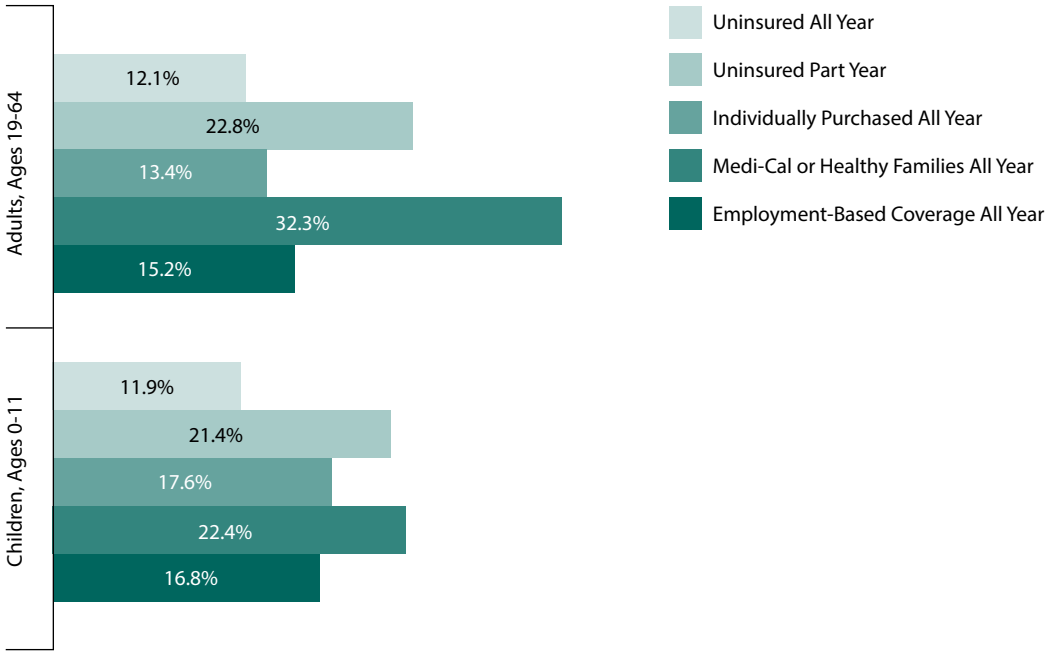
Numbers may not add up to 100% due to rounding.

Source: 2011/2012 California Health Interview Survey

Insurance coverage is associated with higher rates of emergency room (ER) use in the past year. Among adults, the rates of emergency room visits were lowest for those uninsured all year (12.1%), and highest for those with Medi-Cal or Healthy Families (32.3%; Exhibit 38), suggesting difficulty in accessing a doctor's office for regular care. ER visit rates were similar among adults with employment-based insurance (15.2%) and individually purchased insurance (13.4%). Adults who were uninsured for part of the year (22.8%) had even higher rates than those with employment-based insurance or individually purchased insurance. It is not clear why those who were uninsured part of the year had the highest rate of ER visits, but the reasons might include loss of coverage due to illness or poor health status.

The patterns of ER visits were similar for adults and children. Among children, ER visit rates were lowest among those uninsured all year (11.9%; Exhibit 38), higher for those with employment-based and individually purchased coverage (16.8% and 17.6%, respectively), and highest for those who had Medi-Cal and Healthy Families coverage (22.4%) or who had been uninsured part of the year (21.4%).

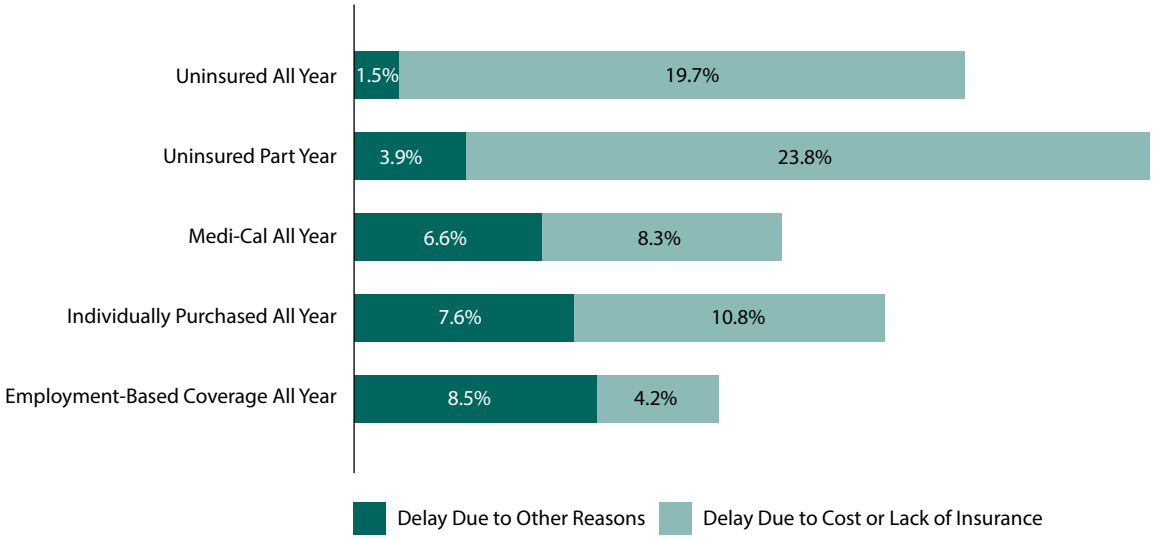
Exhibit 38.
At Least One Emergency Room Visit in the Last 12 Months by Health Insurance Coverage During Last 12 Months Among Nonelderly Persons, Ages 0-64, California, 2012



Source: 2011/2012 California Health Interview Survey

Forgone or delayed care due to cost or lack of insurance is an indicator that financial barriers limit access due to higher levels of out-of-pocket costs. Adults without insurance all year (19.7%) were most likely to report having forgone or delayed needed medical care due to cost or lack of insurance, followed by adults who were uninsured part of the year (23.8%; Exhibit 39). Reporting of forgone or delayed care due to costs was least common among adults with employment-based coverage (4.2%), followed by the other two insured groups.

Exhibit 39.
Reasons for Forgone or Delayed Needed Medical Care by Health Insurance Coverage During Last 12 Months Among Nonelderly Adults, Ages 19-64, California, 2012



Source: 2011/2012 California Health Interview Survey

Access to Care Under High-Deductible Plans

High-deductible plans are designed to reduce the use of non-urgent and discretionary services through greater cost sharing. These plans can be combined with a voluntary savings account to pay for services subject to the deductible. Starting in 2014, all plans in California, including high-deductible plans, must have standard benefits and cover preventive care and some primary care services without applying either a copayment or deductible, in compliance with the ACA.[13, 14] Prior to implementation of the ACA, many of these plans either did not provide comprehensive benefits or varied in cost-sharing levels, and they may thus have negatively impacted access to care.

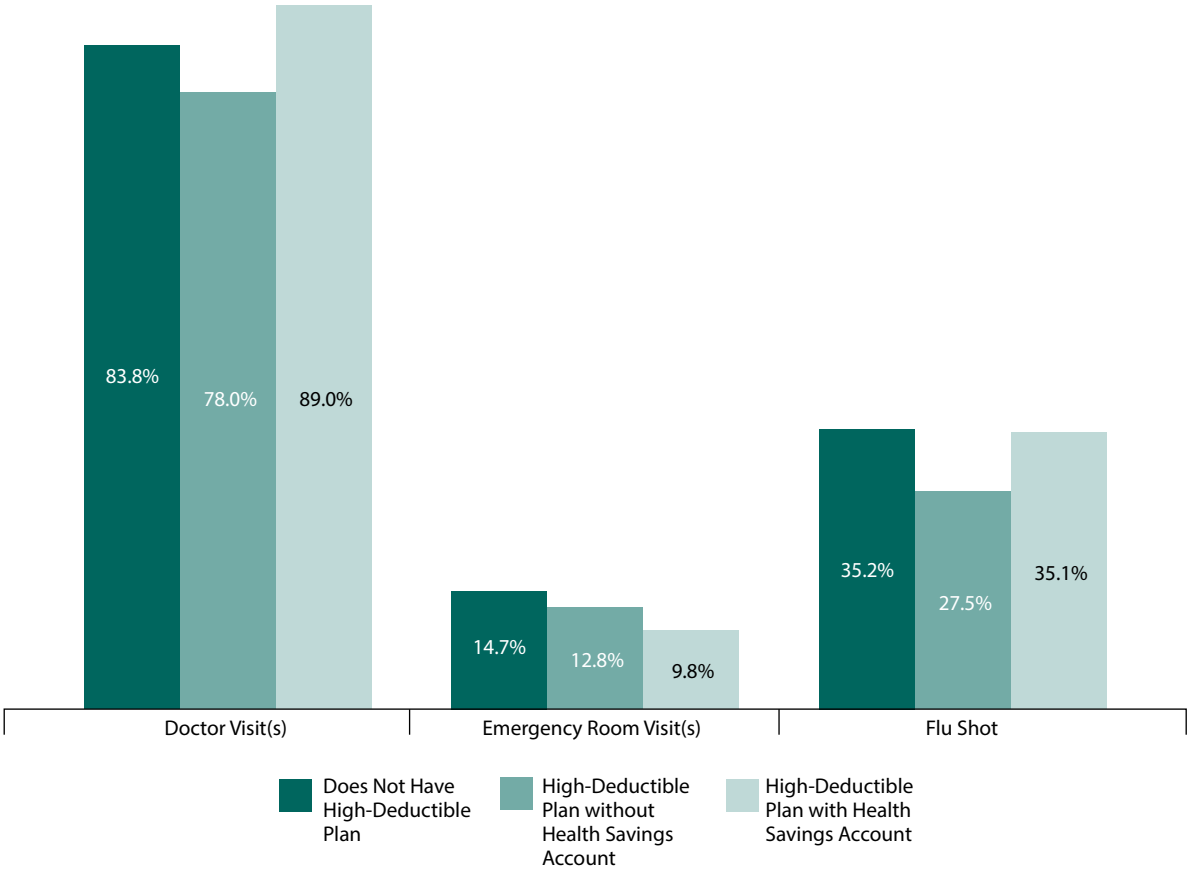
An estimated 15% of employment-based and 18% of individually purchased plans in California were high-deductible plans, and the great majority of these (15% and 13%, respectively) were not associated with health savings accounts (HSAs; data not shown). Measures of access under high-deductible plans, including doctor visits and ER visits in the past year,

13 Pourat N, Kominski G. Private Health Insurance. In Kominski G, ed. *Changing the U.S. Health Care System: Key Issues in Health Services Policy and Management* (4th ed). San Francisco: Jossey-Bass, 2013.

14 Kominski G. The Patient Protection and Affordable Care Act of 2010. In Kominski G, ed. *Changing the U.S. Health Care System: Key Issues in Health Services Policy and Management* (4th ed.). San Francisco: Jossey-Bass, 2013.

Exhibit 40.

Nonelderly Adults with Doctor Visits, Emergency Room Visits, and Flu Shots During Last 12 Months by High-Deductible Coverage and Health Savings Accounts, Ages 19-64, California, 2012



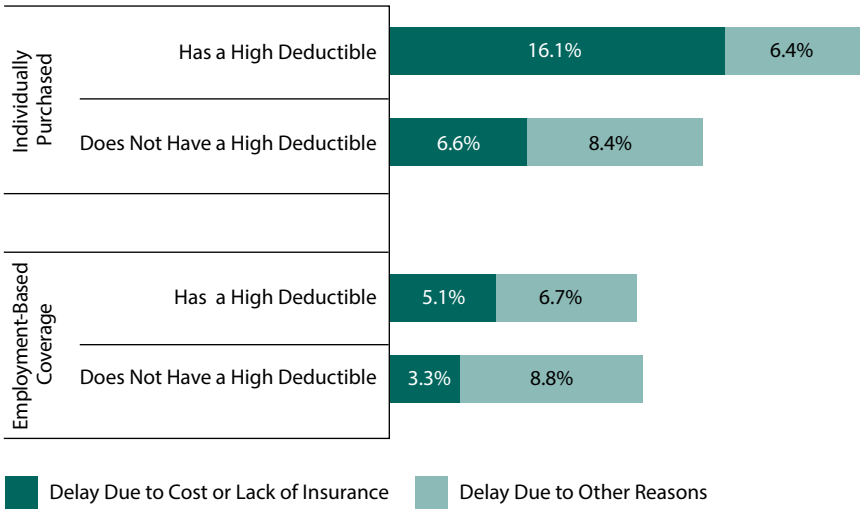
Source: 2011/2012 California Health Interview Survey

showed significant differences based on availability of an HSA (Exhibit 40). Specifically, enrollees with HSAs were more likely to have had at least one doctor visit in the past year (89%) compared to those without an HSA (78%). Enrollees with high-deductible coverage and an HSA were less likely to have visited the emergency room in the past year (9.8%) than those without an HSA (12.8%) or without a high-deductible plan (14.7%).

The rate of flu vaccinations also varied by whether people had high-deductible coverage. Among adults with employment-based coverage, those without high-deductible coverage and those with high-deductible coverage and an HSA were equally likely to receive a flu shot (35.2% vs. 35.1%, respectively), while those with high-deductible coverage without an HSA had a lower rate (27.5%; Exhibit 40).

Forgoing or delaying needed medical care due to cost or lack of insurance was reported more frequently among those covered by individually purchased high-deductible plans (16.1%) compared to those without high-deductible plans (6.6%; Exhibit 41).

Exhibit 41.
Forgone or Delayed Needed Medical Care by High-Deductible Insurance Coverage Among Nonelderly Adults, Ages 19-64, California, 2012

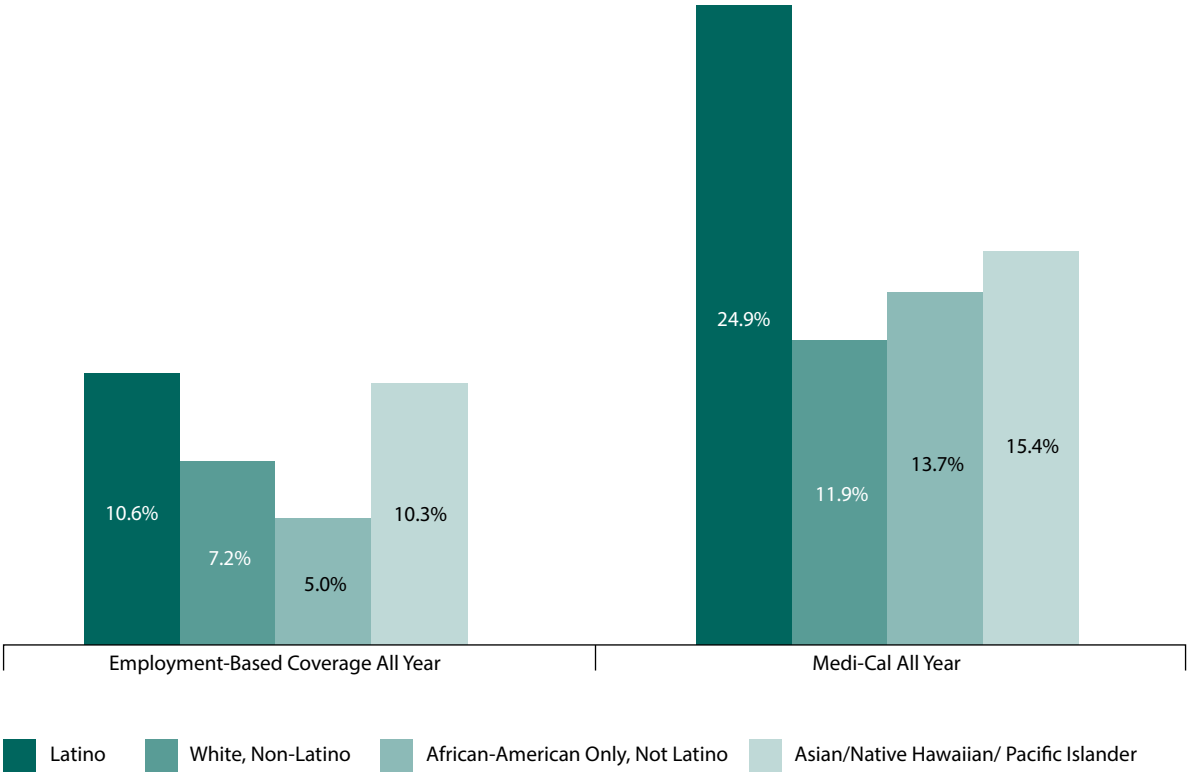


Source: 2011/2012 California Health Interview Survey

Racial/Ethnic Disparities in Access Persist

Insurance coverage increases the likelihood of access significantly for everyone. However, racial/ethnic disparities in access frequently persist despite having health insurance. For example, among adults with employment-based coverage, Latino (10.6%) and Asian American/Pacific Islander adults (10.3%) more frequently reported no usual source of care than white adults (7.2%; Exhibit 42). In contrast, whites more frequently reported no usual source of care than African-American adults (5%). Among Medi-Cal beneficiaries, Latino adults were most likely to report no usual source of care, at 24.9%—substantially higher than all other groups, which reported statistically similar rates.

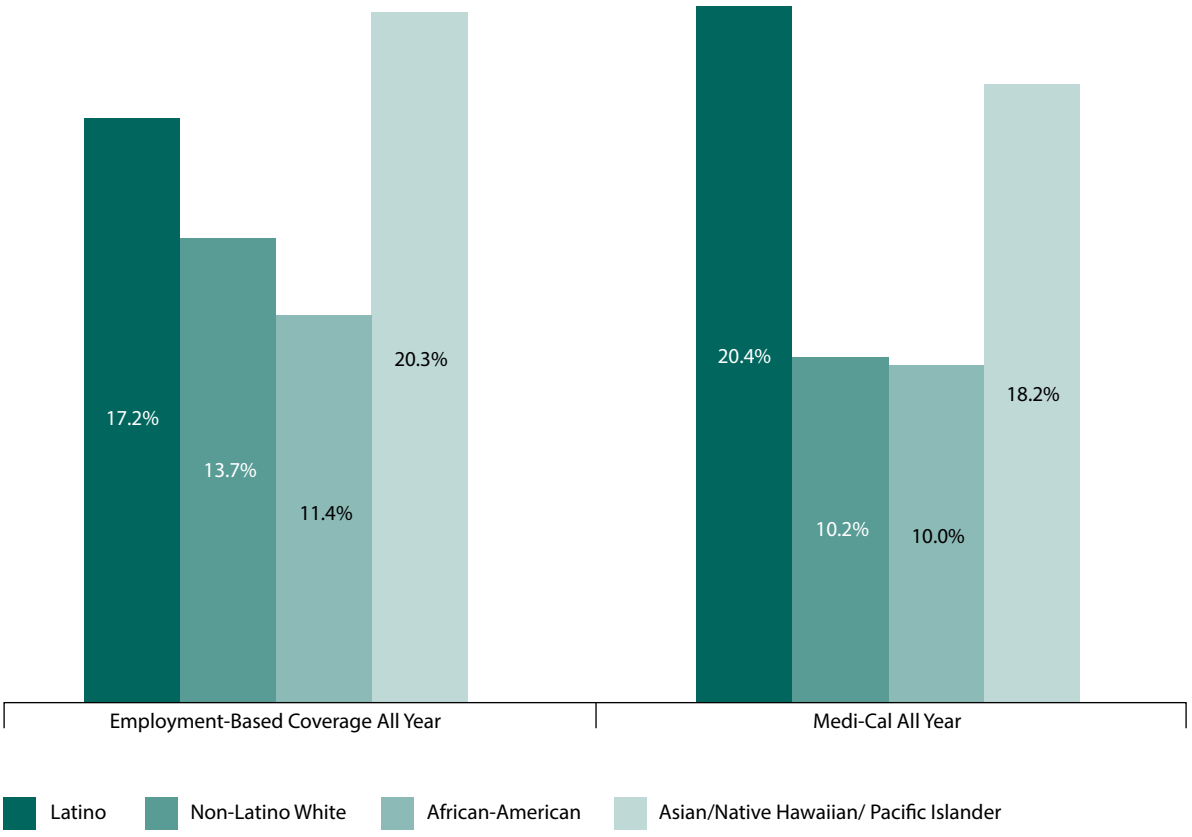
Exhibit 42.
Rates of Not Having a Usual Source of Care by Racial and Ethnic Group Among Nonelderly Adults with Employment-Based Coverage or Medi-Cal All Year, Ages 19-64, California, 2012



Source: 2011/2012 California Health Interview Survey

Disparities in usual source of care coincided with disparities in doctor visits. Among those with employment-based coverage, Asian Americans/Pacific Islanders (20.3%) were most likely to have had no visits to the doctor, and African-Americans (11.4%) were least likely to report this (Exhibit 43). Among those with Medi-Cal coverage, whites (10.2%) and African-Americans (10.0%) were least likely to report having had no doctor visits.

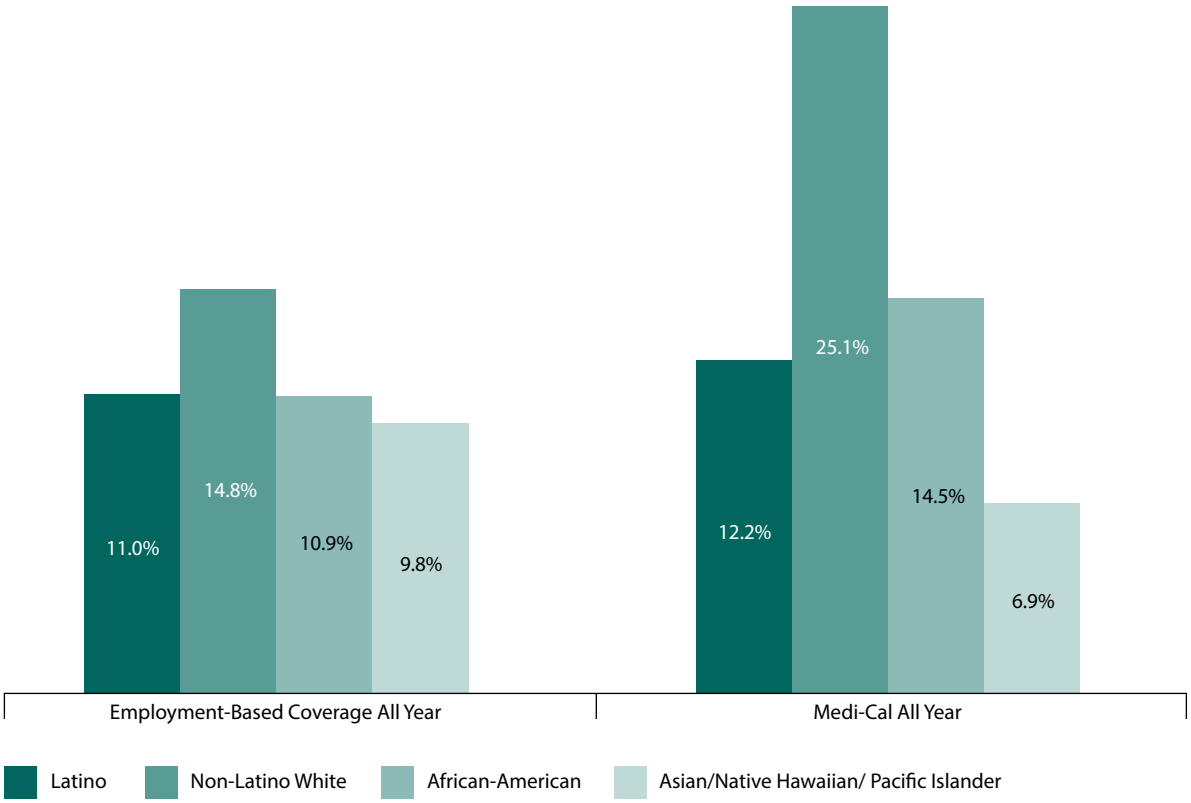
Exhibit 43.
Rates of No Doctor Visits During Last 12 Months by Racial and Ethnic Group Among Nonelderly Adults with Employment-Based Coverage or Medi-Cal All Year, Ages 19-64, California, 2012



Source: 2011/2012 California Health Interview Survey

Despite these disparities in usual source of care and doctor visits, non-whites less frequently reported having delayed or forgone medical care in the past year. Among those with employment-based coverage, whites (14.8%) were more likely to report delays than all other groups (Exhibit 44). The same pattern was also observed among those with Medi-Cal coverage. However, Asian Americans/Pacific Islanders (6.9%) were least likely to report such delays. Underreporting of delays or forgone care is possible, since some non-white populations have been found to underreport health problems.

Exhibit 44.
Rates of Delays in Medical Care During Last 12 Months by Racial and Ethnic Group Among Nonelderly Adults with Employment-Based Coverage or Medi-Cal All Year, Ages 19-64, California, 2012



Source: 2011/2012 California Health Interview Survey

Conclusions

The findings in this chapter confirm that health insurance plays a central role in access to health care. Health insurance is essential to having a usual source of care, which can provide continuity, improve receipt of preventive care services, and reduce use of urgent and emergency services for insured and uninsured alike. Health insurance improves the likelihood of receipt of preventive services such as flu shots, improves rates of doctor visits, and reduces the likelihood of delaying or forgoing needed medical care.

Variations in health care use, particularly among those with public coverage or high-deductible plans, highlight the need for policy interventions to reduce such differences. For example, the higher rates of ER visits for those with Medi-Cal coverage are most likely a reflection of barriers in access to primary care providers who accept Medi-Cal or of an insufficiency of resources to provide better care for Medi-Cal enrollees. Medi-Cal has been transitioning several eligibility categories to managed care; the trend in high rates of ER use will be important to monitor in future reports. Similarly, the variations in service use among enrollees with high-deductible plans highlight the importance of cost-sharing protections for these individuals.

Racial/ethnic disparities in access to care despite insurance coverage are a significant and persistent problem that highlight the need for policy solutions addressing cultural, linguistic, and systemic barriers to access. Policy solutions include, but are not limited to, tailoring care delivery to target populations and improving the cultural and linguistic competency of providers.

The successful enrollment of previously uninsured individuals in Covered California and Medi-Cal following the implementation of the ACA bodes well for access to preventive and other needed health care by newly insured Californians. However, the data provided in this chapter indicate that while health insurance alleviates barriers in access to care, other barriers—such as the capacity of the system to provide care to the newly insured population—should remain a central policy focus.

5 The Affordable Care Act and Its Impact on California's Uninsured

Gerald F. Kominski

The Affordable Care Act (ACA) of 2010 is expected to substantially reduce the high rate of uninsurance in California and the nation. The major provisions of ACA did not go into effect until the beginning of 2014, with the availability of federal subsidies to buy insurance through Covered California and the state's Medi-Cal expansion. Therefore, this report provides an essential baseline for the health insurance status of Californians in the period just prior to the implementation of ACA provisions that are expected to yield a significant reduction in the number of uninsured Californians. As of May 2014, Covered California reported that almost 1.4 million Californians had purchased insurance through the exchange, including 1.2 with subsidies, and roughly 2.0 million more had enrolled in Medi-Cal, with another 800,000 applications still being processed. Although not all of these individuals were previously uninsured, we expect that these overwhelming numbers will produce significant reductions in the number of uninsured Californians that will be documented in the next edition of this report.

The ACA is the most significant piece of health care legislation since the enactment of Medicare and Medicaid in 1965, and it promises to substantially reduce the high rate of uninsurance in California and the nation. Because the major provisions of ACA did not go into effect until 2014, Californians continued to experience high rates of uninsurance in 2011/12, the time period covered by this report. Although the state had experienced significant economic recovery since the Great Recession that began in late 2008, 4.26 million nonelderly Californians reported being uninsured all year in 2012, and another 2.66 million reported being uninsured part of the year. The overall rate of uninsurance was lower in 2012 compared to our last report using 2009 data for those ages 0-39, but the rate was slightly higher for those ages 40-64.

California was the first state to establish a state-based marketplace – or health benefit exchange – under the ACA, known as Covered California. In October 2013, Covered California opened for business. Despite some relatively minor glitches, it avoided the major problems experienced by the 36 states that defaulted to the federally facilitated marketplaces operated as part of the healthcare.gov website. California's commitment to broadly expanding coverage under the ACA produced tremendous success in enrollment both in exchange-based policies and in the Medi-Cal program. In addition, about 1.9 million Californians were newly enrolled in Medi-Cal, including almost 650,000 who were previously enrolled in the state's Low-Income Health Program (LIHP) Medicaid 1115 waiver demonstration project. LIHP allowed counties to leverage their expenditures for eligible enrollees—uninsured adults who are citizens or legal residents with at least five years of residency and with incomes below 200% of the federal poverty level—to qualify for federal matching funds for health care services provided to LIHP enrollees. LIHP therefore

served as a "Bridge to Reform" by providing health care coverage for 650,000 Californians who would otherwise have remained uninsured until 2014. LIHP enrollees were automatically transitioned into Medi-Cal on January 1, 2014, without the need to enroll individually. In total, Covered California enrolled more than 2.5 million Californians in either private insurance offered through the exchange or in Medi-Cal. To place this accomplishment in context, Covered California enrolled more than twice the number of individuals covered by CalPERS, and it enrolled more Californians than all but two of the largest private insurers in the state.

Of course, not all the individuals enrolled by Covered California were previously uninsured. We expect that many of the 1.4 million Californians who purchased insurance through Covered California both with and without subsidies were previously insured. These individuals took advantage of either federal subsidies or more affordable premiums offered through the exchange to purchase more affordable insurance. These efforts to make insurance more affordable provide important financial benefits to low- and middle-income Californians, but they won't reduce the rate of uninsurance. Previous research by Center researchers, in collaboration with UC Berkeley and

using the California Simulation of Insurance Markets (CalSIM) model, suggested that 57 percent of those enrolling in Covered California with subsidies and 75 percent of those newly eligible for Medi-Cal were previously uninsured.[15] If these estimates prove accurate, more than 1.5 million Californians were newly insured in 2014 due to the ACA. This total is in addition to the 650,000 LIHP enrollees who were "pre-enrolled" in Medi-Cal, plus the more than 500,000 young adults ages 19-26 who were newly insured through their parents' insurance policies after 2010 as a result of the ACA.[16] Therefore, in our next report, we have good reason to expect that between 2.6 and 2.7 million Californians will have been newly insured by the end of 2014 as a result of the ACA.

In this report, we've already observed some of the early impacts of the ACA, including a reduction in the rate of uninsured young adults ages 19-26. Given the substantial first-year success of Covered California in meeting and exceeding its enrollment targets, we believe that significant reductions in the number of uninsured Californians have already occurred in California. We expect these reductions to show up in the 2013/14 CHIS survey. While the recovery from the Great Recession has produced improvements in the unemployment rate, the state budget, and the overall economic conditions of California, those improvements have not produced substantial improvements in the health insurance status of Californians, at least in terms of stemming the erosion in employment-based insurance. As a result, the ACA may be even more important to securing the health insurance status of millions of Californians in the future who otherwise might have been uninsured despite the growth of the state's economy and its ongoing recovery from the Great Recession.

15 CalSIM version 1.8 Statewide Data Book, 2014–2019. Available at *http://healthpolicy.ucla.edu/programs/health-economics/projects/CalSIM/Documents/CalSIM_Statewide.pdf*.

16 Families USA. *The New Health Care Law: Fact Sheet*, March 2011. Available at *http://familiesusa.org/sites/default/files/product_documents/Benefits-of-Health-Care-Law.pdf*.

Our Mission

The UCLA Center for Health Policy Research improves the public's health by advancing health policy through research, public service, community partnership, and education.

Visit our website at **www.healthpolicy.ucla.edu** for more information on our free data, publications, services, and events.

The California Endowment

The California Wellness Foundation

UCLA CENTER FOR HEALTH POLICY RESEARCH

10960 Wilshire Boulevard, Suite 1550
Los Angeles, California 90024
Phone: 310.794.0909
Fax: 310.794.2686
Email: chpr@ucla.edu

Penn LDI Leonard Davis Institute of Health Economics

Robert Wood Johnson Foundation

Window Shopping on Healthcare.gov and the State-Based Marketplaces: More Consumer Support is Needed

In-Brief

This data brief examines the window-shopping experience that consumers encountered on each health insurance marketplace website during the first two weeks of the Affordable Care Act's second open enrollment period. The marketplaces have made some progress toward adopting the recommended "Top 5 Rules for Decision Support." Shoppers found plenty of sorting and filtering options, but insufficient information about providers and little true decision support. Although there is still a long way to go, there are grounds for optimism about further progress for the next open enrollment period.

Research has shown that choice architecture can have a significant impact on the decisions that people make when choosing among available options. Coined by behavioral economists, the term "choice architecture" refers to the conscious effort to design the environment in which people make decisions, with the goal of improving those decisions. In the context of the web portals for the health insurance marketplaces, choice architecture can include the order in which the available health plans are displayed, the amount and type of information that is displayed regarding each plan, as well as the availability of sorting and/or filtering options, just to name a few. Good choice architecture does not necessarily focus on the number of options (although there is concern that too many options may overwhelm the consumer), but rather on structuring choice environments so that consumers are most likely to pick the option that is optimal for them, based on their needs and preferences.

Based on existing research on choice architecture, with assistance from LDI's Tom Baker and his co-author Eric Johnson, and with funding from the Robert Wood Johnson Foundation, the Pacific Business Group on Health (PBGH) developed in 2013 the "Top 5 Rules for Decision Support" for the ACA's health insurance marketplaces. PBGH recommended that the marketplaces: 1) provide individualized total cost estimates to allow consumers to make meaningful financial comparisons; 2) offer an individualized, smart plan presentation that displays plans in the order of their fit for the consumer selecting the plan, but allows customized sorting and filtering; 3) include short cuts that allow consumers to choose plans without detailed comparisons if they wish; 4) use an information hierarchy that highlights what matters most to consumers and allows them to access additional information in a second layer, and 5) include an integrated provider directory that allows consumers to determine which individual providers and how many different kinds of providers are in the networks of each plan. These basic recommendations guided our investigation into the features of each state's marketplace website.

Dr. Charlene Wong's recent article in the Annals of Internal Medicine, "The Experience of Young Adults on HealthCare.gov: Suggestions for Improvement," also provided insight that guided our investigation. Dr. Wong's study followed a group of educated young consumers as they went through the insurance enrollment process on HealthCare.gov last year. Study participants struggled with insurance terminology ("deductible," for example), felt overwhelmed by the amount of information, misunderstood eligibility for subsidies, and expressed a desire for more and better decision support.

WHAT WE DID:

Our team of researchers collected data by visiting the websites for each of the state-based health insurance marketplaces and Healthcare.gov during the initial 15 days of the second open enrollment (November 15-30, 2014), systematically engaging in the window shopping experience, and filling out a survey of the web portal features that were available without creating an account.

We identified over 25 aspects of choice architecture that we used to compare the web portals. At least two researchers independently surveyed each web portal; supervisors audited the results and resolved any discrepancies by visiting the web portal. The research team took and retained detailed screenshots of web pages in order to allow each answer in the survey to be verified by supervisors and available for subsequent research and analysis. Our process simulated a typical shopping experience on each marketplace. It is possible that we may

have missed certain features, but, if so, those features were not apparent to multiple observers with experience navigating the web portals and, thus, would be unlikely to be readily apparent to an ordinary consumer.

In order to standardize data collection, researchers provided the same demographic information when window shopping on each state's website, wherever possible: 30 years old, female, $25,000 annual income (alternately, $10,000 was used when answering questions related to Medicaid), and one person per household. These basic demographics ensured that our "shoppers" would be eligible for tax credits and cost sharing subsidies (gross income between 138% and 250% of the Federal Poverty Level (FPL)), and that pregnancy status could be factored into potential Medicaid eligibility, where applicable.

FINDINGS

Total cost estimates: None of the web portals offer consumers a personalized total cost estimate that shows consumers the sum of their premiums (net of subsidies) and estimated out-of-pocket expenses. The California and Idaho marketplaces point in the right direction, however, by presenting estimated total costs based on low, medium and high use of medical services.

Smart presentation of plans: None of the web portals are able to present plans following PBGH's "smart organization" recommendation, but California and Minnesota point in the right direction. California provides an initial sort organized by estimated overall cost, and Minnesota provides an initial sort organized according to consumer preference.

Although Healthcare.gov and most of the state marketplaces have robust sorting and filtering capacities along most of the dimensions that we looked for, it is doubtful that these capacities, alone, promote good decisions. In most cases the portals first present plans according to premium, from least to most expensive, and then offer users the ability to sort and filter along other dimensions, without suggesting, or providing a tool that the consumer can use to determine, an "all things considered," personalized best fit. The research shows that consumers need more help than this.

Shortcuts: None of the marketplace web portals implement the PBGH recommendation that consumers be given "the choice between the long road (e.g., more preference questions and plan details) and the short cut (e.g., fewer preference questions and plan details)."

Information hierarchy: All of the web portals employ some version of an information hierarchy that highlights summary information in the initial presentation and allows consumers to see additional information in a second layer.

Provider directory: Only six of the state-based marketplace web portals contain an integrated provider look-up, and only three of those – Kentucky, Massachusetts, and Washington – include a look-up for participating hospitals. Healthcare.gov does not contain an integrated provider directory for the states that we reviewed.

Additional findings: In addition to examining whether the web portals implemented the PBGH decision support recommendations in the window shopping experience, we analyzed whether the web portals 1) informed consumers of Medicaid eligibility, 2) "nudge" those consumers who are eligible for the very valuable cost sharing subsidies toward the silver plans that are eligible for these subsidies, 3) provide quality ratings, 4) contain a prescription drug formulary look-up tool analogous to the recommended provider look-up tool, and 5) contain easy to find definitions of terms as recommended by Dr. Wong.

All of the marketplaces except New York inform window shopping consumers of Medicaid eligibility (we understand that the New York real shopping experience does so). Five of the state portals provide the recommended cost sharing eligibility nudge. Five of the states provide plan quality ratings. Only one of the web portals – Colorado – contains an integrated formulary look-up tool, and that tool is hard to find on the Colorado web portal. Finally, most of the web portals contain easy to find definitions of health insurance terms, but Healthcare.gov and five of the state portals do not employ the preferred pop-up definitions that appear whenever the cursor points to a health insurance term.

Table 1 presents the web portal survey results regarding total cost estimates, provider directory, and the aspects of decision support not included in the PBGH recommendations.

Table 2 presents the web portal survey results regarding smart presentation of plans.

Comparison between window shopping in the first and second open enrollment: We also compared the results of the second open enrollment window shopping survey with a partial survey conducted during the first open enrollment. These comparisons are available in an online appendix. There were relatively few differences in choice architecture between the first and second open enrollment window shopping experience. This is unsurprising given the short time between the first and second open enrollments. Differences include more robust sorting and filtering capacities in the second open enrollment on Healthcare.gov and some states, the availability of the overall cost estimates on the California and Idaho portals, greater use of the cost sharing nudge, provider look-up tools, and quality ratings in the second open enrollment web portals. Most of these differences are encouraging steps in the right direction.

DISCUSSION

The web portals for the health insurance marketplaces are making progress toward following choice architecture recommendations but there is still a long way to go.

The portals generally provide robust sorting and filtering options, but they do not provide robust decision support. Except for the limited information provided on the California and Idaho portals, consumers cannot compare their total estimated costs under the available plans. Nor is it possible for consumers to see the plans ranked in terms of best fit for them, though Minnesota's MNsure portal has taken some steps in that direction.

With that said, it is important to emphasize that the PBGH total cost and smart presentation recommendations were very difficult for the public web portals to implement in time for the fall 2014 open enrollment period, as the necessary data analytics and technology solutions are only just now being developed. Medicare.gov has total cost calculators available for Part D prescription drug plans, but not for Medicare Advantage plans, which are more analogous to the health plans available on the marketplaces. Based on recent developments in decision support technology, we expect to see substantial progress toward adopting these recommendations in the next open enrollment period.

The web portals also have a long way to go in order to provide adequate integrated provider directories. Most sites are limited to linking to individual plan directories and searches. Provider look-up tools have proven to be a difficult challenge across the health care marketplace. With the increasing emphasis on narrow network plans, there is a pressing need for tools that will allow consumers to find out which providers are in which networks and, even more importantly, to value those networks.

While only one of the web portals has a drug and formulary look-up tool, those tools present much less of a technical challenge, suggesting that the absence of those tools represents a judgment about priorities. The robust drug look-up and formulary cost tools available on Medicare.gov for Medicare Part D prescription drug plans suggests that Healthcare.gov and the state marketplace portals will be able to make rapid progress on developing those tools once they become a priority.

Finally, the adoption of the cost-sharing subsidy nudge by five of the states suggests that the marketplaces may be willing and able to employ low cost and easy to implement choice architecture recommendations. The challenge going forward is to encourage Healthcare.gov and the remaining web portals to adopt this recommendation and to identify more such recommendations.

About the Authors

This Data Brief was written by Tom Baker, JD, William Maul Measey Professor of Law and Health Sciences, University of Pennsylvania Law School and Wharton Health Care Management Department, Adrienne Beatty, JD, Senior Research Assistant, Health Insurance Exchanges Research Group, LDI, Gabbie Nirenburg, JD, Legal Analyst & Project Manager, Health Insurance Exchanges Research Group, LDI and Janet Weiner, MPH, Associate Director for Health Policy, LDI.

About The Leonard Davis Institute of Health Economics

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

About the Robert Wood Johnson Foundation

For more than 40 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are striving to build a national Culture of Health that will enable all 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.

Table 1. Decision Support

	Total Cost Estimates		Provider Directory	Other Decision Support					
STATE	Individualized Total Cost Estimate	Standardized Total Cost Estimate	Integrated Provider Look-Up	Premium Subsidy Calculator	Integrated Drug Look-Up	Quality Ratings	Definitions	Alerted to Medicaid Eligibility	CSR Subsidy Nudge
HealthCare.Gov				✓			✓ Glossary	✓	
California		✓		✓		✓	✓ Pop-Ups	✓	✓
Colorado			✓	✓	✓	✓	✓ Pop-Ups	✓	
Connecticut				✓		✓	✓ Pop-Ups	✓	✓
District of Columbia								✓	
Hawaii			✓	✓			✓ Glossary	✓	
Idaho		✓		✓			✓ Pop-Ups	✓	
Kentucky	*		✓	✓				✓	
Maryland			✓	✓		✓	✓ Pop-Ups	✓	✓
Massachusetts			✓	✓			✓ Pop-Ups	✓	
Minnesota				✓			✓ Glossary	✓	
New York				✓		✓	✓ Pop-Ups		
Rhode Island				✓			✓ Pop-Ups	✓	
Vermont			-				✓ Glossary	✓	✓
Washington			✓	✓			✓ Pop-Ups	✓	✓

* *Kentucky's portal has an out-of-pocket cost estimator that requires the user to report average costs and frequency of office visits and drugs.*

Table 2. Smart Presentation of Plans

	Initial Sort	Are Premiums Displayed Post-Subsidy?	Total Cost Estimate		Post-Subsidy Premiums		Max Out of Pocket Cost		Deductible		Metal Level		Insurance Company		Quality Rating		Plan Type		Provider		Plan Compare Feature	Other Sort/Filter Options
STATE			Sort	Filter	Sort	Filter	Sort	Filter	Sort	Filter	Sort	Filter	Sort	Filter	Sort	Filter	Sort	Filter	Sort	Filter		
HealthCare.Gov	Premium Post-Subsidy: Cheapest to most expensive	✓			✓	✓	✓	✓	✓			✓		✓				✓			✓	Filter by "Medical Management Programs"
California	Out of Pocket cost lowest to highest, based on medical use	✓	✓		✓							✓			✓						✓	
Colorado	Premium Pre-Subsidy: Cheapest to most expensive				**	**		✓	✓	✓		✓		✓						✓*	✓	
Connecticut	Premium Pre-Subsidy: Cheapest to most expensive				**	**			✓	✓	✓	✓	✓	✓	✓	✓					✓	Under filtering, can choose how much of tax credit to apply to monthly premium
District of Columbia	Not Available (Sample only, by metal level)																					
Hawaii	Premium Pre-Subsidy: Cheapest to most expensive				**	**						✓	✓	✓				✓			✓	
Idaho	Premium Post-Subsidy: Cheapest to most expensive	✓	✓		✓		✓		✓	✓		✓		✓			✓				✓	Filter by HSA-qualified
Kentucky	No discernible order				**	**		✓	✓	✓		✓		✓	✓	✓				✓	✓	
Maryland	Premium Post-Subsidy: Cheapest to most expensive	✓			✓	✓			✓	✓	✓	✓	✓	✓	✓	✓					✓	Under filtering, can choose how much of tax credit to apply to monthly premium
Massachusetts	Premium Pre-Subsidy: Cheapest to most expensive				**	**		✓	✓	✓		✓		✓						✓	✓	
Minnesota	"My Preference Match"				**				✓	✓	✓	✓									✓	Filter by wellness program, HSA-qualified
New York	Premium Post-Subsidy: Cheapest to most expensive	✓										✓		✓		✓					✓	Sort by "Coverage Type" (med/dental)
Rhode Island	Premium Post-Subsidy: Cheapest to most expensive	✓			✓	✓		✓	✓	✓	✓	✓		✓						✓*	✓	
Vermont	Not Available (Sample only, by metal level)																					
Washington	Premium Post-Subsidy: Cheapest to most expensive	✓			✓	✓	✓	✓	✓	✓		✓		✓				✓		✓	✓	Filter by HSA-qualified, "Health Plan Wizard" function

** While these states allow users to filter by provider, the providers that can be filtered do not include hospitals.*
*** These states display pre-subsidy premiums only and thus only allow users to sort and/or filter by pre-subsidy premiums.*

THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

Filling the need for trusted information on national health issues...

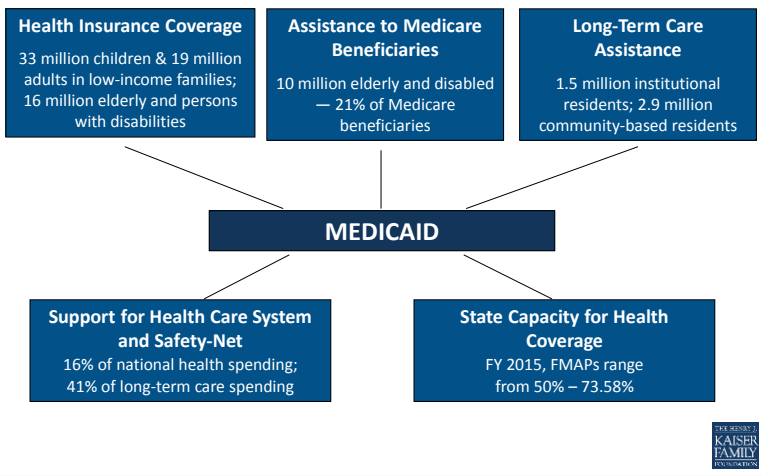
January 2015 | Fact Sheet

Medicaid Moving Forward

Medicaid is the nation's main public health insurance program for people with low incomes, and it is the single largest source of health coverage in the U.S. At last count, Medicaid covered over 68 million Americans – more than 1 in every 5 – at some point during the year. States design and administer their own Medicaid programs within federal requirements, and states and the federal government finance the program jointly. Medicaid plays many roles in our health care system (Figure 1). Medicaid coverage facilitates access to care for beneficiaries, covering a wide range of benefits and tightly limiting out-of-pocket costs for care. As a major payer, Medicaid is a core source of financing for safety-net hospitals and health centers that serve low-income communities, including many of the uninsured. It is also the main source of coverage and financing for both nursing home and community-based long-term care. Altogether, Medicaid finances 16% of total personal health spending in the U.S.

Figure 1

Medicaid's Role in Our Health Care System



The Affordable Care Act (ACA), enacted on March 23, 2010, expanded the Medicaid program significantly as part of a broader plan to cover millions of uninsured Americans.[1] Specifically, the ACA expanded Medicaid eligibility to nearly all non-elderly adults with incomes at or below 138% of the federal poverty level (FPL) – about $16,105 for an individual in 2015. This expansion established a new coverage pathway for millions of uninsured adults who were previously excluded from Medicaid, beginning January 1, 2014. The law also provided for 100% federal funding of the expansion through 2016, declining gradually to 90% in 2020 and future years. However, the Supreme Court ruling on the ACA in June 2012 effectively made the Medicaid expansion optional for states.

Beyond expanding Medicaid, the ACA introduced other reforms that improve the program in all states, regardless of their Medicaid expansion decision. The law required states to simplify and modernize their enrollment processes, and to create a coordinated eligibility and enrollment system for Medicaid, the Children's Health Insurance Program (CHIP), and the Marketplace, to facilitate enrollment and promote continuity of coverage. The ACA also established an array of new authorities and funding opportunities for delivery system and payment reform initiatives in Medicare, Medicaid, and CHIP, designed to advance better and more cost-effective models of care, particularly for those with high needs and costs, whose care is poorly

coordinated, leading to both serious gaps and costly redundancy. Finally, the law provided new options and incentives to help states rebalance their Medicaid long-term care programs in favor of community-based services and supports rather than institutional care. Collectively, these provisions have accelerated Medicaid innovation already underway in many states. Because Medicaid covers many of the highest-need populations in the U.S., states have unique financial and policy leverage to reform the systems of care that serve them.

Between action in many states to strengthen the Medicaid program and far-reaching ACA provisions in key Medicaid domains, Medicaid is in a period of historic transformation. While data and analysis on the impact of the changes underway will take time to emerge, this fact sheet provides a current profile of Medicaid and highlights developments in the program unfolding at the federal and state level.

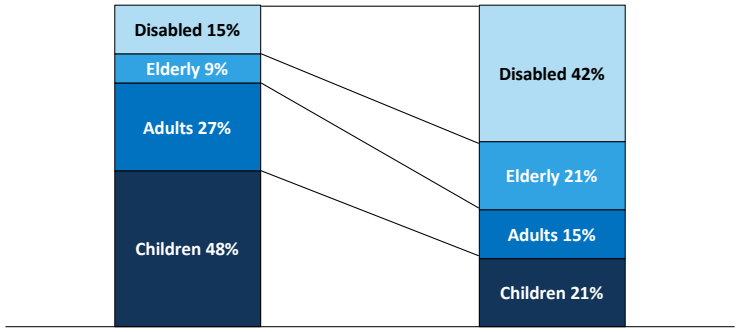
Who does Medicaid cover?

Before the ACA, federal law provided federal funding for Medicaid only for specified categories of low-income individuals: children, pregnant women, parents of dependent children, individuals with disabilities, and people age 65 and older. States were required to cover individuals in these groups up to federal minimum income thresholds, but also had the option to expand coverage to people at higher income levels. Importantly, prior to the ACA low-income adults were largely excluded from Medicaid. In FY 2011, the most current year for which national data are available, about three-quarters of all Medicaid beneficiaries were children and non-elderly, non-disabled adults (primarily, working parents), and the elderly and younger people with disabilities accounted for the remaining one-quarter (Figure 2).

Over the last 25 years, many states have taken action to expand coverage for children. To illustrate, while federal law required states to provide Medicaid for children up to at least 100% FPL (133% FPL for infants), as of October 2014, 26 states (including DC) had expanded eligibility to at least 255% FPL under Medicaid or CHIP, and in 20 of these states, the eligibility cut-off was over 300% FPL. Together, Medicaid and CHIP now cover more than 1 in every 3 children, and the role of the programs is even larger among low-income children and children of color. In December 2013, over 28 million children were enrolled in Medicaid and 5.8 million were enrolled in CHIP.[2]

Figure 2

Medicaid Enrollees and Expenditures, FY 2011



SOURCE: KCMU/Urban Institute estimates based on data from FY 2011 MSIS and CMS -64. MSIS FY 2010 data were used for FL, KS, ME, MD, MT, NM, NJ, TX, UT, OK but adjusted to 2011 spending levels.

The history of Medicaid coverage of adults is sharply different. In 2013, before the ACA Medicaid expansion took effect, the median state Medicaid income eligibility cut-off for working parents was 61% FPL and, in most states, non-elderly adults without dependent children ("childless adults") were categorically ineligible for Medicaid.[3] States' income eligibility thresholds have typically been higher for the elderly and people with disabilities. States generally must provide Medicaid automatically to seniors and people with disabilities who receive Supplemental Security Income (SSI) benefits, for which the federal benefit rate is 74% FPL.[4] States also have the option to cover elderly individuals and people with disabilities who have more income or high medical

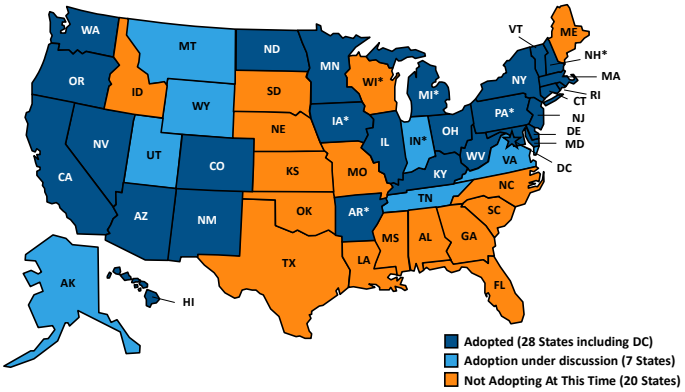
expenses relative to their income.[5] The ACA did not alter the Medicaid eligibility rules for these two groups, but some adults with disabilities with too much income to qualify through the Medicaid disability pathway may now qualify for Medicaid through the adult expansion group (in states that have adopted the expansion).

In FY 2010, 14% of all Medicaid beneficiaries – over 9 million – were "dual eligible" seniors and younger persons with disabilities who are covered by Medicare as well. One of every five Medicare beneficiaries is a dual eligible. Dual eligible beneficiaries are very poor and many have high health and long-term care needs. Medicaid assists them with their Medicare premiums and cost-sharing, and covers full Medicaid benefits for a large majority of them – most importantly, long-term services and supports, for which Medicare benefits are very limited.

Key ACA reforms. The ACA fundamentally reformed Medicaid by establishing eligibility for nonelderly adults, and also by putting in place a uniform, national minimum income eligibility threshold of 138% FPL for nearly all individuals under age 65. The effect of these changes was to establish Medicaid as the coverage pathway for low-income people in the ACA's broader system for covering the uninsured. As noted earlier, although the Medicaid expansion was intended to be national, the Supreme Court ruling essentially made it optional for states. To date, 28 states (including DC) have adopted the expansion and 7 states are discussing it, while 16 states are not adopting the expansion at this time (Figure 3). Between the period leading up to the first ACA open enrollment period in October 2013, and October 2014, Medicaid and CHIP enrollment increased by approximately 9.7 million individuals reporting data for both periods.[6]

Figure 3

Status of Medicaid Expansion Decisions, December 17, 2014

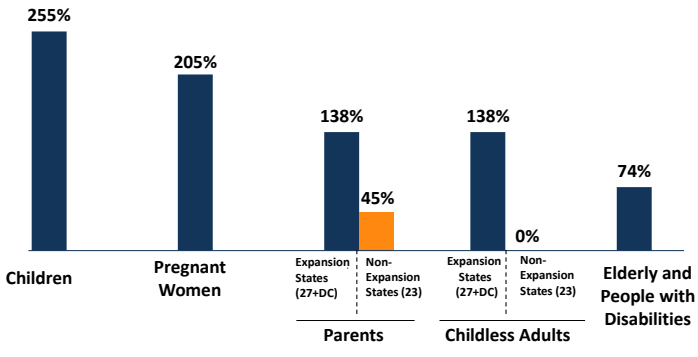


NOTES: "Under discussion" indicates executive activity supporting adoption of the Medicaid expansion. *AR, IA, MI, and PA have approved Section 1115 waivers; IN has a pending waiver to implement the expansion. The PA waiver is set to go into effect on January 1, 2015, but the newly-elected governor may opt for a state plan amendment. NH has submitted a waiver to continue its Medicaid expansion via premium assistance. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

States' Medicaid expansion decisions have major implications for low-income adults. Whereas the expansion states provide Medicaid for adults up to 138% FPL, as of January 2015, the median Medicaid income limit for parents in the non-expansion states is just 45% FPL (about $10,732 for a family of four), and in nearly all of the non-expansion states, childless adults remain ineligible for Medicaid (Figure 4).[7] While Medicaid and CHIP enrollment rose by nearly 17% nationally between October 2013 and October 2014, the increase was 24% in the Medicaid expansion states, compared to 7% in the non-expansion states.[8] Because the ACA

Figure 4

Median Medicaid/CHIP Eligibility Thresholds as a Percent of the Federal Poverty Level, January 2015



NOTE: Thresholds reflect the standard 5 percentage-point income disregard for all groups except the elderly and people with disabilities.
SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2015. Data for elderly and people with disabilities from March 2014 MACPAC Report to Congress, Table 11.

provided Medicaid eligibility for low-income adults, it did not provide financial assistance to purchase Marketplace coverage for those below 100% FPL. As a result, in the states not adopting the Medicaid expansion, nearly 4 million uninsured poor adults fall into a "coverage gap."[9]

The ACA protected the gains in children's coverage that have been achieved over time in Medicaid and CHIP. The national Medicaid minimum income eligibility threshold of 138% FPL applies to all children up to age 19, and the law requires states to maintain the eligibility limits they had in place when the ACA was enacted (at a minimum), through September 30, 2019. Also, as of 2014, states must provide Medicaid coverage for children aging out of foster care, up to age 26. Finally, the ACA extends CHIP funding through 2015, and provides for a 23 percentage-point increase in the federal matching rates under CHIP during the period FY 2016-2019 if the Congress extends CHIP funding beyond 2015.[10]

What services does Medicaid cover?

Medicaid covers a wide range of services to meet the diverse needs of the populations it serves. Medicaid benefits include both acute care services and a broad array of long-term services and supports that Medicare and most private insurance plans exclude or tightly limit. States have flexibility to charge limited premiums and cost-sharing in Medicaid, subject to federal parameters. Premiums are generally prohibited for beneficiaries with income below 150% FPL. Cost-sharing for people with income below 100% FPL is limited to "nominal" amounts specified in federal regulations, with higher levels allowed for beneficiaries at higher income levels. However, certain groups are exempt from cost-sharing, including mandatory eligible children, pregnant women, most children and adults with disabilities, people residing in institutions, and people receiving hospice care. In addition, certain services are exempt from cost-sharing: emergency services, preventive services for children, pregnancy-related services, and family planning services. Total Medicaid premiums and cost-sharing for a family cannot exceed 5% of the family's income on a quarterly or monthly basis.[11]

States are required by federal law to cover specified "mandatory" services in Medicaid, and they can also elect to cover many services designated as "optional" (Figure 5); these benefits apply to adults eligible for Medicaid under pre-ACA eligibility rules. Many states choose to cover prescription drugs (all states), dental care, durable medical equipment, and personal care services. The Medicaid benefit package for children, known as EPSDT (Early and Periodic Screening, Diagnosis, and Treatment), is uniquely comprehensive, addressing children's developmental as well as health care needs, and includes many services that are critical for children with special health care needs. Under EPSDT, children up to age 21 are entitled to all medically necessary Medicaid services, including optional services, even if the state does not cover them for adults.

Figure 5

Medicaid Benefits: Mandatory and Selected Optional Services

Mandatory services	Selected optional services
• Inpatient and outpatient hospital services; • Physician, midwife, and nurse practitioner services; • Early and periodic screening, diagnosis, and treatment (EPSDT) for children up to age 21; • Laboratory and x-ray services; • Family planning services and supplies; • Federally qualified health center (FQHC) and rural health clinic (RHC) services; • Freestanding birth center services (added by ACA); • Nursing facility (NF) services for individuals age 21+; • Home health services for individuals entitled to NF care; • Tobacco cessation counseling and pharmaco-therapy for pregnant women (added by ACA); and • Non-emergency transportation to medical care	• Prescription drugs • Dental care • Durable medical equipment • Personal care services • Home and community-based services (HCBS)

NOTE: Enrollees eligible for Medicaid prior to ACA expansions receive "mandatory" services. Many states also choose to cover services that federal law designates as "optional" for adults, including some of the services listed above.

In addition to the mandatory NF and home health benefits, which are mandatory long-term care services, states also cover many optional home and community-based services (HCBS).[12] HCBS include targeted case management, personal care services, family and caregiver training and support; rehabilitative services, housing coordination to help individuals locate and obtain community housing; and a diversity of other services. Medicaid is the main payer for institutional and community-based long-term care in the U.S., financing 40% of total spending in this area.[13]

Until relatively recently, federal law generally required states to provide the same benefits to all Medicaid beneficiaries statewide. Legislation enacted in 2006 gave states limited flexibility to provide "benchmark" benefits to some Medicaid beneficiaries based on one of three commercial insurance plans specified in the law or a benefit package determined appropriate by the HHS Secretary. However, few states actually used the benchmark authority. States also have authority to use Medicaid dollars to pay premiums for job-based health insurance for Medicaid beneficiaries who are offered it, an approach known as "premium assistance." States must generally provide wrap-around services and cost-sharing protection to fill in any gaps between the private coverage and Medicaid.

Key ACA reforms. Under the ACA, most adults in the new Medicaid expansion group receive "Alternative Benefit Plans" (ABPs), which is the new term for the Medicaid benchmark options just mentioned. Medicaid ABPs must include the same ten essential health benefit (EHB) categories that Marketplace plans under the ACA must include. In addition, ABPs must provide parity between physical and mental health/substance use disorder benefits, offer the full range of EHB preventive services, and cover family planning services and supplies, FQHC and RHC services, and non-emergency medical transportation. Compared to traditional Medicaid benefits for adults, ABPs based on commercial insurance products may provide broader coverage of some services (e.g., behavioral health care, preventive care) and narrower coverage of other services (e.g., prescription drugs, long-term services).[14] All but a few states have aligned their ABP with their traditional Medicaid benefit package for adults. Certain populations must have access to all Medicaid state plan benefits, even if they are eligible for Medicaid through the new adult expansion group. They include individuals who are medically frail or have special medical needs, including people with disabling mental health disorders and complex medical conditions, dual eligible beneficiaries, and specified other beneficiary groups.

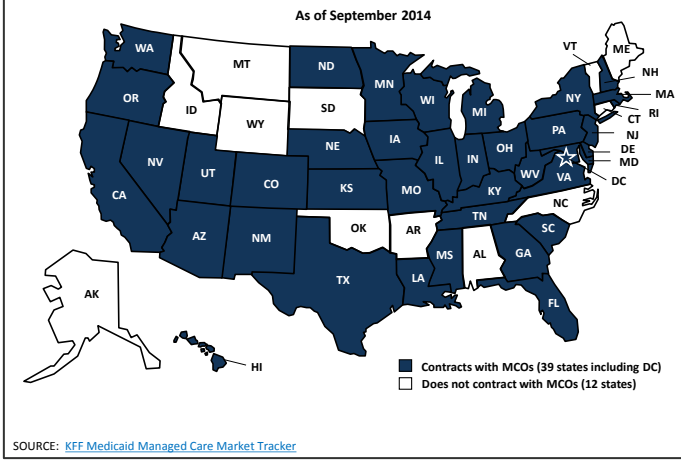
Revised regulations on Medicaid premiums and cost-sharing establish a uniform maximum copayment amount of $4 for outpatient services and $75 per inpatient admission for those with income below 100% FPL. States can charge these individuals up to $8 for non-preferred drugs and non-emergency use of the emergency department; as before, they can charge higher cost-sharing for beneficiaries with income above 100% FPL.[15] The prohibition against premiums for those at or below 150% FPL, the exemptions mentioned earlier, and the 5% aggregate cap on premiums and cost-sharing remain in place.

How do Medicaid beneficiaries get care?

Most Medicaid beneficiaries obtain their care from private office-based physicians and other health professionals. Safety-net health centers and hospitals also play a major role in serving the Medicaid population. Thirty-nine states now contract with comprehensive managed care organizations (MCOs) to serve at least some Medicaid beneficiaries, and nationally, over half of all Medicaid beneficiaries – primarily, children and parents – get their care through these plans (Figure 6). States pay the MCOs a monthly premium for each enrolled Medicaid beneficiary. States are relying increasingly on MCOs, expanding managed care to include higher-need Medicaid populations, such as people with disabilities and dual eligible beneficiaries, as well as Medicaid expansion adults. States are also adopting managed long-term services and supports. Many Medicaid beneficiaries who are not in risk-based MCOs are enrolled in Primary Care Case Management (PCCM) programs, in which states continue to pay providers on fee-for-service basis but also pay primary care providers an additional small monthly fee to coordinate care for their Medicaid patients. Both risk-based managed care and PCCM programs can be understood, in part, as vehicles for establishing networks of participating providers and garnering greater access to care for Medicaid beneficiaries.

Figure 6

States Contracting with Comprehensive Medicaid Managed Care Organizations (MCOs)



SOURCE: KFF Medicaid Managed Care Market Tracker

On the long-term care front, states have been working over the last several decades to rebalance their programs by devoting more of their long-term care spending to HCBS rather than institutional care. While the majority of Medicaid long-term care spending still goes toward institutional care, the share spent on HCBS continues to grow. In FY 2011, HCBS accounted for 45% of total Medicaid long-term care spending, up from 32% in FY 2002.[16]

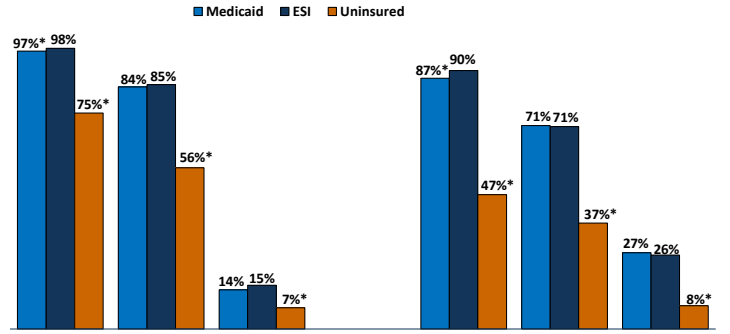
Key ACA reforms. The ACA includes many investments, funding opportunities, demonstration programs, and new authorities designed to drive health care delivery and payment system reforms in Medicaid and other public insurance programs. These provisions have accelerated ongoing innovation in Medicaid programs, including implementation of models like patient-centered medical homes and accountable care organizations (ACOs) that involve a more central role for preventive and primary care, increased care coordination for beneficiaries with complex needs, and financial incentives linked to performance. States are combining and integrating these approaches in different ways with their underlying delivery and payment systems in Medicaid. The ACA also provides states with expanded options and enhanced federal financing to improve access to and delivery of Medicaid long-term services and supports, and to incentivize states to devote a greater share of their long-term care spending to HCBS. Nearly every state has adopted at least one of six key Medicaid LTSS options contained in the ACA, with many states pursuing multiple options.[17]

How is access to care in Medicaid?

Medicaid beneficiaries fare much better than the uninsured on key measures of access to care, utilization, unmet need, and financial protection. The vast majority of Medicaid beneficiaries have a usual source of care, compared to sizeable shares of the uninsured who do not, and they are significantly more likely to see a doctor (Figure 7). Medicaid also lowers financial barriers to care and limits out-of-pocket costs, and Medicaid beneficiaries are much less likely than the uninsured to report unmet health care needs.[18] [19] [20]

Figure 7

Access to Care by Health Insurance Status, 2013



NOTES: Access measures reflect experience in past 12 months. Respondents who said usual source of care was the emergency room are not counted as having a usual source of care. *Difference from ESI is statistically significant (p<.05)
SOURCE: KCMU analysis of 2014 NHIS data.

Comparisons between Medicaid and private insurance are also informative. Research based on national surveys shows that both children and adults in Medicaid have access to and use primary and preventive care at rates comparable to their counterparts with employer-sponsored insurance (ESI). When demographic, health status, and socioeconomic differences between the two insured populations are controlled, the shares with a usual source of care are similar, as are the shares with any office or doctor visit, and the shares with any specialist visit.[21] Likewise, controlling for these differences, the percentages of children with unmet needs for medical care, dental care, or prescription drugs due to cost are comparable between the two insured groups (and low); among adults, rates of unmet needs due to cost are lower for those with Medicaid, although unmet needs due to non-financial barriers, like transportation, are higher for Medicaid adults.

Although analyses of survey data show quite robust access to care in Medicaid,[22] other research highlights important challenges and gaps. Physician participation is more limited in Medicaid than in Medicare or private insurance.[23] Physicians' lower participation in Medicaid is often attributed to low payment rates in Medicaid, although evidence on the impact of fees on participation is mixed.[24] Low participation of psychiatrists in Medicaid and shortages of substance abuse treatment professionals[25] are a particular concern because of the high prevalence of behavioral health conditions among Medicaid beneficiaries; for beneficiaries with physical and behavioral health comorbidities, lack of access to behavioral health care can adversely affect management of their physical chronic conditions as well. Dentist participation in Medicaid is also low, but children with Medicaid are on par with privately insured children in terms of dental care (overall, use of dental care for children falls well below recommended levels). Adult access to dental care in Medicaid is a more significant problem. Coverage of adult dental services is optional in Medicaid and many states only cover care for pain relief or emergency dental care for injuries, trauma, or extractions; many also impose tight dollar caps on adult dental benefits.[26]

According to a 2012 report by the General Accountability Office, 38 states reported that they experienced challenges securing sufficient provider participation in Medicaid, with the leading reasons being overall

provider shortages and low Medicaid payment rates.[27] "Secret shopper" studies indicate more limited availability of new patient appointments for Medicaid beneficiaries compared to privately insured people.[28] As managed care expands, provider payment rates are increasingly a matter of MCO policy rather than states' Medicaid fee schedules and MCOs are responsible for establishing provider networks that are adequate to meet the needs of their enrollees. State and federal enforcement of network adequacy standards is essential to ensure that Medicaid managed care enrollees have robust access to care. Two recent reports by the HHS Office of Inspector General highlight significant shortcomings in oversight, including limited state enforcement actions against MCO violation of access standards and widespread inaccuracies in Medicaid provider directories.[29] Finally, Medicaid beneficiaries face other barriers to access, including limited access to after-hours care and lack of transportation.

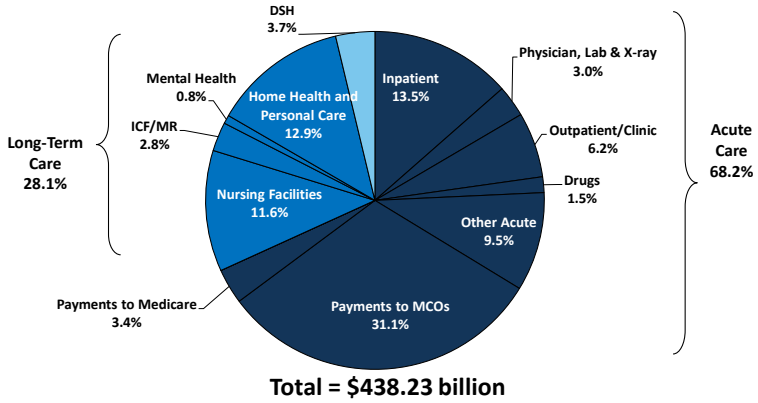
Key ACA reforms. The ACA made a number of major investments to expand access to care in Medicaid as enrollment in the program grows. For 2013 and 2014, the law raised Medicaid fees for most primary care physician services to Medicare fee levels, providing full federal financing for the increase. As a result, Medicaid fees for the affected services rose by an average of 73% overall. About 15 states plan to extend the increase in 2015, at least in part, at their regular matching rate. However, in the other states, Medicaid fee-for-service rates will revert to state-set levels. The ACA also funded a vast expansion of community health centers and the National Health Service Corps, which supplies many of the physicians and other health professionals who staff them and provide care in underserved areas. As a result of these investments, along with the Medicaid expansion, which new revenues to health centers for many previously uninsured patients, health centers have been able to open many new sites, provide more comprehensive primary care services, including dental care and behavioral health services, and serve an increasing number of patients, who now number over 21 million.

How much does Medicaid cost and how is it financed?

In FY 2013, Medicaid spending on services totaled almost $440 billion. About two-thirds of all spending was attributable to acute care and more than one-quarter was associated with long-term care (Figure 8). Supplemental payments to hospitals that serve a disproportionate share of Medicaid and uninsured patients, known as "DSH," accounted for 3.7% of spending, and Medicaid spending for Medicare premiums and cost-sharing on behalf of dual eligible beneficiaries totaled 3.4%. As mentioned earlier (Figure 2), almost two-thirds of all Medicaid spending for services is attributable to the elderly and persons with disabilities, who make up just one-quarter of all Medicaid enrollees. Dual eligible beneficiaries alone account for almost 40% of all spending, driven largely by spending for long-term care. The 5% of Medicaid beneficiaries with the highest costs drive nearly half of all Medicaid spending (Figure 9). Their high costs are attributable to their extensive needs for acute care, long-term care, or often both.

Figure 8

Medicaid Expenditures by Service, with DSH Payments and Payments to Medicare, FY 2013

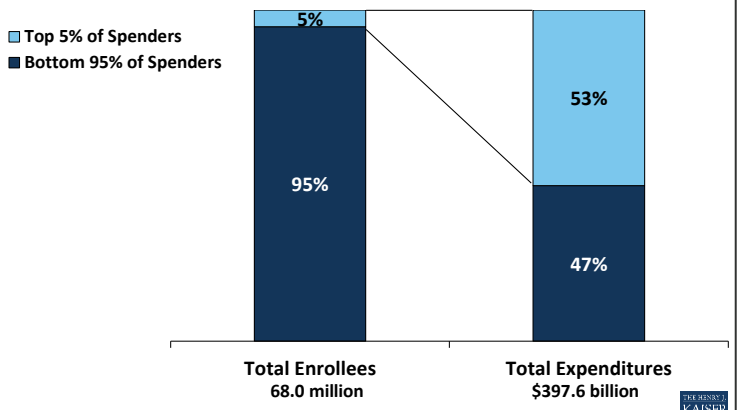


NOTE: Excludes administrative spending, adjustments and payments to the territories.
SOURCE: Urban Institute estimates based on FY 2013 data from CMS (Form 64), prepared for the Kaiser Commission on Medicaid and the Uninsured.

Medicaid spending is driven by multiple factors, including the number and mix of enrollees, medical cost inflation, utilization, and state policy choices about benefits, provider payment rates, and other program factors. During economic downturns, enrollment in Medicaid grows, increasing state Medicaid costs at the same time that state tax revenues are declining. States under recessionary pressures have frequently sought to constrain Medicaid spending through actions such as cutting provider payment rates or reducing benefits.

Figure 9

Distribution of Medicaid Expenditures: Top 5% of Spenders Account for More than Half of Total Spending



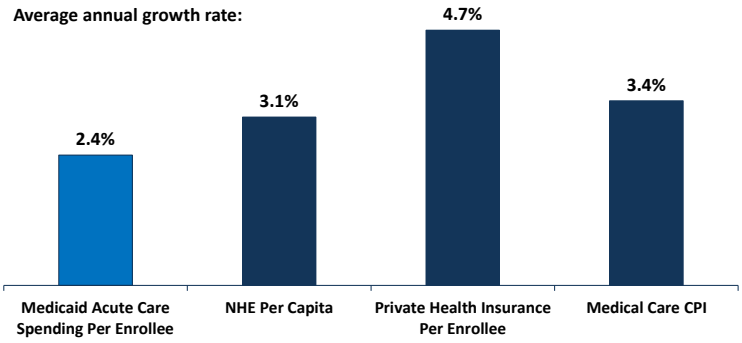
SOURCE: KCMU/Urban Institute estimates based on data from FY 2011 MSIS and CMS-64. MSIS FY 2010 data were used for FL, KS, ME, MD, MT, NM, NJ, OK, TX, and UT, but adjusted to 2011 CMS-64.

Increasingly, states are undertaking more fundamental transformation of their Medicaid payment and delivery systems both to control costs and to improve care, particularly for high-cost populations. Over the period FY 2007-2012, average annual growth in Medicaid spending for acute care services was 5.6%, but on a per-enrollee basis, the rate was 2.4% – less than the rate of growth in both national health expenditures per capita and private health insurance premiums, and less than medical cost inflation (Figure 10).[30]

States and the federal government share the cost of Medicaid. The federal government matches state Medicaid spending at least dollar for dollar for beneficiaries eligible for Medicaid under pre-ACA law. The federal match rate, known as the Federal Medical Assistance Percentage, or FMAP, varies based on state per capita income according to a formula specified in federal statute. The FMAP for FY 2015, which began October 1, 2014, ranges from the federal floor of 50%, to 73.6% in Mississippi, the poorest state today.[31] In 2012, the most recent year for which data are available, the federal share of total national Medicaid spending was about 57%.[32]

Figure 10

Growth in Per-Enrollee Medicaid Spending on Services vs. Other Health Spending Benchmarks, FY 2007-2012



NOTE: Medicaid acute care spending includes payments to managed care organizations. NHE means National Health Expenditures. CPI means Consumer Price Index.
SOURCE: Medicaid estimates from Urban Institute analysis of data from the Medicaid Statistical Information System (MSIS), Medicaid Financial Management Reports (CMS Form 64), and Kaiser Commission and Health Management Associates data. NHE and private health insurance data from Centers for Medicare & Medicaid Services Office of the Actuary, National Health Statistics Group. Medical care CPI from the Bureau of Labor Statistics, Consumer Price Index Detail Report Tables.

Key ACA reforms. The expansion of Medicaid in the states that have implemented it, and greater participation in Medicaid nationwide due to increased outreach and simplified eligibility and enrollment processes, is leading, as intended, to growing enrollment in Medicaid and, in turn, to higher total Medicaid spending. The federal government finances the vast majority of the new costs associated with the Medicaid expansion to adults – the federal match for newly eligible adults is 100% through 2016, and phases down gradually to 90%. In addition, the ACA provides enhanced federal financing for a multitude of investments that all states can make, including, for example, the creation of health home programs for Medicaid beneficiaries with chronic conditions, options to expand HCBS, and improvements in Medicaid data systems.

All states, including those not expanding Medicaid, are seeing increased Medicaid costs because of increased participation in Medicaid among people who are eligible under pre-ACA rules. States receive their regular federal match for these beneficiaries. States expanding Medicaid will pay a small share of the cost for the expansion adults beginning in 2017, reaching a maximum of 10% in 2020. However, many of these states expect offsets or net savings due to reduced state spending for uncompensated care and state-funded mental health and other programs, broader economic effects of the Medicaid expansion, such as job growth, increased income and state tax revenues, and other impacts. States that are not expanding Medicaid are forgoing substantial federal funding for expanded coverage of their low-income residents.

Looking Ahead

Already an integral source of coverage and access for low-income Americans, including many individuals with complex health and long-term care needs, Medicaid's role is growing further as the expansion to low-income adults and other key Medicaid reforms take hold. It will be important to track and assess how the program evolves under the ACA, and as Medicaid innovation at the state, health plan, and provider level advances and spreads. The unprecedented transformation and experimentation now underway in Medicaid provide an opportunity to identify successful enrollment and retention systems, strategies to ensure access to care, effective models of person-centered and coordinated care, and payment systems that align financial incentives with goals for quality and cost. Progress in all these areas can further strengthen the Medicaid program and benefit the millions of people it serves.

[1] The health reform law also provided for new health insurance Marketplaces and premium subsidies for individuals with income between 100% and 400% FPL.

[2] Vernon Smith et al., *Medicaid Enrollment: June 2013 Data Snapshot* and *CHIP Enrollment: June 2013 Data Snapshot* (Kaiser Family Foundation, January 2014), http://kff.org/medicaid/issue-brief/medicaid-enrollment-june-2013-data-snapshot/ and http://kff.org/medicaid/issue-brief/chip-enrollment-june-2013-data-snapshot/

[3] *Where Are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults as of January 1, 2014* (Kaiser Family Foundation, January 2014), http://kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/

[4] States that elect the "209(b)" option are permitted to use financial eligibility standards that are more restrictive than federal SSI rules. However, these states must allow SSI beneficiaries to establish Medicaid eligibility through a "spend-down" by deducting their out-of-pocket medical expenses from their income. See http://kff.org/health-reform/issue-brief/the-affordable-care-acts-impact-on-medicaid-eligibility-enrollment-and-benefits-for-people-with-disabilities/ for a more detailed discussion.

[5] *March 2014 Report to the Congress on Medicaid and CHIP* (Medicaid and CHIP Payment and Access Commission (MACPAC), March 2014). See Table 11.

[6] *Medicaid & CHIP: October 2014 Monthly Applications, Eligibility Determinations and Enrollment Report*, CMS, December 18, 2014, http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/october-2014-enrollment-report.pdf

[7] Of the states not moving forward with the expansion, only Wisconsin provides full Medicaid coverage to adults without dependent children as of 2014.

[8] Op.cit. CMS.

[9] Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update* (Kasier Family Foundation, November 2014), http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/

[10] Robin Rudowitz et al., *Children's Health Coverage: Medicaid, CHIP and the ACA* (Kaiser Family Foundation, March 2013), http://kff.org/health-reform/issue-brief/childrens-health-coverage-medicaid-chip-and-the-aca/

[11] *Medicaid: A Primer* (Kaiser Family Foundation, March 2013), http://kff.org/medicaid/issue-brief/medicaid-a-primer/

[12] *Medicaid Home and Community-Based Services Programs: 2010 Data Update* (Kaiser Family Foundation, March 2014), http://kff.org/medicaid/report/medicaid-home-and-community-based-service-programs/

[13] KCMU estimates based on 2012 CMS National Health Expenditure Accounts data, available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html

[14] MaryBeth Musumeci, Julia Paradise, Erica Reaves, Henry Claypool, *Benefits and Cost-Sharing for Working People with Disabilities in Medicaid and the Marketplace* (Kaiser Family Foundation, October 2014), http://kff.org/report-section/benefits-and-cost-sharing-for-working-people-with-disabilities-in-medicaid-and-the-marketplace-key-themes-8644/

[15] Federal Register, Volume 78, Number 135, July 15, 2013, http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/html/2013-16271.htm

[16] KCMU and Urban Institute analysis of Centers for Medicare & Medicaid Services (CMS)-64 data.

[17] Molly O'Malley Watts et al., *How is the Affordable Care Act Leading to Changes in Medicaid Long-Term Services and Supports (LTSS) Today? State Adoption of Six LTSS Options* (Kaiser Family Foundation, April 2013), http://kff.org/medicaid/issue-brief/how-is-the-affordable-care-act-leading-to-changes-in-medicaid-long-term-services-and-supports-ltss-today-state-adoption-of-six-ltss-options/

[18] Genevieve Kenney and Christine Coyer, *National Findings on Access to Health Care and Service Use for Children Enrolled in Medicaid,* MACPAC Contractor Report No. 1, March 2012.

[19] Sharon Long et al., *National Findings on Access to Health Care and Service Use for Non-elderly Adults Enrolled in Medicaid,* MACPAC Contractor Report No. 2, June 2012, http://www.urban.org/publications/1001623.html

[20] Teresa A. Coughlin et al., *What Difference Does Medicaid Make?* (Kaiser Family Foundation, May 2013), http://kff.org/medicaid/issue-brief/what-difference-does-medicaid-make-assessing-cost-effectiveness-access-and-financial-protection-under-medicaid-for-low-income-adults/

[21] Coughlin et al., Kenney and Coyer, and Long et al., op. cit.

[22] Genevieve M. Kenney, Brendan Saloner, Nathaniel Anderson, Daniel Polsky, and Karin Rhodes, *Access to Care for Low-Income Medicaid and Privately Insured Adults in 2012 in the National Health Interview Survey: A Context for Findings from a New Audit Study,* Urban Institute, April 2014, http://www.urban.org/publications/413089.html

[23] Sandra L. Decker, "Two-Thirds of Primary Care Physicians Accepted New Medicaid Patients In 2011–12: A Baseline To Measure Future Acceptance Rates," *Health Affairs* 32(7), July 2013, http://content.healthaffairs.org/content/32/7/1183.abstract; Andrew Bindman, Andrew Chu, and Kevin Grumbach. *Physician Participation in Medi-Cal, 2008,* California Healthcare Foundation, July 2010, http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20PhysicianParticipationMediCal2008.pdf; Peter

Cunningham and Jessica May, *Medicaid Patients Increasingly Concentrated Among Physicians*, Tracking Report No. 16, August 2006, http://www.hschange.com/CONTENT/866/

[24] Stephen Zuckerman, Aimee F. Williams and Karen E. Stockley, "Trends In Medicaid Physician Fees, 2003–2008," *Health Affairs* 28(3), May/June 2009, http://content.healthaffairs.org/content/28/3/w510.full#ref-26

[25] *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issue,* Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, January 24, 2013, http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf

[26] *Medicaid Benefits: Dental Services* (Kaiser Family Foundation), http://kff.org/medicaid/state-indicator/dental-services/

[27] *Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance*, General Accountability Office, November 2012, http://www.gao.gov/products/GAO-13-55

[28] Karin Rhodes, Genevieve Kenney, A Friedman et al., "Primary Care Access for New Patients on the Eve of Health Refrom," JAMA Internal Medicine 2014: Online First, https://archinte.jamanetwork.com/article.aspx?articleid=1857092; Joanna Bisgaier and Karin Rhodes, "Auditing Access to Specialty Care for Children with Public Insurance," *New England Journal of Medicine*, June 16, 2011, http://www.nejm.org/doi/full/10.1056/NEJMsa1013285

[29] *State Standards for Access to Care in Medicaid Managed Care*, Office of Inspector General, U.S. Department of Health and Human Services, September 2014, http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf; Access to Care: Provider Availability in Medicaid Managed Care, Office of Inspector General, U.S. Department of Health and Human Services, December 2014, http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf

[30] Rachel Garfield and Katherine Young, *Enrollment-Driven Expenditure Growth: Medicaid Spending During the Economic Downturn, FY 2007-2011* (Kaiser Family Foundation, April 2013), http://kff.org/medicaid/report/enrollment-driven-expenditure-growth-medicaid-spending-during/

[31] *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*, http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/ (FY 2015).

[32] *Federal and State Share of Medicaid Spending*, http://kff.org/medicaid/state-indicator/federalstate-share-of-spending/

By Kelly Krinn, Pinar Karaca-Mandic, and Lynn A. Blewett

State-Based Marketplaces Using 'Clearinghouse' Plan Management Models Are Associated With Lower Premiums

DOI: 10.1377/hlthaff.2014.0627
HEALTH AFFAIRS 34,
NO. 1 (2015): –

ABSTRACT The state-based and federally facilitated health insurance Marketplaces, or exchanges, enrolled more than eight million people during the first open enrollment period, which ended March 31, 2014. There is significant variation in how states have designed and implemented their Marketplaces. We examined how premiums varied with states' involvement in the Marketplaces through governance, plan management authority, and strategy during the first year that the exchanges have been open. State-based Marketplaces using "clearinghouse" plan management models had significantly lower adjusted average premiums for all plans within each metal level compared to state-based Marketplaces using "active purchaser" models and the federally facilitated and partnership Marketplaces. Clearinghouse management models are those in which all health plans that meet published criteria are accepted. Active purchaser models are those in which states negotiate premiums, provider networks, number of plans, and benefits. Our baseline estimates provide valuable benchmarks for evaluating future performance of states' involvement in governance, plan management, and regulatory authority of the insurance Marketplaces.

Kelly Krinn is a recent graduate of the master of public policy program at the Humphrey School of Public Affairs, University of Minnesota, in Minneapolis.

Pinar Karaca-Mandic (pkmandic@umn.edu) is an associate professor in the Health Policy and Management Division, School of Public Health, University of Minnesota.

Lynn A. Blewett is a professor in the Health Policy and Management Division, School of Public Health, University of Minnesota.

The Affordable Care Act (ACA) includes many provisions designed to make health insurance coverage more accessible and affordable. The health insurance Marketplaces, or exchanges, are a hallmark of the ACA and enrolled more than eight million people in private, qualified health plans during the first open enrollment period, October 1, 2013, to March 31, 2014.[1]

There is significant variation in how states have designed and implemented their Marketplaces. Some have developed their own state-based approaches; others have developed partnerships with the federal government; and still others have opted for a federally facilitated Marketplace, in which the Department of Health and Human Services (HHS) runs the exchange for them. When a state runs its own Marketplace, it is required to establish a governance body to manage the exchange, create an online portal for consumers, formulate a method of raising revenue to fund the exchange in the future, and encourage enrollment through a marketing campaign and customer assistance. Sixteen states and the District of Columbia have chosen to develop their own state-based Marketplaces; seven states have chosen to create state-federal partnership Marketplaces; and twenty-seven states have chosen or defaulted to HHS to implement their Marketplaces either as a federally facilitated exchange with the state conducting plan management (eight states) or with the federal government conducting plan management (nineteen states) (Exhibit 1). Plan management for the Marketplaces involves approving quali-

EXHIBIT 1

State Marketplace Models, By Governance, Plan Management Authority, And Plan Management Strategy, 2014

Marketplace model	Plan management authority	Plan management strategy	States
STATE-BASED			
State-based Marketplaces, active purchaser model	State operates all core Marketplace operations	Active purchaser	CA, CT, KY, MD, MA, NV, NY, OR, RI, VT[a]
State-based Marketplaces, clearinghouse model	State operates all core Marketplace operations	Clearinghouse	CO, DC, ID, HI, MN, NM, WA[b]
STATE-FEDERAL PARTNERSHIP			
State-federal partnership Marketplaces	State conducts plan management on behalf of federal government, federal government operates remaining core Marketplace functions	Clearinghouse	AR, DE, IL, IA, MI, NH, WV[c]
FEDERALLY FACILITATED			
Federally facilitated Marketplaces with state conducting plan management authority	State conducts plan management on behalf of federal government, federal government operates remaining core Marketplace functions	Clearinghouse	KS, ME, MT, NE, OH, SD, UT, VA[d]
Federally facilitated Marketplaces	Federal government operates all core Marketplace operations	Clearinghouse	AL, AK, AZ, FL, GA, IN, LA, MS, MO, NJ, NC, ND, OK, PA, SC, TN, TX, WI, WY[e]

SOURCES Dash et al. Health policy brief: health insurance exchanges and state decisions (see Note 4 in text); and Commonwealth Fund. Health insurance marketplaces (see Note 5 in text). [a]67 rating areas. [b]39 rating areas. [c]56 rating areas. [d]58 rating areas. [e]281 rating areas.

fied health plans and being proactive in contracting with plans in regard to quality targets and premium rates. In all state-based and state-federal partnership Marketplaces, states assume plan management authority.

State-based Marketplaces differ in their approaches to plan management. Six states and the District of Columbia have chosen the "clearinghouse" model of management, in which all health plans that meet published criteria are accepted into the Marketplace. Ten states have chosen the "active purchasing" model, in which they can directly negotiate premiums, provider networks, and number and benefits of plans sold in the Marketplace, or can contract with a select group of health plans.[2]

States adopting an active purchaser model can be more selective about number and characteristics of plans compared to states employing a clearinghouse model, using their contracting in an attempt to add value for consumers. For example, California's active purchasing model requires insurers to offer a plan in all tiers of each of four metal levels—bronze, silver, gold, and platinum—and makes Marketplace participation a requirement in order to sell catastrophic plans in the exchange.[3] All federally facilitated and state-federal partnership Marketplaces use the clearinghouse model.

These variations in how states implement and regulate their Marketplaces raise several important questions: Did plan premiums vary across state-based, state-federal partnership, and federally facilitated Marketplace governance models? Did premiums in state-based Marketplaces using active purchaser models differ from those using clearinghouse models? Did premiums in federally facilitated Marketplaces with states performing plan management differ from those with federal plan management authority?

This study provides the first look at assessing the premium differences across different Marketplace models, using data on premiums posted for 2014 (open enrollment period: October 1, 2013, to March 31, 2014). Consistent with previous literature,[4,5] we classified the Marketplaces into five exclusive groups (Exhibit 1): state-based Marketplaces with active purchaser plan management strategy; state-based Marketplaces using the clearinghouse plan management strategy; state-federal partnership Marketplaces; federally facilitated Marketplaces with the state conducting plan management; and federally facilitated Marketplaces with the federal government conducting plan management. We stratified our analysis by plan type (bronze, lowest-cost silver, second-lowest-cost silver, and gold),[6] and controlled for a rich set of plan characteristics and rating-area characteristics.

We found that state-based Marketplaces using clearinghouse management models had lower premiums compared to state-based Marketplaces using active purchaser models and compared to federally facilitated Marketplaces and state-federal partnership Marketplaces. We found no difference in premium levels between the state-federal partnership Marketplaces and the federally facilitated Marketplaces.

Study Data And Methods

We used information from the Henry J. Kaiser Family Foundation[5] and the Commonwealth Fund[7] to identify state policy choices regarding Marketplace governance, plan management authority, and plan management strategy.

For purposes of regulation, states divide themselves into geographic rating areas. The number of areas range from a single statewide rating area in smaller states (Rhode Island) to sixty-seven rating areas in larger states (Florida). In all, there are 501 rating areas throughout the fifty states and the District of Columbia. Insurers offering coverage in a Marketplace can decide to participate in some or all rating areas within each state. To participate in a rating area, insurers must offer at least one silver and one gold plan. These health plans must at minimum meet the ACA essential health benefits requirements.[8]

We collected data on premiums and plan characteristics (deductible, coinsurance rate, and out-of-pocket maximum) for the lowest-cost bronze, lowest-cost silver, second-lowest-cost silver, and lowest-cost gold plans for each of the 501 rating areas. We also used data from the recently released Health Insurance Exchange Compare data set, which provides premium and benefit design information on all silver plans sold in each Marketplace rating area.[9] In addition, for each rating area we collected the number of participating insurers as well as the number of bronze, silver, and gold plans offered. We supplemented these data with demographic, socioeconomic, and political characteristics for the rating area and at the state level.

OUTCOME VARIABLE: MARKETPLACE PREMIUMS We used two different data sources for premiums. First, from each state's Marketplace website we collected the lowest bronze, lowest silver, second-lowest silver, and lowest gold premiums in each rating area. For the federally facilitated and state-federal partnership Marketplaces, we collected data on similar plan premiums from HHS, state Marketplace consumer websites, and other publicly available state government documents.[10] Premiums were collected for a twenty-nine-year-old nonsmoker earning more than 400 percent of the federal poverty level (greater than $45,960) and not eligible for any premium subsidy. We chose this age to represent the young adult demographic, ages 25–34, which has the highest rates of uninsurance of any age group of US citizens.[11]

Second, from the recently released Health Insurance Exchange Compare data set, we obtained data on the premiums for all silver plans offered in any Marketplace for the fifty states and the District of Columbia.[9] These data included premium information for single nonsmokers ages twenty-seven and fifty.

EXPLANATORY VARIABLES: PLAN CHARACTERISTICS Coinsurance, deductible, and out-of-pocket maximums for the lowest-cost bronze, silver, and gold plans, as well as the second-lowest-cost silver plan, were obtained from ValuePenguin, a website that collects premium information from the Marketplaces.[12] Data on plan network size and scope were not available. We provide further details on specific data sources in online Appendix Exhibit 1.[13] From the Health Insurance Exchange Compare data set, we extracted plan-level information on insurer group (such as Blue Cross Blue Shield, Cigna, Anthem, and Coventry); medical and pharmacy deductible; out-of-pocket maximum; and, for all silver plans, whether the plan was a health maintenance organization (HMO), exclusive provider organization (EPO), point-of-service (POS) plan, or preferred provider organization (PPO).

Plans with a higher coinsurance rate and deductibles and lower out-of-pocket costs were hypothesized to have lower premiums. HMO, EPO, and POS plans were hypothesized to have lower premiums relative to PPO plans.

INSURANCE AND PROVIDER MARKET CHARACTERISTICS From the same sources of data on premiums, we also collected information on the total number of participating insurance companies in each geographic rating area, to serve as a proxy for insurer competition. Insurers that face higher competition from other insurers typically have lower premiums. Hospital market structure can also potentially influence premiums because, in general, hospitals in concentrated markets have greater leverage to negotiate reimbursements from insurers.[14,15] The most widely used measure of market concentration is the Herfindahl-Hirschman Index, calculated by the squared sum of hospital market share, which is measured by dividing the hospitals' staffed beds by the total staffed beds in the market. This measure was calculated using data from the *Dartmouth Atlas of Health Care*[16] (see Appendix Exhibit 1 for details).[13]

POPULATION CHARACTERISTICS We used the County Health Rankings 2010 for demographic, economic, and health characteristics aggregated to the geographic rating areas within states.[17] These characteristics included the unemployment rate for the working-age population (ages 18–64), uninsurance rate (ages 64 and younger, including children), median household income, population size, share of population residing in a rural (nonmetropolitan) area, age (percentage younger than 18, 18–64, and 65 and older), sex (percentage female), and racial and ethnic composition (percentage Hispanic, non-Hispanic white, non-Hispanic African

American, Asian, and other non-Hispanic) of the population.

Again, using data from County Health Rankings 2010, we included the following health indicators representing the rating areas' adult population (ages 18–64): self-reported health status (percentage fair or poor); prevalence of diabetes, obesity, and low-birthweight births; and overall per capita medical costs.[17] (See Appendix Exhibit 1 for details on data sources.)[13]

STATE REGULATORY CHARACTERISTICS In addition to rating area-level market characteristics, we included several characteristics of the state-level regulatory and insurance market environment using data from the Kaiser Family Foundation and the National Conference of State Legislatures (see Appendix Exhibit 1).[13] A state's rate review process can vary from simply monitoring premium rate increases to an active review process that requires insurers to justify premiums annually.[18] We included an indicator for whether or not a state used prior approval in its rate review strategy. We controlled for the Medicaid Fee Index, as it is an indicator of how fee-for-service reimbursement rates vary among states.[19]

We also included state-level premium data for each state's individual health insurance market before the implementation of the Marketplaces. These data are from the Manhattan Institute and represent weighted state average premium levels for 2013 based on the five lowest-cost plans in the most populous ZIP code of each county for a twenty-seven-year-old.[20]

We also included as a control variable an indicator for whether the state recommended a plan for the Marketplace to act as the essential health benefit benchmark beyond those prescribed by the ACA.[21] To cover these additional benefits, insurers may need to increase premiums in these states. Finally, we included an indicator for whether the state expanded Medicaid under the ACA expansion option.

STATISTICAL MODELS We conducted two sets of analyses. First, we examined premiums of the lowest-cost plans, by metal type (bronze, silver, and gold), as well as the second-lowest-cost silver plans in each rating area. Next, we examined premiums of all silver plans. In the first analysis, the unit of observation was the plan type (lowest-cost bronze, lowest-cost silver, second-lowest-cost silver, and lowest-cost gold) for each rating area. In the second analysis, our unit of observation included premiums for each silver plan offered in each rating area. We estimated generalized estimating equations models using gamma family distribution, with the logarithm of premiums as the dependent variable.[22] The logarithmic link function was selected based on the Box-Cox test, and gamma family was selected based on the modified Park test.[23]

An initial goal of most state-based Marketplaces was to get enough insurers to participate.

The primary independent variables of interest were indicators for the Marketplace models, as defined above. The first analysis also included indicators for plan metal type and the interaction terms of exchange types with plan metal types. All models allowed for a multivariate adjustment for the plan, insurance, provider, population, and state regulatory characteristics listed above. Because plans and rating areas are clustered within states, we allowed for standard errors to be correlated within states.

We predicted adjusted premiums for each Marketplace model and for each plan metal type (first analysis). We tested differences in adjusted premiums among the different models of Marketplaces in both analyses.

LIMITATIONS This study provides a preliminary understanding of how different Marketplace models are associated with premiums, using cross-sectional data across rating areas during the first year of ACA Marketplace implementation. The cross-sectional study design did not allow for fully controlling for systematic differences across rating areas and states. While we included a rich set of rating area-level and state-level economic, demographic, and market characteristics as control variables, future work can lessen the concern on confounding variables as new years of data from Marketplaces become available.

A related limitation is the limited ability to address how states selected their particular Marketplace models. To the extent that factors we did not observe and control for were correlated both with the model of Marketplace and the premiums, our analysis was not able to provide causal inferences. Nevertheless, presenting early evidence on premium differences by Marketplace models provides a valuable benchmark for evaluating the Marketplace performance in the future.

Another data limitation is that in the first analysis, we analyzed premiums for a specific age

group (age twenty-nine). We needed to select an age group to collect comparable data across all rating areas. Because age rating requirements under the ACA limit premium variation across age groups of like individuals to a 3:1 ratio, we believe that our findings are generalizable to other age groups. The second analysis allows for examining premiums for twenty-seven- and fifty-year-olds and provides a robustness test for the differences in premiums.

Study Results

CHARACTERISTICS OF THE RATING AREAS BY MARKETPLACE MODEL Exhibit 2 presents characteristics of the 501 rating areas by Marketplace model type. The mean number of insurers selling plans in any rating area was the highest among state-based Marketplaces (5.0 in those with an active purchaser plan management strategy and 4.5 in those using the clearinghouse model) and lowest among the federally facilitated Marketplaces (3.9 in those with the state conducting plan management and 3.2 in those with the federal government conducting plan management).

The percentage of rating areas in states with prior-approval rate-review regulation was similar among state-based Marketplaces (71.6 percent in those with an active purchaser plan management strategy and 82.1 percent in those using the clearinghouse model), state-federal partnership Marketplaces (76.8 percent), and federally facilitated Marketplaces where states conduct plan management (75.9 percent) but lower among federally facilitated Marketplaces with the federal government conducting all Marketplace functions (67.3 percent).

Rating areas also varied substantially on the number located in states that opted to expand Medicaid under the ACA expansion option. More than 80 percent of the rating areas in state-based and state-federal partnership Marketplaces were located in Medicaid expansion states, compared to 29.3 percent in federally facilitated Market-

EXHIBIT 2

Selected Characteristics Of Rating Areas, By Marketplace Model

	SBM-A (67)		SBM-C (39)		SPM (56)		FFMS (58)		FFM (281)	
Characteristic	Mean or percent	SD	Mean or percent	SD	Mean or percent	SD	Mean or percent	SD	Mean or percent	SD
RATING AREA AND STATE MARKET AND REGULATORY CHARACTERISTICS										
No. of insurers in rating area	5.0	2.5	4.5	1.4	4.1	2.7	3.9	1.5	3.2	1.8
Percent of rating areas in states with state prior rate approval	71.6%	45.4%	82.1%	38.9%	76.8%	42.6%	75.9%	43.2%	67.3%	47.0%
Percent of rating areas in states with state Medicaid expansion in 2014	100.0%	0.0%	82.1%	38.9%	98.2%	13.4%	29.3%	45.9%	4.3%	20.3%
Percent of rating areas in states where state recommended essential health benefit beyond those prescribed by ACA	100.0%	0.0%	59.0%	49.8%	67.9%	47.1%	37.9%	48.9%	11.7%	32.3%
Premiums pre-ACA, 2013	$191.9	$126.1	$157.0	$76.9	$112.6	$36.3	$145.0	$44.4	$134.2	$30.7
RATING AREA POPULATION AND HEALTH CHARACTERISTICS, 2010										
Total population	1,369,273	1,618,221	588,505	834,875	586,186	767,190	522,813	551,951	497,135	933,220
Percent living in rural area	21.0%	20.1%	32.0%	21.3%	39.8%	20.6%	36.9%	20.3%	39.1%	24.8%
Unemployment rate (16 and older)	9.9%	3.2%	8.0%	1.6%	8.7%	1.8%	7.3%	1.9%	9.7%	2.6%
Uninsured rate (18–64 year old)	15.3%	5.9%	17.2%	5.3%	15.0%	3.3%	15.8%	2.7%	20.3%	5.2%
Obesity rate (adults)	25.9%	4.2%	24.9%	4.6%	30.8%	2.8%	29.2%	2.9%	31.0%	4.5%
Diabetes rate (adults)	8.6%	1.5%	7.5%	1.6%	10.1%	1.9%	9.4%	1.6%	10.9%	2.1%
Per capita medical costs	$8,922	$1,201	$7,875	$578	$9,237	$925	$8,961	$1,014	$9,866	$1,476
Median household income	$56,658	$13,510	$50,331	$8,818	$46,388	$9,600	$47,690	$9,343	$42,937	$8,294

SOURCES County Health Rankings 2010 (see Note 17 in text); Henry J. Kaiser Family Foundation (see Note 7 in text); and National Conference of State Legislatures. For details, see online Appendix Exhibit 1 (see Note 13 in text). **NOTES** Numbers of rating areas in 2014 are in parentheses. SBM-A is state-based Marketplaces with active purchaser plan management strategy. SBM-C is state-based Marketplaces using the clearinghouse model. SPM is state-federal partnership Marketplaces. FFMS is federally facilitated Marketplaces with the state conducting plan management. FFM is federally facilitated Marketplaces with the federal government conducting plan management. SD is standard deviation. ACA is Affordable Care Act.

places with the state conducting plan management and 4.3 percent in federally facilitated Marketplaces with the federal government conducting plan management. Similarly, state-recommended essential health benefits beyond those prescribed by the ACA were much less common in rating areas with federally facilitated Marketplaces relative to state-based and state-federal partnership Marketplaces.

Baseline population demographic and health characteristics were largely similar across different Marketplace models. Rates of obesity and diabetes were slightly lower in state-based Marketplaces relative to other Marketplace models, but the difference was not statistically significant. The uninsurance rate was slightly higher in federally facilitated Marketplaces with the federal government conducting all Marketplace operations relative to all other Marketplace models.

PREMIUMS OF THE LOWEST-COST PLANS, BY METAL TYPE Exhibit 3 presents premiums for the lowest-cost bronze, lowest-cost silver, second-lowest-cost silver, and lowest-cost gold plans adjusted for the plan, insurance, provider, population, and state regulatory characteristics listed above in our multivariate models. State-based Marketplaces using a clearinghouse model had significantly lower adjusted lowest plan premiums across the board relative to all other Marketplace models.

Among the state-based Marketplaces, comparison of clearinghouse and active purchaser models allowed for examining whether premiums differed between the models. Across the board, the clearinghouse model had lower premiums than the active purchaser model (lowest-cost bronze: $157.53 versus $179.49; lowest-cost silver: $196.92 versus $225.37; second-lowest-cost silver: $205.30 versus $245.27; and lowest-cost gold: $233.96 versus $266.91).

Comparison of state-based Marketplaces using the clearinghouse model relative to state-federal partnership Marketplaces and federally facilitated Marketplaces with the state conducting plan management allowed for examining premium differences across state-based, state-federal partnership, and federally facilitated Marketplace governance authorities. In all three models, the state conducts plan management through a clearinghouse model, but Marketplaces differ in their governance authority. Across the board, state-based Marketplaces using the clearinghouse model had lower premiums relative to state-federal partnership Marketplaces or federally facilitated Marketplaces with the state conducting plan management. For example, among the lowest-cost silver plans, premiums in state-based Marketplaces using the clearinghouse model were $196.92 compared with $229.87 in state-federal partnership Marketplaces and $224.02 in federally facilitated Marketplaces with the state conducting plan management. Premiums in the latter two models did not differ significantly.

Among the federally facilitated Marketplaces, premiums were not significantly different between federally facilitated Marketplaces with the state conducting plan management and those with the federal government conducting plan management. This finding suggests that among the federally facilitated Marketplaces, whether the state or federal government conducted plan management was not associated with any significant premium differences.

Exhibit 4 presents adjusted premiums for all silver plans for a twenty-seven-year-old and a fifty-year-old. Premiums were the lowest among state-based Marketplaces with clearinghouse models ($221.64 for a twenty-seven-year-old;

EXHIBIT 3

Adjusted Lowest Premium, By Metal Level And Marketplace Model, For A Twenty-Nine-Year-Old Nonsmoker, Fifty States And The District Of Columbia, 2013 Open Enrollment Period

	Lowest-cost bronze plans		Lowest-cost silver plans		Second-lowest-cost silver plans		Lowest-cost gold plans	
Model	Mean ($)	*p* value	Mean ($)	*p* value	Mean ($)	*p* value	Mean ($)	*p* value
SBM-A	179.49	0.008	225.37	0.006	245.27	<0.001	266.91	0.007
SBM-C	**157.53**	Ref	**196.92**	Ref	**205.30**	Ref	**233.96**	Ref
SPM	182.51	0.004	229.87	0.003	242.72	0.001	272.92	0.003
FFMS	185.14	0.003	224.02	0.019	234.91	0.014	268.97	0.012
FFM	189.94	<0.001	233.16	<0.001	241.63	<0.001	277.35	<0.001

SOURCE Estimates from multivariate models. **NOTES** Significance denotes difference from SBM-C (the reference category). Boldface indicates the lowest premium in the plan metal type. All models allowed for a multivariate adjustment for plan, insurance, provider, population, and state regulatory characteristics. The 2013 open enrollment period was October 1, 2013, through March 31, 2014. SBM-A is state-based Marketplaces with active purchaser plan management strategy. SBM-C is state-based Marketplaces using the clearinghouse model. SPM is state-federal partnership Marketplaces. FFMS is federally facilitated Marketplaces with the state conducting plan management. FFM is federally facilitated Marketplaces with the federal government conducting plan management.

$380.46 for a fifty-year-old) relative to all other exchange models. The only exception was for the fifty-year-old's premiums, for which there was no significant difference between state-based Marketplaces using the active purchaser model and those using the clearinghouse model ($395.56 versus $380.46). Premiums did not differ significantly between state-federal partnership Marketplaces, federally facilitated Marketplaces with the state conducting plan management, and federally facilitated Marketplaces with the federal government conducting plan management models.

In Appendix Exhibit 2,[13] we present the association of plan, insurance market, provider market, population, and regulatory characteristics with premiums from our multivariate analyses of lowest premium plans by metal type. Plans with higher deductibles had lower premiums.

The existence of a larger number of insurers offering coverage in a rating area was associated with lower premiums. We also found that premiums were relatively higher for plans sold in areas with greater demand—that is, urban areas with populations larger than 100,000. With respect to provider market structure, we found that rating areas associated with limited hospital competition (Herfindahl-Hirschman Index greater than 2,500) were associated with higher premiums. Rating areas with higher physician fees, as measured by the Medicaid Fee Index, and those with higher pre-ACA premiums had significantly higher Marketplace premiums than areas with lower physician fees and lower pre-ACA premiums.

In our analyses of all silver plans (see Appendix Exhibit 3),[13] we found that health plans with tighter networks, such as HMOs, had lower adjusted premiums (for both twenty-seven- and fifty-year-olds) relative to EPO, POS, and PPO plans. The association between premiums and insurance and provider market structure was no longer significant. Higher pre-ACA premiums were significantly associated with higher Marketplace premiums.

EXHIBIT 4

Adjusted Silver Plan Mean Premiums (Across All Silver Plans Offered), By Marketplace Model, For Twenty-Seven-Year-Old And Fifty-Year-Old Nonsmokers, 2013 Open Enrollment Period

	Twenty-seven-year-old nonsmoker		Fifty-year-old nonsmoker	
Model	Mean ($)	*p* value	Mean ($)	*p* value
SBM-A	258.25	0.023	395.56	0.56
SBM-C	**221.64**	Ref	**380.46**	Ref
SPM	273.70	0.004	450.24	0.021
FFMS	279.63	0.003	473.79	0.005
FFM	263.79	0.012	446.62	0.020

SOURCE Estimates from multivariate models. **NOTES** Significance denotes difference from SBM-C (the reference category). Boldface indicates the lowest premium in the plan metal type. All models allowed for a multivariate adjustment for plan, insurance, provider, population, and state regulatory characteristics. The 2013 open enrollment period was October 1, 2013, through March 31, 2014. SBM-A is state-based Marketplaces with active purchaser plan management strategy. SBM-C is state-based Marketplaces using the clearinghouse model. SPM is state-federal partnership Marketplaces. FFMS is federally facilitated Marketplaces with the state conducting plan management. FFM is federally facilitated Marketplaces with the federal government conducting plan management.

Discussion

Our study provides the first look at assessing the differences in premiums across Marketplace models. Our primary finding is that in 2014, the first year of the Marketplace implementation, state-based Marketplaces using a clearinghouse model had significantly lower adjusted average premiums for all plans within each metal level when compared to state-based Marketplaces having active purchasing models and to federally facilitated and state-federal partnership Marketplaces. We did not find significant differences in average adjusted plan premiums between federally facilitated and state-federal partnership Marketplaces for all metal levels.

An initial goal of most state-based Marketplaces was to get enough insurers to participate in the exchange and to offer a variety of plans across the metal levels. Some analysts and stakeholders have argued that state-based Marketplaces using active purchasing models could be better equipped than others to keep premiums in check. Active purchasers, by definition, are more engaged than those in clearinghouses are in selecting and contracting with health insurers and negotiating premiums using price and quality metrics.[24] In addition, active purchasers may be more involved than clearinghouses are in monitoring premiums and health plan market shares. Others contend that greater engagement in Marketplace plan management will result in an increase in premiums because of increased administrative costs associated with complying with additional plan participation requirements, quality reporting, and meeting other certification criteria.[25] Moreover, as many stakeholders and brokers had suggested prior to Marketplace implementation, a clearinghouse model may allow a larger pool of insurers to enter the market, creating more competition across plans.

It may be too early for the state Marketplaces with active purchasing models to be very active or to have made a meaningful impact on premiums. Indeed, most states faced time and staffing limitations during the first year trying to get health plans to participate in and implementing

their Marketplaces. Additional years of data and analysis will provide a more comprehensive picture of the Marketplace models and their impact on premiums.

We also found that state-based Marketplaces with a clearinghouse had lower premiums compared to state-federal partnership and federally facilitated Marketplaces that also used the clearinghouse model. It could be that states' decision to set up their own Marketplaces instead of partnering with the federal government or defaulting to the federally facilitated Marketplace indicates a greater level of engagement with the Marketplace, and perhaps more political will to deal with the challenges of running an exchange. In addition, states that set up their own Marketplaces may already have the infrastructure needed to monitor premiums, enrollment, network adequacy, and other plan requirements. Moreover, state-based Marketplaces can have greater local authority to facilitate outreach and enrollment activities, leading to potential increases in enrollment and more competition for enrollees.

In our analyses of the lowest-premium plans in the rating area by metal type, we found, as expected, that higher insurer competition (a greater number of insurers offering coverage in the rating area) and higher hospital competition (lower hospital Herfindahl-Hirschman Index) are associated with lower premiums. This latter finding is consistent with the theoretical prediction that hospitals in less competitive markets can have greater leverage to negotiate larger reimbursements from insurers, resulting in higher premiums. However, the association between premiums and insurance and provider market structure was no longer significant in our analysis of all silver plans. This may be because in such analyses, we were able to control for more-detailed plan types related to plan network size and scope (HMO versus EPO, POS, and PPO plans). For example, within HMOs having a limited number of hospitals in their networks, the overall degree of hospital competition in the rating area likely does not influence hospitals' ability to negotiate higher reimbursements from insurers. In general, competition findings should be interpreted with caution, because during the first year of these Marketplaces there was substantial uncertainty about the types of people who would enroll and their expected health care costs. This uncertainty may have influenced insurers' entry decisions as well as their negotiations with providers and pricing of the health plans. As insurers learn the market and the characteristics of enrollees in future years, it will be important to monitor insurer and provider competition.

It may be too early for the state Marketplaces with active purchasing models to be very active.

Conclusion

While our findings are limited to the first year of the Marketplaces, going forward, our baseline estimates provide a valuable benchmark for evaluating performance of state involvement in governance, plan management, and regulatory authority. Evaluation of these different Marketplace models, as well as monitoring states' different strategies and activities in engaging with the Marketplaces, is an important topic for future studies. ■

The authors presented brief findings at the American Society of Health Economists Fifth Biennial Conference, Los Angeles, California, June 23–25, 2014. Pinar Karaca-Mandic acknowledges support from the National Institutes of Health, Career Grant No. K01AG036740. [*Published online December 17, 2014.*]

NOTES

1 Department of Health and Human Services. Health insurance Marketplace: summary enrollment report for the initial annual open enrollment period [Internet]. Washington (DC): HHS; 2014 May [cited 2014 Nov 6]. (ASPE Issue Brief). Available from: http://aspe.hhs.gov/health/reports/2014/marketplaceenrollment/apr2014/ib_2014apr_enrollment.pdf

2 There are distinctions and overlap in the literature when referring to "active purchasers," "market organizers," and "selective contractors" as plan management techniques. For the purposes of this study, grouping these ten states together, regardless of the minutiae, signifies a group of states that are taking a more active role in plan management compared to other states.

3 Weinberg M, Haase LW. State-based coverage solutions: the California Health Benefit Exchange [Internet]. New York (NY): New America Foundation, Commonwealth Fund; [cited 2014 Nov 6]. Available from: http://www.commonwealthfund.org/~/media/files/resources/2011/jun/weinberg_haase_cmwf-presentation-53111.pdf

4 Dash S, Monahan C, Lucia KW. Health policy brief: health insurance exchanges and state decisions [serial on the Internet]. 2013 Jul 18 [cited 2014 Nov 6]. Available from: https://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=96

5 Commonwealth Fund. Health insurance Marketplaces [Internet]. New York (NY): Commonwealth Fund; 2014 [cited 2014 Nov 6]. Available from: http://www.commonwealthfund.org/interactives-and-data/maps-and-data/state-exchange-map

6 Data did not include premiums for platinum plans because of inconsistencies in platinum offerings. Insurers are not required to offer platinum plans, and in many rating areas no platinum plans exist.

7 Henry J. Kaiser Family Foundation. State decisions for creating health insurance Marketplaces, 2014 [Internet]. Menlo Park (CA): KFF; 2014 [cited 2014 May 22]. (Page content has now been updated for 2015). Available from: http://kff.org/health-reform/state-indicator/health-insurance-exchanges/

8 National Conference of State Legislatures. State health insurance mandates and the ACA essential benefits provisions [Internet]. Washington (DC): NCSL; 2014 Mar [cited 2014 Nov 6]. Available from: http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx

9 Breakaway Policy Strategies. Health insurance exchange (HIX) compare: data on Marketplace plans from every state and District of Columbia [Internet]. Princeton (NJ): Robert Wood Johnson Foundation; 2014 May [cited 2014 Nov 6]. Available from: http://www.rwjf.org/en/research-publications/find-rwjf-research/2014/03/breakaway-policy-dataset.html

10 Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Health insurance Marketplace premiums for 2014 databook [Internet]. Washington (DC): HHS; 2013 Sep 25 [cited 2014 Nov 6]. Available from: http://aspe.hhs.gov/health/reports/2013/marketplacepremiums/datasheet_home.cfm

11 Twenty-nine years of age represents the middle of the young adult age range and an age still eligible to enroll in a catastrophic plan.

12 ValuePenguin. Affordable Care Act (Obamacare) health insurance exchanges [Internet]. New York (NY): ValuePenguin; [cited 2014 Nov 6]. Available from: http://www.valuepenguin.com/ppaca/exchanges

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

14 Gaynor M, Ho K, Town R. The industrial organization of health care markets [Internet]. Cambridge (MA): National Bureau of Economic Research; 2014 Jan [cited 2014 Nov 6]. (Working Paper No. 19800). Available from: http://www.nber.org/papers/w19800.pdf

15 Ho K, Lee RS. Insurer competition and negotiated hospital prices [Internet]. Cambridge (MA): National Bureau of Economic Research; 2013 Sep [cited 2014 Nov 6]. (Working Paper No. 19401). Available from: http://www.nber.org/papers/w19401.pdf

16 Dartmouth Atlas of Health Care. Care of chronically ill patients during the last two years of life: deaths occurring in 2010 [Internet]. Hanover (NH): Dartmouth Institute; [cited 2014 Nov 6]. Available from: http://www.dartmouthatlas.org/tools/downloads.aspx?tab=40

17 University of Wisconsin Population Health Institute. 2010 county health rankings national data [Internet]. Madison (WI): University of Wisconsin; [cited 2014 Nov 6]. Available for download from: http://www.countyhealthrankings.org/rankings/data

18 Henry J. Kaiser Family Foundation. State statutory authority to review health insurance rates, individual plans [Internet]. Menlo Park (CA): KFF; 2012 [cited 2014 Nov 6]. Available from: http://kff.org/other/state-indicator/rate-review-individual/

19 Zuckerman S, Goin D. How much will Medicaid physician fees for primary care rise in 2013? Evidence from a 2012 survey of Medicaid physician fees [Internet]. Washington (DC): Urban Institute, Kaiser Commission on Medicaid and the Uninsured; 2012 Dec 13 [cited 2014 Nov 6]. Available from: http://kff.org/medicaid/issue-brief/how-much-will-medicaid-physician-fees-for

20 Howard P, Roy A, Freyman Y. The Obamacare impact: how the health law affects the affordability of your health care [Internet]. New York (NY): Manhattan Institute for Policy Research; [cited 2014 Nov 6]. Available from: http://www.manhattaninstitute.org/knowyourrates/index.htm

21 Henry J. Kaiser Family Foundation. Essential health benefit (EHB) benchmark plans, as of January 3, 2013 [Internet]. Menlo Park (CA): KFF; 2013 [cited 2014 Nov 6]. Available from: http://kff.org/health-reform/state-indicator/ehb-benchmark-plans

22 Ballinger GA. Using generalized estimating equations for longitudinal data analysis. Organizational Research Methods. 2004;7(2):127–50.

23 Deb P, Manning W, Norton E. Modeling health care costs and counts [Internet]. Paper presented at: American Society of Health Economists—Madison Conference; 2006 Jun 4–7; Madison, WI [cited 2014 Nov 6]. Available from: http://www.unc.edu/~enorton/DebManningNortonPresentation.pdf

24 Cantor JC, Koller M, Brownlee S, Michael M, Belloff D, Hughes R. Stakeholder views about the design of health insurance exchanges for New Jersey: volume I: findings from stakeholder forum discussions and survey [Internet]. New Brunswick (NJ): Rutgers Center for State Health Policy; 2011 Aug [cited 2014 Nov 6]. Available from: http://www.cshp.rutgers.edu/Downloads/8980.pdf

25 Corlette S, Volk J. Active purchasing for health insurance exchanges: an analysis of options [Internet]. Washington (DC): National Academy of Social Insurance; 2011 Jun [cited 2014 Nov 6]. Available from: http://www.nasi.org/research/2011/active-purchasing-health-insurance-exchanges-analysis-option